TRAINING FOR LEADERSHIP AND ADVOCACY TEAMS TO REDUCE ALCOHOL HARM IN YOUNG PEOPLE IN SELECTED COUNTRIES IN THE WESTERN PACIFIC REGION (MODULE 3)

18–20 June 2019
Phnom Penh, Cambodia
Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People in Selected Countries in the Western Pacific Region (Module 3)
18–20 June 2019
Phnom Penh, Cambodia
MEETING REPORT

TRAINING FOR LEADERSHIP AND ADVOCACY TEAMS
TO REDUCE ALCOHOL HARM IN YOUNG PEOPLE
IN SELECTED COUNTRIES IN THE WESTERN PACIFIC REGION
(MODULE 3)

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Phnom Penh, Cambodia
18–20 June 2019

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

August 2019
NOTE

The views expressed in this report are those of the participants of the Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People in Selected Countries in the Western Pacific Region (Module 3) 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 Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People in Selected Countries in the Western Pacific Region (Module 3) in Phnom Penh, Cambodia from 18 to 20 June 2019.
EXECUTIVE SUMMARY

Every minute one person dies from alcohol-related harm in the World Health Organization (WHO) Western Pacific Region. Young people are especially at risk for alcohol-related injury (e.g. drink–driving, violence), risky sexual behaviour and suicide.

Regular recreational drinking during adolescence is the clearest predictor of alcohol dependence in adulthood. Over time it increases the risk for alcohol dependence and other noncommunicable diseases (NCDs) such as cancer and liver cirrhosis.

In order to build capacity of a core group of alcohol control champions, the WHO Regional Office for the Western Pacific has been conducting a series of trainings for leadership and advocacy since 2017. Building on Modules 1 and 2, which were held in Da Nang, Viet Nam (14–16 November 2016) and Vientiane, Lao People’s Democratic Republic (18–20 September 2018), respectively, Module 3 introduced participants to various alcohol control interventions under the WHO SAFER Framework – a WHO-led roadmap comprising high-impact strategies to accelerate progress in curbing the harmful use of alcohol and achieve development targets.

The objectives of Module 3 of the training were:
1) to introduce tools, good practices and approaches to implement the WHO SAFER Framework in participating countries;
2) to determine priorities, opportunities and next steps for action on alcohol control in the Region and in national action plans of participating countries; and
3) to reinforce leadership competencies and skills for alcohol control.

Sixteen participants from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam participated in the workshop. They consisted of national-level government officers, alcohol control programme managers, clinicians and youth advocates. The workshop consisted of 13 sessions – including presentations, small group and plenary discussions, and a site visit – over three days.

Technical sessions were organized around key interventions of the SAFER Framework, namely: strengthening restrictions on alcohol availability; advancing and enforcing drink–driving countermeasures; facilitating access to screening, brief interventions and treatment; enforcing bans/comprehensive restrictions on alcohol advertising, sponsorship and promotion; and raising prices on alcohol through excise taxes and pricing policies. In addition, a technical session focusing on countering alcohol industry interference was conducted.

While progress has been observed across all participating countries in some areas of alcohol control, it is uneven across the recommended interventions and insufficient to meet global and regional targets. Breakthroughs were most commonly reported in alcohol taxation and pricing, drink–driving countermeasures, and awareness campaigns. Far less progress has been observed in restricting alcohol availability, banning or restricting marketing, and facilitating access to screening, brief interventions and treatment.

At the conclusion of the workshop, participants developed multisectoral action plans to be implemented in 2020–2021. These plans are aligned with WHO’s SAFER Framework.
Country teams likewise called on WHO to continue supporting alcohol control in the Region through technical support, capacity-building, knowledge transfer, and the development of tools and other resources.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAC</td>
<td>blood alcohol concentration</td>
</tr>
<tr>
<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
</tr>
<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>SAFER</td>
<td>strengthen restrictions on alcohol availability</td>
</tr>
<tr>
<td></td>
<td>advance and enforce drink–driving countermeasures</td>
</tr>
<tr>
<td></td>
<td>facilitate access to screening, brief interventions and treatment</td>
</tr>
<tr>
<td></td>
<td>enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion</td>
</tr>
<tr>
<td></td>
<td>raise prices on alcohol through excise taxes and pricing policies.</td>
</tr>
<tr>
<td>SBCC</td>
<td>social and behaviour change communication</td>
</tr>
<tr>
<td>SEATCA</td>
<td>Southeast Asia Tobacco Control Alliance</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CONTENTS

EXECUTIVE SUMMARY ........................................................................................................... 2
ABBREVIATIONS ................................................................................................................... 4

1. INTRODUCTION .................................................................................................................. 1
   1.1 Background ..................................................................................................................... 1
   1.2 Objectives ....................................................................................................................... 1
   1.3 Participants ...................................................................................................................... 2
   1.4 Organization .................................................................................................................... 2
   1.5 Opening session ............................................................................................................... 2

2. PROCEEDINGS ..................................................................................................................... 3
   2.1 Global and regional updates on alcohol control ............................................................... 3
   2.2 Country progress on alcohol control (Cambodia, Lao People’s Democratic Republic, Mongolia and Viet Nam) ......................................................................................................................................................... 3
   2.3 SAFER Framework: Promoting health and development by preventing and reducing alcohol-related harm ............................................................................................................................................................................. 5
   2.4 Country action planning .................................................................................................. 10

3. CONCLUSIONS AND RECOMMENDATIONS .................................................................. 13
   3.1 Conclusions .................................................................................................................... 13
   3.2 Recommendations ......................................................................................................... 14

ANNEXES ................................................................................................................................. 16
   Annex 1: Agenda .................................................................................................................. 16
   Annex 2: Programme of activities ....................................................................................... 17
   Annex 3: List of participants ............................................................................................... 19
   Annex 4: Evaluation of the workshop ................................................................................ 22
   Annex 5: Participant’s workbook ........................................................................................ 26

Keywords

Alcohol drinking - adverse effects / Alcoholism - prevention and control / Adolescent / Alcohol-related disorders / Health promotion / Regional health planning / Leadership
1. INTRODUCTION

1.1 Background

Every minute one person dies from alcohol-related harm in the World Health Organization (WHO) Western Pacific Region. Young people are especially at risk for alcohol-related injury (e.g. drink–driving, violence), risky sexual behaviour and suicide.

Regular recreational drinking during adolescence is the clearest predictor of alcohol dependence in adulthood. Over time it increases the risk for alcohol dependence and other noncommunicable diseases (NCDs) such as cancer and liver cirrhosis.

Following recommendations from the Regional Forum on Protecting Young People from the Harmful Use of Alcohol convened in 2016, the WHO Regional Office for the Western Pacific has been organizing a series of training workshops for leadership and advocacy teams from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam since 2017. These training workshops aim to build capacity of a core group of public policy leaders, local clinicians, and community and youth advocates to support alcohol harm prevention and reduction efforts in their respective countries.

Building on Modules 1 and 2, which were held in Da Nang, Viet Nam (14–16 November 2016) and Vientiane, Lao People’s Democratic Republic (18–20 September 2018), respectively, Module 3 introduced participants to various alcohol control interventions under the WHO SAFER Framework – a WHO-led roadmap comprising high-impact strategies to accelerate progress in curbing the harmful use of alcohol and achieve development targets. Technical sessions were organized around key interventions of the SAFER Framework, namely: strengthening restrictions on alcohol availability; advancing and enforcing drink–driving countermeasures; facilitating access to screening, brief interventions and treatment; enforcing bans/comprehensive restrictions on alcohol advertising, sponsorship and promotion; and raising prices on alcohol through excise taxes and pricing policies. In addition, a technical session was also conducted focusing on countering alcohol industry interference.

The same participants who attended the first two modules from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam were invited to attend Module 3.

1.2 Objectives

The objectives of Module 3 of the training were:

1) to introduce tools, good practices and approaches to implement the WHO SAFER Framework in participating countries;
2) to determine priorities, opportunities and next steps for action on alcohol control in the Region and in national action plans of participating countries; and
3) to reinforce leadership competencies and skills for alcohol control.
1.3 Participants

Sixteen participants from Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam participated in the workshop. They consisted of national-level government officers, alcohol control programme managers, clinicians and youth advocates. Resource persons and staff members from the WHO Regional Office for the Western Pacific and the WHO Cambodia Country Office provided Secretariat support for the workshop. A list of participants, temporary advisers and Secretariat members is available in Annex 3.

1.4 Organization

The workshop consisted of 13 sessions – including presentations, small group and plenary discussions, and a site visit – over three days. Day 1 focused on setting the scene and reviewing progress with presentations on global and regional updates on alcohol control, a recapitulation of Modules 1 and 2 of the training, and country updates regarding progress in alcohol harm reduction. Each technical session began with an introductory presentation followed by small group discussions and intercountry dialogue at plenary. Technical sessions on raising prices on alcohol and advancing and enforcing drink–driving countermeasures were conducted on the afternoon of Day 1.

On Day 2, technical sessions on enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion, and facilitating access to screening, brief interventions and treatment were conducted in the morning. Participants then proceeded to a site visit to the Mental Health Department of the Khmer-Soviet Hospital in Phnom Penh in the afternoon.

Technical sessions on strengthening restrictions on alcohol availability and countering alcohol industry interference in policy-making and implementation were conducted on Day 3. The meeting concluded with an action planning workshop and evaluation session. The meeting agenda and programme of activities are provided in Annexes 1 and 2, respectively; the participant’s workbook, which includes guidance for the small group discussions and action planning workshop, is included in Annex 4.

