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DRAFT REGIONAL STRATEGY TO REDUCE ALCOHOL-RELATED HARM

Alcohol is one of the most significant risks to health. The harmful use of alcohol is responsible for 4% of disease burden and 3.2% of all premature deaths globally. In the Western Pacific Region, alcohol-related harm accounts for 5.5% of the burden of disease. In addition to the impact on public health, there are substantial social and economic costs associated with the harmful use of alcohol. While consumption levels in some countries and areas in the Region are levelling off, the reverse is happening in many others. Further, changing patterns of drinking, such as binge drinking and more frequent and heavy drinking among young people, tend to lead to more harm. Public health policy responses in many countries and areas are either absent, weak or need updating.

Global trends and the situation in the Region urgently necessitate a regional public health-oriented alcohol strategy. The proposed Western Pacific Regional Strategy to Reduce Alcohol-Related Harm (Annex) is a logical follow up to the Fifty-eighth World Health Assembly resolution WHA58.26 concerning public health problems caused by the harmful use of alcohol.

The draft Strategy reviews the global and regional situation and provides a framework for action in Member States and for the Region. It is intended to provide balanced guidance, based on available evidence, to be implemented at the country and regional levels, taking into account the Region's economic, social and cultural diversity.

The Regional Committee is requested to review and endorse the draft Regional Strategy to Reduce Alcohol-Related Harm.

1. PUBLIC HEALTH PROBLEMS CAUSED BY THE HARMFUL USE OF ALCOHOL

Growing concerns about alcohol-related harm led Member States in May 2005 to adopt a resolution at the Fifty-eighth World Health Assembly (WHA58.26) concerning the public health problems caused by the harmful use of alcohol. The resolution refers to the alarming "extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people in many Member States". It also requests Member States "to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol".

Concern over the impact on public health of the harmful use of alcohol and the need to strengthen responses have been discussed at previous sessions of the Regional Committee for the Western Pacific, and it was requested that the subject appear on the agenda of a future session of the Regional Committee.

1.1 Global overview

Harmful use of alcohol is one of the most significant risks to health globally. According to *The World Health Report 2002*, the harmful use of alcohol worldwide is responsible for 4% of disease burden and 3.2% of all premature deaths. This translates into 58.3 million disability-adjusted life years lost and 1.8 million deaths. The risk is on approximately the same order of magnitude as tobacco, which is responsible for 4.1 % of the global disease burden. Harmful use of alcohol is associated with more than 60 types of disease and other health conditions, including mental disorders and suicide, several types of cancer, and other noncommunicable diseases such as cirrhosis, as well as intentional and unintentional injuries. It also is associated with other high-risk behaviours, including unsafe sex and the use of other psychoactive substances.

Alcohol-related problems not only affect the individual drinker, they have a significant effect on others, including family members, victims of violence and accidents associated with alcohol use, and the community as a whole. Drinking to intoxication, for example, also typically affects non-drinkers. It is strongly associated with unintentional injuries, including injuries and fatalities as the result of driving while intoxicated, and negative social consequences such as aggressive behaviour, family disturbances and reduced industrial productivity.

1.2 The situation in the Western Pacific Region

Alcohol-related harm is a major issue in the Western Pacific Region. Data from the WHO *Global Status Report on Alcohol 2004* show that 5.5% of the disease burden in the Region is attributable to the harmful use of alcohol. It also shows that there has been a steady increase in per capita consumption in the Region since the mid-1980s[1].

The damage caused by the harmful use of alcohol is spread evenly across the Region. Despite the different levels of per capita consumption, there are many ways in which the Western Pacific Region countries and areas face similar types of alcohol-related harm. Transportation-related injuries across the Region are strongly associated with the harmful use of alcohol, with 20%–50% of traffic accident fatalities in the Region related to alcohol use. There also is a close relationship between violence and drinking in the Region.

Drinking by young people is of growing concern throughout the Region. Young people are beginning to drink at younger ages in many countries and areas throughout the Region, and binge drinking, which is a particularly dangerous pattern of alcohol consumption, is on the rise.

2. ISSUES

A look at the global and regional situations highlighted the following issues:

2.1 The need to raise public awareness of the problems caused by the harmful use of alcohol

Public awareness of the problems caused by the harmful use of alcohol and, in particular of some of the specific types of harm, is low or almost completely lacking in many of the countries and areas in the Region. Closely related to this is the low level of involvement of the community and nongovernmental organizations in advocacy and in responding to the problem.

[1] Country specific data in this chapter come from country reports which were prepared by participants in the Technical Consultation on the Development of a Strategy to Reduce Alcohol-Related Harm, 15-17 March 2006, Manila, Philippines.

