



Challenges and Opportunities Implementing the WHO Global Strategy on Alcohol

Donald W. Zeigler, *American Medical Association*

Thomas F. Babor, *University of Connecticut School of Medicine, Farmington, CT*

Challenges and Opportunities Implementing the WHO Global Strategy on Alcohol

Donald W. Zeigler, *American Medical Association*
Thomas F. Babor, *University of Connecticut School of Medicine, Farmington, CT*

Abstract

This article draws on publications and announcements of the World Health Organization, United Nations and national governments, recent professional medical and health policy journals, and nongovernmental organizations to summarize the background and implications of recent international public health initiatives on the topic of alcohol.

KEYWORDS: WHO, alcohol, global alcohol policy, noncommunicable diseases, health impact assessments, social determinants of health

Author Notes: The core of this review that is related to the World Health Organization's Global Alcohol Strategy is based on a summary of the policy presented by an expert panel at the November, 2010 meeting of the American Public Health Association. The findings and conclusions in this article are those of the authors and do not necessarily represent the official positions or policies of the American Medical Association or the University of Connecticut. Conflicts of interest: None declared. Corresponding author: Donald W. Zeigler, Prevention and Healthy Lifestyles, Medical and Public Health, American Medical Association, Chicago, IL 60654, United States of America. Email: donald.zeigler@ama-assn.org.

Introduction

In May 2010, the World Health Assembly of the World Health Organization (WHO) adopted a resolution to support a global strategy to reduce the harmful use of alcohol (WHO 2010b), based on estimates of alcohol's contribution to the global burden of disease and on evidence showing the effectiveness of policies designed to reduce the harm it causes (Babor et al. 2010; Room, Babor, and Rehm 2005; Anderson, Chisholm, and Fuhr 2009). Now that the strategy has been adopted, it is time for the world medical community to meet two new challenges. The first is to support an expansion of the evidence base so that it applies not just to the western developed countries where most of the world's alcohol research is concentrated, but also to other regions of the world where alcohol consumption is increasing and where the policy response is still relatively weak. The second challenge is to use scientific research to guide the adoption of effective alcohol policies at the national level in all WHO Member States. The purpose of this paper is to review the role of scientific research and public health advocacy in the adoption of the global strategy, describe the actual contents of the strategy, and discuss its implications for alcohol policy in countries throughout the world, especially in the context of new global attention to noncommunicable diseases (NCDs) and social determinants of health.

This article draws on publications and announcements of the World Health Organization, United Nations (UN) and national governments, recent medical and health policy journals, and the experience of nongovernmental organizations to summarize the background and implications of recent international public health initiatives on the topic of alcohol and to describe new resources that alcohol control advocates can utilize to promote evidence-based alcohol policy.

The Public Health Need for a Global Strategy

Epidemiological research on alcohol over the past two decades has advanced to the point where reasonably accurate estimates of alcohol consumption can be obtained from most of the UN Member States. These data, combined with research on the causal role played by alcohol in numerous health conditions, have made it possible to estimate the burden of disease and disability associated with alcohol at the national and international levels.

Rehm et al. (2009) have developed quantitative estimates of the contribution of alcohol as a risk factor to the global burden of disease and injury, with special emphasis on so-called alcohol-use disorders—i.e., alcohol dependence and harmful use of alcohol as outlined in the International Statistical Classification of Disease tenth revision (ICD-10). Alcohol-use disorders,

especially for men, are among the most disabling disease categories for the global burden of disease. However, this disease category is not the only one linked to alcohol: more than 30 ICD-10 three-digit or four-digit codes include alcohol in their name or definition, indicating that alcohol consumption is a necessary cause. Furthermore, more than 200 ICD-10 three-digit disease codes exist in which alcohol is part of a component cause (Rehm et al. 2009).

According to the 2011 WHO Global Status Report on Alcohol and Health (WHO 2011b), the harmful use of alcohol results in approximately 2.5 million deaths each year, with a net loss of life of 2.25 million, taking into account the estimated beneficial impact of low levels of alcohol use on some diseases in some population groups. Harmful drinking can also be very costly to communities and societies.

In 2004, 4.5% of the global burden of disease and injury was attributable to alcohol: 7.4% for men and 1.4% for women. This accounted for 4.4% of global mortality in all age groups. In 2004, the alcohol-attributable disease burden was estimated worldwide at 3.7% of deaths and 4.4% of disability-adjusted life years (DALYs) (WHO 2011a). The DALY is a public health measure that extends the concept of potential years of life lost due to premature death to include equivalent years of “healthy” life lost by virtue of being in states of poor health or suffering from disability.

The world’s highest alcohol consumption levels are found in the developed world, including Western and Eastern Europe. High-income countries generally have the highest alcohol consumption, but high income and high consumption do not always translate into high alcohol-related problems and high-risk drinking. Despite their high levels of alcohol consumption, Western European countries have relatively low alcohol-attributable mortality rates, though their alcohol-related disease burden may be high. Many Eastern European countries have the highest consumption, risky patterns of drinking, and, accordingly, high levels of alcohol-related deaths and disabilities. Every fifth death is due to harmful drinking in the Commonwealth of Independent States, the regional organization whose participating countries are former Soviet Republics. The rates of disease and disability attributable to alcohol are also quite high in Mexico and in most South American countries (WHO 2011a).