1.5 Opening session

Dr Nargiza Khodjaeva, acting WHO Representative to Cambodia, delivered the opening remarks on behalf of Dr Takeshi Kasai, WHO Regional Director for the Western Pacific. In his prepared remarks, Dr Kasai underscored the importance of protecting young people from the harmful use of alcohol and reiterated WHO’s commitment to supporting countries in advancing and implementing policies that address this significant threat to public health.
2. PROCEEDINGS

2.1 Global and regional updates on alcohol control

Mr Martin Vandendyck, Technical Lead for Mental Health and Substance Abuse, WHO Regional Office for the Western Pacific, provided updates on the global and regional burden of alcohol-related harm and introduced the WHO SAFER initiative.

Globally, more than 3 million people die each year from an alcohol-related cause. The harmful use of alcohol is a causal factor in more than 200 diseases, health conditions and injuries. Over 5% of the global burden of disease and injury is attributable to alcohol. As such, it is a significant threat to public health and a major obstacle to sustainable development due to its adverse effects on the health and well-being of alcohol users, their families and their communities.

Data on alcohol per capita consumption from 2000 to 2016 indicate a rising trend in the Western Pacific Region, surpassing the global average. Comparing data from 2000 and 2016, all of the participating countries in the workshop registered increased alcohol per capita consumption, with the most significant increase recorded in the Lao People’s Democratic Republic.

Among the three alcohol control interventions monitored by WHO, the most significant progress was observed in increasing excise taxes on alcoholic beverages (indicator 6c). Full achievement and partial achievement of this indicator was reported by 26% and 69% of Western Pacific Member States, respectively. On the other hand, enacting and enforcing restrictions on physical availability of retailed alcohol via reduced hours of sale (indicator 6a) was reported as fully achieved by 21% and partially achieved by 74% of the Member States. Significantly lagging behind is progress in enacting and enforcing bans or comprehensive restrictions on exposure to alcoholic beverages across multiple types of media (indicator 6b). While 21% of Western Pacific Member States reported full achievement of this indicator, the majority (74%) reported no achievement whatsoever.

WHO’s new SAFER initiative is designed to accelerate progress in implementing these interventions at the national level. It includes three interlinked components to support country implementation: an action package of effective alcohol policy and programme interventions, WHO/United Nations–led programmes focusing on country action, and a multi-stakeholder communication and advocacy campaign. Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam are among the countries that were identified for priority support in implementing the SAFER initiative.

2.2 Country progress on alcohol control (Cambodia, Lao People’s Democratic Republic, Mongolia and Viet Nam)

Representatives from the different country teams reported on progress in reducing alcohol-related harm in their respective countries, including follow-up from action plans that were developed from earlier modules of the training.

Cambodia

In Cambodia, the Government has progressively been introducing various advertising bans since 2015. These include bans on alcohol advertising on television during prime time...
(between 06:00 and 20:00) and 15 days before and after major festivals such as Khmer New Year, Chinese New Year and the Water Festival; bans on advertising depicting youth-oriented activities; and bans on the depiction of alcohol in music videos and films in association with stress, tension or anxiety.

In addition, public education campaigns broadcast over traditional media (television) and social media, and various youth-led and youth-oriented activities (e.g., competitions, leadership workshops, press conferences) have been carried out to raise public awareness and mobilize young people for alcohol control advocacy. Progress at the subnational level has been observed, with several communes adopting alcohol regulations and carrying out community-based activities. At the national level, the establishment of an inter-ministerial committee on alcohol reduction and education has been proposed, and a sub-decree to regulate alcohol advertising, promotion and sponsorship has been drafted following a series of consultations.

**Lao People’s Democratic Republic**

Whole-of-government advocacy in the Lao People’s Democratic Republic has supported progress in addressing alcohol. For example, alcohol advertising billboards within the airport in Vientiane have been taken down, and a meeting for high-level officials was convened to raise awareness of alcohol-related harm within government. Sobriety and speeding checks, as well as alcohol-free roads, were also implemented in Vientiane during Lao New Year to deter drink–driving and public intoxication.

Four workshops that focused on the harmful use of alcohol among young people were convened to raise awareness and mobilize various stakeholders. At the national level, a Prime Ministerial Decree on alcohol control is currently under development and will be submitted to the Ministry of Justice for due consideration.

**Mongolia**

Progress in Mongolia has been focused mostly on services, with addiction treatment now available at all levels of health care – from primary to tertiary care and specialized care at the National Center for Mental Health. A 24/7 helpline was also launched to provide general information and offer consultation for mental health issues, including alcohol dependence.

A training programme on reducing alcohol consumption among young people was also implemented. The programme trained peer educators, school doctors, social workers and other school-related personnel in secondary schools, colleges and universities in Ulaanbaatar and surrounding areas.

**Viet Nam**

As a result of sustained advocacy and multisectoral partnerships, the National Assembly of Viet Nam approved the country’s first comprehensive alcohol control law on 14 June 2019. Several provisions of the law are based on WHO’s *Global Strategy to Reduce the Harmful Use of Alcohol*. While the law is comprehensive insofar as it supports the implementation of multiple alcohol control interventions, certain sections of the law could still be further strengthened in the future. Sub-law documents to guide the law’s enforcement are currently under development.
2.3 SAFER Framework: Promoting health and development by preventing and reducing alcohol-related harm

Strengthening restrictions on alcohol availability

Dr Cornelius Goos, Public Health Consultant and Chair of the Alcohol Policy Network Europe, provided an overview of interventions to restrict alcohol availability.

Interventions to restrict the availability of alcohol include reducing the number of outlets selling alcohol, reducing the number of hours or days when alcohol can be sold, setting a minimum age to purchase alcohol, and controlling illicit or unrecorded alcohol production. A settings-based approach can support the uptake and enforcement of these interventions. Such settings include, but are not limited to, alcohol-free schools, workplaces, commercial establishments, as well as alcohol-free events or gatherings.

Among all the countries participating in the workshop, illicit or unrecorded alcohol production remains a significant challenge within their jurisdictions. These include illegally produced or smuggled alcohol, homemade alcohol, and surrogate alcohol in which components not fit for human consumption are included in the formulation. These forms of alcohol undermine alcohol control measures, particularly pricing controls through taxation, and can also cause harm due to the presence of toxic substances usually in the form of additives.

It is critical for all forms of alcohol available in the market to be covered by current regulatory regimes. Governments may consider offering financial incentives to encourage registration and quality control, and affix tax stamps to help track movement of alcohol products. Food safety interventions provide another set of tools and policy levers that governments can use to reduce alcohol-related harm.

Poor enforcement of existing laws and regulations represent a significant barrier to limiting the availability of alcohol across the countries participating in the workshop. Sociocultural norms and practices also contribute to the problem as they are often tied to the consumption of homemade alcohol. There is also generally low awareness and understanding of the risks associated with the consumption of illicit or unrecorded alcohol among the general public and policy-makers. This further impedes progress in addressing the issue.

Country teams acknowledged the value of a settings-based approach to restricting the availability of alcohol. These include declaring alcohol-free holidays and banning alcohol within government premises to set an example and promote alcohol-free workplaces. Social and behaviour change communication (SBCC) was cited as a strategy to raise awareness and support broader culture change over time.

Advancing and enforcing drink–driving countermeasures

Mr Martin Vandendyck discussed WHO tools and guidance to address drink–driving. Mr Lam Nguyen, Technical Officer, WHO Viet Nam, shared Viet Nam’s successful experience in implementing road safety initiatives.

A drastic increase in motorization across the Western Pacific Region has significantly increased the number of registered vehicles. This has led to an increase in the number of road traffic crashes, compromising public health and safety, especially of vulnerable road users such as
pedestrians, cyclists, and riders and passengers of motorcycles. The harmful use of alcohol is a major risk factor for road traffic crashes, with the risk increasing exponentially beginning at a blood alcohol concentration (BAC) level of 0.04 g/dL.

Drink–driving laws should be based on a BAC limit of no more than 0.05 g/dL for the general population and 0.02 g/dL for young or novice drivers. Strictly enforcing a drink–driving law can reduce the number of road deaths by 20%. This requires close coordination with law enforcement authorities (e.g. police) to ensure its effectiveness. Current BAC limits among countries participating in the workshop are compliant with recommendations for the general population. However, none of these countries have set lower limits for younger or novice drivers.

Enforcement should be “intelligence-led”, with actions informed by local data, responsive to community norms and perceptions, and supported by political commitment. A phased approach to scaling up programmes and interventions is recommended. Some common enforcement methods include screening drivers in high-risk scenarios – for example, outside establishments selling alcohol, after major events or festivals where alcohol is served, or in the evening as most people head home after having drinks.

Viet Nam has achieved significant progress in reducing the public health burden from road traffic crashes by applying a combination of different interventions consistently over time, including policy reform, strong enforcement, capacity-building and social marketing. For example, several media campaigns were launched across multiple channels (television, print, online) to raise awareness and contribute to an enabling environment. Key messages from these campaigns have reached at least 60% of the country’s entire population. Furthermore, legislative change has been supported by the strengthening of institutional capacity through study visits, technical workshops and a demonstration site. As a result, data from 2010 to 2014 indicated a declining trend in road traffic deaths.

Lack of local data and equipment (e.g. alcohol breath analysers), coupled with limited institutional capacity, are among the challenges cited by countries participating in the workshop. Country teams also acknowledged that multisectoral coordination to support enforcement of existing drink–driving laws and regulations is essential to improving road safety. Alongside these interventions, community participation is also critical to building public support for these measures.

Facilitating access to screening, brief interventions and treatment

Dr Cornelius Goos discussed the rationale for facilitating access to services to reduce the overall burden of alcohol-related harm and provided an overview of available tools and resources.

Treatment for alcohol dependence and related disorders often starts more than 10 years after the disorder has started. At this advanced stage of the disease, recovery is more difficult, and the rate of relapse is higher. In general, it is recommended that regular screening be integrated in general health settings and treatment started early to increase its overall effectiveness.

