SUBREGIONAL TRAINING FOR LEADERSHIP AND ADVOCACY TEAMS TO REDUCE ALCOHOL HARM IN YOUNG PEOPLE (MODULE 1)

14–16 November 2017
Da Nang, Viet Nam
TRAINING REPORT

SUBREGIONAL TRAINING FOR LEADERSHIP AND ADVOCACY TEAMS TO REDUCE ALCOHOL HARM IN YOUNG PEOPLE, MODULE 1

Convened by:

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NOTE

The views expressed in this report are those of the participants of the Subregional Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People, Module 1, and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Subregional Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People, Module 1, in Da Nang, Viet Nam from 14 to 16 November 2017.
CONTENTS

SUMMARY ................................................................................................................................................. 1

1. INTRODUCTION ....................................................................................................................................... 2
   1.1 Training organization .......................................................................................................................... 2
   1.2 Training objectives ............................................................................................................................. 2

2. PROCEEDINGS ......................................................................................................................................... 2
   2.1 Opening session ................................................................................................................................. 2
   2.2 Leadership and advocacy to reduce alcohol harm in young people ................................................. 3
   2.3 Overview of alcohol harm with a focus on young people ............................................................... 3
      2.3.1 Global and regional burden of alcohol harm ............................................................................ 3
      2.3.2 How alcohol harms young people ......................................................................................... 4
      2.3.3 Global targets and strategies for alcohol harm reduction ....................................................... 4
      2.3.4 Influence of alcohol industry .................................................................................................. 4
   2.4 Country alcohol harm burden in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam .................................................................................................................. 5
   2.5 Group work 1: What are the causes and consequences of alcohol harm in young people in my country? ............................................................................................................................................. 6
   2.6 Panel discussion: Alcohol policy “best buys” and restriction of illicit and informally produced alcohol ........................................................................................................................................ 6
      2.6.1 Availability of alcohol ................................................................................................................ 6
      2.6.2 Pricing policies ............................................................................................................................ 7
      2.6.3 Marketing of alcoholic beverages ............................................................................................. 8
      2.6.4 Restriction of illicit and informally produced alcohol ............................................................... 8
   2.7 Group work 2: What is my country’s response to alcohol harm in young people? ........................ 8
   2.8 Site visit: Da Nang Psychiatric Hospital ......................................................................................... 10
   2.9 Supporting young people and their families in reducing alcohol harm ......................................... 11
   2.10 Next steps for strengthening alcohol harm reduction in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam ...................................................................................... 12

3. CONCLUSIONS AND RECOMMENDATIONS ......................................................................................... 12
3.1 Conclusions .............................................................................................................. 12
3.2 Recommendations ...................................................................................................... 13
  3.2.1 Recommendations for Member States ......................................................... 13
  3.2.2 Recommendations for WHO ................................................................. 14

ANNEXES

ANNEX 1. List of participants, temporary advisers, observers and secretariat ................. 15
ANNEX 2. Training programme .................................................................................. 20
ANNEX 3. Group work: What is my country’s response to alcohol harm in young people? 23
ANNEX 4. Group work: Country action plan ................................................................. 27

Keywords

Alcohol related disorders / Alcoholism / Alcohol drinking- adverse effects / Adolescents /
Capacity-building / Leadership
SUMMARY

The Subregional Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People, Module 1, took place in Da Nang, Viet Nam from 14 to 16 November 2017. A team of participants from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam attended the training.

The first day was dedicated to the overview of alcohol harm with a focus on young people. Alcohol is the world’s fifth leading risk factor for disease burden. In the Western Pacific, 5.9% of all deaths are attributable to harmful use of alcohol. Harmful consumption of alcohol has many negative consequences; it not only leads to many neuropsychiatric disorders and noncommunicable diseases but also is associated with several communicable diseases. Especially among children and young people, it is further linked to injuries.

Adolescence is a key time of behaviour change in an individual’s life cycle and for brain reorganization. Alcohol consumption during this period adversely affects these developmental changes. Further, young people have particular reactions to alcohol as compared to adults; while they are less sensitive to sedation and mobility effects, they are more sensitive to its social and rewarding effects. These reactions can make young people easily intoxicated, placing them – and the community – at risk of physical, sexual and emotional harm. Furthermore, young people can develop dependence on alcohol more quickly than adults, and persons who initiate drinking at early ages tend to develop alcohol problems later in life.

The Global Strategy to Reduce the Harmful Use of Alcohol endorsed in 2010 lists 10 target areas for alcohol harm reduction, ranging from leadership to the role of the health and welfare sectors. There is also global consensus over the need to decrease harmful use of alcohol by 10% as part of the strategy to address noncommunicable diseases.

The second day focused on the most effective interventions: alcohol policy “best buys” and restriction of illicit and informally produced alcohol. Measures that reduce alcohol consumption and alcohol-related harm specifically among young people are: setting legal minimum drinking ages; regulating access to settings and events that young people frequent; and screening problematic use and early interventions. The site visit to the district mental health facility pointed also to the need for strengthening informal and primary health care services interventions.

The last day continued on the topic of health service response to the harmful use of alcohol. Besides policy and legislative measures, additional interventions such as family, school and community action can prevent or reduce alcohol consumption. There are evidence-based interventions for the clinical management of young patients with harmful alcohol use and/or alcohol use disorder.

Using inputs from the group work, countries drafted action plans and prepared follow-up actions at the country level for the next year. Rotation of the hosting among the participating countries for the organization of Modules 2 and 3 will be considered to strengthen common interest and promote joint ownership of the course.
1. INTRODUCTION

1.1 Training organization

A Subregional Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People, Module 1, took place in Da Nang, Viet Nam from 14 to 16 November 2017. The training was organized by the World Health Organization (WHO) Regional Office for the Western Pacific. A team of participants from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam, three WHO temporary advisers, one resource person, one observer and seven WHO Secretariat representatives attended the training. An informal consultation to develop the training package was held in Manila, Philippines on 29–30 June 2016 to develop the training package. The training will be delivered in three modules over a one-year period.

The list of participants is available in Annex 1 and the training programme is available in Annex 2.

1.2 Training objectives

The objectives of the training were:

1) to develop leadership competencies and skills for advocacy that can be applied to practical and appropriate approaches to alcohol harm reduction in young people;

2) to discuss tools, best practices and country experiences on alcohol harm reduction in young people;

3) to identify opportunities to build a regional network of alcohol harm reduction advocates; and

4) to develop a plan that includes priority cost-effective interventions for alcohol harm reduction in young people.

2. PROCEEDINGS

2.1 Opening session

Opening remarks were delivered by Dr Hai-Rim Shin, acting Director of the Division of NCD and Health through the Life-Course, on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific.

