Statement of Concern

February 8, 2013

Drafting Committee:

Professor Thomas F. Babor, USA
Ms Katherine Brown, UK
Professor David Jernigan, USA
Dr Nazarius Mbona Tumwesigye, Uganda
Professor Gerard Hastings, UK
Dr Ronaldo Laranjeira, Brazil
Professor Isidore Obot, Nigeria
Mr Sven-Olov Carlsson, Sweden
Dr Evelyn Gillan, UK
Professor Wei Hao, China
Mr Øystein Bakke, Norway
Professor Mike Daube, Australia
Ms Kate Robaina, USA
Professor Peter G. Miller, Australia
Professor Peter Anderson, UK
Dr Aurelijus Veryga, Lithuania
Professor S Casswell, New Zealand
Professor Sungsoo Chun, South Korea

THE INTERNATIONAL PUBLIC HEALTH COMMUNITY RESPONDS TO THE GLOBAL ALCOHOL PRODUCERS' ATTEMPTS TO IMPLEMENT THE WHO GLOBAL STRATEGY ON THE HARMFUL USE OF ALCOHOL

Summary

On October 8, 2012, thirteen of world's largest alcohol producers issued a set of commitments to reduce the harmful use of alcohol worldwide, ostensibly in support of the World Health Organization's 2010 Global Strategy to Reduce the Harmful Use of Alcohol. As an independent coalition of public health professionals, health scientists and NGO representatives, we are submitting this public Statement of Concern to the WHO Secretariat in response to the activities of the global alcohol producers. Based on their lack of support for effective alcohol policies, misinterpretation of the Global Strategy's provisions, and their lobbying against effective public health measures, we believe that the alcohol industry's inappropriate commitments must be met with a united response from global health community.

Our reservations can be summarised as follows:

1) The commitments are based on questionable assumptions, as stated in the signatories' Preamble.

2) The actions proposed in the five commitments are weak, rarely evidence-based and are unlikely to reduce harmful alcohol use.

Global Alcohol Policy Alliance

3) Prior initiatives advanced by the alcohol industry as contributions to the WHO Global Strategy have major limitations from a public health perspective.

4) The signatories are misrepresenting their roles with respect to the implementation of the WHO Global Strategy.

This Statement calls upon the WHO and its Regional Offices to clarify the roles and responsibilities of "economic operators" in the implementation of the WHO Global Strategy; implement stronger conflict of interest policies and continue to avoid partnerships with the commercial alcohol industry, its "social aspects" organisations and other groups funded by the commercial alcohol industry. Member States are urged to ensure resources are available to provide evidence based input for policy development which is independent of commercial and vested interests. They are also encouraged to establish funding sources independent of commercial and other vested interests to carry out research and public health advocacy work.

In addition, we recommend that the global alcohol producers refrain from engagement in health-related prevention, treatment, research and traffic safety activities, as these tend to be ineffective, self-serving and competitive with the activities of the WHO and the public health community. The global producers are encouraged to cease their opposition to effective, evidence-based alcohol policies, and refrain from product innovations that have high abuse potential and appeal primarily to youth and other vulnerable groups.

Finally, we recommend that the public health community avoid funding from industry sources for prevention, research and information dissemination activities; refrain from any form of association with industry education programmes; and insist on industry support for evidence-based policies.

It is concluded that the global producers' activities in support of the WHO Global Strategy are compromising the work of public health experts, the WHO, its regional offices, and the NGOs working in the public health area to deal with the global burden of disease attributable to alcohol. Unhealthy commodity industries such as the global alcohol producers should have no role in the formation of national and international public health policies.

Background

The global producers of beer, wine, and spirits recently expressed support for the World Health Organization's Global Strategy to Reduce the Harmful Use of Alcohol[1], stating that they "take seriously the important positive role Member States have identified for producers, distributors, marketers, and sellers of beer, wine, and spirits in enhancing global action on this important issue".[2] The commitments, developed with the assistance of the International Center for Alcohol Policies (ICAP) and the Global Alcohol Producers Group (GAPG), were signed by 13 of the world's leading alcohol producers, herein referred to as the signatories. The same 13 companies are also the sponsors of Global Actions on Harmful Drinking (global-actions.org), described as a "consortium of initiatives dedicated to helping reduce the harmful use of alcohol" in support of the WHO Global Strategy.

