IOGT INTERNATIONAL

Box 128 25
SE-112 97 Stockholm
Sweden

T: +46 721 555 036
info@iogt.org
www.iogt.org

AIAP
For the full potential of alcohol policies

Official Response
Kristina Sperkova
International President

To: World Health Organizations
appendix3@who.int

IOGT International response **31.08.2016**

WHO Discussion Paper (July 25, 2016)

Updating Appendix 3 of the WHO NCDs Global Action Plan

IOGT International

IOGT International is the premier global network for evidence-based policy measures and community-based interventions to prevent and reduce alcohol-related harm.

With our 129 Member Organizations from 55 countries, we work in communities around the world for the prevention and reduction of alcohol-related harm, including Non-communicable diseases (NCDs), by promoting scientific, evidence-based policies independent of commercial interests. Therefore IOGT International and our Member Organizations have closely followed and been actively engaged in the global political and research processes to address and curb the burden of NCDs.
We are thankful for this opportunity – referring to the WHO Discussion Paper Version July 25, 2016, including the proposal to update Appendix 3 of the NCDs Global Action Plan 2013 – 2020.

Discussion points

IOGT International welcomes the WHO Discussion Paper dated July 25, 2016. We acknowledge that especially Appendix 3 is a crucial resource and the main tool guiding and informing decision-makers about high-impact, evidence-based, cost-effective and population-based interventions to prevent and reduce NCDs. As such

the current process of discussing and refining the menu of policy options for Member States is a vital opportunity to refine the list of interventions in line with latest independent scientific evidence.

In our submission, IOGT International on behalf of our Member Organizations, provides a detailed response to the menu of policy options suggested in the new draft for appendix 3, focusing on alcohol policy measures.

Comments on overarching/ enabling actions

In summary, IOGT International supports the list of "Overarching/ enabling actions", for addressing harmful use of alcohol as a risk factor for NCDs. We commend the strong and systematic link to the WHO Global Alcohol Strategy (GAS).
In addition, IOGT International suggests the following concerning the fourth bullet point:

- Amend bullet point to read:
  "Support communities in adopting effective approaches and interventions to prevent and reduce the harmful use of alcohol, in particular with regard to developing and supporting alcohol-free environments, especially for youth and at-risk groups," to account a crucial issue of NCDs prevention addressed by Guiding Principle G) in the WHO GAS.

Comments on list of specific interventions

In summary, IOGT International supports the list of specific interventions and suggests the following improvements:

- Continuation of the alcohol policy "Best Buys" as part of Appendix 3 in the NCDs Global Action Plan, as the evidence base for the Best Buys measures is robust (**See charts below**[1]).

[1] *Babor et al, Alcohol No Ordinary Commodity*

- Enhancement of policy coherence and adoption of whole-of-government approach, what we call the Alcohol in All Policies (AiAP) approach, in curbing alcohol-related harm and consequently NCDs – to foster synergy effects and sustainable policy outcomes for health promotion, as well as eliminating adverse effects from other policy areas such as trade, or agriculture.
- Prevention of, safeguarding against and effective identification of possible conflicts of interest when addressing the NCDs burden in partnerships with the private sector.
- No role for the alcohol industry and their Social Aspects and Public Relations Organizations in the implementation of the WHO GAS and the NCDs Global Action Plan.
- Inclusion of minimum unit pricing (MUP) under A1, to account for latest evidence indicating effectiveness in reducing alcohol mortality, morbidity and health inequalities.
- Amend the wording under A2 to read:
  "Enforcement of bans or comprehensive restrictions on exposure to alcohol advertising and promotion (across multiple types of media)" in order to take into account evidence showing that *exposure* to alcohol marketing is associated with alcohol-related harm.
- Amend the wording under A3 to include minimum legal purchase age, to read as follows:
  "Enforcement of restrictions on the physical availability of retailed alcohol (via reduced density of retail outlets and reduced hours of sale, and increased legal age limits.)
- Amend the wording under A5 to bring the specific intervention in line with the overarching action, to read as follows:
  "Provision of brief psychosocial intervention for persons with alcohol use

disorders, including persons affected by alcohol use disorders and associated conditions."

