RESPONSE TO THE WORLD HEALTH ORGANIZATION'S CONSULTATION ON THE FIRST DRAFT OF THE GLOBAL ALCOHOL ACTION PLAN 2022–2030

Summary

Alcohol Focus Scotland (AFS) is Scotland's national charity working to prevent and reduce alcohol harm. We want to see fewer people have their health damaged or lives cut short due to alcohol, fewer children and families suffering as a result of other people's drinking, and communities free from alcohol-related crime and violence.

AFS has identified several opportunities to strengthen the Action Plan draft, to better enable the WHO Secretariat to achieve its goal of considerably reducing morbidity and mortality due to alcohol use as well as related social consequences. AFS also endorses the responses from EUROCARE, the Global Alcohol Policy Alliance (GAPA), Institute of Alcohol Studies (IAS) and Alcohol Policy Futures.

1. The role of economic operators

We are concerned that while conflicts of interest are identified as a challenge to the implementation of the Global Alcohol Strategy, concrete steps to tackle them are insufficiently prominent in the Action Plan. We recommend that, as part of the Action Plan, WHO develop principles and guidance for Member States in identifying and managing conflicts of interest associated with engaging alcohol industry stakeholders in alcohol policy processes. The development of proper governance mechanisms to protect against conflicts of interest in alcohol policy should form part of the Action Plan's operational objective 2.

It is important to recognise that the alcohol industry is a diverse group of stakeholders, including industry-funded NGOs and research institutes. This broad definition should apply to actions in the Plan which seek to limit industry engagement. Specifically, proposed action 1 under Action Area 6 for international partners, civil society organisations and academia should stipulate that independence should be maintained from all alcohol industry bodies, not just producers and distributors.

Proposed measures for alcohol industry bodies should be listed separately, with clear details of how the conflicts of interest between economic objectives and public health goals will be dealt with via the Action Plan.

2. Terminology

As concluded in a 2018 global study by the Global Burden of Disease Collaborators, it is now clear that there is no safe level of alcohol consumption, a position which is endorsed by WHO. The term "harmful use of alcohol" is therefore no longer compatible with evidence that has developed since the publication of the Global Strategy in 2010 and may contribute to public confusion about the perceived health benefits of drinking**.** We recommend that the term "harmful use" is updated to "alcohol use" and/or "alcohol-related harms" throughout the Action Plan, with a summary of the evidence supporting this amendment included in the introduction.

3. Content

The important role of the three "best buy" alcohol policies and those included in the WHO SAFER initiative should be made more explicit. Action area 1 should therefore specifically relate to the implementation of the "best buys" and associated targets and indicators should refer to each of these policies individually, as opposed to the existing combined term of "high-impact policy options and interventions".

As outlined in the draft Action Plan, the economic benefits of effective alcohol policies are clear. We recommend that a specific action is allocated to the WHO Secretariat to develop toolkits for Member States to better communicate the returns on investment from "best buy" policies and other measures outlined in the SAFER programme.

We welcome the proposal to reconvene the WHO Expert Committee on Problems Related to Alcohol Consumption. However, we recommend that the remit of the Committee be expanded to include providing recommendations on the way forward. We also recommend that this Committee be tasked with exploring important policy options referred to in the draft Action Plan, including "calls for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control, and discussions about the feasibility and necessity of such a legally binding international instrument" (p.7).

4. Structure

The first draft of the Action Plan would benefit from some structural revisions to make it more focussed and concise. We recommend that actions and targets are reviewed and revised to produce a clear set of measurable indicators against which to evaluate progress on delivering the Action Plan.

5. Monitoring and reporting

To prevent the sunsetting of reporting requirements, the Action Plan should clearly outline the need for biennial reporting to the World Health Assembly (WHA) on the progress of its implementation, at least for the duration of the Action Plan (2022-2030). How international partners, civil society organizations and academia could contribute to such reporting should be clarified and agreed upon prior to implementation of the Action Plan.

Introduction

Alcohol Focus Scotland (AFS) is Scotland's national charity working to prevent and reduce alcohol harm. We want to see fewer people have their health damaged or lives cut short due to alcohol, fewer children and families suffering as a result of other people's drinking, and communities free from alcohol-related crime and violence.

