WHO Western Pacific Regional Strategy to Reduce Alcohol-Related Harm:

How to develop an action plan to implement the strategy

World Health Organization
Western Pacific Region

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**WHO Western Pacific Regional Strategy to Reduce Alcohol-Related Harm:
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Introduction

In September 2006, the Member States of WHO's Western Pacific Regional Committee unanimously endorsed a **Regional Strategy to Reduce Alcohol-Related Harm**. The strategy was developed with input from technical experts and government and nongovernment stakeholders from across the region, and is based on a rigorous review of the effectiveness of strategies to reduce alcohol-related harm.

The **Regional Strategy** provides an excellent foundation for the development of country-level policies and implementation plans. Four core areas are identified in the strategy and a range of possible actions outlined under each area.

Purpose and audience

The purpose of this book is to assist government agencies and ministries, in collaboration with nongovernmental agencies and organisations, to develop country level national alcohol policy and action plans.

The "Resource Book"

The book is a tool to assist in translating the Regional Strategy into appropriate action at national and local community levels.

It follows the structure of the **Regional Strategy** and provides further detail, including reference to the evidence on which the Strategy is based, and examples of good practice. The examples are drawn from the Western Pacific Region as far as possible, but also draw on good practice and evidence from beyond the Region. The Resource Book is intended to complement the **Regional Strategy** and to be read in conjunction with it.

Prioritizing strategies for action

While each country will need to consider which strategies are appropriate and feasible to adopt, it is emphasized that implementation of a number of the approaches outlined in the R**egional Strategy to Reduce Alcohol-Related Harm** is likely to be required in order to curtail alcohol-related harm. Some strategies can add value and impact, but others are essential if any significant impact on alcohol-related harm is to be achieved.

National-level alcohol policies and action plans

An alcohol policy is an organized set of values, principles and objectives for reducing the harm experienced from alcohol use. It defines a vision for the future and helps to establish a pathway for action. The policy may also indicate the level of priority that a government assigns to reducing alcohol-related harm relative to other social and health priorities. It is generally formulated to cover a 5–10-year time period.

An alcohol action plan (sometimes also referred to as a programme or implementation plan) is a detailed scheme for implementing the evidence-based strategies that will reduce alcohol-related harm. The plan allows for the implementation of the vision and objectives outlined in the policy. A plan usually includes strategies, time-frames, resources required, any legislative or regulatory framework required, targets to be achieved, indicators and activities.

A national-level alcohol policy will be established in relation to other health, welfare and economic policies. It is therefore essential that intersectoral collaboration occurs at all stages of development and implementation of an alcohol policy. Often these policies will be supportive of each other; at other times they will not, and conflicting objectives will need to be reconciled. The extent to which the policy development process is transparent and open for public and professional input is likely to contribute to the nature and effectiveness of the policy.

In particular, a national alcohol policy may have to reconcile conflicting values between the promotion of health and reduction of harm on the one hand and the economic values that are embodied in principles of free trade on the other. It has been argued by some that, given the diverse interests of the many government sectors with an interest in alcohol policy, it may not be possible to achieve consensus on any but the least effective and therefore least contentious policies. Even so, in the absence of a written national policy, it is possible for opportunities to arise which allow for effective strategies of the sort outlined in the **Regional Strategy** to be implemented.

The role of the industries that produce, market, distribute and sell alcoholic beverages in the development and implementation of a national alcohol policy needs to be carefully considered and made explicit. A lead may be taken from the resolution of the Member States of the Western Pacific Region, who called on the Regional Director of WHO to "(4) collaborate with Member States, relevant international agencies, academic institutions, nongovernmental organizations

and other appropriate stakeholders to promote evidence-based, multisectoral approaches for the prevention and reduction of public health problems caused by the harmful use of alcohol" and "(5) to continue consulting with the private sector, particularly the alcohol beverage industry, over ways it could contribute to reducing the harmful use of alcohol" (WPR/C57.R5). In other words, the industries have responsibilities in relation to their practices and the likely impact on alcohol-related harm, but are less likely to be appropriate as participants in the development of a national alcohol policy.

Structure, scope and institutional responsibility for a national alcohol policy

Essential factors for the success of a policy include the structure of the policy, its scope and the institution responsible for its oversight.

The **structure** of alcohol policy varies according to the national context. In some cases, this will take the form of resolutions of parliament. In others, a comprehensive piece of legislation may be enacted; and in yet others, a written policy, which requires the implementation of different laws and regulations to meet its objectives, will form the structure of the policy.

When new legislation is drafted, it is useful for it to include an explicit statement of the objectives in passing the legislation, such as to reduce the harmful use of alcohol and improve public health and community well-being. This is useful in its subsequent interpretation. For example, laws regulating alcohol sales will require detailed decision-making by licensing authorities, which may later be challenged in court. Sections stating legislative aims are increasingly common in regulatory law to guide later decisions. Another value of such a statement of objectives is revealed if the legislation is challenged under the impact of a trade treaty (see Section Three: 4.3.3 below).

Many Australian states' liquor licensing acts include a public health objective (often alongside other objectives related to tourism and the local economy). For example, the Queensland Liquor Act includes the objective:

"to regulate the liquor industry in a way compatible with minimising harm arising from misuse of liquor; and the aims of the National Health Policy on Alcohol; and to regulate the sale and supply of liquor in particular areas to minimise harm caused by alcohol abuse and misuse and associated violence".

The New South Wales Liquor Act states: "A primary object of this Act is liquor harm minimisation, that is, the minimisation of harm associated with misuse and abuse of liquor (such as harm arising from violence and other anti-social behaviour). The court, the board, the director, the commissioner of police and all other persons having functions under this Act are required to have due regard to the need for liquor harm minimization when exercising functions under this Act. In particular, due regard is to be paid to the need for liquor harm minimization when considering for the purposes of this Act what is or is not in the public interest."

The **scope** of an alcohol policy may vary from coverage of, for example, only treatment issues or only issues pertaining to the sale and distribution of alcohol. Different sectors have responsibility for different aspects of alcohol policy, and this may make the development of an integrated alcohol policy very challenging. The sectors that have an important potential role to play in reducing alcohol-related harm range from health and welfare to justice and correction and economic, trade and taxation sectors. Without adequate involvement in a national alcohol policy of all relevant sectors and collaboration to achieve a shared objective of reducing alcohol-related harm, the effectiveness of the policy will be reduced.

The scope of an alcohol policy may also include an explicit statement of the goals the policy seeks to achieve. The statement of goals may take a variety of forms, depending on the national context. A common overarching goal is the **reduction of alcohol-related harm**. Depending on the national situation, more specific subgoals or objectives, such as a focus on reducing consumption by younger people or reducing harm associated with public drunkenness or traffic crashes, may be appropriate. In some countries in the Region in which drinking is less prevalent, but which are exposed to market expansion, a goal of arresting the spread of drinking might be appropriate.

The **institutional** responsibility for a national alcohol policy is relevant to its likely effectiveness. The involvement of so many sectors suggests the need for endorsement of an alcohol policy at the highest level. It is desirable that the policy should be the responsibility of the national government. While implementation responsibilities will necessarily be assigned widely to different sectors of central and local government and nongovernmental organizations, it may be helpful if a single agency or committee with strong leadership provides coordination and assures accountability.

Regardless of the exact structure and format of the policy, the most important issue is for government to have a policy that is approved at the highest level and includes the key effective and cost-effective strategies as outlined in the **Regional Strategy to Reduce Alcohol-Related Harm (4.1–4.3).**

Development of a national alcohol policy

This requires relevant and accurate data and dissemination of this information in ways that will influence the process of policy development. Evidence, when disseminated to the relevant stakeholders in a timely manner, can have a number of effects. It can influence the position of alcohol on the political agenda; the way in which the issues, including possible solutions, are framed; and the extent to which key players are motivated to take action.

Mechanisms to provide for the collection and analysis of pertinent data are covered in the **Regional Strategy to Reduce Alcohol-Related Harm (4.4.1)**.

The process of developing a national policy on alcohol is largely political. To a lesser degree, it involves technical actions and capacity-building. The role of nongovernmental organizations (NGOs) and civil society can be important in developing an effective national alcohol policy, and timely information exchange and collaboration across sectors are essential.

A useful first step may lie in determining the scope of existing country- and community-level alcohol policies and regulations in order to identify the requirements for new or revised legislation. As with all steps in the policy development process, this will provide opportunities for collaborative relationships to be built.

Because of the high level of concern in Thailand about the increases in alcohol consumption, the Thai government established the National Alcohol Consumption Control Committee (NACCC) in 2004. The NACCC was to be the collaboration centre for relevant public agencies and representatives from civil society. At the very first meeting, all participants shared the same concern about the loopholes in the existing alcohol-related laws and regulations; they were seen as fragmented, overlapping, outdated, difficult to implement, having different and conflicting purposes, and having no owner in some areas. The NACCC then agreed to contract a group of law academics to review the existing laws and regulations extensively and explore the opportunity to strengthen them. This review led to the proposal for a new Alcohol Consumption Control Act, with the clear purpose of controlling alcohol-related problems. This concept was adopted by NACCC and the Cabinet, then later put into the legislation process, and finally enacted in 2008.

The development of a national alcohol policy will reflect an assessment of the national situation, including forecasts of trends in the marketing of alcohol, the income of the population and demographic change, with young people constituting a particularly important group.

An alcohol action plan

It is very common for potentially effective national alcohol policies to fail to meet their objectives because of lack of adequate implementation. In order for the policy to achieve change and reduce alcohol-related harm, it needs to be accompanied by an action plan that identifies the key stakeholders needed to effect change and the processes and mechanisms by which implementation will occur.

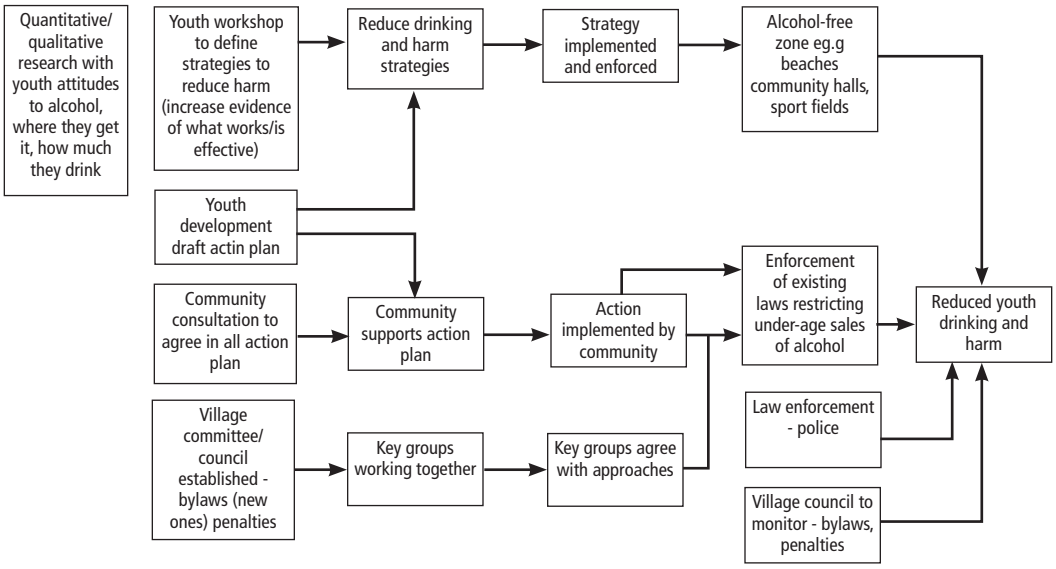
As with the development of the national alcohol policy, the development of an alcohol action plan will benefit from the use of a collaborating mechanism. This is likely to allow for participation from health, police, justice, local councils and other relevant implementation agencies. It will also include NGO/civil society and community sectors such as women's groups, organizations supporting young people, church groups, school principals' associations, religious and spiritual leaders and village councils.

