

Issue 2 2014

THE GLOBE



**GAPA Board meets in Brazil to
Plan Global Alcohol Policy
Conference in Edinburgh 2015**

THE GLOBE

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The Global Alcohol Policy Alliance held a Board Meeting in São Paulo in May 2014. The Board commenced with a workshop organised by Associação Paulista para o Desenvolvimento da Medicina at which over 400 delegates from Brazil attended. In this edition we publish a special article written by Matheus Lourenço and Ronaldo Laranjeira on Brazil: An unregulated alcohol market.

BRAZIL: An unregulated alcohol market

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The global burden of disease is 6.5% for men and 1.3% for women, while the alcohol-attributable burden of disease in the two regions of the Americas which include most of the Latin American countries varies between 8.6% and 17.3% for men and 2.2% and 4.1% for women.

Worldwide average consumption of pure alcohol per adult is of 6.2 litre/year; in Brazil the average is 8.7 litre/year. Alcohol consumption per capita in Brazil increased by 74.5% from 1970 through 1990. In Brazil, it is not necessary to have a special licence to sell alcoholic beverages. In 2005, the number of beverage points of sale was approximately 1 million, which corresponds to 1 point of sale for every 170 inhabitants.

Research on alcohol policies suggests that alcohol supply at low prices has increased beverage availability in the most diverse environments. In Brazil, a 1-litre bottle of locally produced spirits (40% alcohol), costs \$0.50, and a 350ml can of beer costs \$0.20. Alcohol is cheaper than a can of cola (\$0.40) or a bottle of milk (1-litre for \$0.90). In the peripheries of large cities, bars have become the main environment in which young people socialize. The result has been the trivialization of alcohol consumption, tolerance of violations, and an increase in traffic accidents. The average

volume of alcohol consumption and patterns of drinking, especially heavy drinking occasions, contribute to this disease burden. Binge drinking is a factor of risk for acute alcohol problems such as car crashes, particularly in younger age groups.

Binge Drinking

Alcohol consumption is highly concentrated in a small group of heavy drinkers. In the U.S.A. and Sweden, 40% of all alcohol is consumed by the top 5% and 10% of drinkers by volume, respectively. In Switzerland, the top 8% of drinkers accounted for 50% of all alcohol consumed. The top 2.5% of drinkers in Brazil consumed 14.9% of all alcohol consumed in the country in the past year, the top 5% consumed 27.4%, and the top 10% consumed a little less than half (44.2%). Despite this distribution, alcohol-related problems are typically distributed across a wider range of drinkers. The majority of high-risk drinkers actually met criteria for moderate volumetric intake, and importantly, this “moderate volume, high binge” group also accounted for the majority of societal problems among all binge drinkers. Drinking pattern plays an important role in the distribution of alcohol problems in society.

Binge drinking is defined as the consumption of five or

more drinks of alcohol (i.e., a 5 ounce glass of wine at 12% alcohol, a 1.5 ounce of spirits 80% proof or a 12 ounce can of beer at approximately 4% alcohol) on one occasion for males and four or more drinks for females. Binge drinking exposes the individual to a variety of risks, including damage to physical health, unprotected sex, unwanted pregnancy, overdose, falls, violence (including fights), domestic violence and homicides, car accidents, difficulties in school, and suicide. Worldwide, about 11.5% of drinkers have weekly binge drinking episodes, with men outnumbering women by four to one. Binge drinking is also more common in poorer countries, among single individuals and those with lower educational achievement. Individuals between 18 and 44 years of age are four times more likely to engage in binge drinking. Compared to other countries, Brazil has a wider age range of individuals who engage in binge drinking and about 40% of Brazilian men and 18% of women 18 years of age and older, report binge drinking in the past year.

Alcohol Industry

Over the last decade, the Brazilian alcohol industry – which for years has ignored alcohol problems – inaugurated responsible drinking programs. The evidence shows how difficult it is to confirm whether the responsible drink-

ing programs have been undertaken systematically to reduce alcohol problems, or merely as part of a public relations strategy to reduce criticism and potentially forestall government regulations. Studies on the responsible drinking programs undertaken in North America, Europe and Australia, found that they were not effective as prevention strategies and had more to do with public relations than public health. The responsible drinking programs are positioned as part of corporate social responsibility programs to revive notions of social responsibility in corporations. Corporate social responsibility is used as an implicit transnational standard and a form of self-regulation to offset potential criticism and political interference.

The legitimacy of this approach must be questioned as it raises concerns that rules could be constructed based on self interest rather than on democratic principles of the 'greater good', or scientific evidence for effective policies. Industry-led campaigns for responsible drinking are inevitably a double-edged sword, designed to elicit multiple interpretations from the audience, as messages that promote responsible drinking also promote drinking itself with little or no countervailing argument to 'not drink'. The net effect is that epidemiological problems related to alcohol could end up being attributed to those irresponsible individuals who misuse the drug by drinking in excess, drinking and driving, and drinking at too young an age, while the industry is able to market their products with messages that continue to

encourage people to drink. In Brazil, policy developments on alcohol marketing have evolved slowly. Not following any health agenda, this approach continues to promote consumption, while, at the same time, demonstrating concern for public health and their ability to self regulate, which must help to stave off government regulation.

An important tactic in contemporary lobbying, pioneered by the tobacco industry, is the construction of doubt about the content of scientific evidence. The alcohol industry foster doubt about strong evidence and promote weak evidence, whilst appearing to be demonstrating corporate social responsibility. This has been shown to influence policy makers across a wide range of health and environmental concerns, as well as on public opinion.

Alcohol is not an ordinary commodity: people experience pleasure with alcohol consumption; alcohol generates jobs and tax revenues for states and countries, and the alcohol industry has an active and powerful lobby pressuring governments and legislators around the world to weaken alcohol-control policies. Alcohol industry actors have been strongly criticized for producing incomplete and distorted views of the evidence and influencing research funding and publication in biased ways. The alcohol industry actors misrepresent strong evidence, promote weak evidence, make unsubstantiated claims, and promote alternatives without evidence, to influence policy creation.

Case Study: FIFA World Soccer Cup 2014

The Fédération Internationale de Football Association (FIFA) required Brazil to suspend a national ban on the sales of alcohol beverages in soccer stadia during the 2014 World Soccer Cup. FIFA's actions were linked to a multimillion-dollar contract that the organization had with Budweiser.

The alcohol sales ban in Brazil began in Brazil in 1995 as a response to a violent fight between the supporters of two opposing soccer teams which led to one death and many injuries. The Lei do Torcedor (Spectator Law) passed in 2003, states that, in order to have access to sport events, spectators cannot have objects, beverages or prohibited substances capable of generating or enabling acts of violence.

The 'Lei Geral da Copa' was passed in June 2012, which eliminated the article banning alcoholic beverages from soccer games during the World Cup.

Policymaking

Policy options have developed in response to growing concerns about the scale of the problems caused by alcohol. Measures to raise the price of alcohol and control its availability, along with restrictions on marketing activities, are the most effective. The industry has consistently opposed whole-population approaches and favoured targeted interventions that focus on a supposedly problematic minority. Alcohol control policies in public health are aimed at decreasing per capita

consumption to minimize alcohol problems.

The scientific support for the interventions highlighted in the WHO's 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 or heavy drinking. 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 in public health is relatively high, especially if the informal market and illegal alcohol production can be controlled. When universal measures are combined with the 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 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. The CLARION Declaration, issued in 2008 by a coalition between Non-governmental organizations (NGOs) and professional societies, 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 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, within the field of alcohol research, no financial support should be accepted from the industry. This 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, policies that differed markedly from those proposed by WHO. 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.

