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ALCOHOL CONSUMPTION AND ALCOHOL-RELATED PROBLEMS

This document is submitted to the Health Assembly to provide information on the steps that have been taken to intensify WHO's programme on alcohol-related problems in response to resolution WHA36.12. It consists of an updating of document EB75/INF.DOC./7 and takes into account the discussions which took place on this topic at the seventy-fifth session of the Executive Board.

I. INTRODUCTION

1. Recent decades have witnessed considerable increases in alcohol consumption and in alcohol-related problems in countries in all regions of the world. In the WHO European Region, the number of countries with an annual per capita intake of more than 10 litres of pure alcohol increased from three in 1950 to 18 by 1979. Countries in the WHO Western Pacific Region report sharp increases in alcohol-related health damage, in alcohol-related crimes, and in alcohol-related accidents during the 1970s.[1] Similar reports have emerged from countries in other WHO regions, including those with long traditions of abstinence from alcohol. Although some countries in Western Europe and North America are now reporting a levelling off and even a modest decline in alcohol consumption, the global trend is still that of continuing growth, with particularly sharp increases in commercially produced alcoholic beverages in some developing countries in Africa, Latin America and the Western Pacific.[2] Because of the positive association which generally exists between trends in consumption and trends in alcohol-related problems, this increase is likely to have enormous public health implications.

2. The World Health Assembly has responded to this serious situation. In May 1979 the Thirty-second World Health Assembly recognized "that problems related to alcohol, and particularly to its excessive consumption, rank among the world's major public health problems" (resolution WHA32.40). The Technical Discussions at the Thirty-fifth World Health Assembly three years later, on "Alcohol consumption and alcohol-related problems: development of national policies and programmes", brought together participants from more than 100 countries. The results of their discussions were echoed in resolution WHA36.12[3] at the Thirty-sixth World Health Assembly (May 1983).

3. This information document summarizes the steps which have been taken within the Mental Health programme to implement paragraph 4(1) of that resolution, which requests the Director-General:

> (1) to continue and intensify WHO's programme on alcohol-related problems as an integral part of the strategy for health for all through a primary health care approach, as envisaged in the Seventh General Programme of Work, and, in accordance with resolution WHA32.40:
>
> (a) to strengthen further WHO's capacity to respond to requests from Member States to support their efforts in dealing with alcohol-related problems;
>
> (b) to carry out studies on factors affecting alcohol consumption patterns and on measures to influence these patterns;

(c) to promote further joint consideration by the organizations of the United Nations system and nongovernmental organizations of the problems associated with alcohol and their alleviation;

(d) to seek additional funds from relevant United Nations bodies as well as governmental and nongovernmental sources.

II. WHO'S PROGRAMME

Focus on alcohol-related problems

4. During the period of the Sixth General Programme of Work (1978-1983), a major change occurred in WHO's activities in the area of alcohol abuse. The concept of "alcoholism" was replaced with the much broader range of "alcohol-related problems".[4] In consequence of this important shift in emphasis, a number of broad lines of action were started, which relied upon the active involvement of all WHO regions and reflected the growing concern of Member States throughout the world. The work in the European Region and in North America in the alcohol policy area was of particular importance,[5,6,7,8] whilst in the Western Pacific Region alarm at increasing alcohol consumption led to the adoption of a wide-ranging resolution (WPR/RC33.R15) by the Regional Committee in 1982.

5. Information from 80 countries on the prevention of alcohol-related problems was collated by WHO and published[9] and an Expert Committee on Problems related to Alcohol Consumption held.[10] In addition, WHO carried out a large collaborative study in measuring and improving community responses to alcohol-related problems in Mexico, Scotland and Zambia.[11,12]

Current programme strategy

6. In an effort to respond to the challenges contained in resolution WHA36.12, activities have been concentrated on major priority areas. These areas were selected as a result of a careful assessment of expressions of needs by countries and after consultation with WHO regional offices. Significant developments in each of these areas are highlighted below.

Advocacy of the public health interest

7. Activities in the advocacy area were intended to strengthen WHO's capacity to respond to requests from Member States (resolution WHA36.12, paragraph 4(1)(a)). Four specific lines of work have been developed.

