Submission to the World Health Organization on the 'Working Document for development of an Action Plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol'

9 December 2020

Alcohol Healthwatch is an independent charitable trust in Aotearoa New Zealand working to reduce alcohol-related harms and inequities. We are contracted by the Ministry of Health to provide a range of regional and national health promotion services. These include: providing evidence-based information and advice on policy and planning matters; coordinating networks and projects to address alcohol-related harms, such as alcohol-related injury, Fetal Alcohol Spectrum Disorder and supply to minors; and coordinating or otherwise supporting community action projects.

Thank you for the opportunity to provide feedback on the Working Document for the development of an Action Plan to strengthen the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

If you have any questions on the comments we have included in our submission, please contact:

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Introduction

1. Alcohol Healthwatch applauds the World Health Organization's commitment to proceed with the consultation on the development of an Action Plan (2022-2030) to implement the Global Strategy to Reduce the Harmful Use of Alcohol.

2. Alcohol use remains prevalent in many countries, with global projections forecasting an increased prevalence.[1] In Aotearoa New Zealand, the prevalence of drinking is high, with around 81% of adults (aged 15+ years) reporting past-year use in 2019/20.

3. A notable change over the last decade has been the increase in women's drinking in Aotearoa New Zealand, particularly among population groups that were majority abstainers. For example, whilst more than one-half of Asian women and Pacific women reported abstaining from past-year drinking in 2011/12, more than one half reported past-year drinking in 2019/20.[2]

4. There has been little change in the overall prevalence of hazardous drinking in Aotearoa New Zealand. In 2019/20, 20.9% of the total population of adults aged 15+ years were classified as hazardous drinkers (AUDIT score ≥8).[2] Hazardous drinking prevalence remains highest among young adults aged 18-24 years old (36.8% males, 27.9% females).[2]

5. Whilst adolescents have shown positive changes with a lower prevalence of hazardous drinking, significant increases in hazardous drinking have been found among middle-aged to older adults.

6. Māori (Aotearoa New Zealand's indigenous population) experience substantial inequities in hazardous alcohol use. In 2019/20, 43.7% of Māori men were hazardous drinkers, compared to 34.3% of Pacific men and 31.4% among European/other men.[2] Among women, the differences are even greater, with 29.2% of Māori women reporting hazardous drinking, compared to 16.1% of Pacific women and 14.0% of European/other women.[2]

7. Among OECD and EU countries, Aotearoa New Zealand has one of the highest rates of youth (15-19 years) suicide.[3] There are substantial ethnic inequities in suicide rates in Aotearoa New Zealand, with Māori significantly more likely to die from suicide.[4] It is clear that alcohol use disorders are a strong risk factor for suicide.[5]

8. In 2019, the third Universal Period Periodic Review of New Zealand by the Human Rights Council[6] noted the following:

   New Zealand had unacceptably high levels of family violence. One in three women in New Zealand experienced physical, emotional or sexual violence from a partner in their lifetime.

9. Of the recommendations made by the Human Rights Council, many related to addressing violence against women, sexual violence, family and domestic violence and child abuse. Research in Aotearoa New Zealand shows that heavy episodic drinking patterns are associated with more aggression involving alcohol within relationships, and alcohol involvement is associated with increased severity of victimisation.[7]

10. It is clear that strong actions taken on alcohol can assist to reduce the suffering in Aotearoa New Zealand from high rates of suicide and violence. The WHO can, and should, assist Aotearoa New Zealand in this regard.