Another significant implication for alcohol policy is consideration of the social



Conference delegates

determinants of health shaped by the distribution of money, power, and resources at global, national, and local levels. These are the conditions under which people are born, grow, live, work, and age, including the health system.

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.

Policymaking is not a purely rational process, informed only by evidence. It is, by definition, political, and thus subject to a wide range of influences, and this complexity warrants dedicated investigations. Public interest is not served by industry actors' involvement in the interpretation of research evidence. Alcohol industry actors continue to exercise strong influence on alcohol policies across the world. Commercial conflicts of interest

should be made explicit and policy makers should treat industry actors' interpretation of evidence with extreme caution. It is for public debate whether and to what extent the health of the population may be compromised by the commercial interests of the industry, and whether the apparent economic contributions of the alcohol industry fully take into account the health and other social costs their activities incur. For policy makers, key questions concern how the pursuit of commercial interests can lead to the marginalization of scientific evidence in decision-making.

In order to address public health effectively, there must be scientific knowledge, political leadership to implement effective health policies, and social movements led by influential organizations. NGOs have contributed significantly to the process of implementing health policies.

Case Study: Diadema

WHO estimates that, during the year 2000, the homicide rate in the UK and the US were 1 and 6 per 100,000 inhabitants respectively. During the same period Brazil had an estimate of 27 per 100,000 inhabitants with about 130 gun-related deaths a day. Between 1980 and 2004 the murder rate in Brazil more than doubled, becoming the leading cause of death between 15 and 44 year olds.

During 1999, the city of Diadema had one of the highest rates of homicides in Brazil, reaching 103 per 100,000

inhabitants. Data showed that 65% of the homicides were alcohol-related and that most assaults on women and homicides occurred in or close to bars, between 11pm and 6am.

In July 2002, a new law was introduced. This law required all alcohol retail outlets to close at 11pm. Before this law, bars were open 24 hours a day.

The results were significant. There was an annual reduction of 106 murders (30 per 100,000 inhabitants). In a country where the overall rate of homicide is so high, the impact of reducing opening hours of alcohol outlets demonstrates the relationship between alcohol and violence, and the effectiveness of restricting drinking hours as a public health measure. Despite the criticism by bar owners, the mayor who introduced the law was re-elected.

Diadema is viewed as a successful example of policy-induced crime reduction. Adoption of dry laws seems indeed associated with a drop in homicides. In adopting cities, average monthly homicides in the 12 months subsequent to adoption were 3.71 per 100,000 inhabitants, a 20% decrease from the previous 12

months and a more significant drop than the non-adopting cities. Adoption of dry laws would have induced a decrease in homicides between 10% and 29% in São Paulo, from the most to the least conservative estimates. A very rough computation implies gains of 1.9 and 5.5 million dollars annually in the city of São Paulo. These are underestimated since they do not include medical expenses, costs associated with family disintegration, and psychological costs.

Drinking and Driving

According to WHO, nearly 1.2 million people die in accidents on roads. The drinking and driving association is one of the main factors that potentialize accidents. Under the effect of alcohol, the individual is seven times more likely to die in a driving accident. Studies show that the blood alcohol level of 0.5-0.9 g/l has as much as a 9-fold increased risk of being in a fatal car crash, and up to 0.2 g/l the risk is nearly doubled. In Brazil there is evidence indicating that drinking and driving occur at a much higher rate, 34.7%,



Speakers Panel

than in other countries with the tradition of monitoring driving under the influence.

In Diadema, 23.7% of drivers had a detectable level of alcohol in their blood, while British Columbia (Canada) night-time drivers, and United States weekend night-time drivers tested positive 8.1% and 12.4%, respectively.

A recent study by the São Paulo Legal Medicine Institute, on traffic fatalities and alcohol consumption in 2005, showed that almost half the traffic accidents were associated with parties and bars, and took place between 12am and 6am at weekends. According to the Ministerio da Saude, 40,610 people died in 2010 in car accidents in Brazil. Starting in 1989, a traffic code stipulated a BAC limit of 0.08g/l for drivers. These early studies indicated a prevalence of 27% of drivers with BAC over the legal limit. Later, this limit was reduced to 0.06g/l by Act 9503 of 1997. However, between 1998 and 2006, alcohol remained the main factor associated with traffic accidents and the prevalence of intoxicated drivers was between 23% and 38%, which led lawmakers to lower the tolerance of alcohol use by drivers. In Brazil, fatal accidents are in second place in the ranking of external causes: expenses resulting from traffic accidents amount to R\$28 billion per annum, and the number of deaths, 34,000/year, corresponds to one death every 15.45 min. The new Dry Act (2008) suspends driving privileges for 12 months, results in 7 points

added to the driver's licence and a fine of R\$955,00 at 0.2dg of alcohol per litre of blood (which could be just a single glass of beer). Concentrations above 0.6dg/l, (2 glasses of beer), could result in the detention of the driver and prosecution, which could lead to 6 to 36 months in prison.

The results show that the number of positive breath tests decreased 45% after the new law. In the first month following the Dry Act, the numbers of ambulatory care demands decreased by half in hospitals, and traffic deaths decreased by 63% downtown and 14% on the roads. This is a significant contribution to safety and a considerable saving for public health. Weekend-night drivers are usually 20-to-30-year-old males of a high educational and socio-economic level. About one-third of them have already been involved in a traffic accident. Most drivers in this group agree that driving drunk is the most severe traffic infraction, and they are thus in favor of using the breath test as a measure to control alcohol consumption and driving. The profile of those who drink and drive, is 22-45 year old males, having previously been involved in traffic accidents. The probability of positive breath tests is more than one-and-a-half times greater for those who usually drive after drinking and almost double for those who usually drink alcohol at least once a week. The percentage of adults who drove after drinking an excessive amount of alcoholic beverages dropped from 2.2% to 0.9% in the first two months

after the law was introduced, and increased again to 2.8% in 2009.

In Minas Gerais the data showed a reduction of nearly 50% in the prevalence of individuals driving with any level of alcohol in the blood after the new law took effect. One year after the Dry Act, there was an average reduction of 6.2% on the victim rates. In Belo Horizonte the prevalence fell from 37.5% in 2007 to 19.4% in 2008.

In a study, findings demonstrated that 70% of drivers interviewed agreed that drunk driving puts others at risk, 90% also favoured the use of breath tests as a preventative measure. Popular support for the laws, surveillance upkeep and improvements in public transportation may be crucial to enable a change in attitudes toward drinking and driving.

Conclusion

Despite a high abstention rate (35% for men and 59% for women), Brazil is identified by the alcohol industry as having considerable potential for market growth. There are eight factors predisposing to an alcohol storm in Brazil:

1. Economic growth

Economic growth in developing nations expands the local alcohol industry and makes developing nations targets for market expansion by ever-growing transnational producers of alcoholic beverages. The expansion results in increased

alcohol availability, increased alcohol consumption and higher levels of alcohol-related problems. In Brazil, consumption has almost tripled since the 1960s. Beer industry estimates suggest that beer consumption has been growing steadily at a rate of 6-7% a year.

2. Multiple factors pushing up consumption

Advertising, pricing and availability increase consumption. Marketing strategists aim for low prices as the population has a low level of disposable income. The costs of production are also cheaper.