WHO has developed several tools for screening, brief interventions and treatment that can be integrated into existing systems to facilitate their uptake and scale-up. ASSIST and AUDIT are screening tools for substance use disorders, with the latter focusing exclusively on alcohol. These
tools can help in risk assessment and diagnosis and prompt brief interventions and referrals as needed.

Brief intervention is a focused technique to impart practical advice to help reduce alcohol consumption. It typically consists of one to five sessions of short duration (5–20 minutes). The intervention is particularly suited for primary health care as part of a comprehensive approach to prevention and continuity of care. Evidence indicates that it is effective in reducing alcohol consumption, especially in primary health-care settings when delivered consistently, and the effects are replicable across different contexts.

Country teams expressed interest in integrating these tools into broader alcohol harm reduction strategies. Building capacity of health workers to deliver these tools will be key. Apart from delivering these services in primary health-care settings, country teams also highlighted the need to integrate these tools into other community services such as support groups, schools and workplaces. Development of information, education and communication (IEC) materials is also important to improving knowledge and awareness of health-care professionals in applying the tools.

Enforcing bans/comprehensive restrictions on alcohol advertising, sponsorship and promotion

Dr Taisia Huckle, Senior Alcohol Researcher from SHORE Research Centre at Massey University, provided an introduction to alcohol marketing, with a focus on digital communication. Dr Orratai Waleewong, Researcher from the Health Promotion Policy Research Center of the Ministry of Public Health of Thailand, shared lessons learnt from Thailand’s experience in regulating alcohol marketing.

The overall aim of alcohol marketing is to mainstream the use of alcohol by creating a social environment where its use is normalized and the positive aspects of drinking alcohol are dominant. This is achieved by extending the use of alcohol into new social contexts, recruiting new consumers (in particular, young people and women), introducing sweet and low-potency beverages to new consumers, and counterbalancing information about its harms with positive messaging. The effects of marketing are cumulative, create and maintain brand allegiance, and cement behaviour over time.

There are many forms of marketing, such as non-digital (television, point-of-sale, sponsored events) and digital (social media, Internet) marketing strategies. Alcohol marketing campaigns typically integrate both non-digital and digital strategies into the overall plan in order to maximize reach and frequency. Exposure to alcohol marketing leads young people to drink at a younger age and in larger amounts.

Alcohol companies were early adopters of digital marketing as a strategy to fuel growth in emerging markets. These platforms facilitate brand engagement through various gimmicks and activities that invite users to co-create content (e.g. by asking users to post about their drinking experience). Some platforms even provide access to online alcohol delivery services. Because of their relative low cost and high capacity for targeting consumers through data analytics, these platforms offer a cost-effective approach to initiating and maintaining drinking behaviour. In many jurisdictions, there are currently no regulations that cover digital marketing.
A comprehensive public health approach to regulating marketing is recommended. Such an approach treats all alcoholic beverages the same way, bans alcohol marketing in both non-digital and digital settings, and supports a global approach to banning alcohol marketing in digital media.

In Thailand, alcohol advertising regulations evolved over a long period of time. Over that period, advertising regulations were introduced progressively from time-bound bans (e.g. television ads are prohibited to run before 22:00) to bans that forbid alcohol advertising within 500 metres of schools and religious places; bans on ads that contribute to the misperception that alcohol consumption leads to social success, sexual attractiveness and health benefits; and bans on ads that involve public figures or celebrities who are below 20 years old.

Despite the evolution of advertising regulation in Thailand, many legal loopholes still exist. These include the following: creative advertising, sponsored and branded events, brand sharing and brand stretching, product placement in films, product development and merchandising, price promotions, direct marketing in drinking venues, and corporate social responsibility programmes. Transnational advertising – for example, alcohol sponsorship of global events and digital advertising – is an emerging threat, notwithstanding the complexity of any attempt at regulating these forms of marketing.

Multisectoral efforts – including the involvement of police authorities – has helped to strengthen enforcement of existing regulations. Thailand is also pioneering the use of mobile applications to report violations and strengthen surveillance systems.

Absent or weak regulation of digital marketing of alcohol is a major obstacle to addressing this issue across countries participating in the workshop. Furthermore, integrated marketing campaigns are backed by large corporations with access to enormous resources and networks. This only highlights the need to adopt a strategic approach that combines advocacy for policy change with social mobilization and community engagement. Young people can be very persuasive advocates and are spending more and more time on digital platforms. Country teams recognize that public health advocacy and communication campaigns must leverage the reach of these digital channels.

*Raising prices on alcohol through excise taxes and pricing policies*

Dr Waleewong discussed various approaches to raising prices of alcohol products through excise taxes and other pricing policies.

In general, there are seven domains for alcohol pricing policies, including tax regimens, regular pricing reviews, bans on price promotions, setting minimum prices for alcohol, providing price incentives for non-alcoholic beverages, and reducing or stopping subsidies to economic operators in the area of alcohol.

The price of alcohol is the main factor influencing alcohol consumption (volume and drinking patterns) and its related harms (e.g. chronic disease, injuries, negative social consequences). The more affordable alcohol becomes, the more people drink. Pricing policies have a direct effect on the availability of alcohol, which, in turn – alongside social norms and marketing – influences initiation and maintenance of drinking behaviour.
Taxation is an effective way of reducing alcohol consumption through pricing policies. It is a “win-win-win” solution benefiting public health, raising domestic resources and revenue, and reducing social inequality by protecting vulnerable segments of the population such as young people and the poor. In low- and middle-income countries, an increase in 10% of the price of alcohol is associated with a 6.4% reduction in its consumption (5% for beer and 7.9% for wines and spirits). They are especially effective in reducing alcohol consumption among lower socioeconomic populations.

Raising prices of alcohol also reduces alcohol-related harm. A 10% increase in alcohol taxes has been associated with a 3.5% decline in all harms associated with alcohol-related disease and injuries. Increasing tax rates is one of the most cost-effective alcohol control measures.

Domestic revenues raised from taxing alcohol can be subsequently earmarked to support public health and other social services. In Thailand, its health promotion foundation, ThaiHealth, is funded from excise taxes collected from sale of tobacco and alcohol. Other earmarked alcohol taxes in Thailand support its public broadcasting service and fund sports and other support services for the elderly.

Across countries participating in the workshop, the price of alcohol products is still generally very low and there are no mechanisms for regular price increases to adjust for inflation and other factors. Industry interference to contravene any attempt to increase prices is also rampant. However, pressure to raise government revenue offers an opportunity to advocate for higher excise taxes on alcohol and closer collaboration between the Ministry of Finance and the Ministry of Health. Country teams further highlighted the role of nongovernmental organization (NGO) networks to support monitoring of the implementation of pricing policies and the appropriation of earmarked funds.

Special session: Countering alcohol industry interference

Dr Huckle provided an overview of industry interference in alcohol policy development and implementation, including examples of common strategies used by the industry. Updates regarding the development of an alcohol industry interference index, building on lessons learned from the WHO Framework Convention on Tobacco Control (FCTC), were discussed by Dr Waleewong.

Alcohol is produced and marketed by large transnational corporations whose interests are primarily motivated by generating sales and ensuring profits for their shareholders. At global, regional and national levels, the industry is very well organized, with trade organizations and a network of partners to advance their agenda.

Protection from alcohol industry interference in alcohol policy development and implementation is necessary in view of their aggressive expansion into low- and middle-income countries, the impact of economic and trade agreements on public health, the significant resources and networks at their disposal, and the growing prominence of digital marketing, which remains largely unregulated.

Lobbying is a common strategy used by the industry that focuses on building long-term relationships with policy-makers by providing and interpreting information to promote corporate interests. Pro-industry messaging typically attempts to shift responsibility for alcohol-related
harm to individual consumers and away from industry actions. This is accomplished through public relations (e.g. corporate social responsibility, corporate philanthropy) initiatives that promote a positive image and responsible drinking campaigns that employ ambiguous messaging to reframe the issue.

Research focusing on industry interference and independent monitoring networks are currently limited. Generating local evidence on industry interference (e.g. lobbying, unethical influence) is critical to raising awareness of these tactics and spurring multisectoral action. Civil society, NGO networks and the media play important roles in promoting transparency and exposing conflicts of interest.

Experience from the WHO FCTC is particularly instructive in this regard given the long history of countering tobacco industry interference in policy-making and implementation. Article 5.3 of the WHO FCTC describes practical steps for countries and partners to undertake in order to counter industry interference. This guidance can be extended to supporting efforts to counter the alcohol industry as well. One tool that has been helpful in uncovering the extent of tobacco industry interference is an index developed by the Southeast Asia Tobacco Control Alliance (SEATCA). The index lists seven dimensions that can be used to describe and quantify the extent of industry interference. Development of a similar index is currently underway and is envisioned to support action to address alcohol industry interference.

Country teams acknowledge the rampant nature of alcohol industry interference and support the generation of local evidence and civil society networks to address this issue. Transparency and accountability will be key.