2.2 The need for regular systematic surveillance and recording systems on alcohol consumption and alcohol-related harm

Although there is growing evidence in the Region about the extent of the harmful use of alcohol and its consequences, regular systematic surveillance and recording systems on alcohol production, consumption and related harm are not in place in many developing countries.

2.3 The need for comprehensive interventions for alcohol-related problems

There are few if any community-based programmes for prevention, treatment and care in many parts of the Region. It is well understood that effective interventions for alcohol-related harm must address a complete range of problems for people whose use of alcohol may range from hazardous consumption to alcohol dependence.

2.4 The need for capacity development in response to alcohol-related harm

Appropriate programmes for capacity development are largely lacking. Alcohol-related problems tend to remain unrecognized within primary care settings, and in the health care and welfare systems as a whole.

2.5 The need for public health-oriented alcohol policy

There is a wide variety of policy responses in the Region. In some countries and areas there are well developed and sophisticated public health-oriented alcohol policies in place, with effective enforcement mechanisms. In a number of other countries and areas, there may be an adequate legislative framework, but implementation and enforcement are inadequate. And in the majority of countries and areas in the Region there is a complete lack of public health-oriented alcohol policy.

3. DEVELOPMENT OF THE DRAFT REGIONAL STRATEGY

Global trends, as well as the situation in the Region, urgently necessitate a regional public health-oriented alcohol strategy. The preliminary draft of the Regional Strategy to Reduce Alcohol-Related Harm was prepared following the review of existing information on alcohol-related harm, resolutions of the World Health Assembly and the Regional Committee for the Western Pacific, recommendations from previous meetings, existing regional and national strategies and plans, and key

literature on effective policies, strategies and implementation. A number of recent meetings also contributed to the development of the draft, including the 2004 Meeting on Alcohol and Health in the Pacific, cosponsored by the Secretariat for the Pacific Community and WHO in Noumea, New Caledonia, a follow-up session to the Noumea meeting held in Auckland, New Zealand, in June 2005, and the Meeting of NGOs from Asia-Pacific Region on Alcohol Policies, held in Auckland in December 2005.

The Technical Consultation on the Development of a Strategy to Reduce Alcohol-Related Harm was held 15–17 March 2006 in Manila, Philippines. The consultation reconfirmed grave concern over the impact of the harmful use of alcohol in the Western Pacific Region and concluded that the draft Strategy constitutes an effective tool to reduce the public health problems caused by the harmful use of alcohol. After revisions based on feedback from the technical consultation, the draft was then presented to all Member States and distributed for consultations with nongovernmental organizations and other stakeholders. An open consultation with representatives of the alcohol industry was conducted on 8 June 2006 in Manila, which provided an opportunity for the WHO Regional Office for the Western Pacific to exchange views and information with the private sector on how to reduce alcohol-related harm. The comments and feedback from these consultations have been considered in preparation of the current version of the draft Strategy.

The draft Strategy proposed the following strategic core areas for national action and regional collaboration:

- reducing the risk of the harmful use of alcohol
- minimizing the impact of the harmful use of alcohol
- regulating the accessibility and availability of alcohol
- establishing mechanisms to facilitate and sustain implementation of the Strategy.

The actions identified in these core areas are neither exhaustive nor prescriptive. Governments may apply or consider applying programmes or activities, including those which are not specifically mentioned, depending on available opportunities and specific situations, and as appropriate to their individual national contexts.

While the inclusion of all the opportunities and approaches listed is not a requirement for an effective strategy to reduce all alcohol-related problems, it is important to realize that the

implementation of isolated measures is unlikely to be effective. The effectiveness of the proposed Strategy depends to a great extent on combining as many measures as possible.

4. ACTIONS PROPOSED

WHO considers it important for all Member States to assess their situation in terms of the harmful use of alcohol and the burden of alcohol-related harm.

Member States are invited to use the Strategy as a guide in developing and strengthening public health-oriented alcohol policy and in establishing mechanisms to monitor progress.

It is requested that the Regional Committee review and endorse the draft Regional Strategy to Reduce Alcohol-Related Harm.

ANNEX

Draft REGIONAL STRATEGY TO REDUCE ALCOHOL-RELATED HARM

World Health Organization
Western Pacific Region

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1. INTRODUCTION

Alcohol has been consumed since ancient times. Throughout history, the drinking of alcoholic beverages has played an important role in social and cultural events in many societies. Social norms and values have always surrounded the use of alcoholic beverages. In some societies, the use of alcohol is banned on religious grounds.