3. Demographics

Developing countries have an attractive demographic for the alcohol industry as the population structure is characterized by an inverted pyramid. Since most alcohol consumption occurs among young adults (30 years of age and younger) these countries offer the best possible age structure for marketing alcoholic beverages.

4. Corporate targeting of developing countries

Market expansion by international conglomerates is sometimes conducted by acquiring at least partial ownership of local industry. Forecasts indicate that the Andean region of South America will have an annual compound growth rate in beer volume of 4% over the

next 5 years (global average of 2%).

5. International trade agreements

When international market expansion collides with public health concerns in a particular country, the regulation of international trade greatly favors the alcohol industry. International trade agreements (e.g. General Agreement on Tariffs and Trade and the newer General Agreement on Trade in Services) basically see alcohol as just another commodity. This happens in both developing and developed countries, and the World Trade Organization enforcement of such agreements has led to a weakening of public health-based alcohol controls.

6. Baiting the trap

International reaction to the growth of the alcohol industry, which usually comes with promises of job creation and much-needed expansion on the tax-base, is not an exception. Careful analysis, however, suggests no real multiplier effect on job creation in developing societies, and the most likely effect of the increased industrialization is a loss of direct employment. Expansion of the tax-base is also illusive in developing societies because higher prices may lead to a shift in consumption from legally to illegally produced

beverages. For the alcohol industry, market expansion is cheaper to achieve in developing countries by means of acquisitions, rather than by costly advertising wars in developed markets. Whatever gains made in jobs and taxes are actually lost due to the impact on the public's health.

7. Weaknesses in developing countries' public health infrastructure

Developing nations usually have a weak system of public health control on alcoholic beverages. The ministries of health in these nations, all with limited economic resources, must respond to public health priorities such as malnutrition, sanitation and endemic infectious diseases, which do not affect developed nations at the same level. The development and enforcement of alcohol control policies, therefore, is not a high priority. Regarding specific alcohol control policies, most of these countries do not have state monopolies over the production or sales of alcoholic beverages. Hours of sale, advertising rules, legal age limits and the legal blood alcohol level to drive a car, to mention a few examples, may all be legally prescribed but are rarely or unevenly enforced.

8. WHO in danger of being compromised

Recognizing the threat that alcohol consumption poses

to public health worldwide is well received by most, but the potential of such recognition may be impaired. It may lead the alcohol industry and its allies in the scientific and business community to intensify their lobbying activities under the guise of ‘consultation’ with governments; it may help legitimize the industry’s request for a seat at the table to discuss alcohol control

policies, when such policies are not in the industry’s interest, and it may make it easier for governmental sectors, not interested in alcohol control policies, to establish partnerships with industry that may eventually lead to a weakening of such policies.

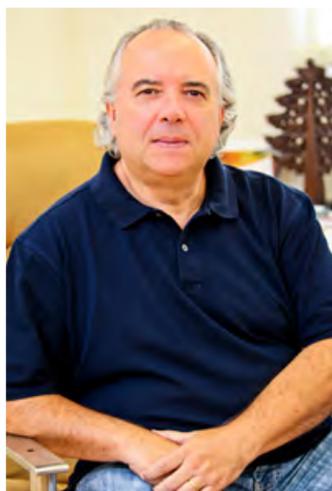
Public opinion surveys on alcohol control policies show that most Brazilians support limiting hours

and places for sale, banning alcohol advertisements on TV, and increasing taxes on alcoholic beverages. This is a long battle, and a long term sustainable strategy is needed to implement alcohol control policies in developing countries.

Professor Ronaldo Laranjeira awarded the 2014 ISAJE Griffith Edwards Prize

The 2014 ISAJE Griffith Edwards Prize to a career scientist has been awarded to Professor Ronaldo Laranjeira.

Professor Laranjeira has been awarded the Prize due to his impact as clinician, educator, articulator, promoter and implementer of public policy in the area of alcohol and drugs, in Brazil, but also internationally.



Professor Ronaldo Laranjeira

Laranjeira’s extensive research is eclectic and covers clinical trials as well as epidemiological studies of alcohol and other drugs, with different disciplinary perspectives. He has been a leading figure in the development of research data that can inform decision making, and as a leading figure in the Brazilian Society for Alcohol and Drug Research. He is a strong advocate for research integrity.

His educational activities have been of great importance for establishing a Brazilian research field but also for health work development in a large and less well-resourced country.

His research work has been pivotal in informing public policies in a country without such a tradition. Over the course of many years, these efforts, coupled with a focus on

knowledge and dissemination through the media, the organization of national conferences and participation in national and international addiction associations, have resulted in changing the way addiction is viewed and preventive and treatment efforts are carried out in Brazil.

Professor Laranjeira has, thus, actively influenced national alcohol and drug policy, but he is also internationally important as a board member of the Global Alcohol Policy Alliance and a senior consultant to the WHO and PAHO.

Young Onset Dementia - Intoxication Foremost Risk Factor

Swedish study finds that heavy drinking as a teenager is a risk factor for developing dementia before the age of 65.

The Swedish study, carried out by researchers at the University of Umeå and led by Professor Peter Nordstrom, tracked 488,484 men conscripted for mandatory military service from September 1969 through to December 1979.

During the course of an extensive 37-year follow-up period, 487 men were diagnosed as having young onset dementia (YOD), at an average age of 54 years.

Intoxication foremost risk factor

The findings indicate that mild or severe alcohol intoxication was the factor most often connected to the onset of dementia in the follow-up period. It increased the risk of dementia almost five-fold, with an estimated 'hazard ratio' (HR) of 4.82.

Stroke or the use of anti-psychotic drugs increased the dementia risk almost three-fold, with an HR of 2.96 and 2.75, respectively. Suffering from depression or having a father with dementia nearly doubled the risk, with HR 1.89 and 1.65, respectively. Other risk factors include drug intoxication, low cognitive function, low body

height and high systolic blood pressure at the time of conscription. Collectively, these factors accounted for 68 % of the YOD cases identified.

Commenting on the study, Jess Smith, a research officer at the UK's Alzheimer's Society, said: "We are a long way off knowing exactly why some people develop dementia and others don't. However, what this study shows once again is that many of the things we are beginning to identify as risk factors are controllable. Kicking excessive teenage drinking or drug habits into touch and treating conditions such as depression early could be key to reducing your risk of dementia in later life."

Teen binge drinkers binge in their twenties

Teenagers who binge drink continue to drink heavily in their 20s, an Australian study has found. The findings of the study challenge the frequently made assumption that youthful bingeing is just a phase that is passed through.

2,000 teenagers, who were followed for 15 years from 1992, found high levels of past-week binge drinking. Half of male participants aged 14 to 17 had consumed five or more alcoholic drinks on a single occasion in the past week. A third of the female teenagers also reported binge drinking in the previous week. The major finding was that more than 90% of male teen binge drinkers continued to drink at these levels or more in their 20s, as did 70% of the females.

The findings, published online in the British Medical Journal Open, are based on secondary analyses of a landmark study of Victorian secondary school students led by Professor George Patton of the Centre for Adolescent Health at the Murdoch Children's Research Institute in Melbourne. The students were interviewed at six six-monthly intervals during their teens and then again when they were aged 20-21, 24-25, and 29 years. Lead author of the analysis was Professor Louisa Degenhardt from the National Drug and Alcohol Research Centre at the University of New South Wales.

"The persistence of binge drinking into young adulthood suggests the need for a range of policies to reduce its

uptake at a young age, such as limiting alcohol's availability, increasing costs and discouraging 'drinking to get drunk,'" Degenhardt said.