State of the art: Evidence concerning alcohol policy measures

Since the publication of the WHO NCDs Global Action Plan in 2013, the evidence-base concerning the harmful consequences of alcohol use and the policy measures that are cost-effective and high-impact in preventing and reducing such harm, including NCDs, such as cancer, heart disease and diabetes.

The 2014 WHO Global Status Report on Alcohol shows that annually 3.3 million deaths are attributable to alcohol. Every 10 seconds a human being dies due to alcohol. This mortality rate represents 5.9% of all deaths worldwide, and 5.1% of the global burden of disease and injury[2].

Alcohol and cancer

Alcohol use is a human carcinogenic and is linked to 7 types of cancer[3]. Evidence has been published that corroborates the WHO's International Agency for Research on Cancer (IARC) classification of alcohol as a group one carcinogen[4]. A World Cancer Research Fund report from 2016 found strong links between alcohol use and stomach cancer[5].

Evidence shows that alcohol is a carcinogen, with no safe levels of alcohol use concerning cancer risk. New evidence also shows that low-dose alcohol use does not have health benefits[6]. A major review of existing evidence concluded in 2016 that regular moderate alcohol use had no net health benefits compared to abstention or

[2] *WHO Global status report on alcohol and health 2014*
[3] *Connor, J. (2016), Alcohol consumption as a cause of cancer, Addiction. doi: 10.1111/add.13477*
[4] *World Health Organization International Agency for Research on Cancer (2012), Consumption of Alcoholic Beverages, IARC Monographs on the Evaluation of Carcinogenic Risks to Humans Volume 100E*
[5] *World Cancer Research Fund International (2016), Diet, nutrition, physical activity and stomach cancer*
[6] *IOGT-NTO and Swedish Society for Medicine (2014), The effects of low-dose alcohol consumption*

occasional alcohol consumption[7]. The latest available evidence supports the statement that there is no level of alcohol consumption that is without risk to health.

Addressing alcohol like other risk factors

Regarding the overarching/enabling actions for reducing harmful use of alcohol, IOGT International recommends that, as is the case with the Tobacco Use and Unhealthy Diet, this section should more clearly refer to "Strengthening the effective implementation of the global strategy to reduce harmful use of alcohol". The specific recommended target areas for action could then be listed in two tables below:

- The existing "Specific interventions with WHO-CHOICE analysis" table,
- Plus an "Other interventions from WHO Guidance (without WHO-CHOICE analysis)" table.

This would put stronger emphasis on the hierarchy of effectiveness of the interventions and would bring the format of the list of policy actions related to alcohol harm in line with other NCD risk factors.

Evidence to support 'best buy' policy options to reduce alcohol harm

Price (relating to A1: Increase in excise taxes on alcoholic beverages)

The research consensus that raising the price of alcohol is among the most effective means of reducing alcohol-related illness and injury has only grown stronger in recent years, bolstered by an ever-growing evidence base across a range of countries. For example, in 2015 the Organization for Economic Co-operation and Development (OECD) endorsed the raising of taxes on alcohol, including it among a suite of cost-effective measures that it estimated would cost US$1,000/DALY in Germany and $3,000

[7] *Stockwell, T. et al (2016), Do "moderate" drinkers have reduced mortality risk? A systematic review and meta-analysis of alcohol consumption and all-cause mortality, Journal of Studies on Alcohol and Drugs 77:2, pp186-98.*

in Canada[8].

Marketing (relating to A2: Enforcement of bans or comprehensive restrictions on alcohol advertising)

As with pricing policies, the inclusion of policy actions to enforce bans or comprehensive restrictions on alcohol advertising and promotion, including sponsorships as one of the three best buys has been reinforced in recent years by international institutions and academic researchers.

