REPORT

REGIONAL TECHNICAL CONSULTATION ON THE GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL

Convened by:

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NOTE

The views expressed in this report are those of the participants of the Regional Technical Consultation on the Global Strategy to Reduce the Harmful Use of Alcohol and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Regional Technical Consultation on the Global Strategy to Reduce the Harmful Use of Alcohol, which was held in Auckland, New Zealand from 24 to 26 March 2009.
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Key words

Alcohol drinking / Alcohol-related disorders — prevention and control
A Regional Technical Consultation on the Global Strategy to Reduce the Harmful Use of Alcohol took place in Auckland, New Zealand, from 24 to 26 March 2009. The consultation was jointly organized by the World Health Organization (WHO) Regional Office for the Western Pacific and WHO Headquarters. Participants included representatives of 26 Member States in the Region, a temporary adviser from a WHO collaborating centre, and WHO staff (Annex 1).

The objectives of the consultation were:

1. to ensure effective collaboration and consultations with Member States on developing a draft global strategy to reduce harmful use of alcohol;

2. to contribute to on-going national and subregional processes, national needs, priority areas for global actions and coordination; and

3. to provide examples of best practices with special emphasis on at-risk populations, young people and people affected by the harmful drinking of others.

In the course of the consultation, WHO Headquarters staff updated participants on the status of the draft global strategy on the harmful use of alcohol and the on-going series of regional technical consultations, while WHO Regional Office staff gave a brief update on regional activities.

Working groups were formed to review the proposed structure of the global strategy in some detail. The outcomes of the group discussions were reported back to the plenary. A number of recommendations and suggestions emerged from the groups, although the draft structure of the strategy was judged to be generally sound. Participants confirmed the usefulness of a global strategy as a framework for local, national and regional activities.
1. INTRODUCTION

1.1 Background

On 24 May 2008, the Sixty-first World Health Assembly (WHA) adopted resolution WHA61.4 on the strategies to reduce the harmful use of alcohol. The resolution requests the Director-General of the World Health Organization (WHO) "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". The resolution also urges Member States to collaborate with the WHO Secretariat in developing a draft global strategy on harmful use of alcohol to support and complement public health policies in Member States.

As mandated by resolution WHA61.4, the WHO Secretariat is organizing technical regional consultations with representatives of Member States in all WHO regions during the first half of 2009.

The purpose of the regional technical consultations is to ensure effective collaboration with Member States on developing a draft global strategy to reduce harmful use of alcohol. Member States are invited to provide their views on possible areas for global action and coordination, and on how the strategy can best take national needs and priorities into account. In addition, Member States are encouraged to provide information on ongoing important national and subregional processes which could feed into the strategy development process, as well as examples of best practices with special emphasis on at-risk populations, young people and people affected by the harmful drinking of others.

One of the objectives of the regional consultations is to ensure that the strategy is based on all available evidence and existing best practices in Member States and that the policy options proposed in the strategy take 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. The consultations will also focus on the appropriate role of different stakeholders in policy formulation and implementation, and on how social, cultural and economic realities can be adequately and appropriately taken into account in a global strategy to reduce harmful use of alcohol.

1.2 Objectives

(1) To ensure effective collaboration and consultations with Member States on developing a draft global strategy to reduce harmful use of alcohol.

(2) To contribute to on-going national and subregional processes, national needs, priority areas for global actions and coordination.

(3) To provide examples of best practices with special emphasis on at-risk populations, young people and people affected by the harmful drinking of others.
1.3 Opening remarks

After a traditional New Zealand cultural welcome (*powhiri*), Honourable Peter Dunne, Associate Minister of Health of New Zealand, welcomed participants to the consultation. He referred to the WHO Western Pacific Region’s strategy to reduce alcohol-related harm and said he hoped the global strategy would identify strategies on how to deal with different issues such as alcohol marketing and pricing. He also stressed that alcohol policies need to be tailored and directed at certain target groups, such as young people. A global strategy by necessity needs also to strengthen community action.

Dr Shin Young-soo, WHO Regional Director for the Western Pacific, in his opening remarks (delivered by Dr Wang Xiangdong, Regional Adviser in Mental Health and Control of Substance Abuse, Annex 4) welcomed the distinguished participants and thanked the Government of New Zealand for hosting the consultation. He said the Western Pacific Region endorsed the regional strategy to reduce alcohol-related harm in 2006, which also took place in Auckland. The regional strategy is increasingly being translated into action in several Member States. This regional consultation is an important step to move towards concerted action to reduce alcohol-related harm. In developing a global strategy, various barriers need to be overcome to develop and implement public health-oriented alcohol policies.

The opening remarks were followed by self-introductions. Participants included representatives of 26 Member States in the Region, a temporary adviser from a WHO collaborating centre, and WHO staff from Headquarters and the Regional Office (Annex 1).

1.4 Appointment of Chairperson, Vice-Chairperson and Rapporteur

Dr Ashley Bloomfield of New Zealand was appointed as Chairperson, Dr Hao Wei of China as Vice-Chairperson and Dr Gombodorj Tsetsegdary of Mongolia as Rapporteur.

2. PROCEEDINGS

2.1 Background and context of regional consultation

Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, Department of Mental Health and Substance Abuse, WHO Headquarters, presented the background to the consultation and gave an overview of the history and process leading to resolution WHA61.4 in 2008. As mandated by the resolution, the WHO Director-General is requested to prepare a draft global strategy to reduce harmful use of alcohol. The resolution also urges Member States to collaborate with WHO in developing a draft global strategy to support and complement public health policies in Member States. Regional technical consultations with representatives of Member States will take place in all WHO Regions, as part of the process.

