24 October 2019

GAPA Position Paper on:

WHO Director General's report on the implementation of WHO's global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward

WHO issued a discussion paper 24 October and opened a web-based consultation until 4 November. This is part of a process to fulfil the request from the World Health Assembly 2019 [1] to report on the implementation of WHO's global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward.

More information the discussion paper and the link to the submission form can be found here: https://www.who.int/health-topics/alcohol/online-consultation.

In this paper the Global Alcohol Policy Alliance (GAPA) highlights important elements for consideration and encourages its own network and the wider global health community to take part in the consultation.

Introduction

GAPA Chair, Professor Sally Casswell, in a recent Lancet commentary "Will alcohol harm get the global response it deserves?" argues "The commercial drivers and industry practices of transnational alcohol corporations require a Framework Convention for Alcohol Control to replace the global strategy". She argues the expansion of marketing in the social media, which countries are unable to control, and the expanding network of trade treaties and economic agreements, which are supportive of industry interests, are additional reasons to call for a legally binding treaty on alcohol similar to the FCTC. The 2019 World Health Assembly decision to ask for a recommendation on the way forward provides an ideal opportunity for actors in the global health governance arena to challenge the previous lack of action and give governments in LMICs the support they are asking for, to support achievement of the SDGs, and to ameliorate the NCD epidemic" [2].

Inadequate Global Response

As the WHO Global Status Report on Alcohol and Health, 2018, points out: "alcohol remains the only psychoactive and dependence-producing substance with significant global impact on population health that is not controlled at the international level by legally-binding regulatory frameworks" [3]. The WHO global strategy to reduce the harmful use of alcohol [4], a non-binding agreement, was endorsed in 2010 but implementation has been poor reflecting a lack of resource and political will. Technical expertise in alcohol control measures is often lacking at national levels and the lack of adequately resourced international and regional secretariats has exacerbated the lack of impact of the global strategy. In the absence of philanthropic funding and limited WHO and other intergovernmental resources, there has been little investment in capacity building in low- and middle-income countries. WHO has recently hosted a collaboration with civil society, GAPA included, in developing the technical package SAFER to support Member States in developing cost effective interventions to reduce alcohol harm, including the "best buys" [5]; taxation, regulating availability and banning or regulating alcohol marketing. However, as yet the resources allocated to the

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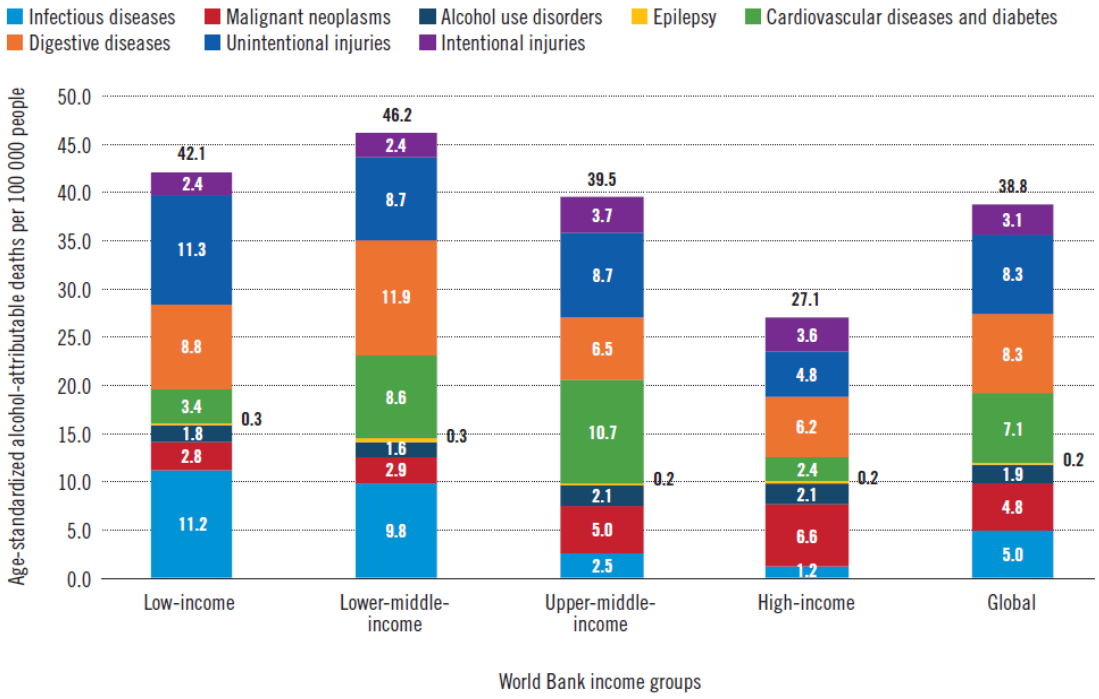
implementation of the global strategy and SAFER remain inadequate and without a stronger commitment in the global environment is unlikely to have a sufficient impact.

