

# **SPC/WHO<sup>1</sup> Meeting on Alcohol<sup>2</sup> and Health in the Pacific**

## **SPC Headquarters, Noumea, New Caledonia, 28-30<sup>th</sup> September 2004**

### **1. Introduction and Objectives**

#### **1.1 Background**

In September 1985 a joint conference on alcohol related problems in Pacific Island Countries, hosted by the Secretariat of the Pacific Community and the World Health Organization for governmental and non-governmental organizations recommended that governments and agencies:

- document the social, health and economic harm done by alcohol;
- undertake annual reviews of legislation on alcohol;
- establish and enforce effective regulation;
- legislate to reduce the harm done by alcohol;
- focus particularly on alcohol-related violence, and
- guarantee at least one per cent of the funds out of the revenue of the sales of alcohol to fund plans and actions to prevent and reduce the harm done by alcohol.

Little progress has been made on much of this agenda since that time.

In 2003 the SPC Public Health Programme established a section to ensure the development of effective practice for alcohol policies, prevention and education. Following discussions at SPC in 2003 it was decided to hold a Pacific wide meeting to review the developments on alcohol and health in the Pacific. This meeting aimed to provide an opportunity for Member States to review policy, identify plans and outline some concrete actions to address the impact from alcohol.

In discussions with both the World Health Organization, South Pacific Office in Suva, Fiji and the Ministry of Health in New Zealand they agreed to collaborate in resource and support for the meeting, which enabled a full invitation to be given to all Pacific countries and territories.

Invitations were extended to all countries and responses were received from all countries. Finally, official representatives of 17 Pacific Islands and territories from the following countries attended as follows: Cook Islands, Federated States of Micronesia, Fiji, Polynesie Francaise, Guam, Kiribati, Marshall Islands, Nauru, Niue, Nouvelle Caledonie, Palau, Papua New Guinea, Soloman Islands, Tokelau, Tuvalu, and Wallis et Futuna. A list of participants and observers is provided in Annex ....

#### **1.2 Objectives of the meeting**

The objectives for the meeting were as follows:

Participants to the meeting would:

- ∞ Review current knowledge of alcohol use and patterns of change and development within the Pacific;
- ∞ Identify current policy, plans, regulation or legislation in regard to alcohol within Member States and the Region;

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<sup>1</sup> In addition to the SPC/WHO collaboration, support for the meeting was provided by the New Zealand Ministry of Health.

<sup>2</sup> Alcohol includes commercially produced, non-commercially produced, home brew and illicit alcohol.

- ∞ Consider and recommend options for national and/or Pacific regional strategy; and
- ∞ Produce a summary report for governments.

### **1.3 Programme Outline and Agenda**

A copy of the programme outline for the meeting is attached in Annex ....

While several plenary presentations were made each day, a large portion of time was set aside for brief country reports and for enabling country groups to review policy directions and the future needs within country to address the use and harmful consequences of alcohol.

Professor Sally Casswell presented a keynote address on “Alcohol and Public Policy; Evidence for Effectiveness” and a presentation on “What is Harm Minimisation in the Pacific.” Professor Casswell is Director of the Centre for Social and Health Outcome Research and Evaluation (SHORE) at Massey University in New Zealand, and is Chair of the Alcohol Policy Strategy Advisory Committee, of the World Health Organisation. Key elements of this presentation are presented in Section II of this report under the evidence for effectiveness.

Dr Peter Anderson presented information on “Alcohol – What are the real risks?” and on two other topics including some lessons from the “The European Action Plan on Alcohol” and “Effectiveness of Brief Intervention Strategies.” Further details of these presentations are also included in later sections of this report.

Key World Health Organization representatives from three tiers attended the meeting. Dr Ken Chen from the South Pacific Office in Suva spoke of the need to review policies and look at the effective responses to the problems caused by alcohol. Dr Vladimir Poznyak, Acting Coordinator from the Department of Mental Health and Substance Abuse of WHO, Geneva spoke on recent alcohol policy developments within WHO. Dr Hao Wei, Medical Officer in the section of Mental Health and Control of Substance Abuse at the Western Pacific Regional Office in Manila spoke on “Mental Health and Alcohol” as well as presenting the first country data from the WHO STEPS Surveillance which is being widely implemented within the Pacific Countries.

Other presentations, some details of which are presented in the later sections of this report were made by other speakers as follows:

- Bruce Wight from the Commonwealth Department of Health and Aging in Canberra presented information on key policy and regulation on drink driving and the importance of community based intervention strategies;
- Helen Tavola from the Pacific Islands Forum Secretariat discussed the trade issues surrounding the Pacific Island Countries Trade Agreement; and
- Derek Rutherford from the Global Alcohol Policy Alliance outlined the developments taking place in some of the non-government agencies globally and plans that are in place to also include the Pacific in these global developments.

Prior to the meeting a questionnaire was circulated to all participants requesting information on the current policy and position within countries on alcohol. A copy of the questionnaire is attached in Annex ... Details of the results of this questionnaire are presented in the later sections of this report, including the outcomes from the working groups that included barriers to change within countries and resources and measures that are needed to support the implementation of effective policy.

## **2. Presentations and Findings**

Alcohol use has increased in the Pacific particularly over the last 50 years. Currently, alcohol represents one of the most significant risks to health globally. The 2002 World Health Report showed alcohol as the leading risk in low mortality countries in the developing world accounting for 6.2% of all health risks and 9.2% in the developed countries. Reports from countries gave clear evidence of this topic as being very important in the Pacific region.

Data from the World Health Organization finds that of the 2 billion people who consume alcoholic beverages worldwide, over 76 million are diagnosed with alcohol use disorders at any one time. Globally, alcohol causes 3.2% of deaths (1.8 million) and 4.0% of ill-health and premature death (58.3 million years); it is the leading risk factor for disease burden in the Western Pacific Region which includes the Pacific Islands Countries and Territories. Alcohol is a drug of dependence and can cause 60 or more different types of disease and injury. Alcohol is also responsible for widespread social, mental and emotional harms, including crime and family violence, which are of particular importance in the Pacific Islands Countries and Territories. The combined impact leads to very significant costs to society. Alcohol not only harms the user, but those surrounding the user, including the unborn child, children, family members, and the sufferers of crime, violence and drink driving accidents. This is often referred to as environmental alcohol damage or “passive drinking”.

