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# Report from a consultation with representatives of intergovernmental organizations on ways they could contribute to reducing the harmful use of alcohol

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Department of Mental Health and Substance Abuse  
World Health Organization  
Geneva, 2009



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## Opening

The meeting was opened at 09:30 by Mr Alex Ross, Director of Partnership and United Nations Reform at the World Health Organization (WHO), on behalf of Dr Benedetto Saraceno, Director of WHO's Department of Mental Health and Substance Abuse who was unable to attend. Participants introduced themselves in turn. Mr Ross described briefly the consultative process of developing the draft global strategy for reducing the harmful use of alcohol, as requested by the World Health Assembly. He stressed that the purpose of the present meeting, within the consultative process, was to share views from the perspectives of the different intergovernmental organizations (IGOs). A text on the scope and purpose of the meeting is contained in Annex 1.

## Welcome

Dr Ala Alwan, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health, welcomed the participants from 15 IGOs on behalf of WHO Director-General Dr Margaret Chan. The full list of participants can be seen in Annex 2. Dr Alwan briefly summarized the health, social and economic damage done by alcohol and asked participants to contribute their input both to the process of developing the global strategy and to the implementation of the strategy if it is approved. He emphasized that the programme was intended to enable IGO representatives to give WHO advice and guidance on this issue. The programme of the meeting is included in Annex 3.

## Introduction

Dr Vladimir Poznyak, Coordinator of the WHO team on Management of Substance Abuse, introduced the growing body of knowledge regarding the extent of the harmful use of alcohol

In particular, he pointed out that:

- Alcohol is now almost as important as tobacco as a health risk factor in terms of disability – adjusted life years or DALYs. (DALYs represent the sum of years of potential life lost due to premature death and the years of productive life lost due to disability.) Apart from the illnesses usually associated with alcohol such as liver damage, psychosis and cardiovascular disease, alcohol is increasingly associated with certain cancers – including colon-rectal cancer. Even a proportion of breast cancer in women is attributable to alcohol. Alcohol is also significant risk factor for tuberculosis and AIDS deaths, where it interferes with treatment regimens.
- Up to 2% of global gross domestic product (GDP) may be lost due to the harmful use of alcohol (including alcohol-related illnesses, premature mortality, drink-driving, violence, criminality, absenteeism).
- The global burden of disease (GBD) due to the harmful use of alcohol is uneven; for instance, it is very high in the countries of the former Soviet Union but quite low in Africa. At the same time, however, the burden is growing in all regions as cultural norms change and as the impact of globalization is felt. Although abstention from alcohol has traditionally been the

norm in many cultures, abstention rates are declining. As alcohol use increases, so does vulnerability to the growing burden of social and health problems.

Next, Dr Poznyak outlined the process of moving from a World Health Assembly resolution in 2008 (resolution WHA61.4), which asked for a draft global strategy to reduce harmful use of alcohol, to preparing a draft strategy and delivering it to the World Health Assembly in 2010. The text of World Health Assembly resolution WHA61.4 is included in Annex 4.

In May 2008, the resolution was introduced to the 61<sup>st</sup> World Health Assembly by Kenya and Rwanda – an indication that alcohol is causing harm in developing countries. The resolution asked for the draft global strategy to be prepared through a collaborative process with Member States and also for a consultative process with all stakeholders on ways that they could contribute to reduce harmful use of alcohol. This latter process included, in 2008, web-based public hearings, a meeting with “economic operators” (representatives of the major producers of alcoholic drinks), and a meeting with nongovernmental organizations (NGOs) and health professionals.

In 2009, regional meetings were with representatives from WHO member states in each of the six WHO regions marked the beginning of the collaborative process with Member States to develop the draft global strategy. Dr Poznyak explained that a “Working document for developing a draft global strategy to reduce harmful use of alcohol” had been prepared, bringing together suggestions that have emerged from the consultative process for elements to be included in the strategy. Following and informal consultation with delegates of member states on 8 October, the draft global strategy will be prepared. It will be submitted to the WHO Executive Board in January 2010 and – if approved by the board – to the 63<sup>rd</sup> World Health Assembly in May 2010.

## **Summary of interventions from representatives of intergovernmental organizations**

The comments made by participants were personal views given from the perspective of staff of IGOs with a different focus from that of WHO. The comments did not represent the official views of the participants’ organizations. A number of issues became clear from the interventions.