The Scientific Understanding of Alcohol Policy

Combined with the growing amount of epidemiological data on the harmful effects of alcohol, there has been a long history of research pertaining to alcohol policy (Bruun et al. 1975; Edwards et al. 1994). The scientific support for the interventions highlighted in the World Health Organization’s (WHO) global

strategy is extensive, particularly with respect to treatment and early intervention, drink-driving countermeasures, limits on the availability of alcohol, restrictions on alcohol marketing, pricing and tax policies to discourage frequent and heavy alcohol consumption, and controls on the social contexts that promote excessive drinking (Babor et al. 2010; Room, Babor, and Rehm 2005; Anderson, Chisholm, and Fuhr 2009). Many of these interventions are universal measures that restrict the affordability, availability, and accessibility of alcohol. Given their broad reach, the expected impact of these measures on public health is relatively high, especially if the informal market and illegal alcohol production can be controlled. When universal measures are combined with interventions targeted at high-risk populations, such as adolescents (age restrictions), automobile operators (drink-driving), alcoholics (treatment and support), and hazardous drinkers (brief interventions in primary healthcare), the combined effect is likely to be substantial.

The Policy Response to Alcohol-Related Problems

The world would be in a much healthier place than it is today if scientific information were the only resource needed to address public health epidemics caused by toxic substances. In addition to knowledge, two other ingredients are needed to protect population health: political leadership to implement effective health policies, and social movements led by influential organizations acting in the public interest (Thamarangsi 2009). In modern times nongovernmental organizations (NGOs) have contributed significantly to the process of implementing effective health policies, as reflected in the period leading up to the adoption of the WHO global strategy on alcohol. For example, in 2005 the World Medical Association (WMA), a global federation of national medical associations representing more than nine million physicians, adopted a resolution recommending comprehensive national alcohol policies that educate the public, create legal interventions, put in place regulatory and other environmental supports, and promote national and sub-national policies that follow evidence-based practices (World Medical Association 2005). The resolution also addressed global trade policy, arguing that alcohol must be considered as an “extra-ordinary commodity”. It therefore proposed that measures affecting the supply, distribution, sale, advertising, promotion, or investment in alcoholic beverages be excluded from international trade agreements when they are likely to have a negative impact on public health, as when a country is forced to lower its taxes on imported alcohol. The WMA statement also called for consideration of a Framework Convention on Alcohol Control. The resolution had an immediate impact on its member associations. Swedish physicians used the statement to urge

their government to treat alcohol as special in trade talks in Hong Kong. The New Zealand Medical Association referenced it to strengthen its advocacy for raising the legal drinking age from 18 to 20. Similarly, in November 2006, the American Public Health Association adopted a statement calling for a Framework Convention on Alcohol Control, similar to the Framework Convention on Tobacco Control (American Public Health Association 2006).

The World Health Organization Resolution

Increasingly aware of the magnitude of health and social problems related to alcohol, the World Health Assembly, representing the health authorities of all UN Member States, called on the World Health Organization in May 2008 to prepare a draft global strategy on alcohol. During the next two years, WHO held round-table meetings with business interests, NGOs, and health professionals, as well as six WHO regional meetings. At the meeting of NGOs and health professionals in Geneva in November 2008, the World Medical Association reiterated its alarm over the weakening of restrictions on production and marketing of alcoholic beverages, which increased availability and accessibility of alcohol and was thereby responsible for changing drinking patterns across the world. The WMA called for governmental, medical, and healthcare interventions (World Medical Association 2005).

In addition, the WMA led a coalition of the World Health Professional Alliance to testify at the WHO Executive Board in Geneva in January 2010. WMA spoke for the Alliance, which represents 26 million healthcare professionals and is composed of the International Council of Nurses, the World Dental Federation, the International Pharmaceutical Federation, and other professional groups from 130 countries. The coalition strongly supported the WHO draft alcohol strategy but also emphasized the need to strengthen policy recommendations regarding price, availability, drink-driving countermeasures, and marketing. Moreover, the Alliance stated that the role of health professionals in prevention and treatment of alcohol abuse should be given more attention, underlining the pivotal role that they can play in terms of education, advocacy, and research. The health professionals also said that the role of business interests in the implementation of the strategy should be clearly limited so that policies and programs at all levels are developed on the basis of public health interests, independent of commercial influence (World Medical Association 2010).

In 2010, the American Public Health Association (APHA), the largest professional organization of its kind, urged the U.S. delegation to the WHO to strongly support the global alcohol strategy. The APHA said that continued global economic development together with the erosion of public health policies create

the potential for alcohol-related problems, particularly in developing countries. These advocacy efforts by the world medical community were instrumental in persuading the World Health Assembly to adopt the “Global Strategy to Reduce the Harmful Use of Alcohol” in May 2010 (WHO 2010b).