Global leadership on reducing the harmful use of alcohol is essential to achieving improved health and social outcomes for individuals, families and communities across the world. AFS welcomes the opportunity to respond to the World Health Organization's consultation on the first draft of the Global Alcohol Action Plan 2022-2030. AFS also endorses the responses from EUROCARE, the Global Alcohol Policy Alliance (GAPA), Institute of Alcohol Studies (IAS) and Alcohol Policy Futures.

Scotland is an international leader in promoting evidence-based alcohol policies. We have a clear national framework for tackling alcohol-related harm at population level, which draws directly on and explicitly references WHO's comprehensive policy action package, SAFER and the three 'best buys'. Yet, despite the commitments and achievements of the Scottish Government's Alcohol Frameworks, including the implementation of minimum unit pricing (MUP) across Scotland in 2018, levels of alcohol harm in Scotland remain high, blighting and shortening many lives.

In 2020, 1,190 people in Scotland died from a cause wholly attributable to alcohol ('alcohol-specific'); contributing to a total of over 10,000 deaths over the past decade.[1] There are also significant inequalities in alcohol-related harm, with those living in the most deprived communities over 4 times more likely to die[2] and seven times more likely to be hospitalised than those in the least deprived communities.[3]

These official statistics do not capture even half of the alcohol health harm experienced in Scotland. In addition to health problems solely caused by alcohol, alcohol is a causal factor in a further 200 diseases and conditions.[4] There were an estimated 3,705 deaths attributable to alcohol consumption, equating to 6.5% of the total deaths in Scotland in 2015.[5]

Harm from alcohol also affects others around the drinker including children and other family members, friends, co-workers and the wider community. In addition, alcohol is a drain on our hard-pressed public services and a brake on economic growth. The total annual cost of alcohol harm is estimated at £3.6 billion.[6]

There is therefore still much work to be done in reducing alcohol-related harm in Scotland and across the world. **WHO's leadership and support are vitally important in focusing collective attention on alcohol problems and in encouraging and enabling Member States to take evidence-based action to realise the Global Strategy.**

The role of economic operators

We welcome the Action Plan's acknowledgement of the major challenge presented by alcohol industry actions to undermine, interfere with and obstruct health policy goals. We also welcome the effort to tightly define the role of industry. However, we believe that this effort is undermined by the inclusion of the alcohol industry in every action area. These economic operators have a clear conflict of interest when it comes to the majority of actions identified by the Action Plan. To include them in the action areas as the Plan currently does undermines both its purpose and feasibility. It also raises the risk that actions for industry may do more harm than good in an effort to fit within a framework that is relevant to public health actors only. **We recommend the discussion of industry activities is confined to a specific section, that identifies the limited "proposed measures" which it is appropriate for them to take, given the restricted roles attributed to them and recognising the conflict of interest.** 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.

We further recommend that any benefits associated with industry dialogue are made explicit. Specifically, evidence on how dialogue with industry helps WHO in its objective to secure the enactment, enforcement and evaluation of SAFER strategies. If no benefits can be demonstrated, then the industry dialogue must be questioned. Justification is needed for why WHO is committing to meet with industry representatives more frequently than public health stakeholders. If no justification can be offered, we suggest that WHO reduce the frequency of meetings with industry.

It is important to recognise that the alcohol industry is a diverse group of stakeholders, including industry-funded NGOs and research institutes. This broad definition should apply to actions in the Plan which seek to limit industry engagement. **Specifically, proposed action 1 under Action Area**

6 for international partners, civil society organisations and academia (p.27) should stipulate that independence should be maintained from all alcohol industry bodies, not just producers and distributors.

The Action Plan gives due recognition 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 Global Alcohol Strategy, concrete steps to tackle them are insufficiently prominent in the Action Plan. For example, they are not recognised in the operational objectives nor is the WHO Secretariat tasked with monitoring or countering commercial influences. This role currently falls exclusively to civil society, with Member States tasked with protecting policy from industry interference, however no guidance currently exists on how to do this for alcohol policy. 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. 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.

We recommend that, as part of the Action Plan, WHO develop principles and guidance for Member States in identifying and managing conflicts of interest associated with engaging alcohol industry stakeholders in alcohol policy processes. We recommend that the development of proper governance mechanisms to protect against conflicts of interest in alcohol policy should form part of the Action Plan's operational objective 2.

