

Movendi International response to the discussion paper

World Health Organization Implementation of the WHO global strategy to reduce the harmful use of alcohol since its endorsement, and the way forward

1. Overview of analysis of challenges, setbacks and shortcomings

Question #1:

What, in your organization's view, have been the most important achievements, challenges and setbacks in implementation of the WHO global strategy to reduce alcohol consumption and related harm since 2010?

Short introduction

This analysis illustrates some success and important progress facilitated by the WHO Global Alcohol Strategy (WHO GAS) since its adoption in 2010. Nevertheless, Movendi International examination of nearly a decade of implementation of the WHO GAS outlines in detail how the strategy is largely ineffective, inadequate, and in parts even outdated.

1.1 Noteworthy WHO Global Alcohol Strategy achievements

Over nearly a decade of WHO GAS implementation, some (remarkable) achievements, successes and positive trends have been recorded. There are country success stories of evidence-based alcohol policy formulation and implementation in which the WHO GAS played an important role. There have been landmark achievements for alcohol prevention and control in global policy-making processes that would likely not have happened without the WHO GAS. There have been successes in knowledge generation and science production facilitated by the WHO GAS.

Simply put:

Thanks to the WHO GAS there has been **some progress in some areas**. Without the WHO GAS the **alcohol policy situation would have been even worse**; but this doesn't mean that the current overall situation is good.

Success in terms of WHO GAS Priorities:

The achievements of the WHO GAS implementation can be categorized according to its own four priority areas. Especially two priority areas have seen positive developments, namely “Public health advocacy, partnership...” as well as “Production... of knowledge”. A third priority area “Technical support and capacity-building” has also seen achievements but has overall a more mixed evaluation due to substantial shortcomings.

Successful action in terms of WHO GAS Objective:

The achievements of the WHO GAS implementation can be categorized according to its own five objectives. One objective can be considered achieved: “Strengthened knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm.”

Data underpinning Movendi International assessment:

The WHO research initiative on alcohol, health and development has generated important knowledge about alcohol’s health harms and international research has vastly improved understanding of alcohol’s harm to others, including prevalence of fetal alcohol spectrum disorders.

The refining of WHO’s Global Information System on Alcohol and Health has facilitated significant improvements in the production, analysis and dissemination of knowledge on alcohol consumption, related harm and effective policy responses.

WHO’s work in partnership with other major UN agencies has promoted alcohol’s role in the efforts to realize the commitments of the SDGs and beyond.

1.2 WHO Global Alcohol Strategy is ineffective

Over the past decade, the world has not seen progress regarding alcohol prevention and control: neither in reducing alcohol consumption and related harm, nor in increasing alcohol policy best buy implementation.

Simply put:

The WHO GAS has been ineffective in facilitating action in terms of two its priority areas and one of its objectives. WHO failed at the highest level over nearly a decade to adequately act upon the WHO GAS and address alcohol harm as the global health emergency that it is. Member States have failed to make use of the WHO GAS and live up to their duty of protecting their citizens from alcohol harm and promoting the Human Right to health and well-being for all.

Ineffective action in terms of WHO GAS Priorities:

- 1a. Public health advocacy
- 1b. Public health partnership
3. Dissemination of knowledge

Ineffective action in terms of WHO GAS Objective:

1. Raised global awareness of the magnitude and nature of the health, social and economic problems caused by harmful use of alcohol, and increased commitment by governments to act to address the harmful use of alcohol.

Data underpinning Movendi International assessment:

The World Health Organization reports that the global situation regarding alcohol policy development and implementation is still far from effectively protecting populations from alcohol harm¹.

This illustrates that the public health advocacy, and partnerships generated by nearly a decade of WHO GAS implementation have not had the anticipated and necessary impact. It also shows that knowledge dissemination has been ineffective over the past nine years. All together this leads to substantial shortcomings both in raising the level of awareness and recognition of the real harms of alcohol and the commitment of countries to act.

1.3 WHO Global Alcohol Strategy is inadequate

While the WHO GAS has been ineffective in facilitating substantial action according to two priority areas and in achieving one of its objectives, the situation is even worse for two more priority areas and three more objectives.

Simply put:

The WHO GAS has been inadequate in generating action in terms of technical support, capacity building and recourse mobilization. This has undermined and hampered the work on a number of objectives, including enhancing Member State capacity, strengthening partnerships, and applying information meaningfully in policy development.

Ineffective action in terms of WHO GAS Priorities:

¹ WHO Global status report on alcohol, 2018:

https://www.who.int/substance_abuse/publications/global_alcohol_report/en/

2. Technical support and capacity-building
4. Resource mobilization

Ineffective action in terms of WHO GAS Objective:

3. Increased technical support to, and enhanced capacity of, Member States for preventing the harmful use of alcohol and managing alcohol-use disorders and associated health conditions.
4. Strengthened partnerships and better coordination among stakeholders and increased mobilization of resources required for appropriate and concerted action to prevent the harmful use of alcohol.
5. Improved systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development and evaluation purposes.

Data underpinning Movendi International assessment:

WHO's own analysis provides the evidence, emphasizing that current trends and projections of alcohol consumption point towards increase of total per capita consumption worldwide in the coming decade.

Clearly the target of a 10% relative reduction by 2025 has been out of reach and will remain out of reach. So far, the WHO GAS has failed in facilitating the mobilization of resources, technical capacity, and partnerships necessary to turn the tide on global alcohol harm.

Both in terms of infrastructure build and toolbox created since the adoption of the WHA GAS in 2010, the alcohol control community remains poorly equipped². Technical tools are scarce and insufficiently developed, still and supply of capacity building programs fall s short of demand. In nearly a decade, only three WHO Global Alcohol Status Reports have been produced³.

The detailed analysis:

Inadequate alcohol availability regulation worldwide

Most countries have some form of control of availability, such as a licensing system, but do not use it to regulate access in a public health perspective. For example, less than one third of countries reporting to WHO in 2016 indicated the existence of regulations on outlet density and/ or days of sale. Even after nearly a decade of WHO GAS, there are still countries without any legal minimum purchase age. Those tended to be low-income or

² WHO website: alcohol governance, https://www.who.int/substance_abuse/activities/globalstrategy/en/

³ WHO website: Global alcohol strategy, https://www.who.int/substance_abuse/activities/gsrhua/en/

lower-middle-income countries, the greatest number of which is in the WHO African Region.

It's not only that **alcohol availability regulation remains inadequate**, according to findings from the WHO Global Alcohol Status 2018, **to compound the situation, alcohol is actually becoming more widely and easily available**. The number of licences to produce, distribute and sell alcohol – a marker for increased rather than decreased availability – is increasing in much of the world, particularly in lower-income countries, according to the discussion paper (page 7).

Inadequate treatment coverage for alcohol use disorder worldwide

The WHO Global Alcohol Status Report shows that levels of treatment coverage vary substantially across countries. Only 14% of reporting countries indicated high treatment coverage, i.e. treatment coverage of more than 40%. But 28% of reporting countries indicated very limited or close to zero treatment coverage. WHO data shows that treatment coverage rises with national income. All of the responding countries that reported close to no treatment coverage were low- or lower-middle-income countries and the majority (70%) with high treatment coverage had upper-middle or high incomes.

Unfortunately, the most common response globally and in nearly every region was that countries did not know the level of treatment coverage (67 countries globally, 40%).

This shows how heavy a burden alcohol use disorder places on health systems and how ill-equipped most systems currently are. But the **WHO GAS is clearly failing to increase understanding of the alcohol burden on health systems, to mainstream alcohol policy considerations into policy discussions about universal health coverage and to specify the role and potential of the primary health care system to help reduce and prevent alcohol harm**.

Inadequate alcohol marketing regulations worldwide

The majority of countries that submit data to WHO indicate they now have some type of restriction of alcohol advertising for all media types. But digital alcohol marketing restrictions are comparatively far behind, suggesting that regulation in many countries continues to lag behind technological innovation in the alcohol industry. In 2016, 123 countries reported on alcohol marketing restrictions across all media and beverage types. But of these 28% had no regulations on any media type. Most of the countries that reported no restrictions across all media types were located in the African or Americas regions.

Inadequate alcohol pricing regulations worldwide

Increasing the price of alcohol is the single most effective strategy to reduce and prevent alcohol-related harm. Studies repeatedly find that increasing the price of alcohol is

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

associated with reductions in alcohol harm. For instance, over 50 years a 20% increase globally in alcohol taxes could avert 9 million premature deaths and generate almost US\$9 trillion in additional revenues in present discounted value⁴.

