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Editorial

Alcohol policy is becoming a truly global issue

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IN THE FACE OF OPPOSITION FROM alcohol-producing countries, Cuba in particular, the Swedish initiative for global action on the harmful use of alcohol in the 2007 World Health Assembly (WHA) came to nothing. The following year, however, an initiative to create an alcohol strategy – this time proposed by three African nations – resulted in a WHA resolution that requested the WHO to develop a global strategy on combating the harmful use of alcohol. The strategy was unanimously approved by the WHA in 2010. This time, too, Cuba and Sweden played an important role, but now they worked side by side as the main negotiating partners of the Executive Board finalising the amendments to the proposed strategy.

Europe has traditionally been the continent with the highest per capita alcohol consumption levels and also with a heavy burden of alcohol-related disease. And yet, in most European countries since the mid-1970s, alcohol consumption has either remained stable or has in fact declined. Until now, that is: since the turn of this century, WHO statistics show that per capita alcohol consumption has started to increase in the European region.

Alcohol consumption is also growing in many low and middle income countries outside Europe. Lower alcohol consumption in the less developed countries is partly accounted for by the large share of abstainers. Together with the large share of unrecorded, illicit or informal alcohol, this gives alcohol industry and commercial legal alcohol producers great expectations of expanding their markets in these regions. The target populations of the aggressive sales tactics also include young people.

Health advocates in low and middle income countries have expressed their concern of rising alcohol consumption levels and related harm, arguing for stricter alcohol control. The same level of consumption may cause even more adverse consequences in low than in high income countries, partly because of the more hazardous drinking patterns. The population may also be more vulnerable to the adverse effects because of environmental factors such as poor health care facili-

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ties and worse road safety conditions.

Alcohol use also increases the risk of some communicable diseases common in many low income countries, including pneumonia, tuberculosis, and HIV/AIDS. Alcohol use impacts these through health behaviour by, for example, increasing risky sexual behaviour and decreasing treatment compliance and through being an immunosuppressant. The connection between alcohol and communicable diseases is important in many developing countries, and they have taken an increased interest in alcohol policy.

Alcohol industry has a dual role in many low income countries. While alcohol products cause severe damage on the health and welfare of the population, there is no denying the central and alluring role that the alcohol industry may play in creating jobs and state revenue in countries where there is a dearth of both.

The alcohol industry has also offered its helping hand in many developing countries by formulating an overly industry-friendly and ineffective alcohol policy. The Global Strategy to reduce the harmful use of alcohol admits that economic operators are important players as developers, producers, distributors, marketers and sellers of alcoholic beverages but the strategy also states that economic operators should prevent and reduce harmful alcohol use in their core roles, not as alcohol policy makers.

The WHO strategy to reduce the harmful use of alcohol is timely. It has been followed by regional strategies in all six regional offices of the WHO, and many countries are expected to adopt national policies along these lines. In the South East Asia region of the WHO, alcohol advertising is already almost totally prohibited. The increasing interest towards alcohol policy in this region is exemplified by Thailand, which has had a very ambitious alcohol policy programme already before the WHO strategy and which last year hosted its sixth national alcohol conference with 700–800 participants.

That interest in alcohol policy has expanded is a fact. When it was published in 1994, the book *Alcohol Policy and the Public Good* was translated into eight European languages. The second edition of its successor *Alcohol: No Ordinary Commodity* came out in 2010 and has already been translated into Spanish and Thai, and is being translated into Korean. There is also an initiative to move alcohol on the United Nations agenda as a market-involved risk factor for non-communicable diseases.

We have a substantial scientific knowledge base for policy makers on the effectiveness and cost-effectiveness of strategies and interventions to prevent and reduce alcohol-related harm. The limitation of this knowledge base is that much of the research evidence comes from high income countries, which have long implemented alcohol control measures and have researchers trained to study the effectiveness and cost-effectiveness of these policies. Still, in addition to implementing alcohol control measures, developing countries are also investing in alcohol research. This was impressively demonstrated in the recent KBS Thematic Meeting in Kampala, Uganda, in November 2010 (see conference report in this issue). The creation of the *African Journal of Drugs and Alcohol Studies* in 2000 is another example of increasing research activities in Africa. We are therefore hopeful that the time

is near when we will see a nuanced and balanced picture of the effects of alcohol control measures in different settings and contexts.

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