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EDITORIAL

The WHO Global Strategy to Reduce the Harmful Use of Alcohol

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The World Health Organization was established in 1948. From its inception, it urged Member States to take all measures to control the scourge of centuries, smallpox. Evidence already existed on the methods required. In 1953, the first Director-General failed to persuade the World Health Assembly to undertake this. It was not until 1958 that a Soviet delegate persuaded the Assembly to accept responsibility for a global eradication programme. By 1966, the World Health Assembly agreed that continuing smallpox spread in several countries was intolerable and eventually, over the next 10 years, sustained efforts by many health workers achieved the goal of global eradication.

The WHO has progressively brought to the attention of the Assembly another global threat to health, the harmful use of alcohol. But it was not until the Sixty-Third World Health Assembly in May 2010 that delegations from all 193 Member States reached a consensus on a strategy to confront the harmful use of alcohol. Resolution WHA63.13 was adopted.

Patient work over many years by WHO staff and advisors, including a formal consultation in 2008 with Member States and stakeholders, has now been brought to fruition by Dr Vladimir Poznyak, of the section for the Management of Substance Abuse at WHO, and his team. The result of their labours, and of the Assembly, is available online at http://www.who.int/substance_abuse/msbalcstragegy.pdf. It is now published in print and can be obtained from WHO, Geneva, in Chinese, Russian, Spanish, French, Arabic and English.

The document notes that preventing and reducing the harmful use of alcohol is often given a low priority among decision-makers despite compelling evidence of its serious public health effects. Being apprized of the evidence, the Assembly has endorsed measures that many governments eschew. For example, regarding the marketing of alcoholic beverages, the Strategy states: 'The exposure of children and young people to appealing marketing is of particular concern, as is the targeting of new markets in developing and low- and middle-income countries with a current low prevalence of alcohol consumption or high abstinence rates. Both the content of alcohol marketing and the amount of exposure of young people to that marketing are crucial issues.' Even since this strategy was formulated, evidence continues to accrue showing that young people's total consumption of alcohol, and not just their brand preference, is influenced by sponsorship, the media and social media (Gordon *et al*, 2010; O'Brien *et al*, 2011).

On the matter of price, a point which legislators under pressure from competing stakeholders often take a bodyswerve, the Strategy is clear: 'Consumers, including heavy drinkers and young people, are sensitive to changes in the price of drinks. Pricing policies can be used to reduce underage drinking, to halt progression towards drinking large volumes of alcohol and/or episodes of heavy drinking, and to influence consumers' preferences. Increasing the price of alcoholic beverages is one of the most effective interventions to reduce harmful use of alcohol.'

The Strategy makes allowances for differences between countries, and with regard to alcohol taxation, the Strategy realizes the difficulty faced by some low- and mid-income countries where the ready availability of illicit alcohol may mean that high taxation has unintended effects. In such circumstances, tax changes must be accompanied by efforts to bring the illicit and informal markets under effective government control. Creative ways to approach this, and evaluative research, are still needed.

The Global Status Report on Alcohol and Health (WHO, 2011) launched in Geneva on 11 February 2011 illustrates the continuing work by WHO to support Member States in collecting information, to better assist them in their efforts to reduce the harm from alcohol.

Although the spread of intoxicant substances in a population can resemble the spread of a harmful virus, WHO's celebrated role in eradicating smallpox cannot serve too far as a model for reducing harm from alcohol—ethyl alcohol is a molecule easily created from abundant raw materials, but societies have shown that, with a will, it is possible to regulate its use. But as for any substance that, like alcohol, can hijack fundamental brain neural pathways (Nutt, 1999; Clapp *et al*, 2008), there may always be some who fall prey.

REFERENCES

Clapp P, Bhave SV, Hoffman PL. (2008) How adaptation of the brain to alcohol leads to dependence: a pharmacological perspective. *Alcohol Res Health* **31**:310–39.

Gordon R, MacKintosh AM, Moodie C. (2010) The impact of alcohol marketing on youth drinking behaviour: a two-stage cohort study. *Alcohol Alcohol* **45**:470–80.

Nutt D. (1999) Alcohol and the brain. Pharmacological insights for psychiatrists. *Br J Psychiatry* **175**:114–119.

O'Brien KS, Miller PG, Kolt GS *et al*. (2011) Alcohol industry and non-alcohol industry sponsorship of sportspeople and drinking. *Alcohol Alcohol* **46**:210–13.

WHO. (2011) **Global Status Report on Alcohol and Health** http://www.who.int/substance_abuse/publications/global_alcohol_report/en/index.html.