

THE GLOBE

Alcohol advocacy
Lessons to be learned
from tobacco



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THE GLOBE

GLOBAL ALCOHOL POLICY ALLIANCE

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ISSN 1460-9142

World trade and youth drinking - a global concern

A previous editorial observed that alcohol reaches all parts of the globe and that no part remains immune from the problems associated with intoxication and dependence.

Global concern about the problem grows. We have previously highlighted the World Health Assembly (WHA) resolution of May 2005 and that of the American Medical Association, which we are pleased to report, was adopted at the World Medical Association's meeting in October in Santiago.

In this issue we highlight the WHO Europe Framework on Alcohol Policy and the first WHO Pan American Conference on Alcohol Policy in Brasilia.

The European Union's DG SANCO is in the midst of preparing an alcohol strategy with particular concern over the problems associated with the levels of youth drinking.

European nongovernmental organisations have, for some time, not only seen the need to work at community and national level but also at regional. EUOCARE continues to broaden its network. A similar development is beginning to take place in the Asia Pacific region under the aegis of the Global Alcohol Policy Alliance.

From the various reports in this edition, whether it be from Europe, the Americas, Asia or the Pacific Islands, two common concerns stand out: the impact of globalisation and youth drinking.

The alcohol industry, due to globalisation, the liberalisation of trade and the consolidation of companies, has increased its influence on governments to promote industry friendly policies to the detriment of public health. So much so that Michelle Swenarchuk urges health officials (page 29) to be involved in the formulation of trade policy to achieve some balance

between the demands of trade and health in order to prevent the undermining of alcohol control policies. The European Framework document confirms such advice in stating: "the ability of governments had been substantially weakened to use some of the most effective tools to prevent and reduce alcohol-related harm due to the growth of trade agreements".(page 5)

Young people's drinking occurs at an earlier age than previous generations and its consequences are seen in accidents, anti- social behaviour, hospital admissions, health damage and dependence. There is denial by the alcohol and advertising industry that young people are a prime target of advertisements or that advertising has an impact on consumption. Recent evidence from an extensive longitudinal study challenges such a view. The study finds that young people exposed to more alcohol advertisements tend to drink more alcohol. As David Jernigan comments on the study: "The fact that young people...were more likely to drink more over time in environments with alcohol advertising, even when controlling for alcohol sales in those environments, suggests that it is exposure to alcohol advertising that contributes to the drinking rather than the reverse."

The message to governments from this study is quite clear: if politicians are serious about tackling youth drinking then restrictions on advertising (and sponsorship see Robert Sparks page 29) need to be implemented.

As far back as the WHO Conference in 2001 European health ministers signed up to the following principle: All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages".

Obituary

It is with deep regret that we report the death of Andrew Varley. He was an assistant editor of both the *Globe* and *Alcohol Alert*. He had cancer and for a long time bravely fought it. To his wife, son and daughter we extend our sympathy.

WHO Europe – framework for alcohol policy

Member States at the Fifty-fifth session of the Regional Committee for Europe in Bucharest in September 2005 had a lengthy debate on a resolution to continue its alcohol strategy for the region. Members had before them a report on alcohol in the WHO European Region; an outline of alcohol policy: current status and the way forward; and a background paper for the framework for alcohol policy.

The WHO European Region has the highest alcohol consumption of all the WHO regions – twice as high as the world average. Around 600,000 Europeans died of alcohol-related causes in 2002, representing 6.3% of all premature deaths in the Region that year; more than 63 000 of those deaths were of young people aged 15–29 years. The relative contribution to disability was even higher, alcohol use accounting for 10.8% of the total disease burden. This made alcohol use the third leading risk factor for death and disability in the Region.

It is estimated that adults in the European Region drink on average 12.1 litres of pure alcohol per person per year, i.e. more than twice the global level of 5.8 litres (Fig. 1). Even though women account for only 20–30% of overall consumption, it was still the highest proportion in the world. The report recognised the large variations in per capita consumption among the countries in the Region, although the variations became much less significant if abstainers were excluded from the calculations.



The Framework report stated that Governments now had much stronger evidence than they had 20 years ago on which to base alcohol policies and referred to a recent review that rated 32 strategies or interventions in terms of their degree of effectiveness.

Broadly effective strategies included alcohol control policies, drink-driving countermeasures and brief interventions for hazardous and harmful drinkers. Measures for which it had been difficult to find a direct positive effect on drinking

patterns or problems included education in schools, public service announcements and voluntary regulation by the alcohol industry.

The latter measures should be used only as part of a comprehensive strategy to tackle alcohol-related harm. What was needed in the longer term were sustainable alcohol policies and programmes that reduced both hazardous and harmful patterns of drinking; reduced the overall volume of drinking; separating drinking from certain activities and situations (such as driving or operating machinery, at the workplace and during pregnancy); and the provision of adequate help for people with alcohol problems and their families.

The report maintained that the ability of governments had been substantially weakened to use some of the most effective tools to prevent and reduce alcohol-related problems due to the growth of trade agreements, common markets and the processes of globalization. There was need, from a public health perspective, for concerted international action to clearly recognize that alcohol is a special commodity in terms of the very substantial harm associated with its use.

Future action and goals needed to be set within a policy action framework. This would encompass the European Charter on Alcohol, the European Alcohol Action Plan (EAAP) and the Declaration on Young People and Alcohol, as the principal documents for alcohol policy development in the Region

The Framework proposals recognised that drinking customs and habits were deeply rooted in

many European cultures. Effective action required the development and application of evidence-based recommendations and strong political commitment.

The Framework saw the necessity that alcohol policies and actions had to be based on the best scientific evidence about effectiveness and cost-effectiveness, and be sensitive to cultural diversity. It strongly advocated that where the science was uncertain, the precautionary principle should be applied and priority given to protecting the health and welfare of the population.

Regional and global solutions to the problems should be explored to deal with increasing levels of cross-border trade and price differences. It was important that Member States acknowledge other countries' laws and regulations which were aimed to prevent or reduce alcohol-related harm.

The Framework reaffirmed the important principle agreed by the Ministerial Conference in 2001 that public health approaches to alcohol problems needed to be formulated by public health interests without any formal or informal veto from other actors.

Developments and initiatives by the European Union, with its 25 member states, had important consequences for public health policy development in the Region. There had been several notable public health initiatives by the European Union (EU) in recent years: its partnership in the WHO Ministerial Conference on Young People and Alcohol (2001), Council Recommendation on the drinking of alcohol by young people, Council Conclusion on a Community

strategy to reduce alcohol-related harm, reiterated in 2004, and the alcohol component of the Public Health Programme all showed the growing and active role of the EU in preventing or reducing alcohol-related harm in Europe.

Mention was made of Eurocare's project "Alcohol policy network in the context of a larger Europe: Bridging the Gap", co-financed by the European Commission for the years 2004 to 2006. The project included partners in 30 European countries and cooperates with other regional organizations. The main aims of the project were to create an alcohol policy network in the EU member countries and to strengthen the development of an integrated Community strategy to reduce alcohol-related harm in the context of a larger Europe. The network has produced a set of "Bridging the Gap Principles" for a policy on alcohol in Europe.

Challenges

The Framework recognised important challenges for policy in the future:

- The large traveller's allowances for personal use within the EU, have restricted the ability of several national governments to control sales to residents and have forced down alcohol tax rates in some countries.
- Extensive region-wide marketing strategies by the drinks industry, many of which appeal to young people, demonstrated the trans-national nature of modern marketing.
- The further growth of trade agreements and the continuation of the processes of globalization

Member States are recommended to develop or review their national

WHO subregion ^a	Total consumption ^b	% unrecorded of total ^c	% heavy drinkers ^d	% drinkers among males	% drinkers among females	Consumption per drinker ^e	Average drinking pattern ^f
Euro A	12.9	10%	15.7	90	81	15.1	1.3
Euro B 1	9.3	40%	9.9	77	57	14.3	2.9
Euro B 2	4.3	51%	4.5	54	33	9.9	3.0
Euro C	13.9	38%	18.6	89	81	16.5	3.6
World	5.8	40%	5.1	60	32	12.3	2.5

Table 1: Characteristics of adult alcohol consumption in different subregions of WHO's European Region in 2000 (population-weighted averages across countries) (5,6,7)

a Euro A: Andorra, Austria, Belgium, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland, United Kingdom.

Euro B: Albania, Armenia*, Azerbaijan*, Bosnia and Herzegovina, Bulgaria, Georgia, Kyrgyzstan*, Poland, Romania, Slovakia, The Former Yugoslav Republic Of Macedonia, Tajikistan*, Turkmenistan*, Turkey, Uzbekistan*, Yugoslavia (*subsumed as B2; rest is B1).

Euro C: Belarus, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Ukraine.

b Estimated total alcohol consumption per resident aged 15 and older in litres of absolute alcohol (recorded and unrecorded).

c Percentage of total adult per capita consumption which is estimated to be unrecorded.

d Estimated % rate of heavy drinking (males >40g and females >20g) among those aged 15+.

e Estimated total alcohol consumption (in litres of absolute alcohol) per adult drinker aged 15+.

f Estimated average pattern of drinking (1–4 with 4 being the most detrimental pattern).

strategies and action plans. The ten areas for action in the European Alcohol Action Plan continued to be of central importance for the implementation of national alcohol policies and should be seen as an integral part of the Framework. These areas are: information and education; public, private and working environments; drink-driving; availability of alcohol products; promotion of alcohol products; treatment; responsibilities of the alcoholic beverage industry and hospitality sector; society's capacity to respond to alcohol-related harm; nongovernmental organizations; and formulation, implementation and monitoring of policy. Local communities need to adopt policies that set targets, identify responsible agencies and forms of accountability, and adequately involve NGOs.

Advocacy was necessary to raise public awareness of the extent of alcohol-related harm in the community and to gain public acceptance of effective policy measures. A strong case could be made for restricting availability through an effective taxation policy, limiting the number of outlets for alcohol, and limiting the hours of sale. Programmes for responsible beverage service could also effectively reduce problems, if they are combined with active enforcement by police and licensing authorities. Availability plays a particularly important role in youth drinking, where the enforcement of age limits on alcohol sales has proved to be an effective tool in reducing drinking.

Education and information should be combined with other measures in a comprehensive strategy. Education of minors is best implemented by state agencies and other independent education agencies which have the necessary professional expertise and focus their activities on a healthy young generation.

While research on the long-term effectiveness of school-based information on behaviour has been disappointing, parental programmes appeared more promising. Delaying the onset of drinking was important.

A focus day on preventing alcohol-related problems

The Framework suggested the possibility for raising awareness in society of the negative health and social consequences of alcohol by initiating a national focus day on preventing or reducing alcohol-related problems. Used in combination with other more long-term measures, such a focus day could be an important instrument in increasing knowledge of the extent and magnitude of alcohol-related problems and stimulate support for effective alcohol policy options.

European Coalition on Alcohol Policy Development

Member States and international organizations and institutions will be invited to join a coalition that could create the necessary support for and achieve the implementation of effective alcohol policies in the Region.