11. The COVID-19 pandemic has many substantial implications for alcohol use, with impacts likely to be both immediate and long-term.[8] The longer term impacts are believed to include a normalisation of home drinking, reinforcing or introducing drinking as a way to self-medicate

symptoms of stress, anxiety, boredom and an increased prevalence of newly diagnosed patients with alcohol use disorders (as well as relapse among persons with a disorder).[9–13]

12. Many people will use alcohol to cope with the on-going impacts of the pandemic. Research shows that individuals who drink for coping reasons are at a heightened risk of developing problems with alcohol.[14] Depression and anxiety have been found to be associated with drinking to cope.[14] Factors such as unemployment, time spent unemployed, redundancy, increased workloads and reduced workplace morale due to loss of staff are also likely to result in a heightened vulnerability to developing new, or exacerbating existing, alcohol-related problems.[15]
13. The global health pandemic has the potential to increase alcohol harm inequities. This is already evident in the Aotearoa New Zealand context, with a larger proportion of Māori drinking more heavily post lock-down when compared to pre lock-down (22%), in comparison to other ethnic groups (Pasifika 10%, non-Māori/non-Pasifika 13%).[16]
14. Strong, evidence-based actions, free from alcohol industry interference, are required to prevent and reduce inequities during these challenging times.

Recommendations

a) The equity lens must be more explicit within the Working Document

15. We believe that the Working Document requires a stronger equity lens, that is embedded and made explicit throughout. All decisions and actions (by Member States and others) must consider and plan for equity from the outset.
16. As described above, Māori are significantly more likely to drink hazardously than non-Māori and experience substantially greater life loss from alcohol.[17] Māori are disproportionately harmed from living in close proximity to alcohol outlets[18] and Māori children are five times more likely to be exposed to alcohol marketing than European children in their everyday lives.[19]
17. The inadequate partnership with, and protection of, Māori with respect to alcohol-related harm is currently the subject of a claim filed with the Waitangi Tribunal. This claim asserts that by failing to implement effective policies the Government is in breach of Te Tiriti O Waitangi (the Treaty of Waitangi) which was signed by Māori chiefs and the Crown in 1840.
18. Whilst the Working Document notes the equity gap of implementing effective alcohol policies between low-income and high-income countries, we also wish to signal the substantial inequities in drinking and harm that exist within countries.
19. We urge the WHO to honour its commitment to improving indigenous health, by including actions and indicators that explicitly address equity. For example, the proposed actions for Member States should include the following:
    a. Action Area 2 (Advocacy, awareness and commitment): When Member States produce national reports on alcohol consumption and alcohol-related harm, progress towards equity must be measured and reported.
    b. Action Area 5 (Knowledge production and information Systems): When Member States collect national data on alcohol use and harm, an equity lens must be built into the data

collection process. Equity indicators are of paramount importance. Knowledge production should honour and promote indigenous knowledge systems to gather data on alcohol use and harm. In Aotearoa New Zealand, a lack of equity-specific data and knowledge generation has contributed to entrenched inequities in alcohol harm (especially between Māori and non-Māori). If equity is not measured, then it can't be improved.

c. Action Area 6 (Resource mobilisation): Resource distribution must seek to restore power and resources to the people and communities who have been most harmed. In Aotearoa New Zealand, developments are needed that ensure Māori have control over the strategies used, and managing and delivering their own services whilst working in partnership with the State. Earmarking funding from alcohol taxes should be utilised to restore power and resources.

d. Action Area 3 (Partnership, dialogue and co-ordination): Indigenous populations must be visible in the plan and specifically described as mutual partners with the State, and not rendered invisible by being subsumed into a list of stakeholders to engage in relevant processes.

20. An equity assessment should consider the impact of interventions and policies to reduce alcohol-related inequities, the gaps in knowledge to be addressed, the needs and values of groups experiencing inequities, the plan for partnership with groups disproportionately harmed as well as monitoring and evaluation by equity.

21. An equity and human rights approach must also explicitly recognise and address the relationship between racial discrimination and alcohol use. In the report of the third Universal Period Periodic Review of New Zealand by the Human Rights Council[6], the following was noted:

The impacts of colonization continued to be felt, through entrenched structural racism and poorer outcomes for Māori.