Dr Poznyak emphasized the importance of input from Member States in terms of ideas and recommendations for a draft global strategy and to share evidence of effectiveness from local and national experiences. The global strategy should add value and complement national initiatives. Among the challenges are increased alcohol-attributable harm in low- and middle-income countries, reductions in abstention in those countries, alcohol hindrance in social development, and a need to extend beyond the health sector and national boundaries.
Dr Wang gave a regional overview, from the adoption of the Regional Strategy to Reduce Alcohol-related Harm in 2006 to the current work on finalizing a regional action plan. The regional strategy is expected to provide guidance on national policy, a framework for collaboration and a tool for advocacy and resource mobilization. The draft action plan will be published shortly and will present actions to be taken both by Member States and WHO by 2013. To support that work, a resource book on national policy development will also be published.

2.2 Scope of the consultation

The WHO Secretariat outlined the working document for the consultation, “Towards a global strategy to reduce harmful use of alcohol”, which was circulated to participants prior to the consultation. The working document would guide the work carried out during the consultation. The Secretariat proposed that the draft strategy should be structured around six main areas:

1. background with a situational analysis;
2. scope and aims of a global strategy;
3. basic principles for action;
4. policy options and priority areas;
5. implementation considerations; and
6. follow-up (e.g. assessment and re-examination of the actions taken).

After the Secretariat introduced each of the main areas of the draft global strategy, country participants were divided into three groups, with each small group having a chairperson and a rapporteur. Group 1 was chaired by Dr Kwang Kee Kim, and Dr Franklin Diza acted as rapporteur. Group 2 was chaired by Mr George Phillips, and Ms Joanne Chandler acted as rapporteur. Group 3 was chaired by Dr Sylvia Wally, and Dr Paula Vivili acted as rapporteur. After each small group session, the groups reported back to the plenary on their deliberations. A number of recommendations and suggestions emerged from the groups, although the draft structure of the strategy was judged to be generally sound. Participants confirmed the usefulness of a global strategy as a framework for local, national and regional activities.

2.3 Situational analysis

Mr Dag Rekve, Technical Officer, Department of Mental Health and Substance Abuse, WHO Headquarters, said the purpose of the situational analysis is to bring together all relevant information and to synthesize the evidence base in terms of the size and magnitude of the alcohol-attributable harms and existing interventions and good practices. This analysis will show existing gaps and will help to identify needs and potential for action at all levels. The discussion paper identified two global challenges, namely: increased alcohol-attributable harm in developing countries and the need for actions in all relevant policy areas known as an intersectoral approach.

Participants raised a number of issues and concerns that will be considered in drafting a global strategy. For example, they noted that the national political reality and context are and that most governments consider economic development to be a priority. Participants said that economic operators often lobby against effective policies. A global strategy should identify the ultimate goal, e.g. promoting a certain pattern of drinking or controlling production in some way.
In terms of the varying country contexts, “informal alcohol” and consumption of alcohol in combination with other substances, such as tobacco and illegal drugs, must be considered. For the global strategy to be successful, several non-health sectors need to play leading roles in many of the key policy areas.

Specific challenges identified for the Western Pacific Region included: advertising, trade agreements, informal alcohol, women as new consumers of alcoholic beverages, income generation from alcohol to governments, the need for education and increased awareness at all levels, and the importance of community involvement and capacity-building. Linking alcohol to broader noncommunicable disease work, defining risk populations and highlighting the importance of drinking patterns could be useful strategies.

2.4 Scope, aims and objectives of the global strategy

Participants suggested adding a short chapter called “Background” or “Setting the scene”. This section could cover the role of alcohol (not illegal), social consequences, similarities and differences with tobacco, tension between health and economics, industry role and job creation, case studies showing diversity of countries, evidence-based examples, and recognition of different target groups and policies. Some definitions of concepts and words (e.g. vulnerable groups) are needed at the outset. Beyond discussing a reduction in the harmful use of alcohol, the strategy should suggest ways to prevent it.

In terms of the structure of the strategy, participants suggested adding a seventh section that would highlight lessons and experiences, i.e. what works, what doesn’t work and why. This would help illustrate cultural context.

Participants asked how the global strategy would support Member States in terms of resources, partnerships, and sharing of expertise and experience. Specifically, appropriate attention should be paid to surveillance systems, monitoring and research. This could be partly achieved if, under the sections on implementation and follow-up, the strategy could recommend that countries consider developing and linking national and regional strategies and policies with global alcohol policies. Member States should consider developing national evaluation processes to align with regional and global reporting structures.

2.4.1 Aims and objectives

2.4.1.1 Aims

Two main aims for the global strategy were suggested in the discussion paper for the consultation: The groups suggested re-wording (underlined text) the first aim as follows:

- **Aim 1 (draft):** “To create consensus at the global level for proposed measures and the best way forward to reduce harmful use of alcohol.”
  - To create political consensus at the global level on the best way forward and the necessary commitment to prevent and reduce the harmful use of alcohol and its consequences.
Three alternative proposals for the second aim were made:

- **Aim 2** (draft): “To support and complement public health policies in Member States by seeking synergies and added value of actions at different levels.”
  - To guide and inform development of public policies in Member States by enabling them to respond effectively to the harmful use of alcohol within their own cultural context.
  - To support and complement public health policies in Member States by enabling them to respond effectively to alcohol-related harm through actions at different levels.
  - To guide, support and complement public policies by enabling Member States to respond effectively to alcohol-related harm through actions at different levels.

Some concern was raised about using the words “political consensus”. In some countries, these words refer to a certain political party; in other languages, it is a difficult concept to translate. One suggestion was to use increase commitment instead of “create political consensus”, which would also increase opportunities for involving nongovernmental organizations (NGO) and civil society.

2.4.1.2 Objectives

Some groups raised questions about the objectives presented in the discussion paper. It was suggested that clarity is needed for defining aims, objectives and perhaps goals, and their relationship with each other. Ideally, the objectives should be deliverable, measurable and workable, so that they have clear functions for monitoring and evaluation purposes. It was also suggested than an additional objective on creating global consensus should be added.

The groups made the following detailed suggestions to the four draft objectives:

- **Objective 1** (draft): “Create support for – and provide guidance on – public health policies that reduce harmful use of alcohol.”
  - Revise the wording as follows: To provide guidance and policy development support to Member States that allows them to develop informed and culturally relevant public policies that reduce harmful use of alcohol and its consequences.