### ***Health damage caused by the harmful use of alcohol***

Several participants mentioned their experience of the damage caused by the harmful use of alcohol. In the Commonwealth of Independent States (CIS), for example, there was reported to be a rise in the contribution of alcohol to alcoholic psychosis and cardiovascular problems in both males and females. Increased consumption is also a major economic burden as it drains large financial resources. Countries of the European Union (EU) were reported to be so hard-hit by alcohol-related harm that in 2006 the EU launched its own strategy “to support member states in reducing alcohol-related harm”.

The member states of the Association of Southeast Asian Nations (ASEAN) are from two WHO regions (South-East Asia and Western Pacific) and are very different in terms of tradition and history, cultural and religious beliefs, and levels of economic development. There is generally a low level of alcohol use in these countries but the problem of harmful use was said to be increasing in all



countries – particularly in non-Muslim areas. A specific problem in ASEAN countries was said to be parties and festivals at which people drink alcohol, and some get drunk, and some drive while drunk.

In refugee situations, the acquisition of alcohol was reported to use scarce resources and to cause violence and social problems. Among persons with tuberculosis and HIV, alcohol was said to interfere with treatment.

The United Nations Office on Drugs and Crime (UNODC) pointed to alcohol's close link with unprotected sex, while the participant from the Joint United Nations Programme on HIV/AIDS (UNAIDS) referred to alcohol's role in fuelling both gender-based violence and forced sex.

In discussing the harmful use of alcohol in different contexts, it was mentioned that alcohol is a major problem in prisons worldwide.

### ***Alcohol as a “gateway” to other drugs***

Participants mentioned the role of alcohol as a “gateway” to other drugs. The experience of UNODC was that alcohol frequently featured both in the progression to illicit drugs and in polydrug use. Research was reported to show that cannabis use is related to having been drunk in the past month. There is a strong association between alcohol and the use of other non-injected substances. The most common co-used substances are alcohol, cannabis and stimulants (amphetamines and cocaine), and heavy drinkers are much more liable to use illicit drugs than moderate drinkers. Illicit drug users often use alcohol to modulate the effects of their primary drugs.

The experience of the Council of Europe's Pompidou Group on combating drug abuse and drug trafficking was also that alcohol frequently provides a gateway to illicit drugs and that it is frequently used along with them. The group's experience also indicated that it is often more helpful to refer to psychoactive substances as a group of drugs (which includes alcohol) rather than to legal or illegal drugs. It was also noted that in refugee contexts alcohol and other drugs are frequently found together.

### ***Illicit alcohol***

Illicit (and frequently home-made) alcohol was mentioned as a problem also in south-east Asia where it is often in demand for local festivals and celebrations. The Office of the United Nations High Commissioner for Refugees (UNHCR) deals with displaced persons, and the average period that a person remains displaced is 17 years – often in conditions which are resource-poor with many public health problems. Aid workers have noted that in refugee situations when alcohol is brewed at home it is often made from food provided as aid, leaving the family short of food. UNHCR has conducted pilot projects on substance use in refugee settings in Guinea, Kenya and Thailand.

### ***Marketing***

Several participants raised concern about the apparently uncontrolled marketing of alcoholic drinks in various parts of the world. One asked, for instance, whether there exists any global body that is responsible for controlling the marketing of alcohol (there are some national and regional bodies but there is no global one). In the new reality of market economies in the CIS countries, alcohol viewed as a commercial commodity that is often not regulated properly. There is also an uncritical attitude to advertising that appeals to young people. The situation is perhaps typified by the fact that in

some CIS countries beer is not classified as alcohol. There was a general feeling that the marketing of alcohol in developing countries is frequently aimed at young people, and that sponsorship of popular events by alcohol companies often goes unrestricted. However, several participants mentioned that there is growing concern in developing countries about uncontrolled promotion of alcohol, especially to the young.

### ***Monitoring***

Several participants asked about data on the quantities of alcohol produced, sold and consumed in various parts of the world (this information is contained in WHO's database). A need was expressed for more accurate monitoring of production and consumption of alcohol in the CIS states and elsewhere.