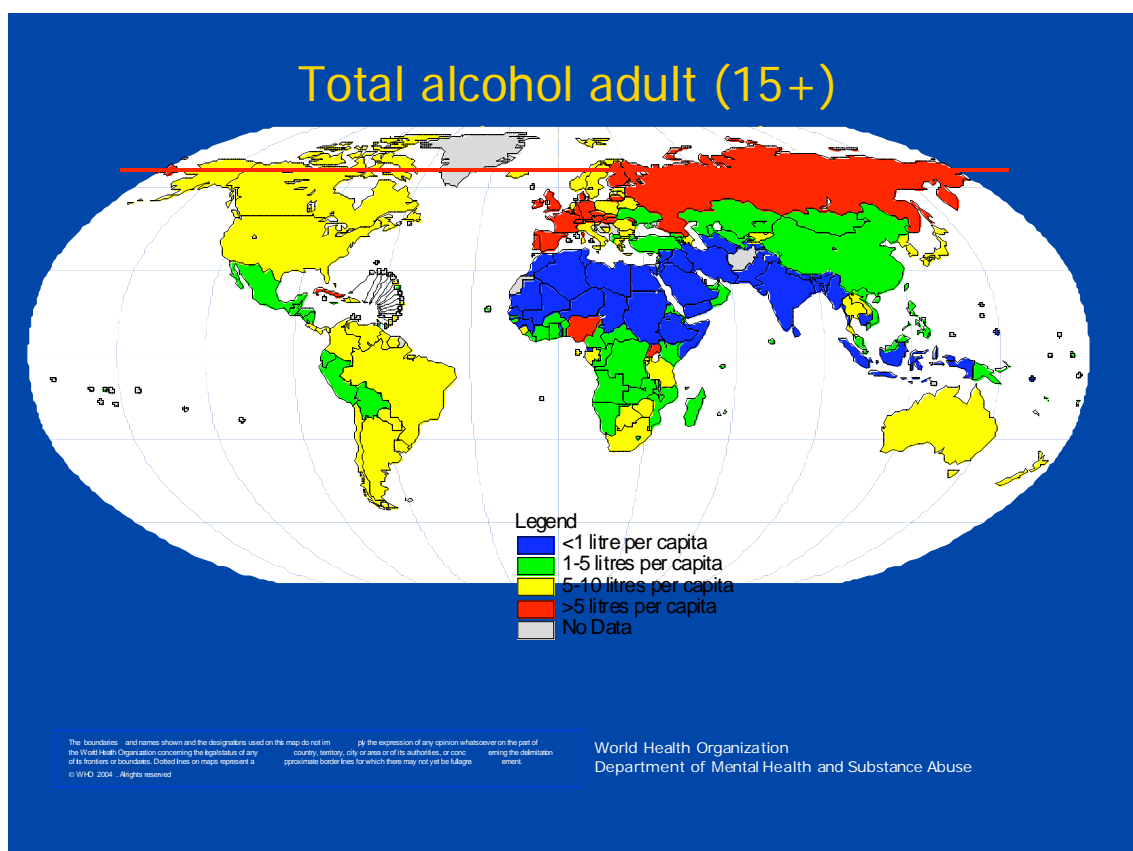
### **2.1 Alcohol consumption**

The distribution of consumption throughout the world is shown in Figure 1 and Table 1. While consumption of alcohol in the Western Pacific is relatively low by world levels, alcohol use is increasing.

The review of current knowledge of alcohol use, patterns of change and development within the Pacific, and current policy, plans, regulation or legislation on alcohol is listed in Annex 1: Country Reports. Because of the diversity of status within the Pacific, a summary of this information is difficult to achieve but the following points outline some areas or cluster situations and trends:

- ∞ The percent of alcohol users in populations varies quite significantly across the region from 20-30% in some low use countries such as the Solomon Islands, Tuvalu and to some extent Vanuatu, up to 80-90% of the population in the French Polynesia, New Caledonia and Wallis and Futuna;
- ∞ There is a strong bias to male drinking in a number of countries including the Federated States of Micronesia, Papua New Guinea, Solomon Islands, Tuvalu and to a large extent Vanuatu;
- ∞ Within most countries, among those who do use alcohol roughly 20-30% are heavy drinkers and exhibit problem drinking behaviours;

- ∞ Many Pacific drinkers drink episodically or in a “binge” way, particularly at weekends;
- ∞ There is a widespread and increasing problem of youth drinking at earlier ages in a large number of the countries. This was reported from the Cook Islands, Federated States of Micronesia, Fiji, Guam, Kiribati, Marshall Islands, Palau, Tonga and Vanuatu.
- ∞ Information from research on Pacific island drinking patterns in New Zealand shows:
  - Pacific born people often have slightly lower drinking patterns in their country of migration than those born in NZ
  - they will often drink almost double the amount of other groups at a sitting (9 drinks as opposed to 5);
  - 30% cannot remember what they did;
  - the levels of problems observed by others present among this group was generally double that of others (18% compared to 10%); and
  - there was increased motor vehicle crashes, sexual harassment and other resultant problems.



**Figure 1: Global total alcohol adult per capita consumption.**

**Table 1. Characteristics of alcohol consumption in different regions of the world, late 1990s (population weighted averages).**

| WHO Region                       | Predominant Beverage type           | Total consumption <sup>1</sup> | % drinkers among males <sup>2</sup> | % drinkers among females <sup>3</sup> | Consumption per drinker <sup>4</sup> |
|----------------------------------|-------------------------------------|--------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| North and Central Africa         | Mainly fermented beverages          | 4.9                            | 47                                  | 27                                    | 13.3                                 |
| Southern Africa                  | Mainly fermented beverages and beer | 7.1                            | 55                                  | 30                                    | 16.6                                 |
| North America                    | Beer, followed by spirits           | 9.3                            | 73                                  | 58                                    | 14.3                                 |
| Latin America                    | Beer, followed by spirits           | 9.0                            | 75                                  | 53                                    | 14.1                                 |
| South America                    | Spirits, followed by beer           | 5.1                            | 74                                  | 60                                    | 7.6                                  |
| Middle East                      | Spirits and beer                    | 1.3                            | 18                                  | 4                                     | 11.0                                 |
| Western Asia                     | Spirits and beer                    | 0.6                            | 17                                  | 1                                     | 6.0                                  |
| Western Europe                   | Wine and beer                       | 12.9                           | 90                                  | 81                                    | 15.1                                 |
| Central Europe                   | Spirits                             | 9.3                            | 77                                  | 57                                    | 14.3                                 |
| Caucasus and Central Asia        | Spirits and wine                    | 4.3                            | 54                                  | 33                                    | 9.9                                  |
| Former Soviet Union              | Spirits                             | 13.9                           | 89                                  | 81                                    | 16.5                                 |
| South-East Asia                  | Spirits                             | 3.1                            | 35                                  | 9                                     | 13.7                                 |
| Indian sub-continent             | Spirits                             | 2.0                            | 26                                  | 4                                     | 12.9                                 |
| Australasia and Japan            | Beer and spirits                    | 8.5                            | 87                                  | 77                                    | 10.4                                 |
| Western Pacific, including China | Spirits                             | 5.0                            | 84                                  | 30                                    | 8.8                                  |

1 Estimated alcohol consumption per resident aged 15 and older, including recorded and unrecorded consumption, litres of absolute alcohol per year.

2 Estimated proportion of male drinkers aged 15 and older.

3 Estimated proportion of female drinkers aged 15 and older.

4 Estimated alcohol consumption per drinker aged 15 and older, litres of absolute alcohol per year.

Source: Rehm *et al.* (2003)

## 2.2 The harm done by alcohol

Table 2 shows the relative risks for various conditions by alcohol consumption for men and women. For many conditions, alcohol increases the risk of disease and injury in a dose dependent manner, with no evidence for a threshold effect. The higher the alcohol consumption, the greater is the risk.

**Table 2. Relative risks for stated conditions**

|   | Women                      |              |       | Men         |              |       |
|---|----------------------------|--------------|-------|-------------|--------------|-------|
|   | Alcohol consumption, g/day |              |       |             |              |       |
|   | 0-<br>19.99                | 20-<br>39.99 | 40+   | 0-<br>39.99 | 40-<br>59.99 | 60+   |
| <b>Neuro-psychiatric conditions</b>                   |                            |              |       |             |              |       |
| Epilepsy  | 1.34                       | 7.22         | 7.52  | 1.23        | 7.52         | 6.83  |
| <b>Gastrointestinal conditions</b>                    |                            |              |       |             |              |       |
| Cirrhosis of the liver                                | 1.30                       | 9.50         | 13.00 | 1.30        | 9.05         | 13.00 |
| Diabetes mellitus                                     | 0.92                       | 0.87         | 1.13  | 1.00        | 0.57         | 0.73  |
| <b>Malignant neoplasms</b>                            |                            |              |       |             |              |       |
| Mouth and oropharynx cancers                          | 1.45                       | 1.85         | 5.39  | 1.45        | 1.85         | 5.39  |
| Oesophageal cancer                                    | 1.8                        | 2.38         | 4.36  | 1.8         | 2.38         | 4.36  |
| Liver cancer  | 1.45                       | 3.03         | 3.60  | 1.45        | 3.03         | 3.60  |
| Breast cancer   | 1.14                       | 1.41         | 1.59  |             |              |       |
| under 45 years of age                                 | 1.15                       | 1.41         | 1.46  |             |              |       |
| 45 years and over                                     | 1.14                       | 1.38         | 1.62  |             |              |       |
| Other neoplasms                                       | 1.10                       | 1.30         | 1.70  | 1.10        | 1.30         | 1.70  |
| <b>Cardiovascular (CVD) diseases</b>                  |                            |              |       |             |              |       |
| Hypertensive disease                                  | 1.40                       | 2.00         | 2.00  | 1.40        | 2.00         | 4.1.0 |
| Coronary heart disease                                | 0.82                       | 0.83         | 1.12  | 0.82        | 0.83         | 1.00  |
| Cerebrovascular disease                               |                            |              |       |             |              |       |
| Ischaemic stroke                                      | 0.52                       | 0.64         | 1.06  | 0.94        | 1.33         | 1.65  |
| Haemorrhagic stroke                                   | 0.59                       | 0.65         | 7.98  | 1.27        | 2.19         | 2.38  |
| Other CVD causes                                      | 1.5                        | 2.2          | 2.2   | 1.5         | 2.2          | 2.2   |
| <b>Conditions arising during the perinatal period</b> |                            |              |       |             |              |       |
| Low birth weight<br>(RR refers to drinking of mother) | 1.00                       | 1.40         | 1.40  | 1.00        | 1.40         | 1.40  |

Source: Rehm *et al.* (2003)

A small level of alcohol consumption generally reduces the risk of heart disease, although the exact size of the reduction in risk and the level of alcohol consumption at which the greatest reduction occurs are still uncertain. Most of the reduction in risk can be achieved by one drink every other day, and beyond two drinks a day the risk of coronary heart disease increases. It appears that alcohol reduces the risk of heart disease rather than a specific type of beverage, such as beer, wine or spirits.. Intoxicating patterns of drinking increase the risk of cardiac arrhythmias and sudden coronary death.