Triennial Framework progress report:

A progress report on the Framework should be produced every third year. The purpose of the report should not only be to estimate the levels of implementation and success of the Framework, but also to alert Member States to emerging challenges and threats to public health and to identify any need for adjustment of the Framework. The progress report should be produced in close collaboration with the network of national counterparts for alcohol policy and relevant collaborating centres.

Triennial high-level forum on alcohol policy in the Region:

A special high-level forum on alcohol should be organized by the Regional Office every third year. The purpose of such a forum would be to discuss the outcomes and recommendations of the progress report and to deliberate on critical or challenging issues regarding alcohol policy, with a particular focus on issues with cross-border implications and other issues that are difficult to resolve in the context of a single Member State.

The Regional Committee adopted the following resolution:

Framework for alcohol policy in the WHO European Region

The Regional Committee,

Reaffirming that the harmful use of alcohol is one of the major public health concerns, with the highest levels of consumption and harm in the WHO European Region;

Recalling its resolution EUR/RC42/R8, by which it approved the first and second phases of the European Alcohol Action Plan, and the European Charter on Alcohol adopted at the European Conference on Health, Society and Alcohol in Paris in December 1995;

Recalling its resolutions EUR/RC49/R8, by which it approved the third phase of the European Alcohol Action Plan, and EUR/RC51/R4 by which it endorsed the Declaration on Young People and Alcohol adopted at the WHO Ministerial Conference on Young People and Alcohol in Stockholm in February 2001;

Recalling World Health Assembly resolution WHA58.26 on public health problems caused by harmful use of alcohol;

Recognizing that the harm done by alcohol is a pan-European problem with serious consequences for public

health and human and social welfare affecting individuals, families, communities and society as a whole, that calls for increased international cooperation and the participation of all Member States in a cost-effective, appropriate and comprehensive response which takes due consideration of religious and cultural diversities;

Acknowledging the existence of socioeconomic and cultural differences, specific biological and genetic features, and variations in physical and mental health;

Noting the need to promote and further strengthen the public awareness of and political commitment to effective measures to combat alcohol-related harm;

Recognizing the threats posed to public health by the factors that have given rise to increased availability and accessibility of alcohol in some Member States;

Recognizing the importance of ensuring that a multidisciplinary and multisectoral approach is a governing idea of the implementation of the Framework for alcohol policy in the WHO European Region;

Aware that public health concerns regarding the harmful use of alcohol need to be duly considered in the formulation of economic and trade policy at national and international levels;

Acknowledging the leading role of WHO in promoting international collaboration for the implementation of effective and evidence-based alcohol policies;

1 Endorses the Framework for alcohol policy in the WHO European Region outlined in document EUR/RC55/11 as a framework for strategic guidance and policy options for Member States in the European Region, taking into account existing political commitments as well as new developments, challenges and opportunities for national and international action;

2 Urges Member States:

a to use the Framework to formulate or if appropriate reformulate national alcohol policies and national alcohol action plans;

b to strengthen international collaboration in the face of increasing levels of common and transboundary challenges and threats in this area;

c to promote a multisectoral and evidence-based approach which recognizes the need for political commitment and the importance of encouraging mobilization and engagement of the community and civil society in the actions needed to prevent or reduce alcohol-related harm;

d to promote alcohol-free policies in an increasing number of settings and circumstances, such as the workplace, in all traffic, young people's environments and during pregnancy;

3 Urges international, intergovernmental and nongovernmental organizations, as well as self-help organizations, to support the Framework and to work jointly with Member States and with the Regional Office to maximize the impact of the Framework's efforts to reduce the negative health and social consequences of the harmful use of alcohol;

4 Requests the Regional Director:

a to mobilize resources in order to ensure adequate health promotion, disease prevention, disease management research, evaluation and surveillance activities in the Region in line with the aims of the Framework;

b to cooperate with and assist Member States and organizations in their efforts to prevent or reduce the harm resulting from alcohol consumption and thereby the level of alcohol-related problems in the Region;

c to mobilize other international organizations in order to pursue the aims of the Framework for alcohol policy in the Region;

d to continue, revise and update the European Alcohol Information System to reflect the new Framework for alcohol policy in the Region and to include a legal database in the system;

e to organize the production and publication of a review of the status of and progress achieved in addressing alcohol-related problems and policies in the Region, to be presented to the Regional Committee every third year.

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Bringing health policy closer to citizens: challenges and future strategy

EU OPEN Forum

The EU Health Forum set up by DG SANCO brings together umbrella organisations representing stakeholders in the health sector to ensure that the EU's health strategy is open, transparent and responds to the public concerns. It seeks to cover four groups of organisations: Non-governmental organisations in the public health field and patients' organisations; organisations representing health professionals and trade unions; health service providers and health insurance; and industry with a particular health interest. The Forum is composed of two elements: a Health Policy Forum with a consistent set of member organizations - at present 46 (of which Eurocare is a member). An Open Forum, held each year, as a platform for general exchange of information and for a discussion with a broader range of groups and interested parties. Around 380 delegates attended the Open Forum in November 2005. At the Plenary session Mr Robert Madelin Director General of DG Sanco gave a general address outlining DG Sanco's present concerns and this was followed by presentations from four groups of organisations. Eurocare this year had the privilege of representing the NGO section. We reprint the presentations of Robert Madelin and Derek Rutherford. Speakers were asked to address the following: 'Does Europe matter?' 'How has the EU affected people's health?', 'should the EU focus on health or is health determined by other factors beyond its influence, i.e. macroeconomic determinants?', 'Which one area in health should the EU prioritise if it had to focus on only one area?' http://europa.eu.int/comm/health/ph_overview/health_forum/open_2005/contributions_en.htm

Robert Madelin Director General DG SANCO

Introduction

I am sure we all agree that Health policy has to respond to the needs and concerns of individual citizens of the European Union. That's why we are here today.

The challenge, as viewed by a Brussels-based policy-maker, is how do we feed the concerns of individual European citizens into such a big thing as European Union health policy? How can the Commission and your organisations work together to develop policies that will meet citizens' expectations? So today the objective is to identify

the challenges facing citizens in their quest for health and what future policy we need. First, I would like to share some thoughts with you on EU health challenges and the need for more governance in health policy. I will then say a few words on citizens' participation, on health systems and health products which are, together with health strategy, the themes of the parallel sessions we want to run in the course of today.

1. EU Health Challenges

Let me pick up a few of the health challenges as we see them.

First, and this is even clearer in a Union of 25 than it was before May last year, there is a huge **health gap**

in population health and in access to healthcare services across the Union.

Citizens from some of the new Member States are expected to live 12 years fewer than a citizen from a Nordic Member State. The mortality rate for ischaemic heart diseases shows an eight fold variation across the Union. Many regions lack high-quality centres of reference with up-to-date equipment and trained staff for some prominent health challenges in their regions.

This health gap goes hand in hand with an economic gap. Bad health impacts on productivity, on labour participation and on growth. This is why we in DG SANCO – and I think it is fair to say, the Barroso College – encourage Member States to position health as a long term investment. We try to do that by providing the data, the studies, and to help to channel more clearly the Structural Funds to health projects in eligible countries and regions.

The second major challenge is the increase in **lifestyle related diseases**. It is a real increase. It is not just that the infectious diseases' burden has gone away and we suddenly notice lifestyle. Lifestyle related diseases are growing rapidly as a threat.

Overweight and obesity affects 14 million EU children and their number is rising by almost half a million a year. Unsurprisingly, therefore, type 2 diabetes is also increasing.

Addressing lifestyle problems – not just nutrition or the lack of exercise, but also smoking or alcohol abuse – will require action from a wide range of stakeholders. We launched an anti-tobacco campaign to help young

people to resist or to quit smoking. We have also created this year a European platform on nutrition and physical activity to encourage concrete action by all our partners to promote healthy eating.

A third challenge is the **health budget** problem. Pressure on health budgets has increased steadily over the past few years, partly because the new technologies and high-quality healthcare that all national health systems need to provide cost more, but also because the message that "health equals wealth" has not got across to the Treasuries of Europe; has not got across to the macro-economists; has not got across to the Heads of State or Government.

Addressing these challenges requires us to contribute both on the demand and on the supply side to find more cost-efficient use of technology; to improve quality without always throwing more money at quality issues; to promote health more actively in order to reduce healthcare demand; and to co-operate between health systems so that we can share the load, for example by centres of reference co-operation. In these areas, I think that in the last couple of years, in the light of the reflection process launched under David Byrne's leadership, we are beginning to see a willingness of Member States to work together not to have a European policy, but to create common approaches to dealing with these common problems.

The fourth challenge I would identify is **ageing**. I received an e-mail from Washington overnight asking: "Who is in charge of ageing in the European Commission?" Well, quite a lot of people should be taking an interest. Again, because Treasury views seem to dominate, ageing is primarily seen as a pension issue or a workforce issue and therefore it is my colleagues in DG Employment and their partners



around Europe who are perhaps the most best known discussants of the ageing issue. But ageing is a major challenge for health and feeds back again through the health aspect into the future prospects for the European economy and for European society.

We expect, as you know, that over the next quarter of a century, the number of people aged 65 and over will increase by 37% and the number of people over 80 will more than double.

We therefore need to have a much more active policy to address the health maintenance needs of this burgeoning section of society, so that people don't just live longer, but have healthy life years. And that is another reason why it is not just life expectancy but "Healthy Life Years" that we have adopted with the European Council as a key performance indicator for the Lisbon process.

Those are the four major challenges we see for the future.

I think what we need to know is whether you agree; whether your major challenges and core business can be found under those four pillars or whether there is something that we would miss if we try to build the European movement for health, the European strategy for health, around those four key drivers.

2. The case for better governance and the new strategy

Let me talk a little about governance. I have already talked about governance by complaining that macro-economists and treasury officials failed to grasp the importance of health policy. Of

course, that is not because those individuals are necessarily opposed to health; it is because somehow the way we run our society fails to give them the data and the incentives to realise the truth that probably all in this room realise.

According to a recent survey (which we run through the so-called Eurobarometer system of EU public opinion polls), half of our citizens think that the European Union could usefully play a greater role in health matters in the coming years. But, at the same time, citizens are worried that they do not get to participate in policy-making.

More than half of them believe that if a decision is taken at EU level, their voice does not count. You have the paradox that on the one hand people like Europe when it works, but on the other hand, they do not think it does work and so they vote against it in referenda.

Knowing that health is a primary concern for citizens, we feel that the public consultations we have carried out around our health strategy show two key things: firstly, they would expect Europe to integrate a strong role on health alongside the strong role on economics, but secondly, they want to be sure that they have a guaranteed say in decisions that affect their health.

Right now the Commission is encouraging a wide public debate on the future of the EU. I think that the debate is particularly important when it comes to health.

I hope therefore that when you go home after this conference, one of the things that you will take the time to say is firstly that you've been to Brussels to talk about health (because most people do not know that this sort of discussion takes place); and secondly that what we have been discussing today is an important part of the debate about re-launching Europe.

