A global strategy to reduce the harmful use of alcohol

Kompetansesentersamling
Sola Strand Hotel, 1 November 2010
Global strategy to reduce the harmful use of alcohol (gsa)

- Endorsed by the World Health Assembly in May 2010
- Developed through a long and intense collaboration between the WHO Secretariat and Member States.
- All important stakeholders were consulted in the process, including the industry and NGOs.
- The strategy gives guidance to Member States and defines priority areas for global action.
- Represents a unique consensus among our 193 Member States on ways to tackle harmful use of alcohol at all levels.
The WHO global strategy to reduce the harmful use of alcohol endorsed by the 63rd WHA resolution

…the global strategy for reducing the harmful use of alcohol is a true breakthrough. This strategy gives you a large and flexible menu of evidence-based policy options for addressing a problem that damages health in rich and poor countries alike. The strategy sends a powerful message: countries are willing to work together to take a tough stand against the harmful use of alcohol.

Dr Margaret Chan
Director-General
World Health Organization
Closing speech at WHA63
The harmful use of alcohol

- Why a global strategy?
- Why now?
- How has the draft strategy been developed?
- What is the content of the strategy?
- How will it be implemented?
Why a global strategy?
WHO governing structure

- UN specialized agency
- 193 Member States
- The World Health Assembly
- Executive Board
- HQ in Geneva
- 6 Regional Committees
- Consensus driven
- Mostly non-binding
WHO core functions:

- providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalysing change, and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.
Global burden of disease
Measuring Disease Burden in Global Burden of Disease (GBD) project

*Years of life lost (YLLs)* take into account the age at which deaths occur by giving greater weight to deaths occurring at younger ages and lower weight to deaths occurring at older ages.

*Disability Adjusted Life Year (DALY)* - an integrated indicator that shows the number of life years that are lost due to premature deaths or cases of disability occurring in a particular year. DALYs for a disease or health condition are calculated as the sum of the YLLs because of premature mortality in the population and the years lived with a disability (YLDs) for incident cases of the health condition.
<table>
<thead>
<tr>
<th>Mortality</th>
<th>%</th>
<th>DALYs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ischaemic heart disease</td>
<td>12.2</td>
<td>1. Lower respiratory infections</td>
<td>6.2</td>
</tr>
<tr>
<td>2. Cerebrovascular disease</td>
<td>9.7</td>
<td>2. Diarrhoeal diseases</td>
<td>4.8</td>
</tr>
<tr>
<td>3. Lower respiratory infections</td>
<td>7.1</td>
<td>3. Depression</td>
<td>4.3</td>
</tr>
<tr>
<td>4. COPD</td>
<td>5.1</td>
<td>4. Ischaemic heart disease</td>
<td>4.1</td>
</tr>
<tr>
<td>5. Diarrhoeal diseases</td>
<td>3.7</td>
<td>5. HIV/AIDS</td>
<td>3.8</td>
</tr>
<tr>
<td>6. HIV/AIDS</td>
<td>3.5</td>
<td>6. Cerebrovascular disease</td>
<td>3.1</td>
</tr>
<tr>
<td>7. Tuberculosis</td>
<td>2.5</td>
<td>7. Prematurity, low birth weight</td>
<td>2.9</td>
</tr>
<tr>
<td>8. Trachea, bronchus, lung cancers</td>
<td>2.3</td>
<td>8. Birth asphyxia, birth trauma</td>
<td>2.7</td>
</tr>
<tr>
<td>9. Road traffic accidents</td>
<td>2.2</td>
<td>9. Road traffic accidents</td>
<td>2.7</td>
</tr>
</tbody>
</table>
Leading causes of attributable global mortality and burden of disease, 2004

<table>
<thead>
<tr>
<th>Attributable Mortality</th>
<th>%</th>
<th>Attributable DALYs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High blood pressure</td>
<td>12.8</td>
<td>1. Childhood underweight</td>
<td>5.9</td>
</tr>
<tr>
<td>2. Tobacco use</td>
<td>8.7</td>
<td>2. Unsafe sex</td>
<td>4.6</td>
</tr>
<tr>
<td>3. High blood glucose</td>
<td>5.8</td>
<td>3. Alcohol use</td>
<td>4.5</td>
</tr>
<tr>
<td>4. Physical inactivity</td>
<td>5.5</td>
<td>4. Unsafe water, sanitation, hygiene</td>
<td>4.2</td>
</tr>
<tr>
<td>5. Overweight and obesity</td>
<td>4.8</td>
<td>5. High blood pressure</td>
<td>3.7</td>
</tr>
<tr>
<td>6. High cholesterol</td>
<td>4.5</td>
<td>6. Tobacco use</td>
<td>3.7</td>
</tr>
<tr>
<td>7. Unsafe sex</td>
<td>4.0</td>
<td>7. Suboptimal breastfeeding</td>
<td>2.9</td>
</tr>
<tr>
<td>8. Alcohol use</td>
<td>3.8</td>
<td>8. High blood glucose</td>
<td>2.7</td>
</tr>
<tr>
<td>9. Childhood underweight</td>
<td>3.8</td>
<td>9. Indoor smoke from solid fuels</td>
<td>2.7</td>
</tr>
<tr>
<td>10. Indoor smoke from solid fuels</td>
<td>3.3</td>
<td>10. Overweight and obesity</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Different perspectives