The WHO Global Alcohol Status Report shows 95% of all reporting countries implement alcohol excise taxes; however, fewer than half of the countries use the other price strategies highlighted in the WHO GAS – such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts.

For example, a 2017 analysis showed that 59% of responding countries had implemented a tax increase on alcoholic beverages since the adoption of the WHO GAS. However, only a third of countries adjust those taxes regularly for inflation, and eight countries (five of them in the WHO European Region) reported increasing their subsidies for alcohol production⁵.

Already in 2010, the World Health Report⁶ illustrated the significant potential of alcohol taxation for population health and for significantly contributing to financing health and development. “Raising taxes on alcohol to 40% of the retail price could have an even bigger impact [than a 50% increase in tobacco taxation]. Estimates for 12 low-income countries show that consumption levels would fall by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in those countries.” However, the **WHO GAS has proven to be inadequate of facilitating global efforts to advance alcohol taxation, for example through a joint initiative.**

The WHO GAS is clearly inadequate for **not facilitating protection of the human right to health and development, particularly with regard to children, adolescents and young people as well as other alcohol abstainers and women**, who are all “emerging markets” and thus target groups for the alcohol industry. Since per capita alcohol consumption is not at all declining at acceptable pace - meaning that vulnerable groups, communities and societies at large remain exposed to serious health, social and economic alcohol harms - technical support, partnerships, and coordination efforts must all be categorised as inadequate.

Inadequate support against alcohol industry interference

The WHO GAS is clearly inadequate given the failure to safeguard national, regional and global alcohol policy development processes from alcohol industry interference.

⁴ Task Force on Fiscal Policy for Health (2019). Health Taxes to Save Lives: Employing Effective Excise Taxes on Tobacco, Alcohol, and Sugary Beverages. Chairs: Michael R. Bloomberg and Lawrence H. Summers. New York: Bloomberg Philanthropies. Available at: <https://www.bloomberg.org/program/public-health/task-force-fiscal-policy-health/>

⁵Jernigan, D. (2017): Global developments in alcohol policies: Progress in implementation of the WHO global strategy to reduce the harmful use of alcohol since 2010, WHO FADAB Background Paper, https://www.who.int/substance_abuse/activities/fadab/msb_adab_gas_progress_report.pdf?ua=1

⁶ World Health Report, 2010, World Health Organization: https://ioqt.org/wp-content/uploads/2019/04/10_summary_en.pdf

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

Even in countries that committed to action on the magnitude of the alcohol problem, the WHO GAS was not enough to stimulate effective policy formulation due to alcohol industry interference and aggressive attempts to derail, obstruct and undermine such attempts at public health policy making. Alcohol industry interference has been studied and revealed on numerous occasions^{7 8}.

There is clearly not enough capacity and resources to safeguard public health alcohol policy-making processes against alcohol industry interference that led to the watering down or complete abandonment of WHO best buy alcohol policy implementation in all regions. Notable examples are South Africa⁹ and Vietnam¹⁰.

This short analysis shows that the **systematic and integrated implementation of the alcohol policy best and good buys is by no means commensurate with the health, social, and economic harm attributable to alcohol.**

From an equity and sustainable development perspective, the differences in the responses to the health and development harms of alcohol use are substantial and urgent action by WHO and Member States is required.

1.4 WHO Global Alcohol Strategy is outdated

Movendi International analysis shows that after nearly a decade of WHO GAS implementation, the strategy is outdated in key aspects of the global governance of alcohol prevention and control:

- International trade and investment agreements¹¹,
- The 2030 Agenda,
- Innovative and increasingly aggressive new practices and technologies of the alcohol industry (self-regulation, CSR, interference, digital marketing, heavy users, etc.)
- WHO's own reforms and landmark transformations (UHC, GPW13 triple billion target),
- Terminology to discuss alcohol harm and alcohol policy solutions, and
- Policy coherence.

Simply put:

⁷ Bakke, Ø. and Endal, D. (2010), Vested Interests in Addiction Research and Policy Alcohol policies out of context: drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. *Addiction*, 105: 22-28. doi:10.1111/j.1360-0443.2009.02695.x

⁸ Scotland: Big Alcohol Again Appeals Against MUP, 2016, <https://ioqt.org/news/2016/11/18/scotland-big-alcohol-appeals-mup/>

⁹ Trangenstein et al. *Substance Abuse Treatment, Prevention, and Policy* (2018) 13:43

¹⁰ Vietnam: Big Alcohol Lobby Destroys Alcohol Law, 2019, <https://ioqt.org/news/2019/06/11/vietnam-big-alcohol-lobby-destroys-alcohol-law/>

¹¹ Barlow et al. *Globalization and Health* (2017) 13:13 DOI 10.1186/s12992-017-0240-x

The WHO GAS is outdated in terms of two of its priority areas and all objectives need recalibration and innovation given rapid developments in the past decade.

Outdated action in terms of WHO GAS Priorities:

1c Public health dialogue

3b Dissemination of knowledge

Outdated action in terms of WHO GAS Objective:

No objectives can be classified as outdated as such but faced with rapid developments in the global governance relevant for alcohol prevention and control, since the adoption of the WHO GAS almost a decade ago, all objectives need recalibration and innovation. In terms of a state-of-the-art response to the alcohol burden, the question is less about what (regarding the WHO GAS objectives) and much more about the how.

Data underpinning Movendi International assessment:

WHO itself reports about Global Information System on Alcohol and Health (GISAH), the WHO Global Alcohol Status Report, the technical tools and capacity building programs as well as partnerships across the UN System and with Member States.

Notwithstanding the question of actual availability, coherence and impact of the listed tools, Movendi International analysis shows that these approaches - while promising and fruitful (with caveats) - urgently need innovation and usage of methods that increase the impact across the WHO GAS objectives and priority areas.

The detailed analysis:

While the **production of knowledge should be considered a (limited) achievement of WHO** and the WHA GAS, there is also room for improvement. The absence of the implementation toolkit for the ten recommended target areas for national action, for instance, is a shortcoming in knowledge production and technical capacity building. In particular the **dissemination of knowledge is faced with significant challenges and must be considered outdated**.

The production of knowledge can further be strengthened in two dimensions:

New or under-researched topics:

Production of knowledge should be strengthened in terms of implementation research, regarding the systematic tracking of alcohol industry interference in all its forms as well as in terms of other topics from the health and development discourse, such as universal health coverage, women's rights and women's health, child rights and children's and

adolescent's health, poverty eradication, environmental degradation (water and food insecurity, biodiversity loss) and economic productivity, as well as drivers and determinants of alcohol abstinence, quitting and delay of onset of alcohol use.

More frequent, timely and useful evidence:

Production of knowledge should also become more timely both in terms of frequency and specificity as well as in terms of relating to high-level political decision-making processes.

Country case studies are crucial; the country profiles should be more frequently updated, fact sheet production and contributions with timely evidence explaining the role of alcohol harm and alcohol policy solutions for specific political discussions, such as UHC, New Urban Agenda, Financing for development etc. are essential to improve both knowledge production as well as dissemination and awareness.

There is a **clear connection between awareness of the alcohol burden, increased political leadership and commitment, and more concerted action** across sectors. Strengthened knowledge base and improved monitoring and surveillance systems are essential to more effectively, timely and compellingly disseminate state of the art scientific evidence and to facilitate better application of information in advocacy and policy development processes.

The **dissemination of knowledge has proven to be ineffective and largely outdated** over the period of WHO GAS implementation. **Three factors have constrained WHO's ability to disseminate knowledge timely, effectively and compellingly.** The scarcity in human and financial resources, the weak global infrastructure for alcohol prevention and control and the lack of leadership at the highest levels of WHO, together pose major challenges to knowledge dissemination.

Scarcity in human and financial resources

The fact that there is no consistent social media communication from WHO about alcohol harm and alcohol policy solutions is a serious concern. There is no strategic approach to messaging about alcohol as a global health emergency and no consistent messaging in the social media. For knowledge dissemination to drive advocacy, policy development and awareness this is a grave concern.

Beyond social media, there is no compelling way of presenting information, other than the website; compelling images, infographics, fact sheets, success stories etc. are all missing. In the WHO regions there is some work in this regard, but they too are constrained by scarcity in human and financial resources.