In accordance with the Framework for Engagement with Non-State Actors (FENSA), WHO should clarify how it will exercise particular caution, especially while conducting due diligence, risk assessment and risk management, in their dialogues with the alcohol industry. For transparency, information on economic operators with whom WHO has engaged should be published on the WHO register of non-State actors. Details of any meetings held should be made publicly available, including records of participants, meeting costs, discussion topics and actions included. WHO should also clarify whether these dialogues will cover alcohol marketing.

Public relations initiatives, often called corporate social responsibility (CSR), are commonly used by the alcohol industry, including education, research, drink driving prevention campaigns, policy involvement and the policies from social aspects organizations. The Action Plan should identify the full range of public relations/CSR initiatives as a form of marketing and policy interference by the alcohol industry. These initiatives should be included as a measure that may "prevent, delay or stop the development, enactment and enforcement" of SAFER interventions under Action area 1.

Terminology

As concluded in a 2018 global study by the Global Burden of Disease Collaborators, it is now clear that there is no safe level of alcohol consumption[7], a position which is endorsed by WHO.[8] Alcohol consumption plays a causal role in several types of cancer, including that of the breast, bowel, mouth, oesophagus, larynx, throat and liver and the risk of developing cancer increases with any amount of alcohol consumed. However, public awareness about alcohol as a cancer risk is low and confusion remains about the perceived health benefits of drinking. This lack of awareness can be attributed to a lack of independent health promotion campaigns about alcohol's health harms combined with alcohol industry misinformation strategies. A 2018 qualitative analysis of alcohol industry websites and documents indicates that the industry engages in misrepresentation of evidence about the alcohol-related risk of cancer.[9]

The term "harmful use of alcohol" is therefore no longer compatible with evidence that has developed since the publication of the Global Strategy in 2010. It may also contribute to public confusion about the perceived health benefits of drinking. It is an imprecise term and implies there is a level of use which is "safe". **We recommend that the term "harmful use" is updated to "alcohol use" and/or "alcohol-related harms" throughout the Action Plan, with a summary of the evidence supporting this amendment included in the introduction. We also recommend that actions under Action area 2 refer to the need to increase public awareness that there is no safe level of alcohol consumption.**

Content

The important role of the three "best buy" alcohol policies and those included in the WHO SAFER initiative should be made more explicit. **Action area 1 should therefore specifically relate to the implementation of the "best buys" and associated targets and indicators should refer to each of these policies individually, as opposed to the existing combined term of "high-impact policy options and interventions".**

In line with WHO's "best buys" and the SAFER initiative, the Action Plan should clearly recommend total bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion, instead of a partial elimination of marketing to minors and other "high-risk groups" by the alcohol industry.

We welcome the amended language in the draft Action Plan relating to the need to prevent drinking among pregnant women (as opposed to all women of child-bearing age). We note the unfortunate media attention that was awarded to this line in a previous version, driven by alcohol industry bodies wishing to discredit WHO.[10] This is an example of how alcohol industry acts in opposition to public health goals, seeking to undermine efforts to reduce alcohol harm through evidence-based policies. However, this episode also highlighted the challenges faced by health professionals when delivering guidance about drinking during pregnancy, and the need for consistent independent heath advice. Analysis of alcohol industry-funded websites has identified major omissions and misrepresentations of the evidence on key risks of alcohol consumption during pregnancy,[11] contributing to confusion and misunderstanding among the public. Research from the UK shows that a lack of training and standardised guidelines from government agencies can act as a barrier to midwives delivering alcohol advice to pregnant women.[12] **We recommend that Action area 2 includes an action for the WHO Secretariat to develop guidance for delivery of alcohol advice to women who are pregnant or trying to conceive and guidance on preventing, identifying, and managing foetal alcohol spectrum disorders (FASD). This will better support Member States in their efforts to protect at-risk populations, as outlined in Action 1 of Action area 2.**