Specific actions that might be undertaken in the **development of the alcohol action plan** include:

- Consider the Regional Strategy, this Resource Book and the National Alcohol Policy.
- Review country and subcountry-level data available on consumption and harms.
- Exchange information on the problems at community level, i.e. ask for stakeholder input on impacts, harms and issues related to consumption of alcohol.
- Identify common concerns and encourage ownership of the development process and the policy/plan.
- Use meetings to identify other possible sources of quantitative or qualitative data and other stakeholders who may wish to collaborate in implementing the policy.
- Identify good practice in subcountry regions, villages and local communities.
- Identify the priorities and responsibilities of each sector/organization and ensure these are reflected in the implementation plan.
- Consult industry representatives about their responsibilities in relation to the implementation of the alcohol action plan.
- Form a cross-sector subgroup to give ongoing input/guidance in the development of the implementation plan, including the organization of consultation with the broader community.

Drafting the action plan will benefit from an understanding of the importance of programme logic to ensure that the activities outlined are designed to meet the objectives established. The following project logic was developed by a working group of participants at the Meeting on Alcohol-Related Harm in the Pacific held in Auckland in May 2008.

Community Action / village - Urban - Reducing Youth Alcohol Related Harm



The process of drafting the alcohol action plan will also benefit from understanding and utilizing principles of community action. Community action projects are projects that seek to address the whole community system and are not necessarily limited to a specific target group. They are not projects delivering services or information that happen to have a community base. Instead they draw on existing community leadership and strengths and have as their goal the improvement of collaboration between sectors, including those paid by the state (such as the police and social workers). The evidence suggests that these projects are effective when enforcement of legislation is a key component of the community action.

A rural drink-drive community action project

New Zealand introduced random breath testing in 1993 and reduced alcohol-related traffic crashes, but they did not decline to the same extent in rural areas. A community action project was established, which involved all the key sectors: police, licensing inspectors, health personnel and some local people. The police negotiated additional funds from HQ and set up mobile "booze buses", which were highly visible, increased awareness of the campaign, and also made it easier for drivers to be processed without needing to travel to the police station. Information from drink drivers about where they had had their last drink was collected and analysed, and this information was used to influence sellers of alcohol to change their policies and to inform police where they should direct their enforcement. There were also some local community activities to increase awareness of the problem. There was a significant decrease in the amount of alcohol-related traffic crashes.

The alcohol action plan will also benefit from the inclusion of time lines, indicators and targets, where possible. Where local data exist, these can be used to decide targets, as in the example below.

Outcome 6: Alcohol-related crimes

Targets by 2003	Indicators	Data Sources	Responsibility for monitoring/ reporting
From 10% to 5%	Proportion of males surveyed who reported being assaulted by someone who had been drinking Proportion of females surveyed who reported being assaulted by someone who had been drinking	Alcohol and Public Health Research Unit and national surveys on drinking	Police
	Proportion of domestic violence incidents attended where alcohol involvement was noted	POL 400 forms and national police reports	Police/Liquor/ Licensing Authority
Comment: Insufficient data available to set target			
From NZ National Alcohol Strategy 2000-2003 (Ministry of Health, 2001:60).			

Local data may be found in countries' reports to the Global Information System on Alcohol and Health (GISAH, (http://apps.who.int/globalatlas/default.asp). Data are available on production and availability, levels and patterns of consumption, harms and consequences, economic aspects, alcohol control policies, prevention and treatment and comparative risk assessments.

Implementing the Alcohol Action Plan

Implementation of the Action Plan will be likely to involve:

- setting up regular interagency collaboration meetings;
- engaging communities and groups in community action on alcohol;
- providing ongoing training, capacity-building and learning opportunities for government, NGO and community stakeholders; and
- providing ongoing funding for community action to ensure the implementation of alcohol policy at the subcountry and local levels.

Implementation also requires the **development of a strategic evaluation plan** that allows for the measurement of the effectiveness of the policy. This will require accessing local technical and evaluation expertise and perhaps also international and regional expertise. Progress will be monitored against the targets and time lines set in the Alcohol Action Plan.

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Four components of a national alcohol policy

The **Regional Strategy to Reduce Alcohol-Related Harm** outlines a range of approaches that are key components of a national alcohol strategy.

1. Reducing the risk of harmful use of alcohol

1.1 Increasing public awareness of alcohol-related harm

Regional Alcohol Strategy (4.1.1)

Ensure adequate public awareness of the health and social consequences of the harmful use of alcohol:

- Develop and disseminate information on the health and social consequences of the harmful use of alcohol to the public

Both government agencies and NGOs may be involved in efforts to increase public awareness of the harm related to alcohol. For example, in Kiribati the Ministry of Health raises public awareness via media programmes and holding meetings in village halls and schools. The Police's "Safer Kiribati Campaign" also addresses alcohol issues. The NGO sector is involved through the work of the churches.

School-based education

School health curricula typically provide information about the risks from alcohol consumption and about local laws. These lessons improve young people's knowledge about alcohol, and may even affect their attitudes to drinking. They can therefore make a contribution to raising awareness about harms. However, alcohol education in the classroom is not effective in changing drinking behaviour and therefore can only be a small contributor to a policy to reduce alcohol-related harm.

Harm to others

Knowledge of the impact of drinking on those other than the drinker may be relevant to public and politicians' decisions on whether alcohol policy is needed. Much of the harm related to the use of alcohol is experienced not by the drinker himself/herself, but by spouses, children, extended family, workmates and others in the community. The Cambodian Demographic and Health Survey found that, whereas 23% of married women had experienced some level of violence, this was 57% for those whose husband 'gets drunk frequently'. In the United Kingdom, estimates produced by the Prime Minister's Strategy Unit suggested that 50% of the alcohol-related costs in the criminal justice system were made up of costs associated with the victims of alcohol-related crime.

Traffic trauma is another important area.

In an economic analysis of alcohol-related traffic crashes in New Zealand in 1996, Miller and Blewden (2001) estimated that 40% of all deaths and almost half of all nonfatal injuries from alcohol-related traffic crashes were to "innocent victims". Of those injured by drinking drivers, 45% of the fatalities and 33% of the non-fatally injured were under 20 years old.

Labelling products

Labelling alcohol products with warnings about health impacts has taken place in some countries. A common message is one referring to the effect of alcohol in relation to fetal alcohol syndrome (FAS) or fetal alcohol spectrum disorder (FASD). In a number of countries in the Region, the industry has placed messages on its products advising against use by underage people (e.g. Lao People's Democratic Republic: "Below 18 years should not drink").

While these tend to be a popular approach, the evaluation of labelling as applied in the United States of America has shown no direct impacts on consumption or alcohol-related problems. How much they contribute to efforts to communicate that alcohol is not an ordinary commodity is not known.

Media and community activities

The Marshall Islands' Alcohol and Substance Abuse Prevention programme distributes information and conducts interviews on the radio to highlight links between alcohol and high local suicide rates among young males, particularly in communities in transition from traditional to urban lifestyles. The use of the media is made more valuable because the programme also provides related training for youth workers and community groups.

Mass media campaigns

Mass media campaigns are expensive and, even if carefully targeted, are unlikely to change behaviour on their own. They are more effective if they explain and support policy changes, such as laws against drink-driving or the sale of alcohol to minors.

- Provide special prevention programmes for high-risk groups (such as young people, women who are pregnant or who are contemplating pregnancy, and certain disadvantaged groups)

- Provide special prevention programmes for high-risk situations and in certain settings (such as schools, workplaces, roads and highways)

Random breath testing (RBT) was introduced in New South Wales, Australia, in 1982. Funds were made available for a greatly increased level of police enforcement and there was widespread publicity in the mass media to convince the average motorist that he or she stood a high chance of being caught if he/she drank and drove. The publicity campaign slogan was: **"How will you go when you sit for the test, will you be under 05 or under arrest?"** RBT immediately reduced fatal crashes by 19.5% overall and by 30% during holiday periods. Further analyses suggest that these effects have been sustained, with high-profile, frequent RBTs helping create the perception that detection is inevitable.

Reducing violence

Research suggests that in some cultures alcohol use exacerbates violence in situations that encourage aggression and among groups most prone to violence. Alienated young men may feel the need to assert masculinity, power and territoriality and, in combination with alcohol, this may lead to crime, suicide and violence. The situation of young men in communities in transition between traditional and urban lifestyles may put themselves and their community particularly at risk. There is also a high level of involvement of alcohol in domestic violence and sexual violence, and research suggests that aggression is more severe when alcohol is involved.

Many Pacific island nations currently have bans in geographically remote areas such as on outer islands, in the highlands and in villages where traditional leadership is strong. These are seen by residents to reduce problems of alcohol-related violence and public disorder.

In Micronesia, the island of Moen in Truk opted for prohibition of alcohol in 1978 after 20 years of legal drinking. This resulted from a campaign by women concerned about violence and aggressive behaviour by young "weekend warriors" drinking in public. Government revenues plummeted and a black market developed, with police tolerating drinking in private. Alcohol consumption appeared to return to pre-prohibition levels, but included more spirits. Despite this, the ban was not felt to be a failure by the Trukese. In 1985, there was 90% support for the law, including from 68% of current drinkers. Drinking had become less visible, public bars were no longer a setting for drunkenness, people felt safer in the streets and the official condemnation of drinking gave support to those who suffered from it. Similar laws were voted for on several other islands.

Bans on alcohol use have also been used in both low- and high-income countries to prevent alcohol use in specific geographical areas. The tourist resort of Rarotonga (Cook Islands) has a ban on beachfront alcohol use, and in the Philippines there are bans on use in public domains. This approach has received some evaluation in high-income countries, but the impacts are not yet completely clear.

Responses to problems of public order and alcohol-fuelled violence have commonly included passing liquor bans – prohibition of consumption of alcohol in particular places, and sometimes at particular times. In New Zealand, evaluations have shown that a critical feature in the success of liquor bans is that the police have the power to arrest when the laws are breached. This ensures that offenders are taken out of the situation for long enough to allow for a cooling down period in an environment that is safer for themselves and others. The number of alcohol-related incidents has been found to decrease and there has been a reduction in litter and vomit in "liquor ban" areas.

Alcohol-related violence also occurs near drinking places where intoxicated people congregate. Urban planning, including good lighting and transport, can reduce injuries.