Alcohol Harm

The global burden of alcohol is substantial [3]. There are an estimated 3 million alcohol deaths globally every year and mortality resulting from alcohol consumption is higher than that caused by diseases such as tuberculosis, HIV/AIDS and diabetes [3].

Figure 1 Alcohol-attributable deaths, by income group and globally, 2016



Alcohol-attributable deaths by disease or injury condition, by national income group and globally (WHO, 2018 [3, p. 82]; the legend, read left to right, shows categories from the bottom up)

Not accounted for in the Global Burden of Disease figures are the health and socio-economic burdens of alcohol including the harm to other than the drinker [6]. Alcohol contributes to inequity. Gender disparity in alcohol consumption is widespread and men account for at least two-thirds of the alcohol consumption in most societies. Male drinking absorbs family resources (e.g., [7]), and is associated with harm to women and children (e.g., [8,9-11]). Alcohol harm also contributes to inequity since the harm per litre of alcohol consumed tends to be greater in poorer than in richer societies [3], and within a society for poorer versus richer people both in high-income countries (e.g., [12,13]) and in low- and middle income countries [14].

Projections for the future

Data on alcohol exposure indicate that between 1990 and 2017 global adult per-capita consumption increased from 5·9 L to 6·5 L and is projected to continue rising [15] and particularly so in Middle Income Countries (MIC) in the Americas, Asia and the Pacific [3]. This lack of progress and projected increases, particularly in middle-income countries indicates the approach taken in the endorsement of a global strategy was not sufficient and a stronger response is needed.

A global health treaty to counter-balance trade treaties, cross border marketing and industry influence

Since the endorsement of the global strategy, developments have made it even less likely a global strategy, if endorsed today, would gain traction. The first is a general absence of policy coherence between trade and health; many countries have, since 2010, signed up to economic agreements that, by allowing corporations to sue governments, have a chilling effect on governments' willingness and capacity to implement effective alcohol policy [16]. The global strategy on alcohol is not of sufficient normative standing to counterbalance these economic agreements. In discussions in the World Trade Organisation context the global strategy on alcohol has rarely been cited as an authority in contrast to the Framework Convention on Tobacco Control (FCTC). For instance, a study of "specific trade concerns" (STCs) raised in the WTO's Technical Barriers to Trade Committee found that over half (12/20) of the tobacco-related STCs since 2005 cited the FCTC, while only 3 of the 46 alcohol-related STCs since 2010 cited the Global Strategy on alcohol [17]. While there are often provisions in trade treaties for exceptions on the basis of public health issues, these provisions are rarely applied. Furthermore, if there is an alternative to the public health measure which is less disruptive to trade, the public health measure will be disallowed even if the alternative is effective in health terms [18].

Alcohol marketing is essential for the transnational alcohol corporations both in its direct recruitment of drinkers and building of brand allegiance but also by normalising alcohol use in new contexts. Alcohol marketing resources are increasingly being shifted to the digital arena, particularly in the social media platforms. These platforms provide the opportunity to use detailed data to target individuals and use 'native' marketing, which does not appear to be marketing material, to influence recipients. LMICs are part of the digital revolution and young people in these countries are exposed to such marketing [19,20]. E commerce in trade agreements, "designed to keep the digital domain, as far as possible, a regulation-free zone", pose new obstacles to national efforts to regulate the availability of alcohol [21].

Third, the consolidation and size of transnational alcohol corporations and an openness in global governance to public–private partnerships have facilitated their increased penetration of national and global health environments and successful subversion of effective alcohol policy [22-24]. Transnational alcohol corporations have used lobbying and corporate social responsibility, including public–private partnerships, to distract from their reliance on very heavy drinking occasions for considerable proportions of their sales and profits [25] and at the same time to present themselves as part of the solution to reducing alcohol harm.

Alcohol industry has become increasingly concentrated over the last decades to the point where the biggest beer and spirits producers control a large part of the global alcohol market. The beer and spirits industries are now dominated by a small number of supranational corporations, with economies larger than those of many nation states [26]. Individually and working together in public relations organisations, such as the International Alliance for Responsible Drinking (IARD) and their national partners, they are active in the global health policy space [27]. In 2013 the public health community raised alarms over their PR activities in relation to the implementation of the WHO global strategy [28]. Recent figures published in T*he Economist* show that the alcohol industry, which in 1999 invested half as much on lobbying in America compared to tobacco, now spend almost a third more [29]. Alcohol industry actors are highly strategic, rhetorically sophisticated and well organized in influencing national policymaking [30]. Their footprint is also visible in LMIC where they ventured into writing the national alcohol policy documents in several African countries [31] and

seriously obstructed the passing and implementation of public health-oriented policies in other countries [32].