Co-author, Professor George Patton, emphasised such policies must target a broader audience than just teenagers.

"Many have had a view that heavy drinking in the teens is a phase that young people will 'mature out of' when they get older. This study is very clear that it is not a 'passing phase' but the beginning of substantial alcohol problems for many young people," Patton said.

New Zealand lowers drink-drive limit

The New Zealand parliament has voted to lower the adult drink drive limit from 80mg% to 50mg%.

Transport Minister Gerry Brownlee said:

"Changes delivered by this legislation will save lives and reduce injuries, and they demonstrate the government's commitment to improving road safety."

The Land Transport Amendment Bill 2013 will lower the adult breath alcohol limit from 400mcg of alcohol per litre of breath, to 250mcg. The blood alcohol limit will reduce from 80mg of alcohol per 100ml of blood, to 50mg.

The legislation creates a new offence for drivers with a breath alcohol level between 251-400mcg, resulting in penalties of an infringement fee of

\$200 and 50 demerit points. For those drivers who refuse or fail to undergo an evidential breath test, the infringement fee will rise to \$700 as well as 50 demerit points.

Drivers who accumulate 100 or more demerit points from driving offences within two years receive a three month driver's licence suspension.

Drinkers have taste for “Open All Hours” policy

The long trading hours of liquor outlets enabling quick access to alcohol has been identified in a research study as being linked to heavy drinking.

The International Alcohol Control (IAC) study, a newly developed international collaborative project, is designed to collect comparative data on alcohol consumption and policy-relevant behaviors in both high- and middle/low-income countries. Initial members of the International Alcohol Control study, including New Zealand, Thailand, Scotland and England, have been joined by Australia, Mongolia, South Africa and Vietnam.

The New Zealand survey was conducted by Professor Sally Casswell from Massey’s SHORE (Social and Health Outcomes and Research Evaluation) and Whariki Research Centre, and funded by the Health Promotion Agency and Health Research Council of NZ.



Professor Sally Casswell

Professor Casswell is the corresponding author for the IAC study, and she and co-author David Jernigan, Associate Professor at Johns Hopkins Bloomberg School of Public Health, USA, are respectively the Chair and Vice-Chair of the Scientific Committee of GAPA, the Global Alcohol Policy Alliance.

Professor Casswell and her colleagues carried out the New Zealand survey prior to changes in the country’s liquor legislation, with data collection including information on respondents’ time of purchase, amounts bought, price paid, varieties of liquor and the location of the purchase. The researchers hope to follow up the 1900 respondents interviewed to assess any impact on the new legislation and they will also be monitoring price changes.

“Our analysis of the relationship between the prices people told us they paid and how much they drank found that people drinking large quantities pay less for their drinks,” Professor Casswell said.

“Those paying lower prices from off-license premises – where most alcohol is sold in New Zealand – were most likely to be daily drinkers; whereas prices paid on-premise in drinking locations, like bars and restaurants, were not linked to frequency of drinking, but were



Professor David Jernigan

linked to how much is consumed in a drinking occasion.”

The survey also showed the heavier drinkers in the survey – both in terms of the quantities consumed and the frequency of drinking – were most likely to have bought alcohol in later hours.

David Jernigan pointed to two specific advances made by the IAC study in regard to issues that have previously vexed researchers. These concern the validity of survey research on alcohol. “One, surveys have been plagued by persistent under-reporting of consumption; by using a beverage and location-specific method for assessing respondents’ consumption, this survey comes very close to covering all the actual consumption in the country as demonstrated by sales data,” Jernigan said. “Two, this study shows that respondents can answer questions about the price they paid for alcohol with reasonable accuracy.”

Policy implications

Professor Casswell said that, while the New Zealand conclusions – that the more available alcohol is, the more likely people will drink heavily – were not startling, the implications of the research findings for local governments and communities were important and timely.

“It is the communities that have to deal with alcohol-related disorders and violence, which are linked to heavier drinking which is, in turn, linked to longer hours spent drinking in bars and pubs. Sales from off-licence premises of takeaway alcohol have also been linked with family violence and child maltreatment.

“Our findings support the importance of limited trading hours, and this is one policy which may be changed quickly given the opportunity in New Zealand for councils to set trading hours – unlike reducing density, for example, which may take longer to achieve,” she says.

David Jernigan explained the international significance of the study. “The IAC study is in particular a landmark effort to test the effects of various alcohol policies on alcohol consumption and problems in low- and middle-income countries,” he said. “The bulk of our present-day evidence comes from high-income countries, and there are questions about how transferable policy solutions may be; this study will help address those questions.”

The study is published in an online issue of *Alcoholism: Clinical & Experimental Research*.

THE INDIAN STATE OF Johnson J.

The Globe has been following the international press reports on the prohibition stance of the Government of Kerala. We asked Johnson J Edayaranmula, a Kerala policy advocate to give us the background to the Government’s alcohol policy.

KERALA – the southernmost State in India, with a population of 33.5 million and known for its highest per-capita consumption of alcohol in the country, has officially adopted a prohibition policy. The State Government has decided to shut down over 730 Liquor Bars and Sundays have been declared as “Dry Days”. The Government has also announced that 10% of the State owned Kerala State Beverages Corporation Liquor Retail Outlets will be closed down each year and over a period of 10 years total prohibition will be implemented in Kerala.

During the past few years both the International and National Media have been highlighting the growing alcoholism in Kerala. The State, known for its high Human Development Index in spite of a low Per Capita Income and lower Gross Domestic Product, has been facing a growing alcohol problem.

To quote a few.....

- In July 2013, the Los Angeles Times published a report about Kerala’s alcohol economy with the headline: “Liquor is the lifeblood of India’s Kerala State.”
- Earlier, The Economist



magazine carried a report with the title “Rum, rum everywhere” declaring Kerala as ‘India’s booziest State’ and highlighting Keralites’ addiction to alcohol.

- In a 2010 story titled ‘Kerala’s love affair with alcohol,’ the BBC News noted: “People in the southern State of Kerala are the heaviest drinkers in India, and sales of alcohol are rising fast.”
- A report appeared in the German News Deutsche Welle titled “From God’s own country to India’s booziest state” says ‘Kerala, often dubbed as God’s own country, is one of India’s most developed States. But it has also become the country’s booziest, witnessing an increase in violence and crimes related to alcohol consumption’.
- The Australian Network News provides a complete picture in their report “Alcoholism, crime on the rise in Indian State of Kerala”, which says “The southern Indian state

KERALA MOVES TOWARDS PROHIBITION

Edayaranmula

of Kerala, often referred to as God's own country, has the best socio-economic indicators in the country. But its alarming alcohol addiction is earning the state a name for all the wrong reasons as the crime rate also increases. The god of choice here is Bacchus, the Roman deity of wine'.

- A thought-provoking article with the caption "Hic, Hic, Hurray!" featured in Deccan Chronicle; 'Kerala state has the nation's highest per capita consumption of booze. It is an undeniable fact that booze is an inseparable part of every social gathering in the state and it always proves to be a dependable source of income for the Kerala government'.
- A report appeared in India News with the title - "Sleepy Kerala is India's booziest state with second highest rate of suicide" highlights - 'A 2011 report by one of India's largest trade bodies (Confederation of Indian Industry-CII) found that Kerala accounted for 16% of national alcohol sales, the largest proportion of any State'.
- Earlier this year, a report in Asia Pacific with the headlines "Alcoholism, crime on the rise in the Indian State of Kerala" reports - Kerala has earned the tag of India's "booziest state", with the highest per capita consumption of liquor in the country'.
- In October 2013, Indiaspend.com report – "The Amazing Jekyll & Hyde Story of India's State-Owned Liquor Barons"

says, 'the southern and small state of Kerala, under the reign of the Kerala State Beverage Corporation, or Bevco as it is known - where the selling of alcohol is so lucrative that it brings in 15% of the state's revenues. And unlike other state-run businesses, its sales (and thus liquor consumption) have been rising dramatically in recent years. Sales have nearly doubled to Rs 8,818 crore in 2012-13 from Rs 4,631 crore in 2008-2009. If we go back to 2001, sales for Bevco have jumped 4 times from Rs 1,337 crore to Rs 8,818 crore'.