And thirdly, at WHO in general there is no consistent and strategic way of communicating about alcohol harm, its magnitude, its human stories, and how it burdens development and the potential of the alcohol policy best buys.

On global level, the **WHO GAS has failed to foster the emergence of a powerful voice highlighting (cross-cutting) alcohol issues and their solutions.**

Weak global infrastructure for alcohol prevention and control

Nearly a decade into the implementation of the WHO GAS, the **world still lacks a global day to raise awareness about alcohol harm and policy solutions.**

Secondly, in contrast to other global health emergencies (that actually kill fewer people), there is **no global ministerial conference on alcohol** under the guidance of WHO.

Thirdly, since 2010, **alcohol policy has not been a stand-alone agenda item at WHO governing body meetings.** In some WHO regions it has more or less disappeared entirely from the agenda over the last decade.

Fourthly, despite nearly a decade of WHO GAS implementation, **WHO does still not do an adequate job in mainstreaming alcohol into other relevant health and development topics.** This constraints the emergence of additional actors, such as UN agencies, and the creation of powerful governance structures such as joint programs or initiatives.

Fifthly, to make matters even worse, there is **no specific WHO program on alcohol** (SDG 3.5) to act as custodian for all challenges listed above and to pay attention to the alcohol burden commensurate with the magnitude of harm.

This means that **the WHO GAS has not facilitated the creation of proper infrastructure that could foster reliable knowledge generation and dissemination and that could promote political awareness, commitment and leadership.**

Lack of leadership at the highest levels of WHO

Alcohol has often been entirely or largely absent - especially compared to tobacco - from relevant speeches and other addresses of WHO leaders¹². **Even symbolic attention to alcohol policy has been low over the period of WHO GAS implementation.** For example, Dr Tedros Adhanom Ghebreyesus, the new WHO Director General, has not attended the high-level side event during UNGA 2018 on alcohol policy, despite the presence of the President of Sri Lanka and numerous ministers of health.

The previous Director General, Dr Margaret Chan, often failed to even mention alcohol harm, the alcohol industry or alcohol policy in her speeches¹³.

Secondly, the **lack of empowerment of cross-sectorial work across departments and units of WHO is apparent** when relevant WHO strategies are being analysed for how they address and respond to alcohol harm.

Thirdly, the lack of streamlining of efforts across the WHO regions, geared to building on best practices from each region to help elevate the work of all regions on alcohol

¹² World Health Organization, Latest speeches, WHO Director General: <https://www.who.int/dg/speeches/>

¹³ Dr Margaret Chan, WHO Director General: Address to the Sixty-ninth World Health Assembly, 2016: <https://www.who.int/dg/speeches/detail/address-to-the-sixty-ninth-world-health-assembly>

prevention and control is also a major challenge for systematic and concerted work on alcohol policy, let alone effective knowledge dissemination.

Fourthly, the **WHO GAS has not facilitated leadership at the highest levels of WHO**, which is a serious concern, given the heavy burden alcohol places on countries around the world. The new **triple billion target¹⁴ of the General Program of Work 13 (GPW13) will not be achieved without more commitment to alcohol policy development**, including knowledge production and dissemination.

1.5 Summary assessment

Movendi International analysis illustrates some success and important progress facilitated by the WHO GAS but highlights that the WHO GAS after nearly a decade of implementation is largely ineffective, inadequate, and in parts even outdated.

The progress at country level - where progress arguably counts the most - on the ten key areas for national action outlined in the WHO GAS has been ineffective and insufficient. The fact that progress was weakest in terms of implementation of the three alcohol policy best buy solutions clearly illustrates that the WHO GAS is inadequate.

A **stronger instrument is necessary to reach agreed targets** for alcohol consumption reduction and health and development promotion. After nearly a decade of implementation of the WHO GAS, **alcohol remains a global health emergency** and is still often overlooked. After nearly a decade of implementation of the WHO GAS, **alcohol remains a major obstacle to sustainable development** but is yet to receive adequate attention.

A more up-to-date, adequate, effective, comprehensive and compelling tool - for example a global treaty - is urgently needed to overcome all the shortcomings of the WHO GAS and to address all the problems that the WHO GAS was ill-designed to tackle from the beginning. Movendi International analysis of the challenges and setbacks regarding the WHO GAS and its implementation provides concrete points for the way forward in alcohol prevention and control. The **challenges surpass the need for improving resource mobilization and strengthening means of implementation** of the current WHO GAS. Significant changes need to be adopted that go beyond better implementation of the WHO GAS, so as to substantially reduce alcohol per capita use and related harm worldwide.

¹⁴ World Health Assembly Approves New Strategic Plan With Focus on “Triple Billion” Targets (2018): <http://www.ictsd.org/bridges-news/bridges/news/world-health-assembly-approves-new-strategic-plan-with-focus-on-“triple>

In addition to updating, improving and strengthening the WHO GAS, as well as developing and adopting a global treaty on alcohol control will be essential for the way forward.

But it is clear that stronger WHO commitment and leadership, and more Member States support and resourcing, as well as better UN system collaboration for concrete initiatives, programs and projects are the most fundamental to deliver on the promises made in 2010, 2013, 2015 and beyond.

Movendi International calls for **6 bold actions** to be taken to deliver on the promises made when the WHO GAS was adopted and reconfirmed in the SDGs.

- I. Revision and update of the inadequate, ineffective and outdated WHO GAS;
- II. Ending the dialogue with the alcohol industry and revising how the WHO GAS addresses the role and harm caused by the alcohol industry;
- III. Improvements to resource mobilization, especially through an alcohol taxation initiative;
- IV. Strengthening of the global infrastructure for alcohol prevention and control and streamlining of the response to the alcohol burden across the WHO and the wider UN system;
- V. Adoption of a bold target to reduce alcohol per capita consumption (and related harm) and increases on Member States commitment;
- VI. Creation of an Expert Committee to solve key weaknesses of the WHO GAS and to provide recommendations for the path towards a global binding treaty on alcohol.

1.6 Flaw in discussion paper: Technical support and capacity building

Movendi International regards the discussion paper's assertion on page 4 as flawed, when it says: "... all WHO regions have developed regional strategies or action plans to provide support to Member States at country level in implementation of the global strategy..."

While all WHO regions indeed might have strategies in place, the above analysis clearly illustrates that **regional and country-level support to Member States has been inadequate.**

This is abundantly clear from evidence for the WHO African region, where a strategy was developed¹⁵ but it failed in facilitating systematic action. Not even a framework for implementation has been adopted, despite attempts and the WHO African Region Status Report in 2013 was by and large the last time alcohol harm was seriously put on the agenda for discussion.

¹⁵ WHO, Regional Office for Africa (2013): Reduction of the harmful use of alcohol: a strategy for the WHO African Region, <https://www.afro.who.int/sites/default/files/2017-06/ahm1608.pdf>

For example, at the 69th Session of Regional Committee for Africa, the regional cancer prevention strategy was discussed, and the report did not even address alcohol once, while tobacco was examined 13 times throughout the document. The report of the regional director did not mention alcohol once either¹⁶, despite the fact that the WHO African region now suffers the biggest relative burden of alcohol harm¹⁷.

There is no dedicated technical staff at the Regional Office of WHO in the African Region to work on the topic of alcohol prevention and control.

This clearly shows that strategies are not enough. Resource allocation at WHO regional and country offices is crucial; as is leadership from Member States to request support from WHO, to mobilise funding for WHO and to pursue collaborative efforts in tackling the alcohol burden; as is systematic efforts to mainstream alcohol policy considerations into all relevant areas of global health discussions at WHO. The WHO GAS has clearly not contributed to overcoming these challenges and persisting shortcomings.

Movendi International wishes that this dimension is better highlighted in future documents reporting on the WHO GAS implementation.

1.7 Flaw in discussion paper: Improving WHO analysis of challenges

Movendi International notes the description of challenges in the discussion paper. While we agree with and support the inclusion of many of the points highlighted, Movendi International proposes a more systematic presentation of the analysis of the challenges below.

Importantly: For an analysis of the implementation of the WHO GAS, it is critical to assess whether the its own objectives have been achieved or not and whether they are still relevant - nearly a decade after their adoption.

1.7.1 Understanding the magnitude (not complexity) of the problem

Recognition of the real harm from alcohol, its magnitude and facettes is essential for galvanising political commitment and sustained action.