- **Objective 2** (draft): “Address relevant policy options and interventions that target the general population, vulnerable groups, individuals and specific problems.”
  - Emphasize that one size does not fit all and mention that those with conflicts of interest should be excluded from policy development. As countries are at different stages of development, some assistance in policy prioritization for given resources is needed.
- Objective 3 (draft): “Define the roles of different stakeholders and mobilize them to take appropriate and concerted actions to reduce harmful use of alcohol.”
  - Change to: To define/advise the roles of different stakeholders and involve them in a social mobilization process to prevent and reduce harmful use and consequences of alcohol.
  - The social mobilization process and process of defining the roles should be inclusive to allow for inter-country variations. The strategy should not go ‘too far’ in defining roles of stakeholders for Member States, as this is a function that should be left to Member States.

- Objective 4 (draft): “Widen and deepen the knowledge base and secure effective and relevant dissemination of this information.”
  - Include dissemination of feedback and evaluation among others, and incorporate a capacity-building component.

2.4.2 Guiding principles

All groups recommended that the term “public health policies” should be replaced by public policies.

The groups made the following detailed suggestions to the proposed principles:

- Principle 1 (draft): “Public health policies to reduce harmful use of alcohol should be formulated by public health interests and should be based on available evidence and best practices.”
  - Change to: “Public policies which aim at reducing harmful use of alcohol and its consequences should be according to public health interests and based on best available evidence and best practices.”

- Principle 2 (draft): “Strategies and policies should address levels, patterns and context of alcohol consumption through a combination of measures that target the population at large, vulnerable groups, such as young people and pregnant women, affected individuals and particular problems such as drink-driving and alcohol-related violence.
  - Place additional emphasis on community involvement, for example by adding “and involve community organizations and civil society”.

- Principle 3 (draft): “Interventions which are implemented should appropriately take into account different national, religious and cultural contexts.”
  - Change to: Interventions that are implemented should take into account, as appropriate, different national, local, religious, cultural and social contexts, as well as resources and capacities of Member States.
- Principle 5 (draft): “Children, young people and those who choose not to drink alcohol should be protected from pressure to drink alcohol.”
  - Replace the words “those who do not drink” with “those who choose not to drink” or alternatively, “children, young people and those adults who do not drink alcohol (for health, religious or other reasons) should be supported in their decision not to drink and protected from pressure to drink alcohol, in order to gain any perceived health and social benefits”.

- Principle 6 (draft): Policies and interventions should place a special emphasis on protection of individuals and communities from the harmful effects of drinking of others.
  - Omit “a special” in “… place a special emphasis…”

- Principle 7 (draft): “Effective prevention, treatment and care services should be available to those affected by harmful use of alcohol,”
  - Change to: Effective prevention, treatment and care services should be available, accessible and affordable for those affected by harmful use of alcohol in accordance with the resources and capacity of Member States.

- Principle 8 (draft): “Stigmatization and discrimination at the individual and societal level should be avoided and prevented in order to improve health-care seeking behaviour and provision of such service.”
  - Change to: Stigmatization and discrimination of groups and individuals should be actively discouraged and avoided in order to improve help-seeking behaviour and the provision of needed services.

Two new principles were suggested. One addressing the need to reduce inequalities between Member States and within Member States, and another addressing harm minimization.

2.5 Policy options

Ten proposed policy areas, as outlined in the working document, were discussed:

1. raising awareness and political commitment,
2. health sector response,
3. community action,
4. drink-driving policies,
5. addressing availability of alcohol,
6. addressing the marketing of alcohol beverages,
7. pricing policies,
8. harm reduction,
9. reducing the public health impact of illegal and informal alcohol, and
10. monitoring and surveillance.
2.5.1 Raising awareness and political commitment

Participants recommended that “political commitment” should be replaced by “government commitment”, “parliament commitment”, “commitment at a high level” or “commitment of decision-makers”. The groups suggested that the approach should be two-pronged: (1) raising awareness of the general population at large about alcohol as a problem, and (2) raising awareness and/or understanding among politicians primarily about effective policies. Educating the constituency on how to raise the alcohol problem with their politicians and how to change attitudes was seen as necessary. For successful outcomes, the health sector needs to link with other sectors, such as trade, agriculture, finance and education, as well as nongovernmental organizations, although the Ministry of Health may wish to be the lead or coordinating agency. The work could be organized through national (international) task forces or ministerial committees. At the international level, ministers could be asked to report back to WHO regularly on progress. To keep the momentum of sustained focus on alcohol, WHO should increase communication about alcohol to the ministerial level. Global alcohol forums held regularly could provide a platform for alcohol policies and enhance a shared understanding of the problem. One of the challenges is the effect of the alcohol industry on the policy process, and the sensitive issue of ‘lobbying’ governments. Ideally, relevant data should be available to show the size of the burden or problem, together with the evidence of effective interventions and a political champion to push the issue. It should be recognized that changing legislation is costly, both in time commitment and financially. To increase capability, the use of research (e.g. cost-effectiveness analysis) as an advocacy tool and the sharing of best practice and expertise among countries would greatly enhance the impact. Media are also useful tools in addressing alcohol-related harm issues. In addition to media, NGOs and civil society have an important role to play as they can advocate for the issues through meetings and exhibitions.

A global strategy could provide a framework to help develop and implement interventions. It could provide guidance on a balanced approach in different contexts. However, a strategy should be flexible to allow for local implementation through local structures. A clear link between local, regional and global strategies should be established.

