IAS Response to WHO Global Alcohol Action Plan

Introduction

The Institute of Alcohol Studies (IAS) welcomes the '*Working document for development of an action plan to strengthen implementation of the Global Strategy to reduce the harmful use of alcohol*' (AP). We share the view expressed in the document that progress on the WHO Global Alcohol Strategy (GAS) has been insufficient and uneven. As outlined the impact of alcohol remains enormous, reaching well beyond individual health consequences and contributing to violence, domestic abuse, crime, and road deaths. Yet, reducing alcohol harm is not given sufficient prominence in policy discussions and agendas across national and international levels.

We agree with the suggestion in the AP that there are early indications of the global pandemic potentially magnifying these impacts: in England, the pandemic has been met with an increase in higher risk drinking.[1] And yet, the global response to the crisis also presents an opportunity. For many countries, COVID-19 has made clear our dependence on emergency health care, hospitals, social care, and police – all core services on which alcohol impacts and which must be protected from avoidable pressures. Furthermore, the disproportionate impact of COVID-19 on those with underlying conditions has illuminated the need to prioritise a preventative policy agenda, of which reducing alcohol harm must be a part.

This makes the AP's success in progressing the GAS essential, and we commend the bold new approach that it represents. We are, however, concerned that the enormous breadth of policies and actions covered risks some of the key priorities being lost in the complexity. We believe that a concise, simpler document with clear aims and objectives linked to well-defined targets and indicators has the best chance of making a tangible difference to the implementation of the GAS.

To that end we will first provide feedback on the structure of the AP and suggest a framework that we think would improve clarity. Secondly, we will provide some suggestions on the content of the document itself.

Suggestions for structural changes

IAS welcomes the ambition of the AP and the range of actions included speaks to the breadth of the problem. We recognize however, that this document sets out an ambitious agenda with numerous targets and actions allocated to a relatively small group of stakeholders, including the WHO Secretariat. The high number of actions, that are not always clearly linked to operational objectives or goals, creates the risk

[1] Public Health England (accessed November 2020). Wider impacts of COVID-19 on health (WICH) monitoring tool.

that the AP will become unwieldy and challenging to effectively implement and/or monitor. In order to strengthen the likelihood of the AP's success, we propose that actions are prioritized based on evidence of effectiveness to encourage efficient resource utilization. Such a prioritization exercise could follow a framework that outlines how proposed actions will help WHO meet its overarching goal of reducing alcohol harm. The incorporation of a logic model or theory of change approach could help to map how activities produce relevant outputs that lead to outcomes, which in turn contribute to broader goals.

To improve clarity, actions for each stakeholder group could be consolidated to demonstrate their relevance to WHO goals, alongside clearly defined roles and responsibilities. We also suggest that expected timelines are given for all activities listed in the AP, including timelines for monitoring and reporting on progress. In that regard, we support the Global Alcohol Policy Alliance (GAPA) proposal to require biennial reporting to the WHO Director General on progress and any challenges identified in implementing the AP at the World Health Assembly.

Suggestions

- Consider an alternative framework for mapping the actions within the document, such as a logic model;
- Prioritise and consolidate the total number of actions within the document;
- Group actions, roles and responsibilities for each stakeholder group separately; and
- Include specific and accountable timelines on all appropriate actions.

Suggestions for content

The role of industry actors

It is IAS's position that the alcohol industry has a clear conflict of interest in public health policy settings due to the health impacts of its products and reflected in its financial and legal obligations to shareholders. Therefore, alcohol industry representatives have no place in the formulation or enforcement of policies to reduce alcohol harm. The alcohol industry has a long and consistent record of obstructing or undermining effective policies. For example, the direct opposition to a SAFER policy is illustrated by the Scotch Whisky Association's protracted legal challenge to minimum unit alcohol pricing and the documented evidence that demonstrates bodies associated with the alcohol industry misrepresent the link between alcohol and cancer.[2]

We welcome the AP's acknowledgement of this challenge, for example the reference to the "*inherent contradiction between the interests of alcohol producers and public health*" and the recognition that the policy process at country level is "*heavily influenced by the commercial interests of alcohol producers and distributers*" (page 4). We also welcome the effort to tightly define the role of industry and support the

[2] The Guardian (2017). UK supreme court rules minimum alcohol pricing is legal; and Petticrew, M. (2017). How alcohol industry organisations mislead the public about alcohol and cancer.

statement that the AP will work to "*ensure that development, implementation and evaluation of alcohol policy measures are based on public health goals and the best available evidence and are protected from interference from commercial interests*" (page 12).