In this context, Movendi International would like to **include the issue of alcohol's harm to others (especially with regard to topics not currently under consideration), cross-border issues of alcohol policy, the inter-sectoral nature of alcohol problems and their solutions and the need for mainstreaming alcohol literacy, including about alcohol myths and alcohol industry tactics, into all relevant policy areas.**

In this context, alcohol's harm to others could become a crucial dimension to unlock synergies across different policy areas by facilitating the recognition of alcohol harm in

¹⁶ WHO African Region 69th Regional Committee Documentation (2019): <https://www.afro.who.int/about-us/governance/sessions/sixty-ninth-session-who-regional-committee-africa>

¹⁷ WHO Global status report on alcohol, 2018: https://www.who.int/substance_abuse/publications/global_alcohol_report/en/

the affected policy areas. This recognition of the real harm of alcohol in turn fosters understanding of the need for alcohol policy solutions to achieve sustainable outcomes in affected policy areas.

However, the **topic of alcohol as obstacle to development deserves more attention and could provide a compelling frame for illustrating the real magnitude of alcohol harm, including harm to others.**

Since alcohol's adverse effects on the individual and society are bigger than those of tobacco, the frame of NCDs in which alcohol is currently located, contributes to the distortion of the understanding of alcohol harm in its full extent. Movendi International analysis of the SDGs shows that 14 of 17 SDGs and more than 50 unique SDG targets are adversely affected by alcohol.

The current response to the alcohol burden as facilitated by the WHO GAS does, however, not capture this reality fully.

1.7.2 Communication about the problem

Since awareness and recognition of the overall alcohol burden on individuals, communities and a population's health, safety, economy and social fabric remains low, the level of commitment to sustained, evidence-based action on alcohol prevention and control is extremely low, compared to other public health issues.

An **important piece of the challenge** in this context - and one that is **not mentioned in the discussion paper** - is the **ability to communicate effectively to translate independent science into awareness and (policy) action.** Clear ways of communicating about alcohol harm, its solutions and the benefits of alcohol policy-making are essential, but have not yet been utilized by WHO (and most Member States). For example, the concept of **"harmful use of alcohol" is highly problematic.** It's a term that is confusing and supports the narrative and myths of the alcohol industry. The term disguises both the real magnitude of the alcohol burden (see above) as well as the motives of the alcohol industry for the public and policy makers.

In implementing the strategy, WHO has not done a good job of raising awareness of what this term actually means. This has allowed the alcohol industry to equate "responsible drinking" with the concept of "harmful use of alcohol" in their attempt to shift the focus to individual responsibility and prevent recognition of the fact that alcohol consumption is neither healthy nor safe. The term contributes to the pervasive alcohol norm and has also created confusing and troubling phrases such as "harmful use of alcohol can be harmful/ problematic" or "harmful abuse of alcohol" etc.

This was predictable. But nearly ten years after the adoption of the WHO GAS it is now important to **revisit, rethink and reframe - to allow WHO and other UN partners to communicate more effectively, clearly and compellingly** about alcohol harm and the alcohol policy solutions.

1.7.3 Solving the problem: Political leadership and policy coherence

A crucial aspect of addressing and solving alcohol problems in a jurisdiction is **policy coherence - something that should not be absent from the analysis of the WHO GAS implementation.**

Often “limited levels of political will and commitment of governments and other stakeholders to support and implement effective measures to reduce” alcohol related harm are directly linked to competing policy goals in other areas. This has become clear in the context of international economic commitments, but it also applies to agriculture policy, free market and competition, even development policy and industry subsidies.

The WHO GAS has not been effective in protecting alcohol policy from these incoherencies and is likely outdated in this regard.

Movendi International supports the analysis that “responsibility for dealing with the problems from alcohol is [often] diffused between diverse systems, professions, government departments, and intergovernmental agencies without any” clear entity/ authority/ institution one that is focused exclusively on and has the mandate to coordinate policy-makers in other sectors to the benefit of advancing alcohol policy solutions. the harmful use of alcohol.

The problem is that **effective models for such cross-sectorial and synergistic approaches are rare and have not been included by WHO in technical capacity building.**

In terms of political leadership, Movendi International analysis shows a clear **lack of concerted global and regional alcohol prevention and control efforts.** For example, the responses in the different WHO regions to the respective alcohol burden varies widely (as described above); good examples and best practices in regions should therefore be highlighted and mainstreamed to facilitate higher levels of commitment and actions across all WHO regions.

The **set of guiding principles contained in the WHO GAS has remained a hidden treasure.** WHO has not been effective in raising awareness about them and in building capacity among countries to understand and implement them.

Therefore, an analysis of how these principles have fared - which ones were useful for Member States, and which ones have been ignored by Member States in the process of alcohol policy development - is critical for the way forward.

To foster policy formulation and implementation, WHO could **utilize the guiding principles more and a toolkit to that end will be an important contribution** to supporting political leadership for alcohol prevention and control.

Another challenge to fostering systematic action, ensuring policy coherence and promoting political commitment and leadership is the lack of resources and capacity

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

(see above); often (but not automatically) this leads to lack of coordination and absence of concerted action for a comprehensive approach.

1.7.4 Alcohol industry: barrier to understanding, awareness, and political commitment

Movendi International supports the analysis of the alcohol industry but would like to see a separate sub-chapter in the discussion of challenges.

The alcohol industry is the driver of the global health emergency that is alcohol harm and poses a formidable barrier to effective implementation of the WHO GAS. Analysis of how the alcohol industry operates to undermine understanding and recognition of the burden of alcohol harm, to hinder awareness and behavior change and to jeopardize and threaten political commitment to evidence-based alcohol policy-making is an integral part of the analysis of the WHO GAS implementation. Alcohol industry interference is certainly driven by globalization and market concentration. At the same time a comprehensive list of their strategies could look like this:

- I. Industry innovations
 - A. Promotion of “healthier” and “safer” products^{18 19}
 - B. Online retail and new delivery models challenge availability regulations^{20 21 22}
- II. Corporate Social Responsibility and public relations²³
- III. Pervasive marketing
 - A. Digital marketing
- IV. Aggressive political activity and interference
 - A. Early agenda setting
 - B. Lobbying against best buys^{24 25 26 27}
- V. Shifting the focus & manufacture false debate
 - A. Challenging legal basis for alcohol control

¹⁸ Big Alcohol: Fooling People About “Safe” Consumption, 2019, <https://iogt.org/news/2019/10/22/big-alcohol-fooling-people-about-safe-consumption/>

¹⁹ NIH Shuts Down Controversial Alcohol Study, Citing Improper Ties To Alcohol Industry, 2018, <https://iogt.org/news/2018/06/16/nih-shuts-down-controversial-alcohol-study/>

²⁰ UK: Online Shops Fail To Check Age On Alcohol Sales, 2015, <https://iogt.org/news/2015/12/11/uk-online-shops-failure-to-check-age-on-alcohol-sales/>

²¹ Amazon Joins Big Alcohol, 2019, <https://iogt.org/news/2019/06/18/amazon-joins-big-alcohol/>

²² Australia: Alcohol Delivery Apps Fuel Harm, 2019, <https://iogt.org/news/2019/09/19/australia-alcohol-delivery-apps-fuel-harm/>

²³ Big Alcohol Wants Youth To Avoid Hangover: A New Strategy Of Pushing Alcohol Culture On Youth, 2019, <https://iogt.org/blog/2019/06/22/big-alcohol-wants-youth-to-avoid-hangover-a-new-strategy-of-pushing-alcohol-culture-on-youth/>

²⁴ USA: Big Alcohol Lobbies against Road Safety, 2019, <https://iogt.org/news/2019/04/24/usa-big-alcohol-lobbies-against-road-safety/>

²⁵ Big Alcohol: Liquor Giants Create Global Lobby Group, 2019, <https://iogt.org/news/2019/07/13/big-alcohol-liquor-giants-create-new-global-lobby-group/>

²⁶ Australia: Big Alcohol Pumps Big Bucks into Politics, 2019, <https://iogt.org/news/2019/04/29/australia-big-alcohol-pumps-big-bucks-into-politics/>

²⁷ Big Alcohol Fights Against Local Alcohol Tax, 2019, <https://iogt.org/news/2019/04/06/big-alcohol-fights-against-local-alcohol-tax/>

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

- VI. Attack legitimate science & intimidate scientists²⁸
- VII. Fund & run disinformation campaigns
- VIII. Frame the issue in highly “creative” ways
 - A. Primacy of economic interests
 - B. Informal alcohol production and sale

While the WHO GAS gives economic operators a role in reducing alcohol-related harm within their core functions as developers, producers, distributors, marketers and seller of alcohol, evidence after nearly a decade of WHO GAS implementation is clearly highlighting the flaws connected to dialogue with the alcohol industry and more specifically with the WHO GAS providing a role in the first place.