2.5.2 Health sector response

Participants recommended defining the roles and expectations of public health and health care sectors in terms of leadership and responsibilities. Health promotion, prevention, early identification and treatment are all important components. Psychological and social treatment and rehabilitation should be given preference over pharmacotherapy. To prepare health workers for the implementation of treatment, training and capacity-building are essential. As a first step, curricula for all health professionals should include harm related to alcohol use. Secondly, training should address how to overcome the barrier of discussing the sensitive issue of drinking with patients and possible cultural issues for screening levels. Another essential component is the existence of culturally validated clinical guidelines. For many settings, the health sector should be encouraged to actively seek and screen risk groups and implement recognized screening programmes. A comprehensive rehabilitation programme could include social and financial support. The health sector has a role to play in legislation and designing alcohol policies. One of the roles is to build the relationship with other stakeholders within government and the community. In many countries, the size of the health care sector necessitates coordination at regional and national levels between different partners. Alcohol programmes can benefit from being linked to other programmes, such as noncommunicable diseases (NCD) or mental health.
A global strategy could contribute to a strengthened health sector response by recommending a focus on the whole spectrum, i.e. from prevention to treatment, and utilizing screening and brief intervention in all health and community settings, promoting the Alcohol Use Disorders Identification Test (AUDIT) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). The different contexts of countries need to be acknowledged and some of the interventions may be limited to health promotion. Interventions could include alcohol counselling centres, telephone help-lines and quit-drinking programmes. The usefulness of using the primary, secondary and tertiary care approach could be explored, acknowledging the role of ‘allied health’ partners. A global strategy could mention thiamine fortification of beer and bread.

2.5.3 Community action

Participants suggested that alongside legislation, a change in social norms and acceptance of intoxication is needed. Guidelines on community mobilization to address changing social norms should be developed. Community best practice interventions on alcohol do exist and other areas of successful community action could be used to share best practice models. Community action on alcohol should be linked with other community development issues, such as poverty. Legislation could give opportunities for community involvement in alcohol licensing. Countries in the Region had a number of examples of action in this area, from local liquor accords to social shaming, by-law prohibitions and strengthening cultural identity of national minorities.

A global strategy could set up a network for community action across countries and regions and highlight the importance of involving a wide range of community stakeholders. It could create an environment that facilitates community action to flourish. The groups recommended that community action should receive priority status in the global strategy, as it requires a major shift in community culture and mindset. Community action projects should be strengthened by sustainable resources and capacity-building activities. Community action could feed into and support monitoring and evaluation at the national level. In this area, public-private partnerships could be useful. A global strategy could encourage the role of religious communities, women’s groups and trade organizations and address cultural customs that create problematic social norms around alcohol. Reducing discrimination and stigmatization are important elements of community action. Community ownership of programmes increases chances of success.

2.5.4 Drink-driving policies

Participants maintained that there is strong evidence of the effectiveness of drink-driving interventions and that examples of best practices are easy to collect. The issue for many countries is expanding current policies and “filling the gaps”. Legislation may be in place, but without enforcement it is of limited effectiveness. It was suggested that monitoring equipment, no longer used in some countries, could be shared with countries with lower resource levels. The group recommended that enforcement could concentrate on traffic police monitoring licensed premises, at times and places where drinking occurs. Drink-driving regulations should be extended to include cars, boats, transport vehicles, trains and airplanes, with different vehicles requiring different limits and penalties.

A global strategy could recommend a global blood alcohol content (BAC) level for drink-driving. It is important to involve communities and raise local awareness and support for any changes or new limits. Drink-driving campaigns, sometimes funded by the alcohol industry, can impact on alcohol health messages, giving the signal that drinking to excess is okay as long as you don’t drive. Campaigns and restrictions need to show sensitivity to local context, gender
and culture. Additional recommendations suggested for a global strategy are random breath tests (rather than selective), suitably strict penalties, counselling or treatment for repeat offenders, and alcolocks, i.e. breath test devices that prevent a motor vehicle from starting when a driver's BAC is elevated. Some countries have lower BAC levels for beginner drivers. Others use toll-free telephone numbers to report suspected drink-drivers.

2.5.5 Availability of alcohol

Most countries have restrictions in place limiting the availability of alcohol. Restrictions can limit hours of sale, place of sale, purchase age, happy hours and alcohol outlet density. A major concern is enforcement. An important focus should be on assisting Member States to develop enforcement of existing restrictions. Addressing gaps in the legislation would also be useful. Local communities, parents and sellers of alcohol need to be educated on the legislation, so they can contribute to the enforcement. There should be strong encouragement to comply with legislation, combined with consequences for non-compliance.

In countries with high levels of corruption, it can be a challenge to find the right agency for enforcing restrictions. Border control could be enhanced and traveller's allowances of duty-free alcohol may need revision. The groups suggested that, when developing a licensing fee structure, the level of fee should ensure an impact and cover the cost of the licensing inspectors. Participants suggested a broad view on availability, to consider how regulation can contribute to “denormalizing” alcohol in society, as opposed to the ready availability of alcohol in supermarkets which “normalizes” alcohol. Restrictions should build on local cultural and/or religious norms, for example, prohibiting the sale of alcohol on Sundays. Informal and illegal production is also an issue even though licensed or otherwise controlled sale points should be the only outlets to sell alcohol. Setting a legal drinking age or purchase age is important, but agreeing on a common age for global purposes will be difficult.

A global strategy could address visible availability in a number of ways. Participants recommended that alcohol should be treated as a special commodity when Member States negotiate trade agreements. Member States could be urged to control the illegal supply of alcohol. A global strategy could help develop basic principles to assist Member States with licensing legislation, which would cover trading hours, license conditions, availability of home brew and illegal alcohol. A global strategy could address the social availability of alcohol, by urging Member States to look at the social supply of alcohol to young people and to set a legal drinking age, not only a minimum age to purchase alcohol.