22. Research in Aotearoa New Zealand found that adolescent students who had experienced ethnic discrimination were more likely to report an episode of binge drinking in the past four weeks.[20]

23. Among Māori adults, experiencing discrimination was found to be significantly associated with elevated levels of hazardous alcohol use.[21] Mediation analysis revealed that 35% of the effect of Māori ethnicity on hazardous drinking could be acting through experience of discrimination.

24. It is clear that racism is a social determinant of health inequities. The WHO needs to play a key role in transforming institutional racism. The Working Document must recognise the role of racism and include strong efforts by Member States to address it.

b) Prioritise the three 'Best Buys' in SAFER to achieve the greatest equity gains

25. We recommend that the Working Document needs to highlight more clearly, and focus on, the most cost-effective policies to reduce alcohol-related harms (and their inequities), especially in the section on 'Key areas for global action'.

26. In particular, high-impact actions need to be developed and prioritised by Member States that:
    - Increase the price of alcohol
    - Reduce availability of alcohol; and
    - Restrict the marketing of alcohol.

27. The above strategies offer the greatest potential to prevent and reduce inequities in alcohol-related harms. The implementation of these requires monitoring and reporting.

28. We further recommend that the Action Plan be strongly framed around every country implementing the five most effective, science-based interventions, as articulated in the SAFER guidance.

29. The monitoring indicators should include specific metrics of SAFER implementation, and countries' reporting on the implementation of SAFER policies should be supported, especially in Low and Middle Income Countries (LMIC), which currently lack adequate resources and are often subject to interference from commercial interests.

c) Preventing and reducing inequities in FASD

30. We believe that Fetal Alcohol Spectrum Disorder (FASD), as a leading cause of preventable disability, should be explictly recognised within the Working Document. The negative impacts on the brain and body of individuals prenatally exposed to alcohol lead many individuals with FASD to experience significant challenges in their daily life. Many will need support with motor skills, physical health, learning, memory, attention, emotional regulation, and social skills.

31. Research studies have shown that:
    - between 10-20% of people in prisons and other correctional settings have an FASD.[22]
    - around 80% of adults with an FASD will not be able to live independently without some level of support.[23]
    - children and adolescents with an FASD have a 95% lifetime likelihood to experience mental health issues.[24]
    - people with FASD have a higher risk (up to five times greater) of suicidal behaviour than the general population.[23,25,26]
    - life expectancy of people diagnosed with Fetal Alcohol Syndrome under the International Classification of Disease (ICD) have a shockingly low life expectancy of 34 years on average. The leading cause of death were external causes, with 15% of these being death by suicide.[26]

32. FASD remains a "hidden disability" and must be given greater attention in our global efforts to reduce inequities in alcohol-related harm. Preventing FASD and reducing its associated secondary harms is imperative and efforts must be visible within the Working Document.

33. National alcohol policies must include evidence-based actions to prevent FASD and its secondary harms. This includes research on prevalence, provision of early diagnosis, delivery of FASD-informed care across sectors, and on-going and sufficient support for individuals and families living with FASD.

34. We recommend that Action Area 2 (Action 2 for Member States) be expanded to include:
    - National alcohol policies should include evidence-based actions to prevent FASD and its secondary harms.

35. Diagnosis before the age of six years is identified as a protective factor associated with a lower likelihood of experiencing secondary harms from FASD.[27] However, in Aotearoa New Zealand diagnostic services for FASD are rarely accessible and often very costly.

36. Failure to provide for early identification denies the individual and wider family the knowledge on which to build strength-based early intervention, thereby furthering inequities. Much of the harms from FASD could be ameliorated by appropriate early intervention that is guided by the individual diagnosis.

37. We therefore recommend that Action Area 4 (Technical support and capacity building) for Member States should expand beyond actions for health professionals to identify and manage hazardous drinking and disorders, to include:
    - Develop and strengthen the capacity of multi-disciplinary health services teams to diagnose Fetal Alcohol Spectrum Disorder.