8. Firstly, it was recognized that the prevention of alcohol-related problems is one essential part of the promotion of health. A major new programme initiative has now begun with an international workshop to develop guidelines for the assessment of health promotion approaches to the reduction of alcohol problems. Four developing countries from different regions are participating in this activity, which is leading to the development and testing of specific approaches to the prevention of alcohol-related public health problems, with special emphasis on the needs of developing countries. Meanwhile, in the European Region, work in prevention has focused particularly on vulnerable and high-risk groups, beginning with a review of different approaches to the prevention of alcohol problems in young people.[13]

9. The second line of work seeks to promote cooperation with the media. An international meeting on alcohol and health held in Geneva in November 1983[14] identified promising advocacy approaches. This meeting involved media practitioners and communication scientists. Their recommendations, which are now being implemented, include the preparation of press kits of basic information on physical diseases caused by alcohol, on alcohol dependence and on alcohol and the family. A review document has also been prepared on the impact of TV on the mental health of adults and children which uses alcohol as a case study.[15]

10. A third important target audience for advocacy is the scientific community. Through the encouragement of research in alcohol, and in particular through the proposals of a 1984 task force on the prevention of alcohol-related problems in adolescence, vigorous attempts are being made to stimulate increasing interest in this area of work.[16] Another good example

of the use of advocacy within the scientific community is the stimulation of work on biological risk factors for alcohol dependence, which relies upon long-term international collaborative effort, involving several centres.

11. A review was undertaken of the various documents on alcohol production, consumption and related health problems issued or drafted by the Organization during the past few years. This review revealed that the information available has been insufficiently exploited for advocacy purposes. A series of publications and documents are now being prepared. These include a comprehensive report on trends in alcohol production and trade, with discussion of their public health implications and suggestions for future work.[2] Articles in World Health Statistics Quarterly, the WHO Chronicle and World Health Forum also deal with this topic. Other publications and documents, bringing together the results of work on alcohol policies[17,18,19] and on community response to alcohol problems,[20] have been issued in early 1985 or are currently in press.

National alcohol policies

12. Activities in the area of alcohol policy are in response to the need to understand which measures can influence alcohol consumption patterns (resolution WHA36.12 paragraph 4(1)(b)). Following a comprehensive review of the world literature, a document has been prepared on policy options for decision-makers.[21] It draws upon previous and current work undertaken in all WHO regions, particularly Europe, where consistent attention to this topic led to a major Symposium on Alcohol Control Experiences in 1983.[17] The draft of the document has been extensively circulated for comment to scientists and decision-makers throughout the world. It distinguishes between those policy measures for which there is now sufficient objective evidence of effectiveness, those for which the evidence is mixed, and those for which there is widespread popular support but little objective information. It will now be used as the basis for a set of pragmatic guidelines for decision-makers.

13. It is hoped that these guidelines will be of use in a wide range of countries, and that opportunities will arise for working with countries to help test the impact of different approaches to policy development and implementation. In the meantime, intercountry and national workshops are being organized in a number of countries, particularly in the African Region. These workshops bring together participants from other sectors as well as health, and serve as a stimulus to the development of local plans of action to reduce alcohol problems. An intercountry collaborative project has begun in the European Region, involving eight Member States in the promotion of studies of alcohol-related problems and responses to them at community level, as part of the development of more effective national programmes.

14. In support of work on national alcohol policies, efforts are also being made to promote the development of sound national and international data bases on alcohol-related problems. The lack of adequate statistical information in this area has been repeatedly deplored in Health Assembly resolutions. Following detailed planning, it has now been established that collaborating centres are especially well placed to play a leading role in developing activities in this area. With support from the Regional Office for the Americas, the Alcoholism and Drug Addiction Research Foundation (Toronto, Canada) and the National Institute on Alcohol Abuse and Alcoholism (Washington, DC) are bringing together groups of scientists from a range of countries to work on the improvement of the measurement of the role of alcohol in casualty statistics.

15. This activity is taking place within the context of continuing work on the development of better indicators of mental health problems and on the improvement of the assessment of physical damage caused by alcohol consumption.

Development of techniques for identification, prevention and management in primary health care settings

16. Work in this area has been developed through a number of specific projects, also designed to strengthen WHO's capacity to respond to requests from Member States (resolution WHA36.12, paragraph 4(1)(a)). Simple procedures for the early detection of alcohol problems in primary health care settings have been developed. Various existing methods were compared,

in order to determine which items should eventually be included in a screening instrument, which was then tested in six countries. A number of reports relating to this activity have been produced and will be available in the near future.

17. The results of the early detection project are being fed directly into work on the development and evaluation of measures to be used for treatment and management of alcohol problems in the primary health care setting. The project on treatment emphasizes the development of effective and simple low-cost methods, designed to increase (a) the number of people who will be reached, (b) the likelihood that health systems can incorporate the relevant knowledge, and (c) the likelihood that countries can afford the cost. Centres in 11 countries have tested the approach in a pilot phase, and have now begun to gather data on various simple treatment interventions. An advice session is being compared with a counselling session and a self-help manual, in order to test their relative effectiveness in reducing consumption and/or alcohol-related problems. An important contribution to this work has been the development of a primary health care manual on responding to alcohol and drug problems, which is also being independently tested in a number of different settings.