Bringing health policy closer to citizens: challenges and future strategy

Too often, I think we as citizens leave the future of Europe to Foreign Ministers and Prime Ministers and similarly important people, and then we wonder why our concerns as citizens are not reflected in any vision for the future of Europe.

The one thing leads to the other. I would very much urge you to take away from this conference the fact that Europe can do things which will be good for health, but only if we in the health community go home and work for that to happen.

And that brings me to the point about participative policy which I made last night. You cannot make health in Brussels for half a billion citizens. You cannot make health in one town for 25 Member States and goodness knows how many regions.

We therefore need to think very carefully about how to bring all the citizens of Europe closer to a European debate about health, while at the same time recognising that whatever we can do within the Union is only a complement to national and regional health policies.

And within those national and regional health policies, each Member State has its own different ways of setting priorities, feeding citizens' concerns into policy-making, and organising health services. So what do we intend to do?

We intend to try to work more closely with citizens' elected representatives, not just in the European Parliament but with national Parliaments. We intend to use the so-called "Plan D", Vice-President Wallström's dialogue plan to respond to the failed referenda, and to use it as one of the platforms for a much broader, more grass roots debate on health as one theme. But in addition to working with central governments and national legislators, we need to find new ways of involving the regions and civil society.

Organisations such as the ones you represent therefore have a key role in voicing and advocating the concerns of citizens. We need your advice not just on what should the content of the strategy be – are our four pillars the right ones? – but also on how can we set about structuring the discussion, structuring the process in such a way that the individuals who are represented by your organisations will notice that people in Brussels are trying to listen to them. It is one thing for us to feel that we are trying to listen, but real democracy only happens when people around Europe notice that we are trying to listen to them. And that is really difficult.

We are not starting from scratch. Here we have the Health Policy Forum, we have the recommendations of that Forum on issues such as health and enlargement; and that Forum plays an important role not just working with DG SANCO but helping to integrate health in other policies such as research.

We also want to use the participation of NGOs in policy-making and that's part of the Health and Consumer programme we proposed this spring. We need more money for that, so we continue to argue for the financial perspectives being discussed in the remainder of this year to double or more than double the modest funds available for health within the overall European budget.

I must say I am not optimistic. But I would also say that budget making is like any other aspect of democracy. So I hope that your organisations are writing to your national counterpart government representatives and to your MEPs to say that you think, as an organisation, that let us say "a euro per citizen by 2013 for health" would be a good idea. If we fail to get that, and you have not written, you will only have yourselves to blame.

Certainly we in DG SANCO continue to fight hard for it in season and out of season. I say to everybody I can contact here in Brussels that a euro per citizen for health is not too much to plan for by the end of the 7 year period for which the budget is now being set. So if you think that this is a reasonable request, please write to those who can take the decision.

The question is how do we use that money, or less money if that's what we get, in order to support your advocacy work? I said last night and I said this morning that we want your organisations to be active not only in regions and the Member States but right across Europe. How can we support you effectively?

Is it a question of better information on health status and policies? If that is the case, then I would encourage you to look at the presentation stand outside the room about our new health portal, which is designed to provide user-friendly information on health in 20 languages.

Can we do anything else to foster the capacity of non-governmental organisations or to foster not just your capacity internally but your ability to network with each other? These are the questions that I think are crucial in terms of governance.

3. Health systems

Let me now come finally to health systems and health products. On health systems, the parallel session is going to look at the scope for fostering co-operation and exchange of best practice between health systems without harmonising national and regional approaches whether on policy or on clinical practice. I believe, as a newcomer to this field eighteen months ago, that the new appetite for this sort of "soft co-ordination" is relatively high amongst national Ministries.

What is lacking is the ability of those who indulge in such co-ordination

in national Ministries, who are often in international departments, to reach out to those who are actually running policy at national and regional level and to reach out beyond administrative structures to those in your organisations who also have an interest. I think there is a discussion which is beginning, but at the moment the participation in that discussion is too narrow.

Thinking about this from a citizens' perspective, I would say that in the health systems field there are questions that your organisations could be asking in the health systems co-operation debate, to see whether it has something in it for you. Maybe three questions:

Firstly, if you have a healthcare need which is not met in the hospital down the road, do you know where you would go?

Secondly, if you were to need healthcare abroad, would you find the same level of quality and safety? What would it take to give you a feeling of comfort equivalent to that you feel in the hospital next door (which I hope is a good hospital), if you went to a hospital 500 or a 1000 kilometres away across one or more national borders?

And finally, how do you feel about issues of redress? Are they important? Do you feel, when you go to a hospital or into the health system, "I am confident because I have redress and so if I go to a foreign country I might not have redress?" Or is that not such an important issue?

All these challenges – under the headings of **patient rights, quality and safety, patient safety** – are issues which are currently on the agenda among the Member States in the High level group that I chair. We are beginning to discuss them, there is an appetite to discuss them, and we are looking to get more input from your organisations to drive that part of our policy-making forward.



4. Health products

Then on health products, and this is my last point, it is clear that products, whether it is medicines or medical technology, are crucial; that they are a major field of innovation; and that Europe is a leading innovator, amongst others, in this field.

The question is for citizens and patients: Do you get the information that you need? Are you happy with the channels whereby European health culture provides you that information?

The parallel session we will be organising on health products will therefore be discussing a set of important relevant issues there: the need for medicines to be available; safety concerns related to new pharmaceuticals; and the cost-effectiveness issue – how to get better European level health technology assessment.

I think the link to those issues is also the one about patient information: Have we got the balance between professionalisation of information flows and general background education right in Europe or not? That is a very old and long running debate in Europe, but it is not one that has gone away.

Conclusion

Let me conclude. The fact that there are so many questions demonstrates the need for this sort of Forum not just to be a day of intensive discussion, but to be the sort of focal point where at regular intervals this community comes together and takes away a series of questions to structure the work we are doing together over the years ahead.

We think that this is a particularly crucial moment. It is crucial for several reasons.

First, the budget is being set for the next seven years. If the UK Presidency is successful, it will be set by Christmas and there will be no further questions about how much money is available until 2013. That is important.

Second, because we are talking about budget we are also talking about strategy and we are doing it at a time when the failure of referenda in certain countries in Europe creates an opportunity – an opportunity to re-position health within the panoply of public policy issues. That opportunity is reinforced by the European Council's decision this year to make Healthy Life Years a performance indicator in the Lisbon process. So far this is a little noticed innovation, it may not even have been noticed by all the Heads of State and Government, as they took the decision in the Spring. It is up to us to make it real.

For those reasons, I think this is the right time to have this meeting. Indeed I hope this is the right meeting. You will tell us at the end if it has met your objectives. I am certainly very pleased to have such good participation and I hope to be able to listen to some of the panel discussion.

Does Europe matter – non-governmental point of view

Derek Rutherford Eurocare

Asking the question ‘Does Europe matter?’ will elicit differing responses, for the EU means different things to different people.

Those, like myself, whose childhood and youth were fashioned and influenced by the immediate post war period of the mid forties and fifties, could clearly appreciate and accept the vision of the founding fathers “to keep the peace of Europe”.

Over the past 50 years we have moved on. We have a different generation of Europeans whose life experience are different from those of the founding fathers. Ask “Why Europe?” in the new Member States, generations brought up in a totally different political environment, often respond, “to maintain our security and protection”.

The economic success of European membership is often the common answer among people from member states that have experienced growth in their GDP’s and standard of living. However, in older member states, opinions reflected in referenda or public opinion polls reveal that the average person in the street is disconnected with Europe, viewing it as irrelevant or meddlesome.

For many, Europe has become the playing field of political and commercial elites.

How then do we get our fellow citizens “to embrace” Europe, to give to them a sense of ownership or partnership? For a new generation we need to challenge

them with the global world - its social and political realities. A world where, the largest economies in the future, are forecast to be China, India and, of course, the United States. To meet such a challenge we need a healthy Europe and a healthy workforce.

In remarks to a Nuffield Trust and EPC meeting last year, Robert Madelin felt that “the overriding priority for the Commission had to be to put the individual back in touch with Europe” and went on to say “a field that affected all, such as health policy, might just be the way to achieve such a connection”.

When posing such a view, I wonder if the Director General had in mind Benjamin Disraeli’s observation: (one of the eminent British Prime Ministers of the 19th century). “The first consideration of a Minister should be the health of the people”.

He strongly objected to those who felt improvements in the social and work conditions of the people would undermine economic prosperity. Disraeli would have applauded Madelin’s view: “Health has to be seen as an economic factor in the Union: healthy life years are a factor in competitiveness”.

From its outset, fifteen years ago, Eurocare’s Charter emphasised that: “the EU can no longer remain solely an economic union, it must become a social community where the collective health interest takes precedence over individual economic interests.”

A major challenge for the public health community will be to succeed in ensuring that the drive towards

less regulation, reducing red tape for business and competitiveness does not come at the expense of public health concerns.

The factor that changed the attitude of the British Trade Union Movement from being anti to pro EC was the European Social Model. A Model, which they felt was losing ground with the then economic decisions of the United Kingdom Government.

Public trust in NGO’s is far, far higher than that in politicians and commercial concerns. This factor makes us well placed to persuade public opinion to the relevance of Europe. Provided (and there is an important caveat) that European institutions ensure a level playing field for our voice in the shaping of policy. The example set by DG SANCO is good, but it would be helpful if other Commission Directorates followed suit.

The European Alcohol Policy Network developed by EURO CARE is a good example of the importance of the EU in social and health policy. All member states, candidate and associate countries are represented, covering NGO’s, Public Health Authorities and academia. It would do well for EU institutions to comply with Treaty obligations. The treaties maintain that the Union should:

“Contribute to the attainment of a high level of health protection” and that “Health protection requirements shall form a constituent part of the Community’s other policies”

Thus the Treaty recognises the impact that EU Council and

Commission policies can have on health. But how far is the principle executed? Have sufficient resources been allocated in order to assess such decisions and their health implications?

It is worth noting that in the debate on excise duty in the nineties, the European Commission accepted the principle that taxes on alcohol had a public health dimension.

In the 1993 White Paper on ‘Growth, Competitiveness and Employment’ it stated: “An increase of excise duty on tobacco and alcohol provides a source of additional budget revenue and a means of preventing widespread social problems, and can help social security budgets to make savings by reducing the need to treat cancer and alcoholism”.

Having been asked to select one area in health that the EU should prioritise, it would have to be one of the five key health issues that the DG considers needs tackling. It would be a lifestyle related social and health problem that also impacts on health inequalities.

The one I have selected causes in the EU:

- 4 out of every 10 homicides - 2,000 per year
- Over 1 in 6 suicides - 10,000 per year
- 1 in 3 road traffic deaths 17,000 per year 10,000 of which are estimated to happen to ‘innocent’ victims
- 200,000 Unprotected sex incidents among 15/16 year olds
- 1 in 7 Child abuse/neglect cases
- After tobacco and high blood pressure it is the third highest risk factoring mortality and morbidity -

Alcohol costs an estimated 125 billion Euros annually, almost half due to lost productivity. It contributes to health inequalities both between and within countries.