Alcohol use remains deeply embedded in many societies. Globally, some 2 billion people consume alcoholic beverages. Alcohol is a source of pleasure to many and a source of income for governments. But the cost to health is high—76.3 million people experience alcohol-use disorders, according to conservative estimates.[2]

This Strategy focuses on reducing the harmful use of alcohol, in particular its impact on public health and welfare. It has been developed on the basis of a review of the literature on alcohol-related harm, experience from countries and areas within and outside the Region, and consultations with technical experts and other stakeholders, such as nongovernmental organizations and the alcohol beverage industry. It is submitted to the Regional Committee for the Western Pacific in response to discussions in its earlier sessions and aims to provide guidance for action to reduce alcohol-related harm in Member States in the Western Pacific Region.

2. THE PUBLIC HEALTH IMPACT OF ALCOHOL USE

2.1 The impact on public health attributable to alcohol

The harmful use of alcohol is one of the most significant risks to health globally. According to *The World Health Report 2002*, the harmful use of alcohol is responsible for 4% of total disease burden. This translates into 58.3 million disability-adjusted life years (DALYs) and 3.2% of all premature deaths globally, or 1.8 million deaths. The risk is on approximately the same order as tobacco, which is responsible for 4.1% of the disease burden globally. Harmful use of alcohol is the foremost risk to health in low-mortality developing countries, where it is responsible for 6.2% of all

[2] *Global Status Report on Alcohol 2004.* World Health Organization, Geneva, 2004.

DALYs. It is the third most serious risk to health in developed countries, where it is responsible for 9.2% of DALYs.

Harmful use of alcohol is associated with more than 60 types of diseases and other health conditions, including mental disorders and suicide, several types of cancer, and other noncommunicable diseases such as cirrhosis, as well as intentional and unintentional injuries. It also is associated with other high-risk behaviours, including unsafe sex and the use of other psychoactive substances. As a result, alcohol-use disorders carry a high degree of co-morbidity with other substance-use disorders, including nicotine dependence, and with sexually transmitted diseases. Recent studies suggest an association between alcohol-use disorders and risk for HIV/AIDS and other sexually transmitted diseases.[3]

Alcohol-related problems not only affect the individual drinker, they have a significant effect on others, including family members, victims of violence and accidents associated with alcohol use, and the community as a whole. The harmful use of alcohol is a cause of considerable expense through lost productivity and costs to the health and welfare, transportation, and criminal justice systems. One estimate puts the yearly economic cost of alcohol abuse in the United States to be US$ 48 billion, including US$ 19 billion for health care expenditures.[4] Studies in other countries, such as Australia, have estimated the cost of alcohol-related problems to be around 1% of the gross domestic product.[5]

Drinking to intoxication, including binge drinking, is a significant cause of alcohol-related harm, accounting for the greatest proportion of DALYs in low-income countries with low mortality. Drinking to intoxication also typically affects non-drinkers. It is strongly associated with unintentional injuries, including injuries and fatalities as the result of driving while intoxicated, and negative social consequences such as aggressive behaviour, family disturbances and reduced industrial productivity.

Young people in developing countries are increasingly drinking in the same harmful patterns as young people in developed countries.[6] Young people are more likely to suffer from alcohol-related traffic accidents, violence and family disruptions related to harmful use of alcohol than other age

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[3] Morojele, N.K., et al. (2006). Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science & Medicine*, 62, 217-227.

[4] Harwood H, Fountain D, Livermore G (1998). *The economic costs of alcohol and drug abuse in the United States, 1992*. Report prepared for the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. Rockville, Maryland, National Institute on Drug Abuse (NIH Publication No. 98-4327).

[5] Collins D, Lapsley G (1996). *The social costs of drug abuse in Australia in 1988 and 1992*. Canberra, Commonwealth Department of Human Services and Health, Australian Government Printing Service (Monograph No. 30).

[6] Rehm, J, Taylor, B., & Patra, J. (2006). Volume of alcohol consumption, patterns of drinking and burden of disease in the European region 2002. *Addiction*, 101, 1086-1095).

groups. In the WHO European Region alone, alcohol consumption was responsible for the deaths of 63 000 young people aged from 15 to 29 in 2002.[7]

Men traditionally drink more frequently and more heavily than women. However, the patterns of drinking for men and women are beginning to converge. While men may still experience more direct drinking-related harm than women, women are often the victims of the harmful use of alcohol by men. Furthermore, the harmful use of alcohol by women can have gender-specific negative consequences, such as unwanted pregnancies, harm to the fetus[8] and increased risk of breast cancer.[9]