The Regional Director expressed his commitment to protecting young people from the harmful use of alcohol. He emphasized that young people are especially vulnerable to the harmful effects of alcohol. This is significant considering that within the Western Pacific Region, Cambodia, the Lao People’s Democratic Republic and Mongolia have the highest total alcohol consumption per capita for young people aged 15–19 years among low- to middle-income countries. When it comes to alcohol, the best advice for young people is “later is better” and “less is better” – that is, start drinking at an older age and avoid binge drinking. However, in the Western Pacific Region, one in three current drinkers aged between 15 and 19 years have engaged in excessive drinking. The onset of many mental disorders peaks during adolescence and young adulthood. Depression and anxiety are closely linked to alcohol consumption. Young people are especially at risk for alcohol-related injury (e.g. drink-driving, violence), risky sexual behaviour and suicide.
Fortunately there are effective measures to control harmful drinking, including: regulating access to and physical availability of alcohol; increasing the price through taxation; and controlling the marketing of alcoholic beverages effectively. In addition, there are evidence-based interventions for the clinical management of young patients with harmful alcohol use and/or alcohol use disorder.

For this reason, WHO has developed the training course to strengthen the leadership and advocacy skills of a local core group of public policy and community leaders on this topic.

2.2 Leadership and advocacy to reduce alcohol harm in young people

Given the scientific evidence of serious impact on morbidity, mortality and harm in other forms (injuries, harm to others, etc.), public-health-oriented alcohol action requires advocacy and leadership. Advocacy is strategic action that can be undertaken, blending science, ethics and politics to help transform systems and improve environments and policies that shape people’s behaviours and choices, and ultimately their health. Advocacy focuses on the general population, particular groups in a community and policy-shaping institutions.

A framework for advocacy in 10 steps was proposed and discussed, as well as the possible roles of health professionals: representing (speaking for people), accompanying (speaking with people), empowering (enabling people), mediating (facilitating communication), negotiating (bargaining with people in power) and networking (building coalitions). Advocacy is about understanding political action, building an evidence-based message, engaging key stakeholders and communicating.

More proactive advocacy to policy-makers and the public is needed to raise awareness and promote action, and to encourage the use of available publications and resources. WHO can assist Member States through public campaigns, technical support, capacity-building and other activities that enable political action, increase competence, and develop tools for effective policies and programmes.

2.3 Overview of alcohol harm with a focus on young people

2.3.1 Global and regional burden of alcohol harm

Worldwide, 3.3 million people die every year due to harmful use of alcohol. Including drink driving, alcohol-induced violence, and a multitude of diseases and disorders, this represents 5.9% of all deaths, or one in 20 deaths globally every year. Twenty-five per cent of mortality among people aged 15–29 years is attributable to alcohol.

Overall 5.1% of the global burden of disease and injury is attributable to alcohol, as measured in disability-adjusted life years (DALYs). Alcohol consumption causes death and disability relatively early in life.

Alcohol use has been associated with increased risk of injury in a wide variety of settings, including traffic injuries (involving vehicles, bicycles and pedestrians), falls, fires, injuries related to sports and recreational activities, and self-inflicted injuries. Harmful alcohol use is linked to different forms of interpersonal violence, such as youth violence, child maltreatment, intimate partner violence, elder abuse and sexual violence. The harmful use of alcohol also brings significant social and economic losses to individuals other than the drinker and society at large.

In the Western Pacific Region, 6.8 litres of pure alcohol was consumed per person aged 15 years or older. More than 30% of this consumption was of unrecorded alcohol – that is, homemade or illegally
produced/sold alcohol. The worldwide total consumption is equal to 6.2 litres of pure alcohol per person 15 years and older.

Today many more young people are drinking and at younger ages. In the Region, 15–30% of young people drink. While the gender gap in prevalence is generally closing, rural–urban differences remain in some countries and areas, with more drinkers in urban areas. Binge drinking is also becoming more common. Young people are reporting increasing alcohol-related harm and risks including injuries, risky sexual activity, suicidality, and impaired relationships and participation in education and employment.

2.3.2 How alcohol harms young people

Specific biological, neurological, social and psychological factors make young people particularly vulnerable to alcohol harm. Adolescence is a key time of behaviour change in an individual’s life cycle and for brain organization. Alcohol consumption during this period adversely affects these developmental changes. Further, young people have particular reactions to alcohol as compared to adults; while they are less sensitive to its sedation and mobility effects, they are more sensitive to its social and rewarding effects. These reactions can make young people easily intoxicated, placing them and the community at risk of physical, sexual and emotional harm. Furthermore, young people can develop dependence on alcohol more quickly than adults, and persons who initiate drinking at early ages tend to develop alcohol problems later in life.

There is debate about the possible beneficial effects of alcohol consumption to cardiovascular health. If such an effect does exist at all, it certainly does not apply to young people. For young people there simply are no health benefits of alcohol consumption. Without a doubt, onset of drinking is best delayed as long as possible and binge drinking is to be avoided completely. Thus, “later is better” and “less is better” summarizes best the guidance emerging from available science.

2.3.3 Global targets and strategies for alcohol harm reduction

The Global Strategy to Reduce the Harmful Use of Alcohol was endorsed in 2010. It focuses on 10 key areas of policy options and interventions at the national level. Evidence shows that among these, the three most cost-effective interventions are: limiting access to and decreasing physical availability of alcohol, increasing prices, and regulating marketing of alcohol. Measures that reduce alcohol consumption and alcohol-related harm specifically among young people are: setting legal minimum drinking ages, regulating access to settings and events that young people frequent, and screening problematic use and early interventions.

The United Nations High-level Meeting on Noncommunicable Diseases and the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 specifically refer to the reduction of harmful use of alcohol. There is also global consensus over the need to decrease harmful use of alcohol by 10% as part of the strategy to address noncommunicable diseases (NCDs).

2.3.4 Influence of alcohol industry

Industry involvement in alcohol policy-making compromises the public health protection aspect of the policy. This is very different from the tobacco or health field, where the WHO Framework Convention on Tobacco Control prohibits the influence of industry.

It is important to note that the consumption among young people is expected to increase due to marketing strategies of the alcohol industry that target them. New sweeter, fruit-flavoured and “lighter” alcohol beverages with the same alcohol content appeal to younger consumers, and advertising is
shifting from traditional approaches to sponsorship of music and sporting events that young people patronize. Social media, which is popular with young people, is now a key marketing instrument.

The huge budgets available for marketing contrast sharply with the resources available for health promotion. Marketing strategies target young people to ensure future growth of the industry. They contribute to earlier onset and heavier drinking among young people. Fortunately, marketing regulations are also cost-effective alcohol control interventions.

Many countries in the Region do not have mechanisms in place to control corporate sponsorship of youth-oriented cultural or sporting events. They also do not have means to regulate the proliferation of marketing and promotion online. The alcohol industry is very active on social media – promoting a positive image of their brands and portraying an attractive lifestyle linked to alcohol consumption. Some have even gone to the extent of negotiating commercial arrangements with Facebook and other social media platforms.

2.4 Country alcohol harm burden in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam

Within the Western Pacific Region, Cambodia, the Lao People’s Democratic Republic and Mongolia have the highest total alcohol consumption per capita of those aged between 15 and 19 years among low- to middle-income countries.