Alcohol plays a considerable role in the lowered life expectancy in the EU 10 compared with the EU15.

If it were any other substance, other than alcohol, there would certainly be demands for governmental action. However, with alcohol we are dealing with not just an irresistible pleasure but massive vested interest.

In 1979 a British Government Minister speaking to the AGM of the National Council on Alcoholism (of which at that time I was the Director) said that alcohol was a lifestyle problem and that dealing with lifestyle problems demanded ‘not incision at the surgeon’s table but decision at the cabinet table.’

The drinks industry responded very quickly to this perceived threat. Critical of what they considered to be the late and inadequate response of the tobacco industry to similar threats, they were determined to set the research agenda. The voice of the public health lobby had to be countered, but, if possible, also wooed.

There is no escaping the fact that there is a conflict of interest between the industry and public health.

It should come as no surprise that we face an alcohol epidemic throughout Europe. An epidemic to which public health authorities have been alerted through the WHO European Alcohol Action Plan; Two WHO Ministerial Health Conferences – the last one advising that “Public Health Policies concerning alcohol need to be formulated by Public Health Interests, without interference from Commercial Interests”. Why does the industry have such a hold on governments when polls of civil society give them such a poor rating? Why do we have inaction on policy relating to advertising when, where polling has been carried out, the public want positive action to curtail volume and content.

At least the European Parliament saw the need for action over alcopops.

The Council of Ministers has issued recommendations on alcohol consumption by young people and called for an EU strategy. It is in the process of being formulated by DG Sanco.

Why address children and young people? Because it is the children who pay the price of the last round!

Much is said about passive smoking, little recognition is given to the third party victims of alcohol. Up to nine million children of the EU will return from school today to a home with a parental drinking problem. 29% of young males between the ages of 18 to 29 will die from an alcohol related cause – the major cause of death for young people in the EU.

The EU is concerned about human rights. The rights of the child should have high importance. One of the five ethical principles of the WHO in relation to alcohol is:

- All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.

While awaiting the DG SANCO alcohol strategy, we can embrace and publicise the newly adopted WHO Alcohol Policy Framework.

But above all else let us remember: **If we take care of the children of Europe, Europe will take care of itself.**

Lessons to be learned from tobacco

Monika Arora, Director, HRIDAY (Health Related Information Dissemination Amongst Youth), New Delhi, India.

Like tobacco, alcohol is also a public health hazard. Tobacco has adverse effects on social, economic, health and environmental factors. Alcohol too has adverse medical, psychological, social and economic impacts. Other similar characteristics between alcohol and tobacco are its increasing social acceptability, dependence on the product, aggressive marketing of the product particularly to recruit youth as its consumers.

Tobacco and Public Health

Tobacco is the second major common cause of death and the fourth leading risk factor for disease. It is responsible for the death of one in ten adults - 5 million deaths a year worldwide. (WHO, Tobacco Free Initiative. Available at www.who.int/tobacco/en/).

By 2030, if present trends continue unchecked, the figure will have increased to 10 million deaths per year, with 70% of these deaths taking place in developing countries. (FCTC, WHO at www.fctc.org).

Alcohol and Public Health

Worldwide, 1.8 million deaths in 2000 were attributable to alcohol use causing 3.2% of all global deaths and contributing to 4% of the disease burden. (World Health Report, WHO, 2002).

Alcohol is the leading risk factor related to the major burden of disease in low mortality developing countries and the third most prevalent risk factor for leading diseases and injuries in developed countries (WHO, 2002). While alcohol consumption is decreasing

in some developed countries, it is on the rise in developing nations. Significant proportion of the student population drink at hazardous level. The burden from alcohol exceeds that from tobacco because alcohol problems tend to take their toll earlier in life. The physiological and social consequences of alcohol use also negatively affect school performance, attendance and productivity at work and relations within the family.

Direct and Indirect Impact of Alcohol and Tobacco

Second Hand Smoke from a smoker's cigarette is harmful to a non-smoker in his/her vicinity. Harmful drinking of alcohol is an underlying cause of injury, violence (especially domestic violence against women and children), disability, social problems and premature deaths (mental ill health affecting individuals, families, communities and society). The consequences of drinking and driving impacts on innocent third parties.

Trends in Consumption

Alcohol consumption is declining in

most of the developed countries, and rising in many of the developing countries and the countries of Central and Eastern Europe.

Males do most of the drinking in these countries, and evidence available regarding patterns of drinking suggests that large amounts of heavy drinking are occurring.

Patterns, context and overall levels of alcohol consumption influence the health of the population as a whole.

Alcohol transnationals are shifting their focus to Asia and other developing countries (young population and a growing economy) as the American and European markets are saturated. With an increase in per capita incomes, trade barriers falling, and alcoholic beverages advancing into new markets in developing countries, alcohol consumption is likely to increase.

Both beer and spirits consumption in India have been rising, possibly due to economic liberalisation of the Indian market. Privatisation and opening up the market to foreign companies dramatically changes the advertising and marketing of alcohol and most countries (such as in Asia) lack alcohol control national policies and strategies.

Alcohol Consumption Among Young in India

In contemporary India, tendency of alcohol consumption has percolated down to youth. Media has played a leading role in encouraging the use of alcohol among the youth through portrayal

of alcohol in congenial social settings, association of alcohol use with glamour and celebrity status and by using direct and indirect advertising.

Age of initiation for alcohol use has progressively reduced in Kerala (India). In 1986, the age was 19. This was reduced to 17 in 1990 and further to 14 in 1994.

Alcohol Industry is following exactly the same marketing and promotion tactics and strategies as were employed by the Tobacco Industry globally and especially in developing countries.

Trends in Tobacco Advertising and Promotion before the enforcement of tobacco control legislations in India



Direct advertising of tobacco products was rampant before the enforcement of tobacco control legislation in India. Billboard advertising of international and domestic brands of cigarettes and chewable forms of tobacco was a common sight. Surrogate Advertising (Brand Stretching) was also common.

Sponsorship of sports events and cultural events by tobacco companies were methods of promoting tobacco brand names. e.g. 'Wills' (brand of Indian Tobacco Company - ITC, a subsidiary of

British American Tobacco) used to sponsor Indian cricket team/matches. Tennis tournaments were sponsored by 'Gold Flake' cigarette (brand of Godfrey Phillips India Ltd.- GPI, a subsidiary of Phillip Morris). Boat racing was sponsored by 'Four Square' cigarettes (brand of GPI). Polo events and golf were sponsored by 'Classic' (cigarette brand of ITC). 'Charms', a cigarette brand sponsored the 'Spirit of freedom concert', a musical event.



'Manikchand', manufacturers of gutkha (chewing tobacco), patronized the Filmfare awards ceremony.

Advertising and Promotion after the enforcement of tobacco control legislations in India.

All direct advertising of tobacco products in all media has been prohibited with the enforcement of National Legislation. Surrogate advertising through brand stretching is a common practice being employed by some tobacco companies. "502 Pataka" a popular beedi (local Indian cigarette) brand is now being advertised as 502 Pataka chai (tea).

Advertising paan masala/ mouth fresheners bearing the same brand name as tobacco products is a common practice. The "Red and White" Bravery Awards are organized by GPI to advertise and promote 'Red & White' brand of their cigarettes.

Tobacco Brand Promotions: International Experience



'Marlboro' and 'Benson & Hedges' (international cigarette brands) extensively advertise by sponsoring Formula 1 race in many countries. British American Tobacco (BAT), sponsored the telecast of the World Cup to Malaysians through the Dunhill brand. BAT offered athletes and sportsmen bicycles and t-shirts. They also give sportsmen shirts imprinted with their product name/logo, e.g. TOBACCO CONGO or EMBASSY.

Lessons to be learned from tobacco

“Bristol” used to sponsor the football matches, in Sri Lanka. The series was called the Bristol Cup. At the same time, Bristol also organized and sponsored a cycle race.

Trends in Alcohol



Billboard advertising of international and domestic brands of alcohol through surrogate means is widely being employed by alcohol industry worldwide. Sponsorship of sports and cultural events is widely being undertaken by alcohol companies in India. “Royal stag” sponsors Indian cricket matches and cricket players. “Shaw Wallace” sponsored the Indian open golfing event as the Royal Challenge Indian open and the Kenya cricket team. “Seagram” sponsors events such as “Chivas Regal Polo championships” and “Chivas Regal Invitational golf challenge” for corporates.

Indirect Advertising

Teacher’s whiskey has launched the Teacher’s Achievement Awards. Other sponsored awards and events include: “Smirnoff international



fashion award”. “Lakme India Fashion Week” was sponsored by Seagram’s Blenders pride.

Surrogate Advertising

“Aristocrat” a popular whisky brand is being advertised as Aristocrat Apple Juice. “Mc. Dowell’s” is advertised as sodas, “Kingfisher” has packaged water bottles. Some alcohol brands have introduced brand promotional items such as: “Haywards 5000” has darting kits, “Bacardi” advertises through its Bacardi blast album and also advertises through parties tied up with rediff.com .



Path to alcohol control

Regulatory strategies for alcohol control thus will have to be formulated on same lines as Tobacco Control. This will require initiating efforts for alcohol control at national, regional and international levels.

Factors Contributing to Global Support for Tobacco Control

Public Outrage

Till the time tobacco use was viewed as an individual’s problem, people and policy makers maintained a luke warm attitude towards introducing any regulatory

measures. International research confirming ill effects of second hand smoke helped in influencing people’s and policy makers’ opinion related to tobacco control. Impact on legislation in India included initiatives such as: the Supreme Court of India banned smoking in public places.

NGOs played a crucial role in creating a supportive environment. Youth led campaigns appealing the government for a comprehensive ban on tobacco advertising through NGOs such as HRIDAY (Health Related Information Dissemination Amongst Youth)-SHAN (Student Health Action Network), created a supportive environment to enforce tobacco control measures.

Community support mobilized through advocacy groups such as TAT-Teachers Against Tobacco; PAT - Parents Against Tobacco and SAT - Students Against Tobacco, generated immense awareness among people to support tobacco control initiatives.

Tobacco industry documents

Revelations that tobacco companies knew all facts related to ill effects of tobacco; tobacco industry’s deceptive marketing practices and their efforts orchestrated to lure the youth into getting addicted to their products, helped in highlighting the hidden profit motives of tobacco transnationals. People and government lost confidence in the tobacco industry and their false claims were not given due importance.

Exposure of Documents targeting Women and Young People

United States Tobacco Journal stated:
“A massive potential market still exists among women and young adults, cigarette industry leaders agreed, acknowledging that recruitment of these millions of prospective smokers comprises the major objective for the

immediate future and on a long term basis as well”.



‘Marlboro’ document says:

The Marlboro Cowboy is chosen to advertise Marlboro cigarettes, “because he is close to the earth. He’s an authentic American hero. Probably the only one. And it worked”. The advertising agent responsible said “We asked ourselves what was the most generally accepted symbol of masculinity in America.”

“Younger adult smokers have been the critical factor in the growth and decline of every major brand and company over the last 50 years... Younger adult smokers are the only source of replacing smokers... If younger adults turn away from smoking, the industry must decline, just as a population which does not give birth will eventually dwindle”.