Purpose and Contents of the Strategy

The global strategy gives guidance to both Member States (i.e., member nations of the UN) and the WHO Secretariat on ways to reduce the harmful use of alcohol. In it, all 193 UN Member States acknowledge the harmful use of alcohol as a major public health issue and the global aspects of the problem. Moreover, the strategy requests that alcohol receive higher priority at the WHO and that more resources be allocated to address these problems. The debate at the World Health Assembly demonstrated concerns about the growing culture of binge drinking among young people worldwide and the expanding influence of alcohol marketing and advertising. Delegates welcomed the evidence-based measures included in the strategy and their potential for successfully addressing alcohol problems.

The global strategy indicated that there are important challenges as well as opportunities for alcohol control. These include the importance of international cooperation on alcohol, the detrimental effects of harmful alcohol use on low- and middle-income countries, and the need to balance public health and economic interests. The strategy has five objectives, which are summarized in Table 1. The strategy proposed 10 policy options and interventions, which are described in Table 2.

The strategy defines key roles for a diverse group of stakeholders. Major partners within the UN system and intergovernmental organizations are urged to collaborate. Research institutions and professional associations are asked to intensify their efforts to support alcohol control. The media should assume the role of supporting the intentions and activities of the strategy. And lastly, civil society has an important part to play in advocacy for effective alcohol control policies, and NGOs are encouraged to form networks and action groups.

Table 1. Objectives of the World Health Assembly's Global Strategy to Reduce the Harmful Use of Alcohol.
<ul style="list-style-type: none">• Raise global awareness of the magnitude and nature of the health, social and economic problems caused by the harmful use of alcohol, and increased commitment by governments to act to address the harmful use of alcohol• Strengthen the knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm• Increase technical support to, and enhanced capacity of, Member States for preventing the harmful use of alcohol and managing alcohol use disorders and associated health conditions• Strengthen partnerships, provide better coordination among stakeholders and increase mobilization of resources required for appropriate and concerted action to prevent the harmful use of alcohol• Improve systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development, and evaluation

Table 2. Target Areas Addressed by the World Health Assembly's Global Strategy to Reduce the Harmful Use of Alcohol.
<ol style="list-style-type: none">(1) Develop leadership with a solid base of awareness and a strong political will and commitment(2) Health services' clinical and advocacy responses(3) Community mobilization for action to reduce problems and support victims(4) Drink-driving policies and countermeasures for deterrence and the development of measures to create a healthy driving environment(5) Regulate the public and commercial availability of alcohol(6) Reducing the impact of marketing of alcoholic beverages, especially targeted to youth(7) Pricing policies to reduce underage drinking and to halt progression towards drinking large volumes of alcohol or episodes of heavy drinking, and to influence consumers' preferences(8) Harm reduction approaches addressing the negative consequences of drinking and alcohol intoxication(9) Reducing the public health impact of illegal and informal alcohol through quality control, inspection, and taxation(10) Monitoring and surveillance

The Special Responsibilities of “Economic Operators”

The strategy encourages “economic operators,” i.e., organizations involved in alcohol production and trade, to reduce harm and not hinder progress in alcohol control. This recommendation is similar to the cautionary statements recently issued by a diverse group of organizations regarding the relationship between the alcohol industry and the public health community. In 2006, the WHO Expert Committee on Problems Related to Alcohol Consumption recommended to the WHO that all interactions with the industry should be confined to a discussion of how the industry can reduce the harm caused by alcohol in the context of their roles as producers, distributors, and marketers of alcohol, and not in terms of alcohol policy development or health promotion (WHO 2007).

In 2008, a coalition of NGOs and professional societies met in Dublin to discuss the influence of the alcohol industry on scientific research (Olafsdottir 2008). The meeting issued a statement, called the CLARION Declaration, which states that there is an inherent incompatibility between protecting the public from the harm done by alcohol and the alcohol industry’s requirement to maximize profit by promoting the sale and consumption of its products. To protect the integrity and legitimacy of alcohol research, and the reputation of academic institutions, the meeting attendees concluded that, in the field of alcohol research, no financial support should be accepted from the industry. Evidence in support of this recommendation was subsequently summarized in an article published in the international journal *Addiction* (Babor 2009).

The CLARION Declaration was a response to reports that the alcohol industry, under the leadership of the International Center for Alcohol Policies (ICAP), a not-for-profit organization supported by major producers of beverage alcohol, was attempting to pre-empt WHO’s work on alcohol policy by organizing a series of policy conferences that issued industry-favorable policy recommendations in a variety of African countries (Bakke and Endal 2010). At these industry-sponsored conferences, government officials, academics, and NGO representatives were asked to endorse the implementation of national alcohol policies that differed markedly from those proposed by WHO. In the Western-Pacific region, ICAP organized similar conferences in Thailand, Viet Nam, Singapore, China, and Korea. An analysis of the African initiative showed that the national plans designed to fit the public health needs of four countries (e.g., Malawi, Botswana, Uganda, and Lesotho) were prepared by a senior executive of SABMiller, one of the world’s largest brewers. The industry policy vision ignores, or chooses selectively from, the international evidence base on alcohol prevention developed by independent alcohol researchers and disregards or minimizes a public health approach to alcohol problems. For example, the

policies proposed by ICAP discourage the use of taxation and controls on alcohol marketing (Bakke and Endal 2010).