In fact, evidence is overwhelming:

- The alcohol industry targets and relies on heavy alcohol users for the bulk of their profits, clearly illustrating their fundamental and direct conflict of interest regarding any measure to reduce and prevent alcohol harm.^{29 30}
- The alcohol industry attacks, undermines, sows doubt about independent science regarding the real harm caused by alcohol and the efficacy of alcohol policy solutions, especially the best buys.^{31 32 33}
- The alcohol industry violates its own self-regulation commitments systematically.^{34 35}

36

²⁸ How To Expose “Scientists” Casting Doubt About Science – The Case Of Alcohol And Cancer, 2017, <https://iogt.org/blog/2017/12/01/expose-scientists-casting-doubt-science-case-alcohol-cancer/>

²⁹ Maani Hessari, N., Bertscher, A., Critchlow, N., Fitzgerald, N., Knai, C., Stead, M., & Petticrew, M. (2019). Recruiting the “Heavy-Using Loyalists of Tomorrow”: An Analysis of the Aims, Effects and Mechanisms of Alcohol Advertising, Based on Advertising Industry Evaluations. *International Journal of Environmental Research and Public Health*, 16(21), 4092. doi:10.3390/ijerph16214092

³⁰ Bhattacharya, A., Angus, C., Pryce, R., Holmes, J., Brennan, A., and Meier, P. S. (2018) How dependent is the alcohol industry on heavy drinking in England?. *Addiction*, 113: 2225– 2232. <https://doi.org/10.1111/add.14386>.

³¹ Petticrew, M., Maani Hessari, N., Knai, C. and Weiderpass, E. (2018). The strategies of alcohol industry SAPROs: Inaccurate information, misleading language and the use of confounders to downplay and misrepresent the risk of cancer. *Drug and Alcohol Review*, 37(3), pp.313-315.

³² Rossow and McCambridge, The handling of evidence in national and local policy making: a case study of alcohol industry actor strategies regarding data on on-premise trading hours and violence in Norway. *BMC Public Health* (2019) 19:44 <https://doi.org/10.1186/s12889-018-6348-y>

³³ Petticrew, M., Maani Hessari, N., Knai, C. and Weiderpass, E. (2018), The strategies of alcohol industry SAPROs: Inaccurate information, misleading language and the use of confounders to downplay and misrepresent the risk of cancer. *Drug Alcohol Rev.* doi:10.1111/dar.12677

³⁴ UK: Alcohol Industry Fails Informing About Harm, 2017: <https://iogt.org/news/2017/08/24/england-uk-alcohol-industry-fails-informing-harm/>

³⁵ Australia: Self-Regulation Fails, Kids See Alcohol Ads, 2016: <https://iogt.org/news/2016/11/17/australia-self-regulation-fails-kids-see-alcohol-ads/>

³⁶ Institute of Alcohol Studies: “Dead on Arrival? Evaluating the Public Health Responsibility Deal for Alcohol, 2015

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

- CSR activity of the alcohol industry does not reduce alcohol harm but might in fact be harmful.^{37 38 39 40 41}
- The alcohol industry targets and exposes young people and minors with their marketing practices.^{42 43 44 45}
- The alcohol industry employs a range of unethical business practices.^{46 47 48}

From this evidence, it is abundantly clear that the technical areas* for dialogue between the alcohol industry and WHO⁴⁹ are outdated and problematic and that this activity has no chance for success by any measure.

For all attempts by WHO to avoid it but this type of dialogue sends conflicting messages and allows the alcohol industry to continue portraying itself as “responsible corporate citizens”, despite overwhelming evidence to the contrary.

Thus, the **dialogue with the alcohol industry and the role that the WHO GAS gives the alcohol industry are serious obstacles to achieving all five objectives** of the WHO GAS. The **dialogues should be ended and the way the WHO GAS addresses the alcohol industry should be revised.**

³⁷ Maani Hessari, N.; van Schalkwyk, M.C.; Thomas, S.; Peticrew, M. Alcohol Industry CSR Organisations: What Can Their Twitter Activity Tell Us about Their Independence and Their Priorities? A Comparative Analysis. *Int. J. Environ. Res. Public Health* 2019, 16, 892.

³⁸ Babor TF, Robaina K, Brown K, et al Is the alcohol industry doing well by ‘doing good’? Findings from a content analysis of the alcohol industry’s actions to reduce harmful drinking *BMJ Open* 2018;8:e024325. doi: 10.1136/bmjopen-2018-024325

³⁹ Melissa Mialon, Jim McCambridge, Alcohol industry corporate social responsibility initiatives and harmful drinking: a systematic review, *European Journal of Public Health*, Volume 28, Issue 4, August 2018, Pages 664–673, <https://doi.org/10.1093/eurpub/cky065>

⁴⁰ Peticrew, M., Douglas, N., Knai, C., Durand, M. A., Eastmure, E., and Mays, N. (2016) Health information on alcoholic beverage containers: has the alcohol industry's pledge in England to improve labelling been met?. *Addiction*, 111: 51– 55. doi: 10.1111/add.13094.

⁴¹ Big Alcohol Puts Women, Newly Born in Harm's Way, 2019, <https://iogt.org/news/2019/10/23/big-alcohol-puts-women-newly-born-in-harms-way/>

⁴² Alexander B Barker, John Britton, Emily Thomson, Abby Hunter, Magdalena Opazo Breton, Rachael L Murray, A content analysis of tobacco and alcohol audio-visual content in a sample of UK reality TV programmes, *Journal of Public Health*, fdz043, <https://doi.org/10.1093/pubmed/fdz043>

⁴³ The City Journal. (2019). Social Media Marketing leads to more Alcohol Consumption, says Australian study - The City Journal. [online] Available at: <http://thecityjournal.net/news/social-media-marketing-leads-to-more-alcohol-consumption-says-australian-study/?ref=upflow.co> [Accessed 17 Jun. 2019].

⁴⁴ Critchlow N, MacKintosh AM, Thomas C, et al Awareness of alcohol marketing, ownership of alcohol branded merchandise, and the association with alcohol consumption, higher-risk drinking, and drinking susceptibility in adolescents and young adults: a cross-sectional survey in the UK *BMJ Open* 2019;9:e025297. doi: 10.1136/bmjopen-2018-025297

⁴⁵ Special Issue: The Regulation of Alcohol Marketing: From Research to Public Health Policy January 2017 Volume 112, Issue Supplement S1 Pages 1–127 Issue edited by: Thomas F. Babor, David Jernigan, Chris Brookes

⁴⁶ Case library of alcohol industry unethical business practices, IOGT International: <https://iogt.org/blog/tag/bigalcoholsexposed/>

⁴⁷ Heineken Company Profile, 2018: <https://iogt.org/news/2018/03/30/heineken-company-profile/>

⁴⁸ Diageo Company Profile, 2018: <https://iogt.org/news/2018/03/08/diageo-company-profile/>

⁴⁹ Dialogue with economic operators in alcohol production and trade, 2018. * Technical areas: self-regulation of alcohol beverage marketing; practices of retail sales and serving; production and packaging; labelling and consumer information; and data on sales and consumption.

1.7.5 Lack of global regulation, norms and standards

A fifth aspect of a comprehensive analysis of the challenges regarding WHO GAS implementation is the lack of global, binding regulation and the absence of collective norms and standards in the field of alcohol prevention and control.

Movendi International supports the emphasis of the fact that alcohol is the only psychoactive substance not under a global regulatory regime.

The absence of effective regional strategies, treaties or plans to comprehensively deal with cross-border issues of alcohol harm, industry practices and alcohol policy implementation is another serious challenge - one that the WHO GAS is ill-equipped to address and guide Member States.

All this means that there is currently no significant and meaningful protection of the human right to health and development against the risks and dangers of alcohol.

And there is no powerful measure to seriously counter the practices and human rights abuses of the alcohol industry around the world.