2.2 Positive effects

Drinking alcohol may also have beneficial effects. Therefore, effective strategies to reduce the harmful use of alcohol should not restrict those people who enjoy alcohol consumption in moderation and in appropriate settings. In many cultures, alcohol plays a widely accepted role as a facilitator in socializing and for relaxation. In health terms, the available evidence suggests that very low alcohol consumption may have a slight positive effect on mortality associated with coronary heart disease in older age groups. This evidence does not in itself constitute a reason to drink or to recommend drinking alcohol, as these potential positive effects are far outweighed by the negative health consequences of alcohol consumption.[10]

2.3 A global movement

Growing awareness of the public health impact of the harmful use of alcohol led Member States in May 2005 to adopt resolution WHA58.26 on this issue at the Fifty-eighth World Health Assembly. The resolution refers to the alarming "extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people in many Member States". It also requests Member States "to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol".

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[7] *Ibid.*

[8] Asley S.J. and Clarren S.K. National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control. Fetal Alcohol Spectrum Disorders. (http://www.cdc.gov/ncbddd/fas/)

[9] Singletary, K.W.; Gapstur, S.M. Alcohol and breast cancer: Review of epidemiologic and experimental evidence and potential mechanisms. *Journal of the American Medical Association (JAMA)*:2143-2151, 2001

[10] Room, R. et al. (2003). Drinking and its burden in a global perspective: policy considerations and options. *European Addiction Research*, 9, 165-175.

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3. THE SITUATION IN THE WESTERN PACIFIC REGION[11]

3.1 Trends in consumption

Data from the WHO *Global Status Report on Alcohol 2004* show that there has been a steady increase in per capita consumption in the Western Pacific Region since the mid-1980s. In general, there are differences in alcohol consumption levels in developed and developing countries in the Region. Some developed countries, such as Australia, Japan and New Zealand, have relatively high per capita consumption (6–9 litres of pure alcohol per year for those 15 years of age and above). In some developing countries in the Region, such as China, Viet Nam and most countries and areas in the Pacific, per capita consumption is relatively low but increasing rapidly. In China, for example, per capita annual alcohol consumption for those 15 years of age or above in 1970 was 0.75 litres, and rose to 4.45 litres in 2001.[12]

It is also important to note that within countries there are significant variations in alcohol consumption and resulting harm for different population groups. This is particularly noticeable in minority populations at the lower end of the socioeconomic scale. In Australia, for example, indigenous people are at least twice as likely to die from high-risk consumption of alcohol as are their non-indigenous counterparts.[13, 14]

3.2 Unrecorded production and consumption

Illegal and semi- or quasi-legal production, sale and consumption of alcoholic beverages, which by their very nature go unrecorded, are also of concern in the Western Pacific Region. In China, unrecorded consumption is estimated at no less than 20%–30% of total consumption.[15] In many developing countries and some developed countries, the consumption of home-brewed or home-distilled alcoholic beverages is not abating. Those beverages continue to be consumed along with

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[11] Unless indicated otherwise country-specific data in this chapter come from country reports which were prepared by participants in the WHO Technical Consultation on the Development of a Strategy to Reduce Alcohol-Related Harm, 15-17 March 2006, Manila, Philippines.

[12] Hao W. et al. Drinking and drinking patterns and health status in the general population of five areas of China. *Alcohol and Alcoholism*, 2004, 39(1):43–52.

[13] Chikritzhs, T., & Pascal, R. (2004). Trends in Youth Alcohol Consumption and Related Harms in Australian Jurisdictions, 1990-2002. *National Alcohol Indicators, Bulletin No. 6*. Perth: National Drug Research Institute, Curtin University of Technology.

[14] Chikritzhs, T., & Pascal, R. (2005). Trends in alcohol consumption and related harm for Australians aged 65 to 74 years, 1990–2003. *National Alcohol Indicators, Bulletin No.8*. Perth: National Drug Research Institute, Curtin University of Technology.

[15] *Op cit*, Ref. 8.

commercially produced alcoholic beverages, which formerly were not as prominent. This poses a particular challenge due to the quantities consumed and the food safety issues involved in the production of unregulated alcohol. For example, it is legal in Viet Nam to sell home-brewed beer commercially, despite the lack of any quality control mechanisms.

3.3 Associated harm

Alcohol-related harm is a major issue in the Western Pacific Region. Based on the data from *The World Health Report 2002*, 5.5% of the disease burden in the Region is attributable to the harmful use of alcohol, which is higher than the global level of 4%.