The United Nations Children's Fund (UNICEF) has developed the multiple-indicator cluster survey, which is now in its fourth version (it began in 1995 and is conducted every five years), to gather data on progress towards a set of children's welfare goals (approved at the World Summit for Children in 1990) and the Millennium Development Goals (approved by the United Nations General Assembly in 2000). The youth module of the survey includes questions related to substance use and alcohol use. UNICEF also has a regional (CIS) action framework for adolescents. The survey has elements that focus on violence in the home and family, adolescents with HIV, and substance use, and could be expanded to gather more information on the harmful impact of alcohol if required.

The Food and Agriculture Organization of the United Nations (FAO) gathers data on production and consumption levels of food and beverages. Data on the production and sale of alcohol products are sent to the WHO database. FAO data come from government sources rather than from industry, and trade data are hard to come by in many countries. FAO's chief contribution to the global strategy is likely to be in ensuring data quality. The EU expressed a desire to improve data collection. The United Nations Educational, Scientific and Cultural Organization (UNESCO) could potentially conduct studies on cultural influences on the use of alcohol.

### ***Building political commitment for a global strategy on reducing harmful use of alcohol***

The interventions of participants made clear that a number of IGOs are already experiencing concern about the harmful use of alcohol, that some have already taken action to combat it, and that others have policy instruments into which the topic of reducing harmful use could be introduced or governing bodies through which political commitment might be obtained.

The African Union (AU), for instance, has no activities specifically related to alcohol but has a number of policy instruments on substance abuse in general – such as the Africa Health Strategy 2007–2015 (which includes evidence-based policy formulation, and recognizes the growing burden of noncommunicable diseases in Africa), and the All-Africa Plan of Action on Drug Control and Crime Prevention (which includes training on prevention of substance abuse and HIV/AIDS, advocacy and capacity-building, and the enforcement of laws on alcohol). The plan of action also involves the sharing of information by civil society. The AU's Social Policy framework also has an area on health (and, within it, on noncommunicable diseases). The framework requires AU member states to give priority to social policies – including on substance abuse – with emphasis on prevention. The AU has a health ministerial meeting every two years so WHO discussions could feed into that to build political commitment

In most states within the CIS, there is a problem of harmful use of alcohol but no integrated intersectoral approach to countering excessive consumption. Therefore the CIS would find it useful to have a global strategy specifically aimed at reducing harmful use of alcohol. The CIS has the potential to organize expert consultations and ministerial meetings in relation to reducing the harmful use of alcohol, and could consider drafting a declaration on the topic to be issued by leaders of the CIS states. The CIS could help build political will, facilitate exchange of information, and involve civil society in the strategy.

ASEAN has twice-yearly meetings of heads of state and could potentially place the topic of reducing harmful use of alcohol on its agenda. This could further the political commitment of leaders to the global strategy and could encourage ministries of health and other ministries to address the issue with WHO and other IGOs. Other possible actions could be to conduct research studies on risk factors and to collect best practices on the response to harmful use.

The member states of the Black Sea Economic Cooperation Organization (BSEC) cooperate in a range of areas such as economic affairs and communication, and also in health care and pharmaceuticals. BSEC's working group on health care and pharmaceuticals has a mandate that includes mental health and the protection of society from harmful habits. The working group is currently working on an epidemiological network and a legal framework relating to the International Health Regulations. BSEC member states are also collaborating on the topics of AIDS, tuberculosis and malaria. BSEC could potentially provide several opportunities for supporting the global strategy, namely: specific projects on reduction of the harmful use of alcohol with technical assistance from WHO, and a memorandum of understanding with WHO (BSEC already has a regional action plan on the trafficking of persons, and might develop one on alcohol). It was stressed that the exchange of information would be very valuable.

It was felt that the European Commission would be positive towards efforts to develop a global strategy to reduce the harmful use of alcohol. The achievement of the EU's own goals relating to the use of alcohol would be supported by a global strategy, and the EU's experience in this area could also contribute to global efforts. In addition, the Council of Europe has a Parliamentary Assembly which has a working group on health that could become the focus for introducing the global strategy to this forum.

The Organisation Internationale de la Vigne et du Vin (OIV) wine sector (indeed, all products of the vine, whether alcoholic or not) and aims to contribute to international harmonization of practices and standards. As a scientific and technical organization, OIV works with international experts and has a committee on safety and health, which includes nutrition as a topic area. This committee could potentially be an initial focus for discussion of the global strategy. Within the context of the OIV, some action has already been taken to reduce the strength of wines.