There is a growing concern regarding the harmful use of alcohol in Cambodia. Data from the Cambodia Socio-Economic Survey 2004, 2007 and 2009 showed that alcohol consumption was increasing from 2004 to 2009. In addition, the WHO STEPwise Approach to Surveillance (STEPS) Survey 2010 showed that 63.5% of respondents were alcohol drinkers, including 53.5% in the past 30 days (current drinkers), of whom 54.5% lived in urban areas and 49.0% lived in rural areas. The share of current drinkers among men was about 2.3 times higher than among women (76.3% male versus 31.9% female), and the average age of current drinkers was between 25 and 44 years.

Alcohol is ubiquitous in Mongolia. The density of alcohol vendors – one shop for every 270 people – is reported to be the highest in the world. Three out of four males and just over half of females are considered alcohol users, indicating that they have had a drink in the past year. The rate of alcohol consumption among users is high, and rising. From 2008 to 2014, per capita (age above 15 years), the amount of alcohol and wine that Mongolians imbibed grew from 5.8 litres to 8.4 litres, which is higher than the global average. Findings from a nationally representative survey of attitudes and knowledge about alcohol found significant differences in the use of alcohol among urban and rural individuals. While nearly one in three drinkers reported having consumed alcohol before lunchtime, the practice is more prevalent in rural (25% of drinkers) than urban (16%) individuals. One in 10 survey participants cited the use of alcohol as a stress reduction technique, though this answer was three times more likely to be heard from an urban participant compared to a rural one. Heavy alcohol use is an entrenched element of celebrations and social interaction with friends and family.

The consumption of alcoholic beverages in the Lao People’s Democratic Republic, at about 75% of the total population, is enormously high. Binge drinking accounted for approximately 16% and drink–driving for 22.2%, attributing to about 40% of road traffic accidents in the Lao People’s Democratic Republic accordingly.
In 2015, the prevalence of alcohol consumption among adults in Viet Nam was about 44% overall (77% among men and 11% among women). While alcohol ranked fourth as the major health risk in Viet Nam, the occurrence of injuries from the harmful use of alcohol was high. Among hospitalized cases due to traffic injury while driving a car, nearly 67% had a blood alcohol level higher than permitted. The same figure for motorcyclists was 28%.

The WHO Global Status Report on Alcohol and Health 2014 provides an overview of alcohol consumption in relation to public health as well as information on the consumption of alcohol in populations, the health consequences of alcohol consumption and policy responses at the national level.

2.5 Group work 1: What are the causes and consequences of alcohol harm in young people in my country?

Participants were asked to describe consequences and factors that contributed to harmful consumption of alcohol in young people based on country context and present these visually in a problem tree. Common themes related to economic, social and health consequences emerged across countries. These included reduced work productivity and income, high expenses for alcohol procurement and alcohol control management for the family and the community, injuries and disabilities from motor vehicle accidents and violence, death from trauma and chronic diseases, fetal disorders, neuropsychiatric disorders, relationship problems with family and friends, public disorder and crimes, and limitation of education and work opportunities.

Root causes of alcohol harm were also common in the four countries: ready availability and affordability of alcohol to young people, including illicit alcohol (i.e., home production and smuggling); a conducive or permissive social environment (e.g., family members either model harmful drinking or do not provide effective guidance to children); attractive advertisements and marketing strategies (i.e., event sponsorships, social media posts); and peer pressure. Countries also identified the lack of public awareness on alcohol harm, specifically the pathophysiologic effects of alcohol on young people, and existing laws related to alcohol harm reduction as issues. Poor enforcement of these laws was also a problem.

After going through the root causes of alcohol harm, current national and local alcohol control interventions that address these were mapped out and discussed during group work 2, as described in section 2.7.

2.6 Panel discussion: Alcohol policy “best buys” and restriction of illicit and informally produced alcohol

The WHO Global Strategy to Reduce the Harmful Use of Alcohol lists 10 target areas for alcohol harm reduction, ranging from leadership to the role of the health and welfare sectors. Of these, the three most cost-effective interventions are restricting access to and availability of alcohol, increasing the price of alcoholic beverages and regulating the marketing. Key factors contributing to heavy consumption of alcohol and related harm among young people include the availability of alcohol, the price of alcohol and alcohol marketing. Illicit and informally produced alcohol needs to be taken into consideration.

2.6.1 Availability of alcohol

The availability of alcohol affects an adolescent’s ability to access and consume alcohol. The physical availability of alcohol is the availability of alcohol in one’s physical environment mediated by the
likelihood that one will come into contact with these sources of alcohol. The social availability of alcohol, sometimes referred to as the social supply of alcohol, refers to the supply of alcohol to minors by social sources, such as friends or parents.

Public health strategies that seek to regulate the commercial or public availability of alcohol through laws, policies and programmes are important ways to reduce the general level of harmful use of alcohol. Such strategies provide essential measures to prevent easy access to alcohol by vulnerable and high-risk groups. Laws, policies and programmes that restrict young people’s access to alcohol are very effective in reducing heavier consumption and alcohol-related harm.

The potential prevention measures are:

- **Minimum legal age limit**: Legislation that sets a minimum legal age is among the most effective means of protecting young people from detrimental drinking and related harm.
- **Enforcement**: A minimum legal purchase age is effective already by itself with minimal enforcement.
- **Outlet density**: Provisions for controlling the numbers and locations of alcohol outlets should be made in legislation.
- **Trading hours**: Provisions for controlling trading hours should be made in national legislation.
- **Alcohol-free environments or settings**: Alcohol-free environments or settings can include alcohol-free events or parties for young people.

### 2.6.2 Pricing policies

The easier it is for young people to purchase or obtain alcohol, the more consumption and harm will occur among young people. The cheaper alcohol is for young people to buy, the more drinking and harm will occur. Taxation policy, which makes alcohol less affordable, is very effective in reducing heavier consumption and alcohol-related harm.

Consumers, including heavy drinkers and young people, are sensitive to changes in the price of drinks. Pricing policies can be used to reduce under-age drinking, to halt progression towards drinking large volumes of alcohol and/or episodes of heavy drinking, and to influence consumers’ preferences. Increasing the price of alcoholic beverages is one of the most effective interventions to reduce the harmful use of alcohol. A key factor for the success of price-related policies in reducing the harmful use of alcohol is an effective and efficient system for taxation matched by adequate tax collection and enforcement.

The potential prevention measures are:

- **Taxes**: Alcohol-specific taxes, which increase the real price of alcohol, are generally an effective strategy to reduce destructive consumption and related harm among young people.
- **Dedicated fund or tax**: A dedicated levy on all imports and manufacturers of alcohol can be set annually by regulations and the levy used for the purpose of reducing harm related to the use of alcohol.
- **Minimum pricing**: Introducing a minimum unit price at which alcohol may be sold may be necessary, particularly if the structure of the market means alcohol is made available below cost to encourage shoppers to purchase additional goods.
- **Alcopop taxes**: While alcopop taxes reduce the consumption of alcopops, this reduction has tended to be offset by substitutions with other beverages.
2.6.3 Marketing of alcoholic beverages

The more alcohol marketing that young people are exposed to, the more alcohol they will consume. Policies that legally restrict alcohol marketing are needed to prevent alcohol companies from recruiting young people to be drinkers (and from encouraging them to be heavier drinkers).