18. Efforts in this area are supplemented by a descriptive survey of the role of general medical practitioners in the management of alcohol-related problems in a range of developing and developed countries.[22] Reports based on studies from 14 centres in 12 countries have been prepared in order to achieve a better understanding of the current practice and the future potential of primary health care workers in identification, treatment and prevention of alcohol-related problems.

19. Work has started in the European Region on the development of model programmes for treatment and rehabilitation, including evaluation methodology and programme implementation, building on the experiences of several Member States. The respective roles of different sectors and services, including lay groups, community networks and non-health sectors, are also being analysed.

20. Meanwhile, in collaboration with the International Labour Organisation (ILO) and the International Council on Alcohol and Addictions, WHO prepared six regional reviews of alcohol-related problems in the employment setting and the responses which are currently offered to them. The Regional Office for the Americas has been especially active in stimulating policies and programmes on alcohol and drug problems in employment settings. Meanwhile, specific proposals have been developed for joint action by ILO and WHO, focusing on preventive measures appropriate for employment settings.

21. A review of the world literature on the prevention and management of alcohol problems in the family setting will be available later in 1985. It will be used to determine ways in which WHO can best approach this complex field and become usefully involved. This remains a topic with great potential for development, and is already an important emphasis within both the advocacy and treatment areas.

International coordination

22. In order to respond to resolution WHA36.12, paragraph 4(1)(c), the interest and involvement of other specialist bodies within the United Nations system has been stimulated through specific projects, for example the collaboration with ILO on alcohol problems in employment settings. At the same time, both UNESCO and UNICEF have been involved in activities within the advocacy area and further opportunities for collaboration are envisaged as these activities develop.

23. In view of the crucial role of nongovernmental organizations, a meeting was organized in May 1984 of all organizations that had an interest in WHO's alcohol programme. A very wide range of nongovernmental organizations sent representatives to this meeting and a joint plan of work, including regular contact and involvement in the programme, has emerged. As a result of regular meetings of intergovernmental and nongovernmental organizations in the European Region, close collaborative links have been established with the Council of Europe for the development of pilot projects on education for health to prevent dependence.

24. Links with such organizations are complementary to existing plans of work with WHO collaborating centres in both developed and developing countries. The network of collaborating centres active in training, teaching and research on alcohol-related problems is already an integral part of the programme. It is anticipated that this network will be expanded to meet future needs both in the regions and globally.

Organization and management

25. The WHO alcohol programme has the benefit of an active and energetic advisory group which reviews the general thrust of the work at global level as well as commenting in detail on specific aspects of it.[23] This advisory group, which includes members of the Executive Board, provides regular critical assessment of the programme within the context of the broader health concerns of the Organization.

26. Although the regular budget allocation for the global alcohol programme is relatively modest, the sum of US$ 200 000 has been made available during the biennium 1984-1985 from the Director-General's Development Programme.[24] In response to country needs, the European Region has now established a separate and identifiable programme on alcohol-related problems, whilst in other regions activities on alcohol- and drug-related problems have tended to be undertaken together.

27. Within the last year, attempts to attract extrabudgetary funding for the global programme in response to resolution WHA36.12, paragraph 4(1)(d) have yielded some positive results. A commitment of continuing support to the programme has been made by the Council of Ministers of Health of the Arab Countries of the Gulf Area; the Norwegian Ministry of Development Cooperation and the Charter Medical Foundation have both provided support for particular activities. Utilizing extrabudgetary funds, a professional staff member has been recruited for an initial period of one year as programme manager for the global alcohol programme. In addition, the United States National Institute on Alcohol Abuse and Alcoholism has seconded a senior staff member to WHO for 15 months, and the Health Education Council, United Kingdom, has agreed to second its alcohol programme manager for one month each year.

III. CONCLUSIONS

28. The activities highlighted in this document fall within the work of the Mental Health programme, which gives central attention to the preservation and enhancement of mental health at all ages in the specific sociocultural settings of Member States. It is within this context that a comprehensive approach to the alleviation of alcohol- and drug-related problems is now being actively developed.

29. This brief description does less than justice to the full range of activities contained within the current WHO alcohol programme. It has, of course, been impossible to present the full range of country and regional programmes. It is hoped, however, that what has been presented here is sufficient to illustrate activities undertaken to develop a coherent response to the priorities advanced in resolution WHA36.12.

30. It is proposed that the alcohol programme should continue to develop within the major areas described above: advocacy of the public health interest; national alcohol policies; development of techniques for primary health care settings; and international coordination. Such a programme is consistent with the stated objectives of WHO's Medium-Term Mental Health Programme[25] and with the overall aims of the Seventh General Programme of Work. The intention is to build up a programme which makes the most cost-effective use of scarce resources, which will attract national and international interest, and which will contribute significantly to the efforts of countries to achieve the goal of health for all.

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