The World Trade Organization (WTO) imposes certain obligations on its members to provide for free trade. Thus there should be no discrimination between imported and domestic goods, though public health considerations may override that requirement. It was noted that WTO agreements include labelling requirements, scientific standards, and transparency obligations (i.e. to publish the measures that fall under the agreements), and that member states are expected to adopt the measures.

## ***Training***

A number of participants referred to their organizations' experience in training, particularly in the areas of social and behavioural change. The Pompidou Group of the Council of Europe, for instance, has 400 projects on the consumption of psychoactive substances in its database. Many are prevention programmes – such as on life skills education and the resistance of negative influences. The group also has a multidisciplinary training course for young scientists on research into psychoactive substances. At the same time, the European Commission has an alcohol and health forum that includes academics, NGOs, industry federations, and a variety of others who have projects in this area.

UNODC already has a training package on “family skills training for drug prevention” that is proving successful. UNODC also has a “Treatnet” training package for staff at local level (i.e. those working in drug dependence treatment and rehabilitation centres) which includes alcohol since alcohol is very much associated with illicit drug use. UNODC signed an agreement with WHO for cooperation on the issue of alcohol in March 2009 and a joint WHO-UNODC programme on drug abuse treatment and care is being developed as a response to polydrug use.

Some participants referred to the importance of patterns of consumption and behaviour when dealing with health concerns related to alcohol. The OIV, for instance, recognizes that some people are at risk (e.g. the young) and that appropriate educational programmes might help to reduce this risk. OIV experts regularly evaluate published studies on alcohol consumption and health (and on the health effects of non-alcoholic products such as grapes and grape juice).

Schools and teachers are important elements in the prevention and early detection of harmful behaviours. The United Nations Educational, Scientific and Cultural Organization (UNESCO) has a web-based training package called FRESH (Focusing Resources on Effective School Health) which is used by a large network. The package includes a section on drugs, alcohol and tobacco, and there would be the possibility of including more information and programmes on reducing the harmful use of alcohol.

In addition, UNAIDS has considerable experience in developing interventions for behaviour change for preventing HIV/AIDS (including use of alcohol, especially by young people), and also for preventing gender-based violence. In 2010 the International Olympic Committee will be holding the first Youth Olympic Games in Singapore. UNAIDS will be there doing prevention education and could include the harmful use of alcohol in this.

In Africa, it was said, programmes on alcohol need to be harmonized, and Africa needs capacity-building and training in the area of the reduction of the harmful use of alcohol.

## ***Advocacy***

There was general agreement that IGOs can assist in promoting the global strategy through a variety of advocacy efforts. The AU, for instance, has declared the last Friday of each year as Africa Healthy Lifestyles Day, which focuses on awareness and advocacy programmes. One of the major contributions of the AU to the global strategy on reduction of the harmful use of alcohol could be advocacy – such as during Healthy Lifestyles Day.

ASEAN launched an action plan on healthy lifestyles in 2002 but little has so far been done at regional level (though there have been a number of local activities). The ASEAN action plan on healthy lifestyles could be revisited in order to address the harmful use of alcohol through this medium. Some Buddhist countries already have campaigns on abstaining from drinking alcohol during the Buddhist Lent (which lasts three months), and these already popular campaigns in ASEAN countries could be supported and expanded.

Both the Council of Europe and the European Commission could also provide options for advocacy within their constituencies. The EU's strategy on alcohol deals with how policies can be introduced in countries with different patterns of drinking and social habits. The emphasis is on supporting member states – e.g. in setting blood-alcohol limits for driving, in setting age limits for buying alcohol, and in engaging wider stakeholders. Much of this involves advocacy at regional and national levels. The EU's experience has been that the support of diverse stakeholders is essential if one is trying to achieve a wide societal shift. Although the European Commission deals only with Europe, if a multinational alcoholic drinks company or leisure enterprise has to set certain standards to meet the requirements of one region, then maybe it could also apply the same standards to its activities elsewhere.

Both the CIS and BSEC showed willingness to assist with advocacy efforts in their member states, and expressed interest in closer WHO involvement in their alcohol-related (and potentially broader health-related) activities. BSEC felt that a WHO presence at a future BSEC working group meeting on health would be helpful to address the harmful use of alcohol.