2.5.6 Marketing of alcohol

A broad definition of marketing is needed, similar to tobacco advertising, and should cover all media, sponsorship, product placements, viral marketing, the Internet and give-aways. Participants expressed strong support for limiting alcohol marketing in all its forms, in particular when targeted at young people. Participants suggested that governments are not always aware of the level of youth marketing, as companies use niche marketing to target youth directly. Member States vary widely in terms of the level and types of existing legislation on alcohol marketing. Global efforts are required, in addition to national regulations, to address both exposure and content of alcohol advertising in all its forms. It was suggested that WHO could assist in assessing existing capacity and ability of Member States to regulate marketing and provide support for improvements. The use of different kinds of price promotions in marketing is common and could be regulated. Media companies should also be educated about the harms of alcohol and alcohol advertising. Caution should be exercised in allowing the alcohol industry to advertise “responsible drinking” as it can lead to pro-corporate response and increase drinking. Marketing of alcohol claiming health benefits should be banned. The placement of alcopops,
such as wine coolers and other blended drinks that appeal to underage drinkers, should be
controlled at points of sale. Health warning labels could be recommended.

Participants recommended, at a global level, the drafting of an international alcohol
convention on advertising to tackle inappropriate marketing to young people and at-risk groups.
The convention could track advertising and the latest research with feedback to WHO, develop a
universal set of protocols for Member States to develop codes of advertising, provide advice to
Member States on working with the industry, be a vehicle to move policy forward and limit
inappropriate marketing and serve as a platform for discussions to restrict inappropriate products
that target at-risk groups.

2.5.7 Pricing policies

The global strategy could promote and recognize taxation and other pricing measures as
one of the most effective policy tools. It is an area where many Member States look for
guidance. A global strategy could help develop a tool guide for using pricing to reduce
alcohol-related harm. One of the difficulties in pricing policies lies in finding a balance between
the rate of tax and a possible illegal or informal market. Controls and enforcement need to be in
place before any taxation of informal production is possible.

A global strategy could recommend a minimum taxation level for import and domestic tax
(where applicable). Alcohol tax rates should depend on alcohol strength. Pricing policies should
discourage discounts and promotion on alcohol, and a minimal price option framework could be
developed. Some countries earmark taxes on alcohol for funding alcohol policy programmes.
One of the possible barriers is the involvement of the government itself in alcohol importing and
selling. It was suggested that the World Bank and WHO could undertake a study on the impact
of taxation on alcohol consumption, similar to the study on tobacco consumption. The global
strategy should discuss options that are available to countries, demonstrating the evidence and
effects of different measures. It should include taxation as part of a balanced package of
measures.

2.5.8 Harm reduction

Participants suggested changing the title of this section to “Drinking environments”,
“Drinking settings”, or “Addressing drinking context” as “harm reduction” may have negative
notations. This policy area should be clearly defined and include the link between alcohol
and violence. WHO should provide guidelines on good practices for promoting harm reduction.
There is a broad range of harm reduction practices, some of which can be difficult to implement
and could increase the risk of consumption and intoxication. Several examples of harm
reduction practices were presented: quality control for content of alcohol products; liquor bans –
to stop fighting in public places; pubs arranging safe transport home; spots checks at restaurants
and bars; responsible server training programmes; partnerships between public health officials,
police and community at local level; restricting public areas for alcohol consumption; and
enforcing closing times for night clubs.

A global strategy could provide guidance on licensing settings, social settings and drinking
patterns. Participants suggested that a global strategy could facilitate the sharing of best practices
and expectations of licensing agreements, for example Australia’s experience with putting a limit
on numbers of patrons, using plastic glasses, limiting opening hours, and banning happy hours.
In the social setting, a global strategy could urge Member States to consider alcohol production
in their countries with a view to reduce excessive amounts and to target specific drinking
behaviours. A global strategy could recommend international health guidelines on alcohol
consumption and could develop and promote an internationally agreed standard drink size.
2.5.9 Reducing the public health impact of illegal and informal alcohol

A number of countries reported problems with homemade or informal alcohol, not only informal alcohol for own consumption, but also informal alcohol for sale. Because of the absence of proper bottling or labelling of contents, the quality of illegal and informal alcohol is difficult to control. Cases of methanol or insecticide poisonings are not uncommon. Different approaches can be taken to tackle informal alcohol, from prohibiting production to partly commercializing it, by taxing the production or requiring a license to be obtained. Informal alcohol is often consumed by older drinkers as well as less affluent or rural audiences, who cannot afford commercial alcohol. Therefore, it is important to empower local communities to enforce regulations and engage community action to raise awareness of the health implications of informal alcohol. Evidence suggests that as income levels increase, there is a partial switch to commercial alcohol. Informal alcohol should not be used as an excuse not to develop, implement and enforce alcohol control measures.

A global strategy should raise increase awareness of illegal and informal alcohol and establish the health problems, in particular through research. A global strategy could help develop a “field test” for testing informal alcohol to avoid health problems and a tracking process for informal alcohol. These measures could be carried out through existing infrastructure. A strategy could support Member States to regulate home brew production and eliminate illegal trade. However, Member States must be mindful of alcohol policy approaches, for example pricing strategies, as these may impact on the production of home brew.

2.6 Implementing the strategy

2.6.1 Tools

A list of the recommended tools put forward by the working groups is shown in Annex 5. In addition to these tools, a number of general points were raised. Incorporating alcohol issues other national health policy areas, for example mental health policy or noncommunicable diseases, could be considered. As first steps, WHO could provide advice to Member States on how to formulate/write national strategies and policies, and thereafter on how to advocate for support from other government agencies, partners and the community at large. One of the first basic tasks is to know how to train the workforce at the community level. Tool kits should be formulated either as a set of step-by-step tools (from beginning to end) or as a group of priority-area tools (depending on perceived priority areas). Tool kits should include: effective interventions and best practices from around the world; a guide on monitoring and evaluation, with key players for implementation identified and their roles defined; and guidelines on working with the hospitality industry regarding relevant alcohol management issues. As part of the process, WHO could assist in mobilizing resources for implementation.

2.6.2 Different contexts

Member States vary widely in terms of the situation regarding the harmful use of alcohol and the resources available to address the issue. For the global strategy to be relevant to all countries, it should focus first on simpler strategies, taking into account best practices, and should use a stepwise approach, increasing intensity of action overtime. A global strategy could focus on identifying target groups and designing appropriate programmes for them. Recommendations for action could be grouped according to resources/income/capacity of countries and prioritized according to consumption prevalence in Member States. The global strategy should recognize alcohol as a development issue and should urge Member States to use and increase their aid budgets to assist implementation of the strategy. A balance between flexibility and a prescriptive approach is needed.
2.6.3 Stakeholders and their role

The working groups identified the key stakeholders and discussed the roles they should play in implementing a global strategy. A list of the suggestions is attached in Annex 5.