2.4 Country action planning

To sustain progress in alcohol control, country teams were tasked to develop multisectoral action plans to be implemented in 2020–2021. These plans are consistent with WHO’s SAFER initiative, with actions identified to support the different interventions. Country teams called on WHO to consider these plans as well in developing the workplan for the 2020–2021 biennium.
### Cambodia

<table>
<thead>
<tr>
<th>Activity</th>
<th>S-A-F-E-R component</th>
<th>Time frame</th>
<th>Deliverable/Output</th>
<th>Support and resource needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilize community support for alcohol control legislation, e.g. NGOs, civil society organizations, People Center for Development and Peace (PDP), Cambodia Movement for Health (CMH)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commune alcohol notification (CAN)</td>
<td>E, S, A</td>
<td>June 2019 to 2021</td>
<td>20 CANs</td>
<td>IOGT-NTO Movement*; WHO</td>
</tr>
<tr>
<td>Follow-up CAN for compliance; 122 CANs</td>
<td>E, S, A</td>
<td>June 2019 to 2021</td>
<td>Commune Investment Plan (CIP)</td>
<td>IOGT-NTO Movement; WHO</td>
</tr>
<tr>
<td>Monitoring use of CIP among 122 CANs</td>
<td>E, S, A</td>
<td>June 2019 to 2021</td>
<td>50% of total CAN will be included in CIP</td>
<td>Commune Councillors</td>
</tr>
<tr>
<td>Provincial workshop on alcohol harm reduction</td>
<td>E, S, A</td>
<td>June 2019 to 2021</td>
<td>15 times</td>
<td>IOGT-NTO Movement</td>
</tr>
<tr>
<td>Provincial campaign</td>
<td>E, S, A</td>
<td>June 2019 to 2021</td>
<td>12 times</td>
<td>IOGT-NTO Movement</td>
</tr>
<tr>
<td>Community discussions and talks</td>
<td>E, S, A</td>
<td>2020 to 2021</td>
<td>30 times</td>
<td>IOGT-NTO Movement</td>
</tr>
<tr>
<td>Stakeholder meetings</td>
<td>S, A</td>
<td>2020 to 2021</td>
<td>10 times</td>
<td>IOGT-NTO Movement</td>
</tr>
<tr>
<td>Youth Coffee Talk</td>
<td>E, S, A</td>
<td>2020</td>
<td>60 times</td>
<td>IOGT-NTO Movement</td>
</tr>
</tbody>
</table>

*IOGT-NTO Movement Sweden or IOGT International is the premier global network for evidence-based policy measures and community-based interventions to prevent and reduce harm caused by alcohol and other drugs.

**Restriction of alcohol marketing by Ministry of Health (MOH)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time frame</th>
<th>Deliverable/Output</th>
<th>Support and resource needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research on alcohol drinking among young people</td>
<td>2019</td>
<td>Research report on alcohol drinking among young people</td>
<td>WHO</td>
</tr>
<tr>
<td>Supporting document for capacity-building (Facts and Myths)</td>
<td>2019</td>
<td></td>
<td>WHO</td>
</tr>
<tr>
<td>Establish inter-ministerial committee (IMC)</td>
<td>2019</td>
<td>IMC sub-decree</td>
<td>MOH/WHO</td>
</tr>
<tr>
<td>Capacity-building for IMC</td>
<td>2019–2021</td>
<td></td>
<td>WHO</td>
</tr>
<tr>
<td>National campaign on the harmful use of alcohol and alcohol advertising</td>
<td>2020–2021</td>
<td></td>
<td>WHO</td>
</tr>
<tr>
<td>Draft legislation for the restriction of alcohol marketing</td>
<td>2019–2019</td>
<td>Sub-decree finalized</td>
<td>WHO</td>
</tr>
<tr>
<td>Mobilize support from Parliament</td>
<td>2020</td>
<td></td>
<td>WHO</td>
</tr>
<tr>
<td>Activity</td>
<td>S-A-F-E-R component</td>
<td>Time frame</td>
<td>Deliverable/Output</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Continue development of alcohol beverages control decree</td>
<td>S</td>
<td>2019</td>
<td>Alcohol control decree approved by the Prime Minister</td>
</tr>
<tr>
<td>Ban alcohol advertisement, promotion and sponsorship</td>
<td>E</td>
<td>2019–2020</td>
<td>Advertisements/billboards removed</td>
</tr>
<tr>
<td>AUDIT integration into hospital patient history form</td>
<td>F</td>
<td>2019–2020</td>
<td>Complete integration of AUDIT to Mittaphab Hospital patient history form</td>
</tr>
<tr>
<td>Increase awareness on harms of alcohol to young people</td>
<td>S, A, F</td>
<td>2019–2020</td>
<td>Young people are provided access to credible information on harmful use of alcohol</td>
</tr>
<tr>
<td>Address drink–driving</td>
<td>A</td>
<td>2019–2020</td>
<td>Road crashes reduced</td>
</tr>
<tr>
<td>Propose specific tax on alcohol</td>
<td>R</td>
<td>2019–2020</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>S-A-F-E-R component</td>
<td>Time frame</td>
<td>Deliverable/Output</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Develop alcohol prevention programme for youth/social mobilization</td>
<td>S</td>
<td>2020–2021</td>
<td>Programme fully developed</td>
</tr>
<tr>
<td>Expand network of civil society and NGOs</td>
<td>S</td>
<td>2020–2021</td>
<td>Increased numbers of civil society and NGOs</td>
</tr>
<tr>
<td>Increase public awareness of harmful use of alcohol</td>
<td>E</td>
<td>2020–2021</td>
<td>Increased public awareness</td>
</tr>
<tr>
<td>Establish lobby group for policy- and decision-makers</td>
<td>S</td>
<td>2020</td>
<td>Lobby group established</td>
</tr>
<tr>
<td>Encourage alcohol-free events settings</td>
<td>S</td>
<td>2020–2021</td>
<td>Increase the number of alcohol-free events and settings</td>
</tr>
<tr>
<td>Establish surveillance system for illicit alcohol, provide incentives for registration</td>
<td>S</td>
<td>2020–2021</td>
<td>Surveillance system established</td>
</tr>
<tr>
<td>Translate and adapt WHO Mental Health Gap (mhGAP) tools and resources</td>
<td>F</td>
<td>2020</td>
<td>Translated and modified tools</td>
</tr>
<tr>
<td>Training and workshops to determine strategies to scale up mhGAP through primary health care and NGOs</td>
<td>F</td>
<td>2020–2021</td>
<td>Uptake of mhGAP in primary health care and NGOs</td>
</tr>
<tr>
<td>Improve implementation of AUDIT, ASSIST</td>
<td>F</td>
<td>2020</td>
<td>Increase the number of screened individuals</td>
</tr>
<tr>
<td>Set up the support group of NGOs</td>
<td>F</td>
<td>2020</td>
<td>Increase number of NGOs</td>
</tr>
<tr>
<td>Increase excise tax on alcohol beverages</td>
<td>R</td>
<td>2020–2021</td>
<td>Increase price of alcohol</td>
</tr>
<tr>
<td>Modify the WHO alcohol control strategy</td>
<td>R</td>
<td>2020</td>
<td>Modified alcohol control strategy</td>
</tr>
<tr>
<td>Pilot use of apps and</td>
<td>E</td>
<td>2020–2021</td>
<td>Increase</td>
</tr>
<tr>
<td>Tools on social media targeting young people</td>
<td>Awareness of young people</td>
<td>Ban surreptitious advertising of alcohol</td>
<td>Decrease surreptitious advertising of alcohol</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------</td>
<td>-----------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>E 2020–2021</td>
<td></td>
<td>Communication strategy developed</td>
<td>WHO</td>
</tr>
<tr>
<td>Develop communication strategy on reducing the harmful use of alcohol among young people</td>
<td>E 2020–2021</td>
<td>Communication strategy developed</td>
<td>WHO</td>
</tr>
<tr>
<td>Improve multisectoral coordination</td>
<td>A 2020–2021</td>
<td>Multisectoral coordination mechanism established</td>
<td>Government</td>
</tr>
<tr>
<td>Activity</td>
<td>S-A-F-E-R component</td>
<td>Time frame</td>
<td>Deliverable/ Output</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Develop multisector action to implement law</td>
<td>SAFER</td>
<td>2020</td>
<td>National action plan</td>
</tr>
<tr>
<td>Communication and public awareness-raising on alcohol law to community</td>
<td>SAFER</td>
<td>July–December 2019</td>
<td>Workshop, media material (e.g. news clips)</td>
</tr>
<tr>
<td>Training and capacity-building for implementation of law</td>
<td>SAFER</td>
<td>2020–2021</td>
<td>Training material, training report, number of trainees</td>
</tr>
<tr>
<td>Develop the sub-law documents</td>
<td>SAFER</td>
<td>July–December 2019</td>
<td>Decree, circular, decision, guideline, regulation</td>
</tr>
<tr>
<td>Compilation of data on results of law’s implementation to inform possible future amendments</td>
<td>SAFER</td>
<td>Now – 2021</td>
<td>Monitoring and recommendation in relation to implementation of drink–driving regulations. Evidence of alcohol use due to lack of control policy on Internet advertising and sponsorship.</td>
</tr>
<tr>
<td>Organize a National Non-Alcohol Day</td>
<td>S</td>
<td>Once a year</td>
<td>Event organized</td>
</tr>
<tr>
<td>Develop decree on administrative penalty</td>
<td>S</td>
<td>2020</td>
<td>Decree</td>
</tr>
<tr>
<td>Review and update Decree 46 on administrative penalty for traffic violations with focus on drink–driving prevention</td>
<td>A</td>
<td>2019</td>
<td>Updated decree</td>
</tr>
<tr>
<td>Develop guideline for screening and interventions for people affected by alcohol</td>
<td>F</td>
<td>2020–2021</td>
<td>Guidelines</td>
</tr>
<tr>
<td>Finalize the essential service package to</td>
<td>F</td>
<td>2020</td>
<td>Circular</td>
</tr>
<tr>
<td>Activity</td>
<td>S-A-F-E-R component</td>
<td>Time frame</td>
<td>Deliverable/ Output</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>ensure sustainable financial resources for prevention and control of alcohol-related harm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy to increase excise tax on alcohol</td>
<td>R</td>
<td>2019–2021</td>
<td>Revised law</td>
</tr>
</tbody>
</table>

The workshop concluded with remarks from Mr Vandendyck. An evaluation of the workshop can be found in Annex 4.
3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

Progress in alcohol control has been observed but is insufficient and uneven across the recommended interventions. Breakthroughs were most commonly reported in alcohol taxation and pricing and drink–driving countermeasures and awareness campaigns. Far less progress has been observed in restricting alcohol availability, banning or restricting marketing, and facilitating access to screening, brief interventions and treatment.