- High blood pressure
- Tobacco use
- Overweight and obesity
- Physical inactivity
- Alcohol use

Deaths
DALYs
The determinants of alcohol related harm

Source: Schmidt et al. 2010
## Total alcohol consumption

<table>
<thead>
<tr>
<th>WHO-Region</th>
<th>Total APC (in litres)</th>
<th>Unrecorded (in litres)</th>
<th>Proportion unrecorded (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>European Region</td>
<td>12.18</td>
<td>2.67</td>
<td>21.9%</td>
</tr>
<tr>
<td>Region of the Americas</td>
<td>8.67</td>
<td>2.01</td>
<td>23.1%</td>
</tr>
<tr>
<td>Western Pacific Region</td>
<td>6.23</td>
<td>1.63</td>
<td>26.2%</td>
</tr>
<tr>
<td>African Region</td>
<td>6.15</td>
<td>1.93</td>
<td>31.4%</td>
</tr>
<tr>
<td>South-East Asia Region</td>
<td>2.20</td>
<td>1.52</td>
<td>69.0%</td>
</tr>
<tr>
<td>Eastern Mediterranean Region</td>
<td>0.65</td>
<td>0.36</td>
<td>56.2%</td>
</tr>
</tbody>
</table>
Alcohol consumption in Europe 2005
Pattern of consumption
Proportion of alcohol-attributable DALYs in WHO subregions – 2004

Source: Rehm et al., 2009b; WHO, 2009
Percentage of disability-adjusted life years (DALYs) attributed to 19 leading risk factors, by country income level, 2004

- Childhood underweight
- Unsafe sex
- Alcohol use
- Unsafe water, sanitation, hygiene
- High blood pressure
- Tobacco use
- Suboptimal breastfeeding
- High blood glucose
- Indoor smoke from solid fuels
- Overweight and obesity
- Physical inactivity
- High cholesterol
- Occupational risks
- Vitamin A deficiency
- Iron deficiency
- Low fruit and vegetable intake
- Zinc deficiency
- Illicit drugs
- Unmet contraceptive need

Source: Rehm et al., 2009b; WHO, 2009
Huge variations in deaths in different sub-groups in the world in 2004

Male total deaths

- Tobacco use
- Alcohol use
- High blood pressure
- High cholesterol
- Physical inactivity
- High blood glucose
- Overweight and obesity
- Unsafe water, sanitation, hygiene

Total deaths females

- Tobacco use
- Alcohol use
- High blood pressure
- High cholesterol
- Physical inactivity
- High blood glucose
- Overweight and obesity
- Unsafe water, sanitation, hygiene

Total deaths males 15-29 in the world

- Tobacco use
- Alcohol use
- High blood pressure
- High cholesterol
- Physical inactivity
- High blood glucose
- Overweight and obesity
- Unsafe water, sanitation, hygiene

Total female deaths 80+ in Europe

- Tobacco use
- Alcohol use
- Overweight and obesity
- High blood pressure
- High blood glucose
- High cholesterol
- Physical inactivity
Population attributable fractions (%) for total male deaths by age groups and regions
Alcohol attributable deaths per million inhabitants by income groups in 2004 (WHO, 2009)
Alcohol attributable fractions (%) for DALYs of different diseases and injuries in the world in 2004

- Alcohol use disorders
- Cirrhosis of the liver
- Liver cancer
- Oesophagus cancer
- Epilepsy
- Violence
- Road traffic accident
- Poisonings
- Hypertensive heart disease
- Drownings
- Other intentional injuries
- Self-inflicted injuries
- Breast cancer
- Falls
- Other neoplasms
- Colon and rectum cancers
- Unipolar depressive disorders
- Prematurity and low birth weight
Division of alcohol attributable deaths by disease or injury in the world for the year 2004

- Unintentional injuries: 26.9%
- Cancer: 19.6%
- Cardiovascular diseases: 21.8%
- Cirrhosis of the liver: 15.1%
- Neuropsychiatric disorders: 5.4%
- Intentional injuries: 11.0%
- Others: 0.2%
Distribution of all alcohol attributable deaths and DALYs by disease and injury in 2004 (WHO, 2009).
Alcohol and infectious diseases: an overlooked causal linkage?