As an independent coalition of public health professionals, health scientists and NGO representatives, we are submitting this public Statement of Concern to the WHO Secretariat in response to the activities of the signatories, particularly the Global Actions on Harmful Drinking (GAHD). The WHO Global Strategy gave the signatories (and the larger group of producers, wholesalers and retailers that we refer to here as the alcohol industry), no authority to engage in public health activities on behalf of WHO or in support of the public health community. It is therefore misleading for the signatories to suggest otherwise. Based on the record of the global alcohol producers and their social aspect organisations during the past five years, we have major reservations about their recent commitments to reduce underage alcohol use, strengthen self-regulatory marketing codes, reduce driving under the influence of alcohol, act responsibly in the area of product innovation, and encourage retailers to reduce harmful drinking. In this context, we note that the WHO has recently expressed reservations about conflicts of interest between commercial actors and public health objectives, as indicated in the WHA resolution 65.6 action 3(3) which mandated the WHO to "develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of programmes consistent with the WHO's overall policy and practice".[3]

As detailed below, our reservations can be summarized as follows:

1) The commitments are based on questionable assumptions, as stated in the signatories' Preamble

2) The actions proposed in the five commitments are weak, rarely evidence-based and are unlikely to reduce harmful alcohol use

3) Prior initiatives advanced by the alcohol industry as contributions to the WHO Global Strategy have major limitations from a public health perspective and

4) The signatories are misrepresenting their roles and responsibilities with respect to the implementation of the WHO Global Strategy. After reviewing our concerns in these four areas, this Statement concludes with recommendations aimed at the WHO Secretariat and its Regional Offices, WHO Member States, the global producers and the public health community.

1) Questionable assumptions

The signatories' core beliefs, as outlined in a Preamble to their commitments document,[2] contains the following statements:

> *We believe the most feasible and effective measures to reduce harmful use of alcohol are evidence-based, take into account drinking patterns and target specific problems*
>
> *We believe that governments, producers and other stakeholders need to work together more vigorously to reduce harm associated with "noncommercial" and unrecorded alcohol, given that it accounts for a significant proportion of all alcohol consumed globally, particularly in many low- and middle-income countries*

The first statement is not consistent with what is known about the most effective, evidence-based alcohol policies, as it implies

erroneously that individual-level programmes directed at high risk drinkers are more feasible and effective than what have been termed the WHO 'best buys' of price, availability and marketing controls.[4] Research monographs[5-7] and integrative reviews[8-10] have identified the most effective policy approaches to reduce alcohol-related harm, both through regulatory measures that target per capita alcohol consumption, and through interventions targeted at high risk drinkers. Pricing and taxation policies, availability controls, drink-driving countermeasures, restrictions on alcohol marketing, specialised treatment for alcohol dependence, and brief interventions for hazardous alcohol use have the most evidence of effectiveness. Many of the strategies are universal measures that restrict the affordability, availability, and accessibility of alcohol, and as such they may come into conflict with commercial interests.

Although some targeted policies (e.g., drink-driving countermeasures such as .05 BAC limit) are demonstrably effective in a limited range of outcomes, these are ignored in the signatories' document and are rarely championed by global alcohol producers. A narrow focus on the "drinking patterns" of targeted subpopulations is unlikely to achieve the objective of reducing harmful alcohol use worldwide by 2018, particularly with respect to noncommunicable diseases like cancer where risk increases with average daily alcohol use. To achieve this objective, both universal and targeted approaches will be needed.

Regarding the second statement, noncommercial alcohol is a complex issue that includes home brewing, illicit distillation, and diversion of legal alcohol to the informal market to avoid taxes. The harm associated with noncommercial alcohol is primarily a function of its alcohol content,[11] not the toxic ingredients (e.g., methyl alcohol) that are sometimes responsible for alcohol poisonings. As such, it is not the role of the alcohol producers to conduct scientific research and take the lead in combatting noncommercial alcohol. The industry lacks expertise in dealing with this complex issue, and they have an obvious conflict of interest in their advocacy for low cost alternatives to noncommercial alcohols. Indeed, some industry activities listed in their Global Initiatives document as contributions to the WHO Global Strategy, such as lobbying to reduce the excise tax on a new sorghum beer product,[12] could increase hazardous alcohol use while failing to address the problems associated with noncommercial alcohol.[13] Governments, health ministries and public health officials are the most appropriate parties to address the harms associated with noncommercial alcohol, not the alcohol industry and its trade associations or social aspects organizations. Their role is to secure the supply of commercial alcohol and to comply with current laws and regulations.