— (R.J. Reynolds Tobacco Company internal memorandum, 29 February 1984)

Litigation

Success in litigation against the tobacco industry was a landmark achievement by government and tobacco control experts.

Lawsuits

Minnesota was the first state in the USA to file an antitrust and consumer fraud lawsuit against the tobacco industry.

Lessons to be learned from tobacco

The Grounds for the Minnesota Tobacco Lawsuit were:

- Tobacco companies mislead the public about smoking and health in violation of Minnesota’s laws against consumer fraud, false advertising and deceptive trade practices.
- Tobacco companies conspired to suppress medical research and to prevent competitors from developing safer cigarettes in violation of Minnesota’s anti-trust laws.
- Tobacco companies intentionally targeted children and concealed the addictive nature of cigarettes.

Minnesota’s Tobacco Settlement achieved:

- \$6.1 billion settlement - four and one-half times the \$1.7 billion the state had sought for extra costs state programs had paid to treat sick smokers. Most of the settlement money was a sanction against the tobacco industry for what it did to addict kids and mislead the public.
- Permanent ban on tobacco marketing that targets children, enforceable with money penalties, injunctions and fines.
- \$202 million fund (3 percent of settlement) to help adults quit smoking and conduct research (called the Minnesota Partnership for Action Against Tobacco).
- Over 33 million pages of secret industry documents opened to the public, including the industry-funded Minnesota Document Depository for public use.
- The settlement proposed a permanent endowment to reduce youth smoking through counter-advertising, classroom education, community partnerships, advocacy, research and evaluation in a comprehensive program to reduce tobacco use in Minnesota.

Texas Law suit Against Tobacco

Texas was the third state in USA to settle a lawsuit against the tobacco industry, reportedly accepting at least \$14 billion over 25 years to reimburse the state for Medicaid money it spent treating smokers

Iowa Lawsuit Against Tobacco Industry

The State of Iowa has filed a lawsuit seeking to recover millions of dollars in restitution and damages from tobacco companies and their research associations. The suit seeks restitution and civil penalties on the consumer fraud count. The suit also asks the court to order the defendants to pay the State millions of dollars in restitution for costs the State paid to provide health care and other services to citizens and employees as a result of tobacco-related diseases, illnesses and injuries resulting from “the defendants’ wrongful conduct and unlawful activities.”

Law Suit Against Tobacco Industry by Attorney General Dennis C. Vacco

He filed suit against the nation’s tobacco companies, claiming that the industry deceived New Yorkers about the health effects of smoking, and illegally lured millions of teenagers to take up the deadly smoking habit. This lawsuit seeks to recoup the billions of dollars spent to treat smoking-related illnesses, including expenditures by private insurers and the taxpayer-funded Medicaid program.

In the 1988 lawsuit by the relatives of Nathan Horton who had died of lung cancer after smoking Pall Malls for thirty years, the American Tobacco Company argued, “cigarette smoking is not injurious to health. Customers are justified in relying on that statement” (Robert Heimann). And a person should not “expect to get lung cancer” or “expect to get emphysema” from

smoking Pall Mall cigarettes (Preston Leake). Also: “the Surgeon General’s dead wrong” (Robert Heimann).

The New South Wales Supreme Court awarded \$450,000 to a nonsmoking bartender after she developed throat cancer after years of heavy exposure to passive smoke. This was the first successful litigation of the kind in Australia.

Legal Law suits in India

PIL filed in the Supreme court of India (1999) by Murlu Deora, a former member of the Indian Parliament on account of inaction of the state in regulating the use of tobacco.

Voluntary Organization in Interest of Consumer Education (VOICE) filed a complaint in 1984 against the Indian tobacco Company (ITC), with the Monopolies and Restrictive Trade Practices Commission (MRTPC) for promoting cigarette smoking using contest programme.

Voluntary Health Association of India (VHAI) filed a petition in 1999 before the High court of Delhi, raising the issue of surrogate advertising by cigarette manufacturing companies by way of sponsorship of sports events.

A petition was filed by Consumer Education and Research Centre (CERC) in the High Court of Gujrat related to treatment of cancer patients recommending compensation for patients with oral cancer.

Consumer Education and Research Society (CERS) has initiated a class action suits for compensation on behalf of some patients with oral cancer, who developed the illness after being addicted to the chewing of gutkha.

Generation Saviour Association (Mohali, Punjab) filed PIL in 1996 in Punjab and Haryana High court to ban smoking in public places.

Advocacy

Efforts by national and international health bodies and NGOs influenced government nationally and internationally. International support letters and congratulatory letters mobilized through the international NGO network were well received by national government.

WHO’s intervention through Framework Convention on Tobacco Control (FCTC) was a landmark public health treaty negotiated by government of member states.

Global effort related to Tobacco Control

World Health Organization’s Framework Convention on Tobacco Control (FCTC) is the first global public health treaty developed in response to the increasing tobacco epidemic. Adopted by World Health Assembly on May 21, 2003 and came into force on February 27, 2005.

The number of countries who have signed FCTC till December, 2005 are 168 and 114 countries have ratified the Convention.

Role of NGOs in Framework Convention

An international Alliance of non-governmental organizations from around the world was formed to support the development of FCTC and combat tobacco industry disinformation. FCA now comprises of more than 200 groups from more than 90 countries. Role of FCA during FCTC negotiations of educating policymakers on various issues related to tobacco control is an excellent example of how NGOs can play a crucial role in strengthening international policies that address cross border issues.

FCA’s ‘Orchid Award’ and ‘Dirty Ash Tray Award’ were a powerful advocacy tool.

Global Link

Managed by the International Union Against Cancer, GLOBALink is the

leading international tobacco control network serving all those active in tobacco-control, and public health.

GLOBALink members range from individuals to international organizations worldwide, and include information centers, news editors, cancer societies, health educators, project officers and congress organizers. Membership to GLOBALink is free of charge.

GLOBALink offers opportunities for Electronic Conferences: This allows users to exchange views on a broad range of issues. Electronic conferences are also designed to help members get national and international support when requested.

Full-text databases: helps find appropriate information or references (news, legislation, directories); hence, a user-friendly document retrieval system provides instant access to many publications, guidelines, calendars and reports.

Home-page service: GLOBALink offers free web/list-hosting to tobacco-control organizations.

Alcohol Marketing in Asia

Transnational alcohol companies use unethical advertising and marketing tactics to get customers particularly the poor. Alcoholic drinks are advertised as products which will bring sexual prowess, success and power. Advertises blatantly make misleading claims about health such as Guinness Stout which suggests it is good for male fertility and virility. Sponsorship and philanthropic activities e.g. Guinness and Carlsberg sponsor cultural, musical and sporting events. Offering scholarships to poor students, and buying computers for rural schools.

Surrogate Advertising

There is a surrogate approach towards liquor advertising in India.



“There is not much that we can do except market ourselves through promotions with the latest being the birthday. Hollywood films like *Scent of a Woman* have helped in brand endorsement”.

- Dr. Amrit Kiran Singh, Vice President and Area Director, South Asia, Brown Forman Spirits Worldwide. *The Asian Age, New Delhi, Sep 26, 2005*

Alcohol Control Policies in Asia

Bangladesh

Law prohibits production, sale and consumption of alcoholic beverages. Importation is allowed for consumption by foreign nationals and tourists.

Bhutan

Selling alcohol under the age of 18 and driving while intoxicated are punishable offences. Fixed limits on brewing to prevent food scarcities.

Indonesia

The Food and Drug Directorate General in the Ministry of Health controls the production and distribution of alcoholic beverages.

Maldives

Law prohibits consumption of alcohol by citizens. Consumption of imported alcoholic beverages by tourists in specified resorts is permitted.

India

Cable Television Network (Regulation) Amendment Bill, 2000, completely prohibits cigarette and alcohol advertisements, which directly and indirectly promote sale of these products (enacted from September 8, 2000).

Nepal

Hotel business and liquor sale and distribution Act (1966) prohibits sale of liquor to anyone under 16 years of age.

No policy to curb the production or sale. Licence to be obtained under the liquor Act (1971) for producing, selling, importing and exporting liquor. Clause 7 of the act allows anyone to produce a small amount of liquor without licence.

Sri Lanka

Alcohol advertising is not permitted on television or radio.

Adverts are freely allowed in print media and on billboards.

Legal minimum drinking age was changed from 20 to 18 in 1993. Special licences for alcohol sales for sporting events.

Licences available for hotels with only 5 rooms.

Thailand

Banning sales to under 18. Warning labels on alcoholic beverage containers and advertising “alcohol

decreases driving ability”. Restriction on alcohol advertising for beverages containing alcohol more than 15 degrees that is banned on radio and television during the period 05.00 – 22.00. Blood alcohol concentration limits for drivers (0.05G percent).

What is needed to reduce the impact of alcohol on health and society:

There is need to advocate for comprehensive national and sub-national policies. Measures to educate the public about dangers of unhealthy use of alcohol. Regulate consumption through legal interventions. A comprehensive ban on alcohol advertising needs to be effectively enforced. Measures that restrict access to Youth need to be introduced. Regulating cross border issues through a Framework Convention on Alcohol control.

Alcohol to be treated as an extraordinary commodity and measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements.

Regional and International efforts needed for alcohol control

Different countries have alcohol policies with varying degrees of emphasis on control of production, distribution and promotion on health education and treatment. Very few countries (especially developing countries) have a comprehensive alcohol control policy.

Global leadership is required to combat the alcohol problem at global level. With the globalization of alcohol markets, alcohol control measures also need to have global inter governmental focal point on alcohol and public health. Though action is required at national level, international bodies and agreements play a crucial role in

Lessons to be learned from tobacco

dealing with issues such as tobacco and alcohol.

Learnings from best practices

Sharing evidence from both developed and developing countries that demonstrates that there are effective policy tools that can be used and recommended to individual governments to reduce alcohol related problems at country level and globally.

Subsequently promote national and sub-national policies that follows 'best practices' from the developed countries that can be adapted by developing countries with appropriate modifications. International trade agreements need to be closely monitored and advocacy needs to focus

unanimously on treating alcohol as an extra-ordinary commodity and should be excluded from these trade agreements.

National and international policies and partnerships are needed to empower communities and to protect them from dangers of alcohol addiction both directly and indirectly. Balanced policies and programmes with regards to the consumption and production of alcohol need to be advocated to national government at all levels and in different sectors.

Effective legislative measures should be recommended to government for inclusion in comprehensive National Alcohol Control Policies. These should include: minimum drinking age, price and taxation

mechanisms and controls on marketing and availability.