Safer City projects in Queensland and in New Zealand have shown that urban planning can contribute to reducing alcohol-related problems – for example, street lighting, safe sites for bus stops, late night bus and taxi services, increasing safety in car parks, and encouraging a range of evening activities that are not all focused on drinking. These were joint initiatives by local councils, community groups, local agencies such as the police, and young people from local high schools.

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Regional Alcohol Strategy (4.1.2)

Promote factors that protect against the harmful use of alcohol:

- Develop and implement health promotion programmes dealing with harmful use of alcohol, which empower people to make healthy choices and are appropriately adapted for individual national contexts

1.2 Promote factors that protect against harmful use

Community action

Policies established at the national level can be made more effective by community action at the local level. Effective community action will involve relevant community groups (such as religious, youth or women's groups) together with local agencies such as police and licensing inspectors. Ideally there will be ongoing funding to employ a coordinator.

A community action project in Sri Lanka was based on the insight that behaviour while intoxicated varies from one culture to another, and that drunken aggression or violence is based on expectations and community tolerance as much as on psycho-pharmaceutical effects. It was noted that violent drinkers selected their victims (the wife, but not the boss) and that social tolerance "privileged" this behaviour by allowing alcohol to be an excuse. The group began to question such behaviour publicly, and to question the way in which positive comments and jokes increased pressure to be a drinker. When the community stopped accepting bad behaviour while intoxicated – at times ridiculing drunks – aggression and violence reduced and so too did levels of consumption.

Alcohol-free Funeral Campaign
Funerals are occasions for drinking in many rural areas in Thailand, where the family of the deceased has to provide alcoholic beverages for guests. A number of NGOs – the StopDrink Network, the Thai Health Promotion Foundation and other community actors – organized the Alcohol-free Funeral Campaign. As part of this Campaign, they assessed and publicized the cost of providing alcohol. The finding that the families who followed the practice of alcohol-free funerals saved, on average, Baht 20 000 (US$600) significantly boosted the expansion of this Campaign to other communities.

The Korean National Alcohol Policy (Blue Bird Plan 2010) has as one of its goals the "Creation of Safe Alcohol Harm-free Social Environment" (2.5). The strategies include: the selection of alcohol-free zones in such places as public parks; legally required education and compulsory treatment for drinking drivers and violators of other alcohol regulations. Also, in order to create an alcohol control-friendly social atmosphere in the medium and long term, restrictions are placed on advertisement and sponsorship of liquor companies and on liquor sales, drinking areas, age and hours (www.mohw.go.kr).

- Provide supportive environments in schools, communities and other social settings that protect people from the harmful use of alcohol, ranging from family support programmes, community and school system support programmes, and increased access to non-alcoholic beverages.

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Regional Alcohol Strategy (4.1.3)

Reduce factors that may facilitate the harmful use of alcohol

1.3 Reduce factors that facilitate harmful use

Pressure to drink

Research has shown that children and teenagers who like ads the most have more positive beliefs about alcohol. They also think that their friends are more frequent drinkers and are more likely to drink than is actually the case. There is strong evidence that the more young people are exposed to alcohol advertising, the more likely they are to start to drink at an earlier age and to drink more heavily. Restrictions on alcohol advertising and other marketing may therefore reduce the pressure on young people to drink. In a country that allows advertising, health promotion messages targeting young people are likely to be dominated by commercial messages promoting alcohol – making it difficult, if not impossible, for health promotion messages to compete.

- Diminish pressures to drink from peer groups and other influences, especially for young people, other high-risk groups and for those who do not wish to drink

There is also evidence that people who are in treatment or who have previously experienced alcohol problems are affected adversely by marketing images and by expectations that drinking is the norm in most social situations.

In Cambodia, Viet Nam, Malaysia and Taiwan, beer brands are sold in bars by branded "beer girls" working on commission or monthly quotas. This leads to pressure on the customer to ensure that the women receive an adequate income.

"Drink responsibly" strategies

One of the approaches commonly promoted and supported by the alcohol industry consists of messages urging drinkers to "drink responsibly" or "drink sensibly". Sometimes these messages are included by the industry as part of their commercial advertising. However, research suggests that the main outcome of this kind of approach is to increase positive evaluations of the advertisers, and interpretations taken from the "drink responsibly" messages are predominantly pro-drinking. Such messages have been described as being strategically ambiguous.

- Provide training in the hospital and retail sectors for the responsible serving of alcohol, including enforcing compliance with the legal minimum age for the sale of alcoholic beverages

Responsible beverage service training

Training for people working in licensed premises is now widespread in some high-income countries. Training typically covers knowledge of the law; ways of ensuring alcohol is not sold to underage or intoxicated drinkers; age identification procedures; and recognizing signs of intoxication. It also covers provision of food, non-alcoholic drinks and entertainment; crowd control and noise reduction; and other useful information for maintaining a safe, enjoyable environment.

Training does not lead to changes in bar environments and reduced service to intoxicated patrons unless it is backed by the active enforcement of laws.

Careful evaluations in the United States of America have shown that server training alone did not have an effect on the server's willingness to supply alcohol to already intoxicated patrons. This happened on only about 5% of occasions both before and after training.

A combined approach of training with enforcement was tested in Michigan state, where, over the course of a year, plain clothes police officers entered bars to watch for and cite servers providing alcohol to intoxicated patrons. Bars that were responsible for more drinking drivers than others received more visits. A presentation about the increased enforcement was given to licensees, reports were provided to visited premises, and there was media coverage. Following this combined approach, there was an increase in refusals to serve intoxicated patrons and a significant decrease in drink-driving arrests. Economic evaluation showed that the benefits greatly exceeded the costs.

In some American states, bar owners and servers of alcohol are held liable for harm caused by patrons whom they have served when drunk. These states have been shown to have lower rates of traffic fatalities and homicides.

The role of security personnel hired by retail establishments is also important. Some research has suggested that their behaviour may sometimes escalate alcohol-related violence rather than prevent it. An Australian project in an area with many nightclubs and bars found that an intervention that included training to improve the quality of the security staff's work did reduce violence.

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Regional Alcohol Strategy (4.1.4)

Regulate and respond to the marketing of alcoholic beverages, including advertising, promotion, and the sponsoring of cultural and sports events, particularly those aimed at young people

1.4 Regulate and respond to alcohol marketing

The advent of sophisticated marketing and the availability of mass media and new technology (such as the Internet and mobile phones) has allowed a level of alcohol marketing that has never been seen before. The global alcohol producers have enormous resources to employ in marketing. This makes the regulation of marketing a major challenge for governments concerned about the impact of marketing on the rate of uptake of drinking in traditionally low-alcohol communities, including earlier and more widespread recruitment of younger people and women to drinking. It is also of concern, particularly in relation to the impact on younger people, in more stable alcohol markets.

The marketing mix

Around half of alcohol marketing budgets now goes to non-advertising forms of marketing such as sponsorships and direct promotions. In many countries in the Region, there is considerable sponsorship of sports teams and events, and therefore linkage of brands with recreation and excitement. Alcohol sponsorship of international sports events reaches all countries in the Region via satellite or local television. These international sponsorships are leveraged with local advertising, website coverage, point-of-sale displays, competitions and branded merchandise, to the extent that local policy permits.

A recent survey in Thailand found that 71% of the youth audience for broadcasts of the 2006 Soccer World Cup, sponsored by ThaiBev, a major alcohol producer, appreciated their support and wanted to repay the sponsor, and this was especially true of younger people [Phoojadkarn newspaper, 13 October 2006].

Alcohol sponsorship also includes sponsorship of music and other cultural events. This is common throughout the Region. Following a global trend, rock concerts and talent quests that attract young people are rapidly becoming as large a vehicle for alcohol brand marketing as sports. Alcohol brands also create their own cultural events.

In Tokyo in 2005, the Swedish vodka brand Absolut picked up on Japanese hip culture by identifying eye-catchingly dressed individuals on the street and inviting them to create a costume inspired by the Absolut bottle. They were then photographed at locations around Tokyo by an award-winning photographer.

One common and effective direct marketing approach is the sale and giving away of alcohol branded merchandise. Branded clothing and equipment are sold from websites and at sponsored events, where small branded items are also given away. United States research links early onset of drinking with young teenagers' ownership of alcohol branded merchandise.

New products that attract young drinkers through their sweet taste, low price and bright packaging (some of which have included cartoon characters) are forms of marketing in themselves. These products look similar to soft drinks or energy drinks, but often have a high alcohol content.

While new marketing methods are becoming very important in the marketing mix, the traditional forms of television and radio advertising, cinema, newsprint and magazines, billboards and point-of-sale advertising remain a major part of the mix.

Research has shown the links between these forms of advertising and the earlier onset of drinking and heavier drinking among young people. A large body of alcohol research now shows that children and teenagers, who like ads the most, have more positive beliefs about alcohol, think their friends drink more frequently and are more likely to drink more.

Controls on exposure to advertising

This has become a major focus for regulation in the United States of America, where it has been shown that youth exposure to alcohol advertising on radio and television and in magazines is widespread and exposure is often greater than that of adults. Advocates there have suggested mandating exposure to levels that make it proportionate to the youth in the population.

A number of countries in the region have policy statements in place that recognize the importance of restricting exposure of young people to alcohol marketing (although the methods may not succeed in adequately limiting exposure). In the Republic of Korea, ads for alcohol products are restricted to after 22:00 on television, and no ads may be shown during youth programmes (Taylor and Raymond, 2000). In Cook Islands, a 1998 Healthy Islands Committee recommended a ban on all forms of alcohol advertising and sponsorship. As a result, alcohol ads are no longer shown on television, except during live sports coverage of international events.

Controls on content of advertising

Much of the effort in restricting advertising, usually through voluntary codes, has focused on the content of advertising, for example, suggesting that alcohol reduces stress or is helpful for social or sexual success. Sophisticated marketing techniques can, however, often get around such codes of content. These codes do not address the way marketing associates alcohol brands and a drinking lifestyle with people's enjoyment of sports and other activities.

China implemented Regulations for Alcohol Advertising on Media in January 1996. Advertisements may not associate drinking with social success, daring, toughness, bravado, stimulation and relaxing, or suggest that alcohol can enhance health and sexual performance (herbal alcohol beverages). In 1996, regulations limited television to two alcohol ads between 19:00 and 21:00, with a maximum of 10 per channel per day at other times; a maximum of two ads an hour on radio; and two ads per issue for newspapers and magazines, but not on the front pages or covers. It has, however, been reported that there is much alcohol advertising that infringes these regulations.

In Viet Nam, the Ministry of Health's 2007 draft National Alcohol Policy proposed banning ads for all imported or local alcohol products with over 4.5% alcohol. It also proposed banning marketing that targeted children and adolescents under 18, alcohol sponsorship for cultural, artistic or sporting activities, alcohol prizes in promotions and competitions, alcohol brand names or icons on vehicles, and advertising alcohol-based tonics. Alcohol ads inside alcohol outlets should not be visible from outside.