Alcohol is one of the most important causes of ill-health and premature death. The estimated attributable fractions are shown in the Table 3

**Table 3. Estimated attributable fractions**

|   | Men | Women |
|---|-----|-------|
| <b>Intentional and unintentional injuries</b> |     |       |
| Drowning                                      | 43  | 25    |
| Falls   | 21  | 8     |
| Homicide                                      | 41  | 32    |
| Self-inflicted injuries                       | 27  | 12    |
| Poisoning                                     | 43  | 26    |
| Other intentional injuries                    | 32  | 19    |
| Motor vehicle accidents                       | 45  | 18    |
| Other unintentional injuries                  | 32  | 16    |
| <b>Neuro-psychiatric conditions</b>           |     |       |
| Alcohol use disorders                         | 100 | 100   |
| Depression                                    | 7   | 2     |
| Epilepsy                                      | 45  | 36    |
| <b>Gastrointestinal conditions</b>            |     |       |
| Cirrhosis of the liver                        | 67  | 58    |
| Diabetes mellitus                             | -6  | -6    |
| Pancreatitis                                  | 40  |       |
| <b>Cancers</b>                                |     |       |
| Mouth and oropharynx cancers                  | 44  | 33    |
| Oesophageal cancer                            | 49  | 41    |
| Liver cancer                                  | 40  | 33    |
| Breast cancer                                 |     | 13    |
| Other neoplasms                               | 11  | 8     |
| <b>Cardiovascular diseases</b>                |     |       |
| Hypertensive disease                          | 36  | 25    |
| Coronary heart disease                        | -16 | -13   |
| Cerebrovascular disease                       |     |       |
| Ischaemic stroke                              | 3   | -46   |
| Haemorrhagic stroke                           | 27  | -13   |
| <b>Reproductive conditions</b>                |     |       |
| Low birth weight                              | 2   | 2     |

Source: Rehm *et al.* (2003)

The risk of death from alcohol is a balance between the risk of disease and injury that alcohol increases and the decreased risk of heart disease from small amounts of alcohol. This balance shows that, except for older people, moderate drinking is not risk free. The level of alcohol consumption with the lowest risk of death is zero or near zero for women under the age of 65, and less than one drink every second day for women aged 65 years or older. For men, the level of alcohol consumption with the lowest risk of death is zero under 35 years of age, about one drink every second day in middle age, and less than one drink a day when aged 65 years or older.

The World Health Organization's Global Burden of Disease (GBD) Study estimates the contribution that different risk factors, such as alcohol have in causing ill-health and premature death. Ill-health and premature death is measured by the disability adjusted life year (DALY), which is a measure of one year of ill-health or premature death.<sup>3</sup> The GBD study finds that for the year 2002, alcohol was the top most important risk factor for the Western Pacific Region B, which includes the Pacific Islands. Overall, injuries account for the largest portion of the disease burden due to alcohol, with 40% in total, and with unintentional injuries by far outweighing intentional injuries. The second largest category is neuropsychiatric diseases and disorders with 38%. Other disease caused by alcohol (such as the non-communicable diseases liver cirrhosis, cancers and cardiovascular disease) each contributes 7% to 8% of the total. The DALY's are listed in Table 4.

**Table 4 . Global burden of disease (DALYs in 1000's) attributable to alcohol by major disease categories for year 2000.**

| Disease conditions  | DALYs  | %      |
|---|--------|--------|
| Cancers: <b>Head and neck cancers, gastrointestinal tract cancers including liver cancer, female breast cancer</b>                                | 4,201  | 7.2%   |
| Neuropsychiatric conditions: <b>alcohol dependence syndrome, depression, anxiety disorder, organic brain disease</b>                              | 21,904 | 37.7%  |
| Cardiovascular conditions: <b>ischaemic heart disease, cerebrovascular disease</b>  | 3,983  | 6.9%   |
| Gastrointestinal conditions: <b>alcoholic liver cirrhosis, cholelithiasis, pancreatitis</b>   | 4,555  | 7.8%   |
| Maternal and perinatal conditions: <b>low birth weight, intrauterine growth retardation</b>   | 123    | 0.2%   |
| Accidents and unintentional injuries: <b>road/transport injuries, falls, drowning and burns, occupational/machine injuries, alcohol poisoning</b> | 15,767 | 27.2%  |
| Intentional and self-inflicted injuries: <b>suicide and assaults</b>  | 7,514  | 12.9%  |
| Alcohol-related disease burden all causes (DALYs)   | 58,047 | 100.0% |

<sup>3</sup> The World Health Report 2002: Reducing Risks, Promoting Healthy Life. World Health Organization, Geneva, 2002.

## 2.4 Alcohol and violence

There is a straight line relationship between alcohol consumption and the risk of involvement in violence, including homicide. This relationship is stronger for intoxication than for overall consumption. A large number of studies have demonstrated a significantly increased risk of involvement in violence among heavy drinkers, who are also more likely to be the victims of violence. There is an overall relationship between greater alcohol use and criminal and domestic violence, with particularly strong evidence in studies of domestic violence. Generally the more serious the crime or injuries, the more likely alcohol is to be involved. Homicides are more likely to involve alcohol than are less serious crimes. A causal link between alcohol intoxication and violence is supported not only by epidemiological and experimental research but also by research indicating specific biological mechanisms that link alcohol to aggressive behaviour.

Violence against intimate partners is much more likely to involve alcohol than is violence against strangers. The risk of alcohol related sexual assaults by strangers seem to be more likely to occur the greater the alcohol consumption of the victim, whereas the risk of alcohol-related sexual assaults by partners or spouses seems to be independent of the alcohol consumption of the victim. A large number of studies have reported a variety of childhood adversities to be more prevalent among children of heavy drinkers than others, although some of these studies have been criticised for methodology. A few recent reports from well-designed studies have shown a higher risk of child abuse in families with heavy drinking parents.

Violence in all its forms, particularly gender-based violence, has existed in Pacific island societies (physical and psychological abuse) but it was not previously associated with alcohol. In fact, aside from a fermented coconut palm drink known in a few Pacific islands, alcohol did not exist. Kava, which cannot be compared to alcohol, was only grown and consumed on certain islands (Fiji, Vanuatu, Wallis, Futuna). In addition, palm wine and kava were only consumed during customary ceremonies and such customary use did not lead to violence in social relations or in male-female relations.<sup>4</sup>

The first large-scale study conducted on violence amongst Pacific Island women, carried out in Samoa in 2000 by the Secretariat of the Pacific Community and the United Nations Population Fund, showed that alcohol was the second most frequent cause of violence towards women. In fact, the reasons that women in Samoa cited in this study as causes of violence against them were first family problems; second, as stated above, alcohol; then refusal to submit to the husband's authority; jealousy; money problems; refusal to have sexual relations; modernisation and the fact that women occasionally went out alone with their friends.

This study also revealed that gender violence leads to deep trauma and

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<sup>4</sup> Basil Thomson, *Decline in the Indigenous Population in Fiji, 1890*. National Archives, Fiji, (HB 1104.F5A3)

disturbance for those children who witness acts of violence against their mothers. Of the 488 women interviewed who had been physically abused, 43.3% said that their children had been witnesses on several occasions to the violence they were subjected to. The study showed that children who witnessed violence were more likely to have nightmares, were more aggressive, and had to repeat grades at school or quit school more often than children who had not witnessed violence in their immediate circles.