Multidisciplinary stakeholders (NGOs, youth groups, women organizations, partners interested in avoiding road accidents, scientists, medical societies and health professionals) need to be brought together at each country level to work collectively on alcohol control that requires a multi-sectoral response. It is also important to train people in these sectors about alcohol issues and to provide specialized training in initiating appropriate advocacy with the government at national level and motivate government to connect at regional and international level for comprehensive global policy on alcohol control.

the Pacific Islands. He particularly welcomed delegates from the Asia Pacific Region, New Caledonia, Fiji, Kiribate, Marshall Islands, Papua New Guinea, Cook Islands, Samoa, Solomon Islands, Tonga, Vanuatu, Cambodia, China, India, Korea,, Malaysia, Mongolia, Nepal, Philippines, Sri Lanka, Thailand and Vietnam.

Dag Rekve of WHO presented the background and the content of the resolution passed by the Fifty-eighth World Health Assembly in May 2005 (WHA58.26 Public Health Problems Caused by Harmful Use of Alcohol).

Dr. Xiandong Wang from WPRO informed the meeting that a Regional Strategy was being developed and consultation on a draft will be undertaken at a technical meeting in Manila in March 2006. It is anticipated the strategy will be on the agenda for the WPRO Regional Committee meeting in September 2006. It is intended to be used as a framework for national policy and an action plan; to be guiding regional and sub-regional collaboration; and to be a tool for advocacy.

During the conference it became evident that whether one came from a small island or a large country there was a commonality of problems which NGO's faced. All were experiencing an increase in alcohol consumption and related harm especially among young people. Countries had much to share with one another and the need to establish a network of non governmental organizations throughout the region was unanimously agreed.

Meeting of NGOs from Asia-Pacific region on alcohol policies

Organized by Global Alcohol Policy Alliance (GAPA) and SHORE (Centre for Social and Health Outcomes Research and Evaluation), Massey University, co-sponsored by the World Health Organization. Auckland, New Zealand, 9-12 December 2005

In December 47 representatives from 26 countries gathered at Massey University for the opening of the conference. The objectives of the meeting were to:

- Build a network of NGOs in the region, involved in supporting effective alcohol policies
- Build regional/sub regional linkages between NGOs, key agencies and civil society
- Strengthen awareness and

understanding of effective alcohol policy in the Asia Pacific region

- Engage NGOs in the region in community action to support development and implementation of effective alcohol policy

Dr Ashley Bloomfield, on behalf of the New Zealand Ministry of Health, welcomed delegates to the meeting. The Ministry had helped to sponsor the meeting with a grant from New Zealand Aid to bring delegates from



Dr. Xiandong Wang



Dr Ashley Bloomfield



Dag Rekve

Letter of Asia- Pacific Nongovernmental Organizations to WHO

After the meeting the nongovernmental delegates held a meeting to formulate the following letter to the WHO.

“The delegates welcomed the WHA resolution and expressed appreciation of the fact that it recognised the role of NGOs in requesting member states to encourage mobilization and active and appropriate engagement of scientific, professional, non governmental and voluntary bodies and civil society in reducing harmful use of alcohol and that the resolution requests the Director-General to collaborate with non governmental organizations to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption.

We note the inclusion of the industry sector in the resolution. We acknowledge they have a limited role in the implementation of policy but reaffirm our belief that it is inappropriate for them to be engaged in the development of alcohol policy.

Concern was also raised over the request to the Director-General “to organize open consultations with representatives of industry and agriculture and trade sectors of alcoholic beverages in order to limit the health impact of harmful alcohol consumption”. We request WHO to ensure that the nature of the open consultation does not imply partnership nor does the communication between the

industry and WHO have the character of negotiations.

We recall the statement made in the European Ministerial Conference, Stockholm, 2001, in which it is stated that public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests.

Alcohol situation in the countries represented

Despite the diversity of the cultures represented there was a commonality in the adverse consequences that the countries are experiencing from the rapidly expanding availability, affordability and marketing of alcohol.

In many of the low to middle income countries represented there is a lack of local research and statistical data that makes advocating for the implementation of evidence based policies difficult.

Alcohol policy

The lack of implementation of evidence based effective policies and in some areas the absence of policies was noted. It was considered that the active role of the alcohol industry in promoting industry-friendly, ineffective policies, government acquiescence in this, and a lack of critical media comment were major contributors in the countries represented in the meeting.

A strong evidence base is available to indicate which policy measures are effective and which are not, as presented in the comprehensive WHO-sponsored study by Babor et.

al.: Alcohol – No ordinary commodity. However, we are pleased that the resolution requires the Director-General to report to the Sixtieth World Health Assembly on evidence based strategies and interventions to reduce alcohol related harm and we look forward to new evidence particularly pertaining to implementation of effective policies in low and middle income countries in the Asia-Pacific region.

Role of NGOs

In many countries there is a lack of adequate resources for NGOs to play an important role in alerting decision makers and civil society about the harm from alcohol use.

Despite the meagre resources available to NGOs the meeting heard many examples of the good work done by NGOs in relation to reducing alcohol related harm.

An Asia-Pacific Alcohol Policy Alliance

We have witnessed the increased globalisation and consolidation of the alcohol industry, in the context of economic liberalisation and free trade. We are concerned that this has increased the relative power of the industry and especially its ability to market its product and promote industry friendly policies.

As representatives of nongovernmental organizations we recognise the need for a regional network of NGOs. This will engage with member states of WHO and regional and international bodies. It will promote effective evidence-based policies to counter the marketing strategies of industry and its encouragement of ineffective policies. It will support and strengthen the work of NGOs throughout the region.”

Alcoholism – before and after tsunami

J. Dinakarlal Thavamony

The tsunami attack on the coast of the Indian peninsula on 26 December, 2004 has had a devastating and shocking effect on all spheres of life. This has jeopardized the life, economy, peace and livelihood of those living on the coastline, especially the fishing communities. The worst affected are Nagai, Cudalore and Kanyakumari Districts of the State of Tamilnadu.

Though rescue operations were not that easily possible, due to the lack of preparedness, the force and power of the tsunami waves and the threat of recurrence, people all over the world were generous in rushing quick, spontaneous and liberal humanitarian assistance for relief operations. The huge loss suffered by the people cannot be amply compensated. Their derailed life with the loss of fishing gear kept on the shores and the present fear they have for the sea, have made fishing almost an impossible activity. The Government of India and the State Government of Tamilnadu came out with compensations for the loss of life, property and livelihood and NGOs and relief agencies all over the world supplemented Government’s operations with sumptuous relief materials.

At the time the Government of Tamilnadu gave cash relief to the affected victims in two installments, a total of five thousand rupees per family besides the compensation for the loss of life and property.

Besides the money, the Government also gave sufficient quantity of rice and basic household articles. The affected families received from generous NGOs and international charitable organizations copious supply of dress, vessels, toilet items, baby food, water storage vessels etc. A day after the Government gave the first installment of cash as relief, it ordered closure of 19 liquor shops close to the coastal belt. (In the

State of Tamilnadu all liquor shops are run by the Government owned Tamilnadu State Marketing Corporation. In the District there are 150 liquor shops with a total sales of Rupees 5000000 to Rupees 7000000 per day on an average.) The reason behind this was that the money given by the Government as relief was used by men for purchasing alcohol and this led to a lot of confusions, including shortage of liquor in the shops leading to fights with the sales persons and frequent drunken brawls.

In the light of this, one has to look into the issue of alcohol abuse in

the fishing hamlets of Kanyakumari District, which is known for the excessive use of alcohol, with 87.1% men using alcohol and 56.27% income of men of the fishing community spent on liquor. Some of the questions that arose: Has alcohol consumption in the coastal fishing hamlets increased after tsunami? Was the major portion of money given as relief spent on alcohol, thereby defeating the very purpose of relief? If this is true, can any meaningful and effective rehabilitative measures be undertaken?

How can we justify the waste of money collected from various sources throughout the world from people who have humanitarian concern for the fellow sufferers? Or should we ignore it saying that it is not a case of abuse of alcohol, but rather a use of it to tide over the agonies consequent to loss of life and properties? Before we answer any of these questions we should have a look at the damage suffered in this District due to the tsunami and also at the data on alcohol consumption before and after the tsunami.

Kanyakumari District with 68 kilometres of coastline had 846 tsunami deaths in the fishing hamlet; 5257 houses, 402 fibre boats, 1423 country boats, 6892 catamarans and 24385 fishing nets were destroyed, leaving many injured and 106 persons missing. It is estimated that this District suffered a loss of Rs.261.776 crores. The worst affected fishing hamlets are Colachel, Kottilpadu, Pillaithepe, Azhikkal, Melamanakudi and Keelamanakudi.

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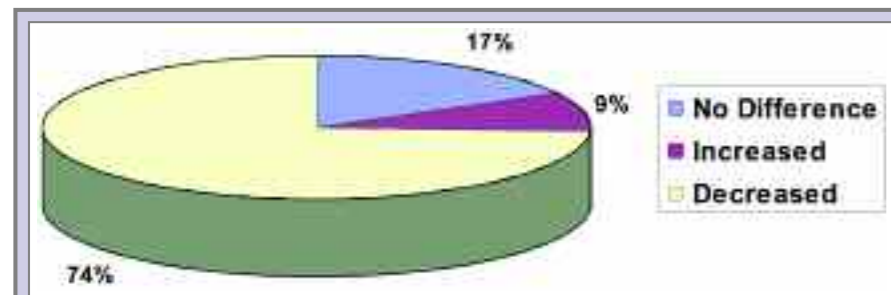


Diagram 1: difference in alcohol consumption after tsunami

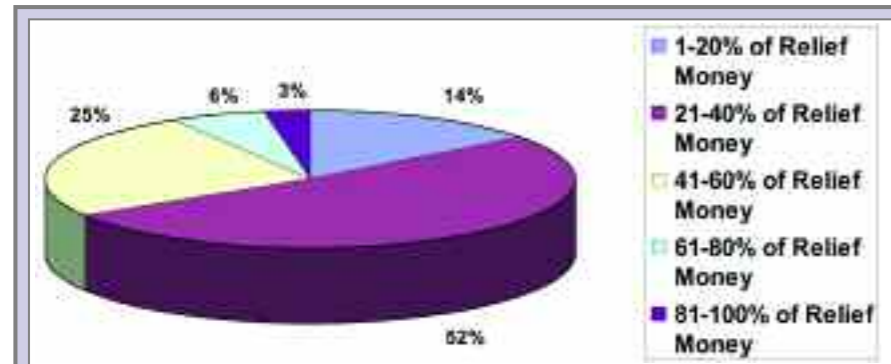


Diagram 2: percentage of relief money spent on alcohol

Shop	Nov 2004	Dec 2004	Jan 2005	Feb 2005
Colachel 1 Shop no. 4805	2998330	1340686	2379640	2198371
Colachel 2 Shop No. 4806	1305131	1373277	1485309	1696879
Colachel 3 Shop No. 4807	1836349	1730273	1501566	2574048
Udayarvilai Shop No. 4804	770103	825531	836941	893950
Total	6909913	5269767	6203456	7363248

Table 1 : TASMACH SHOPS : sales In Indian Rupee before and after tsunami

It must be noted that the sales in the month of January 2005 was completely stopped from the 1st to the 5th in the three shops in Colachel and from the 2nd to the 5th in Udayarvilai. In spite of that it has not shown much of a decrease in January.