Advertising regulations were included in the OECD's list of effective alcohol policies[9]. Across a range of countries, a number of measures of exposure to alcohol marketing have been associated with higher consumption and the related levels of alcohol harm. Most straightforwardly, in the United States[10][11], in Germany, Italy, the Netherlands, and Poland[12]and Scotland[13], among other countries, it has been shown that adolescents and young adults that recall seeing or liking alcohol advertisements consume more frequently and in higher quantities, even controlling for confounders such as previous alcohol intake levels. Alcohol sponsorship has been identified as an influential marketing activity, with a systematic review published in 2016 finding a positive association between exposure to alcohol sports sponsorship and increased alcohol use amongst schoolchildren and adult sportspeople[14].

Availability (relating to A3: Enforcement of restrictions on the physical availability of retailed alcohol)

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[8] *OECD (2015), Tackling Harmful Alcohol Use*
[9] *OECD (2015), Tackling Harmful Alcohol Use*
[10] *Tucker, J. et al (2013), Cross-lagged associations between substance use-related media exposure and alcohol use during middle school, Journal of Adolescent Health 53, pp460-4.*
[11] *Tanski, S. et al (2015), Cued recall of alcohol advertising on television and underage drinking behaviour, JAMA Pediatrics 169:3, pp264-71.*

[12] *de Bruijn, A. (2016), European longitudinal study on the relationship between adolescents' alcohol marketing exposure and alcohol use, Addiction doi: 10.1111/add.13455*
[13] *Morgernstern, M. et al (2014), Favourite alcohol advertisements and binge drinking among adolescents: a cross-cultural cohort study, Addiction 109:12, pp2005-15.*

[14] *Brown, K. (2016) Association Between Alcohol Sports Sponsorship and Consumption: A Sytematic Review, Alcohol and Alcoholism, 1-9 doi: 10.1093/alcalc/agw006*

Evidence supporting the efficacy of restrictions on the availability of alcohol for curbing NCDs has also built over the past few years. As with pricing and marketing, in 2015 the OECD included reduced opening hours among its recommended policies for tackling alcohol-related harm[15].

A number of studies have found a persistent link between shorter opening times and reduced illness and injuries. Among the most notable is a 2011 paper showing that restricting pub closing times in Newcastle, Australia was associated with a 37% reduction in assaults[16]. A follow up study, 3½ years later, found that this effect had been sustained, and assaults remained well below their pre-intervention levels[17].

Evidence from the United States[18], the Netherlands[19] and Norway[20] underpins these findings, clearly showing that longer opening hours are linked to increased violent crimes and ambulance callouts.

Evidence also shows that outlet density is linked to alcohol consumption and related harm[21]. Evidence from Canada shows that a 10% increase in private liquor stores was associated with a 2% increase in alcohol attributable mortality[22].

In addition, there is strong and consistent evidence supporting the use of minimum

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[15] *OECD (2015), Tackling Harmful Alcohol Use*
[16] *Kypri, K. et al (2011), Effects of restricting pub closing times on night-time assaults in an Australian city, Addiction 106:2, pp303-10.*

[17] *Kypri, K. et al (2014), Restrictions in pub closing times and lockouts in Newcastle, Australia five years on, Drug & Alcohol Review 33:3, pp323-6.*

[18] *Schofield, T. & Denson, T. (2013), Alcohol & Alcoholism 48:2, pp363-9*
[19] *de Goeij, M.C. et al (2015), The impact of extended closing times of alcohol outlets on alcohol-related injuries in the nightlife areas of Amsterdam: a controlled before-and-after evaluation, Addiction 110:6, pp955-64.*
[20] *Rossow, I. & Norstrom, T. (2012), The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities, Addiction 107:3, pp530-7.*

[21] *Gmel, G., Holmes, J. & Studer, J. (2015), Are alcohol outlet densities strongly associated with alcohol-related outcomes? A critical review of recent evidence, Drug & Alcohol Review 35, pp40-54.*

[22] *Zhao et al (2013)*

purchase age laws for alcohol: A review of 132 studies published between 1960 and 1999 found very strong evidence that changes in minimum drinking-age laws can have substantial effects on drinking among young people and alcohol-related harm, particularly in relation to road traffic accidents. These effects can often be seen years after young people reach the legal drinking age[23].