- Sufficient evidence for establishing causal relationship between heavy alcohol exposure and incidence and clinical course of tuberculosis (TB).

- No sufficient evidence for incidence of HIV/AIDS, though impact of heavy alcohol use on adherence to treatment regimens is well documented.

Trends in recorded adult per capita consumption
Why now?
Alcohol is a tricky liquid

David Gunnarson, Chairman of the EB 2005
The universe of policy making

Outer world

World 3 Political

World 2 Administrative

NB: Factor x

World 1 Technical
Three "waves" in WHO (globally)

- Early 1950s
  - Three expert committee and sub committee meetings, but no political decisions.

- Early 1980s
  - One expert committee meeting and two WHA resolutions. The wave continued in the WHO European Region.

- Current "wave" (from 2000)
  - One expert committee meeting (2006), two WHA resolutions (2005 and 2008) and separate agenda item on 4 WHAs (2005, 2007, 2008 and forthcoming WHA63). In addition increased activities in all six WHO regions.
World Health Report 2002

- Underweight
- Unsafe sex
- Blood pressure
- Tobacco
- Alcohol
- Unsafe water, sanitation, and hygiene
- Cholesterol
- Indoor smoke from solid fuels
- Iron deficiency
- High Body Mass Index
- Zinc deficiency
- Fruit and vegetable intake
- Vitamin A deficiency
- Physical inactivity
- Occupational risk factors for injury
- Lead exposure
- Illicit drugs

Number of Disability-Adjusted Life Years (000s)
Process leading to the resolution of alcohol at the World Health Assembly 2008

- **WHA57 (May 2004)**: Resolution on health promotion
- **WHA58 (May 2005)**: Resolution "Public health problems caused by harmful use of alcohol".
- **WHA60 (May 2007)**: Report of the Secretariat on strategies to reduce harmful use of alcohol with global assessment of public health problems caused by harmful use of alcohol and discussions on a draft resolution.
- **Informal consultation (December 2007)** with Member States on strategies on reduce harmful use of alcohol – 9 policy areas for action identified.
- **EB122 (January 2008)**: Considered a report from the Secretariat and a draft resolution proposed by Kenya and Rwanda calling for a global strategy to reduce the harmful use of alcohol and recommended WHA 61 to adopt a resolution.
WHA61.4 Resolution
"Strategies to reduce the harmful use of alcohol"

1. URGES Member States (inter alia):

(1) to collaborate with the Secretariat in developing a draft global strategy on harmful use of alcohol based on all evidence and best practices, in order to support and complement public health policies in Member States, with special emphasis on an integrated approach to protect at-risk populations, young people and those affected by harmful drinking of others;

2. REQUESTS the Director-General (inter alia):

(1) to prepare a draft global strategy to reduce harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options, taking into account different national, religious and cultural contexts, including national public health problems, needs and priorities, and differences in Member States’ resources, capacities and capabilities;

(5) to submit to the Sixty-third World Health Assembly, through the Executive Board, a draft global strategy to reduce harmful use of alcohol.
How was the strategy developed?
Process for implementing the WHA 61.4 resolution and preparing a draft global strategy

Stage I. Broad consultation process (October – December 2008)

- Web-based consultation (WHO public hearings) with Member States and other stakeholders on ways of reducing harmful use of alcohol (3-31 October 2008, extended till 15 November 2008)

- Consultation with economic operators on ways they could contribute to reducing harmful use of alcohol (6 November 2008)

- Consultation with NGOs and health professionals on ways they could contribute to reducing harmful use of alcohol (24-25 November 2008).

- Consultation with UN agencies and intergovernmental organizations (8 September 2009)
Process for implementing the WHA 61.4 resolution and preparing a draft global strategy (continued)

Stage II. Draft strategy development

- Regional technical consultations with Member States (February – May 2009) in 6 WHO regions
- Draft development by the Secretariat in collaboration and consultation with Member States (May – October 2009)
- 126th session of the Executive Board
- WHA 63
The six technical consultation took place as follows:

- South-East Asia: 24-26 February, Bangkok, Thailand.
- Africa: 3-5 March, Brazzaville, Congo.
- Western Pacific: 24-26 March, Auckland, New Zealand.
- Eastern Mediterranean: 6-9 April, Cairo, Egypt.
- Europe: 20-23 April, Copenhagen, Denmark.
- The Americas: 6-8 May, Sao Paolo, Brazil.