Despite the considerable amount of cross-national research in support of the alcohol strategy recommended by WHO, many countries outside of the developed western nations have not yet adopted optimal strategies to deal with the growing burden of disease caused by alcohol. For example, the Blue Bird Plan developed by the South Korean Ministry of Health and Welfare focuses primarily on the need to raise public awareness about alcohol harm, improve health promotion activities, reduce the prevalence of alcohol-related problems, and enhance treatment services for persons with alcohol problems (Chun 2010). To make the South Korean plan consistent with the global alcohol strategy, the following measures would also need to be implemented: (1) strengthen the alcohol licensing system related to alcohol sales; (2) revise the Liquor Tax Levy so that it is proportionate to the percentage of alcohol content in different beverages and is high enough to discourage excessive alcohol use; (3) impose greater restrictions on alcohol advertising and other marketing activities that are directed at youth; and (4) improve research, education, and information dissemination in support of better alcohol policies (Babor, Zeigler, and Chun 2010).

As described in the WHO global strategy document, what is needed now is a heightened awareness of the global extent of the alcohol problem and the political commitment to implement evidence-informed alcohol control strategies. The global strategy provides a major opportunity for each nation to re-evaluate its alcohol control policies in light of current evidence. Moreover, policy changes should be made with caution and with a sense of experimentation to determine whether they have their intended results. At the same time, policymakers and NGOs in each country should strengthen the links between science and policy so that promising research findings are identified, synthesized, and effectively communicated to policymakers and the public.

Broader Approaches to Population Health Provide New Opportunities for Alcohol Control

Related to these developments in promoting evidence-informed alcohol policies on a global level, world leaders in September 2000 adopted a declaration committing their nations to a new global partnership to reduce extreme poverty by 2015—that has become known as the Millennium Development Goals (MDGs). Three of the 10 goals relate to health: reduce child mortality (MDG4), improve maternal health (MDG5), and combat HIV/AIDS, malaria and other diseases (MDG6). However, the MDGs did not consider noncommunicable diseases

(NCDs) (UN Millennium Goals). Since then, there has been growing awareness that NCDs are pervasive throughout the world and have implications for development. In 2007, the Caribbean Community called on the UN to address NCDs as major impediments to development. This led the UN General Assembly to “consider integrating indicators to monitor the magnitude, trend and the socio-economic impact” of NCDs into the Millennium Development Goals monitoring system (United Nations 2010). “Underscoring the need for concerted action to address the developmental challenges posed by noncommunicable diseases...[the UN General Assembly called for a] high-level meeting of the General Assembly in September 2011, with the participation of Heads of State and Government, on the prevention and control” of NCDs.

Preparation for this meeting includes regional high-level consultations, a Ministerial conference hosted by the Russian Federation, and informal dialogues with civil society and the private sector (Smith 2011). The Special Session of the UN is expected to adopt resolution EB128/17: “a final outcome document that will generate global momentum and commitment both to implement the global strategy for the prevention and control of [NCDs] and its associated action plan, as an integral part of the global development agenda and in related investment decisions” (World Health Organization 2010c).

As background, the WHO prepared a special report, *The Global Status Report on Noncommunicable Diseases 2010*, the first report on the worldwide epidemic of cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases, along with their risk factors and determinants. The report specifically cites the prominent role of alcohol as a major factor in NCDs. Based on an extensive review of global health problems, the WHO Status Report concluded that of the 57 million global deaths in 2008, 36 million, or 63%, were due to NCDs. In low- and middle-income countries, about 29% of deaths occur before the age of 60. Eighty percent of premature heart disease, stroke, and diabetes can be prevented. Common, preventable risk factors underlie most NCDs and are the result of four particular behaviors (tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol). A large proportion of these deaths occur before the age of 60 during the most productive period of life and the magnitude of these diseases continues to rise, especially in low- and middle-income countries (World Health Organization 2011a).

The report also provided a road map for reversing the NCD epidemic by strengthening national and global monitoring and surveillance, scaling up the implementation of evidence-based measures to reduce risk factors like tobacco use, unhealthy diet, physical inactivity, and harmful alcohol use, and improving access to cost-effective healthcare interventions to prevent complications, disabilities, and premature death.

The 2010 Global NCD Report was developed as part of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, endorsed by the World Health Assembly in 2008 (WHO 2008). The Plan gives equal prominence to alcohol, tobacco, unhealthy eating, and physical inactivity as the major contributors to NCDs.