*Strengthen restrictions on alcohol availability:* Consumption of homemade alcohol poses a serious challenge to curbing alcohol availability as it often falls outside of existing regulatory regimes. Research has indicated that these forms of alcohol are produced and consumed in significant quantities.

Consumption of homemade alcohol is also closely tied to cultural beliefs and practices, which can exacerbate the harmful use of alcohol.

Food safety is another policy lever that governments may apply to support alcohol control. Strategic health communication campaigns and alcohol-free settings (e.g. schools, workplaces, events) are also strategies that may be applied to de-normalize harmful use of alcohol.

*Advance and enforce drink–driving countermeasures:* Insufficient technical capacity, lack of monitoring equipment (e.g. alcohol breath analysers) and irregular implementation pose major challenges to effective enforcement of current drink–driving countermeasures.

High-quality local data are needed to support advocacy and more effective policy implementation.

*Facilitate access to screening, brief interventions and treatment:* There is broad interest in integrating screening, brief interventions and treatment tools (e.g. AUDIT, ASSIST, mhGAP) into minimum service packages delivered through primary health care.

Adaptation of tools into local context, training/capacity-building and development of supporting materials will be necessary to support uptake and scale-up.

*Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion:* The alcohol industry continues to saturate the market with marketing content and messages delivered through multiple channels (e.g. television, out-of-home, digital and below-the-line channels). Owing to the popularity of social media among young people, alcohol marketing on this platform is also increasing in volume and sophistication. New social media platforms are emerging and fast becoming channels for alcohol marketing as well.

Transnational marketing – for example, when consumers from one market are exposed to marketing content produced in a different market, often through digital channels – is a growing concern in light of difficulties in enforcing any form of restriction.

*Raise prices of alcohol through taxation and pricing policies:* Alcohol remains affordable across all countries represented in the workshop. Prevailing alcohol tax rates are low and there are many gaps in pricing policies (e.g. prices are not regularly adjusted for inflation; there is no specific tax on alcohol in some jurisdictions).
Pricing policies offer an opportunity for whole-of-government action on alcohol control, taking into account governments’ interests in revenue-raising measures (e.g. in Cambodia, Viet Nam).

**Countering industry interference:** Alcohol industry interference (e.g. through lobbying, misrepresentation of scientific evidence, use of front organizations) has been observed in all stages of alcohol policy development and implementation.

Corporate social responsibility and philanthropy are strategies used by the industry to promote a positive public image while interfering with alcohol control efforts at the same time.

### 3.2 Recommendations

Recommendations for Member States:

- Implement proposed country activities through multisectoral action plans to advance alcohol control, based on national priorities and as appropriate to the national context.
- Advance alcohol policy development and/or reform through leadership, advocacy, coalition building and strategic health communication.
- Strengthen international cooperation on alcohol control through subregional networks, knowledge exchange and joint undertakings.
- Gather local evidence and data on alcohol consumption, alcohol marketing (especially through the use of digital media) and implementation of existing alcohol control policies and initiatives.
- Document instances of alcohol industry interference and apply corresponding countermeasures.
- Convene national alcohol control events or workshops as a continuation of this leadership programme.
- Strengthen subnational governments and civil society networks for alcohol control, and enjoin young people to support alcohol control advocacy.
- Integrate alcohol screening, brief interventions and management tools into primary health care.

Recommendations for WHO:

- Convene a regional consultation on the implementation of the WHO *Global Strategy to Reduce the Harmful Use of Alcohol*, 10 years since its endorsement, that will inform a report to the Seventy-third World Health Assembly in 2020.
- Incorporate country action plans and priorities into programme planning for the 2020–2021 biennium at regional and country levels.
- Support dissemination, adaptation and implementation of technical tools and resources under the SAFER Framework:
  - Strengthen restrictions on alcohol availability
  - Advance and enforce drink–driving countermeasures
  - Facilitate access to screening, brief interventions and treatment
  - Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
  - Raise prices on alcohol through excise taxes and pricing policies.
• Facilitate opportunities for further training and capacity-building through its network of collaborating centres (e.g. McCabe Centre for Law & Cancer) and other strategic partnerships (e.g. WHO–ThaiHealth Project).
• Provide country support through expert missions, development of technical and other information products, and knowledge sharing.
• Follow-up reporting of alcohol control–related indicators under relevant regional and global frameworks (e.g. global survey on alcohol and health).
• Support high-level advocacy to advance alcohol control initiatives.
ANNEXES

Annex 1: Agenda

AGENDA

1. Opening
2. Introduction to Module 3 of the training and recapitulation of Modules 1 and 2
3. Global and regional updates on alcohol control
4. Country progress on alcohol control (Cambodia, Lao People’s Democratic Republic, Mongolia, Viet Nam)
5. Panel discussion: Setting the scene to advance progress in alcohol control at country level
6. Raising prices on alcohol through excise taxes and pricing policies
7. Advancing and enforcing drink-driving countermeasures
8. Enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
9. Facilitating access to screening, brief interventions and treatment
10. Strengthening restrictions on alcohol availability
11. Countering alcohol industry interference in policy-making and implementation
12. Workshop: Country action planning
13. Evaluation and closing
Annex 2: Programme of activities

PROGRAMME OF ACTIVITIES

Day 1, Tuesday 18 June 2019

08:30 – 09:00  Registration

09:00 – 09:30  Opening remarks

Overview of the training course and introduction of participants

Dr Nargiza Khodjaeva
Acting WHO Representative in Cambodia

Mr Martin Vandendyck
Technical Lead
Mental Health and Substance Abuse Division of NCD and Health through the Life-Course, WHO/WPRO

09:30 – 10:00  Recapitulation of Modules 1 and 2

Dr Cornelius Goos
Public Health Consultant

10:00 – 10:30  Group Photo

Coffee and tea / Mobility break

10:30 – 10:45  Global and regional update with a focus on SAFER

Mr Martin Vandendyck
WHO Secretariat

10:45 – 12:00  Country updates on progress towards alcohol harm reduction in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam

Who Secretariat

12:00 – 12:30  Panel discussion: Setting the scene to advance progress in alcohol control at country level

Dr Cornelius Goos

Dr Orratai Waleewong
Researcher at the Health Promotion Policy Research Center, International Health Policy Program, Bureau of Health Policy and Strategy, Ministry of Public Health of Thailand

Dr Taisia Huckle
Senior Researcher, SHORE & Whariki Research Centre, Massey University

12:30 – 13:30  Lunch break

13:30 – 15:00  Raising prices on alcohol through excise taxes and pricing policies

Dr Orratai Waleewong

15:00 – 15:30  Coffee and tea / Mobility break
15:30 – 16:30  Advancing and enforcing drink-driving countermeasures  

*Mr Martin Vandendyck*

18:00  Welcome reception

**Day 2, Wednesday 19 June 2019**

08:30 – 08:45  Morning energizer  

Recapitulation of Day 1  

*Mr Martin Vandendyck*

08:45 – 10:30  Enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion

*Dr Taisia Huckle*

*Dr Orratai Waleewong*

10:30 – 11:00  Coffee and tea / Mobility break

11:00 – 12:30  Facilitating access to screening, brief interventions and treatment

*Dr Cornelius Goos*

12:30 – 13:30  Lunch break

13:30 – 16:00  Site visit: Government health facility and role of health care in alcohol control (TBD)

*WHO Secretariat*

**Day 3, Thursday 20 June 2019**

08:30 – 08:45  Morning energizer  

Recapitulation of Day 2  

*Mr Martin Vandendyck*

08:45 – 10:30  Strengthen restrictions on alcohol availability

*Dr Cornelius Goos*

10:30 – 11:00  Coffee and tea / Mobility break

11:00 – 12:30  Countering alcohol industry interference in policy-making and implementation

*Dr Taisia Huckle*

12:30 – 13:30  Lunch break

13:30 – 15:00  Workshop: Country action planning

*Dr Jason Ligot*

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

15:30 – 15:50  Module 2 evaluation

*Mr Martin Vandendyck*

15:50 – 16:00  Closing

*Mr Martin Vandendyck*
Annex 3: List of participants

Dr CHHEA Chhordaphea, Director, National Centre for Health Promotion, Ministry of Health, 3 National Road 6A, Kean Khleang, Sangkat Prek Leap, Khan Chroy Changya, Phnom Penh, Cambodia. Telephone: +855 23 432 051, Email: daphea@nchp.gov.kh

Dr RAY Rany, Chief, Tobacco or Health Unit, Ministry of Health, 3 National Road 6A, Kean, Khleang, Russey Keo, Phnom Penh, Cambodia. Telephone: +855 23 432 051, Email: rayrany@nchp.gov.kh

Mr HENG Kimhong, Project Officer, People Center for Development and Peace, No. 69B, Street 186, SangKat Toek Laak III, Khan Toul Kak, Phnom Penh, Cambodia. Telephone: +855 967 888 368, Email: hengkimhong19@gmail.com

Mr LORS Selak, Project Officer, Cambodia Movement for Health, No. 18WH, Street K4A, Tek Thia, Sen sok, Phnom Penh, Cambodia. Telephone: +855 70 250682, Email: sokafs@gmail.com

Dr Khamseng PHILAVONG, Deputy Director, Center of Nutrition, Ministry of Health, Simeuang Village, Vientiane, Lao People's Democratic Republic. Telephone: +856 20 55669983, Email: khamhseng_p@hotmail.com

Dr Viengsakhone LOUANGPRADITH, Deputy Head, Medical Administration and Planning Department, Mittaphab Hospital, Phontong Road, Vientiane, Lao People's Democratic Republic. Telephone: +856 21 710663, Email: moviensakhone@yahoo.com