Reducing the impact of marketing, particularly on young people and adolescents, is an important consideration in reducing the harmful use of alcohol. Alcohol is marketed through increasingly sophisticated advertising and promotion techniques, including linking alcohol brands to sports and cultural activities, sponsorships and product placements, and new marketing techniques such as emails, SMS and podcasting, social media and other communication techniques.

It is very difficult to target young adult consumers without exposing cohorts of adolescents under the legal age to the same marketing. The exposure of children and young people to appealing marketing is of particular concern, as is the targeting of new markets in the region with a current low prevalence of alcohol consumption or high abstinence rates. Both the content of alcohol marketing and the amount of exposure of young people to that marketing are crucial issues. A precautionary approach to protecting young people against these marketing techniques should be considered.

The potential prevention measures are:

- **Marketing ban**: Comprehensive restriction of exposure to alcohol marketing is the most effective means to protect young people from the effects of alcohol marketing, as young people are still exposed to high levels of alcohol marketing when partial bans are implemented.
- **International agreement**: Addressing alcohol marketing in social media and on the Internet would be helped by an international agreement.

2.6.4 Restriction of illicit and informally produced alcohol

In some developing and low- and middle-income countries, informal markets are the main source of alcohol and formal controls on sale need to be complemented by actions addressing illicit or informally produced alcohol. High availability of informal alcohol products, such as home-brewed alcohol, may affect the effectiveness of alcohol taxation and physical availability as public health interventions to reduce consumption and alcohol-related harm.

The existence of a substantial illicit market for alcohol complicates policy considerations on taxation in many countries. In such circumstances, tax changes must be accompanied by efforts to bring the illicit and informal markets under effective government control. Increased taxation can also meet resistance from consumer groups and economic operators, and taxation policy will benefit from the support of information and awareness-building measures to counter such resistance.

Furthermore, restrictions on availability that are too strict may promote the development of a parallel illicit market. Secondary supply of alcohol, for example from parents or friends, needs also to be taken into consideration in measures to control the availability of alcohol.

2.7 Group work 2: What is my country’s response to alcohol harm in young people?

Country teams mapped the local and national policy interventions that were described in group work 1 against the 10 target areas for alcohol harm reduction recommended in the WHO *Global Strategy to Reduce the Harmful Use of Alcohol*. The implementation status of each area was identified. Details of interventions by country can be found in Annex 3.
Of the 10 target areas, drink–driving policies and countermeasures (target area 4) appeared to be the most implemented. These were reported to be fully implemented in three of the four countries; the Lao People’s Democratic Republic country team reported this target area to be partially implemented. Meanwhile, policy options for reducing the negative consequences of drinking and alcohol intoxication (target area 8) were the least implemented. These were partially implemented in the Lao People’s Democratic Republic and Mongolia but reported as not implemented in Cambodia and Viet Nam.

Focusing on the three “best buy” target areas in the WHO Global Strategy, countries provided details on the implementation status of corresponding cost-effective interventions adopted as indicators in the NCD Progress Monitor for the four time-bound country commitments in the 2014 United Nations Outcome Document on NCDs (Table 1).

The imposition of excise taxes on all alcoholic beverages appears to be the most successfully implemented of the interventions. Three of the four countries reported full implementation of this indicator. However, of the “best buys”, comprehensive restrictions on exposure to alcohol advertising require more work. Only Mongolia is fully implementing advertising restrictions on all channels.

At the end of the exercise, country teams prioritized interventions that they would focus efforts on during the one-year period of the leadership training course. Action plans for these interventions were developed in group work 3 (Annex 4).
Table 1. Implementation status of cost-effective interventions

<table>
<thead>
<tr>
<th>Progress monitor indicator</th>
<th>Cost-effective interventions</th>
<th>KHM</th>
<th>LAO</th>
<th>MNG</th>
<th>VNM</th>
</tr>
</thead>
<tbody>
<tr>
<td>6a Availability of alcohol</td>
<td>Member State has enacted and enforced restrictions on the physical availability of retailed alcohol (via reduced hours of sale)</td>
<td>NIP</td>
<td>NIP</td>
<td>F</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>A licensing system or monopoly exists on retail sales of beer, wine and spirits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Restrictions exist for on- and off-premise sales of beer, wine and spirits regarding hours and locations of sales and restrictions exist for off-premise sales of beer, wine and spirits regarding days of sales</td>
<td>NIP</td>
<td>P</td>
<td>P</td>
<td>NIP</td>
</tr>
<tr>
<td></td>
<td>Legal age limits for being sold and served alcoholic beverages are 18 years or above for beer, wine and spirits</td>
<td>NIP</td>
<td>P</td>
<td>P</td>
<td>N</td>
</tr>
<tr>
<td>6b Marketing of alcoholic beverages</td>
<td>Member State has enacted and enforced bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)</td>
<td>NIP</td>
<td>N</td>
<td>F</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Restrictions exist on alcohol advertising for beer, wine and spirits through all channels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detection system exists for infringements on marketing restrictions</td>
<td>NIP</td>
<td>NIP</td>
<td>P</td>
<td>NIP</td>
</tr>
<tr>
<td>6c Pricing policies</td>
<td>Member State has increased excise taxes on alcoholic beverages</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Excise tax on all alcoholic beverages (beer, wine and spirits) is implemented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>There are no tax incentives or rebates for production of other alcoholic beverages</td>
<td>P</td>
<td>NIP</td>
<td>N</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>Adjustment of level of taxation for inflation for beer, wine and spirits is implemented</td>
<td>NIP</td>
<td>P</td>
<td>N</td>
<td>NIP</td>
</tr>
</tbody>
</table>

KHM – Cambodia; LAO – Lao People’s Democratic Republic; MNG – Mongolia; VNM – Viet Nam
NIP – Not in place; N – In place but not implemented; P – In place but partially implemented; F – In place and fully implemented

2.8 Site visit: Da Nang Psychiatric Hospital

Participants visited a governmental health facility, the Quang Nam-Da Nang Psychiatric Hospital, working to prevent and treat alcohol-related problems. The site visit contributed to understanding the needs and opportunities for specialized treatment interventions related to the harmful use of alcohol, including specialized outpatient and inpatient care, pharmacotherapy and psychosocial interventions. Participants from Cambodia, the Lao People’s Democratic Republic and Mongolia were exposed to and could communicate with the experts from Viet Nam about their experiences. It also created an opportunity for Viet Nam’s health professionals to highlight their good practices and to engage with experts from other countries.