Regulation and enforcement of marketing restrictions

- Designate a government agency responsible for enforcement of marketing regulations

Responsibility for enforcing marketing regulations is appropriately that of a government agency. This is particularly important, given the rapid development of marketing opportunities. It is not possible to rely on monitoring by the community or industry self- regulation. Industry self-regulation is the preferred option of the alcohol and media industries and they lobby actively for its adoption and retention. In general, self-regulation is against the vested interests involved and often leads to underregulation and underenforcement.

- Regulate or ban, as appropriate, the marketing of alcoholic beverages

Australia's history of industry self-regulation for alcohol advertising illustrates the weakness inherent in self-regulatory systems. In 1991, two research studies investigated the system. In one, members of the public judged advertisements against the code, and all were regarded as containing aspects that breached the code; however, only one of the complaints made was upheld by the industry council. The system collapsed under criticism and it was not until 1998 that a new code was established, but infringements and unsatisfactory rulings continued. In 2003, an Australia-wide Ministerial Council on Drugs threatened regulation unless improvements were made to the code and to the speed of decisions about complaints. However, a subsequent research study reported that advertisements found by a panel of independent judges to be in breach of the code and submitted to the industry council in the form of complaints were not found to be in breach of the code by the industry council.

Regulation to restrict advertising

Comprehensive restrictions are needed to reduce consumption and harm. To be effective, national policy on alcohol marketing should be as comprehensive as possible in its coverage, including coverage of new and emerging technologies. If alcohol advertising, programme sponsorship and sponsorship of sports, music and cultural events are restricted, there will be displacement to print media or other marketing strategies, but these are less effective and more expensive for reaching mass audiences.

The research supporting the need to restrict advertising and other forms of marketing comes mainly from studies of the impact of different levels of exposure on young people, with surveys of bans at the national level having produced mixed results. The most recent cross-country study found a significant effect of bans.

Saffer and Dave (2002) used data from 20 countries over 26 years, and compared countries depending on whether there was a ban on only spirits advertising, on beer/wine advertising, and on which of three media bans were in place. A variety of other influences including price were controlled for, and it was found that advertising did have an impact on consumption. The results indicated that an increase of one ban could reduce alcohol consumption by 5%–8%.

The most complete regulation covering marketing (the Loi Evin) was introduced in France in 1991, and has also been applied in French territories in the Western Pacific Region.

The Loi Evin

Following a period of unregulated marketing of alcohol, a high level of community and medical concern led to the adoption of legislation to prohibit advertising on television and in cinemas, along with all sponsorship. The advertising that is allowed, in print media for adults, and on some radio channels and billboards, is restricted to information about the product, such as where it was produced and its strength. A real change in alcohol advertising has been observed since 1991. The law has resulted in the language of advertising losing most of its seductive character. It is no longer allowed to use drinkers and drinking atmospheres: there has been a complete disappearance of the drinker from the images, in favour of highlighting of the product itself.

In the law:
A clear definition of alcoholic drinks is given: all drinks over 1.2% alcohol by volume are considered as alcoholic beverages.

Places and media of authorized advertising are defined:

no advertising should be targeted at young people;
no advertising is allowed on TV and in cinemas; and
no sponsorship of cultural or sport events is permitted.

Advertising is permitted only:

in the press for adults;
on billboards;[1]
on radio channels (under precise conditions); and
for special events or places such as wine fairs, wine museums.

When advertising is permitted, its content is controlled:

Messages and images should refer only to the qualities of the products, such as degree, origin, composition, means of production, patterns of consumption.

A health message must be included on each advertisement to the effect that "l'abus d'alcool est dangereux pour la santé" [alcohol abuse is dangerous to health].

[1] The text limited billboard advertising to the places of production and sale. Later, another law permitted billboard advertising anywhere that alcohol was served or sold.

- Engage greater responsibility among commercial interests, for example, though codes of conduct for sale and marketing prices

The strongest model for restriction of marketing is likely to be one in which government establishes a regulatory framework and the relevant industries develop and implement detailed codes of conduct relating to the marketing of their products within this framework.

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1.5 Promote advocacy

Promote advocacy for reducing the risk of the harmful use of alcohol (4.1.5)

- Provide support to agencies that advocate a reduction in the harmful use of alcohol
- Engage all relevant government departments in developing and implementing responses to prevent and respond to the harmful use of alcohol

Involvement of NGOs

Policy development in an area such as alcohol requires sustained, effective input from nongovernmental organizations (as well as the government sector). Such nongovernmental agencies will differ from country to country, but may include voluntary welfare organizations, health professionals and academics. Occasionally, such groups have arisen around the needs of victims of alcohol-related harm, such as the organization Mothers Against Drunk Driving (MADD) in the United States of America.

The Korean National Alcohol Policy (2006) includes as an activity:

(3.1.3) organisation of the 'Blue Bird Forum – a regular meeting with related organisations and civil groups to:

promote a campaign to advertise the seriousness of alcohol harm, create alcohol control-friendly atmosphere (restrictions on liquor drinking areas and hours).

A cost-effective approach for such organizations to raise the profile of alcohol-related issues and educate about effective change to reduce harm is using the public media to carry the message

(rather than paying for an advertising campaign). Typically undertaken by NGOs and community groups, media advocacy involves staging activities that attract media attention as news. It includes doing interviews on radio or television, supplying articles to local papers and building friendly relationships with supportive reporters. Media advocacy can present research, statistics and policy changes in ways that are easily grasped by the public. The media have an impact on the policy process partly because policy-makers and other key stakeholders are influenced by knowing there is public attention on the issue.

Many different government agencies are involved in the formulation and implementation of alcohol policy. Policy systems at the national level are often decentralized and delegated to a number of different and sometimes competing agencies such as the health ministry, the transportation authority and the taxation agency. The health ministry may need to ensure that knowledge about the impacts of alcohol on health and welfare are considered when other government agencies are developing and implementing policy.

2. Minimizing the impact of harmful use of alcohol

2.1 Supporting community organizations

In some country contexts, community organizations can work effectively, either alone, within a regulatory framework, or in collaboration with enforcement sectors, to reduce harm related to alcohol use.

In the Republic of Korea, a store selling alcoholic beverages is designated as a "clean store" if it refuses to sell alcohol to underage people three times. The testing is carried out by an NGO (in 2007, this was the Korean Public Health Association; in 2008, Consumers Korea). A pseudo-attempt to buy alcoholic beverages is made by high school students in randomly chosen big supermarkets or department stores. Seven stores were designated "clean stores" in 2007. In metropolitan areas, the Ministry of Health, Social Welfare and Family Affairs provided financial support to the NGOs. As yet, collaboration with the enforcement sector leading to prosecution has not occurred.

Evaluations have been carried out on community action projects in the United States of America and New Zealand. These have shown the value of a partnership between researchers and community organizations in which researchers bring evidence about which approaches are most likely to be effective and the community partners bring knowledge of the local situation. Without research input, the activities chosen by community organizations may appear useful and easy to achieve (such as holding family fun days or getting involved in classroom education), but contribute little to reducing harm.

Enable community organizations to prevent and respond effectively to alcohol-related problems in the community (4.2.1)

- Provide support to civic organizations, including relevant nongovernmental organizations, to prevent, identify and respond effectively to the negative health and social consequences of the harmful use of alcohol.

Working collaboratively with community leaders who have expressed interest in the issues is essential, as is taking advantage of opportunities as they arise. Media events and coverage of the project have a positive effect on people's feeling of belonging and the legitimacy of the community action project.

In Thailand, the StopDrink Network, a large network that consists of about 140 groups, has organized many alcohol-free campaigns. Student orientation is known for harmful binge drinking in Thailand. The StopDrink Network supported alcohol-free student orientation, and an evaluation survey showed a decreasing incidence of drinking among university students over a three-month period.

The promotion of an alcohol-free Buddhist lent period by the same network led to decreased consumption and road traffic injury during this three-month period.

The StopDrink Network is facilitated and supported by funding from Thai Health, which is funded by a special levy on alcohol (and tobacco) sales.

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Provide a health and social welfare workforce capable of preventing and responding effectively to alcohol-related problems (4.2.2)

2.2 Building workforce capacity

Primary health care deliverers can make important contributions in preventing and responding to alcohol-related problems. Developing their capacity to do so means putting in place strategies and processes that are sustainable as part of a country's primary health care system. This may require making sure that the structure of the service gives priority and resources to alcohol

issues, and ensuring the staff are trained and motivated. It may also require making appropriate linkages, such as with specialist services for referrals (if these exist) and with other key players in the community such as police, NGOs and self-help groups.

In Japan in 1975, a training programme was put in place to train primary health care providers (including public health nurses, doctors and social workers) in detecting and responding to alcohol problems. The programmes take a week and consist of lectures and skills training. There are now 5000 graduates of this course, who have established a professional society, the Japanese Society of Alcohol Related Problems.

- Build capacity of health care providers to detect, prevent and treat harmful use of alcohol more effectively

In many parts of the world, self-help (sometimes called mutual aid) groups exist (e.g. AA, Croix d'or, Danshukai). In these groups, which meet on a regular basis, people who have experienced problems with alcohol support those who are trying to change their drinking habits. Organizations in which families offer support also exist (e.g. Al-Anon). There are often supportive relationships between primary health care (PHC) deliverers and these self-help organizations. In low-income countries where very limited health services exist, they may play a central role. There is some evidence suggesting that such mutual aid approaches are effective compared with no interventions.

- Build capacity and support the primary health care system to act proactively in the community to prevent, identify and respond effectively to the negative health and social consequences of the harmful use of alcohol

In November 2008, the Republic of Korea held its first national week of awareness of alcohol harms. During the week, all public health centres, alcohol counselling centres, community mental health centres, some social welfare centres for low-income families and some hospitals participated in screening. This was done on the street, in workplaces, college campuses and workplaces. Those who were identified as problem drinkers were given information on AA and other treatment options. A special committee set up by the Ministry of Health and Social Welfare and Family Affairs asked every public health centre to organize the events in their local area.

Brief interventions

- Develop and support the introduction and implementation of brief intervention treatment programmes

There is good evidence that, if male heavy drinkers are exposed to a brief advice session, this leads to lower levels of drinking. There is less evidence related to women. These brief interventions can be provided by doctors, nurses and others. They can be delivered in many settings such as health clinics, emergency rooms, schools, or in health-promotion or employee-assistance programmes. The sessions typically last between 5 and 15 minutes, and sometimes booster sessions are offered. There is no evidence that longer interventions produce better results. There is good evidence that brief advice sessions can make a difference, producing small reductions in alcohol consumption, which persist over 12 months or longer. The effectiveness may depend on how well trained and supported the PHC deliverers feel. It is also essential that the advice

session, the context in which it is delivered and the person delivering it are appropriate within the cultural context.

This kind of intervention is much less expensive than longer-term treatment and has been shown to be effective. It has also been shown to be cost-effective, saving more in health, traffic crashes and criminal costs than the cost of implementing the programme.

- Enable easy access to early intervention, treatment and rehabilitation programmes for people with alcohol-related problems and support for their families

In high-income countries, a range of treatment options is commonly offered. There is evidence from the United States of America that treatment can be cost-effective in terms of the reduction in the costs of medical care of the heavy drinker and his or her family members (both of whom have higher medical care costs before treatment). The effect on the drinking problem rates of the population as a whole is very limited, however.