The damage caused by the harmful use of alcohol is spread evenly across the Region. Although per capita consumption is higher in the developed countries of the Region than in most of the less developed countries, the pattern of drinking in the latter is more detrimental than in the former. Patterns of drinking are assessed in terms of their associated risk of harm. A pattern score is based on a range of scores from 1 to 4, with 4 representing the most detrimental pattern, reflecting high frequencies of heavy drinking occasions, drinking outside of mealtime and drinking in public places. The average pattern score for developed countries is 1.16 and for developing countries the pattern score is 2.15.[16]

Despite the different levels of per capita consumption, there are many ways in which the countries and areas in the Western Pacific Region face similar types of alcohol-related harm. Transportation-related injuries across the Region are strongly related to harmful alcohol use. There is a positive trend in some countries in the Region, such as Japan where the number of offences against drink driving in recent years is decreasing. However, it is more common to see an upward trend. In the Republic of Korea, for example, traffic accidents and casualties related to drink driving have increased by about 41% between 1994 and 2004.[17] In New Zealand, alcohol-related fatal crashes and injuries have been decreasing since 1988, but the percentage of fatal and injury crashes where drink driving was a contributing factor has been rising, particularly in younger age groups, since 1999. The decreases have been attributed to the positive impact of lowered legal levels of blood alcohol for

[16] Rehm J, Monteiro M, Room R, Gmel G, Jernigan D, Frick U, Graham K(2001) Steps towards constructing a global comparative risk analysis for alcohol consumption: determining indicators and empirical weights for patterns of drinking, deciding about theoretical minimum, and dealing with different consequences. *European Addiction Research* 7:138–147.

[17] Communication from the Ministry of Health, the Republic of Korea.

drivers[18] and compulsory, random breath testing.[19, 20] The increases have been attributed to the effects of a reduction in the minimum age for the purchase of alcohol.[21, 22]

Unintentional injuries are often associated with the harmful use of alcohol. In Papua New Guinea an estimated 90% of trauma admissions to hospital emergency wards are related to the harmful use of alcohol. There also is a close relationship between violence and drinking in the Region[23,24] as there is elsewhere.[25, 26] A study in Mongolia found that alcohol was involved in 58.4% of all homicides.[27] In Guam, alcohol was involved in 62% of all homicides. Studies conducted in the Pacific island countries and areas show that alcohol often is involved in cases of violence against women. For example, the perpetrator was under the influence of alcohol in 70% of sexual assault cases against women in public places in French Polynesia. In Samoa, alcohol was found to be the second most frequent contributing factor to violence against women.

Drinking by young people is of growing concern throughout the Western Pacific Region. Some countries still have low alcohol consumption among young people, such as the Marshall Islands, where only 11.4% of youth surveyed were regular drinkers. But the general picture emerging in the Region is of growing and heavier use of alcohol by young people. The age of initiation of drinking is occurring at younger and younger ages in many countries and areas throughout the Region, and binge drinking, which is a particularly dangerous pattern of alcohol consumption, is on the rise as well. In

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[18] Land Transport Safety Authority (2004) Road Crash Data from the LTSA, Wellington: LTSA. Accessed 5 April 2005. http://www.landtransport.govt.nz/research/documents/stats-2004-08.pdf

[19] Guria, J., Jones, W., Leung, J. and Mara, K. (2003) Alcohol in New Zealand road trauma. *Applied Health Economics and Health Policy* 2:4, 183-190.

[20] Miller, T., Blewden, M. and Zhang, J. (2004) Cost savings from a sustained compulsory breath testing and media campaign in New Zealand. *Accident Analysis and Prevention* 36 783-794.

[21] Huckle, T., Pledger, M. and Casswell, S. (2006) Trends in alcohol-related harms and offences in a liberalized alcohol environment. *Addiction 101* 232-240

[22] Kypri, K., Voas, R., Langley, J., Stephenson, S., Begg, D., Tippets, A. and Davie, G. (2006) Minimum purchase age for alcohol and traffic crash injuries among 15 to 19-year-olds in New Zealand. *American Journal of Public Health* 96:1, 126-131

[23] Fergusson, D., Lynskey, M. and Horwood, L. (1996) Alcohol misuse and juvenile offending in adolescence. *Addiction* 91:4, 483-494

[24] Han S.T. Current problems of alcohol abuse in the Western Pacific Region and future prospects. *Alcoholism: Clinical and Experimental Research, 1998*, 22(3):177S–180S.

[25] Parker, R. and Rebhun, L. (1995) *Alcohol and homicide: A deadly combination of two American traditions*. New York: State University of New York Press

[26] Room R. and Rossow I. (2001). The share of violence attributable to drinking: What do we need to know and what research is needed? *Journal of Substance Use* 6:218-228.

[27] Communication from the Ministry of Health, Mongolia.