The Quang Nam-Da Nang Psychiatric Hospital opened in 1977 and now has 180 beds for inpatients (5 units: child unit, female acute unit, male acute unit, rehabilitation unit, substance abuse unit). The system includes an outpatient department with a staff of 195 (including 34 medical doctors, 30 psychiatrists, 4 general doctors, 7 psychologists). Besides inpatient and outpatient responsibilities, the hospital is also involved in training and research.
Interventions for alcohol use disorders include detoxification, medication, rehabilitation, occupational therapy, psychotherapy and relapse prevention. A school-based mental health programme, using problem solving therapy in group, has been piloted in four schools. The opportunities for further development include family intervention and follow-up of patients in the community.

2.9 Supporting young people and their families in reducing alcohol harm

The general consensus, based on the research evidence, is that strategies and interventions based on education, without affecting factors such as marketing, availability and affordability, have little to no effectiveness in achieving long-term behaviour change, although they may be effective at increasing knowledge of alcohol and its risks.

A community action approach utilizing and actively promoting collaborative sustained partnerships can lead to improved health outcomes if changes in alcohol environments are achieved. Such an approach may also work to stimulate greater regional consistency and coordination in planning strategic health promotion activities. Further, the evidence suggests that community action approaches can be effective, but the effects are not sustained unless implemented over the long term.

Most evidence for interventions to reduce alcohol-related harm in young people relate to school-based education and prevention programmes. As noted previously, these show benefits in increasing knowledge, but the evidence for their effectiveness in changing drinking behaviour is less clear. For young people outside of the educational system, there is a limited evidence base for successful interventions. Many of the studies are methodologically flawed, which limits the conclusions that may be drawn and their generalizability.

Mutual help and/or self-help organizations, such as Alcoholics Anonymous, are a feasible, cost-effective complement to (or alternative to) formal treatment in many countries and areas for adults. However, there is very limited research on the effectiveness of Alcoholics Anonymous among young people. Findings from a review of the literature suggested that young people may benefit from participation in these groups following treatment, but conclusions were limited by a lack of rigorous research evidence.

At-risk youth require additional effective interventions such as community action, brief interventions and treatment.

The management of high-risk young drinkers can occur in primary health care and other settings using brief interventions. These interventions are low-intensity and short in duration, consisting of 1–3 counselling sessions and education. Brief interventions can be administered by primary care practitioners or other trained professionals, and rigorous evaluations have shown that they can be an effective strategy to reduce consumption and harm among young people.

The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance use disorders especially for low- and middle-income countries. Several resources are available to help reduce the mental health treatment gap and to enhance the capacity of Member States to respond to the large burden of mental, neurological and substance use disorders.

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a technical tool to assist with the early identification of substance-use-related health risks and substance use disorders in primary health care, general medical care and other settings. The ASSIST package was developed to help primary health professionals detect and manage substance use and related problems in primary
and general medical care settings. The package includes three different manuals: (1) *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for Use in Primary Care*, (2) *The ASSIST-linked Brief Intervention for Hazardous and Harmful Substance Use: Manual for Use in Primary Care*, and (3) *Self-Help Strategies for Cutting Down or Stopping Substance Use: A Guide*.

In discussing the gaps in alcohol-related harm clinical management and advocacy for public policy, it was pointed out that most training courses were designed to manage adults. Hence, there was a need to raise awareness that adolescents are physically and emotionally different from adults, and that managing alcohol-related problems in young people requires new skills to be effective.

2.10 Next steps for strengthening alcohol harm reduction in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam

Using inputs from previous group work, countries drafted action plans and prepared follow-up actions at the country level to complete in the next year (Annex 4).

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

The three-day training consisted of lectures, moderated and panel discussions, a site visit to a district mental health facility, and group exercises.

Day 1, which was dedicated to the overview of alcohol harm with a focus on young people and the global targets and strategies for alcohol harm reduction (including the influence of the industry), led to the following conclusions:

- The available data indicate increasing alcohol consumption and increasing alcohol harm in the Region. It is especially concerning in young people.
- There is a need for the continuation of the training. Participants from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam are leaders currently working on the reduction of the harmful use of alcohol in their respective countries and need to be further empowered. They showed great appreciation for WHO’s support in alcohol policy development.
- All countries have not or have only partially accomplished the 2016 time-bound commitments to reduce alcohol harm through the three most cost-effective interventions (pricing policies, restrictions on advertising and promotions, regulations on availability). They will report their progress to the United Nations High-level Meeting on NCDs in 2018.

Day 2, which focused was on the most effective interventions – alcohol policy “best buys” and restriction of illicit and informally produced alcohol – led to the following conclusions:

- All the participants acknowledged the need for better control on alcohol marketing, availability and pricing, focusing first on awareness and using data collected locally to advocate policy and legislative changes.
- Drink–driving control efforts are well under way in some countries; these programmes need to be expanded.
- There was grave concern about increasing efforts of the alcohol industry both in marketing, especially to young people, and in its interference in policy-making.
• Marketing control in countries would be easier if a strong international framework exists.
• Focus on young people is especially indicated by the demographic features and the marketing strategies developed by the industry; nevertheless, an alcohol policy has to have general application.

The site visit to the district mental health facility pointed also to the need for strengthening informal and primary health care services interventions.

Day 3 continued on the health service response to the harmful use of alcohol and development of country action plans and led to the following conclusions:

• Health service delivery needs to be strengthened, focusing on early identification, appropriate clinical management of alcohol use disorders in primary health care and informal services (self-care, families, schools and communities).
• There are commonalities in policy development across the countries; hence, there are opportunities for these countries to move forward together. Nevertheless, there is a need for specific support for identified priority areas at national and subnational levels, addressing the different level of implementation and barriers depending on national context.
• Participants expressed a strong engagement, and there is need to further build on their existing knowledge and experience of their national initiatives. The participative environment created in Module 1 encouraged further training and exchange.

3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged to consider the following:

1) Based on the one-year action plan that have been designed by each country team on the following priority policy options:
   a. Cambodia: to develop legislation on restricting alcohol advertising, promotion and sponsorship
   b. Lao People’s Democratic Republic: to set up a regulatory framework for marketing of alcoholic beverages, raise awareness on the harmful use of alcohol and strengthen the implementation of drink–driving control measures
   c. Mongolia: to strengthen the detection system for infringements of marketing restrictions
   d. Viet Nam: to develop an alcohol control law, including: management of alcohol advertising/marketing; regulating availability of alcohol (time, place); and establishment of a health promotion foundation
2) Participants to provide immediate feedback on the results of the training session including the planning of country activities to their supervisors and relevant institutions in the country.
3) Participants to initiate and lead the implementation of the action plans as designed at the end of Module 1 of the training course.
4) Provide regular feedback to the Regional Office on the process of implementation of the planned country activities.
5) Identify and liaise with relevant nongovernmental organizations and establish a national forum for public health oriented alcohol action.
6) Investigate opportunities for improving information on harm resulting from alcohol consumption with academic institutions and with institutions for public health.
7) Investigate opportunities for research on consumption of illicitly and informally produced alcohol.