2.7 Reporting on the global strategy

Regular reporting on the global strategy should take place, both at World Health Assembly and Regional Committee meetings. An assessment of progress should be made against the aims and objectives of the strategy. The on-going alcohol and health survey is an important part of reporting, but may need improvement, in terms of cultural appropriateness. Annual meetings on the implementation of the strategy could focus on different topics each year. Information on implementation and progress of the strategy should be presented at regional or international forums, including health conferences and other intergovernmental official meetings. Annual reporting should include outcomes and the number of projects and programmes (both quality and quantity) conducted, which are consistent with the aims of the strategy. Reporting should also include changes made to Member States’ legislation to meet the aims of the strategy as well as the level of political and public awareness of the strategy and the harmful effects of alcohol. The reporting process should be designed to provide feedback to WHO on both implementation and other aspects of the strategy. It should use existing reporting frameworks to report information relevant to the strategy and utilize web-based technologies to minimize travel and costs.

Ideally, monitoring should include prevalence, mortality, morbidity and social consequences, although these data may be limited due to interpretation and data quality issues. It would be useful to measure improvements in alcohol data quality and availability. Reporting on the strategy could have standard target areas with identified measures and standard indicators with a core and expanded set. Reporting could take place at the national level (to the WHO Regional Office for the Western Pacific every year), regional level (to the World Health Assembly every three years) and global level (WHO report every three years).

Among the topics raised in the plenary discussion were the importance of reducing the reporting burden for countries, partly through coordination across WHO programmes, and the importance of quality over quantity. The Secretariat informed the participants that WHO is finalizing the new international guidelines on alcohol monitoring for publication towards the end of 2009. Comments were made that the Global Survey on Alcohol and Health (GISAH) includes extensive and complicated indicators for which a guide is needed to help Member States. Several countries indicated a need for capacity-building and that alcohol monitoring is only sporadically carried out, usually under the umbrella of tobacco, noncommunicable diseases, injuries and violence, traffic accidents or mental health.

2.8 Closing session

In summarizing the technical consultation, Dr Gombo dorj Tsetsegdary noted that Member States have reached a common understanding, that being, public health problems caused by harmful use of alcohol are complex and multidimensional and need guidance and support from WHO, as the leading international agency for health issues. The Rapporteur highlighted the following recommendations: (1) international regulations and agreements are needed in the area of marketing of alcohol, (2) a glossary should be prepared to improve understanding among different stakeholders and to effectively implement a global strategy, (3) a dedicated tax from alcohol should be used for alcohol-related harm prevention and control, (4) web-based technology should be used for reporting, and (5) guidelines for each policy area should be developed. In his closing remarks, Dr Poznyak outlined the next stages of the process leading to
the global strategy. A final version of the draft strategy is planned for publication on the
WHO website in early December as part of the documentation of the Executive Board meeting in
January 2010. Dr Wang closed the consultation by expressing his sincere thanks for the work
done by all participants and for the excellent hosting by the New Zealand Government.

3. CONCLUSIONS

(1) Participants reconfirmed that harmful use of alcohol is a public health concern of high
importance for the Region and that action is needed across countries to reduce the alcohol-
related burden.

(2) A global strategy can assist in highlighting this issue and keeping it high on the political
agenda. It can provide countries with guidance on the most effective direction to take.

(3) The proposed structure of the global strategy as outlined in the discussion paper is
generally sound. It was acknowledged that a global strategy needs to reflect the social,
cultural and economic diversity of countries.

(4) Detailed recommendations for the contents of the global strategy are highlighted in the
proceedings section of this report.

(5) Member States look to WHO for capacity-building, and tools and guidance to assist them
in making informed and evidence-based choices for their national strategies.
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PROVISIONAL AGENDA

1. Opening

2. Introduction (background and context of the consultation)

3. Situational analysis (country information and relevant national processes)

4. Discussion on scope, aims and objectives of the Global Strategy to Reduce the Harmful Use of Alcohol

5. Proposed policy options to reduce the harmful use of alcohol (Part I)

6. Proposed policy options to reduce the harmful use of alcohol (Part II)

7. Implementing the Global Strategy to Reduce the Harmful Use of Alcohol at global, regional and national levels

8. National monitoring systems and priority regional implications

9. Conclusion and closing
## TENTATIVE TIMETABLE

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<tr>
<th>Time</th>
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<td>Proposed policy options to reduce the harmful use of alcohol – Part II (continued in small groups followed by a plenary with reporting from the groups)</td>
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### Notes
- Implementation at global, regional and national levels
- Role of global, regional and national frameworks
- National policy development, implementation and evaluation. Role of national contexts
- Role of different stakeholders in policy development and implementation
- Technical tools
- Assessing and re-examining action, indicators and targets
- National monitoring systems, links with regional and global information systems
- Priority regional implications
OPENING REMARKS
BY DR SHIN YOUNG-SOO
WHO REGIONAL DIRECTOR
FOR THE
WESTERN PACIFIC
AT THE REGIONAL TECHNICAL CONSULTATION ON THE GLOBAL STRATEGY
TO REDUCE HARMFUL USE OF ALCOHOL
24–26 MARCH 2009, AUCKLAND, NEW ZEALAND
(delivered by Dr Wang Xiangdong,
Regional Adviser in Mental Health
and Control of Substance Abuse)

HONOURABLE ASSOCIATE MINISTER OF HEALTH, DISTINGUISHED
PARTICIPANTS, COLLEAGUES FROM GENEVA, LADIES AND GENTLEMEN,

It is my pleasure to welcome you to the Regional Technical Consultation on the Global Strategy to Reduce the Harmful Use of Alcohol. I would like to express my sincere appreciation to the Government of New Zealand for organizing the consultation, for the leading role it has played in putting the alcohol issue on the public health agenda, and for valuable and continuous support it has provided WHO on this issue.