The Alcohol Market in Kerala was showing an Annual Growth of 12 % – 67% during the last 30 years. The State Revenue from Alcohol increased from Rs. 407.4 Mn. in 1987-88 to Rs. 75,110 Mn. in 2013-14. The Unrecorded Sales/ Consumption has always been higher than Recorded Sales/Consumption.

Studies by ADIC-India shows that when the Kerala Government has earned Rs. 75,110 Mn. through the Taxes/Excise Departments, almost double the amount has been lost due to the public health harm and social consequences of Alcohol for the Health, Police, Prison, Judiciary, Social Justice, and Traffic Accidents.

As per National Family Health Survey 2009, 30% Adult

Males and 3% Adult Females in Kerala have used Alcohol. Out of this 6% are Daily Users (Dependents). Four distinct trends/patterns are visible in Kerala....

- o Lowering in the age of initiation to alcohol use
- o Increase in the number of Young Drinkers (Adolescents & Youth)
- o Change in Gender - Women & Young Girls started tasting alcohol
- o Hazardous or harmful drinking among users.

The Public Health Harm and Social consequences of Alcohol adversely affects Kerala society. 25% of Hospitalizations, 69% of Crimes, 40% of Road Traffic Accidents, 80% of Divorces and Domestic Violence were linked to Alcohol & Substance Use resulting in huge psychological, physical, financial and social burden on the individuals, families, societies and the State.

Faith organisations have been advocating for a strong alcohol policy.

A most significant event in Kerala was the launch of "MADUMUKTHI" – A Pilot Project on Empowering Communities against Alcohol, Tobacco and Other Substances, conceived by ADIC-India and implemented as a joint initiative of the Dept. of Health & Family Welfare, Kudumbashree State

Mission and ADIC-India with the cooperation of the Departments of Social Justice, Local Self Government, Excise, Police, Youth Affairs, Information & Public Relations and concerned NGOs targeting 140 selected Local Self Government Institutions (10 from each District), 7,00,000 Families and 3 million People covering all the 14 Districts of Kerala in 2013-14, with 100% funding from the Government. This was the first time in the history of Kerala such a comprehensive multi-disciplinary effort in addressing the problem of Alcohol & Substance Use was uniformly implemented through the length and breadth of Kerala.

The outcome was overwhelming. For the first time in the history of Kerala, Alcohol Sales showed a reverse trend in the Financial Year which ended on 31st March 2014, with Liquor Sales dipping by 2% over the previous year, against a past uniform trend of 12% - 67% annual growth. 'Madumukthi', changed the 'alcohol phase' of Kerala, by creating a mass momentum and platform for strong alcohol control policy in the State.

Fortunately, it was during the same period, in connection with the Renewal of Bar Licenses, an old Legal issue pertaining to the existing Bars based on a 2007 Report of the Comptroller and Audit General and the then Excise Commissioner questioning the status and conditions of 418 Bars came up. The Judiciary then intervened and under the direction of the Supreme Court of India the Government of Kerala was forced to close down 418 Bars with effect from 1st April 2014.



Bishops and Clergy Leaders of Six Episcopal Churches in Kerala which met at the Orthodox Bishops House at Chengannur in Kerala State have urged the Government of Kerala to continue with its prohibition policy.

This was an unexpected boost for the Faith Organizations in the State. They demanded the permanent closure of the 418 Bars. The Ruling United Democratic Front (UDF) Government led by the Congress Party had already had 'Phased Prohibition Policy' in their Election Manifesto. The Key decision came from the newly elected President of the ruling Congress Party Mr. V. M Sudheeran - a long-term advocate of the Temperance Movement, who immediately convened a meeting of the State Congress Party which unanimously demanded the permanent closure of the 418 Bars.

In the meantime, ADIC-India made positive use of the situation by convening an "Open Forum on Alcohol Policy", in the State Capital by bringing in all concerned Stakeholders on a common platform jointly with the Regional Resource Training Centre of the Ministry of Social Justice & Empowerment, Govt. of India and FINGODAP Kerala Chapter. The Open Forum urged the Government to adopt a 'people welfare oriented alcohol policy' focusing on raising the standard of living and improvement of public

health as enshrined in Article 47 of the 'Directive Principles of the Constitution of India' and in tune with the 'WHO Global Alcohol Strategy' and the 'UN Resolution on Non-Communicable Diseases'.

This generated a series of Media Discussions and Dialogues in the State. ADIC was fast in sensitizing the Political Leaders, the Faith Leaders, Women, Youth and Cultural Organizations towards the cause of strong control policies.

The result of all this active advocacy is the Government's policy for prohibition.

The challenge will be the implementation of the policy in the State with careful monitoring of the consequences of the policy.

Policy Action in Australia

Raising the legal age for alcohol purchase to 21 “would reduce alcohol-related harm in Australia”

A growing number of Australian public health leaders are calling for the minimum age for purchasing alcohol to be raised from 18 to 21. (The Medical Journal of Australia <https://www.mja.com.au/journal/2014/200/10/should-legal-age-alcohol-purchase-be-raised-21>)

Lead author, Professor John Toumbourou (Deakin University), writes:

“From 2004 to 2010 the percentage supporting this policy increased from 40.7 per cent to 50.2 per cent ... In all states the community is concerned at escalating youth alcohol-related harm. Australians are increasingly aware that this policy is supported by strong evidence that it can reduce youth problems.”

The paper refers to a cross-national study that compared Australian young adults with those in the United States. It found that US youth had lower use of alcohol even after age 21, but also lower use of tobacco and illicit drugs such as amphetamines.

When they were surveyed ten years earlier, as secondary school aged adolescents, the majority

of the US youth (69 per cent) abstained from alcohol, tobacco or illicit drug use compared with 42 per cent who abstained in Australia. Raising the legal age to 21 in the US in the mid-1980s led to a rapid decline in secondary school students using alcohol.

In the paper, the authors also explain how the youth brain is still developing at age 18 and many young people experience irreversible brain damage due to the heavy alcohol use that is now considered normal among young Australians. The authors consider that:

“Raising the legal age will send a clear public health message that alcohol is a neurotoxin for our young people and result in the whole population of adolescents across Australia growing up using less alcohol. This will lead to a generational change in Australian culture toward moderate adult alcohol use gradually becoming more normal.”

Communities “can’t go it alone to cut alcohol related violence”

Community action alone will not significantly reduce binge drinking and related harms, such as violent assaults, without changes to legislation, a major new study from the Australian National Drug and Alcohol Research Centre suggests.

The study was undertaken to examine the effectiveness of community action since the WHO Global Alcohol Strategy emphasises the need for such action to reduce alcohol related harm and risky alcohol consumption.