The purpose of the meetings was to ensure effective collaboration with Member States in the development of a draft global strategy. Member States were invited to provide their views on possible areas for global action and coordination, and on how the strategy best can take national needs and priorities into account.
Discussions on the draft global strategy were pursued in an open-ended informal working group (co-chaired by Cuba and Sweden) during the Board session, and consensus was reached on a revised text. The Board adopted resolution EB126.R11 where it recommends the World Health Assembly to endorse the draft global strategy.
Endorsed the Global strategy to reduce the harmful use of alcohol in the WHA resolution 63.13
What is the content of the strategy?
Structure of the strategy

- Setting the scene
- Challenges and opportunities
- Aims and objective
- Guiding principles
- Policy options and interventions (national level)
- Global action: Key roles and components
- Implementing the strategy
WHO Global Strategy: challenges and opportunities

- Increasing global action and international cooperation
- Ensuring intersectoral action
- According appropriate attention
- Balancing different interests
- Focusing on equity
- Considering the "context" in recommending actions
- Strengthening information.
WHO global strategy: Five objectives

(a) raised global awareness of the magnitude and nature of the health, social and economic problems caused by harmful use of alcohol, and increased commitment by governments to act to address the harmful use of alcohol;

(b) strengthened knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm;

(c) increased technical support to, and enhanced capacity of, Member States for preventing the harmful use of alcohol and managing alcohol-use disorders and associated health conditions;

(d) strengthened partnerships and better coordination among stakeholders and increased mobilization of resources required for appropriate and concerted action to prevent the harmful use of alcohol;

(e) improved systems for monitoring and surveillance at different levels, and more effective dissemination and application of information for advocacy, policy development and evaluation purposes.
The spirit of the strategy

The global strategy:

– complements and supports public health policies in Member States;
– gives guidance for action at all levels;
– sets priority areas for global action;
– contains a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level.

The vision behind the global strategy is improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to harmful use of alcohol and their ensuing social consequences. It is envisaged that the global strategy will promote and support local, regional and global actions to prevent and reduce the harmful use of alcohol.
Priority areas

Priority areas for national action:

- Leadership, awareness and commitment
- Health services' response
- Community action
- Drink-driving policies and countermeasures
- Availability of alcohol
- Marketing of alcoholic beverages
- Pricing policies
- Reducing the negative consequences of drinking and alcohol intoxication
- Reducing the public health impact of illicit alcohol and informally produced alcohol
- Monitoring and surveillance

Priority areas for global action:

- Public health advocacy and partnership
- Technical support and capacity building
- Production and dissemination of knowledge
- Resource mobilization
WHO Global Strategy: National policies and measures

- Member States have a primary responsibility for formulating, implementing, monitoring and evaluating public policies to reduce the harmful use of alcohol. Such policies require a wide range of public health-oriented strategies for prevention and treatment.

- All countries will benefit from having a national strategy and appropriate legal frameworks to reduce harmful use of alcohol, regardless of the level of resources in the country.

- Sustained political commitment, effective coordination, sustainable funding and appropriate engagement of subnational governments as well as from civil society and economic operators are essential for success.

- Health ministries have a crucial role in bringing together the other ministries and stakeholders needed for effective policy design and implementation.
Area 1.
Leadership, awareness and commitment

Sustainable action requires strong leadership and a solid base of awareness and political will and commitment. The commitments should ideally be expressed through adequately funded comprehensive and intersectoral national policies that clarify the contributions, and division of responsibility, of the different partners involved. The policies must be based on available evidence and tailored to local circumstances, with clear objectives, strategies and targets. The policy should be accompanied by a specific action plan and supported by effective and sustainable implementation and evaluation mechanisms. The appropriate engagement of civil society and economic operators is essential.
Area 1.
Leadership, awareness and commitment

For this area policy options and interventions include:

(a) developing or strengthening existing, comprehensive national and subnational strategies, plans of action and activities to reduce the harmful use of alcohol;

(b) establishing or appointing a main institution or agency, as appropriate, to be responsible for following up national policies, strategies and plans;

(c) coordinating alcohol strategies with work in other relevant sectors, including cooperation between different levels of governments, and with other relevant health-sector strategies and plans;