38. Furthermore, adequate training is required across the health, education, care and protection, and justice systems to enable safe and appropriate treatment of individuals with FASD. Without this training and resulting understanding of what works best, FASD harms continue to occur as individuals are misdiagnosed, misunderstood and mistreated.

39. We therefore recommend that Action Area 4 (Technical support and capacity) for Member States includes the following:
    - Develop and strengthen the capacity across sectors to deliver FASD-informed care.

40. Support is also required for individuals and families living with FASD. Children and young people who receive a diagnosis must have a clear pathway for support under an umbrella of disability services. We therefore recommend that Action Area 6 (Resource mobilisation) requires that Member States:
    - Increase allocation of sufficient resources to support individuals and families living with FASD.

41. Finally, we commend the WHO for initiating the International Collaborative Research Project on Child Development and Prenatal Risk Factors with a focus on FASD to help gain a better understanding of its prevalence, severity and impact. In Aotearoa New Zealand, there has been no population-based prevalence study of FASD. We recommend that Action Area 5 (Knowledge production and information Systems) include the following:
    - *Actions for the WHO Secretariat:* Further develop the International Collaborative Research Project on Child Development and Prenatal Risk Factors (with a focus on FASD), and promote and support Member States to conduct a FASD population-based prevalence study.
    - *Actions for Member States:* Support the implementation of the WHO-initiated population-based FASD prevalence study.

d) Requirement for Member States to have a designated 'home' for alcohol control

42. We commend the WHO for proposing that Member States increase allocation of resources to reduce harmful alcohol use. However, we believe that stronger actions need to be proposed that require Member States to have a dedicated 'home' for alcohol control in government services.

43. The New Zealand Government Inquiry into Mental Health and Addiction noted the following with regards to leadership on alcohol control in Aotearoa New Zealand[28]:

Alcohol and other drug policy does not have a clear home within government

Central Government appears to have lost traction on alcohol and other drug issues, although we note the recent formation of a cross-party group on drug harm reduction. Overall, leadership is weak and it is unclear where responsibility for coordinated strategy and policy lie.

Given the significant role that alcohol and other drugs play in people's wellbeing across New Zealand, a unit with a strong cross-sectoral focus dedicated to advancing alcohol and other drug policy is critical.

44. Given the magnitude of harm and inequities, commitment to leadership and stewardship on alcohol control is essential. This is recommended in the Global Alcohol Strategy to reduce Harmful Alcohol Use.[29]

e) Role of economic actors

45. We agree with others that there is a fundamental and irreconcilable conflict between imperative shareholder value maximisation and public health policy interests.[30] In the words of the former WHO Director-General Margaret Chan, "efforts to prevent non-communicable disease go against the business interests of powerful economic operators".[31]

46. It is clear in the Working Document that the WHO recognises industry's "interfering with alcohol policy development and evaluation". However, we believe that the proposed actions for the commercial actors are too weak to be effective.

47. A thematic and content anyalsis of industry submissions to the Department of Foreign Affairs and Trade in Australia found that the industry is actively seeking to shape trade negotiations around alcohol issues. Priority issues for the industry include improving market access, harmonising regulation, improving clarity and transparency, reducing the burden of regulation and preventing monopolies on product names.[32] These issues run counter to the protection of public health and reduction in inequities.