2) Weak programs and policies are unlikely to reduce harmful alcohol use

The signatories' commitments deal with programmes and policies in five areas. The first is "to significantly reduce underage purchase and underage consumption of alcohol beverages by 2018." This is to be accomplished by actively seeking "enforcement of government regulation of under-age purchase and consumption in all countries" where the industry is "commercially active" and that have a minimum purchase age. Although enforcement of under-age purchase and consumption laws is an admirable objective, one that could have a beneficial impact on the growing rates of adolescent alcohol misuse in many parts of the world, we fail to see how such a commitment could be evaluated with sufficient rigor to attribute the industry's activities to any observed changes in so many countries. Without systematic survey research and major enforcement programmes in a large number of countries, this commitment is unlikely to be either fulfilled or proven, particularly in developing countries where age identification is often nonexistent.

Related to this commitment, the producers propose to work with NGOs and IGOs "to develop, promote and disseminate educational materials and programmes designed to prevent and reduce underage purchase and consumption." Here, no specific measures are presented, other than "consulting experts on

the development of best practice educational materials…" Unfortunately, there are no known educational materials that are capable of reducing underage alcohol use and alcohol purchases, as indicated by a recent systematic review of the scientific literature.[5] Furthermore, there is a direct conflict of interest between the economic objectives of the global alcohol producers and the educational needs of young people regarding the risks associated with alcohol consumption. In several instances alcohol industry-sponsored education initiatives may function as an extension of their marketing activities (such as the Carlsberg 'back to school' campaign in Malaysia).[14] In most countries, the norm for children and youth is to grow up free from alcohol, and this should be respected in the signatories' communications and in those of its social aspects organisations.

The second commitment is to strengthen marketing codes of practice, and expand them to include digital media in "all countries in which we actively market our brands." We welcome the acknowledgement from global alcohol producers that alcohol marketing may be linked with harmful consumption and agree that greater regulation is needed – especially concerning digital media. A recent thematic analysis of thousands of internal industry documents obtained by the UK House of Commons Health Select Committee Office in their review of four producers, two of them (Diageo and Molson Coors) signatories of the producers' commitments, found that advertisers target commercial communications to young people despite self-regulatory codes that are supposed to restrict objectionable content such as the suggestion that alcohol can enhance sexual attractiveness.[15]

We therefore question the premise that self-regulation codes should be expanded throughout the world, especially in light of research on industry self-regulation codes suggesting that both the exposure targets and the content guidelines of the alcohol industry's self-regulation codes are systematically violated (see studies conducted in Canada,[16] Ireland,[17] Brazil,[18] Australia,[19-20] the USA,[21-23] the EU,[24,15] and four African nations[26]). In addition, the process of reviewing complaints, withdrawing questionable ads, sanctioning violations, and making revisions to these codes has been shown in several countries[15,20-21,23-24,26-30] to be inadequate for the purpose of protecting vulnerable populations from the negative effects of alcohol marketing. Self-regulation codes in their current form provide inadequate protection against (a) alcohol sponsorships at youth-oriented concerts and major sporting events, (b) product placements in youth-oriented films and television, and (c) marketing messages broadcast in the print, TV, digital and other media. Therefore, we do not believe that this commitment is warranted when a ban on alcohol promotion is the preferred option, especially to protect children and young people. The signatories' additional promise to advertise only in markets that have "a minimum 70% adult audience" is also inadequate, in that a significant proportion of youth are exposed to these markets in countries where this has been studied.[31-35]

The question of digital media is of particular concern, given the lack of effective self-regulation in these media and the inherent difficulty of limiting under-age access to sites with blatant violations of existing self-regulation codes.[15,30,32,36-37]