All these points underline the fact that the WHO GAS has proven inadequate and ineffective in facilitating necessary responses to the global alcohol burden. A stronger instrument is needed.

1.8 Setbacks

In addition to the challenges already outlined, Movendi International analysis has identified four setbacks in the implementation of the WHO GAS, based on the parameters of our analysis above.

1.8.1 Advocacy setbacks

Three striking examples show that the WHO GAS was unable to avoid significant setbacks in terms of public health advocacy:

- The Addis Ababa Action Agenda (AAAA)⁵⁰ for financing development from 2015 failed to include alcohol taxation as important source of domestic resources and triple win measure for health and development promotion, even though tobacco taxation was included; and even though the 2010 World Health Report had already clearly highlighted the potential of alcohol taxation.

⁵⁰ Addis Ababa Action Agenda of the Third International Conference on Financing for Development (Addis Ababa Action Agenda), 2015, https://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

- The 2018 political declaration of the 3rd High-Level Meeting on NCDs⁵¹ is weak on measures to tackle alcohol as an NCDs risk factor and even more problematic in the role it ascribes to the alcohol industry (paragraph 44).
- The New Urban Agenda (NUA)⁵² fails to even mention alcohol despite clear evidence of alcohol's link with violence - a key concern for urban development.

In the cases of the AAAA and the NUA the absence of recognition for the important contribution of alcohol policy is a serious setback, especially because it would have meant to anchor alcohol policy considerations in sectors beyond health, such as SDG 11 (inclusive and safe cities and human settlements) and SDG 16 and 17 (financing for development).

Why is this a setback?

The global conversation (and possibly the policy response) could have advanced much further than the status quo had alcohol violence and alcohol taxation been addressed in the NUA and AAAA respectively. Like the WHO GAS has become a landmark ensuring alcohol policy is considered in global health policy-making processes (as outlined above), similar mechanisms would likely have been unlocked for alcohol policy outside the global health policy sector.

Currently, however, it proves to be very challenging to mainstream alcohol taxation (for instance) into the conversation on financing for development; this in turn makes it more difficult to mobilize support from a broad coalition of stakeholders outside the global health community for alcohol taxation and the alcohol policy best buys.

1.8.2 Setbacks in terms of knowledge production

There is one dimension where the production of knowledge has remained insufficient and that is: technical tools and implementation toolkits for the alcohol policy best buys in particular and the guiding principles as well as the 10 areas of policy options and leadership of the WHO GAS in general. These should have been a major priority immediately after the adoption of the WHO GAS in 2010. But nearly a decade into its implementation, the toolkit is still not available for policy makers.

Why is this a setback?

⁵¹ Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (2018), https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2

⁵² The New Urban Agenda was adopted at the United Nations Conference on Housing and Sustainable Urban Development (Habitat III) in Quito, Ecuador, on 20 October 2016. It was endorsed by the United Nations General Assembly at its sixty-eighth plenary meeting of the seventy-first session on 23 December 2016, <http://habitat3.org/wp-content/uploads/NUA-English.pdf>

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

It affects preparedness and constraints WHO's ability to respond to requests from Member States for technical support and capacity building. In addition, this is a setback because countries that want to implement the WHO GAS lack authoritative resources.

1.8.3 Setbacks in response to alcohol industry

The implementation of the WHO GAS has been a missed opportunity over the last decade to effectively counter the alcohol industry, document and expose their tactics, raise alcohol industry literacy and institute effective conflict of interest policies to avoid corporate capture and alcohol industry interference.

However, the status quo is very different.

- The Global Fund to Fight AIDS, Tuberculosis and Malaria partners with Heineken (currently suspended, but not terminated)⁵³.
- United Nations Institute for Training and Research (UNITAR) partners with AB InBev⁵⁴.
- UNICEF partners with David Beckham, an advertising icon for the alcohol industry⁵⁵.

Why is this a setback?

Partnerships like these provide strategical advantages to the alcohol industry. They help to normalize the alcohol industry; to disguise their responsibility for alcohol harm; to facilitate networking and relation-building with policy makers; and to improve their political capital to interfere even more aggressively.

In addition, these partnerships betray incoherences among UN agencies and programs and show how difficult it is to find a concerted approach, based on common rules, to the alcohol industry.

1.8.4 Setback 10% reduction target

⁵³ Joint Open Letter of Concern About Global Fund Partnering with Big Alcohol, 2018, <https://iogt.org/news/2018/02/13/joint-open-letter-global-fund-80-endorsements-worldwide/>

⁵⁴ Joint Open Letter: Civil Society Expresses Grave Concern About Partnership Between UN Agency UNITAR And Alcohol Giant Anheuser-Busch InBev, 2018, <https://iogt.org/open-letters/joint-open-letter-concern-unitar-partnering-alcohol-giant/>

⁵⁵ Open Letter: Calling Foul On UNICEF And David Beckham, 2015, <https://iogt.org/open-letters/open-letter-to-unicef-calling-foul-on-unicef-and-david-beckham/>

The inclusion of the alcohol policy best buys in NCDs Global Action Plan has been very positive for global alcohol prevention and control. But the voluntary global target of a 10% reduction of per capita alcohol use until 2025 is a very unambitious target⁵⁶.

While the adoption of this voluntary global target on alcohol consumption reduction highlighted the conviction that achieving this decline was feasible, WHO data now shows that there is no progress in reducing the total per capita alcohol consumption in the world in comparison with 2010.” page 6

Why is the 10% reduction target a setback?

The 10% reduction target is actually very unambitious. Not even such a low target has been achieved. Moreover, such a low target is problematic because it implies that alcohol harm is less of a burden and priority compared to the other NCDs risk factors. It also disguises the truth that much more alcohol policy action is needed to effectively prevent and reduce harm (the alcohol burden does not only consist of non-communicable diseases). And it is problematic since it undermines the recognition of the urgency to better protect the human right to health and help achieve the SDGs through tackling alcohol harm.

Unambitious targets might be easier to ignore as they create the impression they could be reached without real action and change.

1.9 Not yet 21st century - Outdated aspects of the WHO Global Alcohol Strategy

Movendi International analysis shows that after nearly a decade of WHO GAS implementation, the strategy is outdated in key aspects of the global governance of alcohol prevention and control:

- I. International trade and investment agreements⁵⁷,
- II. The 2030 Agenda,
- III. Innovative and increasingly aggressive new practices and technologies of the alcohol industry (self-regulation, CSR, interference, digital marketing, heavy users, etc.)
- IV. WHO's own reforms and landmark transformations (UHC, GPW13 triple billion target),
- V. Terminology to discuss alcohol harm and alcohol policy solutions, and
- VI. Policy coherence.

Firstly, the WHO GAS provides **no protection for national alcohol legislation from trade challenges** and countries struggle to protect evidence-based public health (including

⁵⁶ WHO: NCDs and mental health, Global monitoring framework, about 9 voluntary global targets:
<https://www.who.int/nmh/ncd-tools/definition-targets/en/>

⁵⁷ Barlow et al. Globalization and Health (2017) 13:13 DOI 10.1186/s12992-017-0240-x

alcohol policy) measures from attack at the WTO or in trade and investment agreement negotiations and disputes⁵⁸.

Secondly, the arrival of the SDGs is an opportunity for advancing alcohol policy but the **WHO GAS does not provide a compelling platform to tackle alcohol as the massive obstacle to development that it is**, having been adopted half a decade before the Agenda 2030 came into being.

Thirdly, the alcohol industry is constantly innovating its marketing, lobbying and PR practices and its use of technology, employing digital tools, increasingly crossing borders, aggressively attacking alcohol policy and science and sowing doubt and misinformation about the real harm of alcohol. The **WHO GAS is not designed to keep pace with these rapid developments in the alcohol industry** that derail, obstruct, and threaten effective alcohol policy making and knowledge production. Furthermore, the **role that the WHO GAS has ascribed the alcohol industry has been proven harmful and is outdated**.

Fourthly, the WHO reform has changed how the organization engages with so-called non-state actors, how it conducts its business with the new GPW13, how it pursues funding and where it seeks to generate its biggest impact. **The WHO GAS is now out of date even in this internal WHO perspective** - for instance in its failure to facilitate systematic mainstreaming of alcohol policy considerations across all relevant areas of WHO work, such universal health coverage.