The researchers pair-matched 20 rural Australian communities in New South Wales, with populations between 5,000 – 20,000, according to the proportion of their population that was Aboriginal, young people and males. The five year study found that the 10 communities that implemented a range of 13 interventions were able to reduce average weekly alcohol consumption across their local government area and minor harms, such as verbal abuse, but there was no impact on binge drinking or major harms, such as assaults, traffic crashes and hospital inpatient admissions.

The thirteen interventions, which were developed in partnership with the communities themselves, were a mix of: prevention (such as school and work-based education and training and regular media messaging on harms); early intervention (such as screening and brief advice in general practice, pharmacies and hospital emergency departments); and targeting high risk individuals and high risk times and weekends.

The 10 communities that implemented the interventions were picked randomly, and the impact of the interventions was measured using community surveys and routinely collected data from police, hospitals and the road traffic authority.

Commenting on the largest randomised controlled trial of interventions which communities themselves can implement, without specific government legislation, to try to reduce their own rates of alcohol harm, Professor Anthony Shakeshaft, the study leader stated: “It suggests that leaving communities to work together to sort out their own alcohol problems is, quite simply, unlikely to work very well without tighter legislation on things like the availability, price and advertising of alcohol.”

Professor Shakeshaft said the results did not mean that community led solutions were without merit. “We did see changes to overall consumption of alcohol per head, which is an important finding for harms like alcohol-related cancers and disease, and we saw some lower level impacts such as less verbal abuse on the streets, which is an important public amenity issue. It was also apparent that communities had different types of alcohol harms, which shows a role for communities targeting their own issues. But it seems communities by themselves will struggle to control the big immediate impacts, such as assaults, if alcohol is widely advertised, relatively cheap and readily available.”

The study *The effectiveness of community action in reducing risky alcohol consumption and harm: a cluster randomised controlled trial* is published in the journal PLOS Medicine. March 11 2014

Drinkwise Australia under attack

Drink responsibly campaign accused of encouraging drinking

The Australian alcohol industry’s Drinkwise organization has come under fire for running a campaign supposedly to encourage 18-24 year olds to avoid binge drinking but which critics claim actually encourages alcohol consumption.

Drinkwise launched the “*Drinking – Do it Properly*” campaign ostensibly ‘to make the ongoing trend of binge drinking to get drunk less socially acceptable amongst young drinkers, and to encourage those already drinking in safe and moderate ways.’

The campaign was developed in response to an increased prevalence in poor drinking choices by young Australians aged 18-24 years. Nationwide research conducted with young Australians by DrinkWise indicated:

- On a normal night out, over 29% of 18-24 year olds indicate consuming 7+ standard drinks
- On a self-defined ‘big night out’ nearly 30% of 18-24 year olds report consuming 11+ standard drinks

Unlike previous campaigns targeting this age group, *Drinking – Do it Properly* utilises social media channels and a dedicated website howtodrinkproperly.com (<http://howtodrinkproperly.com/>) as a content hub to house the campaign creative. Drinkwise emphasises that the campaign is targeted very specifically. It is not aimed at adults aged over 25. Therefore there are no big TV or commercial radio advertisements or huge billboards. The use of social media is designed to ensure the campaign will be seen and heard by young adults and importantly shared and talked about by those in the 18-24 year old age group.

Within three months of the launch, Drinkwise proclaimed the campaign a success. It claimed that one third of 18-24 year olds who experienced it said they now drank less on a night out, and more than 80 per cent thought about the benefits of moderating alcohol consumption.

However, these claims were promptly rebutted by alcohol and health activists. In a letter to the Medical Journal of Australia, Simone Pettigrew, Mike Daube and Nicole Biagioni, all of the Faculty of Health Sciences, Curtin University in Perth, Western Australia, reported the results of their own evaluation of the campaign, based on a sample of 40 18-21 year old drinkers.

The authors of the letter state that overall, in their view, for this sample the takeout message was that drinking is a normal part of life with distinct

advantages if undertaken at “appropriate” levels. They note that no respondents nominated the number of drinks required to achieve this level. Some commented that they were aware of the need to avoid excessive consumption, but said that it is difficult to stop once drinking has commenced. There was no demonstrated understanding of the National Health and Medical Research Council guidelines, which note that young people up to the age of 25 “are at particular risk of harm from alcohol consumption”.

The authors conclude: “Our study findings suggest that, through its “responsible drinking” advertising, DrinkWise instead risks effectively promoting alcohol consumption to 18–21-year-olds. Of considerable concern is that people aged under 18 are also highly likely to be exposed to this advertisement, given its online placement.”

Alcohol labelling decision “a travesty of justice for unborn babies”

Alcohol industry accused of delaying tactics

An alcohol and health watchdog has condemned a Government decision in Australia and New Zealand to allow the alcohol industry another two years to ‘voluntarily’ warn consumers of the risks of consuming alcohol during pregnancy.

Alcohol Healthwatch Director Rebecca Williams said the industry’s voluntary efforts over the past two years “had

been pathetic and typical of their delaying tactics to avoid regulatory intervention.”

Ms Williams said effective labelling was proven to raise awareness of the risks of consuming alcohol during pregnancy. Children exposed to alcohol in the womb are at risk of serious and permanent brain damage and other life-long disabilities, known as fetal alcohol spectrum disorder. Ms Williams said that the rights of these children are being overlooked to protect the profits of the alcohol industry.

A New Zealand-led application for warning labels was submitted to Food Standards Australia New Zealand in 2006. In response and after years of delay the alcohol industry was given two years to include warning messages on products voluntarily. Those two years were up in December 2013. An independent audit undertaken in Australia showed that alcohol industry efforts were totally inadequate.

The audit of 250 products in Australia found that while there had been some improvements since 2012:

- only 37 percent carried any version of the Drinkwise consumer information messages
- only 26 percent carried a pregnancy-related message
- the majority of warning messages (86 percent) took up less than 5 percent of the label
- of products carrying the industry label most (59

percent) were at the back of the product.

Williams says both the Australia and New Zealand Governments are well aware of the risks associated with drinking alcohol, and they are aware of what is required to address these risks. “Self-regulation and voluntary codes of practice by the alcohol industry are shown to be ineffective and do nothing but delay more effective measures being adopted.”

In a speech about vulnerable children in August 2013 the New Zealand Prime Minister John Key had said, “As Prime Minister, I want to see every one of our children getting the very best start to life. They deserve nothing less.” Ms Williams said better warnings on alcohol products would help many children get a better start.

“This latest alcohol labelling decision clearly demonstrates the power the alcohol industry wields. It is time for Governments ... to push back and make decisions based on the evidence and what is in the best interests of the wider community, especially those without a voice.”

Renewed demand to protect children from alcohol marketing

Families ‘under siege’ from alcohol advertising

The Not for Profit sector has urged the Federal Government of Australia to act quickly to protect children from unrestrained alcohol advertising on television, following the release of a national report into alcohol marketing and advertising.

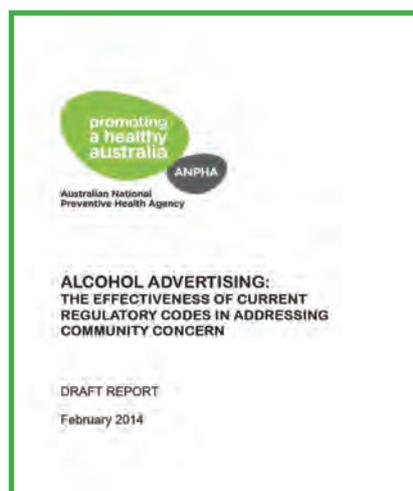
In its Draft Report, the Australian National Preventive Health Agency (ANPHA) says alcohol advertising and marketing is reaching and influencing children and adolescents, and Australia’s current system for protecting them from this advertising is inadequate.