Dr Khatthanaphone PHANDOUANGSY, Head, Health Promotion Division, Hygiene and Health Promotion Department, Ministry of Health, Samsenthai road, Ban thatkhao, Sisattanack District, Vientiane, Lao People's Democratic Republic. Telephone: +856 21 214010, Email: tphandouangsy@yahoo.com

Dr Latsamy SIENGSOUNTHONE, Deputy Director General, Lao Tropical and Public Health Institute, Ministry of Health, Ban Kaognod, Samsenthai road, Ban thatkhao, Sisattanack District, Vientiane, Lao People's Democratic Republic. Telephone: +856 21 250670, Email: slatsamy@yahoo.com

Dr Khandarmaa TSEREN-OCHIR, Senior Officer-in-charge, Noncommunicable Diseases, Department of Public Health, Ministry of Health, Government Building VIII, Olympic Street 2, Ulaanbaatar, Mongolia., Telephone: +976 51 263892, Email: khandarmaa@moh.gov.mn

Dr Narantuya DAVAAKHUU, General Director, National Center for Public Health, Peace Avenue 17, Bayanzurkh District, Ulaanbaatar, Mongolia. Telephone: +976 99088822, Email: narantuyad623@gmail.com

Dr Munkhtuya SUMIYA, Specialist, Addiction Medicine, National Center of Mental Health, Bayanzurkh district, Khoroo IX, Street 52, Ulaanbaatar, Mongolia., Telephone: +976 11 99163697, Email: munkhtuya11@yahoo.com

Ms Jambal TSOGTSGUGAR, President, Mongolian Men's Development Society, Tsetsenkhangai Center, 5F, 502, Bayanzurkh District, Ulaanbaatar, Mongolia. Telephone: +976 98989993, Email: tsogtone@gmail.com
Ms DINH Hai Linh, Officer, Division of NCD Control and School Health, General Department of Preventive Medicine, Ministry of Health, 138A Giang Vo Ba Dinh, Hanoi, Viet Nam. Telephone: +84 3 7367184, Email: dinhhailinh@gmail.com

Ms NGUYEN Thi Minh Huong, Civil Servant, Legislation Department, Ministry of Health, No. 138a Giang Vo Street, Ba Dinh District, Hanoi, Viet Nam. Telephone: +84 936896089, Email: huong.ngtm.89@gmail.com

Dr LAM Tu Trung, Director, Da Nang Psychiatric Hospital, 193 Nguyen Luong Bang Street, Liên Chiểu District, Da Nang, Viet Nam. Telephone: +84 905123410, Email: tutrung.lttrungdn@gmail.com

Ms PHAM Le Thanh, Project Assistant, HealthBridge Foundation of Canada (Viet Nam), Suite 292-203, E4 Building, Diplomatic Compound, No. 6 Dang Van Ngu Street, Dong Da District, Hanoi, Viet Nam. Telephone: +84 973663056, Email: thanh@healthbridge.org.vn

Dr Cornelius GOOS, Public Health Consultant/Chair, Alcohol Policy Network Europe, Vienna, Austria. Email: ceesgoos@hotmail.com

Dr Taisia HUCKLE, Senior Researcher, Alcohol, SHORE & Whariri Research Centre, College of Health, Massey University, PO Box 6137, Wellesley Street, Auckland 1141, New Zealand. Telephone: +64 9 3666136, Email: t.huckle@massey.ac.nz

Dr Orratai WALEEWONG, Researcher, Health Promotion Policy Research Center, International Health Policy Program, Bureau of Health Policy and Strategy, Ministry of Public Health, Muang, Nonthaburi, Thailand. Telephone: + 66 2590 2379, Email: orratai@ihpp.thaigov.net

Ms Evita RICAFORT, Regional Coordinator - Asian Region, McCabe Centre for Law and Cancer, Manila, Philippines. Telephone: +63 2 618 6008, Email: evita.ricafort@mccabecentre.org

Mr Martin VANDENDYCK (Responsible Officer), Technical Lead, Mental Health and Substance Abuse, Division of NCD and Health through the Life-Course, WHO Regional Office for the Western Pacific, United Nations Avenue, Ermita, Manila 1000, Philippines. Telephone: +63 2 528 9858, Email: mvandendyck@who.int

Dr Jason LIGOT, Consultant, Mental Health and Substance Abuse, Division of NCD and Health through the Life-Course, WHO Regional Office for the Western Pacific, United Nations Avenue, Ermita, Manila 1000, Philippines. Telephone: +63 2 528 9334, Email: ligotj@who.int

Dr Daravuth YEL, Technical Officer, Tobacco Free Initiative, Mental Health and Substance Abuse, NCDs and Health throughout the Life-Course (NHL), WHO Cambodia, 1st Floor No. 61-64, Preah Norodom Boulevard (corner St. 306), Sangkat Boeung Keng Kang I, Khan Chamkamorn, Phnom Penh Cambodia., Telephone: +855 2321 6610, Facsimile: +855 2321 6211, Email: yeld@wpro.who.int

Mr Douangkeo THOCHONGLIACHI, National Professional Officer, Tobacco Free Initiative, Mental Health and Substance Abuse, WHO Lao People's Democratic Republic, 125 Saphanthong Road, Unit 5, Ban Saphangthongtai, Sisattanak District, Vientiane Capital, Lao People's Democratic Republic. Telephone: +856 2135 3902, Facsimile: +856 2135 3905, Email: tochongliached@wpro.who.int
Dr Bolormaa SUKHBAATAR, National Professional Officer, Noncommunicable Diseases, WHO Mongolia, N11-Khairkhan Street, 25th Khoroo, Songinokhairkhan, Ulaanbaatar, Mongolia. Telephone: +976 88866349, Email: sukhbaatarb@who.int

Dr Phuong Nam NGUYEN, Technical Officer, Substance abuse, WHO Viet Nam, 304 Kim Ma Street, Hanoi, Viet Nam., Telephone: +84 4 38500300, Facsimile: +84 4 3726 5519, Email: nguyenp@who.int
Annex 4: Evaluation of the workshop

<table>
<thead>
<tr>
<th>Respondents = 19*</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global and regional update with a focus on SAFER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Topic was relevant and useful</strong></td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Presentation was clear</strong></td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Enough time was provided for the session</strong></td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Country updates on progress towards alcohol harm reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Topic was relevant and useful</strong></td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Presentation was clear</strong></td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Enough time was provided for the session</strong></td>
<td>7</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Panel discussion: Innovative approaches to alcohol control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Topic was relevant and useful</strong></td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Presentation was clear</strong></td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Enough time was provided for the session</strong></td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Session 1: Raising prices on alcohol through excise taxes and pricing policies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Topic was relevant and useful</strong></td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Instructions were clear</strong></td>
<td>8</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Enough time was provided for the session</strong></td>
<td>7</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Session 2: Advancing and enforcing drink–driving countermeasures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Topic was relevant and useful</strong></td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Instructions were clear</strong></td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Enough time was provided for the session</strong></td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Day 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 3: Enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship, promotion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Topic was relevant and useful</strong></td>
<td>15</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Instructions were clear</strong></td>
<td>12</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Enough time was provided for the session</strong></td>
<td>10</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Place a check on the appropriate number</td>
<td>Strongly agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Strongly disagree</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------</td>
<td>-------</td>
<td>---------</td>
<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Session 4: Facilitating access to screening, brief interventions and treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic was relevant and useful</td>
<td>15</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Instructions were clear</td>
<td>13</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enough time was provided for the session</td>
<td>12</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Site visit: Government health facility and role of health care in alcohol control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic was relevant and useful</td>
<td>11</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Presentation was clear</td>
<td>9</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enough time was provided for the session</td>
<td>12</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Day 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session 5: Strengthen restrictions on alcohol availability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic was relevant and useful</td>
<td>17</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Instructions were clear</td>
<td>13</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enough time was provided for the session</td>
<td>13</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Session 6: Countering alcohol industry interference in policy-making and implementation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic was relevant and useful</td>
<td>11</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Instructions were clear</td>
<td>10</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enough time was provided for the session</td>
<td>10</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Workshop: Country action planning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic was relevant and useful</td>
<td>16</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Instructions were clear</td>
<td>16</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enough time was provided for the session</td>
<td>16</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Overall evaluation of the workshop:

<table>
<thead>
<tr>
<th>Place a check on the appropriate number</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The training materials were relevant and informative</td>
<td>17</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The materials were easy to understand</td>
<td>15</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The balance between presentations, discussions and group work was good</td>
<td>13</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The general organization promoted a good learning experience</td>
<td>13</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Venue was conducive to learning</td>
<td>13</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>My expectations were met</td>
<td>12</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Please list three key things (knowledge, skills, attitudes, etc.) you have learned that you found most important/useful in strengthening strategic communications in your country.

- Skills, knowledge about SAFER, attitudes
- Give strong evidence, skill in organizing training, skill in detecting alcohol advertising in digital media
- Quality of information, consistency of message, strategic timing of message
- SAFER, pay attention to the health of the community, one step at a time to advance alcohol control
- WHO SAFER Framework, brainstorming to identify gaps, opportunities, threats and action to solve the problems, innovative approaches to alcohol control
- Restricting availability of alcohol, raising prices through taxation and pricing policies, comprehensive bans on advertising, promotion and sponsorship
- SAFER is very important, restricting alcohol availability will be the first thing to go, industry interference, raising prices to reduce alcohol consumption
- SAFER, alcohol availability, advertising and promotion
- Strategic communication: interview, training short course, talk show
- Networking with associations, e.g. youth, medical associations
- Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion

If you feel that something that should have been covered was not, please indicate below.

- More focus on advancing and enforcing drink–driving measures
- Discussion between countries is not well covered

What would you shorten/eliminate from the current programme, if anything?