Fifthly, another dimension that has fallen out of time (and that has never been up to date) is the terminology: after nearly a decade of WHO GAS implementation, it has become clear that a **host of terms have not helped the public or decision-makers to capture the magnitude of alcohol harm; and have instead played into the cards of the alcohol industry**. The term “harmful use of alcohol” has been a problematic comprise in 2010. Since 2010, it has been part of the problem of lack of understanding of the real extent and severity of alcohol harm and has also played into the narrative of the alcohol industry to shift the focus to individual responsibility for any alcohol harm; it has not helped to clearly explain what latest science knows about the real harm of alcohol at individual and population level and it has often led to confusion.

Robust and modern infrastructure for global alcohol prevention and control

⁵⁸ Barlow P, Labonte R, McKee M, Stuckler D (2018) Trade challenges at the World Trade Organization to national noncommunicable disease prevention policies: A thematic document analysis of trade and health policy space. PLOS Medicine 15(6): e1002590. <https://doi.org/10.1371/journal.pmed.1002590>

DISCUSSION PAPER

World Health Organization
Implementation of the WHO Global Alcohol
Strategy since its endorsement, and the way
forward

www.movendi.ngo

The global infrastructure for alcohol prevention and control is weak and fragile. Nearly a decade after the adoption of the WHO GAS, the global infrastructure lacks a host of building blocks:

- I. Global alcohol awareness day,
- II. Global ministerial conference on alcohol policy under WHO patronage,
- III. Regular discussion of alcohol harm and policy solutions at WHO governing body meetings,
- IV. Institution of a specific WHO program on alcohol (or SDG 3.5 in general) and an effective mechanism to mainstream alcohol prevention and control consideration into all relevant health and development topics,
- V. Functioning global network of alcohol policy focal points/ counterparts,
- VI. Global watchdog of alcohol industry practices and interference in alcohol policy-making,
- VII. Institution of global joint UN system initiative on alcohol taxation,
- VIII. Provision of compelling investment case(s) for alcohol prevention and control, and
- IX. Coherent, binding global instrument to institute a comprehensive set norms of standards.

Without such an infrastructure consisting of these (and possibly more) building blocks, especially LMICs will continue to struggle to effectively reduce their alcohol burden and people and communities will continue to be exposed to massive alcohol harm.

2. The Way Forward - Towards alcohol policy of the 21st century

Question #2:

What, in your organization's view, should be priority areas for future actions to reduce the harmful use of alcohol and strengthen implementation of the global strategy to reduce the harmful use of alcohol

2.1 Beyond implementation

Movendi International's analysis shows that the way forward for global alcohol prevention and control must address more than the issue of strengthening implementation. To bring alcohol prevention and control firmly into the 21st century, the outdated aspects of the WHO GAS must be addressed, the inadequate aspects need to be rectified and a more robust infrastructure needs to be created. And we need bigger, bolder targets - in line with the magnitude and severity of the world's alcohol problem.

2.1.1 Addressing the OUTDATED aspects: More adequate response to developments in the world

The WHO GAS Priorities that must be categorized as outdated, are:

1c Public health dialogue

3b Dissemination of knowledge

The WHO GAS Objectives cannot be considered as outdated as such; nevertheless, they are faced with the significant developments since the adoption of the WHO GAS in the global governance of health and development that are highly relevant for alcohol prevention and control. Therefore, all WHO GAS objectives need recalibration.

Developments in the world

Alcohol harm is a global public health emergency and the alcohol industry is a serious risk and barrier to achieving health and well-being for all.

Countries implementing the alcohol policy best buys need stronger protection from alcohol industry interference. Countries also need stronger support with technical capacity building regarding alcohol policy formulation, implementation, monitoring and safeguarding alcohol prevention and control efforts from the alcohol industry.

Cross-border issues (such as digital marketing and cross-border trade) have strongly emerged over the last decade that require better international collaboration to protect the integrity and efficacy of national alcohol policy-making.

The heavy burden of alcohol harm is a global health, sustainable development and social justice issue that requires **stronger and more concerted responses from the UN system on all levels**; alcohol's unique adverse effects across a multitude of SDGs need to be much better taken into consideration and mainstreamed into future policy responses.

The acceleration of trade and investment agreements around the world require urgent responses to protect governments' rights to regulate the alcohol industry and to legislate in the area of alcohol policy.

International illicit financial flows, such as alcohol industry tax schemes, require a policy response that the WHO GAS is not designed to deliver.

Key elements for a state-of-the-art approach to alcohol prevention and control

As outlined above, to bring the global response to the alcohol burden firmly into the 21st century, key elements needs to be put in place:

- Better exploration and examination of new or under-researched topics;
- Dissemination of more frequent, timely and useful evidence in the context of policy development and advocacy;
- Overcoming the scarcity in human and financial resources dedicated to alcohol prevention and control;

- Strengthening the global infrastructure for alcohol prevention and control; and
- Filling the leadership gap for this issue at the highest levels of WHO.

Movendi International proposes the following key actions to address and overcome the identified weaknesses and shortcomings:

- I. Revision and update of the inadequate, ineffective and outdated WHO GAS;
- II. Ending the dialogue with the alcohol industry and revising how the WHO GAS addresses the role and harm caused by the alcohol industry;
- III. Improvements to resource mobilization, especially through an alcohol taxation initiative;
- IV. Strengthening of the global infrastructure for alcohol prevention and control and streamlining of the response to the alcohol burden across the WHO and the wider UN system;

A new WHO Program on alcohol to streamline communication, establish concerted action, act as alcohol industry watchdog, and to ensure effective mainstreaming of alcohol policy considerations across the WHO, the UN system and the wider global governance structure is an important building block.

2.1.2 Addressing the INADEQUATE aspects: Building of stronger infrastructure

Both in terms of infrastructure built and toolbox created since the adoption of the WHA GAS in 2010, the alcohol prevention and control community remains poorly equipped⁵⁹.

The priority areas categorized as inadequate:

2. Technical support and capacity-building
4. Resource mobilization

The objectives categorized as inadequate:

3. Increased technical support to, and enhanced capacity of, Member States for preventing the harmful use of alcohol and managing alcohol-use disorders and associated health conditions.
4. Strengthened partnerships and better coordination among stakeholders and increased mobilization of resources required for appropriate and concerted action to prevent the harmful use of alcohol.
5. Improved systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development and evaluation purposes.

Movendi International proposes the following key actions to close these serious gaps:

⁵⁹ WHO website: alcohol governance, https://www.who.int/substance_abuse/activities/globalstrategy/en/

- New efforts are essential to **develop state-of-the-art technical tools for Member States.**
- Producing a compelling capacity building program, consisting of different modules with online availability, and using modern technology is also critical.

2.1.3 Adopt bold targets

As our analysis has shown, unambitious targets might appear pragmatic or realistic on first glance but they come with inherent risks - especially in the field of alcohol prevention and control. To turn the tide on the global alcohol burden, bold new targets are vital.

For example, a much more ambitious target for the reduction of per capita alcohol use is necessary. Movendi International proposes a target in line with tobacco: **30% reduction of APC until 2030.**

Bold targets are also important in terms of mobilizing resources. Two options for raising resources should be explored: the feasibility of setting up a global impost on alcohol, and a profit levy across the alcohol industry value chain. Movendi International proposes to **set up a technical working group to make recommendations and design a road map.**

Towards a global binding treaty

And thirdly, the time has come for a global, binding treaty on alcohol control. Such an instrument is clearly the best and most ambitious way forward to tackle the host of challenges, shortcomings and problems of the current instrument, the WHO GAS.

The global alcohol epidemic is driven by these factors:

- Trade liberalization,
- Direct foreign investment,
- Global, transnational, marketing (advertising, promotions and sponsorship) increasingly relying on use of technology,
- International tax schemes, and
- Exploitation of cross-border trade.

The case for a global, binding treaty on alcohol control is clear:

1. Protect the human right to health and development,
2. Ensure the achievement of global and national targets for reduction of alcohol use and related harm,
3. Curb alcohol industry interference, and

4. promote global social justice.

Movendi International proposes the following key actions to address and overcome the identified weaknesses and shortcomings:

- V. Adoption of a bold target to reduce alcohol per capita consumption (and related harm) and increases on Member States commitment;
- VI. Creation of an Expert Committee to solve key weaknesses of the WHO GAS and to provide recommendations for the path towards a global binding treaty on alcohol.