48. Also in Australia, it was found that the draft national alcohol strategy was watered down following industry consultation.[33]

49. In Aotearoa New Zealand, the supermarket duopoly has regularly appealed local government efforts to limit alcohol outlet density and reduce trading hours. Community wishes for greater control over licensing decisions have been totally over-shadowed by the legal resources of the alcohol retailers.[34]

50. More notably, the alcohol industry has used corporate philanthopy as a strategy to divert public attention from less altruistic practices (marketing, lobbying, avoidance of stricter regulations, etc.) and rather shape their corporate image to being trusted, caring, socially responsible and even healthy [35]

51. In Aotearoa New Zealand, this is evident from an increasing number of alcohol industry partnerships with cancer, mental health, wellbeing and environmental charities.

i. Prioritising the protection of the child

52. Of particular concern has been the international dissemination of 'Smashed' and other industry-funded school-based education programmes. As an example, 'Smashed' commenced in the

United Kingdom in 2005 and to date has engaged more than half a million students internationally.[36]

53. These programmes are directed at very young students; an age group that has heightened vulnerability to alcohol-related harm. The teaching resources of the 'Smashed' 'responsible drinking' programme have been critiqued and published in a peer-reviewed journal[36], with an accompanying editorial.[37] The involvement of schools in alcohol industry-funded education has the potential to do more harm than good, especially if it replaces the teaching of evidence-based harm reduction materials in the class and has the effect of delaying the implementation of strong alcohol policies.

54. We believe the following statement in the Working Document needs to be addressed by Member States:

    "Economic operators…..are invited to…refrain from engagement in capacity-building activities outside of their core roles that may compete with the activities of the public health community."

55. We are in agreement with Ireland's Health Minister[38] and Education Minister[39] on the need to separate out the alcohol industry from being part of the conversation, with the former stating that "it's completely and utterly bizarre that you'd have a body funded by the drinks industry educating our kids about the dangers of alcohol… I mean it's ridiculous" (para. 3).[38]

56. The commercial determinants of health have also been raised as a children's right issue. Earlier this year, the WHO-UNICEF-Lancet Commission called for the development of a new protocol to regulate against commercial harm to children.[40] The protocol is an optional instrument to the UN Convention on the Rights of the Child.

57. The rationale for developing such a protocol is the recognition of the growing threat of the commercial sector to child health and wellbeing. This includes the ubiquitous presence of alcohol advertising (including digital communications) and exposure to industry-funded education in their schools, both serving to undermine their health and wellbeing.

58. We therefore recommend that the Working Document include the following under Area Action 2 (Advocacy, awareness and commitment) for Member States:
    - Commit to advocating to schools to implement evidence-based alcohol harm reduction education resources and undertake activities to review programmes associated with the alcohol industry.

ii. Commercial actors should be addressed separately in the Working Document

59. Given the above, we are very concerned to see in the Working Document that alcohol industry entities are listed as stakeholders with equal standing alongside civil society and other UN organisations. This is inappropriate, given their explicit conflict of interest and long record of opposing effective alcohol policies, not only in Aotearoa New Zealand but right across our Western Pacific region and beyond.

60. The alcohol industry should not be included as an 'equal' with non-commercial interests but rather, be addressed in a separate section with due regard to their conflict of interest with respect to public health. For example, the structure of the action statements includes a role for economic operators as if they are equivalent to other non-state actors. We oppose this.

61. In 2018, the report of the New Zealand Government Inquiry into Mental Health and Addiction noted the role of commercial actors and stated the following[28]:

    Despite alcohol's harm, New Zealand has a normalised heavy drinking culture that, by and large, does not recognise current alcohol use as a crisis. Strong vested interest groups have incentives to resist change. We see parallels with tobacco control and smoking, and believe a similar approach will be needed to tackle the harmful use of alcohol.

62. In 2018-2020, the New Zealand Government commissioned an independent review into the health system to determine recommendations for system-level changes that would be sustainable, lead to better and more equitable outcomes for all New Zealanders and shift the balance from treatment of illness towards health and wellbeing. The final report noted the following with regards to the commercial drivers of ill health[41]:

    Faced with growing challenges from NCDs, the Review is clear that there is a need for much more concerted action at national, regional and local levels to address the commercial determinants of health.

63. We strongly believe that international plans and strategies can provide countries, such as Aotearoa New Zealand, the explicit provision and mandate to address the commercial determinants of health.