Several participants referred to the dangerous use of alcohol in the work setting. Participants from the International Labour Office (ILO), an organization that sets workplace standards, pointed out that the workplace provides a platform both for interventions and for advocacy. They pointed out the importance of having a healthy workforce and that in the past the ILO has addressed the impact of alcohol and drugs on the workforce. The organization has also done a great deal of work on violence in the workplace. ILO has a clear concern to see a reduction in the harmful use of alcohol and would assist as appropriate. One potential area of advocacy could be in ILO's work on social health protection benefits. The ILO recommends the inclusion of health promotion and advocacy in social health insurance, though preventive care is rarely mentioned in benefit packages and alcohol-related problems are rarely referred to specifically.

It was noted that UNESCO has close links with global networks of journalists.

## **Priority directions and target areas**

This session was introduced by Dr Vladimir Poznyak of WHO who referred to the "Working document for developing a global strategy to reduce harmful use of alcohol". He stressed that this document did not represent the strategy but contained suggestions for inclusion in the strategy and that, as its name implied, it was very much a working document. In particular, he described the sections of the document titled "Setting the scene" (in which alcohol's role in health damage is summarized), "Challenges and opportunities" (namely global action, intersectoral action, priorities, competing interests, equity, the context of alcohol use, and information), "Aims and objectives"

(which are raised awareness, mobilization of parties, support and enhancement of capacity, a strengthened knowledge base, and better monitoring), and the “Guiding principles”. He also took some time to explain why the term “harmful use” was being used and what it meant specifically (in contrast to terms such as abuse or misuse).

Mr Dag Rekve of WHO continued the presentation by describing the 10 target areas of the working document. The 10 areas are: (1) awareness and commitment, (2) health services’ response, (3) community action, (4) drink-driving policies and countermeasures, (5) availability of alcohol, (6) marketing of alcoholic beverages, (7) pricing policies, (8) harm reduction approaches, (9) reducing the public health impact of illegal and informal alcohol, and (10) monitoring and surveillance. He pointed out that for each target area the document contains a rationale, possible policies and interventions, core components, measures to support and complement actions, and mention of issues that might influence implementation in different contexts. Mr Rekve summarized each of the 10 target areas and highlighted specific aspects. On the issue of implementation, he mentioned that the member states had expressed the wish to themselves define how the different stakeholders should be involved.

Discussion was then invited and participants made a number of comments. In general there was strong support for the 10 targets though there was discussion about how they were expressed. For instance, a number of participants felt that terms such as “prevention”, “demand reduction” and “education” should be made more explicit in the list. Some participants also felt that a strategy targeting alcohol alone was missing the point that alcohol is one of a number of psychoactive drugs that cause harm, and that targeting just one substance will have only limited effect.

There was a reminder that the world of work can be a platform for action for most of the target areas, and this could potentially be mentioned in the eventual strategy. In this context, an ILO document called “SOLVE”, which deals with managing psychosocial issues at work, was recommended. And it was suggested that FAO could probably help with a database on prices.

A participant advised care when dealing with the topic of home-brewing in case this should be simply driven underground. She also suggested the inclusion of issues relating to sex workers.

In response, Dr Poznyak said that there are already international policies and conventions on illicit drugs, but this will be the first non-binding international policy specifically on harmful use of alcohol. While prevention is not mentioned explicitly, many of the targets do in fact deal with prevention issues. When preparing the working document, there was a conscious decision not to look at alcohol from the traditional perspectives of promotion, prevention and treatment. He said WHO was aware of the alcohol industry’s educational activities, but added that there has been criticism of this approach – especially where the industry’s educational approach is not backed up by, or does not itself back up, other interventions. He also reminded participants that there was no mandate from member states to discuss a framework convention on alcohol control.

## **Strengthening collaboration**

Proposals for areas where collaboration might be strengthened between IGOs in the area of reducing the harmful use of alcohol were put forward by the WHO team, as follows:

- Communication and information through IGO channels to their constituencies:

- 24 September 2009 deadline for member states (and IGOs) to provide feedback to WHO on the working document;
  - 08 October 2009 informal consultation with member states in the WHO Executive Board room, Geneva;
  - 18–23 January 2010 WHO Executive Board meeting;
  - May 2010 63<sup>rd</sup> World Health Assembly at which time the IGOs would have the right to make statements on the discussions.
- Advocacy and political commitment:
    - agendas of IGOs and their appropriate fora;
    - build on existing policy instruments (e.g. committees, working groups), or establish new ones, to address alcohol;
    - special meetings in collaboration with WHO.
  - Incorporation of harmful use of alcohol into planned or existing frameworks.
  - Use of effective networks (governments, NGOs, academic institutions, other sectors).
  - Developing further or new technical/programme activities:
    - monitoring and surveillance;
    - capacity-building;
    - best practices and knowledge creation;
    - technical support.