(d) ensuring broad access to information and effective education and public awareness programmes among all levels of society about the full range of alcohol-related harm experienced in the country and the need for, and existence of, effective preventive measures;

(e) raising awareness of harm to others and among vulnerable groups caused by drinking, avoiding stigmatization and actively discouraging discrimination against affected groups and individuals.
Area 8. Reducing the negative consequences of drinking and alcohol intoxication

This target area includes policy options and interventions that focus directly on reducing the harm from alcohol intoxication and drinking without necessarily affecting the underlying alcohol consumption. Current evidence and good practices favour the complementary use of interventions within a broader strategy that prevents or reduces the negative consequences of drinking and alcohol intoxication. In implementing these approaches, managing the drinking environment or informing consumers, the perception of endorsing or promoting drinking should be avoided.
Area 8. Reducing the negative consequences of drinking and alcohol intoxication

For this area policy options and interventions include:

(a) regulating the drinking context in order to minimize violence and disruptive behaviour, including serving alcohol in plastic containers or shatter-proof glass and management of alcohol-related issues at large-scale public events;

(b) enforcing laws against serving to intoxication and legal liability for consequences of harm resulting from intoxication caused by the serving of alcohol;

(c) enacting management policies relating to responsible serving of beverage on premises and training staff in relevant sectors in how better to prevent, identify and manage intoxicated and aggressive drinkers;

(d) reducing the alcoholic strength inside different beverage categories;

(e) providing necessary care or shelter for severely intoxicated people;

(f) providing consumer information about, and labelling alcoholic beverages to indicate, the harm related to alcohol.
Next steps


- Establishing a global network of WHO counterparts for implementation of the global strategy. The network will meet in Geneva in February 2011 to discuss the implementation mechanisms.

- Consultations with NGOs and other stakeholders on their contributions (roles and responsibilities) to the implementation of the global strategy

- Resource mobilization to ensure effective implementation at all levels.

- Implementation activities for other priority areas of WHO global action.
WHO International Research Project on Alcohol and Development

- Fetal Alcohol Spectrum Disorders (FASD)
- Harm to others ("collateral damage")
- Implementation of effective alcohol policies in the context of development
- Alcohol and Infectious Diseases
  - TB
  - HIV
Conclusion – "a going concern"

- Harmful use of alcohol should be a "going concern" at local, national, regional and global levels with political and professional attention and allocation of resource in line with the magnitude of the problem.

- The global strategy is a unique opportunity to establish a global fundament for such a going concern.
In the late 1990s, passive surveillance and creation of the Global Alcohol Database (GAD) as the world's largest single database on alcohol. The first Global Status Report on Alcohol was published in 1999, using information from the GAD. In 2002, the first Global Alcohol Policy survey was conducted which added a considerable amount of policy information to the GAD. In 2004, the first Global Status Report on Alcohol Policy was produced as well as the second Global Status Report on Alcohol, using the GAD. In 2006, the web-based Global Information System on Alcohol and Health was created. It serves as the data repository for regional information systems. 2008 and beyond, global surveys and passive surveillance feed into GISAH which will be used for subsequent Global Status Reports and Country Profiles, as well as progress reports on GSA.
GISAH: sources

- Government documents, national statistics
- FAO and other intergovernmental organizations
- National and global surveys
- WHO Global Survey on Alcohol and Health
- Industry data
- Published scientific articles
- Grey literature
There are over 170 numeric indicators and over 50 text indicators on GISAH. Each indicator has information on +/- 100 countries that are continually being updated.

Numeric data can be mapped and/or charted. Both numeric and text files can be downloaded as EXCEL files.

References are provided in separate “Source” files. Information relative to specific indicators is presented in separate “About” files.

Comparative Risk Assessment (CRA) is a special category found on GISAH that displays the indicators and results of the impact of alcohol consumption on the burden of disease.

http://www.who.int/globalatlas/alcohol
GISAH Categories

1. Alcohol Production and Availability
2. Levels of Consumption
3. Patterns of Consumption
4. Harms and Consequences
5. Economic Aspects
6. Alcohol Control Policies
7. Prevention/Treatment
8. Comparative Risk Assessment
Nexts steps in GISAH

- Migrate GISHA to a more user friendly platform
- Continue the development of key indicators in the system
- Continue to develop the regional information systems
- Develop a system for evaluating the implementation of the global strategy to reduce the harmful use of alcohol
- Prepare the 2011/12 Global Survey on Alcohol and Health, including a system for on-line data collection
WHO Department of Mental Health and Substance Abuse
Management of Substance Abuse

Further information at

http://www.who.int/substance_abuse/