64. In agreement with the submission from the Health Coalition Aotearoa, we do not support action statements being structured as invitations to economic operators to act against their own commercial interests by voluntarily adopting effective strategies to reduce consumption and harm; for example, to eliminate marketing and promotion of drinking. This does not represent evidence-based intervention. Equally, we are also concerned that civil society actors are "invited" to provide all proposed monitoring and countering of industry influence, which we see as part of any global action.

65. We recognise that the Working Document refers to economic operators ceasing funding research for lobbying purposes. We strongly believe that this needs to be stronger and clearer or it will be seen as an opportunity to instead increase sponsorship of activities that encourage ineffective interventions. That is not acceptable. We recommend that a better approach might be to provide guidance to civil society and academia not to enter into formal or informal partnerships with industry and underline that alcohol industry funding not be accepted.

66. Further, in the absence of a legally binding health treaty (discussed next), Member States should be encouraged to adopt measures to increase transparency of commercial influence in policy making. Member States could be advised to:
    - Develop explicit agreements or protocols regarding engagement with commercial stakeholders on alcohol policy issues;
    - Monitor media coverage of industry-related issues as well as industry websites;
    - Identify state-funded organisations and activities sponsored by those with alcohol industry interests;
    - Develop and implement regulations that require commercial operators to submit sales data as well as marketing data; and
    - Develop 'cooling down" or "revolving door" legislation to ensure high-level political insiders can't simply shift straight into jobs lobbying the government (and vice versa).

f) An international treaty on alcohol control is inevitable and should be prioritised

67. As described in the Working Document, alcohol remains the only psychoactive substance that lacks legally-binding regulatory instruments at the international level.[42]

68. The current process of developing an Action Plan provides an important and timely opportunity, especially for fostering deliberation of a more effective instrument as well as strengthening the global governance of alcohol.[43]

69. We believe that a stronger global plan and a legally binding framework, akin to the Framework Convention on Tobacco Control (FCTC), are urgently needed to support individual Member States to withstand the industry's opposition to regulation, and to prioritise action on alcohol, as has been advocated previously.

70. Most importantly, the WHO and Member States need to demonstrate strong leadership in advancing the global governance of alcohol control.

71. It is imperative to have a codified international instrument to help Member States, especially low-income countries, to protect population health. There is a growing inadequacy for domestic law and regulations to attain public health objectives at the country level.

72. This is especially in relation to the proliferation of digital advertising, particularly on social media platforms. Collaboration between countries and social media enterprises is necessary to address emerging marketing tactics employed by multi-national firms on digital platforms. A legal framework for alcohol control is an important step towards reducing harm from digital marketing.

73. Also of relevance is Action 6 (in Action Area 2) proposing that Member States ensure appropriate consumer protection measures through development and implementation of labelling requirements for alcoholic beverages. As witnessed in Canada, legal threats are mounted in relation to labelling, particularly for cancer warning labels.[44]

74. Without a legal health treaty, legal challenges and litigation continue to impose a chilling effect on governments to implement effective alcohol policies and interventions. It took more than 20 years of strong advocacy in Australia and Aotearoa New Zealand to ensure an evidence-based alcohol pregnancy warning label is placed on alcohol products.[45] It is incredible to comprehend the suffering by individuals and families across Aotearoa New Zealand and Australia that could have been prevented from earlier implementation of a warning label.