The Plan draws from the WHO alcohol strategy aspects related to alcohol's contribution to NCDs and points to effective prevention strategies for certain cancers, liver cirrhosis, and cardiovascular disease that should target both the amount and patterns of alcohol consumption. The report cites established evidence for the effectiveness and cost-effectiveness of interventions to reduce the harmful use of alcohol with examples from Brazil, China, Mexico, the Russian Federation, and Viet Nam and urges support for implementation of effective measures. The report concludes that “the current available scientific evidence supports prioritization of multiple cost effective policy actions, three of which are **best buys** (emphasis added): increasing alcohol beverage excise taxes, restricting access to retailed alcohol beverages and comprehensive advertising, promotion and sponsorship bans.” These interventions to tackle NCD risk factors are very cost-effective, very low cost to implement, and highly feasible. Also, the report identifies enforcing drink-driving laws (breath-testing) and offering brief advice for hazardous drinking as cost-effective, quite low cost and feasible (World Health Organization 2011a).

Following the lead of the UN and WHO, major professional journals have given prominence to NCDs and the role of alcohol as a key factor. The *Lancet* ran a series of articles on chronic diseases and development in November 2010 as a “contribution to preparations for the September [2011 UN] meeting.” These papers cover a range of diseases—cardiovascular, diabetes, cancer, and chronic obstructive respiratory diseases—and present strategies for substantial health gains, monitoring, and scaling up of interventions (Beaglehole et al. 2011).

In an editorial in the international journal *Addiction*, Room and Rehm (2010) discussed the evolution of the International Agency for Research on Cancer (IARC)'s consideration of alcohol as a carcinogen. They note that, increasingly, this issue is being framed by public health agencies in terms of alcohol's role in NCDs (Room and Rehm 2010). *The Globe*, a publication of the Global Alcohol Policy Alliance (GAPA), published a review in February 2011 entitled “Addressing harmful use of alcohol is essential to realizing the goals of the UN Resolution on non-communicable diseases.” Authors reviewed alcohol's contribution to NCDs and the need for implementing evidence-based strategies recommended in the WHO's alcohol strategy that have the potential to reduce the impact of NCDs by reducing heavy drinking episodes and the prevalence of alcohol use disorders (Parry and Rehm 2011).

In October 2011, the World Medical Association adopted a policy statement on the global burden of chronic diseases, which “are not replacing existing causes of disease and disability (infectious disease and trauma), but are adding to the disease burden.” The WMA indicated that chronic disease prevalence is closely linked to global social and economic development, globalization, and mass marketing of unhealthy foods and other products. Related to the subject of this article, the proposed policy recommends that national governments support global tobacco and alcohol control strategies, promote healthy living, and implement policies that support prevention and healthy lifestyle behaviors. National medical associations should work to create communities that promote healthy lifestyles, increase physician awareness of optimal disease prevention behaviors, and advocate for integration of chronic disease prevention and control strategies in government-wide policies. Individual physicians should encourage prevention behaviors and become community advocates for positive social determinants of health and for best prevention methods (World Medical Association 2011a).

In order to take advantage of the unprecedented opportunity made possible by the first UN High-level Meeting on NCDs, a global alliance between leading scientists and four of the world’s largest NGOs brought together evidence from a five-year collaboration among NCD experts. The NCD Alliance includes the International Diabetes Federation, the Union for International Cancer Control, the International Union Against Tuberculosis and Lung Disease, and the World Heart Federation. These groups represent the four main diseases outlined in the World Health Organization’s 2008–2013 Action Plan for NCDs—cardiovascular disease, diabetes, cancer, and chronic respiratory disease. Initially, the Alliance did not feature alcohol but subsequently created a section on alcohol to correspond to the other risk factors for NCDs. Moreover, the Alliance proposed a short-list of five priority interventions to tackle the increasing global crisis: tobacco control, salt reduction, improved diets and physical activity, reduction in hazardous alcohol intake, and essential drugs and technologies. These have been chosen for their health effects, cost-effectiveness, low costs of implementation, and political and financial feasibility (Beaglehole et al. 2011).

While official UN and WHO documents refer to cooperation with the private sector, NGOs and the head of the WHO have been more cautionary. For example, the *Lancet* series on NCDs specifically mentioned the conflicts between health interests and industries that contribute to NCDs (Beaglehole et al. 2011).

The high-level meeting of the UN General Assembly on prevention and control of NCDs met in New York on September 19–20, 2011. The meeting produced a declaration (UN 2011) which, according to an editorial in *The Lancet Oncology*, was influenced by pressure from governments and lobbyists reflective of national and industry interests. The United States, Canada, and the European

Union—along with several other developed countries—generally opposed setting immediate targets for reducing the prevalence of NCDs and resisted explicit calls for taxation on unhealthy products or industry regulation. Industries, including Anheuser-Busch InBev and Molson Coors Brewing Company, participated as civil society representatives and successfully urged voluntary rather than regulatory approaches (*Lancet Oncology* 2011; Fink and Rabinowitz 2011). Jorge Alday of the World Lung Foundation said that it is “like letting Dracula advise on blood bank security” (Gale and Stanford 2011).