In New Caledonia, the study “Health and Living Conditions of New Caledonian Women” conducted by the French National Institute of Health and Medical Research in 2002 with 1012 women aged 18 to 54 indicated that one out of every eight women had been victim of sexual fondling, attempted rape or rape before the age of 15. Although it is difficult to establish a cause-and-effect link between alcohol and violence, the consequences of this relationship were widely highlighted in New Caledonia. Alcohol abuse is found in 88% of violent crimes, 70% of rapes and sexual aggressions and 80% of cases involving minor and medium delinquency.

## **2.5 Mental health**

People with mental health problems are at particular risk of experiencing problems relating to alcohol. People diagnosed as having an alcohol dependence problem are also more likely to suffer from other mental health problems. Depending on the type of mental health problem, alcohol can lead to poorer outcomes (self-harm, suicide etc.), make the symptoms worse (schizophrenia etc.), interact in a harmful way with the medications prescribed for that problem, and/or with other drugs, contribute to worse moods in the longer term (anxiety and depression); and result in disrupted sleep that may trigger some mental health problems.

Risk of alcohol dependence is significantly increased, particularly where the person drinks to relieve anxiety or change their mood. There is also considerable evidence that people with a mental health problem are more likely than the general population to have an alcohol dependence problem. Alcohol is itself a causal factor in a number of mental health conditions including alcoholic psychosis, alcohol dependence syndrome and alcohol-related dementia. Alcohol can provide temporary relief for people with anxiety, and people with alcohol dependence have reported that alcohol helps to reduce their anxiety. However, while alcohol consumption may bring some relief from anxiety or stress in the short term, it can worsen mood in the longer term, especially with continued drinking over two days or more, and/or at higher levels of consumption.

## **2.6 Alcohol and HIV**

Although official statistics reports 7,320 cases of HIV/AIDS in the Pacific Islands, the World Bank estimates that at least 50,000 people are living with the virus. Over 95% of reported HIV infections occur in Papua New Guinea, French Polynesia, Guam, New Caledonia, and Fiji. There are many unreported cases throughout the region due to the unavailability of testing facilities and generally low levels of surveillance.

General risk factors common in the Pacific include: significant amount of travel into, out of and within the region; tattooing, polygamy practices, uneven levels of development, gender inequalities, increasing levels of violence against women, and variable accessibility of health services.

There is a high prevalence of other sexually transmitted infections and high rates of teenage pregnancies, indicating a high prevalence of risk-taking behaviours and low use of condoms.

The UNICEF State of Health Behaviour and Lifestyle of Pacific Youth, 2001 survey showed amongst 15-19 year olds in Tonga that almost one half of boys reported having had sex, compared to 1 in 8 girls. Boys who had been sexually active showed a higher prevalence of having sex with 4 or more people in the past than girls. More than 20% of boys compared to under 5% of girls reported having unwanted sex when drunk in the past.

In Vanuatu, more than 50% of 15-17 year old boys have had sex compared to 43% of girls. More than 80% of boys have had sex with more than 1 partner. More than 30% of boys and 20% of girls reported to have unwanted sex when drunk in the past.

In the Solomon Islands, a 2002 survey of youth sexuality and urban life found that of 300 young people between 12 and 35 years, 86% have had sex in the past. 22% had not used a condom because they were drunk or stoned. Most drinking places coincided with places that are known for sexual activities (bush, on the road, Log Pond, in vehicles, at the market, gravel pits and seaside).

Alcohol influences high-risk sexual behaviour in two ways. First, as a marker for a risk-taking temperament. Those who drink alcohol may also engage in a variety of high-risk activities, including unsafe sexual practices. Second, as influencing high-risk behaviours during specific sexual encounters by affecting judgment and disinhibiting socially learned restraints. There are thus two different implications for the prevention of high-risk sexual behaviour related to alcohol. Among people who have a risk-taking temperament, reducing alcohol consumption may not reduce high-risk sexual behaviour. Among those who are more likely to take sexual risks when they are drinking than when they are not, reducing alcohol consumption should also reduce high-risk sexual behaviour.

Alcohol also impairs the normal immune responses that protect the body from disease. This means that drinking may increase vulnerability to HIV infection among people exposed to the virus, and, among people who are already HIV infected, alcohol-induced immunosuppression might add to HIV-induced immunosuppression, and speed the onset or exacerbate the pathology of AIDS-related illness.

### 3. Present policy and options available to reduce harm from alcohol

The participants at the meeting considered options for national and/or a Pacific regional strategy and its recommendations for governments and agencies are presented at the end of this report.

In reviewing the country reports presented at the meeting, the following general comments can be made concerning current policies within the Pacific:

- Few countries have any specific policy and plans to deal with alcohol;
- No country appears to have a central coordinating body for alcohol;
- Those countries with some plans generally have not developed collaborative approaches across government and non-government agencies;
- There is wide need for technical assistance in the development of policy and plans; and
- Even countries with existing policy and legislation, have weak or non-existent enforcement of the legislation.

A number of other issues also were presented that will influence policy and its development. These included:

- The prominent area of youth alcohol use and youth suicide, with the need for collaboration with youth action areas across the Pacific and especially for the meeting of youth ministers in 2005;
- The endemic violence against women associated with alcohol use, including sexual harassment. Studies from Samoa and New Caledonia confirmed this with particular bias towards greater problems in the indigenous community; and
- The potential impact of free trade agreements that lower the tariffs and price of alcohol need to be weighed against the health and community effects to reduce the current risks and burden of disease

Over the last twenty five years, considerable progress has been made in the scientific understanding of the relationship between alcohol policies, alcohol consumption and alcohol-related harm. The evidence finds three types of policies that are effective in reducing alcohol's burden:

1. **Population-based policies** such as those on taxation, advertising, regulation of density of outlets, hours and days of sale, drinking locations, and minimum drinking ages;

2. **Problem directed policies** aimed at specific alcohol-related problems such as drink driving; and
3. **Interventions directed at individual drinkers**, such as primary care based brief interventions for hazardous and harmful alcohol consumption.

A 2003 review for the World Health Organization (based largely on evidence from industrialized countries and English language literature) summarized alcohol policy options in terms of their effectiveness, breadth of research support and cost efficiency.

|   | Effectiveness <sup>1</sup> | Breadth of Research Support <sup>2</sup> | Cost Efficiency <sup>4</sup> |
|---|----------------------------|--|------------------------------|
| <b>Pricing and taxing</b>   |                            |  |                              |
| Taxes   | +++                        | +++                                      | +++                          |
| <b>Regulating alcohol promotion</b>                                     |                            |  |                              |
| Advertising bans  | +                          | +  | +++                          |
| Advertising content controls  | ?                          | O  | ++                           |
| <b>Regulating physical availability</b>                                 |                            |  |                              |
| Total ban on sales  | +++                        | +++                                      | +                            |
| Minimum drinking age  | +++                        | +++                                      | ++                           |
| Rationing   | ++                         | ++                                       | +                            |
| Government retail outlets   | +++                        | +++                                      | +++                          |
| Hours and days of sale  | ++                         | +++                                      | +++                          |
| Density of outlets  | ++                         | +  | +++                          |
| Server liability  | +++                        | +  | +++                          |
| Different availability by alcohol strength                              | ++                         | ++                                       | +++                          |
| <b>Drinking-driving countermeasures</b>                                 |                            |  |                              |
| Sobriety checks   | +                          | +++                                      | ++                           |
| Random breath testing (RBT)   | +++                        | ++                                       | +                            |
| Lowered BAC levels  | +++                        | +++                                      | +++                          |
| Administrative license suspension                                       | +++                        | ++                                       | ++                           |
| Graduated licensing   | ++                         | ++                                       | +++                          |
| Low BAC for youth (“zero tolerance”)                                    | +++                        | ++                                       | +++                          |
| Designated drivers and ride services                                    | O                          | +  | ++                           |
| <b>Treatment and early intervention</b>                                 |                            |  |                              |
| Brief intervention  | ++                         | +++                                      | ++                           |
| Alcohol problems treatment  | +                          | +++                                      | O                            |
| Mutual help/self-help attendance  | +                          | +  | +++                          |
| Mandatory treatment of repeat drinking-drivers                          | +                          | ++                                       | ++                           |
| <b>Altering the drinking context</b>                                    |                            |  |                              |
| Training servers to not serve persons to intoxication                   | +                          | +++                                      | ++                           |
| Training bar staff and managers to prevent and better manage aggression | +                          | +  | ++                           |
| Voluntary codes of bar practice   | O                          | +  | +++                          |
| Enforcement of on-premise regulations                                   | ++                         | +  | +                            |
| Safer bar environment/containers  | ?                          | +  | ++                           |

|                                 |    |     |     |
|---------------------------------|----|-----|-----|
| Community mobilization          | ++ | ++  | +   |
| <b>Education and persuasion</b> |    |     |     |
| Alcohol education in schools    | O  | +++ | +   |
| College student education       | O  | +   | +   |
| Public service messages         | O  | +++ | ++  |
| Warning labels                  | +  | +   | +++ |
| Promotion of alternatives       | ?  | +   | ?   |
| Alcohol-free activities         | O  | ++  | ++  |