ANPHA’s report, *Alcohol Advertising: The Effectiveness of Current Regulatory Codes in Addressing Community Concern*, recommends removing the exemption in the Commercial Television Industry Code of Practice that allows for the direct advertising of alcohol products before 8:30pm as an accompaniment to the broadcasting of live sporting events on weekends and public holidays.

The report also recommends improving the alcohol industry’s self-regulatory code - called the Alcohol Beverages Advertising (and Packaging) Code (ABAC), which governs the content of alcohol marketing.

The National Alliance for Action on Alcohol (NAAA) responded to the report’s release by calling on the Government to act quickly to protect children from “dangerously high levels of alcohol advertising”.

Professor Mike Daube AO, Co-Chair of the NAAA and alcohol spokesperson for the Public Health Association of Australia, said Australian families are under siege from alcohol marketing, with children often seeing more alcohol advertising than adults.



“Alcohol has a devastating impact on individuals and the community. It’s time to protect kids from the relentless pressure to drink that comes from unrestrained alcohol advertising on TV, through sports sponsorship and in social media, at all times of the day, 365 days of the year,” Daube said.

“This new report makes it abundantly clear that the Government should act to end

the loophole permitting TV alcohol promotion through sport, and end the current charade of industry self-regulation.”

ANPHA was tasked with examining the current system of regulation around alcohol marketing and advertising. Its Draft Report describes this system, which consists of self-regulatory, co-regulatory and legislative elements, and evaluates its effectiveness. The key purpose of the Review was to assess whether the current mix of provisions is serving to adequately protect children and adolescents (14 to 17 year olds) from exposure to alcohol advertising.

“Considerable public concern exists that marketing and advertising of alcoholic beverages is influencing young Australians and contributing to patterns of harmful drinking,” ANPHA says on its website.

“Australians are now exposed to an extensive amount of alcohol advertising through a variety of traditional media, digital media, promotional activities and sponsorships. Evidence indicates that Australian adolescents are exposed to almost the same level of alcohol advertising as adults aged 18-24.”

Brand-Specific Television Alcohol Ads - A Significant Predictor of Brand Consumption Among Underage Youth

Underage drinkers are three times more likely to drink alcohol brands that advertise on television programs they watch compared to other alcohol brands, providing new and compelling evidence of a strong association between alcohol advertising and youth drinking behavior.

This is the conclusion of a new study from the Center on Alcohol Marketing and Youth (CAMY) at the Johns Hopkins Bloomberg School of Public Health and the Boston University School of Public Health that examined whether exposure to brand-specific alcohol advertising on 20 television shows popular with youth was associated with brand-specific consumption among underage drinkers.

Published in *Alcoholism: Clinical and Experimental Research*, it comes on the heels of a study from the same researchers which found underage drinkers are heavily exposed to magazine advertisements for the alcohol brands they consume.

“Taken together, these studies strengthen the case for a relationship between brand-specific alcohol advertising among underage youth and brand-specific consumption,” said lead author Craig Ross, PhD, MBA, president of Virtual Media Resources in Natick, Massachusetts. “As alcohol continues to devastate so many

young lives, youth exposure to alcohol advertising should be reduced.”

Alcohol is the number one drug among youth and responsible for 4,300 deaths per year, yet alcohol advertising in the U.S. is primarily regulated by the industry itself through a voluntary code which serves as the main vehicle for reducing youth exposure to and appeal of alcohol advertising.

In the current study, researchers surveyed over one thousand young people aged 13-20 recruited from a national Internet panel maintained by Knowledge Networks. All reported consuming at least one drink of alcohol in the past 30 days. The researchers determined all alcohol brands the participants had consumed within the past 30 days, as well as their exposure to alcohol brand advertising on 20 television shows they had watched within the past month.

The researchers found that the relationship between consumption of a brand and advertising exposure for that brand was significant, and that the relationship was strongest at lower levels of exposure. Their results held even after controlling for other factors influencing youth drinking, such as their parents’ drinking, whether the youth chose the brand themselves, the brand’s average price, and the popularity of the brand among adults.

“There is a link between exposure to brand-specific advertising and youth choices about alcohol, independent of other factors,” said study author and CAMY director David Jernigan.

“The question now becomes what do alcohol advertisers do with this information, given the consequences of alcohol consumption in underage youth,” added study co-author Michael B. Seigel, MD, MPH, of the Boston University School of Public Health.

At least 14 long-term studies have found that the more young people are exposed to alcohol advertising and marketing, the more likely they are to drink, or if they are already drinking, to drink more.

“The Relationship Between Brand-Specific Alcohol Advertising on Television and Brand-Specific Consumption Among Underage Youth” was written by Craig S. Ross, Emily Maple, Michael Siegel, William DeJong, Timothy S. Naimi, Joshua Ostroff, Alisa A. Padon, Dina L.G. Borzekowski, and David Jernigan.

This research was supported by a grant from the National Institutes of Health’s National Institute on Alcohol Abuse and Alcoholism (5R01AA020309).

WHO Framework for Engagement with Non-State Actors

For the past three years a rigorous debate has ensued over the quest of the WHO to seek reform of its organisation, in particular over engagement with non-state actors. Behind the initial suggestion for reform lay the need to find greater funds for the WHO through “innovative financing mechanisms”. A number of member states and non-governmental organisations voiced their concern for maintaining the integrity of the world’s leading health body and over conflict of interests between public health and commercial profit.

In October 2013 WHO held a consultation with non-governmental organisations, the commercial sector and member states on the issue. A web-based consultation was also launched. Various draft frameworks for engagement with non-state actors were presented to the Executive Board and finally to the World Health Assembly in May 2014. The document produced also proved to be contentious so that no formal agreement was reached. The British Medical Journal alerted the public health community to its deep concern about the proposed Framework and published a series of letters following an article by Judith Richter, freelance researcher and Associate Senior Research Fellow, on ‘Time to turn the tide: WHO’s engagement with non-state actors and the politics

of stakeholder governance and conflicts of interest’. Lida Lhotska of the International Baby Food Action Network, which had been one of the leaders of the Conflict of Interest Coalition, urged representatives to safeguard and ensure that WHO was strengthened to fulfill its mandate to maintain its independence and integrity. The Global Alcohol Policy Alliance also responded to the BMJ’s call to action (see page 21).

After extensive debate the WHA decided that WHO Regional Committees should further discuss the matter at their meetings later in the year. They were in favour of strengthening relations with non-state actors so long as risk and conflict of interest were accurately described and transparently managed. The benefits of engagement to be weighed carefully against the risks involved. There was a need to clarify distinction between real and perceived conflicts of interest. This was reiterating the advice proffered in a previous Assembly that the following guidelines should underpin WHO’s engagement with the commercial sector and NGOs.

- WHO is an inter-governmental organization, and WHO’s decision making supremacy lies with WHO’s governing bodies;
- WHO is a science and evidence-based organization

espousing a public health approach, and the development of norms, standards, policies and strategies must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest;

- transparency of WHO’s engagement with external stakeholders is paramount; and
- conflicts of interest must be adequately managed.

During this year’s debate, there was agreement on excluding the tobacco industry. Several member states felt that engagement with other industries, such as alcohol, food and beverage industries, those that contravene labour law and cause environmental damage should also be excluded. However on this there was no consensus.

The Globe asked Anya Gopfert, a representative of the International Federation of Medical Students, to give her impression of the debate (see page 22).