However, we believe that across the document as a whole this effort is undermined by the inclusion of the alcohol industry in every action area. Irrespective of how effectively the limited role of the alcohol industry is defined, this implies that they can contribute towards every aspect of the action plan, which is not the case. Alcohol industry representatives have misrepresented their restricted role as outlined in the Global Alcohol Strategy, which resulted in former WHO Director General Dr Margaret Chan issuing a public statement in 2014 confirming the WHO position that "the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests".[3] As aforementioned, we believe that a balance could be struck by limiting the discussion of industry activities largely to a specific section and consolidating the limited roles attributed to them. This would give scope to more precisely delineate their role, without creating the false impression that industry have an active role in all areas, and helping to protect against erroneous and damaging claims of partnership.

Suggestions

- Maintain the recognition of the influence of industry and the importance of industry being excluded from key areas such as policy development and implementation, and confine this discussion to one section of the document.

Conflicts of interest

The AP gives due recognition, as outlined above, to conflicts of interest in alcohol policy, which we firmly support. However, we are concerned that while conflicts of interest are identified as a challenge to the implementation of the GAS, concrete steps to tackle them are insufficiently prominent in the AP. For example, they are not recognised in the operational objectives of the AP nor is the WHO Secretariat tasked with monitoring or countering commercial influences (with the role falling instead exclusively to civil society).

Further, measures to manage conflicts of interest are also largely absent from key instances where they could occur, such as when the WHO Secretariat maintains a dialogue with the industry (page 12) or organizes yearly or biyearly global dialogues with the industry (page 16). The absence of such measures contrasts with WHO's approach to nutrition policy, where a multi-sectoral approach will be accompanied by a risk assessment and management tool for safeguarding against conflicts of interest in nutrition policy development and implementation.[4] We recommend that, as part of the AP, WHO develop principles and guidance for Member States in identifying and

[3] Chan Margaret. WHO's response to article on doctors and the alcohol industry *BMJ* 2013; 346 :f2647

[4] WHO (2017). Safeguarding against possible conflicts of interests in nutrition programmes: Approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level.

managing conflicts of interest associated with engaging alcohol industry stakeholders in alcohol policy processes.

Suggestions

- Conflicts of interest should be explicitly referenced in the operational objectives;
- The WHO Secretariat should be given a role in monitoring and protecting against interference by alcohol economic operators;
- Where the WHO Secretariat meets with industry reference, should be made to how conflicts of interest will be transparently managed; and
- The WHO Secretariat should commit to the development of guidelines for Member States in identifying and managing conflicts of interest associated with engaging alcohol industry stakeholders.

Increase focus on SAFER

IAS supports an evidence-led approach to the development of policies to reduce alcohol-related harm, and for that reason we welcome the work of the WHO on the SAFER initiative and its prominence in the AP. However, we are concerned that the quantity of suggested actions and objectives risks the focus on SAFER being lost. We recommend that actions that relate to the SAFER framework are given priority when assessing the relevance of all actions in the AP.

We support the observation that "*alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally-binding regulatory instruments*" and call on the WHO Secretariat to explore further the "*calls for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control*" (page 4).

Suggestions

- The focus on evidence-based policies and SAFER should be more explicit throughout the document; and
- The WHO Secretariat should commit to explore the feasibility of an international legal instrument to accelerate action to reduce rates of alcohol harm globally

Further consideration of alcohol's wider harms

We welcome the recognition in the AP that alcohol's harm is not limited to individual health consequences but has a far wider societal reach. While these impacts are outlined in '*Setting the scene'* they, by and large, do not receive much prominence in the areas for action. We support the proposed action 4.4 for Member States, to:

> *"Support capacity-building of health professionals, public health experts and representatives of civil society organizations, including mutual help groups and associations of affected individuals and their family members, to advocate for, implement, enforce and sustain implementation of effective measures to*

reduce the harmful use of alcohol, including support of education and training programmes."

However, this is the only action listed in the AP that refers to supporting families affected by alcohol use, and given the vision of the GAS is to "*improve health and social outcomes for individuals, families and communities*" we believe more actions to achieve this goal are required. Importantly, the impact of drinking alcohol during pregnancy and provision of support to prevent and manage foetal alcohol spectrum disorders (FASD), is largely absent from the document (referenced only on page 20 with regards to requiring further research in "*selected low- and middle-income countries*"). Greater attention is required to this issue which is a growing concern for low-,middle- and high-income countries where alcohol consumption during pregnancy remains common, yet prevention efforts and support for those affected by FASD is scarce.[5]

Suggestions

- The further inclusion of alcohol's harms beyond the individual within the action points of the document; and
- Include reference to the impact of FASD and strategies to reduce it globally.

[5] Popova, S. et al. (2017). Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. The Lancet Global Health doi:10.1016/S2214-109X(17)30021-9