In September 2006, here in Auckland, the WHO Regional Committee for the Western Pacific discussed and endorsed the Regional Strategy to Reduce Alcohol-Related Harm. Since then, majority of the Member States in the Western Pacific Region have nominated national focal points for the reduction of alcohol-related harm. The First Regional Meeting on Reducing Alcohol-Related Harm in the Western Pacific Region was held in June 2008 in Manila. It was attended by representatives from 24 Member States as well as temporary advisers from four WHO collaborating centres in the Region. In many of our Member States, efforts are under way to strengthen the response to alcohol-related harm. Some countries already have taken up the challenge by designing national strategies and national public health-oriented alcohol policies. Other countries, have used the Regional Strategy to strengthen already existing policies. And in many countries, work is under way to design and conduct national epidemiological surveys on alcohol use and alcohol-related harm. I am delighted to know that the Regional Strategy is being translated into concrete action.

Alcohol is one of the most significant risks to health. The harmful use of alcohol is responsible for 4% of the disease burden and 3.2% of all premature deaths globally. In the Western Pacific Region, alcohol-related harm accounts for 5.5% of the burden of disease. In addition to the impact on public health, there are substantial social and economic costs associated with the harmful use of alcohol, both for developing and developed countries. No single sector, individual country or WHO region will be able to address the issue alone. This technical consultation is intended to ensure effective collaboration among Member States in developing a draft Global Strategy to Reduce Harmful Use of Alcohol. Over the next three days, you will have the opportunity to contribute to the ongoing national and subregional processes, such as identifying national needs, priority areas for global actions and coordination, as well as, to provide examples of best practices with special emphasis on at-risk populations, young people and those affected by the harmful drinking of others.
We are taking very important steps to move towards concerted global action to reduce harmful use of alcohol. However, we have to be clear about the tough challenges facing us. Public awareness of the problems caused by the harmful use of alcohol is low or almost completely lacking in many parts of the world. For majority of developing countries, there is a complete lack of public health-oriented alcohol policy. In some countries, there is little information about alcohol-related harm and no detailed data on the consumption of alcoholic beverages. The resources allocated for the reduction of harmful use does not match the magnitude of alcohol-related harm. Alcohol-related problems tend to remain unrecognized within primary care settings, and in the health care and welfare system as a whole. I trust that at the end of this consultation, we will have better ideas of how to address these issues and we will be better prepared to work together to overcome various barriers to development and implementation of public health-oriented alcohol policies.

I wish you a productive and enjoyable consultation.

Once again, I wish to thank the Government of New Zealand and the team from the Ministry of Health for their hard work in making this consultation possible.

Thank you.
RECOMMENDATIONS FOR TOOLS TO BE DEVELOPED BY WHO AND RECOMMENDATIONS FOR STAKEHOLDERS AND THEIR ROLES IN A GLOBAL STRATEGY

Tools at the global level to facilitate the implementation of the strategy

<table>
<thead>
<tr>
<th>Area</th>
<th>Tool</th>
<th>Importance</th>
<th>Urgency</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Guidelines for how to implement each target area</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>All</td>
<td>QA and FAQ likely to be asked when attempting to introduce legislation</td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>1</td>
<td>Tools to convince Member States to draft plans / activities, e.g. MOU or through regular reporting. The ideal would be an international convention</td>
<td>High</td>
<td>High</td>
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<tr>
<td>1</td>
<td>Framework for linking different government sectors at national level, e.g. inter-agency body</td>
<td>High</td>
<td>Med</td>
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<tr>
<td>1</td>
<td>Guidance for development of national action plans</td>
<td>High</td>
<td>High</td>
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<tr>
<td>1</td>
<td>International meetings on alcohol – Minister level, for health and other sectors, e.g. finance, police, foreign affairs.</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>1</td>
<td>Tools for advocacy of key people in government / media, e.g. advocacy techniques, cost effective studies, cost studies, research on link between alcohol and poverty</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>1</td>
<td>Resource that mirrors the framework of the strategy, providing more detail on what can be done. Should be as simple as possible.</td>
<td>High</td>
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<tr>
<td>1</td>
<td>Materials to engage or raise awareness among high level decision-makers and should facilitate links to other international organizations and meetings</td>
<td>High</td>
<td>High</td>
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<tr>
<td>1</td>
<td>How to establish legislation</td>
<td>High</td>
<td>ASAP</td>
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<tr>
<td>2</td>
<td>Recommended guidelines for holistic care</td>
<td>High</td>
<td>High</td>
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<tr>
<td>2</td>
<td>Training programme on risks of alcohol, brief interventions etc - for medical students and to re-educate doctors</td>
<td>Med</td>
<td>Med</td>
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<tr>
<td>2</td>
<td>Examples of culturally appropriate tools, e.g. alcohol screening tests</td>
<td>Med</td>
<td>Med</td>
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<tr>
<td>2</td>
<td>Toolkit for the health sector including who to engage and their roles, how to engage,</td>
<td>High</td>
<td>High</td>
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<tr>
<td>Area</td>
<td>Tool</td>
<td>Importance</td>
<td>Urgency</td>
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<tr>
<td></td>
<td>and guidelines including training and capacity-building, case studies, correspondence treatment package or other treatment resources.</td>
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<td>2</td>
<td>Effective interventions</td>
<td>High</td>
<td>ASAP</td>
</tr>
<tr>
<td>3</td>
<td>Effective interventions</td>
<td>High</td>
<td>ASAP</td>
</tr>
<tr>
<td>3</td>
<td>International meetings and networks for NGOs (NGOs important for increasing grass roots action)</td>
<td>Med</td>
<td>Med</td>
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<tr>
<td>4</td>
<td>Study on BAC in Asian communities (note: Singapore doing a study on this)</td>
<td>Med</td>
<td>High</td>
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<tr>
<td>4</td>
<td>Guidelines on BAC limits and best practice for operation, e.g. random breath testing</td>
<td>High</td>
<td>High</td>
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<td>4</td>
<td>Evidence on impact of drink driving campaigns on drinking levels - for discussion with Ministry of Transport to ensure not promoting message OK to get drunk if not driving</td>
<td>High</td>
<td>High</td>
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<tr>
<td>5</td>
<td>Recommendations / best practice on how to limit availability of alcohol through legislation</td>
<td>High</td>
<td>High</td>
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<tr>
<td>5</td>
<td>Mapping the gaps in legislation in different counties (World Health survey)</td>
<td>High</td>
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<tr>
<td>5</td>
<td>Example of best practice for implementation of availability laws, e.g. testing sales to minors</td>
<td>High</td>
<td>Med</td>
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<tr>
<td>6</td>
<td>Information on marketing practices (e.g. targeting of minors)</td>
<td>High</td>
<td>High</td>
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<tr>
<td>6</td>
<td>Regional WHO meeting about regulatory options on marketing</td>
<td>Med</td>
<td>Med</td>
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<tr>
<td>7</td>
<td>Technical information on different models of taxation systems &amp; different taxation levels</td>
<td>Med</td>
<td>Med</td>
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<tr>
<td>7</td>
<td>Manual and web-based data collection tool that could be used internationally or nationally</td>
<td>High</td>
<td>Medium</td>
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<tr>
<td>7</td>
<td>Standard indicators</td>
<td>High</td>
<td>ASAP</td>
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<tr>
<td>9</td>
<td>Technical information on harmful effects of informal and illegal alcohol</td>
<td>High</td>
<td>High</td>
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<tr>
<td>9</td>
<td>Regional meetings for information sharing</td>
<td>Med</td>
<td>Med</td>
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<tr>
<td>9</td>
<td>TOR/membership</td>
<td>High</td>
<td>ASAP</td>
</tr>
</tbody>
</table>
Key stakeholders and their roles in implementing the strategy in reducing harmful use of alcohol