The third commitment refers to the provision of "consumer information and responsible product innovation." Here the document states that "product and packaging innovation brings consumers choices…and fosters robust marketplace competition." Although the possibility of "introducing beverages with lower alcohol strengths" is mentioned, this is not included as a specific commitment. Rather, the signatories only agree "not to produce any beverage alcohol products that contain excessive amounts of added stimulants," and not to market products "as delivering energizing or stimulating effects." No details are provided as to what constitutes "excessive amounts" of stimulants, which have been associated with serious medical reactions and even death.[38-39] We are concerned that these commitments will not address the continued development and marketing of flavored alcohol products, which have been criticized because of their misuse by underage alcohol users, particularly young women.[40-42] In relation to this commitment,

the UK House of Commons Health Select Committee[15] showed that alcohol potency has been communicated to young persons in ways that circumvent the current self-regulation guidelines. Moreover, the commitments say nothing about cheap liquor sachets that have been associated with underage alcohol use in many African countries.[43-45] Nor do they address super-strength alcohol products (e.g., extreme beer), which are becoming commonplace in many emerging markets.

Their third commitment also states that the signatories will develop "a standard set of easily understood symbols or equivalent words to discourage" drinking and driving, underage consumption, and consumption by pregnant women. Whilst there is some evidence to suggest that health information and warning labels can increase knowledge about harmful consumption and change attitudes about drinking, there is no evidence that warning labels are an effective way to prevent driving under the influence of alcohol or other kinds of alcohol-related problems.[46,5]

The fourth commitment pertains to alcohol use and driving. The signatories say that they "have an important role to play in helping to prevent and reduce both drink-drive morbidity and mortality." Although some countries have witnessed significant reductions in alcohol-related motor vehicle accidents after implementing lower BAC limits, penalties for noncompliance, random breath testing and other policies,[5] these have rarely benefited from the cooperation of global alcohol producers. Indeed, the industry in many countries has been opposed to the most effective strategies. Moreover, the pilot projects that the signatories propose to conduct are unlikely to demonstrate either sufficient efficacy or adequate population reach to affect the growing fatality rates in low and middle income countries.

Finally, the fifth commitment (enlisting the support of retailers to reduce harmful alcohol use) seeks to discourage irresponsible promotions ("to the extent legally permissible"). It also supports responsible point-of-sale marketing as well as "measures to prevent under-age drinking through, e.g., proof-of-age requirements, and the training of retail staff…"

Despite these laudable objectives, the available research suggests that these measures are ineffective without consistent enforcement that is independent of the industry's retail network.[5,47]

In summary, weak programmes and policies are unlikely to reduce harmful alcohol use. The proposed actions ignore the evidence-based practices most likely to affect population rates of alcohol-related problems, i.e., availability controls and taxation/pricing policies. The commitments of the global alcohol producers are not in line with state-of-the-art scientific evidence, which builds the foundation for the WHO Global Alcohol Strategy and the Zero Draft in the WHO NCDs consultation process. ICAP and the global producers' advocate for corporate social responsibility activities and consistently oppose the "best buys" [48] mentioned in Reducing the economic impact of NCDs in low- and middle-income countries,[4] which are supported not only by research in high income countries,[5] but also increasingly in low and middle income countries as well.[10] Other actions conducted by the signatories, including their own lobbying activities, point to a general lack of support for effective, evidence-based alcohol policies. In South Africa and Lithuania several of the global producers opposed bans on alcohol marketing. In Scotland the global spirits producers have united to oppose the introduction of minimum unit pricing, despite scientific evidence showing that price controls are one of the most effective means of reducing harms caused by alcohol.[49] In Brazil, the global producers succeeded in changing a law banning alcohol from football stadiums, to prevent violence.[50] According to financial reports filed with the US Government, the Global Alcohol Producers Group, of which most of the signatories are members, spent over one million dollars on lobbying WHO since they were established in 2005. These activities seem to contradict the WHO Global Strategy (para 12 (c), which states that the signatories have a "responsibility to act in ways that do not undermine the implementation of public policies and interventions to prevent and reduce harmful use of alcohol."