2. Continue utilizing the WHO Global Strategy to Reduce the Harmful Use of Alcohol as the lead document in the further development of national policy and strategies.

3.2.2 Recommendations for WHO

WHO is requested to consider the following:

1) Provide rapid follow-up to discussions held in the training sessions and to the individual country action plans drafted.

2) Provide technical support to individual countries in the implementation of their action plans including support for further translation and dissemination of key documents and for consultation missions by experts (e.g. on legislation, on introducing screening and brief interventions, on data collection, or on drafting policies and strategies).

3) Plan and prepare shortly for the detailed implementation of Module 2 of the training course through one common training session. The principal focus of the training should be aligned with the common target area identified in the country action plan: regulation of marketing of alcoholic beverages. Module 2 should also include how to respond to the increasing efforts by the industry to influence policy-making processes, communication as well as advocacy and social mobilization of professional associations and community organizations.

4) The tentative time frame is April 2018 for Module 2 and November 2018 for Module 3.

5) Consider rotation of the hosting among the participating countries for the organization of Modules 2 and 3 so as to strengthen common interest and feeling of joint ownership of the course.

6) Consider combining Modules 2 and 3 with national advocacy conferences.

7) Support prevention, early identification and appropriate clinical management of alcohol use disorders in primary health care.

8) Consider developing support materials for strengthening substance abuse responses in families and in schools.

9) Ensure that high priority continues to be given to the reduction of alcohol-related harm within the NCD framework.

10) Explore complementary activities with other international activities to reduce alcohol-related harm (such as the ThaiHealth project with WHO headquarters).
ANNEXES

ANNEX 1. LIST OF PARTICIPANTS, TEMPORARY ADVISERS, OBSERVERS AND SECRETARIAT

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ANNEX 2. TRAINING PROGRAMME

Day 1, Tuesday 14 November 2017

08:30 – 09:00 Registration

09:00 – 09:30 Opening remarks

Overview of the training course and introduction of participants

Pre-test

09:30 – 10:00 Leadership and advocacy to reduce alcohol harm in young people

Dr Hai-Rim Shin
Acting Director
Division of NCD and Health through the Life-Course (DNH)
WPRO

Mr Martin Vandendyck
Technical Lead
Mental Health and Substance Abuse
DNH, WPRO

10:00 – 10:30 Group Photo

Coffee and tea / Mobility break

10:30 – 12:00 Overview of alcohol harm with a focus on young people

Global and Regional burden of alcohol harm

How alcohol harms young people

Dr Cornelius Goos
International Public Health Consultant
Chair, Alcohol Policy Network Europe

Dr Carmela Mijares-Majini
Consultant
Mental Health and Substance Abuse
DNH, WPRO

Dr Surasak Chaiyasong
Director, Health Promotion Policy Research Center, International Health Policy Program (IHPP)
Assistant Professor and Deputy Dean
Mahasarakham University, Thailand

Dr Yvonne Bonomo
Director, Department of Addiction Medicine, St. Vincent’s Hospital (Melbourne) Australia

12:00 – 13:00 Lunch break
13:00 – 15:00  Global targets and strategies for alcohol harm reduction (including the influence of industry)

Country presentations:
Country alcohol harm burden in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam

15:00 – 15:30  Coffee and tea / Mobility break

15:30 – 17:00  Group work 1: What are the causes and consequences of alcohol harm in young people in my country?

18:00  Welcome reception

Day 2, Wednesday 15 November 2017

08:30 – 08:45  Morning energizer

Recapitulation of Day 1

08:45 – 10:00  Panel discussion: Alcohol policy “best buys” (pricing policies, restrictions on advertising and promotions, regulations on availability) and restriction of illicit and informally produced alcohol

10:00 – 10:30  Coffee and tea / Mobility break

10:30 – 12:00  Group work 2: What is my country’s response to alcohol harm in young people?

12:00 – 13:00  Lunch break

13:00 – 16:00  Site visit: Da Nang Psychiatric Hospital

Day 3, Thursday 16 November 2017

08:30 – 08:45  Morning energizer

Recapitulation of Day 2
08:45 – 10:00  Supporting young people and their families in reducing alcohol harm

Health service delivery: Integrated intervention system to treat alcohol-related problems with a focus on young people  

Dr Yvonne Bonomo  
Mr Martin Vandendyck

10:00 – 10:30  Coffee and tea / Mobility break

10:30 – 12:00  Patients: Self-help strategies for cutting down or stopping substance use  

Ms Julia Stafford

Family and community: Initiatives to help families and communities to reduce alcohol harm in young people  

Dr Surasak Chaiyasong

12:00 – 13:00  Lunch break

13:00 – 15:00  Next steps for strengthening alcohol harm reduction in my country  

WHO Secretariat

Group work 3: Personal and group reflections: How can I, personally, and we, as a group, contribute to our country’s response to alcohol harm in young people?

Plenary session: Strengthening of an intercountry network for alcohol harm reduction

15:00 – 15:30  Coffee and tea break

15:30 – 15:50  Post-test

Module 1 evaluation

15:50 – 16:00  Closing  

Dr Kidong Park  
WHO Representative in Viet Nam
ANNEX 3. GROUP WORK: WHAT IS MY COUNTRY'S RESPONSE TO ALCOHOL HARM IN YOUNG PEOPLE?

Cambodia

<table>
<thead>
<tr>
<th>10 target areas of the Global Strategy</th>
<th>Policy option or intervention</th>
<th>Name of policy or legislation</th>
<th>Implementation status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Leadership, awareness and commitment</td>
<td>Public education, advocacy integration, school curriculum</td>
<td>National strategic action plan, Alcohol technical working group</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>2 Health services response</td>
<td>Counseling on SA at health facilities</td>
<td>SOP, MPA clinical guideline for health facilities</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>3 Community action</td>
<td>Community projects, commune alcohol notification, community counseling</td>
<td>NGO’s initiative</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>4 Drink–driving policies and counter-measures</td>
<td>Enforcement_BAC 0.805mg/liter</td>
<td>Law on road traffic 2015</td>
<td>Fully implemented</td>
</tr>
<tr>
<td>5 Availability of alcohol</td>
<td>Ban sale of alcohol at educational facilities, health facilities</td>
<td>Ministerial Prakas (MOH, MOEys), Draft legislation</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>6 Marketing of alcoholic beverages</td>
<td>Ban of alcohol on TV, national radio during prime time (6:00-8:00pm)</td>
<td>Ministry of Information Prakas</td>
<td>Not implemented</td>
</tr>
<tr>
<td>7 Pricing policies</td>
<td>Increase excise tax on alcohol products</td>
<td>subdecree dates 29 December 2015</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>8 Reducing the negative consequences of drinking and alcohol intoxication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Reducing the public health impact of illicit alcohol and informally produced alcohol</td>
<td>Monitoring of alcohol home brew</td>
<td>Ministry of Industry</td>
<td>Not implemented</td>
</tr>
<tr>
<td>10 Monitoring and surveillance</td>
<td>Step survey 2010, 2016</td>
<td></td>
<td>Partially implemented</td>
</tr>
</tbody>
</table>
### Lao People's Democratic Republic