- Should provide more time on country sharing experiences
<table>
<thead>
<tr>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>It has been excellent, thank you so much!</td>
</tr>
<tr>
<td>It’s a wonderful opportunity to share information and experiences. It’s useful to build a network to advance alcohol harm prevention.</td>
</tr>
<tr>
<td>Step by step I have gained knowledge in this field, including an appreciation for the big picture and some ideas I can develop in my hospital.</td>
</tr>
<tr>
<td>All three modules were very useful for alcohol control in my country.</td>
</tr>
<tr>
<td>The workshops were useful as they encouraged government to work/focus on alcohol beverage control, e.g. ban marketing, raise awareness, etc.</td>
</tr>
<tr>
<td>Well organized. Thank you very much for having me in this training. Please continue to support us in the future.</td>
</tr>
<tr>
<td>The three modules built upon each other nicely.</td>
</tr>
</tbody>
</table>

*Four participants could not make it to Day 1 of the training.*
Annex 5: Participant’s workbook

Training for leadership and advocacy teams to reduce alcohol harm in young people in selected countries in the Western Pacific (Module 3)

Phnom Penh, Cambodia
18–20 June 2019

Disclaimer: This workbook was developed by the Mental Health and Substance Abuse Unit of the WHO Western Pacific Regional Office for use at the Training for Leadership and Advocacy Teams to Reduce Alcohol Harm in Young People, 18–20 June 2019 in Phnom Penh, Cambodia. The workbook is not a formal publication at this time, and is not for sale or use for commercial purposes.
<table>
<thead>
<tr>
<th>Time</th>
<th>Tuesday, 18 June</th>
<th>Time</th>
<th>Wednesday, 19 June</th>
<th>Time</th>
<th>Thursday, 20 June</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 – 09:00</td>
<td>Registration</td>
<td>08:30 – 08:45</td>
<td>Morning energizer and recapitulation of Day 1</td>
<td>08:30 – 08:45</td>
<td>Morning energizer and recapitulation of Day 2</td>
</tr>
</tbody>
</table>
| 09:00 – 09:30 | Opening remarks by a/WHO Representative in Cambodia  
       | Overview of the training course and introduction of participants | 08:45 – 10:30 | Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion  
       | - Including social media and alcohol | 08:45 – 10:00 | Strengthen restrictions on alcohol availability  
       | - Including public health impact of illicit alcohol production |
| 09:30 – 10:00 | Recapitulation of Module 1 and 2 |           |                          |           |                         |
| 10:00 – 10:30 | Group Photo  
       | Coffee and tea / Mobility break | 10:30 – 11:00 | Coffee and tea / Mobility break | 10:00 – 10:30 | Coffee and tea / Mobility break |
| 10:30 – 10:45 | Global and regional update with a focus on SAFER | 11:00 – 12:30 | Facilitate access to screening, brief interventions and treatment  
       | - Including role of Primary Health Care and national medical associations in alcohol control | 10:30 – 12:30 | Countering alcohol industry interference in policy making and implementation |
| 10:45 – 12:00 | Country update on progress towards alcohol harm reduction in Cambodia, the Lao People’s Democratic Republic, Mongolia and Viet Nam |           |                          |           |                         |
| 12:00 – 12:30 | Panel discussion: Innovative approaches to alcohol control  
       | - Including priority setting |           |                          |           |                         |
| 13:30 – 15:00 | Raise prices on alcohol through excise taxes and pricing policies  
       | - Including lessons learnt from WHO-Thai Health alcohol control initiative | 13:30 – 16:00 | Site visit: Government Health Facility and role of health care in alcohol control | 13:30 – 15:00 | Workshop: Country action planning  
       | - Including plenary discussion on Regional priorities for alcohol control |
| 15:00 – 15:30 | Coffee and tea / Mobility break |           |                          | 15:00 – 15:30 | Coffee and tea / Mobility break |
| 15:30 – 16:30 | Advance and enforce drink driving counter measures  
       | - Including role of law enforcement in alcohol control |           |                          | 15:30 – 15:50 | Module 2 evaluation |
|              |                        | 15:50 – 16:00 |                        |              | Closing remarks by Mr Martin Vandendyck, Technical Lead, Mental Health and Substance Abuse, WHO/WPRO |
# Table of contents

**Timetable**

**Introduction:**
- Protecting young people from the harmful use of alcohol  
- Workshop objectives  
- WHO SAFER Framework

**Workshop sessions:**
- S – strengthen restrictions on alcohol availability
- A – advance and enforce drink driving counter measures
- F – facilitate access to screening, brief intervention and treatment
- E – enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion
- R – raise prices on alcohol through excise taxes and pricing policies

Countering alcohol industry interference in policy making and implementation

**Country action planning**
Protecting young people from the harmful use of alcohol

Every minute one person dies from alcohol-related harm in the WHO Western Pacific Region. Young people are especially at risk for alcohol-related injury (e.g. drink-driving, violence), risky sexual behaviour and suicide. Young people often underestimate the risks associated with excessive use of alcohol and potentially impaired decision-making.

Regular recreational drinking during adolescence is the clearest predictor of alcohol dependence in adulthood. Over time it increases the risk for noncommunicable diseases (NCDs) such as cancer and liver cirrhosis. These consequences impose significant direct costs to society such as health care related expenses. Indirect costs from lost productivity due to absenteeism, unemployment, decreased output, reduced earnings potential and lost working years due to premature pension or death account for as high 76-91% of the total burden to society.

In response to this significant threat to public health, countries have committed to nine voluntary NCD targets, including a 10% relative reduction in the harmful use of alcohol. Regulations regarding the availability of alcohol, comprehensive restrictions on alcohol advertising and promotions, and price increases through taxation are among the cost-effective interventions recommended by the World Health Organization (WHO).

Empowering leaders for alcohol control advocacy in the Western Pacific

Last April 2016, the WHO Regional Office for the Western Pacific (WPRO) convened a Regional Forum on Protecting Young People from the Harmful Use of Alcohol in Hong Kong SAR, China. The forum was organized to highlight the significant burden of the harmful use of alcohol in the Region and share evidence-based interventions and good practices to prevent and control harmful use among young people in particular. Among the main recommendations of the forum was to prioritize assisting countries in advancing their national agenda by: 1) raising awareness and advocacy, 2) developing and implementing effective controls through policy and legislation and advice on industry interference, and 3) networking and subregional cooperation.

Following these recommendations, WHO WPRO has been organizing a series of training workshops for leadership and advocacy teams from Cambodia, Lao People's Democratic Republic, Mongolia and Viet Nam since 2017 – these countries have the highest total alcohol consumption per capita among those aged 15-19 years in low- and middle-income countries in the Western Pacific Region.
Module 1 was held in Da Nang, Viet Nam last 14-16 November 2017 and focused on the burden of alcohol-related harm in these countries and its impact on young people. Experts discussed alcohol policy 'Best Buys' and the restriction of illicit and informally produced alcohol. Countries were guided to conceptualize action plans to advance their national agendas.

The follow-up Module 2 was held in Vientiane, Lao People's Democratic Republic last 18-20 September 2018. Following recommendations from countries from the first module, the follow-up workshop focused on strategic communication to raise awareness and build advocacy coalitions. Reducing the impact of marketing of alcoholic beverages, particularly among young people and adolescents, and price interventions was also given special emphasis. The workshop coincided with a national advocacy event in the country to gather support for the passage of a subnational decree banning all forms of alcohol marketing.

Progress has been noted in each country since the first module was concluded in 2017:

- **Cambodia**: Pretesting and finalization of information, education and communication (IEC) materials on alcohol control following a series of consultative meetings with the National Center for Health Promotion, Ministry of Health (NCHP);
- **Lao People's Democratic Republic**: Drafting of subnational decree banning all forms of alcohol marketing following intergovernmental consultations involving 80 participants from various ministries — health, education and sports, industry and commerce, justice, information culture and tourism, transportation, public security, as well as the office of the Prime Minister and the National Assembly;
- **Mongolia**: Training of secondary schools by the School of Public Health, Mongolian National University of Health Sciences (MNUMS) to implement a youth program to reduce alcohol consumption; and,
- **Viet Nam**: Drafting of a national law on alcohol control, focusing on the regulation of alcohol availability, advertising and drink-driving, following intergovernmental consultations from various ministries — health, justice, culture, trade and industry, planning and investment, and transport.

Module 3 will build on the earlier modules and introduce concepts and tools under the WHO SAFER Framework — a WHO-led roadmap comprised of high impact strategies to accelerate progress in curbing the harmful use of alcohol and achieve development targets.
Meeting objectives

The objectives of module 3 of the training are:

1. To introduce tools, good practices and approaches to implement the WHO SAFER Framework in participating countries;
2. To determine priorities, opportunities and next steps for action on alcohol control for the Region and in national action plans of participating counties;
3. To reinforce leadership competencies and skills for alcohol control advocacy that can be applied to practical and appropriate approaches to alcohol harm reduction in young people.
WHO SAFER Framework

SAFER has been developed to meet global, regional and country health and development goals, and to reduce human suffering and pain caused by the harmful use of alcohol.

The overall objective of the SAFER initiative is to provide support for Member States in reducing the harmful use of alcohol by boosting and enhancing the ongoing implementation of the global alcohol strategy and other WHO and UN instruments. SAFER will focus on the most cost-effective priority interventions (“best buys”) using a set of WHO tools and resources to prevent and reduce alcohol-related harm.

Three key principles will drive the SAFER initiative forward: implement, monitor, and protect.

1. Advocacy, resource mobilization, technical capacity building and programmatic action at country level are key components in the implementation of SAFER.
2. SAFER implementation must be supported by strong monitoring systems, to enable accountability and progress tracking. Such systems, at the country level, should include monitoring of sales, consumption, health and social harms, economic impact, and industry practices. WHO will incorporate SAFER monitoring into its global monitoring and surveillance system.
3. SAFER will support countries by ensuring that alcohol control measures are guided, formulated and implemented by public health interests and as such are protected from industry interference and commercial interests.