Other Public Health Frameworks Provide Leverage for Alcohol Control

1. Health in All and Health Impact Assessments

The global attention to NCDs appropriately elevates alcohol to prominence as a major contributor to the global burden of disease and a preventable impediment to development. Concurrently, there are several other approaches to health policy that provide further opportunities for alcohol control and tools to leverage in advocacy.

Non-governmental organizations have recently advanced the concept of “health in all policies.” For example, the WHO-sponsored conference in Australia April, 2010, produced the “Adelaide Statement on Health in All Policies” which seeks to engage leaders and policymakers at all levels of government—local, regional, national, and international—to emphasize that government objectives are best achieved when all sectors include health and well-being as a key component of policy development. According to the statement, causes of health and well-being lie outside the health sector and are socially and economically formed. Although many sectors already contribute to better health, significant gaps still exist. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to well-being and supportive environments (WHO and Government of South Australia 2010).

Similarly, in the United States where there has been experience with the use of environmental impact assessments, Health Impact Assessments (HIA) have become a framework for assessing the implications of health in all policies. HIA are used to evaluate objectively the potential health effects of a project or policy before it is built or implemented. Such assessments can provide recommendations to increase positive and minimize adverse health outcomes. The HIA framework is used to bring potential public health impacts to the decision-making process for

plans, projects, and policies that fall outside of traditional public health arenas, such as allowed business density and advertising restrictions (US CDC).

According to this approach, systematic assessments of health effects are needed to inform the development of policies and to include health in other sector agendas. Although there is substantial scientific knowledge on the adverse health effects of several environmental factors, regulatory policies often fail to reflect such knowledge adequately. Moreover, policy decisions made outside of the health sector may influence many determinants of health. Accordingly, HIA involve working with a range of decision makers and stakeholders to support the building of healthy public policy. They study upstream health determinants in an integrated way, rather than concentrating on single risk factors, and are a resource for risk governance in environment and health. HIA's overall objective is to provide decision makers with sound information on any policy's implications for health (World Health Organization).

In the United States, HIA are a rapidly emerging practice. The U.S. Department of Health and Human Services recommends the use of HIA as a planning resource for implementing the national Healthy People 2020 goals. HIA are also regularly performed in Europe and Canada. Some countries have mandated HIA as part of a regulatory process while others use it on a voluntary basis (US CDC). HIA may be a useful tool for leveraging alcohol policy as many policy decisions can be shown to have health and social implications.

Another recent example of the application of "health in all policies" and "health impact assessments" is the U.S. government's National Prevention Strategy, released in June 2011, which provides evidence-based recommendations to improve the nation's health through the active engagement of all sectors of society. Developing the Strategy involved 17 agencies across all segments of the national government to envision a prevention-oriented society where all sectors recognize the value of health for individuals, families, and society and work together to achieve better health for all Americans. The strategy's seven priority areas are: tobacco free living; preventing drug abuse and excessive alcohol use; healthy eating; active living; injury and violence-free living; reproductive and sexual health; and mental and emotional well-being (US HHS 2011). Alcohol policy experts will note that alcohol relates to all seven priority areas.

2. Social Determinants of Health

Another important conceptual framework in contemporary health policy with significant implications for alcohol policy is consideration of the social determinants of health. These are the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local

levels, which are themselves influenced by policy choices (World Medical Association 2011b).

The WHO has held conferences and developed major publications on the social determinants of health (CSDH 2008; Blas and Sivasankara Kurup 2010). Planners for a WHO global conference in Rio de Janeiro, October 2011, in unofficial documents, suggest that tackling the NCD epidemic, especially in low- and middle-income countries, is impossible without acting on social determinants in as much as there are similar drivers of inequities and the conditions addressed in the health-related millennium development goals. They suggest solutions that involve various sectors that include environment, transport, agriculture, finance, trade, and community planning. The document suggests that fiscal policies can be used to control risk factors for NCDs by reducing alcohol and salt intake, preventing obesity, promoting physical activity, and reducing consumption of tobacco and fat.

Discussion

This article has reviewed the background to the historic WHO global alcohol strategy in the context of related global initiatives on noncommunicable diseases, social determinants of health, and framing all public policies with consideration of their impact on health. These developments provide unprecedented opportunities and tools for alcohol control at the international, national, and sub-national levels.

Despite the considerable amount of cross-national research in support of the alcohol strategy recommended by WHO, many countries outside of the developed western nations have not yet adopted optimal strategies to deal with the growing burden of disease caused by alcohol.

As described in the global strategy document, what is needed now is a heightened awareness of the global extent of the alcohol problem and the political commitment to implement evidence-informed alcohol control strategies. The global strategy provides a major opportunity for each nation to re-evaluate its alcohol control policies in light of current evidence and recommendations. Policymakers and NGOs in each country should strengthen their links with science so that promising research findings are identified, synthesized, and effectively communicated to the public. Moreover, framing alcohol problems and interventions in the language and context of health in all, health impact assessments and social determinants of health may support arguments and policy, and achieve greater traction.