Mr Ross of WHO told participants that the real focus of the work that will be done in this area if the strategy is approved will not be WHO but its member states. He invited final comments on strengthening collaboration, in particular asking if participants knew of any alcohol-related items on their organizations' agendas in the next 12 months. He also asked how IGOs could use their means with their member states to advance interventions to reduce the harmful use of alcohol.

In the discussion that followed, it was mentioned that the next AU meeting of heads of state will take place later in 2009, and it was hoped that the AU countries could come to the 63<sup>rd</sup> World Health Assembly in 2010 with a common proposal on the global strategy.

There was a comment from the Pompidou Group of the Council of Europe that, when it comes to implementation of the global strategy, member states will need to take into consideration other systems and methods that are being used in relation to other substances. The point was made that alcohol should not be treated differently from other psychoactive drugs when it comes to implementation, even if WHO's member states asked for the strategy to focus only on the harmful use of alcohol.

It was explained that ASEAN has a mechanism for linking health to other sectors, which could be very helpful for implementation of the global strategy. It was further stressed that countries would

also need to work through civil society groups, NGOs and faith-based organizations. On 6–7 November 2009 there will be an ASEAN meeting on tobacco control in Bangkok. Although the ASEAN member states have asked for alcohol to be dealt with by a separate body from that which handles tobacco, it might be possible for the tobacco body to take care of alcohol on a temporary basis until a separate body is established.

The European Commission will be having ongoing discussions with EU member states on the EU alcohol strategy and, should the global strategy on reducing harmful use of alcohol be approved by the 63<sup>rd</sup> World Health Assembly, this would become a part of those discussions.

The OIV will have governing body meetings in October 2009 and March 2010, and the global strategy on reducing harmful use of alcohol could be added to the agenda. Otherwise, when the strategy is launched, OIV member states are likely to give their feedback on it and OIV may be called on to help them implement it.

The BSEC working group on health care will meet in November 2009 and an invitation was extended to WHO send a representative to the meeting to introduce the draft global strategy. If the global strategy includes an action plan, BSEC would welcome this.

Dr Poznyak mentioned that WHO would hold a meeting in October on the indicators for monitoring the strategy, and IGOs would be welcome to send representatives as observers. He asked participants to let the alcohol team at WHO know of further collaboration between their IGOs and WHO.

Mr Ross closed the meeting at 16:30.



## **Annexes**

**Annex 1. Scope and purpose of the consultation**

**Annex 2. List of participants in the consultation**

**Annex 3. Programme of the consultation**

**Annex 4. Resolution WHA61.4 on “Strategies to reduce harmful use of alcohol” (63<sup>rd</sup> World Health Assembly, May 2008)**





# ***WORLD HEALTH ORGANIZATION***

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**Consultation with representatives of intergovernmental organizations on ways they could contribute to reducing harmful use of alcohol.**

**8<sup>th</sup> September 2009 - Geneva, SWITZERLAND**

**Salle C - WHO Headquarters**

## **SCOPE AND PURPOSE**

On 24 May 2008, the 61st session of the World Health Assembly adopted an important resolution on "Strategies to reduce the harmful use of alcohol". The resolution calls for the development by 2010 of a draft global strategy to reduce the harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options. In addition the WHO Secretariat requested to collaborate and consult with Member States, as well as consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol. It is as a part of this latter request that the Secretariat of the World Health Organization is inviting representatives of selected intergovernmental organizations to a consultation meeting in Geneva on 8<sup>th</sup> September 2009.

The meeting will have a global focus, but to ensure broad representation worldwide and also regional intergovernmental organizations will be invited.

The main focus of the consultation will be on how the intergovernmental organizations could contribute to reducing harmful use of alcohol worldwide and support the development, implementation and monitoring of strategies and programmes aimed at the reduction of alcohol-related harm. Furthermore, an additional focus will be on exploring possible ways for a more structured interaction at global level between the WHO Secretariat and intergovernmental organizations, also in the context of implementation of the above-mentioned World Health Assembly resolution.