2.2 Strengthen WHO Global Alcohol Strategy implementation

Movendi International expresses our surprise that the only really concrete proposal from the discussion paper in this context is the dialogue with the alcohol industry. All other proposals remain rather vague and un-specific.

Above we have clearly outlined why this type of dialogue has fallen out of time, should be terminated and actually the entire role of the alcohol industry should be revised in the WHO GAS.

Furthermore, the **practice of conducting alcohol policy impact assessments should be promoted** as a means of strengthening implementation. Governments should conduct these assessments in regular intervals to examine the impact of and potential gains through alcohol policy development in terms of health (healthy lives), productivity and revenue gains.

Where necessary, WHO should be able to provide guidance in how to conduct these assessments.

Movendi International recommends going **beyond the intra- and intergovernmental coordination mechanism** dimension promoted in the discussion paper. While this is certainly important, guidance should be provided for how to engender the highest level of political leadership and for how to maintain political attention and sustained action on alcohol policy.

Movendi International proposes the **development of the WHO case for making alcohol policy the priority it should be** - by outlining the health, productivity, safety and revenue gains from investments in the alcohol policy best buys; and by illustrating how this can be achieved and what leadership in this area looks like.

And finally, as outlined above, Movendi International recommends a more ambitious approach than suggested in the discussion paper with regard to the 10% reduction target. It should be regarded as the bare minimum and too unambitious in the face of the alcohol burden.

2.2.1 Increase WHO leadership and commitment

There is a clear need for better, stronger and more systematic commitment from WHO to alcohol prevention and control. Our analysis has clearly outlined crucial points.

Strategic questions for the World Health Organization

To describe efforts in support of better implementation of the WHO GAS, the following questions should be answered with regard to WHO leadership:

- I. How is WHO planning to ensure alcohol policy is effectively mainstreamed into other relevant SDGs policy areas?
- II. How is WHO ensuring alcohol in its cross-cutting nature and burden is properly addressed across the triple billion targets?
- III. How is WHO addressing trade's adverse impact on health and health policy making, including with regard to alcohol?
- IV. How is WHO planning to better translate evidence into policy action? For example concerning the topic of alcohol and cancer?
- V. How is WHO planning to better promote the right of children, youth, and adults to be protected from pressures to consume alcohol?
- VI. What will WHO do more to document and expose alcohol industry interference?
- VII. What is WHO planning to do in order to improve and streamline work on alcohol control across the regions?
- VIII. What will WHO do to streamline work on alcohol across the UN system?

Answers to this set of strategic questions - they can also be applied to the Member States level - provide a systematic way forward to assert and improve WHO leadership in tackling the global alcohol burden. Answers will pave the way for better implementation of and improvements to current commitments.

2.3 New priority areas and new opportunities

While the NCDs and SDGs agendas have certainly contributed to maintain a certain level of political attention for alcohol prevention and control, Movendi International does not agree with the assertion of the discussion paper that these two agendas will ensure alcohol policy stays on the radar.

The obstacles to highlight alcohol policy in both contexts are considerable. The last ten years have shown this.

Ensuring alcohol policy is and becomes the priority it should be requires specific, systematic efforts, as well as leadership and commitment to raise awareness and increase the level of alcohol literacy in other sectors.

In addition, other issues, especially UHC, trade and women's, children's and adolescent's health are also important frames/ policy areas for mainstreaming alcohol policy.

The availability of new opportunities and priority areas illustrates the need to actually update the WHO GAS, before it will be replaced by a global, binding treaty.

2.3.1 Movendi International list of new opportunities

Movendi International proposes the following new opportunities to be explored to advance alcohol prevention and control:

- I. Abstention rate and maintaining low alcohol use prevalence: For the alcohol policy of the 21st century this is a key opportunity to protect the human right to health and development and to promote a life course approach to healthy lives.
- II. Investment case for the alcohol policy best buys (SAFER technical package): For the alcohol policy of the 21st century this is an essential advocacy tool that has the potential to help visualizing the benefits of an integrated and comprehensive approach to alcohol policy development. These cases should include health, social, economic/ productivity and revenue gains.
- III. Gender equality and women empowerment: As the women's rights movement is gathering steam, this is an opportunity to broaden the alcohol control coalition and include the women empowerment community.
- IV. Sustainable development: each SDG that is adversely affected by alcohol provides an opportunity!

2.3.2 Movendi International list of new WHO Global Alcohol Strategy priority areas

From the discussion paper, we support:

- I. Increasing focus on the health needs and Human Rights of alcohol abstainers, and more attention being paid to the prevention of initiation;
- II. Mainstreaming alcohol harm and policy consideration more systematically into the policy conversations about Universal Health Coverage and primary healthcare to better facilitate alcohol prevention, screening and treatment, to better address co-morbidities, to improve the skills of the health workforce to identify and address alcohol problems. In fact, this conversation should be further broadened, to include the potential of alcohol taxation for UHC, and the potential of alcohol prevention and control to ease the burden on the health system.
- III. Investments in improvements of monitoring, surveillance, and evaluation systems.
- IV. Concerted efforts to increase health literacy and stimulate alcohol industry literacy.

Movendi International would like to propose additional priority areas:

- I. Alcohol and Human rights:
 - A. Children and adolescents
 - B. Women and girls
- II. Alcohol and sustainable development
 - A. Key SDGs such as 10, 11, 12
 - B. Poverty, hunger
 - C. Financing for development
- III. Illicit financial flows, corruption
- IV. Alcohol taxation initiative
- V. Improve response to cross-border alcohol policy issues and facilitate cross-border collaboration
- VI. Alcohol and policy coherence
 - A. Trade
 - B. Development
 - C. Democracy
 - D. Health

3. The Way Forward

This is a summary overview for all the concrete proposals Movendi International suggests for an ambitious and constructive way forward - to bring alcohol prevention and control firmly into the 21st century, after nearly a decade of implementation of the WHO GAS.

1. Recommendation for more ambitious per capita reduction target
Movendi International calls for a target of a 30% reduction of per capita alcohol consumption until 2030.

2. Expert committee for the innovation of global alcohol prevention and control
Movendi International calls for the creation of a WHO Expert Committee to make concrete recommendations towards the innovation and strengthening of global alcohol prevention and control.

The WHO Expert Committee shall have the following mission:

1. Contribute to updating the WHO GAS: update priority areas, add new/ update objectives (protect against industry interference), update terminology, revise the role of industry, etc;
2. Make recommendation for evidence-based measures to protect alcohol abstainers, especially children and youth, and to help maintaining low alcohol use prevalence;

3. Make recommendations for the protection of the Human Right to Health, especially for women and girls (CEDAW), as well as children (CRC) through alcohol prevention and control;
 4. Make recommendations for the improvement of monitoring and surveillance, as well as protection against industry interference;
 5. Make proposal for how to set a regular agenda item/ ensure regular assessment and discussion of alcohol harm and policy response;
 6. Elaborate the case for a global binding treaty, sketch out the potential and devise a roadmap.
 7. Report back through the WHO governing bodies in 2022.
3. Set up “Joint global initiative for alcohol taxation” led by WHO, together with UNDP, the World Bank, the OECD, development partners, and civil society to enhance technical capacity and facilitate implementation of evidence-based alcohol taxation regimes.
 4. Request the Director General to present a plan for mainstreaming alcohol at WHO Secretariat level, to re-establish the global alcohol policy counterparts’ network and for how to properly address alcohol beyond the NCDs context:
 1. Report back through the WHO governing bodies in 2021.
 5. Establish World Alcohol-Free Day, October 3rd, as global alcohol awareness day.
 6. Call for an annual WHO Alcohol Status Report
Movendi International proposes the set-up of WHO processes and structures that allow for the timely delivery of annual alcohol status reports to better inform policy development and drive knowledge dissemination.
 7. Make the bi-annual Forum on alcohol policy permanent and explore options for WHO to host it in collaboration with member states, as well as the possibility of regional forums.
 8. Arrange in 2025 the first ever WHO Global Ministerial Conference on Alcohol Prevention and Control
Movendi International calls for a global ministerial conference on alcohol prevention and control, possibly in 2025, to facilitate high-level stock-taking and renewing of political commitment towards 2030.
 9. Technical working group on resource mobilization
Movendi International calls for the formation of a technical working group to make recommendations and design a road map concerning options for resource mobilization,

DISCUSSION PAPER

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forward

for example through exploring the feasibility of setting up a global impost on alcohol, and a profit levy across the alcohol industry value chain.