<table>
<thead>
<tr>
<th>Action Package</th>
<th>National Action</th>
<th>Global Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>S – strengthen restrictions on alcohol availability</td>
<td>IMPLEMENT – Strong political will, adequate resources, and technical and institutional capacity are critical to enacting the SAFER interventions at the country level.</td>
<td>WHO Technical Guidance – Technical note, policy briefs, factsheets, implementation toolkits, monitoring framework, guidance on protection from industry interference</td>
</tr>
<tr>
<td>A – advance and enforce drink driving counter measures</td>
<td>MONITOR – Strong monitoring systems must support SAFER implementation to enable accountability and track progress.</td>
<td>WHO/UN Joint Programme – Capacity building, support networks, technical support</td>
</tr>
<tr>
<td>F – facilitate access to screening, brief interventions and treatment</td>
<td>PROTECT – Alcohol control measures must be guided and formulated by public health interests and protected from industry interference and commercial interests.</td>
<td>Communication and Advocacy – Partnerships, SAFER events, resource mobilization, SAFER initiative visibility</td>
</tr>
<tr>
<td>E – enforce bans/comprehensive restrictions on alcohol advertising, sponsorship and promotion</td>
<td>R – raise prices on alcohol through excise taxes and pricing policies</td>
<td></td>
</tr>
</tbody>
</table>
S – strengthen restrictions on alcohol availability

Enhancing and enforcing restrictions on commercial or public availability of alcohol through laws, policies and programmes are important ways to reduce harmful use of alcohol. Such strategies provide essential measures to prevent easy access to alcohol by young people and other vulnerable and high-risk groups.

Licensing allows national or local governments to limit the number of outlets and to set licensing conditions such as maximum trading hours. Prohibiting the sale or consumption of alcohol during specific events or locations (such as youth events, sporting events, music festivals and on school or university campuses) is another way to restrict availability.

**Session format:** 105 minutes
- Plenary presentation – 30 minutes (Dr Cornelius Goos)
- Small group discussion – 40 minutes
- Open forum – 20 minutes

**Objective:** At the end of this session, participants would have been introduced to approaches to strengthening restrictions on alcohol availability, including restricting the production of illicit alcohol, and determined opportunities and threats for strengthening current national or local regulations.

**Guide questions for small group discussion:**
1. What are the gaps or weaknesses of restrictions on alcohol availability in our country?
2. What are the opportunities and threats for strengthening restrictions on alcohol availability?
3. What are our considerations for addressing the production of illicit alcohol?
A – dvance and enforce drink driving counter measures

Road users who are impaired by alcohol have a significantly higher risk of being involved in a crash. Enacting and enforcing strong drink-driving laws and low blood alcohol concentration limits via sobriety checkpoints and random breath testing will help to turn the tide.

Effective road safety policy must encompass measures that (1) reduce the likelihood that a person will drive following the consumption of alcohol, and (2) create a safer environment that reduces harm from alcohol-related road traffic crashes.

Crash risks are not uniform for drivers of all ages. Research has shown that at the same blood alcohol concentration (0.05-0.05 g/dl), drivers aged 16-20 were 57% more likely to be involved in a crash than drivers aged 25-34 years. Stringent police enforcement is crucial to the effectiveness of these measures.

Session format: 60 minutes
• Plenary presentation – 20 minutes (Dr Taisia Huckle)
• Small group discussion – 20 minutes
• Open forum – 20 minutes

Objective: At the end of this session, participants would have been introduced to good practices and approaches in enforcing drink driving counter measures, and identified strategies for engaging with law enforcement, and other relevant stakeholders, in their implementation.

Guide questions for small group discussion:
1. What are the gaps or weaknesses of drink driving measures in our country?
2. How can we more effectively engage law enforcement, and other relevant stakeholders, in advancing and enforcing drink driving measures?
F – facilitate access to screening, brief intervention and treatment

Health professionals have an important role in helping people to reduce or stop their drinking to reduce health risks, and health services have to provide effective interventions for those in need of help and their families.

Health professionals must not underemphasize the dangers of alcohol and support patients who are suffering from its ill effects, in particular those who have difficulties to control alcohol use and who use alcohol as a means of covering up other serious problems such as depression. The inclusion of screening and brief interventions into primary health care can be an effective, efficient way to reduce alcohol-related harm among drinkers and their families.

Session format: 90 minutes
- Plenary presentation – 20 minutes (Dr Cornelius Goos)
- Small group discussion – 40 minutes
- Open forum – 20 minutes

Objective: At the end of this session, participants would have been introduced to various tools that can be used for screening, brief intervention and treatment (e.g. AUDIT, ASSIST, mhGAP) and determined strategies to introduce, integrate and scale-up these interventions through primary health care and the involvement of national medical associations.

Guide questions for small group discussion:
1. What tools are needed and/or relevant in our primary health care system to support alcohol control?
2. How can we introduce, integrate and scale up these interventions through primary health care and national medical associations?
3. How can we integrate these interventions to broader initiatives related to universal health coverage?
E – nforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion

Bans and comprehensive restrictions on alcohol advertising, sponsorship and promotion are impactful and cost-effective measures to prevent and reduce alcohol harm. Enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising, sponsorship and promotion in the digital world will bring public health benefits and help protect children, adolescents and abstainers from the pressure to start consuming alcohol.

Marketing of alcohol influences social norms that govern the public’s beliefs, attitudes and consumption. A continuous and diversified bombardment of positive images about alcohol drinking is ongoing through direct and indirect means. These marketing tactics have proliferated across different social media platforms as the use of social media becomes more and more popular. Apart from raising brand and product awareness, social media channels are now virtual points-of-sale as they become more integrated with e-commerce websites and delivery services (e.g. through the use of apps).

**Session format:** 105 minutes
- Plenary presentation – 30 minutes (Dr Jason Ligot); 15 minutes (Dr Orratai Waleewong)
- Small group discussion – 30 minutes
- Open forum – 30 minutes

**Objective:** At the end of this session, participants would have been introduced to the use of social media to increase awareness, access and availability of alcohol beverages, especially tactics targeting young people. Participants will also be introduced to case studies of national action to curb alcohol marketing through social media.

**Guide questions for small group discussion:**
1. What are examples of the use of social media to increase awareness, access and availability of alcohol beverages in our country?
2. What are opportunities and threats for the development or implementation of comprehensive restrictions on alcohol marketing, especially through digital or social media?
3. How can we better engage young people through social media to support alcohol control?
Raise prices on alcohol through excise taxes and pricing policies

Alcohol taxation and pricing policies are among the most cost-effective alcohol control measures. An increase in excise taxes on alcoholic beverages is a proven measure to reduce harmful use of alcohol. It provides governments revenue to offset the economic costs of harmful use of alcohol.

Young people are especially price-sensitive. An estimated 35% of alcohol-related deaths would be prevented by doubling the alcohol tax. Alcohol levies should be tied to alcohol volume, not to types of alcoholic beverages, and adjusted regularly for inflation. The added revenue from these raised taxes can be used to promote public health.

Session format: 90 minutes
- Plenary presentation – 20 minutes (Dr Orratai Waleewong)
- Small group discussion – 40 minutes
- Open forum – 30 minutes

Objective: At the end of this session, participants would have been introduced to good practices and approaches in raising prices of alcohol, and determined opportunities and threats to increasing alcohol prices within their country.

Guide questions for small group discussion:
1. What are the gaps or weaknesses of alcohol pricing policies in our country?
2. What are current opportunities and threats to raising alcohol pricing policies in our country?
3. How can we effectively monitor pricing policies to strengthen implementation?
Countering industry interference in alcohol policy making and implementation

Industry interference in policy making and implementation is a well-documented obstacle to effective action to address noncommunicable diseases. The recognition of the impact of so-called commercial determinants of health has highlighted the need to expose and counteract industry tactics.

While alcohol industry interference is not as well-documented as tobacco industry interference, and global guidelines are not as categorical in the absence of a similar instrument such as the Framework Convention on Tobacco Control for alcohol, there are well-documented examples of industry interference especially in terms of interfering with marketing regulation. Examples of industry interference strategies are: lobbying and misinformation; constituency building; policy substitution, development and implementation; litigation and other legal challenges; and, financial incentives or disincentives.

A critical understanding of these different strategies, and the tactics employed under each one, is crucial to addressing the harmful use of alcohol.

Session format: 90 minutes
- Plenary presentation – 30 minutes (Dr Taisia Huckle)
- Small group discussion – 45 minutes
- Open forum – 45 minutes

Objective: At the end of this session, participants would have been introduced to various examples of alcohol industry interference and strategies or approaches to countering industry interference in alcohol policy making and implementation.

Guide questions for small group discussion:
1. What are examples of alcohol industry interference in our country?
2. What aspects of our policy environment are susceptible to alcohol industry interference?
3. How can we more effectively monitor alcohol industry interference?
4. What strategies or approaches can we adopt to counter alcohol industry interference?
Country action planning

Recalling action plans from Modules 1 and 2, as well as inputs from the past three days on implementing the SAFER initiative, country teams are asked to develop action plans to be implemented from 2020-2021. Teams are likewise requested to identify support and resource needs, which include areas for WHO support.

Objective: At the end of this activity, participants would have developed country action plans comprised of key activities organized according to the SAFER Framework.

Instructions:
1. Working as a team, identify priority activities to advance alcohol control in your country. Where possible or appropriate, please indicate which component of the SAFER framework the activity corresponds to (activity may correspond to more than one or encompass all).
2. Using the worksheet provided, determine timelines (note: activities to be implemented from 2020-2021), target deliverables or outputs and support and resource needs for each activity.
## Country action plans

Country team members:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

40
## Country action plans

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Country action plans

Country team members:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>