<table>
<thead>
<tr>
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<th>Policy option or intervention</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Leadership, awareness and commitment</td>
<td>Alcohol control law dissemination</td>
<td>Alcohol control law (2014), Alcohol control act (2015), PM decree on: Ban beer shop near the educational institutions</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>Health services response</td>
<td>Develop subnational alcohol control law, Advocacy meeting, Policy dialogue on alcohol harms</td>
<td></td>
<td>Partially implemented</td>
</tr>
<tr>
<td>Community action</td>
<td>Action plan on alcohol control</td>
<td></td>
<td>Not implemented</td>
</tr>
<tr>
<td>Drink–driving policies and counter-measures</td>
<td>Alcohol breath testing</td>
<td>Traffic law, transportation law</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>Availability of alcohol</td>
<td></td>
<td></td>
<td>Partially implemented</td>
</tr>
<tr>
<td>Marketing of alcoholic beverages</td>
<td>Advertising and marketing ban</td>
<td></td>
<td>Partially implemented</td>
</tr>
<tr>
<td>Pricing policies</td>
<td>Raise taxation</td>
<td>Tax law (2015)</td>
<td>Fully implemented</td>
</tr>
<tr>
<td>Reducing the negative consequences of drinking and alcohol intoxication</td>
<td>Multisectoral meeting raising awareness to young people</td>
<td></td>
<td>Partially implemented</td>
</tr>
<tr>
<td>Reducing the public health impact of illicit alcohol and informally produced alcohol</td>
<td></td>
<td></td>
<td>Partially implemented</td>
</tr>
<tr>
<td>Monitoring and surveillance</td>
<td>STEPS survey</td>
<td></td>
<td>Partially implemented</td>
</tr>
</tbody>
</table>
## Mongolia

<table>
<thead>
<tr>
<th>10 target areas of the Global Strategy</th>
<th>Policy option or intervention</th>
<th>Name of policy or legislation</th>
<th>Implementation status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Leadership, awareness and commitment</td>
<td>- Alcohol-free Mongolia initiative - President Mongolia - No-alcohol province (Fully implemented)</td>
<td></td>
<td>Not implemented</td>
</tr>
<tr>
<td>2 Health services response</td>
<td>- AA programme - Youth clinic</td>
<td>- Medical assistance law - Mental health law - Law on compulsory treatment and compulsory labour of person</td>
<td>Fully implemented</td>
</tr>
<tr>
<td>3 Community action</td>
<td>- No alcohol bar - No alcohol day (one day of the month - Partially implemented)</td>
<td>- Administrative liability law</td>
<td>Fully implemented</td>
</tr>
<tr>
<td>4 Drink–driving policies and counter-measures</td>
<td>- Point programme</td>
<td>- Law on alcoholism - Law on prevention of crime</td>
<td>Fully implemented</td>
</tr>
<tr>
<td>5 Availability of alcohol</td>
<td>- No sale after 00:00 am - Social media control (Not implemented)</td>
<td>- Law on alcoholism</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>6 Marketing of alcoholic beverages</td>
<td>- Modeling - follow stores</td>
<td>- Law on prevention of crime - Law on advertising</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>7 Pricing policies</td>
<td>- tax</td>
<td>- Customs law - Excise tax law - Standardization and conformity assessment law</td>
<td>Not implemented</td>
</tr>
<tr>
<td>8 Reducing the negative consequences of drinking and alcohol intoxication</td>
<td>- Press conference - training for schools</td>
<td></td>
<td>Partially implemented</td>
</tr>
<tr>
<td>9 Reducing the public health impact of illicit alcohol and informally produced alcohol</td>
<td>- Advocacy - Education programme</td>
<td>Law on prevention of crime</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>10 Monitoring and surveillance</td>
<td>- STEPS survey - NCD, KAP survey</td>
<td>Law on prevention of crime</td>
<td>Partially implemented</td>
</tr>
</tbody>
</table>
### Viet Nam

<table>
<thead>
<tr>
<th>10 target areas of the Global Strategy</th>
<th>Policy option or intervention</th>
<th>Name of policy or legislation</th>
<th>Implementation status</th>
</tr>
</thead>
</table>
| 1 Leadership, awareness and commitment | - reduce supplies  
- reduce demand  
- health promotion  
- harm reduction | National policies on alcohol control abuse till 2020, Decision No. 244/QA-TTG | Partially implemented |
| 2 Health services response | - Treatment guideline for alcohol dependence, mental disorder | National Institute for Mental Health guideline | Partially implemented |
| 3 Community action | - Social movement for alcohol harm prevention  
- Education for children on alcohol harm | Youth Union’s guideline and annual plan  
Youth Federation’s action plan | Partially implemented |
| 4 Drink–driving policies and counter-measures | - Alcohol test  
- Alcohol check point  
- Licence suspensions  
- Education | Road safety law | Fully implemented |
| 5 Availability of alcohol | - Reduce alcohol availability | Part of 244/QA-TTG decree 105/2017 (licencing) | Not implemented |
| 6 Marketing of alcoholic beverages | - Ban of advertising of spirits  
- Regulating of alcohol content advertising | Advertising law No. 76, 2012 | Partially implemented |
| 7 Pricing policies | - Taxation | Excise tax law No. 70, 2014 | Partially implemented |
| 8 Reducing the negative consequences of drinking and alcohol intoxication | - Care for intoxicated person | Guideline on restaurants with traffic safety – responsible driver | Not implemented |
| 9 Reducing the public health impact of illicit alcohol and informally produced alcohol | - Control illicit trade  
- Control of home-made alcohol | Control of home-made alcohol decree 105/2017 | Partially implemented |
| 10 Monitoring and surveillance | - Monitor alcohol use | STEPS survey 2010-2015 | Partially implemented |
ANNEX 14. GROUP WORK: COUNTRY ACTION PLAN

**COUNTRY:** Cambodia

**Team members:** Dr Chhea Chhoraaphea, Dr Ray Rany, Dr Yel Daravuth, Mr Lors Selak and Mr Heng Kimhong

**Priority intervention:**
1. **Demoralization harmful use of alcohol**
   - Develop materials for health, education and advocacy:
     - Fact sheet on harmful use of alcohol on young people
     - Booklet, leaflets on harm of alcohol
     - Disseminate materials to relevant stakeholders, press media…
     - Counter-advertisement
   - Timeframe: April 2018
   - Deliverable/Output: Fact sheet (for policy makers and professionals), Booklet, leaflet
   - Support and resource needs: Technical (information, data), Budget

2. **Restriction of alcohol advertising, promotion and sponsorship**
   - Timeframe: March 2018
   - Deliverable/Output: Training conducted with participants from ministries
   - Support and resource needs: International resource persons, Budget