<sup>1</sup> **Evidence of Effectiveness**—This criterion refers to the scientific evidence demonstrating whether a particular strategy is effective in reducing alcohol consumption, alcohol-related problems or their costs to society. The following rating scale was used:

- 0 Evidence indicates a lack of effectiveness
- + Evidence for limited effectiveness.
- ++ Evidence for moderate effectiveness.
- +++ Evidence of a high degree of effectiveness
- ? No studies have been undertaken or there is insufficient evidence upon which to make a judgment.

<sup>2</sup> **Breadth of Research Support.** The highest rating was influenced by the availability of integrative reviews and meta analyses. Breadth of research support was evaluated independent of the rating of effectiveness (i.e., it is possible for a strategy to be rated low in effectiveness but to also have a high rating on the breadth of research supporting this evaluation). The following scale was used:

- 0 No studies of effectiveness have been undertaken
- + Only one well designed study of effectiveness completed.
- ++ From 2 to 4 studies of effectiveness have been completed.
- +++ 5 or more studies of effectiveness have been completed.
- ? There is insufficient evidence on which to make a judgment.

<sup>3</sup> **Cost efficiency**—This criterion seeks to estimate the relative monetary cost to the state to implement, operate and sustain this strategy, regardless of effectiveness. For instance, increasing alcohol excise duties does not cost much to the state but may be costly to alcohol consumers. In this criterion, the lowest possible cost is the highest standard. Therefore, the higher the rating, the lower the relative cost to implement and sustain this strategy. The following scale was used:

- o Very high cost to implement and sustain
- + Relatively high cost to implement and sustain.
- ++ Moderate cost to implement and sustain.
- +++ Low cost to implement and sustain.
- ? There is no information about cost or cost is impossible to estimate.

Source: Babor et al (2003).

### 3.1 Taxation

There is a very broad evidence base for the effectiveness of taxation, which is low cost to implement. The public health approach to alcohol taxation policy regards tax as the crucial umbrella policy.

### 3.2 Advertising bans

There is some evidence for the effectiveness of advertising bans. Marketing in the Pacific region is taking many different forms, e.g. e-mailing young adults venues for promotion of new beverages.

### 3.3 Availability

Minimal legal purchase age and restrictions on availability are effective. With lower availability, there are fewer problems. Minimal legal purchase age restrictions are difficult to implement. Complementary methods to control informally produced alcohol also need to be considered.

The Pseudo-patron Community Action Project in New Zealand was set up to reduce off license supply to young people less than 18 years of age. During 2002, young people who looked 18 years old were given ten dollars and sent to buy alcohol. Information was recorded whether age identification was

requested and age signage displayed. The information was fed back to the licenses, and the number of sales made without identification verification dropped from 61% in 2002 to 46% in 2003.

The Pacific Action for Health Project (PAHP) used a satellite based Geographical Information System (GIS) to map alcohol, tobacco, kava & sour toddy outlets. The results informed Liquor Licensing Act reviews for outlet density, community input and exclusion zones. GIS data could be linked with police data to map the locality of crimes and outlets.

### **3.4 Drink driving**

Drink driving with random breath testing and establishing and lowering blood alcohol concentrations, with breathalysers and resources to implement them, can reduce alcohol-related road traffic fatalities.

The objectives of Australia's Drink Driving strategy are to reduce the incidence of injuries and fatalities due to drink driving and to reduce the incidence of injuries and fatalities to pedestrians when intoxicated. The strategy is built on a deterrence approach, with legislation, random breath testing, and high penalties. Punishment includes fines, cancellation of licences, attending courses, community service, paying for damages, bail conditions, effects on the family, placing names in the newspapers in some jurisdictions, and loss of job or difficulty in getting work. In 1981, 44% of fatalities recorded a blood alcohol concentration (BAC) of 0.05 or more. By 1997, this had fallen to 28%.

### **3.5 Brief Interventions**

Recognizing that alcohol is implicated in a very wide variety of physical and mental health problems in a dose dependent manner, primary health care providers have the opportunity of identifying people with hazardous and harmful alcohol consumption. Since primary health care involves the treatment of many common physical and mental conditions, their causes deriving from alcohol use need to be addressed and managed through screening and brief intervention (SBI) programmes.

One way of describing the effectiveness of SBI activity is to calculate the number who will benefit from reduced hazardous and harmful alcohol consumption and the occurrence of alcohol-related problems as a consequence of screening and brief intervention. For one adult patient to benefit, it has been suggested that 385 need to be screened, followed by a brief intervention for those found at risk. This figure compares favourably with other screening activities. For example, the number needed to screen for hypertension is 1250 and for colorectal cancer 3300. The number needed to treat is about 8 for both hazardous and harmful alcohol consumption and for alcohol-related harm. This means that 8 drinkers at risk need to be offered advice for one to benefit. This compares favourably with brief advice from a primary health care provider to cigarette smokers, where about 20 smokers have to be offered advice to quit for one to benefit.

A systematic review of the literature has concluded that the best screening instrument for use in primary care is the AUDIT (Alcohol Use Disorders

Identification Test) developed by the World Health Organization. Scores of 8 or more on the AUDIT predict a future risk of engaging in hazardous drinking, physical and social harms and health care utilization.

The core components of brief interventions include:

1. Give Feedback
2. Provide Information
3. Enable a goal to be established
4. Give Advice on Limits
5. Provide Encouragement

Brief interventions in primary health care are also highly cost effective. In the Western Pacific B Region of the WHO, the cost effectiveness of brief interventions for hazardous and harmful alcohol consumption is US\$536 per year of ill health and premature death avoided. In other words, if a primary health care provider is going to undertake a new activity in clinical practice, giving brief advice to drinkers with hazardous and harmful alcohol consumption will generate one of the best health benefits for the primary health care population than spending five minutes doing almost anything else available in clinical practice.

Providing support to primary health care providers is effective in increasing their screening and brief intervention rates. A supportive working environment is one in which screening and counselling materials, training and support with difficult cases are all available. But, to be effective, the training and support needs to be built on the needs and attitudes of the providers themselves. Where primary health care providers are able to reach 50% of the at risk drinkers, then 49 years of ill health and premature death per 100,00 population could be saved.

### **3.6 Community mobilization**

Community mobilization brings everyone together including the police, the media, community organizations, women's groups, and licensing authorities to ensure an efficient utilization of resources in community to reduce alcohol related harm. Australia's National Alcohol Strategy views two main approaches to community-based interventions: the community as a media market and as a setting where drinking takes place (the environmental perspective). Communities can be defined as geographical proximity of people (a town), social proximity, (a school), and ethnic grouping (Aboriginal communities in Australia). The Australian strategy includes activities for geographically isolated communities, interventions in the drinking environment and workplace interventions.

The Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI) project is a demonstration project designed to show that alcohol-related harm can be reduced by mobilising the whole community. It involves community development and mobilisation, provision of alternative activities, health education and marketing, policy changes and local networking

improvements (improved collaboration between individuals, business and government).

The responsible server training project aims to educate staff and licensees on law, safety and health, combined with law enforcement approaches, local laws and alcohol accords that are agreements between stakeholders committed to reduce alcohol-related harms.

To be effective, workplace interventions should be developed specifically for each workplace at a certain time of year and involve all staff from conception to implementation.

### **3.7 Education**

Extensive research has confirmed that education alone does not work in the long term in reducing the harm done by alcohol. Although education will be part of an alcohol policy response, consideration needs to be made of who needs to be educated, what is the information that needs to be communicated, and what is the best approach. The media are important avenues for communication, particularly when they are used to support effective public policies, for example, on drinking and driving. Education is not an effective use of resources to educate young people in the class room setting. For example, a more effective way would be to use the money for license inspectors to monitor licensing.