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# ***WORLD HEALTH ORGANIZATION***

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**Consultation with representatives of intergovernmental organizations on ways they could contribute to reducing harmful use of alcohol.**

**8<sup>th</sup> September 2009 - Geneva, SWITZERLAND**

**Salle C - WHO Headquarters**

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## **WHO SECRETARIAT**

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**Mr Dag Rekve**, Technical Officer, Management of Substance Abuse, Department of Mental Health and Substance Abuse, Noncommunicable Diseases and Mental Health

**Mr Alex Ross**, Director, Partnership and UN Reform

**Mr Igor Rozov**, External Relations Officer, Coordination with UN and other Intergovernmental Agencies

**Dr Benedetto Saraceno**, Director, Department of Mental Health and Substance Abuse (unable to attend)

**Ms Egle Granziera**, Legal Officer, Government Bodies and Public International Law

**Dr Isy Vromans**, Technical Officer, Management of Substance Abuse, Department of Mental Health and Substance Abuse, Noncommunicable Diseases and Mental Health





# ***WORLD HEALTH ORGANIZATION***

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**Consultation with representatives of intergovernmental organizations on ways they could contribute to reducing harmful use of alcohol.**

**8<sup>th</sup> September 2009 - Geneva, SWITZERLAND**

**Salle C - WHO Headquarters**

## **PROVISIONAL AGENDA**

Registration

**1. Introduction**

Welcome remarks

Introduction of the participants

Resolution WHA61.4 and follow up activities by the WHO Secretariat

**2. Statements or presentations from represented organizations on ways they could contribute to reducing harmful use of alcohol**

**3. Collaboration among intergovernmental organizations on priority directions and target areas for reducing harmful use of alcohol worldwide**

**4. Next steps for strengthening collaboration of intergovernmental organizations, also within the context of implementation of WHA61.4.**

**5. Conclusions and closure of the meeting**

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**Agenda item 11.10 24 May 2008**

**SIXTY-FIRST WORLD HEALTH ASSEMBLY WHA61.4**

## **Strategies to reduce the harmful use of alcohol**

The Sixty-first World Health Assembly,

Having considered the report on strategies to reduce the harmful use of alcohol and the further guidance on strategies and policy element options therein;

Reaffirming resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse and WHA57.16 on health promotion and healthy lifestyles;

Recalling resolution WHA58.26 on public-health problems caused by harmful use of alcohol and decision WHA60(10);

Noting the report by the Secretariat presented to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public health problems caused by harmful use of alcohol;<sup>1</sup>

Noting the second report of the WHO Expert Committee on Problems Related to Alcohol Consumption<sup>2</sup> and acknowledging that effective strategies and interventions that target the general population, vulnerable groups, individuals and specific problems are available and should be optimally combined in order to reduce alcohol-related harm;

Mindful that such strategies and interventions must be implemented in a way that takes 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;

Deeply concerned by the extent of public health problems associated with harmful use of alcohol, including injuries and violence, and possible links to certain communicable diseases, thereby adding to the disease burden, in both developing and developed countries;

Mindful that international cooperation in reducing public-health problems caused by the harmful use of alcohol is intensifying, and of the need to mobilize the necessary support at global and regional levels,

<sup>1</sup> Documents A60/14 and A60/14 Add.1.

<sup>2</sup> WHO Technical Report Series, No. 944, 2007.

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**1. URGES Member States:**

- (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) to develop, in interaction with relevant stakeholders, national systems for monitoring alcohol consumption, its health and social consequences and the policy responses, and to report regularly to WHO's regional and global information systems;
- (3) to consider strengthening national responses, as appropriate and where necessary, to public health problems caused by harmful use of alcohol, on the basis of evidence on effectiveness and cost-effectiveness of strategies and interventions to reduce alcohol-related harm generated in different contexts;

**2. REQUESTS the Director-General:**

- (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;
- (2) to ensure that the draft global strategy will include a set of proposed measures recommended for States to implement at the national level, taking into account the national circumstances of each country;
- (3) to include full details of ongoing and emerging regional, subregional and national processes as vital contributions to a global strategy;
- (4) to collaborate and consult with Member States, as well as consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol;
- (5) to submit to the Sixty-third World Health Assembly, through the Executive Board, a draft global strategy to reduce harmful use of alcohol.

Eighth plenary meeting, 24 May 2008  
A61/VR/8

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**Department of Mental Health and Substance Abuse**  
**World Health Organization**  
**Geneva, 2009**

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