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Regional Alcohol Strategy (4.2.3)

Reduce drink driving through special programmes, in particular through establishing and enforcing a maximum legal blood alcohol

In line with the best international practices, set a legal low maximum blood alcohol level for drink driving violations

2.3 Reduce drink driving

Alcohol-related traffic crashes are a significant contributor to alcohol-related harm.
There is a measurable increase in driving impairment at low levels of alcohol in the blood.

Blood alcohol levels

Worldwide, drink-drive legislation in 60 out of 83 countries (countries with religiously mandated zero limits excluded) now set a blood alcohol content (BAC) limit of 0.05 g or less per 100 ml.

In the Western Pacific Region, Fiji, Malaysia, Singapore and New Zealand have limits of 0.08 g/100 ml (although New Zealand's Land Transport Safety Authority has recommended 0.05 g/100 ml). South Korea has a BAC of 0.05 g/100 ml, as have all states and territories of Australia since 1989. China and Japan have a BAC of 0.03 g/100 ml. Not all countries in the Western Pacific Region have established legal BACs.

In New South Wales, road crash fatalities showed a decline after the lowering of the legal BAC from 0.08 g/100 ml to 0.05 g/100 ml, despite limited promotion and enforcement at that time. Researchers considered that this effect might not have been sustained, had random breath testing not been introduced two years later. However, states that reduced their BAC to 0.05 g/100 ml over the 1980s showed lower proportions of alcohol-impaired drivers killed, compared with states that had not yet done so.

The usefulness of the BAC level as a strategy is reduced if breath/blood analysis technology is not readily available to police. This is the case in a number of countries in the Western Pacific Region. A commitment to enforcement is also required once the BAC level is established in law and the technology is available.

In June 2002, Japan lowered its BAC from 0.05 g/100 ml to 0.03 g/100 ml and increased penalties for drink-driving. This resulted in statistically significant decreases in numbers of alcohol-impaired drivers and alcohol-related motor vehicle crashes. The evidence suggests that the lower BAC legal limit and perceived risk of detection are the two most important factors in a sustained change in drinking and driving behaviour in Japan. There were also significant decreases in alcohol-related crashes, alcohol- related injuries and single-vehicle night-time crashes among 16–19-year-old drivers.

Younger drivers

The Organisation for Economic Cooperation and Development (OECD) and the European Union (EU) now recommend a BAC of 0.02 g/100 ml or less for novice drivers or young drivers, who are more susceptible to alcohol than older drivers. For example, in January 2006 the Netherlands lowered its BAC for novice drivers to 0.02 g/100 ml for their first five years, based on evidence that young male drivers in particular were involved in a quarter of all crashes and were not responding to existing measures.

All states of the United States of America now set 0.02 g/100 ml BAC for drivers under the legal drinking age. A survey of 5000 high school seniors found that in states that had passed a specific BAC for young people 19% fewer drove after drinking alcohol, and 23% fewer had driven after five drinks.

- Develop and enforce, where appropriate, a system of frequent random blood alcohol testing

Random breath testing

Random breath testing (RBT) is an effective means of ensuring compliance with drink-driving laws.

In the small island nation of Niue, there is an effective drink-drive intervention in place. In 1997, a BAC law was passed with a limit of 0.05. Police are equipped with sniffer equipment and an Alcometer. Drivers are stopped randomly at checkpoints and if they fail the sniffer test, they are asked to take the Alcometer test (people who refuse are arrested). In the case of positive tests, prosecution follows – 90% of drinking drivers have been prosecuted in Niue since the law was passed.

The key element of RBT is its randomness and visibility so that potential drinking drivers know there is a reasonable chance they will be detected. RBT began in Scandinavia, Finland and France in the 1970s. The aim of RBT is to create a sense of unease about drinking and driving among potential offenders through highly visible police enforcement, which gives the impression of being unpredictable, unavoidable and ubiquitous. RBT is performed at arbitrarily selected, highly visible checkpoints – often on main roads – which are varied from day to day and from week to week. The checkpoints are not announced publicly. Motorists passing a checkpoint who are pulled over for preliminary roadside breath tests are selected in a haphazard fashion and all drivers who are pulled over are asked to take a breath test regardless of personal or vehicle characteristics. Drivers returning a negative breath test result are not detained and usually drive away after a delay of less than one minute.

New Zealand legislation in 1993 set breath and blood alcohol limits for adults and drivers under 20, and gave police powers for random compulsory breath tests ("anyone, anytime, anywhere") followed by evidential blood tests. At the same time, zero tolerance for youth was introduced. From 1995, enforcement of RBT was stepped up through the introduction of "booze buses", supported by a hard-hitting media campaign. "Booze buses" streamlined processing on the spot and were supported by community programmes. Deaths from road crashes involving alcohol fell from 44% of all road crash deaths in 1990 to 26% in 2001. Injuries sustained in alcohol-related road crashes also fell, from 26% in 1990 to 14% in 2003.

From a cost-to-government perspective, compulsory breath testing more than paid for itself. The buses were particularly cost-effective. Estimated benefit–cost ratios were highest for the comprehensive package, which included RBT, the media, booze buses and community action projects, although RBT by itself saved more money than it cost.

Automatic loss of driver's licence

- Develop and enforce a system of administrative driving licence suspensions or revocations to ensure quick and effective consequences for those who violate drink-driving regulations

The speed with which a penalty is applied also affects the effectiveness of a penalty. Administrative suspension of driver's licences allows immediate action when drivers are detected with BAC levels beyond the legal limit.

Ontario, Canada introduced administrative licence suspensions for drink-driving in 1996. This required that anyone charged with having a BAC over 0.08 g/100 ml or refusing a breath test would have their licence suspended for 90 days from the time the charge was laid. This change was followed by an estimated 17.3% reduction in fatally injured drivers who were over the legal limit.

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2.4 Enforce laws to prevent alcohol-related crime and disorder

In Australia, police estimate that 60% of the incidents they attend relate to the consumption of alcohol, with 44% of those relating to licensed premises. In Korea, 63% of those committing homicide and 63% of those convicted for violence were found to have been drunk. Heavy

drinking was also associated with violence against wives. Police Community Perceptions Surveys carried out by the Pacific Region Policing Initiative have suggested that alcohol is presenting serious problems in the Pacific.

Police enforcement strategies have been shown to be effective at increasing rates of refusal to serve alcohol to obviously intoxicated and underage customers by staff in licensed premises and in reducing alcohol-related crime and alcohol-related injuries.

One approach to policing to reduce alcohol-related harm in New Zealand has involved ongoing collaboration between the police, the licensing inspectors (employees of the city councils) and staff of the public health units. These met regularly to discuss information obtained by the police in a "Last Drink Survey" in which everyone arrested by the police was asked where they had had their last drink. Those drinking premises that were mentioned an unusual number of times (about 10% of the premises) were targeted for special attention in order to reduce sales to intoxicated patrons and underage drinkers.

In New South Wales, Australia, data collection about alcohol's involvement in police-attended incidents was collected in a pilot project. This was a collaboration between the health sector, researchers and the police (with funding additional to normal police resources). Four pieces of information were routinely collected by the police: whether the person had consumed alcohol prior to the incident; level of intoxication based on behavioural indicators; where alcohol was consumed; if licensed premises, the name and address. Licensees were given feedback about incidents reported to have occurred following consumption on their premises and police visited to carry out audits and discuss them with licensees. During a six-month trial period, there was a 22% reduction in the number of intoxicated patrons involved in incidents that followed reported consumption on audited premises. Following this, the programme was adopted as part of routine policing practice in New South Wales.

Training and higher priority given to alcohol policing are needed to achieve effective change. Additional resources may be required, and the collection of data that illustrate the role of alcohol in crime can be useful in assisting redirection of policing priorities.

The Saving Lives Project was conducted in six communities in Massachusetts, United States of America. It was designed to reduce alcohol-impaired driving. Each community had a paid full-time coordinator who organized a task force with representation from key agencies. The programmes were designed locally and included enhanced police enforcement, media campaigns, police training, high school peer-led education and college education campaigns. During the five years of the programme, Saving Lives cities experienced a 25% greater decline in fatal crashes than the rest of Massachusetts.

Regional Alcohol Strategy (4.2.4)

Provide further active involvement of the law enforcement sector in preventing and responding to alcohol-related problems, in particular to alcohol-related crime and other antisocial behaviour and the negative effect on public order of harmful use of alcohol

- Promote close collaboration between health and law enforcement sectors to enable a public health and public safety approach to the harmful use of alcohol

- Provide training to the law enforcement sector on how to prevent and respond to alcohol-related problems

- Encourage the law enforcement sector to develop and implement strategies responding to the harmful use of alcohol

In situations where a proactive policing approach to alcohol has not been the priority, NGOs and community groups can play an important role in highlighting the need for increased enforcement.

In Thailand, a group of academics and researchers, the Media Monitoring Project, played a significant role as the independent watchdog in monitoring alcohol advertising practices. The findings of this project showed the high incidence of violation and circumvention of the advertising regulations, including the presence of hidden promotion. The data were publicized through the media, and this action by the NGO group encouraged the enforcement agencies to take action.

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3. Regulate accessibility and availability

Regional Alcohol Strategy
Establish and enforce regulatory mechanisms for alcoholic beverages (4.3.1)

- Establish and enforce a minimum legal age for the purchase and sale of alcoholic beverages and a ban on the sale of alcohol to intoxicated persons

3.1 Establish and enforce regulatory mechanisms for alcoholic beverages

Minimum age to purchase alcohol

Research shows that the younger people start regular drinking, the more likely they are to experience problems from heavy drinking at a later age. Young people experience more harm than adults from drinking the same amounts. Recent research also shows that alcohol can have adverse impacts on adolescent brain development.

Given the particular vulnerability of younger people, a policy that sets a minimum age at which alcohol may be sold to young people and at which they may buy it has been found to be an effective policy for reducing harm. The age of purchase may also be the minimum age for drinking, as in some American states.

Setting the minimum age for purchase in licensing legislation means that sellers can lose their licence, as well as being prosecuted by police in court. It may be a prosecutable offence for underage drinkers to buy alcohol or to show false ID. But the main focus of such Acts is on prohibiting adults – licensees and their staff – from selling or supplying alcohol to underage drinkers, and a requirement to check proof of age is often included.

New Zealand reduced its minimum purchasing age from 20 to 18 years in 1999. There was a marked increase in the proportions of those in the age group newly entitled to purchase alcohol who were consuming large amounts of alcohol on typical drinking occasions. There were even larger increases among those in the younger age groups (16–17 and 14–15 years) showing a spillover effect. Following the law change, there was an increase among the 18–19-year-olds in alcohol-related traffic crashes and in presentations with alcohol intoxication to hospital emergency rooms.

During the period 1970 to 1985, a number of American states first reduced their drinking age to 18 years and then, following concern over the impacts, reinstated an age of 21 years. This provided a series of natural experiments, which were evaluated by many studies. They found that raising the age reduced traffic crashes for those aged 18–21 and also after people reached the legal age for drinking. This change in drinking age also reduced alcohol-related injury admissions to hospital and injury fatalities. It was concluded that, compared with a wide range of other efforts to reduce underage drinking, increasing the legal age for consumption and purchase was the most effective.