Australia's School Health and Alcohol Harm Reduction Project (SHARP) uses the experience of students and teachers to intervene before the start of drinking behaviour. The project includes coherent and consistent messages, developmentally appropriate information, resilience skills training, relating strategies to objectives, a focus on prevalent and harmful use, peer leadership, adequate initial coverage and follow-up and cultural sensitivity.

The 2005 Pacific Youth Strategy aims to strengthen health education and promotional programmes aimed at addressing youth health issues at regional and national levels, and involve young people in the planning, development and implementation of these programmes. It conducts peer education training programmes for young people on understanding sexual behaviour in adolescents; strategies for controlling alcohol and cigarette consumption; prevention of drugs and physical abuse; and coping with anxiety and depression. It aims to develop and strengthen appropriate 'youth-friendly' health services, sensitive to the health needs of young people in member countries and territories.

## **4. Developing and implementing alcohol policy**

### **4.1 Alcohol Policy at the Global Level**

The World Health Organizations' 2004 Resolution WHA57.16 urges Member States to include the harmful use of alcohol in the list of lifestyle-related risk factors as stated in the world health report 2002, and to give attention to the prevention of alcohol-related harm and promotion of strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol,

especially among young people and pregnant women, in the workplace, and when driving.

The World Health Organization published its review of the state of the world's alcohol policy in July 2004. WHO's Global Status Report presents one page profiles on alcohol policy for 117 Member States covering 86% of the world's population (see figure). It provides an overview for each alcohol policy area.

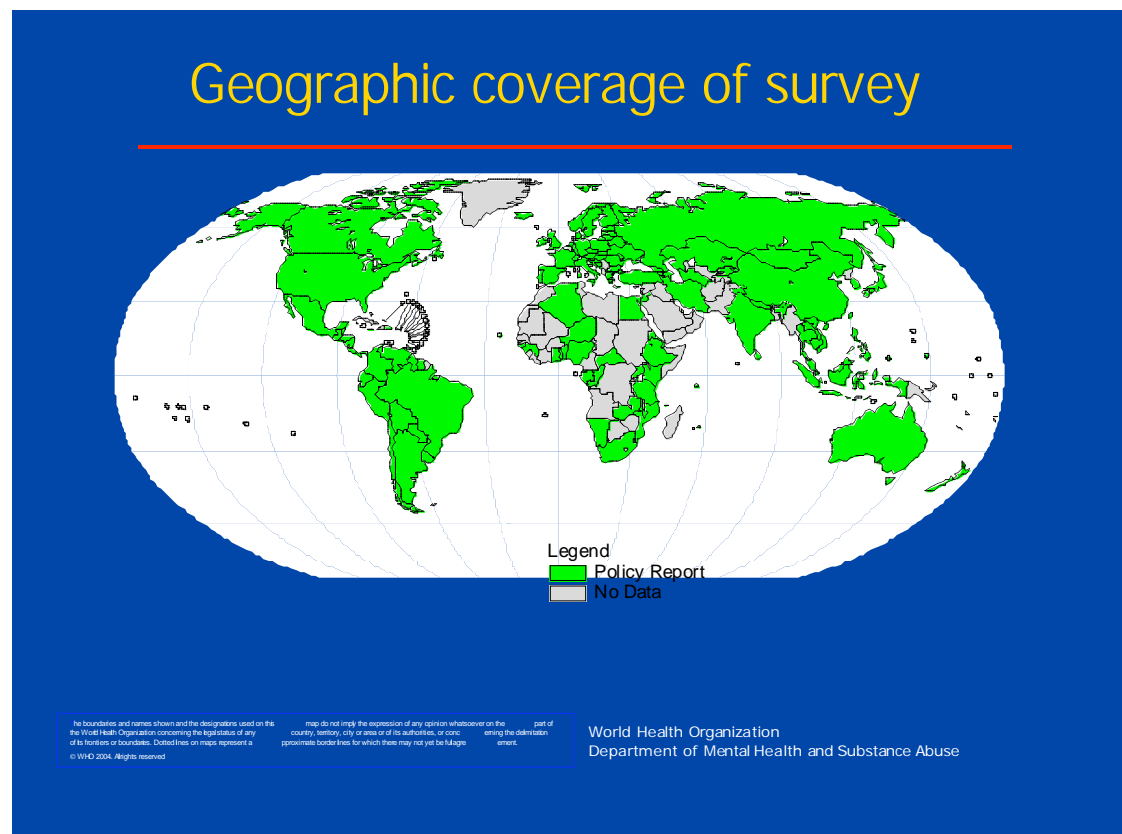


Figure 2. Global geographic survey of alcohol policy.

Figure 2 shows that alcohol policy can be implemented and that a large amount of policy already exists. More than half of the countries have restrictions on the place and time of sale of alcoholic beverages; three quarters have an age limit of purchase of 18 years or less; and two thirds have legal BAC level for driving of 0.6g/L or less.

Table 5: Policy implementation areas within countries – global data

| Policy area   |                              | Proportion of countries with policy area (%) |
|---|------------------------------|--|
| State monopoly on the sale of beer, wine or spirits                         |                              | 15%  |
| License for the sale of beer, wine or spirits                               |                              | 73%  |
| Restrictions on:  | density of outlets           | 16-22%                                       |
|   | places of sale               | 56-61%                                       |
|   | days of sale                 | 26-28%                                       |
|   | hours of sale                | 45-47%                                       |
| Age limit for purchase (15-18 years)  |                              | 70-77%                                       |
| Legal BAC for driving of "0.6 g/L   |                              | 67%  |
| Alcohol-specific tax  | >30% retail price of beer    | 25%  |
|   | >30% retail price of wine    | 28%  |
|   | >50% retail price of spirits | 30%  |
| Partial or total bans on advertising (in brackets total ban)                | National TV                  | 44-60% (16-29%)                              |
|   | Print media                  | 28-34% (4-11%)                               |
|   | Billboards                   | 32-38% (9-14%)                               |
| Partial or total bans on beer sponsorship of sports (in brackets total ban) |                              | 24% (8%)                                     |

Table 5 shows that in some areas there is still a long way to go, particularly with increased taxes on alcohol. . Taxes on Alcohol are justified to correct the misinformation on alcohol's dependence producing and harmful effects and to reflect alcohol's costs to society and to people others than the user. Alcohol taxes are a cost effective way of reducing harm, with an impact on heavier and younger users. Further taxes can help to correct alcohol's contribution to socio-economic differentials in mortality. Because the demand for alcoholic beverages tends to have low price elasticity, alcohol taxes provide an effective public policy option, in both reducing the economic costs of alcohol use and raising government revenue at the same time. However, less than one third of countries have a high tax on alcohol, defined as more than 30% of the retail price of beer or wine and more than 50% of the retail

price of spirits. In contrast three fifths of the world's countries have tobacco taxes which are more than 60% of the retail price.

#### **4.2 Alcohol policy development in the Pacific Islands**

On a scale from 1 (low priority) to 10 (high priority), country representatives considered alcohol policy (mean of 14 representatives = 4.6, SD= 2.14) and prevention programmes (mean of 14 representatives = 4.7, SD= 2.81) just towards low priority.

Following the group work, country representatives considered the main advances that were needed to support implementation of evidence-based alcohol policy are:

1. Government commitment and political will
2. Increased tax
3. Regulatory measures: legislation and multi-sectoral approaches
4. Enforcement and compliance of existing and new legislation
5. Prevention, promotion and public health workforce development and capacity building
6. Data, surveillance, research and evaluation, including monitoring, information sharing and best evidence for policy and interventions
7. Funding support
8. Strategic Plans, Action Plans and Implementation Plans
9. Co-ordination and networking across sectors – community, civil society, NGOs, police, health, customs, regional and national, including Churches, women's groups and others
10. Need to change social norms through advocating and educating for change and in achieving political and policy maker support
11. Tailoring to the needs of the community
12. Promoting greater opportunity for youth

To achieve these advances, the following were considered important:

1. Lobbying regarding legislative and policy changes
2. Mobilizing community stakeholders, and extend partnerships and coalitions
3. Economic studies
4. Local information
5. Multi-sectoral approaches
6. Increased and sustained funding
7. Development of regional, national and local strategies, plans and action plans
8. Establishment of a regional/national agency to advise on alcohol policy and to have a co-ordination role
9. A skilled and trained workforce
10. Increased community awareness of the harm done by alcohol and ownership of the issue
11. Change in political climate and support for alcohol policy interventions
12. Changes in health priorities and funding

### **4.3 The information base for alcohol policy**

The growing burden of non-communicable diseases (NCD) represents a major challenge to health development. Population-based primary prevention is the most cost-effective approach to reduce the burden of non-communicable diseases. Risk factor surveillance for NCD can help to guide the development and implementation of disease prevention and health promotion policies. The WHO STEPwise approach is to build one common approach to defining core variables for surveys and to achieve data comparability over time and between countries. STEPS offers an entry point for low and middle income countries to get started in NCD prevention and control activities.