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role/Responsibility</th>
<th>Level of Interaction</th>
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</thead>
<tbody>
<tr>
<td>Public Health NGOs</td>
<td>Advocacy, social services</td>
<td>Active collaboration</td>
</tr>
<tr>
<td>International agencies, e.g. WTO, UNICEF UNDP,</td>
<td>Varies - Treatment of alcohol within their activities, e.g. trade agreements or Aid</td>
<td>Consultation</td>
</tr>
<tr>
<td>WorldBank</td>
<td></td>
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<tr>
<td>Regulatory Agencies, e.g. Licensing, marketing</td>
<td>Implementation of policy</td>
<td>Active collaboration</td>
</tr>
<tr>
<td>Advertisers</td>
<td>Responsible advertising</td>
<td>Sharing information</td>
</tr>
<tr>
<td>Media</td>
<td>Responsible advertising</td>
<td>Sharing information</td>
</tr>
<tr>
<td>Producers of alcohol</td>
<td>Quality assurance, make a profit</td>
<td>Sharing information</td>
</tr>
<tr>
<td>Retailers of alcohol</td>
<td>Implement laws on sale, responsible practices</td>
<td>Consultation</td>
</tr>
<tr>
<td>Economic operators (e.g. GAPG, ICAP)</td>
<td>Assist with in-kind support for implementation, campaigns that are consistent with strategy, providing info e.g. sales data and success of strategy.</td>
<td>Cautious information sharing and consultation. Clear rules of engagement required.</td>
</tr>
<tr>
<td>MS Governments including</td>
<td>Direct responsibility for implementing the strategy in their nations, reporting, providing resources/assistance if possible within the nation and the region, identifying a lead agency with public health interests</td>
<td>Active collaboration</td>
</tr>
<tr>
<td>• Trade negotiators</td>
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<tr>
<td>• Law enforcement</td>
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<tr>
<td>• Health</td>
<td></td>
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<tr>
<td>• Religious</td>
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<tr>
<td>• Aid</td>
<td></td>
<td></td>
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<tr>
<td>• Education</td>
<td></td>
<td></td>
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<tr>
<td>• Finance/tax</td>
<td></td>
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<tr>
<td>• Social services</td>
<td></td>
<td></td>
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<tr>
<td>International NGOs (e.g. IHRA, GAPA, AA)</td>
<td>Provide research, information and other assistance to support the strategy</td>
<td>Active collaboration</td>
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<tr>
<td></td>
<td>Facilitate links between other NGOs and governments</td>
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<td></td>
<td>Lobby governments</td>
<td></td>
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<tr>
<td>Health professionals and academics</td>
<td>Lobby governments to support strategy</td>
<td>Information sharing, consultation and collaboration</td>
</tr>
<tr>
<td></td>
<td>Implementation</td>
<td></td>
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<tr>
<td></td>
<td>Provide and direct research to support strategy</td>
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<tr>
<td></td>
<td>Provide a credible voice for community and governments</td>
<td></td>
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<tr>
<td>Community groups</td>
<td>Provide in-kind assistance</td>
<td>Information sharing, consultation and</td>
</tr>
<tr>
<td></td>
<td>Assist implementation</td>
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<tr>
<td>Stakeholder</td>
<td>Role/Responsibility</td>
<td>Level of Interaction</td>
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<td></td>
<td>Provide a voice for diverse issues</td>
<td>collaboration</td>
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<tr>
<td></td>
<td>Mobilize community action</td>
<td></td>
</tr>
</tbody>
</table>
| Other international religious groups | In-kind assistance  
Spiritual assistance  
Facilitate links between MS, NGOs  
Increase impact on community | Collaboration and consultation                                                       |
| Legal profession            | Provide legal assistance                                                             | Consultation and active collaboration in their sphere of influence                  |
|                             | Provide advice on necessary law changes                                              |                                             |
|                             | Mobilize community action against non-compliance                                     |                                             |