Viet Nam currently prohibits the sale of alcohol of more than 14% alcohol by volume (ABV) to children under 16 years of age. Its new National Alcohol Policy proposes banning the sale of all alcohol over 4.5% ABV to those aged under 18 and alcohol over 14% ABV to those aged under 25. It also proposes fines of VND200 000 to VND500 000 for offences. It will ban the selling of alcohol in schools, vocational training schools, recreational areas, parks and playing fields for children and adolescents. Bottle shops will have to be more than 100 metres away from such facilities.

Australia has legislated to prevent "social supply" to underage drinkers. The states' liquor laws typically make it illegal for adults to purchase on behalf of minors; that is, the offence to be proved is the purchase, rather than supply to a minor. New South Wales recently addressed this by making it illegal for any adult to supply alcohol to a minor without direct approval from their parent, guardian or spouse.

- Regulate the sale of alcohol to limit the places where and times when alcoholic beverages can be sold

Sale to intoxicated people

In some American states, bar owners and servers of alcohol are held legally liable for harm caused by patrons whom they have served when drunk. The effect of prosecutions of the sellers of alcohol and the publicity these prosecutions receive reduces sales to intoxicated people. These states have been shown to have lower rates of traffic fatalities and homicides.

Places and hours of sale

There is considerable research evidence to suggest that the number and density of places where alcohol can be purchased have an effect on alcohol-related harm. In many countries within the Western Pacific Region, there is evidence of a considerable increase and high levels of physical availability of alcohol. In Mongolia, the number of points of sale and service of alcoholic beverages has increased. As a result, it has become possible for people to purchase alcoholic beverages within a walk of 50–700 m, 24 hours a day. This has impacted on the consumption of alcoholic beverages. In Australia, people who lived closest to licensed premises reported more drunkenness and property damage in their neighbourhoods.

Consistent evidence links increases in hours or days of alcohol sales to increases in harm, including traffic injury, street disorder and violence. Even small or local changes have significant local harm impacts, but little effect on total sales. This indicates that later or longer trading contribute disproportionately to heavy drinking and drunken behaviour. Research in Western Australia linked higher levels of patron intoxication and high levels of local violence to later pub trading hours. In Australia, it has been found that heavier drinkers are more likely to take advantage of longer trading hours than are lighter or more moderate drinkers. A recent study showed that the United Kingdom's new law allowing sales up to 24 hours a day trebled night-time alcohol-related emergency admissions to one London inner city hospital.

- Develop and enforce a commercial licensing system to regulate the production, importation and wholesale and retail sale of alcoholic beverages

In Tennant Creek, Australia, an Aborigine community successfully campaigned to have pubs and bottle shops closed on Thursdays so that pay cheques would go home to feed families. On other days, takeaway sales were limited to between noon and 21:00. Evaluations found a 19.4% decrease in drinking over the next two years, with reduced arrests and admissions to hospitals and women's refuges. In the early, most stringent phase, reductions were as high as 34% for hospital admissions and 46% for women's refuge admissions.

A licensing system

Many of the effective policies outlined in the Regional Strategy rely on a controlled alcohol market. Such control allows for safety standards to be met, as well as ensuring that restrictions on accessibility and price are effective harm-reduction methods. There is evidence of the need

for such controls to be imposed and enforced within the Region. For example, the material supporting the Mongolian resolution on alcohol concluded that the controls and implementation of laws on production, import, trade and services were not satisfactory.

In Australia and New Zealand, legislation regulates the retail sale of alcohol by establishing an authority with powers to license people of good character to sell alcohol (for drinking on the premises or to take away). It lays down criteria for responsible operation of the outlet, together with processes and sanctions for suspending or cancelling the licence for noncompliance. The licences are granted for a limited period such as a year, so they come up for regular review and renewal. It is intended that the licence application fee or annual operating fee will cover the costs of administration, monitoring and enforcement.

New Zealand has a two-tier licensing system. A licensing committee at local government level grants unopposed licences and renewals and employs inspectors to monitor on-, off- and club-licensed premises. Local police and public health officers also report on licence applications and renewals, and the three agencies are encouraged to work closely together. There is also a process for objections from the public. To distance contested decisions from small town relationships and politics, opposed licence applications/renewals and applications for variation, suspension or cancellation of licences or managers' certificates go to a national-level Liquor Licensing Authority. Even licence suspension for a few days can have a considerable impact on profitability, and is a risk that helps encourage compliance with the law. There is a right of appeal to the courts, but premises may not continue to trade while this is heard.

- Establish minimum standards for the production of alcoholic beverages to ensure that alcoholic beverages being produced and imported meet beverage safety requirements and that home-brewed and home-distilled alcoholic beverages are either prohibited from commercial sale or strictly controlled

Regulate production, import and sale

In a number of countries in the Region, there is informal production of alcohol, which undermines the effectiveness of alcohol control policy, as well as sometimes being unsafe. For example, Viet Nam requires local producers of alcohol for sale to use facilities licensed by the Ministry of Health for product quality, hygiene and food safety. However, there is thought to be a high level of informal production in the form of home-produced beer and spirits. Under its proposed National Alcohol Strategy, the Ministry of Health planned to bring home-produced alcohol into the systems for hygiene inspection and licensing for sale through giving a stronger role to district commune authorities in monitoring and education.

Mongolia experienced methanol poisoning caused by locally produced alcoholic beverages. In response, a temporary ban was placed on all sales and serving of alcoholic beverages for a one-month period from December 2007 to January 2008 while investigations were made. This initiative involved the Police Department, the State Inspectorate Agency (which determined methanol levels), health care services (which provided mobile services for methanol poisoning) and the media who assisted with public awareness-raising. The ban on sales had dramatic effects on the numbers of people admitted for trauma, especially from wounding, and more than halved the numbers admitted to police sobering stations. The government moved to adopt technical requirements for local production, improved inspection, increased taxation and made taxes relative to the strength of the beverage.

In addition to the informal sector (home-brewed and -distilled beverages), the Region has some experience with illegal production on a commercial scale.

Illegal production was addressed by the Fiji government, and a factory making alcohol was closed down. Following the crackdown on illegal production and distribution, there was an increased demand for licences. However, in order to maintain restrictions on availability, the government introduced a major increase in the licensing fee in April 2008, which reduced the number of applications. This policy approach was a response to concerns over the extent of alcohol-related crime being experienced in Fiji.

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Establish an alcohol taxation system as a means of reducing the harmful use of alcohol (4.3.2)

3.2 Alcohol taxation systems

Taxation on alcohol is an effective strategy for reducing alcohol-related harm when it contributes to increasing the retail price of alcohol and consequently reduces consumption and harm, including levels of crime and violence. There is considerable research evidence demonstrating the effect of taxation on both consumption and harm.

Young drinkers and heavy drinkers are particularly sensitive to the price of alcohol, making a focus on the price of alcohol (relative to other goods) particularly effective.

- Without prejudice to the sovereign rights of states to establish their taxation policies, serious consideration should be given to the implementation of an alcohol taxation system as an effective mechanism to decrease the harmful use of alcohol

A number of different ways to tax alcohol are employed. These commonly include a reflection of the absolute alcohol content of a beverage (volumetric) and sometimes the value of the product (ad valorem tax). New products coming to the market and changing conditions mean that taxations systems need to be reviewed regularly.

Rates to reflect alcohol content (volumetric)

A graduated scale of tax rates based on pure alcohol content reflects the potential for harm from different alcoholic beverages. Sufficient graduations are needed to avoid undertaxing at the top end of any category.

In Japan, the tax for different beverage types varied until recently. Traditional and European-style beer were taxed on malt content, so brewers developed a "third generation" of beers made from peas to incur lower tax. These sold for 60% of the price of standard beers. A new tax scale from May 2006 introduced parity between alcohol types so that tax reflected the alcohol content.

Inflation-proofing

Inflation and increases in income make alcohol more affordable; this leads to more consumption and more harm. Adjusting the tax levels on alcohol to keep in line with increases in the costs of other goods is an appropriate response. Both Australia and New Zealand have automatic inflation adjustment biannually as part of their alcohol excise tax. However, particularly in times of economic growth, increased incomes can mean that affordability is increased. This requires a policy response in which tax is adjusted in line with wages.

Targeted taxes

In 1998, China increased its tax rate on spirits in an effort to shift a tradition of heavy spirits drinking towards lower-alcohol beverages. It also restricted production and import licences for spirits, and banned advertising on television. At the same time, decreases in the real price of beer and wine, plus increased production, resulted in increases in consumption of these beverages. The reduction in spirits consumption due to taxation and reduced production resulted in an initial drop in the consumption of total absolute alcohol. But as beer and wine consumption have continued to increase, recent years have shown a stabilization in absolute alcohol consumed.

- Consider taxation of alcoholic beverages based on their alcohol content

Certain beverages may be seen to present particular risks in some contexts: for example, higher-potency beverages and those packaged in ways that make them easy to buy and to transport. Sweet pre-mixed spirits beverages (alcopops or ready to drinks (RTDs) constitute a newly developed product. Many of these are very attractive to young starter drinkers, and also to young women. There has been concern that this might encourage young people to drink at an earlier stage. France, Switzerland, Germany and Denmark have all ensured that their tax rates do not favour alcopops.

- Administer special taxes for alcoholic beverages targeted at vulnerable groups such as young people

Australia's Northern Territory is a particularly heavy-drinking area. In 1992, it imposed an additional levy on alcohol that resulted in a 22% reduction in adult per capita consumption over the next four years, including reductions in hazardous drinking patterns. Availability restrictions, health promotion and treatment services were also introduced. But it seems likely that it was the tax that contributed most to reducing the burden of alcohol-attributable injury and chronic deaths in the short term. It may also have contributed to reduced chronic illness in the longer term.

Taxing the cheapest drinks

There is evidence that the heaviest drinkers buy cheaper drinks, giving them a unit of alcohol at a lower cost than the drinks less heavy drinkers buy. For this reason, taxes that differentially affect lower-priced drinks may be more effective at reducing heavy drinking and harm.

Minimum prices

Taxation is useful as a way to reduce harm from alcohol to the extent that it maintains or decreases the affordability of alcohol. However, there are other influences on affordability, such as income growth and very cheap prices. The ability of large retailers (such as supermarket chains) to purchase in bulk and then sell alcohol very cheaply to draw people into the store has led advocates in some high-income countries to suggest that a minimum price approach might be useful. Minimum price is a mechanism that has most impact on the cheapest drinks.

An expert Workshop on Price convened by Scottish Health Action on Alcohol Problems has recommended that: "The Scottish Government should establish minimum prices for alcoholic drinks".

Fixing minimum drinks prices can achieve health goals that raising alcohol taxes alone cannot by preventing below-cost selling and the deep discounting of alcohol in which some retailers engage. Fixing minimum drinks prices is possible under both United Kingdom and EU competition law, provided that minimum prices are imposed on licensees by law or at the sole instigation of a public authority. In jurisdictions where this is not possible under competition law, a process of adjusting taxation levels, taking into account retail price levels, may be feasible.