Effective strategies are available and will form the basis of a legally binding health treaty on alcohol

The case of Russia indicates that systematic implementation of evidence based alcohol policies since the early 2000s resulted in a decrease in all cause mortality along with a decrease in alcohol consumption and an increase in life expectancy [33].

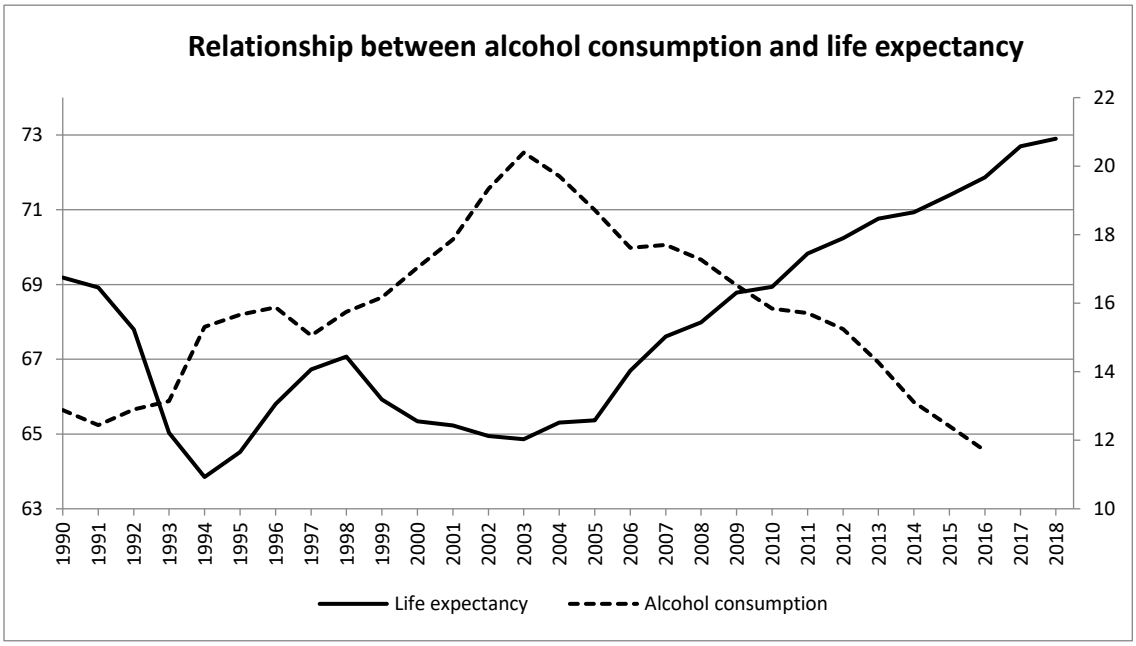


Figure 2: Trends in life expectancy in years (left scale) and total alcohol consumption in litres per capita (right scale). taken from Nemtsov, Neufeld and Rehm, 2019 [34].

The WHO 'best buys' and 'good buys' in the context of a legally binding treaty which also excludes the alcohol industry from engagement in policy development, as Clause 5.3 of the FCTC does, will prevent the projected increase in alcohol harm globally.

Many academics, including the Global Burden of Disease Alcohol and Drug Use Collaborators [35-38], and professional organisations, including the World Medical Association, have long called for a similar legally binding framework for alcohol [39]. GAPA adopted this as its advocacy goal in 2016.

In summary there is a need for a process leading to endorsement of a global legally binding treaty on alcohol in order:

* to counterbalance effects of international trade and economic treaties on alcohol control policy

* to negotiate a strong symbolic statement, denormalising alcohol

* to foster international cooperation in controlling the alcohol market including the marketing of alcohol in the digital ecology;

* to create an intergovernmental forum, and a secretariat with resources to facilitate implementation of the best buys including standards on taxation; on control systems limiting times and places of sale and service; and on all forms of marketing

* to provide a clear statement of limits on the role of economic operators, as in Article 5.3 of the FCTC.

GAPA recommends:

That member states request the Director General of the World Health Organisation to investigate, in consultation with Member States and civil society (without conflict of interest), the necessity and feasibility of an international legally binding treaty to reduce the harmful use of alcohol

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