   - Collect sample/experiences from ASEAN countries and other restriction of advertising, promotion and sponsorship
   - Timeframe: March 2018
   - Deliverable/Output: WHO Technical support
   - Support and resource needs: Budget

   - Generate local evidence on burden of alcohol use, pattern of use, perception of alcohol use and attitude towards alcohol advertisement
   - Timeframe: October 2018
   - Deliverable/Output: Research resources available
   - Support and resource needs: Technical support, Budget

   - Draft legislation on restriction of alcohol advertisement, promotion and sponsorship
   - Timeframe: October 2018
   - Deliverable/Output: Draft
   - Support and resource needs: Technical support, Budget

   - Meeting with relevant stakeholders to review the draft (expected to be 6 meetings)
   - Timeframe: April 2019
   - Deliverable/Output: Draft finalized
   - Support and resource needs: Technical support, Budget

   - Submission of the draft legislation to Council of Minister
   - Timeframe: May 2019
   - Deliverable/Output: Draft approved
   - Support and resource needs: Technical support

   - Community mobilization to support prevention of harmful use of alcohol (Capacity-building)
   - Timeframe: March 2018
   - Deliverable/Output: Five communes establish community network on alcohol harm reduction
   - Support and resource needs: People Center for Development and Peace (PDP) and IOGT

   - Technical support to commune leaders to prevent harmful use of alcohol
   - Timeframe: October 2018
   - Deliverable/Output: Five commune alcohol notification (CAN)
   - Support and resource needs: PDP - IOGT
**COUNTRY:** Mongolia  

**Team members:** Dr Tsolmonbayar, Mr Lkhamsuren, Dr Ninjbadgar, Mr Gantulga  

**Priority intervention:** Detection system exists for infringements on marketing restrictions

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeframe</th>
<th>Deliverable/Output</th>
<th>Support and resource needs</th>
</tr>
</thead>
</table>
| Advocacy for journalists                          | 2017/12                            | Report                 | - WHO-financial  
- MOH  
- MNB-technical                                                  |
| Social media challenge                             | Start time December 1st 2017/12 - 2018/2 | Share report  
Frame report          | - MOH  
- NCPH  
- NCMH  
- NGOs                                                        |
| Youth leadership conference                        | 2018/3                             | Trained leaders        | - WHO-financial  
- MOH  
- Mongolian Youth Union Tech  
- NCPH  
- Others                                                          |
| Positive post challenge                            | December 1st 2017/12 - 2018/3      | Share, like report     | - WHO-financial  
- MOH  
- NCPH  
- NCMH                                                          |
| 30' Animation (Advocacy for produce)               | 2018/5                             | View report            | - WHO-financial  
- MOH  
- NCPH                                                          |
| Amend advertising law to increase cost of alcohol advertisement | 2018/9 | Draft law              | - MOH  
- WHO-technical support  
- WHO-financial                                                  |
| National animation 30' "Anti-alcohol"             | 2018/May                           | View report            | - Mongolian national broadcasting  
- WHO  
- NCPH  
- MOH                                                          |
**COUNTRY:** Viet Nam

**Team members:** Mrs Pham Thi Hoang Anh, Mr Nguyen Huu Tu, Mr Lam Tu Trung, Dr Lam Nguyen Tuan, Mr Tran Quoc Bao

**Priority intervention:** Support for development of a strong alcohol control law, including: management of alcohol advertising/marketing; regulating availability of alcohol (time, place); establishment of Health Promotion Foundation

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeframe</th>
<th>Deliverable/Output</th>
<th>Support and resource needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizing workshop with ministries and National Assembly members</td>
<td>6 - 12 months</td>
<td>Stronger draft for alcohol control law</td>
<td>Technical and funding support</td>
</tr>
<tr>
<td>Developing advocacy materials package</td>
<td>6 months</td>
<td>Advocacy materials developed and disseminated</td>
<td>Technical and funding support</td>
</tr>
<tr>
<td>Conducting media communication and advocacy</td>
<td>6 - 12 months</td>
<td>Communication and advocacy activities e.g. TV talk shows</td>
<td>Technical and funding support</td>
</tr>
<tr>
<td>Organizing youth campaign to reduce alcohol harm in young people</td>
<td>6 - 12 months</td>
<td>Series of activities and communication</td>
<td>Technical and funding support</td>
</tr>
</tbody>
</table>
COUNTRY: Lao People’s Democratic Republic

Team members: Dr Kaison, Dr Latsamy, Dr Khathanaphone and Dr Viengsakone

Priority intervention: to set up regulatory framework for marketing of alcoholic beverages, raise awareness on harmful use of alcohol and strengthen the implementation of drink–driving counter-measures

<table>
<thead>
<tr>
<th>Activity</th>
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<th>Deliverable/Output</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Drink–driving:</td>
<td>Q1-Q3 2018</td>
<td>- Stakeholder understood the harmful use of alcohol</td>
<td>- MOH</td>
</tr>
<tr>
<td>1. Stakeholder meeting</td>
<td></td>
<td>- Police officials had knowledge and be able to use the alcoholizer</td>
<td>- Police</td>
</tr>
<tr>
<td>2. Training on the usage of Alcoholizer to police</td>
<td></td>
<td></td>
<td>- Transport</td>
</tr>
<tr>
<td>3. Using the alcoholizer in 4 districts in Vientiane capital</td>
<td></td>
<td></td>
<td>- WHO</td>
</tr>
<tr>
<td>Alcohol marketing control:</td>
<td>Q4 2017</td>
<td>- Draft subnational decree on ban all forms of alcohol marketing is available</td>
<td>- MOH</td>
</tr>
<tr>
<td>1. Develop subnational decree on ban on all forms of alcohol marketing</td>
<td>Q3 2018</td>
<td>- Draft action plan on alcohol reduction is available</td>
<td>- MOICT</td>
</tr>
<tr>
<td>2. Develop alcohol reduction action plan</td>
<td></td>
<td></td>
<td>- WHO</td>
</tr>
<tr>
<td>Multisectoral meeting on actions to reduce harmful use of alcohol in young people</td>
<td>Q4 2018</td>
<td>- Politician understood the harmful use of alcohol in young people</td>
<td>- MOH</td>
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<tr>
<td>(Celebration of National Day of No Alcohol)</td>
<td></td>
<td></td>
<td>- Police</td>
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<td></td>
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<td></td>
<td>- Transport</td>
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<td>- MOES</td>
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<td></td>
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<td>- Politicians</td>
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<td></td>
<td></td>
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<td>- Youth</td>
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<td></td>
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<td>- WHO</td>
</tr>
<tr>
<td>Awareness raising on harmful use of alcohol</td>
<td>Q1-Q4 2018</td>
<td>- Increased knowledge on harmful use of alcohol among youth and adults</td>
<td>- MOH</td>
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<td>- MOES</td>
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<td></td>
<td>- Mass media</td>
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<td></td>
<td></td>
<td></td>
<td>- Youth union, Women's union</td>
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</tbody>
</table>