Japan, 9.9% of young people were defined as problem drinkers[28] and in the Pacific island countries and areas binge drinking has been identified as a common practice.

Few data are available to date on the socioeconomic costs of the harmful use of alcohol. In the Republic of Korea, a study estimates the socioeconomic costs of the harmful use of alcohol to be 2.86% of gross domestic product.

3.4 The challenges

Public awareness of the problems caused by the harmful use of alcohol and, in particular, of some of the specific types of harm is low or almost completely lacking in many countries and areas in the Region. Closely related to this is the low level of involvement of the community and nongovernmental organizations in advocacy and in responding to the problem.

Although there is growing evidence in the Region about the extent of the harmful use of alcohol and its consequences, regular systematic surveillance and recording systems on alcohol production, consumption and related harm are not in place in many developing countries. In five of the countries that responded to a recent survey from the WHO Regional Office for the Western Pacific, there was little information about alcohol-related harm and no detailed data on the consumption of alcoholic beverages. While there is an abundance of anecdotal evidence on harmful patterns of drinking, reliable data from well-designed epidemiological surveys on alcohol use are scarce. Further strengthening the evidence base is necessary to encourage and facilitate appropriate policy responses.

There are few, if any, community-based programmes for prevention, treatment and care in many parts of the Region. It is well understood that effective interventions for alcohol-related harm must address a complete range of problems for people whose use of alcohol may range from hazardous consumption to alcohol dependence. However, acute detoxification is often the only kind of service available. Brief intervention strategies, as opposed to long hospital-based treatment, are cost effective, especially where resources are limited. But to date there is very limited experience in the Region with this approach.

[28] Suzuki K et al. (2001) Drinking behaviours of Japanese adolescents' problem drinker—report of 1996 national survey. *Nihon Arukoru Yakubutsu Igakkai Zasshi*, 36(1):39–42.

Appropriate programmes for capacity development are largely lacking. Alcohol-related problems tend to remain unrecognized within primary care settings, and in the health care and welfare system as a whole. This is due, in part, to inadequate undergraduate and postgraduate training in the subject. A lack of professionals and non-professionals trained in the prevention, screening, treatment and rehabilitation of alcohol-use disorders and alcohol-related health conditions obviously hinders the implementation of effective prevention, treatment and rehabilitation programmes. Other conditions also hinder the implementation of effective programmes, including a lack of adequate resources and public health infrastructure.

There is a wide variety of policy responses in the Region. In some countries and areas there are well developed and sophisticated public health-oriented alcohol policies in place, with effective enforcement mechanisms. In a number of other countries and areas, there may be an adequate legislative framework, but implementation and enforcement are inadequate. And in the majority of countries and areas in the Region, there is a complete lack of public health-oriented alcohol policy.

Many countries in the Region are experiencing rapid social change and economic transitions. There is growing concern over the potential impact of trade agreements on alcohol consumption and related harm. Measures which affect supply and demand for alcoholic beverages, such as special import duties, are affected by multilateral or bilateral trade agreements. These agreements, in accordance with global trade pacts, aim at facilitating the free flow of goods and services and consequently tend to abolish restrictions.

Concern over the impact on public health of the harmful use of alcohol and the need to strengthen responses have been expressed at previous sessions of the Regional Committee for the Western Pacific, most recently at the fifty-fifth session in Shanghai in 2004, at which time it was requested that the subject appear on the agenda of a future session of the Regional Committee.

4. THE STRATEGY

This Strategy focuses on reducing the harmful use of alcohol, and consequently addresses the health and welfare sector as its first audience. However, due to the impact alcohol-related problems have in nearly all facets of life, a multisectoral approach is required. Other sectors of particular relevance include education, finance, transportation and traffic, public order, and law enforcement.

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Further, a successful strategy to reduce alcohol-related harm will have a positive influence on a number of health domains. It will contribute to lessening the burden of noncommunicable diseases, to better mental health, to a decrease in violence and injuries, and it has the potential to improve adolescent, child and reproductive health. A successful strategy will constitute a practical example of health promotion. Reciprocally, work in these domains can support effective strategies to reduce alcohol-related harm. It is therefore important to develop and implement an alcohol strategy in close cooperation with other health initiatives. It is also important to emphasize that improving disease surveillance, data collection and monitoring are critically important for effective strategy.

The following clusters are strategic core areas of effective public health-oriented alcohol policy that address the challenges identified:

- reducing the risk of harmful alcohol use
- minimizing the impact of the harmful use of alcohol
- regulating the accessibility and availability of alcohol
- establishing mechanisms to facilitate and sustain implementation of the Strategy.