3) Prior industry initiatives have major limitations from a public health perspective

The global producers' claim that their commitments should be evaluated in the context of the industry's current initiatives,[51] which are promoted as contributions to the WHO Global Strategy. An analysis of the 406 activities conducted by the industry between 2006 and 2009[52] indicates a predominance of actions that have no scientific evidence of effectiveness in changing alcohol consuming behavior or reducing alcohol-related problems. Most deal with popular but ineffective strategies, such as information campaigns, designated driver programmes, internal industry policies, and self-regulation initiatives. Indeed, some of the activities (promoting voluntary self-regulation of marketing activities, teaching 16 year-olds to use alcohol responsibly) are likely to increase youth exposure to alcohol marketing or to encourage alcohol use.

Sixteen of these initiatives are part of the UK's Public Health Responsibility Deal, which was begun as a partnership among government, industry representatives, NGOs and public health officials. In 2011, the public health representatives, including The British Medical Association, the Royal College of Physicians, Alcohol Concern, the British Association for the Study of the Liver, the British Liver Trust, and the Institute of Alcohol Studies, decided to withdraw from the partnership, "citing the inherent conflict of interest"[53] and the ineffectiveness of its industry-sponsored programmes.

In summary, the global initiatives promoted by the alcohol industry and advertised by ICAP as indicative of the industry's social responsibility campaign are overwhelmingly based on approaches of unknown or minimal effectiveness, or which have been shown to be ineffective through systematic scientific research. Moreover, the industry initiatives only rarely include practices considered by the WHO and the public health community to have good evidence of effectiveness, and few have been evaluated in low and middle income countries where they are now being disseminated.

4) The signatories have misinterpreted their roles and responsibilities with respect to the implementation of the WHO Global Strategy

The signatories and other industry representatives state that they support the WHO Global Strategy to Reduce the Harmful Use of Alcohol. Their current "global actions" and future commitments are proposed as their contributions to the Global Strategy, in their roles as "economic operators." In another document prepared by ICAP[48], it is stated that "the adoption of the WHO Global Strategy…has legitimated industry's ongoing efforts and has opened the door to the inclusion of producers as equal stakeholders."

The Global Strategy states that "Economic operators in alcohol production and trade are important players in their role as developers, producers, distributors, marketers and sellers of alcoholic beverages. They are especially encouraged to consider effective ways to prevent and reduce harmful use of alcohol within their core roles mentioned above, including self-regulatory actions and initiatives."

As noted previously, the producers' record in the design, management and enforcement of their own self-regulation framework has been inadequate. And by taking a direct role in the dissemination of health information, the conduct of scientific research and the implementation of public health and traffic safety measures, we believe that the signatories have misinterpreted the role defined for them in the Global Strategy, based on our reading of prior documents issued by the WHO, public health organisations and NGOs. For example, in 2001, the health ministers of the European Union adopted a declaration on alcohol and young people, the preamble to which stated that "[p]ublic health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests."[54] This was reiterated in both the Global Strategy itself (para 12.(a)), and in the European Alcohol Action Plan, which was endorsed in September 2011 by the 53 Member States of the WHO's European Region.[55] In 2006, a WHO Expert Committee[56] on alcohol advised the WHO Secretariat to have no cooperation with the alcohol industry, based in part on ICAP's

questionable record of public health activities on behalf of its alcohol industry sponsors.[57] In 2007, a group of alcohol scientists and NGO representatives issued the Clarion Declaration, advising the alcohol research community to avoid working with the alcohol industry because of the obvious conflict of interest.[58] This was in part based on what the group saw as an inherent incompatibility between protecting the public from the harm done by alcohol and the alcohol industry's need to maximize profit by promoting the sale and consumption of its products.

Furthermore, nothing in the Global Strategy would explain the industry's involvement in the development of national policies for governments in Africa and Asia, using the WHO Global Strategy as a reason to promote industry-favorable policies without the participation of the WHO or the public health community. In one case,[57] national policies were formulated at meetings sponsored by ICAP to fit the specific needs of four different African countries. These plans were found to be virtually identical, with all documents originating from the MS Word document of a senior executive of SABMiller, one of the ICAP's funders. Subsequent to the publication of this analysis, one of ICAP's chief consultants was sanctioned by his employer, the government of South Australia, for misrepresenting his government affiliation in the drafting of these reports.[59]