Conclusions and Policy Implications

Alcohol, until recently, has been less prominent on the global health agenda than tobacco and other health risk factors. However, the recent adoption of the WHO global strategy draws high-level attention to an impressive number of evidence-based alcohol control options. Moreover, increased global attention to “health in all” and “social determinants of health” provide new perspectives to address multiple factors affecting health. Alcohol and its social factors are included.

There are significant and very promising implications for alcohol control flowing from the priority being given to noncommunicable diseases. Alcohol is a major contributor to NCDs and many of the clinical and environmental interventions to address tobacco, diet, and physical inactivity are similar to those demonstrated to be the most effective for alcohol control. However, unlike campaigns against infectious diseases, addressing NCDs requires substantial attention to the significant conflict between the interests of public health and those of commercial, market, and trade interests. Such “market-involved risk factors” that are part of globalization require vigorous and sustained attention by international organizations and nation states as well as the NGO community. According to Room and Rehm (2010), the “conceptual banding together of NCDs is partly to direct attention to dealing with those diseases in the context of international development policy. However, there is another factor clearly recognized as binding them together: that to a considerable extent the different major NCDs involve common risk factors.” The growing consensus is that four major risk factors for NCDs are alcohol, tobacco, diet, and lack of physical exercise. Fortunately, alcohol has risen to relatively equal status as a recognized public health problem. The September 2011 UN NCD summit and the WHO alcohol strategy provide unprecedented opportunities for systematically addressing alcohol control.

References

- American Public Health Association. 2006. “A Call for a Framework Convention on Alcohol Control.” American Public Health Association. <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1339>.
- Anderson, P., D. Chisholm, and D. Fuhr. 2009. “Effectiveness and Cost-Effectiveness of Policies and Programmes to Reduce the Harm Caused by Alcohol.” *Lancet* 373: 2234-2246.
- Babor, T. 2009. “Alcohol Research and the Alcoholic Beverage Industry Issues, Concerns and Conflicts of Interest.” *Addiction* 104: 34-47.

- Babor, T., R. Caetano, S. Casswell, G. Edwards, N. Giesbrecht, K. Graham. et al. 2010. *Alcohol: No Ordinary Commodity— Research and Public Policy*. Oxford: Oxford University Press.
- Babor, T., D. Zeigler, and S. Chun. 2010. “The Challenges Ahead: Implementing the WHO Global Strategy on Alcohol in the Republic of Korea.” *Journal of Korean Alcohol Science* 11 (2): 1-9.
- Bakke, O. and D. Endal. 2010. “Alcohol Policies Out of Context: Drinks Industry Supplanting Government Role in Alcohol Policies in Sub-Saharan Africa.” *Addiction* 105 (1): 22-28.
- Beaglehole, R. et al. 2011. “Priority Actions for the Non-Communicable Disease Crisis.” *Lancet* 377: 1438-1447.
- Blas, E. and A. Sivasankara Kurup. 2010. *Equity, Social Determinants and Public Health Programmes*. Geneva: World Health Organization.
- Bruun, K., G. Edwards, M. Lumio, K. Mäkelä, L. Pan, R.E. Popham, R. Room, W. Schmidt, O.-J. Skog, P. Sulkunen, and E. Österberg. 1975. *Alcohol Control Policies in Public Health Perspective*. Helsinki: The Finnish Foundation for Alcohol Studies.
- Chun, S. 2010. “Issues of Korean Alcohol Policy for Health Plan.” *Korean Journal of Alcohol Science* 56-59.
- CSDH. 2008. “Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.” *Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization.
- Edwards, G., P. Anderson, T.F. Babor, S. Casswell, R. Ferrence, N. Giesbrecht, C. Godfrey, H.D. Holder, P. Lemmens, K. Mäkelä, L.T. Midanik, T. Norström, E. Österberg, A. Romelsjö, R. Room, J. Simpura, and O.-J. Skog. 1994. *Alcohol Policy and the Public good*. Oxford Medical Publications: Oxford, UK.
- Fink, S. and R. Rabinowitz. 2011. “The UN’s Battle with NCDs: How Politics, Commerce, and Science Complicated the Fight Against an ‘Invisible Epidemic’.” *Foreign Affairs*, September 20.
- Gale, J. and D. Stanford. 2011. “Nestle, Glaxo Lobby UN Over Biggest ‘Epidemic’ Battle Since AIDS.” *Bloomberg News*, September 16.
- Lancet Oncology Editorial. 2011. Two Days in New York: Reflections on the UN NCD Summit. *The Lancet Oncology* (September 23). DOI:10.1016/S1470-2045(11)70272-8.
- NCD Alliance. 2011. <http://www.ncdalliance.org/alcohol>.
- Olafsdottir, H. 2008. “The Dublin Meeting on Alcohol Research and Industry.” *Nordic Studies on Alcohol and Drugs* 25: 313-315.