Government revenue

The revenue gained from alcohol taxation means that government's fiscal interests are compatible with public health goals. Some of the effective actions required under the Regional Strategy to Reduce Alcohol-Related Harm require expenditure. The specific alcohol taxes contribute to government funds and offset these costs, as well as contributing to the monetary costs incurred by alcohol-related harm.

The effect of price changes on alcohol consumption is described as the price elasticity of demand. It has been shown (in many high-income countries) that alcohol is inelastic. This means that when the price increases there is a drop in consumption, but this is not large enough to reduce government revenue. Therefore, tax can be used as a strategy to reduce harm and still contribute to government's need for revenue.

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Regional Alcohol Strategy. Consider alcohol-related harm reduction when participating in international trade and economic agreements (4.3.3)

- Ensure regulation of alcoholic beverages to avoid illegal importation

- Apply or establish, where necessary, coordination mechanisms involving ministries of finance, health and trade, as well as other relevant institutions, to address issues related to the harmful use of and international trade in alcohol

3.3 International trade and economic agreements

Illegal importation

Policies affecting the price and availability of alcohol need to apply to all the alcohol beverages consumed. Unrecorded alcohol from informal or illegal production or cross-border smuggling can undermine the effectiveness of alcohol tax if they are available at lower prices or at times and in places that commercial alcohol is not.

Viet Nam has faced particular problems from illegal beverages, with official estimates stating that around 30%–40% of all spirits sold are smuggled products. The government is addressing this with stronger border controls, tax stamps on alcohol containers and monitoring of retail sales outlets. The tax stamp system has needed improvement, however, as excise stamps became available very cheaply on the black market and vendors continued to find ways of evading the tax.

Health impacts of trade in alcohol

Research on trade treaties and alcohol commissioned by WHO concluded that "the more effective an alcohol policy is in reducing alcohol consumption – and hence, generally, alcohol related harm – the more likely it is to clash with trade treaty rules". The effect of trade agreements in relation to alcohol-related harm happen via an effect on policies, but also because the free flow of products with increased competition and promotion can have a direct effect on the alcohol market and consumption.

There are examples of policy liberalization in the Region. The removal of tariffs on imported spirits and wine when China joined the World Trade Organization (WTO) led to increased availability of imported spirits in city supermarkets and hypermarkets. By 2006, "booming sales" were reported. This undermined Chinese policy to reduce the total alcohol consumed. In Taiwan, China, alcohol advertising was severely restricted, but this was eased as part of Taiwan's bid to join the WTO and in response to pressure from its trading partners.

The General Agreement on Trade in Services (GATS) and other recent treaties provide a general exception to protect human or environmental health. In some cases, when clear statements have been made that restrictions should remain in place for health reasons, these have been allowed. Japan excluded its alcohol distribution services when it joined GATS. Governments can list "exceptions/bracketing" for certain goods or services (but the expectation is that coverage will be gradually increased).

In the Pacific region, there has been a successful case of exclusion of alcohol from a trade treaty. In 2001, all parties to the Pacific Island Countries Trade Agreement (PICTA) of the Pacific Islands Forum agreed to defer the coverage of alcohol and tobacco for further consideration. In 2004, nongovernmental organizations (NGOs) and health officials raised concerns about the possible inclusion of alcohol at a meeting hosted by WHO, the Secretariat of the Pacific Community (SPC) and the Pacific Ministers of Health and of Trade. The SPC prepared a report on likely health impacts for the 2005 Pacific Health Ministers meeting, which recommended strongly against inclusion. The Health Ministers made a recommendation against inclusion to the Trade Ministers who were meeting on PICTA the following month. These Ministers chose to exclude alcohol and tobacco for a further two years. In 2007, the issue was revisited, tobacco was excluded for another two years, and it was decided there were to be consultations with the partner countries about the inclusion of alcohol.

In regions of the world that have included alcohol under trade treaties, cases have been brought before the WTO and the EU courts to challenge national policies seen by trading partners as barriers to trade and competition. However, international courts have upheld government's right to prohibit or restrict alcohol advertising in the interests of public health. France was able to defend its health-protecting alcohol advertising policies on public health grounds. Sweden's ban on print media advertising was changed to allow ads for beverages of under 15% alcohol by volume. This followed a challenge by an international magazine. However, the Swedish legislation was rewritten to make public health objectives explicit, and bans in the other media were maintained. The courts also allowed Sweden to keep its retail monopoly, provided it offered the public a diversity of products and did not favour Swedish products over others.

- Continue to develop or enhance capacity at the national level to track and analyse the potential impact of trade and trade agreements on harmful alcohol use

- Collaborate with other Member States and with competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health

The Loi Evin
The ban on alcohol advertising in binational broadcasts in France was upheld by the European Court of Justice in 2004. The court stated:

"It is for Member States to decide on the degree of protection which they wish to afford to public health and on the way in which that protection is to be achieved."

"The law (reduces) the occasions on which television viewers might be encouraged to consume alcoholic beverages."

"The French rules on television advertising are appropriate to ensure their aim of protecting public health."

The laws "do not go beyond what is necessary to achieve such an objective".

Source: C-262/02 and C-429/02.

Tariffs v alcohol taxes

Under regional or bilateral trade agreements that include alcohol or when countries are members of the WTO, governments must give equal treatment to imported and domestic products. Tariffs on imported alcohol must be lowered. Tariffs on alcohol are often an important source of government revenue for less developed economies. They can, however, be replaced by an alcohol-specific tax on both imports and domestic production. Following the removal of tariffs as part of a trade treaty, excise tax policy can set tax rates at a level appropriate to counter the expected effects of increased free trade on alcohol availability, price competition and marketing.

It is likely that trade treaties do pose a threat to public health by increasing the availability and variety of beverages available, and the expectation is that all goods and services will eventually be included. However, there are actions that governments can take to exclude alcohol from agreements, to increase taxation in order to replace tariffs and to maintain restrictions on marketing. A clear rationale needs to be stated that this is done to protect health.

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3.4 Enforcing legislation and regulation

Enforce and apply legislation, regulation and policy (4.3.4)

- Ensure that enforcement agencies appropriately enforce the regulation of alcoholic beverages
- Enforce minimum-age requirements for the purchase, consumption and sale of alcoholic beverages

It is very common that, even when legislation is in place, the law is not enforced. In Nuku'alofa, capital of Tonga, a controlled purchase operation, in which young people were sent into alcohol outlets by police to attempt to purchase alcohol, was carried out. It showed that, out of 142 purchase attempts by young people aged 11 to 16 years, 85% were successful. Of the 21 unsuccessful attempts, 10 outlets did not sell alcohol, one was out of stock and only 10 refused. Publicizing this kind of situation and increasing enforcement can reduce access to alcohol by young people.

In the Auckland Region of New Zealand, a purchase survey showed that 60% of young people were sold alcohol without providing age identification. An intervention was put in place that achieved coverage in the media, gave direct feedback to the retailers and worked with police to encourage increased enforcement of minimum purchase age law. A follow-up purchase survey showed there had been a significant drop in sales without identification to 46%. The publicity surrounding this data collection and related community action contributed to the NZ Police establishing routine controlled purchase operations. New Zealand guidelines for conducting controlled purchase operations are available on the Internet (www.alac.org.nz).

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Provide systems to collect and analyse pertinent data (4.4.1)

- Assign a lead agency to develop an alcohol information system and to analyse information for policy development. This may be a principal task for a new, specialized institution; it may also be a new task for an existing agency with a broader scope of activities, such as a national institute for public health

4. Establishing mechanisms to facilitate and sustain implementation of the Strategy

Local evidence on alcohol consumption and problems is very useful to inform the development of alcohol policy. This might include estimates of consumption from records kept for taxation purposes, numbers of licensed/nonlicensed sellers of alcohol, drink-drive offences, alcohol-related violence, self-harm and concerns expressed by key community groups or decision-makers.

In high-income countries, data on alcohol-related hospitalization will be relevant. But it is less likely to reflect alcohol-related harm in low- and middle-income countries where access to hospital is much less widespread.

4.1 Provide systems to collect and analyse pertinent data

Lead agency for alcohol data

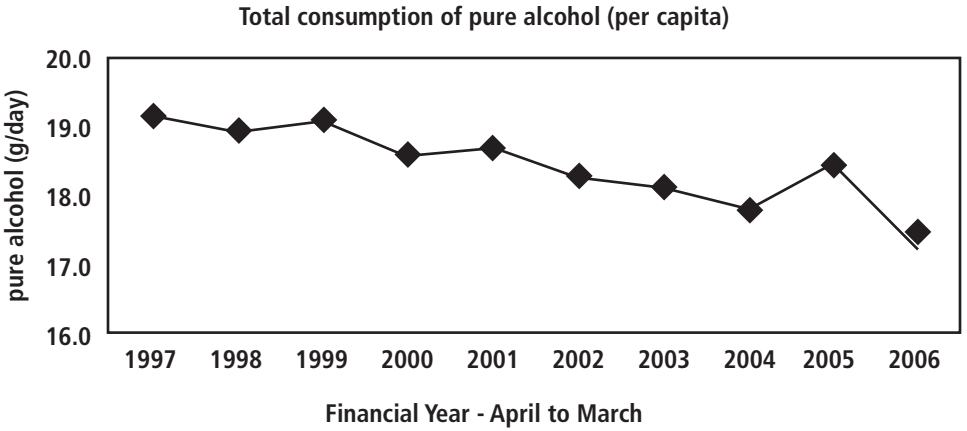
In Thailand, the Center of Alcohol Studies (CAS) was established in 2004 to be the managing agency for alcohol-related knowledge. Apart from funding research to assist Thai alcohol policy development, it has also had an important role in publicizing the findings. It provides information to public media, including responding to particular situations and the actions of stakeholders. The CAS Director has become a key informant for the public media, and attends all policy debates. Furthermore, the events organized by CAS, including the annual National Alcohol Conference, are key opportunities for alcohol policy advocacy, as they are usually attractive to public media.