The WHO STEPS Framework for risk factors provides a complete package, including planning templates and assistance, train the trainers courses, standardised materials and methods, access to on line data support and assistance in report writing. STEPS uses up-to-date NCD/risk factor data for policy and planning and is a part of the WHO's global activities and Regional Networks. The aggregated data is represented in WHO's Global NCD InfoBase.

The STEPS framework has been used in the Federated States of Micronesia, Fiji, the Marshall Islands, Samoa and Tonga. Some of the first Pacific STEPS information was presented at the Meeting from Fiji and Samoa.

### **4.4 Governmental action**

#### ***European Alcohol Action Plan of the World Health Organization***

Examples of international governmental action are the European Charter on Alcohol and the European Alcohol Action Plan endorsed by the 52 member States of the European Region of the World Health Organization.

The European Charter on Alcohol lists five rights in relation to alcohol policy:

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

The European Alcohol Action Plan contains ten action areas to support alcohol policy that meets the rights:

1. Inform people of the consequences of alcohol and of the effective measures that can be taken to prevent or minimize harm
2. Promote public, private and working environments protected from accidents and violence.
3. Establish and enforce laws that effectively discourage drink–driving.
4. Promote health by controlling the availability and influencing the price of alcohol.
5. Implement strict controls on direct and indirect advertising of alcohol.
6. Ensure the accessibility of effective treatment.
7. Foster awareness of ethical and legal responsibility of alcohol industry.
8. Enhance the capacity of society through the training of professionals.
9. Support nongovernmental organizations.
10. Formulate broad-based programmes in Member States; specify clear targets for and indicators of outcome; monitor progress; and ensure periodic updating of programmes based on evaluation.

The Action Plan calls on all European countries to have a comprehensive broad-based alcohol policy, and a system for reporting on alcohol consumption and for monitoring and evaluating the implementation of alcohol policy and the harm that can be done by alcohol. The Plan suggests that each country develop a country programme containing an action plan on alcohol with clear targets; establishes a body to coordinate the country programme and provide adequate funding for that function with a specific timetable to ensure implementation and monitoring of country-based action plans; and establishes an effective framework for monitoring and evaluating alcohol consumption and for tracking indicators of the harm that can be done by alcohol and alcohol control policy responses (this process may require the development of appropriate standardized research tools).

***European Union and European Commission*** The Constitutional Treaty of 18 June 2004 gives the Community the competence to establish incentive or other measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

The European Council Conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm stipulate that a high level of health protection shall be ensured in the definition and implementation of Community activities, in fields such as research, consumer protection, transport, advertising, marketing, sponsoring, excise duties and other internal market issues, while fully respecting Member States' competencies.

The Recommendation of the Council of the European Union of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents, calls for concerted action to reduce the harm done by alcohol to young people and, amongst other issues, stresses that (a) producers do not produce alcoholic beverages specifically targeted at children and adolescents;

and (b) alcoholic beverages are not designed or promoted to appeal to children and adolescents.

#### **4.5 Non-Governmental Organizations (NGOs)**

Non-Governmental Organizations (NGOs) have particular strengths that make them valuable partners of government and intergovernmental organisations. They provide effective ways of mobilizing community resources, attracting people and persuading them to give of their time and skills. They can work with a whole range of other bodies in health, the social services, education and industry. They have flexibility in identifying and responding to needs without being weighed down by top-heavy decision-making structures that stifle innovation. They can mobilise civil society for the promotion of alcohol policies which safeguard individuals, the family and society from the negative consequences of alcohol use. The services NGOs provide are user friendly.

The contribution of NGOs and voluntary organisations is greatest when they can complement and collaborate with academic institutions and statutory organisations. They can include alcohol specific organizations that address drink driving, advertising and marketing watchdogs, underage drinking, and problem drinkers, and general social organisations, such as residential and neighbourhood groups, women's organisations and groups, youth organisations, family organisations, church groups, employee associations and support and counselling groups.

Governments should support NGOs and networks that have experience and competence in advocating alcohol policies and NGOs and networks that have a specific role to play in informing and mobilising civil society with respect to alcohol-related problems, lobbying for policy change and effective implementation of policy at government level, as well as exposing the harmful actions of the alcohol industry.

Governments must recognise the independence of NGO's, ensure their freedom from industry constraints, give the ability for their critical appraisal of government policy, and provide for their financial support. NGOs must recognise that policy advocacy should be based on scientific knowledge, cultural sensitivity, and be politically pragmatic.

#### ***Examples:***

##### **4.5.1 Eurocare**

An European example of an NGO is Eurocare, which was formed in 1990 as an alliance of voluntary and non-governmental organisations representing a diversity of views and cultural attitudes and concerned with the impact of the European Union on alcohol policy in Member States. Eurocare works with both the WHO and the European Union.

In 1992 Eurocare was invited as a NGO observer to the first WHO government counterparts meeting of the European Alcohol Action Plan. Since then Eurocare has attended all 13 WHO Counterparts meetings. It presented the NGO Statement to the first WHO Ministerial Conference in Paris on

Health, Society and Alcohol signed by over 80 European NGOs. At the Second WHO Ministerial Conference on Alcohol and Young People in Stockholm in 2001, Eurocare was responsible for a working group on alcohol problems in the family.

Eurocare's paper on employment recognized that higher duties would assist in preventing alcohol problems based on the polluter pays principle. Following its presentation the European Parliament adopted a resolution calling for excise duties to take into account health considerations, and requesting that the external costs of alcohol should be assessed in all member states.

With a three year project grant of €1.2 million from the European Commission, Eurocare created a European Platform on alcohol policy with representation in all Member States. The platform, which involves non-governmental organizations, public health, governmental officials, researchers, programme implementers is creating alcohol policy reports in all the member states, is encouraging member states to implement the European Council's recommendation on alcohol and young people, is developing a comprehensive approach across the European Union on a community strategy to reduce alcohol related harm and is producing an alcohol advocacy training manual and course.

Eurocare's Policy on Alcohol for Europe recognises that alcohol is no ordinary commodity and recognizing that evidence based policy that reduces the harm done by alcohol is a public good,. The Policy addresses the following issues:

- I. Reduction in drinking driving
- II. Education, communication, training and public awareness
- III. Regulation of the alcohol market
  - III.1 Packaging and labelling of alcohol products
  - III.2 Price and tax measures to reduce the harm done by alcohol
  - III.3 Illicit trade in alcoholic products
  - III.4 Travellers allowances within the European Union
  - III.5 Restrictions on the availability of alcohol
  - III.6 Sales to minors
  - III.7 Alcohol advertising, promotion and sponsorship
- IV. Reducing harm in drinking and surrounding environments
- V. Interventions for individuals and families
  - V.1 Interventions for hazardous and harmful alcohol consumption and alcohol dependence
  - V.2 Interventions and assistance for family members of people with alcohol dependence
- VI. Implementing policies
- VII. Research, surveillance and exchange of information

Each European country (and, where relevant, local community, municipality and region within a country), and the European Union as a whole, should develop, implement, periodically update and review comprehensive

multisectoral alcohol policy strategies, plans and programmes. Research and research programmes, surveillance, and exchange of information at the local, regional, country and European levels in the field of alcohol policy should be developed and promoted. Similar implementation to that in Europe may be possible in the future within the Pacific.