Shop	Dec.24, 2004	Dec.31, 2004
Colachel 1 Shop No. 4805	243440	37997*
Colachel 2 Shop No. 4806	112283	35740*
Colachel 3 Shop No. 4807	166494	22280*
Udayarvilai Shop No. 4804	60114	101450

Table 2: TASMACH SHOPS : Sales on Christmas Eve and New Year Eve, 2004

* Shops closed before dusk on 31 Dec, 2004

To understand the problem of alcoholism after the tsunami a study was conducted in the six worst affected fishing hamlets. 76.8% of the men interviewed were in the habit of consuming alcohol. They said that they were spending 604 rupees per week on an average on alcohol before the tsunami. They claim that, as tsunami has jeopardized fishing activities, they are not able to spend that much on alcohol now, and according to their statement the average amount spent on liquor now works out to 419 rupees per week. Their contention is that, now they spend on alcohol only 69.26% of the amount they were earlier spending. According to the data collected, 17.14% persons show no difference in the consumption of liquor after tsunami. 8.57% have increased and 74.29% have decreased consumption.

Men in these fishing hamlets agreed that they used the relief money given by the government to purchase alcohol. Out of the sample interviewed, 14.28% spent 1 to 20 % of the relief money on alcohol; 51.42% spent 21 to 40% and 25.71% spent 41 to 60%. Whilst 5.71% admitted to have spent 61 to 80% of the relief money on alcohol, 2.85 % spent the entire relief amount on alcohol.

Though incidents of tsunami victims selling relief materials to buy alcohol are reported, none of the victims interviewed said that they sold relief materials.

Visit to the tsunami affected hamlets, especially at night, does not show any sign of reduction in alcohol consumption as claimed by the victims. Some of the victims interviewed claim that in the absence of fishing activity, they don't get any money to buy liquor. Hence a study was conducted in four shops close to the worst affected hamlets Colachel and Kottilpadu. The sales in these shops

Alcoholism – before and after tsunami

in the months of November and December, 2004 and January and February, 2005 show that there is an increase in the sales in three shops. This disproves the claim of the victims that there is a decrease in the consumption of liquor after tsunami.

Due to violence and riot Shop Nos. 4805, 4806 and 4807 were closed down well before the dusk on 31 December, 2004, just five days after tsunami and the day the victims got the first installment of relief money. A comparison between sales on

Christmas and New Year Eves in Shop No. 4804 shows that tsunami has not affected the sale of alcohol, instead, the relief money has increased the sales.

What do these data point at? Let us not be judgmental and point our accusing finger saying that the relief money has only helped in increasing the consumption of alcohol. Every victim has a sad story to narrate and a justification to give in using alcohol as a coping mechanism.

What should be the concern of one who is involved in the fight against alcohol and what is the lesson that has to be learnt? A lot of effort is to be put in to bring about reduction in the consumption of alcohol by men in the coastal fishing hamlets if any effective developmental activity is to take place. The Government and international organizations like the WHO has to look into the health of the tsunami victims, with a focus especially on alcohol induced diseases. It must also be reiterated here that unless the international

One of the relief efforts

Dr Arulraj from his hospital in Tuticorin, Tamil Nadu was able, with support from friends in the UK, to carry out relief work to the widows and orphans in his area. A children's day care centre was established providing play and educational materials. Sewing machines were distributed to widows and tricycles for five physically handicapped children; distributed saris and cloth to women and children, and provided schoolbags to children. Four medical camps were organised and a training programme was carried out with social workers and volunteers to support women and children suffering from trauma.



charitable and relief organizations that have come forward to undertake relief and rehabilitation work, address themselves to the issue of alcoholism in the tsunami affected fishing hamlets of Kanyakumari District of the State of Tamilnadu, their attempts to mitigate the sufferings of the victims through humanitarian aid, will not bear the desired fruit.

The State Government earns good revenue through sales of liquor and so it has the responsibility of taking care of the health needs of the

people, especially diseases caused by alcohol. The liquor policy should be looked into and a part of the revenue should be set apart for prevention, treatment and rehabilitation. International organizations and charitable institutions in the West should keep a part of the relief money intended for tsunami victims to fight against alcoholism. Setting up counseling centres, and treatment centres for alcoholics of the coastal area will go a long way in rehabilitating the tsunami victims.

About the author: Prof. J. Dinakarlal Thavamony, who is teaching English in Scott Christian College, Nagercoil, Tamilnadu, India has worked on “Impact of Alcoholism on Women in the Fishing Hamlets of Kanyakumari District” for his Ph.D



New research underscores need to reduce youth exposure to alcohol ads

Young people exposed to more alcohol advertisements tend to drink more alcohol, according to a new study in the January issue of Archives of Pediatrics and Adolescent Medicine.

Young people are beginning to drink at an earlier age than ever before and their actions can have consequences ranging from poor grades to alcoholism and motor vehicle crashes, according to background information in the article. Several studies have found an association between exposure to alcohol advertisements and youth drinking, but have not been able to establish whether heavier drinkers pay more attention to advertising or whether the advertising influences youth to drink, the authors write. The alcohol industry in the United States has no federal restrictions on its advertising but is subject to voluntary codes dictating that 70 percent of the audience for their advertisements be adults older than age 21. The authors report that these ads still appear frequently in media more likely to be seen by young people than by adults.

Dr Leslie B. Snyder, of the University of Connecticut, Storrs, and colleagues interviewed a random sample of young people aged 15 to 26 years in 24 U.S. media markets four times between 1999 and 2001. The researchers interviewed 1,872 young people in the first wave, 1,173 of the same respondents in the second, 787 in the third and 588 in the fourth.

Young adults who reported viewing more alcohol advertisements on average also reported drinking more alcohol on average—each additional advertisement viewed per month increased the number of drinks consumed by 1 percent. The same percentage increase, 1 percent per advertisement per month, applied to underage drinkers (those younger than age 21) as well.

The authors also analyzed youth drinking in relation to advertising dollars spent in respondents’ media markets, based on information purchased from an industry source. They also purchased information about total alcohol sales in each state. “It is important to control for total alcohol consumption levels because markets with greater sales may attract more alcohol advertising from brands competing to sell in markets with more heavy drinkers,” they write. Even with this control, young people drank 3 percent more per month for each additional dollar spent per capita in their market. Youth in markets with high advertising expenditures (\$10 or more per person per month) also increased their drinking more over time, reaching a peak of 50 drinks per month by age 25.

“Given that there was an impact on drinking using an objective measure of advertising expenditures, the results are inconsistent with the hypothesis that a correlation between advertising exposure and drinking could be caused entirely by selective attention on the part of drinkers,” the authors report. “The results also contradict claims that advertising is unrelated to youth drinking amounts: that advertising at best causes brand switching, only affects those older than the legal drinking age or is effectively countered by current educational efforts. Alcohol advertising was a contributing factor to youth drinking quantities over time.”

In an accompanying editorial, **Dr David H. Jernigan**, of the Center on Alcohol

Marketing and Youth at Georgetown University, Washington, D.C., comments: “The work of Snyder et al marks the first time that a national longitudinal sample of young people in the United States has been studied and the first time that self-reported exposure has been complemented by an objective measure of how much alcohol advertising is available in the media environment in which young people live,”

He goes on to say that the paper “calls into question the industry’s argument that its roughly \$1.8 billion in measured media expenditures per year have no impact on underage drinking. The fact that young people, regardless of drinking behavior at baseline, were more likely to drink more over time in environments with more alcohol advertising, even when controlling for alcohol sales in those environments, suggests that it is exposure to alcohol advertising that contributes to the drinking, rather than the reverse.”

These and other recent findings, Dr. Jernigan writes, “point to alcohol advertising as an important arena

for interventions seeking to reduce underage drinking and its tragic consequences.”

The study, funded by the National Institute on Alcohol Abuse and Alcoholism, is the first-ever national longitudinal survey of the influence of alcohol advertising on youth.

For more information, e-mail mediarelations@jama-archives.org



First Pan American conference on alcohol policy

Country representatives, researchers and alcohol policy experts from 27 countries met in Brasilia, Brazil from November 28-30 for the first ever Pan American Conference on Alcohol Policy, co-sponsored by the Pan-American Health Organization (the regional office of WHO for the Region of the Americas) and the National Anti-Drug Secretariat of the Brazilian government.



The Region of the Americas has one of the highest burdens of disease resulting from alcohol use of any region in the world. Across the entire region, 4.8% of deaths and 9.3 percent of the total burden of disease is attributable to alcohol.

In the low child and adult mortality countries of Latin American in particular, male mortality and years of life lost due to disability and death caused by alcohol (DALYs) are extremely high. For 15-29 year old

males in these countries, 24.7% of deaths and more than 30% of DALYs are caused by alcohol.

Experts, practitioners and policy makers from 14 countries made presentations to the conference. Highlights included a speech by Jorge Armando Felix, Minister of the Institutional Security Cabinet and President of the National Anti-drug Council in Brazil, who opened the meeting by saying that it was important to monitor the impact of

alcohol on work, life, and health. Brazil is creating an inter-ministerial group to work on an alcohol public policy since 11.2% of the population is alcohol dependent and 65.2% of middle and primary school children have tried alcohol.

Jurgen Rehm, commenting on the relationship between alcohol consumption and harm, stated that it is important to address patterns of drinking as well as overall level of drinking. For some disease conditions, there is a dose-response relationship to alcohol consumption.

For instance, if you drink 2 drinks a day you have a 12% higher risk breast cancer, and if you drink 4 drinks per day the risk of breast cancer is elevated by 24%. Global estimates of alcohol's contribution to the burden of disease assume that some patterns of drinking may have health benefits, but less than 1% of the population is drinking in a pattern that is protective for the heart, and many people are drinking too much on certain days resulting in injuries, alcoholic cardiomyopathy and mental disorders.

Ronaldo Laranjeira demonstrated the effect of limiting bar opening hours in Diadema, Brazil. This district near Sao Paulo had been known as the homicide capital of the country because of its high murder rates. In 1999, the district had approximately 4,800 bars, more than 1 bar for every 800 inhabitants.

In 1999 there were 374 homicides in the district with 49.47% of the homicides occurring between 21.00 hrs – 06.00 hrs. In 2002 the authorities cut the hours of opening to 06.00 hrs to 23.00 hrs. Evaluation of the law's effects showed that after two years it had led to a drop in homicides of 45% (some 273 lives saved) and a reduction in violence against women of 25.8% (224 aggressive incidents prevented).

Michelle Swenarchuk speaking about WTO trade rules said that although governments may adopt "necessary" measures to protect public morals and health, in 12 out of 14 trade disputes over domestic regulations, the challenged regulation was found not 'necessary' by trade panelists. She concluded that the health policy exception is not a reliable defense when a measure is challenged.

The World Spirits Alliance has set trade liberalization as a high priority. Among its objectives are significant liberalization and, where possible, elimination of tariffs including the removal of 'peak' tariffs; liberalization of non-tariff trade barriers and of restrictions on services including distribution and advertising; and enhanced measures to facilitate trade in distilled spirits. The EU is pressing

countries to remove alcohol controls and restrictions. Current negotiations over the General Agreement on Trade in Services (GATS) are pressing for a 'necessity test' suggesting that 'restrictions or prohibitions on marketing and advertising' to be subjected to such a test.