75. It is clear that trade and economic agreements have become a legal tool manipulated by the alcohol industry to undermine public health measures. Below are some examples:

    - The Alcohol Minimum Pricing Bill (passed by the Scottish Parliament in 2012) was challenged by the alcohol industry under EU single market law. The industry challenged the compatibility of the proposed bill at the time with the EU law. This included a claim that the Scottish legislation could constitute a quantitative restriction on trade and distort competition among alcohol distributors.[46]

    - Alcohol marketing and advertising restrictions introduced in France, known as 'The Loi Evin', were challenged by the alcohol industry stakeholders in the European Court.[47]

76. We believe that lessons can be drawn from the Framework Convention on Tobacco Control. The negotiation process of the WHO FCTC facilitated multilateral collaboration on aspects of tobacco control that transcended national boundaries. It also promoted national action and international co-operation.[48]

77. Since the WHO FCTC came into force in 2005 (after the 40th member state had ratified the treaty), the Conference of the Parties has become a venue for Member States to collaborate, deliberate on tobacco control policies, and develop new guidelines and protocols (e.g. Guidelines on Article 5.3, Protocol on illicit tobacco trade). The WHO FCTC has also advanced the development of domestic law.[49] It has provided a legal framework for implementation and given government's the authority to act.[50]

78. Lastly, the WHO FCTC has provided legal weight to Member States in times of legal challenges launched by the tobacco industry.

79. In a study of the 96 court decisions concerning legal challenges to tobacco control measures[50], the WHO FCTC was cited in 45 decisions. Decisions both citing and not citing the WHO FCTC were largely decided in favour of governments, with 80% of WHO-FCTC-citing and 67% of non-WHO-FCTC citing cases upholding the measure in its entirety and on every ground of challenge.

80. As the authors note in the study, it was difficult to 'prove' that the WHO FCTC was directly responsible for the positive outcome of any particular case, despite the higher number of citations in cases that were upheld. Many cases were decided on multiple grounds, each of which alone could be sufficient to dismiss a challenge. A lack of counterfactual, for what would have happened if there was no WHO FCTC, limits determination of causality.[50]

81. However, the WHO FCTC and its guidelines have helped to translate a large and complex body of scientific evidence into a format that is understandable to legal institutions and assimilable to legal concepts. The WHO FCTC has also demonstrated international consensus in support of public health measures and assisted to establish whether or not a measure is reasonable, proportionate or justifiable.[50]

82. We believe that an Framework Convention on Alcohol Control is inevitable. This generation should be leaving a legacy for the next by protecting its rights to be free from alcohol harm and interference from the alcohol industry.

83. Whilst the Framework is in development, we recommend the Working Document put in place a set of guidelines similar to Article 5.3 of the WHO FCTC. See paragraph 66.

84. Further, we support GAPA's position on strengthening the provisions of the WHO Framework for Engagement with Non-State Actors (FENSA), by including specific reference to alcohol as well as improving the implementation of FENSA.

g) In many countries, per capita consumption is not a sound measure

85. Whilst we support consistent measurement in relation to alcohol consumption, we believe that the use of per capita consumption as a Global Target indicator is increasingly becoming out-of-date and meaningless. Alcohol policy decisions must be informed by sound data.

86. Estimates of per capita consumption are usually derived from assumptions regarding the alcohol content of dominant alcohol types. However, over time, alcohol beverages have changed in their average strength (i.e. alcohol by volume).

87. Per capita estimates need to take into account these changes. For example, the alcohol content of table wine has changed considerably over the past few decades.[51] In Aotearoa New Zealand, per capita estimates assume that wine is 11% alcohol strength[52] and this is likely to be a significant under-estimate.

88. Other countries, such as Australia, have updated their per capita measures to take into account the changes in the alcohol market. Using up-to-date estimates, the per capita alcohol consumption was found to be increasing in Australia; remarkably different to the stable per capita use reported using unadjusted data.[53]

89. Any reporting of per capita alcohol use needs to acknowledge this significant limitation. Alternatively, we recommend that the Working Document encourages Member States to continually update the assumptions that underpin per capita alcohol measurement.

h) Earmarked funding from alcohol tax revenues in Global target 6.2

90. We support the recommendation to Member States to increase allocation of resources for reducing the harmful use of alcohol and increasing coverage of prevention and treatment interventions.