As outlined in the draft Action Plan, the economic benefits of effective alcohol policies are clear. In addition to research conducted under the auspices of the WHO that demonstrated high returns on investment for "best buys" (p.8), a recent OECD report concluded that tackling alcohol harm is an "excellent investment"[13]. We support the Action Plan statement that "studies on the costs and benefits of alcohol control measures and development of investment cases can help to overcome resistance to effective alcohol control measures in view of financial and other revenues associated with alcohol production and trade" (p. 23), however, the current draft does not include an action to take this forward. **We recommend that a specific action is allocated to the WHO Secretariat to develop toolkits for Member States to better communicate the returns on investment from "best buy" policies and other measures outlined in the SAFER programme.**

We welcome the proposal to reconvene the WHO Expert Committee on Problems Related to Alcohol Consumption. However, **we recommend that the remit of the Committee be expanded to include providing recommendations on the way forward.** This will ensure the Committee's remit fully addresses the 2019 WHA decision 72(11) asking the Director-General to report on "the implementation of WHO's Global Strategy to reduce the harmful use of alcohol since the first decade since its endorsement, and the way forward". **We recommend that this Committee be tasked with exploring important policy options referred to in the draft Action Plan, including "calls for a global normative law on alcohol at the intergovernmental level,** modelled on the WHO Framework Convention on Tobacco Control, and discussions about the feasibility and necessity of such a legally binding international instrument" (p.7).

Structure

Whilst it is clear the draft Action Plan has been condensed following consultation with stakeholders, the first draft would still benefit from some further structural revisions to make it more focussed and succinct. There are currently a number of repetitive statements, actions and targets. Such a large number of commitments risks diluting the impact of the Action Plan and increasing the burden on stakeholder reporting. **We recommend that actions and targets are reviewed and revised to produce a more concise and focussed set of measurable indicators against which to evaluate progress of the Action Plan.** For example, global targets 1.1, 1.3 and 2.1 could be amalgamated to form a single goal relating to the proportion of countries that have protected citizens through the introduction and enforcement of SAFER alcohol policies, and global targets 4.1, 4.2 and 6.1 could be reviewed and revised to develop one target linked to increased capacity and resources.

Proposed actions for individual stakeholder groups (Member States, WHO Secretariat, international partners, civil society organisations and academia) and proposed measures for economic operators should be consolidated and listed separately to the Action Areas. This will provide the opportunity to review each stakeholder group's list of specific actions and measures to ensure they are relevant, appropriate and avoid repetition throughout the document. The present structure leads to stakeholder actions and measures that are not always suitable, or that represent repetitions from other sections.

As noted above, a particularly concerning aspect of the current structure is that it lends legitimacy to alcohol industry bodies in each and every section of the Action Plan, allocating proposed measures for economic operators throughout the document. This contradicts the preamble text which identifies the influence of the alcohol industry as a major challenge to progress of the Global Strategy, and it also contradicts the WHO-led SAFER initiative which "recognizes the need to protect public health-oriented policy-making from interference by the alcohol industry".[14]

Alcohol industry bodies do not have relevant contributions to make to every Action Area and their inclusion in the spirit of 'multi-stakeholder engagement' is clumsy and potentially harmful. For example, including a proposed measure for economic operators under Action Area 4, Capacity Building, offers an instruction from WHO for alcohol companies to increase their capacity to produce and sell their products:

> *Economic operators in alcohol production and trade are invited to implement capacity-building activities within their sectors of alcohol production, distribution and sales, and refrain from engagement in capacity-building activities outside their core roles that may undermine or compete with the activities of the public health community.*

This represents a clear contradiction to the public health goals of the Action Plan. **We recommend that proposed measures for alcohol industry bodies are listed separately, to avoid such unintended consequences, with clear details of how the conflicts of interest between economic objectives and public health goals will be dealt with via the Action Plan**.

Monitoring and reporting

We are concerned about the lack of specific time intervals for review and reporting of the implementation of the Action Plan. **We recommend that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan for at least the duration of the Plan.** This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies. How international partners, civil society organizations and academia could contribute to such reporting should be clarified and agreed upon prior to implementation of the Action Plan.

Prior to the review of the SDGs and Action Plan in 2030, a progress report and recommendations for the way forward for reducing alcohol harm through alcohol policy should be submitted to the WHO governing bodies by 2028 at the latest to ensure there is no further delay to proportionately addressing any persistent barriers to progress identified through the course of the Action Plan.

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