Swenarchuk urged health officials to become involved in trade policy formations; to intervene in current GATS negotiations to prevent liberalization that undermined alcohol controls; and to promote increased political oversight of trade negotiations in order to introduce balance in trade policy goals.

Robert Sparks told the conference that in a media intensive society, meanings and values connected with drinking are increasingly shaped by the mass media, television, movies, music and consumer brand advertising. Major international drink corporations are using sport and event sponsorship increasingly to gain competitive advantage in the global market. Consequently there is a need to assess the impact of alcohol sponsorship and alcohol control policies in more global terms.

The advantage of sponsorship for the alcohol industry is the political

impression it gives of corporate good citizenship; exploits under developed markets and develops strategic alliances. Beer sponsorship in particular improves the image and desirability of beer promoting an image of fun and increases the number of beer drinking occasions.

"We are seeing a growing sophistication and integration of sponsorship linked marketing methods" said Sparks. Sports sponsorship functions as an implicit form of social marketing, attributes socially desirable qualities to alcohol products, and raises the question "Does alcohol sponsorship affect consumption?" Sparks maintained that youth have been found to be particularly vulnerable to sponsorship messages. Sponsorship insinuates beer and drinking into youth culture, outside the context of family controls and normalises association between masculinity, sport and beer. Sparks referred to the view of Patrick Stokes, the Chief Executive of Anheuser Busch, that sponsorship sells drinking as a functional component of socializing, dating and having fun. Sparks concluded that the challenge of such sponsorship required a cross-national global strategy.

Following three days of presentations and discussion, the conference participants adopted the following declaration:

BRASILIA DECLARATION ON PUBLIC POLICIES ON ALCOHOL

The participants of the First Pan American Conference on Alcohol Policies held in Brasilia, Brazil, on 28-30 November 2005:

Recalling and reaffirming the World Health Assembly Resolution (WHA) 58.26 of the World Health Organization, which urges Member States to develop, implement and evaluate effective strategies and programs for reducing the negative health and social consequences of harmful use of alcohol;

Recognizing that scientific evidence has established that hazardous and harmful consumption of alcohol causes premature death, disease and disability;

Concerned that in many countries there is significant unrecorded alcohol consumption, and recorded production and consumption of alcohol is at high and rising levels;

Recognizing that the harm done by alcohol is a national and regional public health and social problem in the Americas, despite the cultural differences between the nations;

Alarmed that alcohol is the leading risk factor for the burden of disease in the Americas and alcohol-related harms have been neglected in the Region;

Recognizing that alcohol is also a cause of violent deaths, intentional and unintentional injuries, particularly among youth;

First Pan American conference on alcohol policy

Noting that alcohol is also a cause of death, disability and social harms to people other than the drinker;

Aware that the few studies that exist of the costs of alcohol use suggest that alcohol problems create heavy economic as well as health and social burdens;

Concerned that alcohol interacts with poverty to produce even greater consequences for those who do not have access to basic resources for health and sustenance;

Concerned that indigenous peoples, migrants, streetchildren and other highly vulnerable populations in the Americas suffer disproportionately from the negative impact of alcohol;

Emphasizing the risk of harm due to alcohol consumption during pregnancy;

Recognizing the threats posed to public health by the increased availability and accessibility of alcoholic beverages in many countries in the Americas;

Concerned that alcohol advertising, promotion and sponsorship are reaching young people, and undercut efforts to reduce and prevent underage alcohol use;

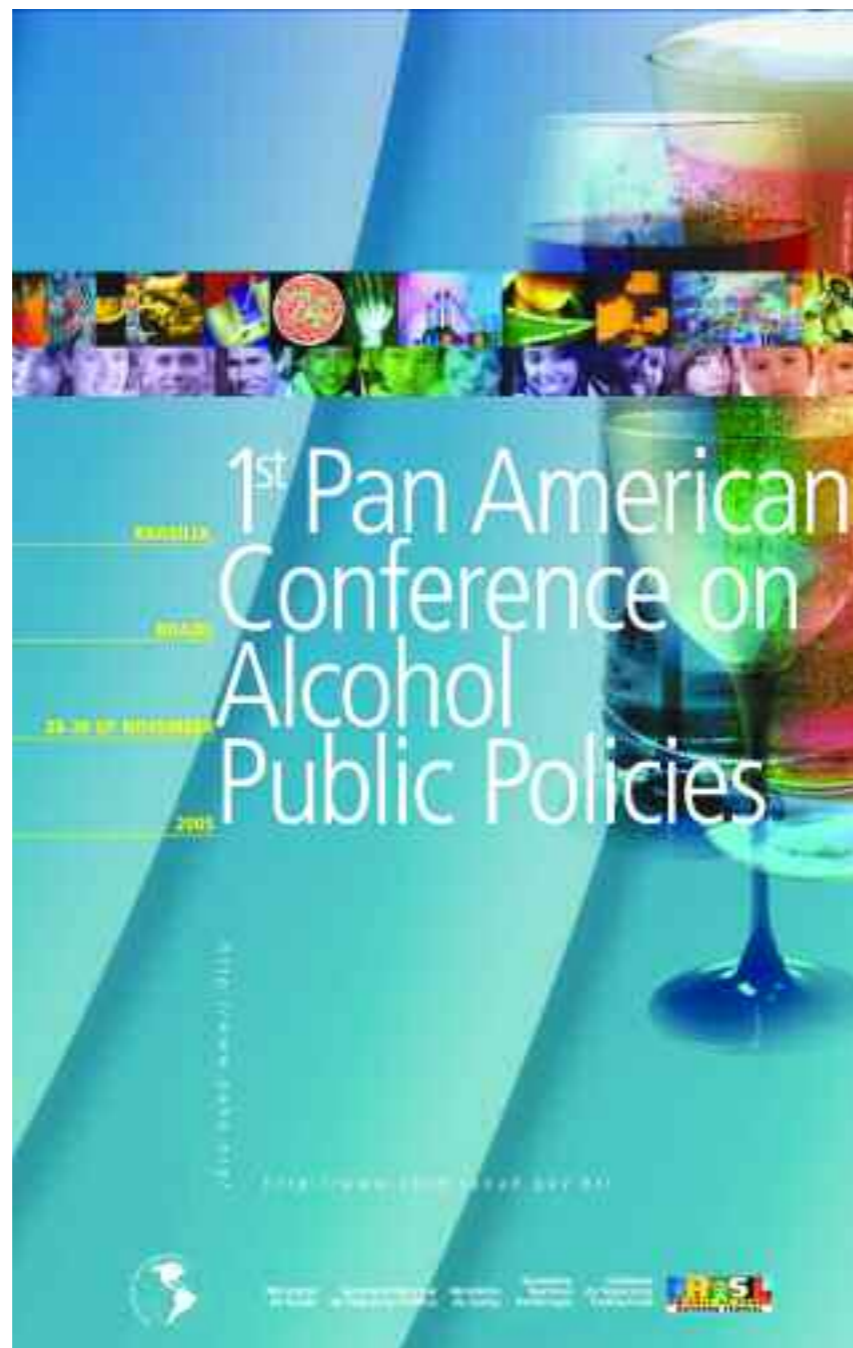
Mindful of compelling evidence of the effectiveness of strategies and measures aimed at reducing alcohol consumption and related harm;

Recognizing that the approaches related to harmful consumption of alcohol should consider different models and especially the strategies for reduction of social harm and health harm;

Recognizing that international cooperation and the participation of all countries in the Region is needed to reduce the negative health and social consequences of alcohol consumption;

Recommend

- Preventing and reducing alcohol consumption-related harms should be considered a public health priority for action in all countries of the Americas.
- Regional and national strategies need to be developed, incorporating culturally-appropriate evidence-based approaches to reduce alcohol consumption-related harm.
- These strategies need to be supported by improved information systems and further scientific studies of the impact of alcohol and the effects of alcohol policies in the national and cultural contexts of the countries of the Americas.



- A regional network of collaborators on the reduction of alcohol consumption-related harms, nominated by the countries of the Americas, should be established, with the technical cooperation and support of PAHO.
- Alcohol policies whose effectiveness has been established by scientific research need to be implemented and evaluated in all countries of the Americas.
- Priority areas of action need to include heavy drinking occasions, overall alcohol consumption, women (including pregnant women), indigenous peoples, youth, other vulnerable populations, violence, intentional and unintentional injury, underage drinking, alcohol consumption-related injury and alcohol use disorders



Further publications available from the Institute of Alcohol Studies

Counterbalancing the Drinks Industry

Counterbalancing the Drinks Industry: A Report to the European Union on Alcohol Policy

A response to a report published by the European drinks industry and a defence of the WHO Alcohol Action Plan for Europe.

Alcohol Policy and The Public Good

Alcohol Policy and the Public Good: A Guide for Action

An easy-to-read summary of the book written by an international team of researchers to present the scientific evidence underpinning the WHO Alcohol Action Plan for Europe

Medical Education

Medical Education in Alcohol and Alcohol Problems: A European Perspective

A review of educational programmes on alcohol and alcohol problems in European medical schools, identifying gaps in provision and proposing guidelines for a minimal educational level within the normal curriculum of under- and post-graduate medical students.

Alcohol Problems in the Family

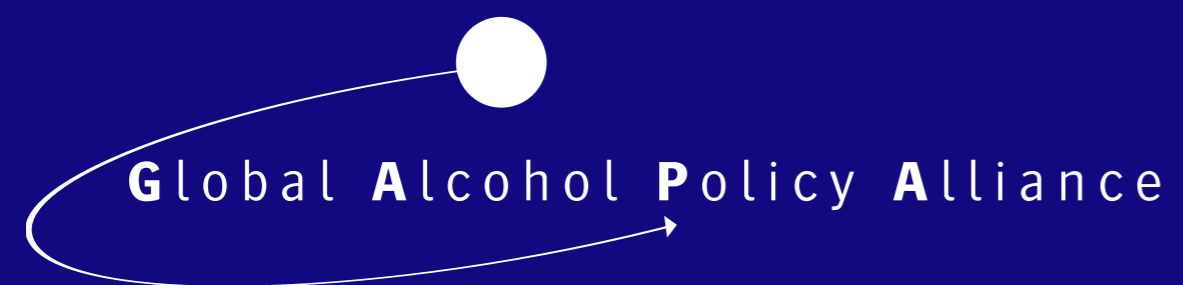
Alcohol Problems in the Family: A Report to the European Union

A report produced with the financial support of the European Commission describing the nature and extent of family alcohol problems in the Member Countries, giving examples of good practice in policy and service provision, and making recommendations to the European Union and Member Governments.



Marketing Alcohol to Young People

Children are growing up in an environment where they are bombarded with positive images of alcohol. The youth sector is a key target of the marketing practices of the alcohol industry. The booklet depicts the marketing strategies of the industry and shows how advertising codes of practice are being breached.



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