The actions identified in the subsequent core areas for national action and regional collaboration are neither exhaustive nor prescriptive. Governments may apply or consider applying programmes or activities, including those which are not specifically mentioned, depending on available opportunities and specific situations, and as appropriate to their individual national contexts.

While the inclusion of all the opportunities and approaches listed is not a requirement for an effective strategy to reduce all alcohol-related problems, it is important to realize that the implementation of isolated measures is unlikely to be effective. The effectiveness of the proposed Strategy depends to a great extent on combining as many measures as possible.

4.1 Reducing the risk of harmful use of alcohol

4.1.1 Ensure adequate public awareness of the health and social consequences of the harmful use of alcohol:

- develop and disseminate information on the health and social consequences of the harmful use of alcohol to the public;

- involve other relevant sectors, in particular law enforcement and the criminal justice system to increase public awareness about the harmful use of alcohol;

- provide special prevention programmes for high-risk groups (such as young people, women who are pregnant or who are contemplating pregnancy, and certain disadvantaged groups); and

- provide special prevention programmes for high-risk situations and in certain settings (such as schools, workplaces, roads and highways).

4.1.2 Promote factors that protect against the harmful use of alcohol:

- develop and implement health promotion programmes dealing with harmful use of alcohol which empower people to make healthy choices and are appropriately adapted for individual national contexts; and

- provide supportive environments in schools, communities and other social settings that protect people from the harmful use of alcohol, ranging from family support programmes, community and school system support programmes, and increased access to non-alcoholic beverages.

4.1.3 Reduce factors that may facilitate the harmful use of alcohol:

- diminish pressures to drink from peer groups and other influences, especially for young people, other high-risk groups and for those who do not wish to drink; and

- provide training in the hospitality sector and retail sector for the responsible service of alcohol, including enforcing compliance with the legal minimum age for the sale of alcoholic beverages.

4.1.4 Regulate and respond to the marketing of alcoholic beverages, including advertising, promotion, and the sponsoring of cultural and sports events, in particular those aimed at young people:

- designate a government agency responsible for enforcement of marketing regulations;

- regulate or ban, as appropriate, the marketing of alcoholic beverages; and

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- encourage greater responsibility among commercial interests, for example through codes of conduct for sale and marketing practices.

4.1.5 Promote advocacy for reducing the risk of the harmful use of alcohol:

- provide support to agencies that advocate a reduction in the harmful use of alcohol; and

- engage all relevant government departments in developing and implementing responses to prevent and respond to the harmful use of alcohol.

4.2 Minimizing the impact of harmful use of alcohol

4.2.1 Enable community organizations to prevent and respond effectively to alcohol-related problems in the community:

- provide support to civic organizations, including relevant nongovernmental organizations, to prevent, identify and respond effectively to the negative health and social consequences of the harmful use of alcohol.

4.2.2 Provide a health and social welfare workforce capable of preventing and responding effectively to alcohol-related problems:

- build capacity of health care providers to better detect, prevent and treat harmful use of alcohol;

- build capacity and support the primary health care system to act proactively in the community to prevent, identify and respond effectively to the negative health and social consequences of the harmful use of alcohol;

- develop and support the introduction and implementation of brief intervention treatment programmes;

- develop and support the introduction and implementation of appropriate specializations in addressing alcohol-related harm in the health care system; and

- enable easy access to early intervention, treatment and rehabilitation programmes for people with alcohol-related problems and support for their families.

4.2.3 Reduce drink driving through special programmes, in particular through establishing and enforcing a maximum legal blood alcohol content level:

- in line with the best international practices, set a legal low maximum blood alcohol level for drink driving violations;
- develop and enforce, where appropriate, a system of frequent random blood alcohol testing; and
- develop and enforce a system of administrative driving licence suspensions or revocations to ensure quick and effective consequences for those caught driving drunk.

4.2.4 Provide further active involvement of the law enforcement sector in preventing and responding to alcohol-related problems, in particular to alcohol-related crime and other antisocial behaviour and the negative effect on public order of harmful use of alcohol:

- promote close collaboration between health and law enforcement sectors to enable a public health and public safety approach to the harmful use of alcohol;
- provide training to the law enforcement sector on how to prevent and respond to alcohol related problems; and
- encourage the law enforcement sector to develop and implement strategies responding to the harmful use of alcohol.