91. We support the target for ring-fenced funding from alcohol tax revenues and further support Action 1 that provides for Member States to also use other innovative mechanisms to increase funding. This will give more flexibility to Member States to fund prevention and treatment interventions for alcohol use disorders and alcohol-related health conditions. However, we believe earmarked alcohol tax revenue is the ultimate goal.

92. As described previously, we further recommend that within the earmarked funding pool, further earmarking of monies should be made for priority populations. For example, in Aotearoa New Zealand, specific and sufficient funding should be provided to Māori, so that programmes and services can be developed by Māori, for Māori.

i) More regular reporting on implementation

93. In agreement with the submission from the Health Coalition Aotearoa, we are concerned about the lack of specific time periods for review and reporting of the implementation of the Action Plan. Given the importance of intergovernmental collaboration to reduce alcohol harm, we ask that the Director-General be requested to report to the World Health Assembly biennially on the progress of implementing the Global Action Plan. This should include any challenges faced by Member States and the nature and extent of collaboration between UN agencies.

94. In addition, prior to the review of the SDGs in 2030, a progress report and recommendations for the way forward for alcohol policy should be submitted to the WHO governing bodies in 2028.

j) WHO Secretariat prioritising leadership on alcohol and cancer awareness

95. We support Action 2 of Action Area 2 (Advocacy, awareness and commitment) for the WHO Secretariat to develop and implement an organisation-wide communication plan to support actions to reduce the harmful use of alcohol, targeting different population groups and using different communication channels.

96. We strongly recommend that the WHO take leadership in increasing communications regarding alcohol-cancer risks.

97. Awareness of alcohol-cancer links in Aotearoa New Zealand remains low. In one study, 13.8% (14.6% females, 12.8% males) of respondents could list (unprompted) alcohol as a risk factor for cancer. In relation to unprompted dietary risk factors for cancer, 40.8% of the respondents listed alcohol as a risk factor (41.8% females, 39.5% males).[54] Awareness among Māori is unknown.

98. In relation to particular cancers, research shows that New Zealanders have a very low level of awareness of the risk of alcohol use for bowel and female breast cancer.[55]

99. Research shows that knowledge of alcohol-cancer links can produce favourable changes in intentions to reduce consumption[56], with the bowel cancer warnings producing the most effective results.[57]

100. Furthermore, knowledge of alcohol-cancer links is associated with increased public support for high impact, evidence-based alcohol policies.[56–59] As such, we believe that strategies to increase awareness of alcohol-cancer links represent an important component of advocacy for the 'Best Buys'.

101. We strongly recommend the WHO include increasing awareness of alcohol-cancer links in the development of the proposed communications plan. Other important issues include the impact of alcohol on mental health and suicide, family violence, reduced child wellbeing, and immunity (in relation to health pandemics).

k) Normalisation of alcohol use

102. We support the submission of the Health Coalition Aotearoa that recommends the Working Document recognise the many cultures (whether based on ethnicity, religion, age or peer group) who have not normalised use of alcohol. In cultures and societies where alcohol is used, this has often traditionally been small scale home production that is now being replaced by commercial alcohol and aggressive marketing by transnational corporations, leading to increased consumption and harm. Especially in LMICs, this is placing huge burdens on governments and NGOs, through social and health services and systems.

Conclusion

103. Strong actions taken to reduce alcohol use and harm can significantly improve the wellbeing of every person in Aotearoa New Zealand, for this generation and the next. In particular, our most vulnerable (children, women, disadvantaged populations) will benefit the most from leadership taken on alcohol.

104. The entrenched inequities in alcohol harm in Aotearoa New Zealand must be prioritised and addressed. In particular, New Zealand must uphold its obligations to Te Tiriti o Waitangi to protect Māori health.

105. By strengthening the Working Document, the WHO can greatly support Aotearoa New Zealand to reduce its shamefully high youth suicide and family violence rates. The possibilities for Aotearoa New Zealand to reach its potential are endless. We all have a duty to act.

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