Additional comments

Under Objective 1, to raise the priority awarded to the prevention and control of NCDs, IOGT International wishes to draw attention to the recently agreed UN Sustainable Development Goals (SDGs), which include a target under Goal 3 to 'strengthen the prevention and treatment of substance abuse… including harmful use of alcohol'.
The inclusion of this prevention goal within the SDGs highlights the impact alcohol harm has on sustainable human development. In fact, alcohol harm is a substantial obstacle for achieving 12 out of the 17 SDGs[24].
This reaffirms the importance of tackling alcohol harm via public policies that have strong evidence of effectiveness.

However, under Objective 2, which includes 'strengthening multisectoral action and partnerships', IOGT International wishes to highlight that competing interests exist within the SDGs and other public policy areas which jeopardize progress made in preventing and reducing alcohol harm. These include trade agreements that enshrine investor rights and limit governments' ability to regulate harmful commodities and protect public health and social welfare. These also include partnerships with the private sector[25]. With reference to trade liberalization, IOGT International supports calls for enhanced policy coherence that would ensure that commitments in agriculture or trade are developed in ways that protect and promote health.

[23] *Wagenaar AC, Toomey TL. (2000), 'Alcohol policy: gaps between legislative action and current research', Contemporary Drug Problems, 27, pp. 681–733*
[24] *IOGT International (2016), Alcohol and the Sustainable Development Goals – major obstacle to development*
[25] *Collin, J, Casswell, S, 'Alcohol and the Sustainable Development Goals', The Lancet, vol 387 June 25, 2016*

With reference to partnerships with the private sector, IOGT International joins calls from civil society organizations for the WHO to ensure that health policy is protected from vested interests, in particular producers of unhealthy commodities such as alcohol, soft drinks, infant formula and processed foods high in fat, salt and sugar[26]. Guidelines should be developed for Member States to support them in preventing, identifying and managing conflicts of interest when implementing policies to tackle NCDs.

On behalf of IOGT International,
Yours sincerely,

Kristina Sperkova
International President

IOGT International

Stockholm, 31 August 2016

Esbjörn Hornberg
Executive Director

IOGT International

Stockholm, 31 August 2016

[26] *Conflict of Interest Coalition Statement of Concern*

Strategy or intervention	Effectiveness	Breadth of research support	Crossnational testing
PRICING AND TAXATION			
Alcohol taxes	+++	+++	+++
Minimum price	?	+	0
Bans on price discounts and promotions	?	+	0
Differential price by bevarage	+	+	+
Special or additional taxation on alcopops and youth-oriented beverages	+	+	+

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Strategy or intervention	Effectiveness	Breadth of research support	Crossnational testing
REGULATING PHYSICAL AVAILABILITY			
Ban on sales	+++	+++	++
Bans on drinking in public spaces	?	+	+
Minimum legal purchase age	+++	+++	++
Government monopoly on retail sales	++	+++	++
Restricitions on density of outlets	++	+++	++

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Strategy or intervention	Effectiveness	Breadth of research support	Crossnational testing
RESTRICTION ON MARKETING			
Legal restrictions on exposure	+/++	+++	++
Legal restriction on content	?	0	0
Alcohol industry's voluntary self-regulation codes	0	++	++

Strategy or intervention	Effectiveness	Breadth of research support	Crossnational testing
DRINK DRIVING COUNTERMEASURES			
Sobriety check points	++	+++	+++
Random breath testing	+++	++	++
Lowered BAC limits	+++	+++	+++
Low BAC for young drivers (zero tolerance)	+++	++	++
Designated drivers and ride services	0	+	+
Severity of punishment	0/+	++	++

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Strategy or intervention	Effectiveness	Breadth of research support	Crossnational testing
TREATMENT AND EARLY INTERVENTION			
Brief intervention with at-risk drinkers	+++	+++	+++
Mutual help/ self-help attendance	++	++	++
Medical and social detoxification	+++	++	++
Pharmaceutical therapies	+	++	++

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