- Utilize existing data, including data on production and sale, as well as data from the health care and law enforcement systems, to enhance knowledge about trends in consumption, drinking patterns and harm

Using relevant data

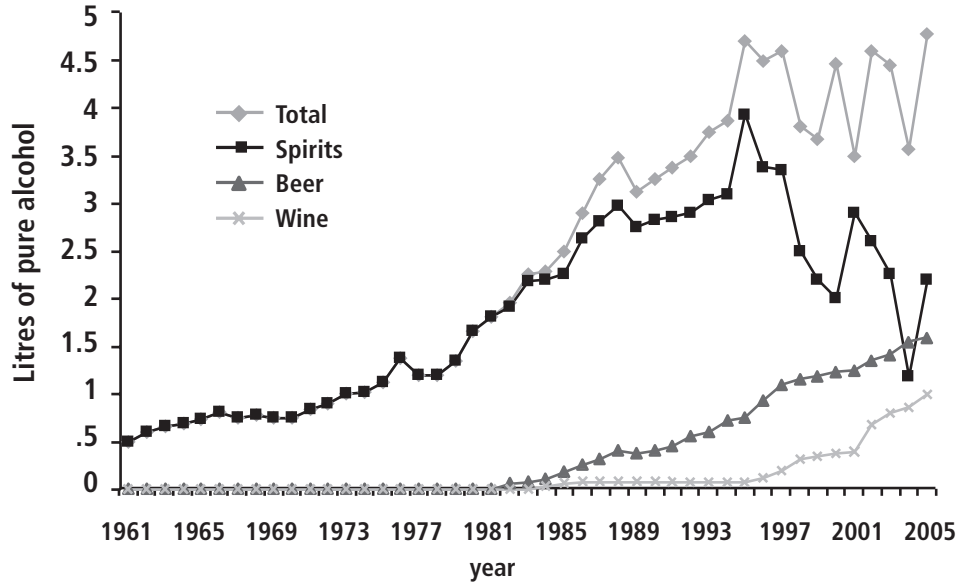
The World Health Organization continuously monitors alcohol consumption and harm, and produces regular global reports. The indicators used by WHO may be useful for countries to include in their national monitoring systems. These indicators and all country data can be found under the Global Information System on Alcohol and Health (GISAH, at: http://apps.who.int/globalatlas/default.asp). The estimates of per capita consumption provide a useful guide to changes over time, which are likely to indicate changes in levels of harm.

Data may also be obtainable from tax authorities. Japan's National Tax Agency provided data on per capita alcohol consumption, showing a decline from 19 to 17 grams per day from 1997 to 2006. (Japan has almost no unrecorded consumption.)



Source: *Hidenori Y. Country Report in Japan. First Regional meeting on reducing alcohol-related harm in the Western Pacific Region, Manila, 3–5 June 2008.*

In contrast, data from China's National Bureau of Statistics shows expansion since 1961 and stabilization since 1997. (This does not include unrecorded consumption, which is known to be high in some parts of China.)



Source: *Hao W. China: alcohol today. First Regional meeting on reducing alcohol-related harm in the Western Pacific Region, Manila, 3-5 June 2008.*

- Establish a surveillance system involving population-based surveys, hospital admissions and other available surveillance data, to provide information on alcohol use, drinking patterns and alcohol-related harm, and consider involving academic institutions in the implementation of such a system

There is often a variety of data gathered and held by different government sectors, which can be brought together to inform policy development.

The development of the Korean National Alcohol Policy was informed by data on increases in death and injury in alcohol-related traffic crashes provided by the Road Traffic Safety Authority (2004). These showed increases in the death toll since 1990 and a 23% increase from 2002 to 2003. Other harm data were provided by the Ministry of Gender Equality and Family (2005), who found that heavy drinking (defined as 1 bottle of Soju or more at a time, 3–4 times a week) was associated with both physical abuse and sexual assault within the family (www.mohw.go.kr).

In New South Wales and New Zealand, data are improving the enforcement of liquor laws by providing feedback to police and licensees about alcohol-related crime following drinking on licensed premises. The system, called Alcolink, has been shown to contribute to a reduction in alcohol-related crime.

- Support country and regional research assessing the relationship between the harmful use of alcohol in general, and binge drinking in particular, and the related adverse health and social consequences

Collecting and analysing data on consumption and harms

Data showing the consumption of alcohol may be available from population surveys. These may provide information about the consumption of different beverages (including noncommercial alcohol) as well as the pattern of drinking (how often and how much is consumed during a drinking session). They may also show which sectors of the community are drinking at what level. Where surveys are carried out in an identical manner over time, trends can be monitored and used to inform policy.

In 2001, researchers from a WHO Collaborating Centre in Hunan province, China organized the collection of data about alcohol consumption and health status from 24 992 community residents aged 15 years or older, using a structured questionnaire provided by WHO. These data showed that the annual alcohol consumption per capita (at 4.47 litres of pure alcohol) was higher than in the 1990s. Alcohol consumption was found to play a role in the development of alcohol-related physical diseases.

WHO STEPS is an approach to surveillance of risk factors for noncommunicable diseases that includes a small number of survey measures of alcohol consumption. By using the standard questionnaires and procedures, the STEPS information can be used to assess a country's own status and also to make comparisons with other countries. For example, from data on Fiji collected in 2002/03, it can be seen that the gap between the genders is particularly large, with 40% of men and only 5% of women recorded as current drinkers. In Samoa, it was reported

that 45% of current male drinkers aged 25–64 years had drunk five or more drinks on at least one day in the past week, whereas 16% of current female drinkers had drunk four or more. The prevalence of drinking is higher in younger age groups in many of the Pacific countries.

The collection of complete information from survey respondents allows for measures of the amounts people typically drink during a drinking session, their frequency of drinking and, combining these together, the volume they drink over a specified time period such as a year. A set of similar questions has been used in New Zealand and in Hubei province in China. By keeping the methods used the same over time, it has been possible to measure trends in consumption and make comparisons.

A survey was carried out in Wuhan City in 2002 and 2005 using four main questions about drinking:

1. Have you ever drunk alcohol in your life?
2. Did you drink alcohol in the last 12 months?
3. How often did you drink in the last 12 months? (Once a year; two to three times a year; four to five times a year; once every two months; once a month; twice a month; once a week; twice a week; three to four times a week; five to six times a week; once every day; two or more times every day.) A number is assigned to each code, for example, once a year = 1, once a day = 365, and when added up, these give an annual frequency.
4. Thinking of a typical drinking occasion, what kind of alcohol do you usually drink? All the beverages consumed are recorded and then people are asked: And on this typical occasion, how much beer would you be drinking? The question is repeated for all the different kinds of alcoholic beverages people report they have consumed. The amount of alcoholic beverage in the drinks (bottles, glasses, etc.) and the potency of the drink are multiplied to give the total of absolute alcohol drunk, and all the beverages are added together to give the total for a typical occasion.

The results from the surveys in Wuhan City showed that the number of people who were current drinkers had increased between 2002 and 2005 (from 68% to 74%) and this was more common in women over 50 years and men and women aged 18 to 19 years. Comparing the data with a comparable survey in a metropolitan city in New Zealand (Auckland), it was found that while fewer women drank in Wuhan and those that did drank smaller amounts, more Wuhan men drank and they drank larger quantities than the Auckland men.

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Alochol and injury in emergency rooms

A WHO collaborative study on alcohol and injuries was carried out in 12 countries between 2000 and 2002. It included two cities from the Western Pacific Region, Auckland (New Zealand) and Changsha (China). The study involved interviews and breath analysis of people attending hospital emergency departments. The results showed that the proportion of injury cases with alcohol involvement ranged from 6% to 45%. New Zealand was among the higher rates at 36%, while China recorded less than 20%. The results are likely to reflect differences in alcohol consumption as well as other cultural differences. The study design investigated whether alcohol had contributed to causing the injuries, and found that it had.

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4.2 Developing mechanisms for ongoing coordination and collaboration

The number of different government agencies required to be involved in effective alcohol policy makes coordination and collaboration between the sectors very important in all country contexts.

Lead agency for alcohol policy

A national-level mechanism focused on alcohol policy to facilitate the building of relationships between people in different sectors, exchange of information and development of effective implementation techniques is very important. A number of countries in the Region have not established such a body.

In others, there are established collaborations across government sectors. In Japan, the Ministry of Health, Labour and Welfare (MHLW) takes a major role in alcohol policy. However, there is a higher level of coordination by the Cabinet Office, which ensures collaboration between MHLW, National Tax Agency, National Police Agency and the Ministry of Education, Culture, Sports, Science and Technology. The involvement of the Tax Agency in this coordination is useful, given the importance of taxation policy for alcohol control policy.

In 2003, the Mongolian parliament passed a resolution to ratify the "National Programme on Prevention and Control of Alcoholism" and the "Plan of Action for Implementation of the National Programme on Prevention and Control of Alcoholism". The responsibility for this activity was given to the Board of Directors of the National Council on Prevention of Crime to organize activities on implementation of the National Programme at the national level. Parliament charged government, ministries, agencies, other state entities and local administrative organizations at all levels with implementation at the local level within their jurisdiction.

Cross-sector collaboration

Many countries in the Region have involvement of community groups and nongovernmental organizations in the response to alcohol-related problems in the community. For example, in Kiribati the Protestant church organizes social nights for young people on pay days (to avoid all the pay being spent). However, sustainable mechanisms to support the involvement of community groups are not common.

Develop a national public health-oriented, evidence-based alcohol policy, appropriate to individual national contexts (4.4.2)

- Establish or identify a national body that has the responsibility of developing and updating a national public health-oriented alcohol policy
- Provide adequate support to this national body through funding and public health-oriented expertise
- Establish sustainable national mechanisms for appropriate intersectoral government cooperation with the involvement of relevant community groups and institutions to ensure effective coordination and implementation of the policy

- Establish funding mechanisms, such as dedicating a portion of alcohol taxation revenue to support prevention and reduction of alcohol-related harm

Funding mechanisms

A number of countries in the Region have health promotion foundations. These have been set up with dedicated taxes from tobacco and alcohol in order to provide funding for control activities and health promotion. One of these is the Western Australian Health Promotion Foundation "Healthway". A former executive director of Healthway wrote a report for WHO's Western Pacific Regional Office about how to establish such foundations based on a dedicated tobacco tax (http://www.wpro.who.int/publications/PUB_9290611715.htm).

In New Zealand, an agency, the Alcohol Advisory Council (ALAC), funded from a levy on alcohol sales, complements the work of the Ministry of Health on alcohol policy. One aspect of ALAC's work is running regular conferences attended by people from many sectors involved in implementing alcohol policy. These cover issues such as: monitoring and enforcement; Initiatives to reduce intoxication; policy, planning and evaluation; and evaluation of community projects.

- Ensure that all actions under the national policy are duly followed up, evaluated and assessed

Evaluation and assessment

The establishment of objectives with targets and time-frames in the planning stages of a national policy and alcohol action plan will allow for monitoring of outcomes of the policy. These will often be high-level measures (such as estimates of per capita consumption or alcohol involvement in violent crime). As they may be influenced by other factors (e.g. economic growth and police recording practices), they provide indicative information only.

In a programme logic approach (see p 7), the contributions made by all the collaborating agencies can be specified and evaluation of the extent to which their processes meet the agreed activities can be monitored. Intermediate measures, such as survey measures of youth drinking, successful purchases by underage youth and prosecutions of licensees for sale to intoxicated patrons, can be decided upon and measured over time.

A useful evaluation framework is one that has a strategic focus and allocates (often scarce) evaluation resources according to various criteria. These can include: how much is already known from overseas research as to its likely effectiveness, how innovative and adapted to local conditions the intervention is, and how expensive it is. It is sometimes appropriate to give evaluation support during the early stages of the implementation of the intervention (formative evaluation) and to use the evaluation resource to make sure the intervention is being applied as intended (process evaluation). This can be done before (or instead of) applying the resource to measuring effectiveness (outcome or impact evaluation).

A partnership with an academic institution with evaluation expertise may be useful, especially if innovative interventions are being tried and are deemed appropriate for in-depth evaluation.

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