#### **4.5.2 Global Alcohol Policy Alliance**

The Global Alcohol Policy Alliance (GAPA) was established at an International Conference in Syracuse, the United States, in August 2000. Since then there have been two workshops in Bangkok for the south-east Asia and Pacific Regions, the formation of Indian Alcohol Policy Alliance, and the setting up of regional offices in London, Delhi, Bangkok and Auckland.

GAPA aims to:

- Provide a forum for alcohol policy advocates;
- Disseminate information internationally on effective alcohol policies and policy advocacy;
- Bring to the attention of international governmental and non-governmental agencies and communities the social, economic and health consequences of alcohol consumption and related harm;
- Advocate for international and national governmental and non-governmental efforts to reduce alcohol-related harm world wide;
- Co-operate with national and local organisations and communities to alleviate alcohol-related problems;
- Monitor and promote research on the impact of international trade agreements on alcohol-related harm;
- Monitor the activities of the alcoholic beverage industry;
- Place priority on research and advocacy regarding those parts of the world where alcohol problems are increasing; and
- Ensure that member groups in those areas have the technology and support capacity to participate in a global network for communication and action.

#### **4.6 Alcohol Policy and Trade issues**

The Pacific Island Countries Trade Agreement (PICTA) requires Forum Island Countries to liberalise (i.e. abolish tariffs) towards other Forum island Countries within 8 years up to 2010 and the Small Island States and Less developed Countries to do so within 10 years until 2012. Alcohol and tobacco was exempted from liberalisation for the first two years until the outcome of a study on the Integration of Alcohol and Tobacco into the PICTA. At the Ministers of Trade meeting in April 2005, a decision will be made on whether to include these products. A report was prepared for the Pacific Islands Forum Secretariat, the "Final Report, the Inclusion of Alcohol and Tobacco Products in the PICTA," by Dr. Wadan Narsey of the Pacific Institute of Advanced Studies in Development and Governance of the University of the South Pacific. At the April 2005 meeting, Ministers for Trade could defer the decision, they could treat alcohol and tobacco as other goods, they could treat them separately at least until 2008, or they could leave them out.

Since the Narsey report did not study the health implications of integrating alcohol and tobacco into the PICTA, the Secretariat of the Pacific Community has requested a report from on the likely health impacts of inclusion or exclusion of alcohol and tobacco from PICTA. The report will obtain current data on tobacco and alcohol, their health impacts in the Pacific, impacts on the issue of inclusion or exclusion of tobacco and alcohol from PICTA; and provide recommendations to the Pacific Islands Forum Secretariat for consideration by Forum Members.

The new report will describe the health effects of tobacco and alcohol use and look at the effects of including tobacco and alcohol in trade agreements. It will also consider the consequences of reducing or eliminating tariffs under PICTA as a result of the other agreements, as many Forum Island Countries are parties to international trade agreements besides PICTA. It will describe the positions of the World Health Organization, World Trade Organization, and World Bank on the health-trade issue and conclude with recommendations for action within the Pacific.

## **5. Conclusions and Recommendations**

As a culmination to the SPC/WHO Meeting on Alcohol and Health in the Pacific the participants outlined the following conclusions and recommendations:

*Recognising* that the harm done by alcohol is a problem with serious consequences for public health and social and economic welfare in the Pacific that calls for international cooperation and the participation of all Pacific Island Countries and Territories in an effective response,

*Recognising* that alcohol consumption is one of the most important risk factors in the Pacific Region for ill-health and premature death,

*Recognising* that alcohol is particularly important in its role in violent deaths, including drink driving fatalities, homicide and suicide, and in violence within the family and to other people,

*Recognising* that economic, social and cultural changes, including urbanization exacerbate the harm done by alcohol,

*Concerned* about the increase in the use of alcohol, binge drinking and the harm done by intoxication amongst young people,

*Recalling* the 2003 Tonga Commitment of the Ministers of Health to reduce non-communicable diseases across the region, and recognising that effective action against non-communicable diseases requires an effective focus on alcohol,

*Recalling* Resolution WHA57.16 (2004) of the World Health Organization, which urges Member States to promote strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol,

*Recognising* that taxation is an effective strategy to reduce the harm done by alcohol, and that effective country based taxation and other policies to reduce the harm done by alcohol can be affected by alcohol's inclusion in regional and global trade agreements,

*Recognising* that the scientific evidence is clear that a range of cost effective approaches are available to reduce the harm done by alcohol, and that these can be implemented in socially and culturally appropriate ways,

*Emphasising* the special contribution that nongovernmental and community organisations can make to alcohol policies and programmes and the vital importance of their participation in local, national and international alcohol policy and programme efforts,

*Recognising* that strong political commitment is necessary to support coordinated responses, taking into consideration the need to take measures:  
to protect all persons from the harm done by other people's drinking, such as traffic accidents and violence;  
to reduce the harm done by alcohol, and to promote and support reductions in hazardous and harmful alcohol consumption and dependence on alcohol;  
to promote the participation of traditional leaders and communities in the development, implementation and evaluation of alcohol policy programmes;  
and  
to address youth and gender-specific risks when developing alcohol policy strategies,

*Recognising* that international and regional cooperation, capacity building and financial assistance is needed to establish and implement effective alcohol policies and programmes,

*Recognising* that policies and programmes to reduce the harm done by alcohol require sustainable funding,

*Recognising* the benefits to participating countries which have resulted from the Pacific Action for Health Project, and

*Recognising* the technical assistance and support provided by the Secretariat of the Pacific Community and the Regional and Headquarters Offices of the World Health Organization,

Official representatives of 17 of the Pacific Island Countries and Territories who attended the meeting recommend the following:

1. The Technical Report of the meeting is circulated to governments, relevant organisations in the countries, donor organisations and relevant regional and international organisations;

2. A working group comprising interested members of the 2004 SPC/WHO meeting on alcohol and health in the Pacific with input from representatives from key non-governmental organisations, is convened by the SPC in collaboration with the Western Pacific Regional Office of the WHO during the first quarter of 2005 to enable follow up to this meeting and to develop a draft Regional Action Plan to reduce the harm done by alcohol, within the context of existing regional activities, including the Tonga Commitment and the Healthy Islands initiative;
3. Following the working group meeting, a broader meeting should be convened of the Pacific Island Countries and Territories, the SPC, the WHO, donors, regional organisations and relevant non-governmental organisations to further the development of the draft, and to prepare a coordinated plan for donor cooperation prior to wider consultation with and consideration by Pacific Island Countries and Territories;
4. Where these are not already in place, Pacific Island Countries and Territories are urged to convene inter-agency coalitions and partnerships, including representatives of governmental and non-governmental organisations, public health, health, law enforcement, social welfare, women's and youth groups to receive the report of the meeting and to strengthen national efforts through the development of appropriate national plans of action;
5. The country coalitions should consider the feasibility of increased and sustainable funding for alcohol policies and programmes through the establishment of a national health foundation or similar organisation, where such foundations or organisations are not in place, which could be funded through a proportion of tax on alcohol;
6. Mechanisms should be encouraged at the country level to enhance the efficient planning, coordination and management of alcohol related projects and programmes;
7. The SPC and the WHO are requested to provide technical assistance and capacity building to the Pacific Island Countries and Territories to support their efforts to reduce the harm done by alcohol, including efforts to establish health foundations or similar organisations;
8. The SPC and the WHO are requested to work with the Pacific Island Countries and Territories to increase the availability and analysis of data on alcohol use, its health and social consequences and its economic costs, also linked to the broader context of NCD prevention and surveillance;
9. Donors are invited to consider expansion of the Pacific Action for Health project to as many Pacific Island Countries and Territories as possible, including reviews on existing alcohol policies;

10. The Pacific Island Countries and Territories and regional organisations should work to ensure that regional and global trade agreements such as the Pacific Islands Countries Trade Agreement (PICTA) do not limit the capacity of signatory countries to utilize taxation or other policy measures to prevent the public health and social disorder consequences of alcohol;
11. A network of representatives of Pacific Island Countries and Territories on alcohol policies and strategies should be established and supported by SPC in collaboration with the Western Pacific Regional Office of the World Health Organization and in partnership with the Global Alcohol Policy Alliance; and
12. The Western Pacific Regional Office of the World Health Organization is invited to include alcohol as a technical topic in its September 2005 Regional meeting. Further, Member States are invited to raise the issue of the prevention of the harm done by alcohol at the Pacific Islands Forum and at forthcoming regional meetings of ministers of health, trade and youth.

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