- Parry, C. and J. Rehm. 2011. "GAPA Brief: Addressing Harmful Use of Alcohol is Essential to Realising the Goals of the UN Resolution on Non-communicable Diseases (NCDs)." London: *The Globe* Issue 1 2011. Global Alcohol Policy Alliance, February 17.
- Rehm, J., C. Mathers, S. Popova, M. Thavorncharoensap, Y. Teerawattananon, J. Patra. 2009. "Global Burden of Disease and Injury and Economic Cost Attributable to Alcohol Use and Alcohol-Use Disorders." *Lancet* 373 (June 27): 2223–2233.
- Room, R., T.F. Babor, and J. Rehm. 2005. "Alcohol and Public Health." *Lancet* 365: 519-530.
- Room, T. and J. Rehm. 2010. "Alcohol and Non-communicable Diseases – Cancer, Heart Disease and More." *Addiction* 106: 1-2.
- Smith, R. 2011. "Moscow Meeting Marks 'Beginning of a Different WHO,' Says Director General." *BMJ* 342: d2766 doi: 10.1136/bmj.d2766.
- Thamarangsi, T. 2009. "The Triangle That Moves the Mountain and Thai Alcohol Policy Development: Four Case Studies." *Contemporary Drug Problems* 36: 245-277.
- United Nations (UN). May 2010. "Prevention and Control of Non-communicable Diseases." A/Res/64/265.
http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/265&Lang=E.
- United Nations (UN). 2000. "Millennium Goals."
<http://www.un.org/millenniumgoals/bkgd.shtml>
- United Nations (UN). 2011. "Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable diseases." September 19.
http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1
- US Health and Human Services. 2011. "National Prevention Strategy."
<http://www.healthcare.gov/center/councils/nphpphc/strategy/report.pdf>
- US Centers for Disease Control. 2011. *Health Impact Assessment*.
<http://www.cdc.gov/healthyplaces/hia.htm>.
- World Health Organization (WHO). 2011. "Health Impact Assessment."
<http://www.who.int/hia/en/>
- World Health Organization (WHO). 2004. *Global Status Report on Alcohol*. Geneva: World Health Organization
- World Health Organization (WHO). 2007. *Expert Committee on Problems Related to Alcohol Consumption, 2nd report (WHO Technical Report Series 944)*. Geneva: World Health Organization.
http://www.who.int/substance_abuse/expert_committee_alcohol_trs944.pdf.
- World Health Organization (WHO). 2008. *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases*.
<http://www.who.int/nmh/Actionplan-PC-NCD-2008.pdf>

- World Health Organization (WHO). 2010a. *Global Strategy to Reduce the Harmful Use of Alcohol*. Geneva: World Health Organization.
- World Health Organization. 2010b. "Global Strategy to Reduce the Harmful Use of Alcohol." WHA63.13. http://apps.who.int/gb/ebwha/pdf_files/WHA63-REC1/WHA63_REC1-P2-en.pdf
- World Health Organization (WHO). 16 December 2010c. "Prevention and Control of Noncommunicable Diseases." WHO EB128/17. http://apps.who.int/gb/ebwha/pdf_files/EB128/B128_17-en.pdf
- World Health Organization (WHO). 2011a. "Global Status Report on Noncommunicable Diseases 2010." http://whqlibdoc.who.int/publications/2011/9789240686458_eng.pdf.
- World Health Organization (WHO). 2011b. "Global Status Report on Alcohol and Health." http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf.
- World Health Organization (WHO). 2011c. "Moscow Declaration. First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control." Moscow, 28-29 April 2011. http://www.who.int/nmh/events/moscow_ncds_2011/conference_documents/moscow_declaration_en.pdf.
- World Health Organization (WHO). 2011. Regional Office for Europe. *Health Impact Assessment*. <http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/health-imp.act-assessment>.
- World Health Organization and the Government of South Australia. *Adelaide Statement on Health in All Policies*. Adelaide, Australia 2010.
- World Health Professions Alliance. December 2010. "WHPA Statement on Non-Communicable Diseases and Social Determinants of Health." http://www.whpa.org/WHPA_statement_NCD_SDH.pdf.
- World Medical Association. 2005. "Statement on Reducing the Global Impact of Alcohol on Health and Society." 56th WMA General Assembly. Santiago, Chile. <http://www.wma.net/en/30publications/10policies/a22/>
- World Medical Association. 2008. "Statement on Behalf of World Medical Association." *Report From A Roundtable Meeting With Nongovernmental Organizations and Health Professionals on Harmful Use of Alcohol*. Department of Mental Health and Substance Abuse. World Health Organization Geneva, 2009. http://www.who.int/substance_abuse/activities/msbngoreport.pdf
- World Medical Association. 2010. *World Medical Association Joint Intervention. 126th Session of the WHO Executive Board*. Geneva, January 2010. http://www.wma.net/en/20activities/30publichealth/60alcohol/WHO_EB126_Prevention_of_alcohol_abuse_-_WHPA_statement.pdf

World Medical Association. 2011a. "Statement on the Global Burden of Chronic Disease" (adopted at the 62nd General Assembly in Montevideo, Uruguay, October 2011)

World Medical Association. 2011b. "Statement on Social Determinants of Health" (adopted at the 62nd General Assembly in Montevideo, Uruguay, October 2011).