67th World Health Assembly: WHO framework of engagement with non-State actors

The Global Alcohol Policy Alliance agrees with the concerns expressed over the risk of the conflict of interest involved in the governance reforms now being discussed at the WHA. We have been following with concern the unfolding events leading to the present debate about WHO relations with non-State actors. In the process, we have also voiced our opinion in consultation meetings held between WHO and Civil Society organizations. In the present reform process, measures to safeguard WHO's integrity and authority must prevail over any wish to draw the private sector closer to global health policy making. There are certainly sectors beyond the tobacco and arms industries (ref discussion paper A67-6) in which profit making for the corporations is detrimental to public health.

We are particularly concerned that the Global Strategy to Reduce the Harmful Use of Alcohol and the NCD Global Action Plan 2013-2020 must be safeguarded from the risks posed by the alcohol industry.

The global alcohol industry, due to the saturation of Western markets, has, over the past decades, targeted the BRIC countries (Brazil, Russia, India and China). However, they are now turning their attention to Africa – a continent already beset by communicable diseases and facing a serious rise in non-communicable diseases. In June 2010, the **WHO African Regional Committee** cautioned, “there is need to regulate the content and scale of alcohol marketing and the promotion of alcoholic beverages in particular sponsorship, product placement as well as internet and promotional merchandising strategies.” The Committee went on to say, **“No other product so widely available for consumer use accounts for so much premature death and disability as alcohol”**.

The **World Bank** has highlighted the risks posed by the alcohol industry regarding misinformation about the social and health consequences of drinking.

“People are not always fully aware of the health (and other) consequences of unhealthy lifestyle choices such as smoking, alcohol abuse, physical inactivity, and poor diet. They may also be misled by deliberately distorted information promoted by the food, alcohol, and tobacco industries.”

“Most cost-effective measures to reduce risk factors are in the domain of agencies or ministries other than health, such as ministries of trade, finance, agriculture, and transport, but may challenge vested interests and face strong lobbying by tobacco, alcohol, and other industries. Therefore, while they include some of the cheapest and most effective interventions (such as tobacco and alcohol taxation), they may be politically difficult to achieve, requiring robust, high-level leadership and/or effective impacts to build partnerships and garner broad support.”

Whilst the alcohol industry maintains that it supports the WHO Global Strategy to Reduce the Harmful Use of Alcohol, it consistently opposes three of the most effective strategies for reducing alcohol related harm, namely: availability of alcohol, marketing of alcoholic beverages and pricing policy. It is clear that the commercial desire for profit outweighs any concern for the harm it causes and is a hindrance to the implementation of effective strategies to reduce such alcohol related harm.

It is quite clear that WHO needs to establish clearly defined criteria when dealing with conflicts of interest in order to safeguard its integrity.

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Chair
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21 May 2014

Who should get a say in WHO policies?

As a relative newbie to navigating the field of global health, I am consistently amazed by the rapid evolution and increasing complexity of this world. It is this situation, with the vast number of civil society organisations (CSOs) and other global health actors, which forms the backdrop to the current non-state actor debate at the World Health Organization (WHO). The continuous increase in the number of CSOs in official relations with WHO since its creation has resulted in there being an astounding 190 CSOs attending the 67th World Health Assembly in May 2014. Despite this figure, the WHO was relatively late to prioritise reform of non-state actor engagement; whereas the UN began discussing the need to develop engagement with non-governmental organisations from observation to incorporation as early as 1992.

I attended my first World Health Assembly in May 2013. Then, I found myself wearing a rather bemused smile as I wandered the corridors of WHO, collecting countless sheets of paper and attempting to decipher the roles of the various CSOs that I met and what the point of CSO statements were. Even prior to this experience, I had begun following the WHO reform discussions on non-state actors, however it was in May 2013 that I really began to understand the urgency behind the need for reforming the system. By the time it came to WHA67 in 2014, I was critically listening to debates specifically on the non-state actor engagement framework and attempting to form an opinion and understanding of the issue and the differing perspectives. This topic has not had an easy ride, and as I prepared for WHA 2014, I did not see how the latest proposal sufficiently addressed concerns raised on previous drafts (and the earlier Global Health Forum) with regards to conflict of interest. Consequently, I anticipated that the discussions at WHA67 would not be significantly different to previously.

The discussion took quite some time, and necessitated a couple of extended breaks. Many member states and civil society organisations (CSOs) retained serious concerns about managing conflict of interest in the new proposal. These concerns and the risks associated with conflict of interest, seemed to me to be a serious threat to public health, and I was surprised there was not more opposition from member states. Some



Anya Gopfert

countries, such as Colombia, however presented their fears in a clear and concise statement which emphasized that the proposal did not do enough to categorize risk, thereby treating CSOs and industry with the same approach. The delegate from Colombia was also concerned that, “(the proposal) does not identify the benefits that WHO would enjoy as a result of interaction with NSAs.” Other countries were also concerned about the engagement with transnational corporations who may be judged to present a conflict of interest towards WHO’s policy making. To me, it seems that these concerns bring to the forefront the driving principle of the WHO, or what should be at the centre of every decision, the protection of global public health.

The strongest objections however came from the CSOs themselves. I feel that this debate has been a unifying one for the CSOs who are currently in official

relations with the WHO. Although there is a great potential for CSOs to increase their power within the WHO with this reform, and even to a certain extent within this proposal, the threat posed global public health by the conflict of interest risk unites many CSOs in their opposition to the proposal. IBFAN emphasized in their intervention that although many concerns have been addressed, that the “risk of WHO’s constitutional mandate and functions being unduly influenced by WHO’s own secondary interest, eg. its efforts to secure funding” were too great.

And so, the 67th WHA pushed forward the proposal for further discussions at the Regional Meetings in the Autumn of 2014. This was much to the dismay of the UK and France who seemed largely in favour of pushing through the proposal as it stands. It seems that this will be an extremely tough nut to crack, and although I personally do not support the proposal from WHA67, it remains to be seen how this debate can be closed when industry and transnational corporations are lobbying so heavily for further engagement with the WHO. I do not know if there will ever be a proposal which attempts to offer different levels of engagement depending on the conflict of interest risk which is associated with the individual CSO, corporation or other organization. However, for the time being we retain the current system, and CSOs must continue to ensure that there are member states who share their opinions on this debate and all others, in order that they can make their voices count. I look forward to seeing where this goes in the future, and hope that WHO can find a solution which ultimately is the best for global public health and policy making.

Anya Gopfert
Medical Student
Newcastle University



Global Alcohol Policy Alliance



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The conference website will be up and running soon. To register your interest in the conference, please email: gapcscotland@alcohol-focus-scotland.org.uk

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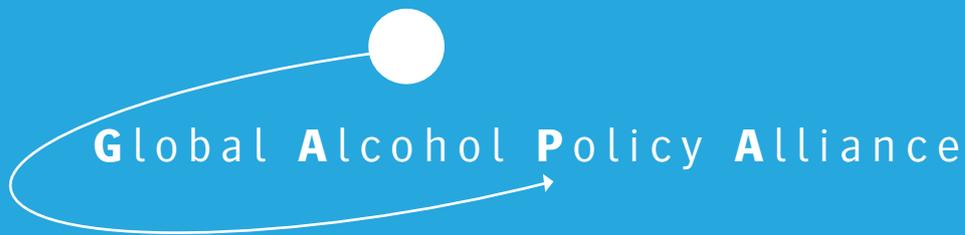
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