4.3 Regulating accessibility and availability to reduce the harmful use of alcohol

4.3.1 Establish and enforce regulatory mechanisms for alcoholic beverages:

- establish and enforce a minimum legal age for the purchase and sale of alcoholic beverages and a ban on the sale of alcohol to intoxicated persons;
- regulate the sale of alcohol to limit the places and times that alcoholic beverages can be sold;
- develop and enforce a commercial licensing system to regulate the production, importation and wholesale and retail sale of alcoholic beverages; and

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- establish minimum standards for the production of alcoholic beverages to ensure that alcoholic beverages being produced and imported meet beverage safety requirements and that home-brewed and home-distilled alcoholic beverages are either prohibited from commercial sale or strictly controlled.

4.3.2 Establish an alcohol taxation system as a means of reducing the harmful use of alcohol:

- without prejudice to the sovereign rights of states to establish their taxation policies, serious consideration should be given to the implementation of an alcohol taxation system as an effective mechanism to decrease the harmful use of alcohol; and

- consider taxation of alcoholic beverages based on their alcohol content and administer special taxes for alcoholic beverages targeted at vulnerable groups such as young people.

4.3.3 Consider alcohol-related harm reduction when participating in international trade and economic agreements:

- ensure regulation of alcoholic beverages to avoid illegal importation;

- apply or establish, where necessary, coordination mechanisms involving ministries of finance, health and trade, as well as other relevant institutions, to address issues related to the harmful use of alcohol and international trade;

- continue to develop or enhance capacity at the national level to track and analyse the potential impact of trade and trade agreements on harmful use of alcohol; and

- collaborate with other Member States and with competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health.

4.3.4 Enforce and apply legislation, regulation and policy:

- ensure that enforcement agencies appropriately enforce the regulation of alcoholic beverages; and

- enforce minimum-age requirements for the purchase, consumption and sale of alcoholic beverages.

4.4 Establishing mechanisms to facilitate and sustain implementation of the Strategy

4.4.1 Provide systems to collect and analyse pertinent data:

- assign a lead agency to develop an alcohol information system and to analyse information for policy development. This may be a principal task for a new, specialized institution; it may also be a new task for an existing agency with a broader scope of activities, such as a national institute for public health;

- utilize existing data, including data on production and sale, as well as data from the health care and law enforcement systems, to enhance knowledge about trends in consumption, drinking patterns and harm;

- establish a surveillance system involving population-based surveys, hospital admissions and other available surveillance data, to provide information on alcohol use, drinking patterns and alcohol-related harm, and consider involving academic institutions in the implementation of such a system; and

- support country and regional research assessing the relationship between the harmful use of alcohol in general, and binge drinking in particular, and the related adverse health and social consequences.

4.4.2 Develop a national public health- oriented, evidence-based alcohol policy, appropriate to individual national contexts:

- establish or identify a national body that has the responsibility of developing and updating a national public health-oriented alcohol policy;

- provide adequate support to this national body through funding and public health-oriented expertise;

- establish sustainable national mechanisms for appropriate intersectoral government cooperation with the involvement of relevant community groups and institutions to ensure effective coordination and implementation of the policy;

- establish funding mechanisms, such as dedicating a portion of alcohol taxation revenue to support prevention and reduction of alcohol-related harm; and

- ensure that all actions under the national policy are duly followed up, evaluated and assessed.

4.4.3 Establish regional mechanisms to support the efforts of individual countries to reduce alcohol-related harm:

- provide effective communication at the subregional level, and as appropriate at the regional level, between relevant national institutions involved in public health-oriented alcohol policy-making;

- establish a network of national counterparts, nominated by governments of Member States, for the exchange of information and support for implementation of the Strategy;

- develop a regional alcohol information system for the collection and analysis of data on alcohol consumption and its health and social consequences; and

- establish a regional pool of expertise on public health-oriented alcohol policy and programme development.

5. CONCLUSION

The proposed Western Pacific Regional Strategy to Reduce Alcohol-Related Harm as outlined in this document is designed as a menu of best practices to reduce alcohol-related harm and to facilitate policy development and implementation at the country level. Countries and areas in the Western Pacific Region are to take guidance from this Strategy according to their specific needs and situations.

This Strategy will pave the way for concerted regional action, including stronger cooperation among countries and areas. The existing variety of experience and policy responses in the Region provides great opportunities for more collaboration among countries and areas. Such cooperation can be at regional and subregional levels. A good example of subregional cooperation was the First

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Meeting on Alcohol and Health in the Pacific sponsored by the Secretariat of the Pacific Community and the World Health Organization and held in Noumea, New Caledonia, in September 2004.

Upon endorsement by the Regional Committee, the WHO Regional Office for the Western Pacific will take a leadership role in relation to the Strategy outlined in this document by advocating the Strategy, by providing technical support to assist countries and areas, and by providing appropriate coordination mechanisms in the Region to put the Strategy in place.