In yet another case of role confusion regarding WHO, an evaluation of the signatories' "Global Actions" commissioned by ICAP and prepared by a business consulting agency[60] referred to the "challenges" of helping the WHO when the WHO and its regional offices have kept ICAP at "arms length." The report states that "Potential opposition in some quarters could be circumvented by the deployment of efforts targeted at areas with greater potential for success, such as possibility turning to different states in Mexico where WHO/PAHO is less active" (p. 14). What is also revealed in the Channel Research report is that ICAP is now moving into the direct funding of contract research that will be published in regional and international journals. As one analysis of the moral hazards of alcohol industry funding has shown,[61] this kind of direct industry funding carries the risk of bias, agenda setting and reputational damage to the research field itself. With the anticipated publication of a series of case studies, research on non-commercial alcohol, which by some estimates accounts for more than one-third of the world production, will be dominated by a literature tainted by a major conflict of interest.[62]

As suggested in the recommendations below, we believe that the alcohol industry and its trade organisations should not be involved in scientific research and public health programme sponsorship. This issue was recently raised in relation to the "Tavern Intervention Program (TIP)" funded by the Global Fund and implemented by SABMiller in South Africa. TIP is designed to minimise alcohol related harm in men and reduce the spread of HIV/AIDS. A recent article in the WHO Bulletin questions the value of this programme, stating that "our experience is that the liquor industry is inclined to support alcohol interventions that have limited impact on alcohol use at a population level. These interventions allow the industry to be seen to be fulfilling social and legal obligations to address alcohol abuse while simultaneously ensuring that sales and profits are maintained."[63]

In summary, we do not feel it is the role of the alcohol industry to engage in public health activities, drink-driving prevention, education programmes, treatment of alcohol problems and other initiatives that are best managed by professionals who are free of conflicts of interest and trained in traffic safety, addiction medicine, childhood education and public health. The Global Strategy in no way has "legitimated" the activities proposed in the signatories' commitments. In this context, it is reasonable to ask if the signatories' activities and commitments are consistent with para 48.(i) of the Global Strategy, which states that in continuing its dialogue with the private sector, the WHO needs to give "appropriate consideration…. to the commercial interests involved and their possible conflict with public health objectives."

Recommendations

We close with a set of recommendations directed at the World Health Organization, its Member States, the global alcohol producers, and the public health community.

1. Role of WHO

In setting and implementing their public health policies with respect to alcohol control, WHO needs to protect these policies from commercial and other vested interests. The WHO Global Strategy does not give the global alcohol producers a role in public health policy development or implementation. They are only encouraged to "consider effective ways" to address alcohol problems within their core roles, rather than as public health professionals. The dialogue with the private sector prescribed in Global Strategy (section 48.(i)) should be informed by the following considerations:

As a matter of urgency, clarify the roles and responsibilities of economic operators in the implementation of the WHO Global Strategy, giving special attention to the activities expected of the developers, producers, distributors, marketers and sellers of alcoholic beverages

Realise the mandate of the WHA resolution 65.6 action 3(3) to develop a risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of programmes consistent with the WHO's overall policy and practice

Continue to refuse offers of partnerships with the commercial alcohol industry, its social aspects organizations and other groups, platforms and forums substantially funded by the commercial alcohol industry

Implement strong conflict of interest policies such that employees are required as a condition of the WHO employment to avoid subsequent employment with commercial interests that represent or are substantially funded by the commercial alcohol industry for at least two years following termination of their employment with the WHO

Engage professional scientific organizations and NGOs in a critical review of industry-science –public health relationships

Convene an international group of public health and media experts independent of alcohol industry interests to conduct a systematic review of studies relevant to the performance of industry self-regulation codes of responsible marketing, and to recommend steps to be taken to control alcohol marketing

2. Member States

The national and local governments of WHO Member States are often the targets for much of the information dissemination undertaken by the commercial and vested interests. It is important to note the imbalance in the resources available to undertake such stakeholder marketing work and ensure that critical appraisal of the industry's material is resourced and made available in a timely fashion. In collaboration with the WHO Regional Offices, it is recommended that Member States:

Establish funding sources independent of commercial and other vested interests to carry out research and public health advocacy work, for example by establishing a health promotion agency funded by taxation on unhealthy commodities including alcohol

Establish an independent lead agency to address alcohol issues and advise on policy options. Such an agency should be protected from influence of commercial and vested interests

Do not engage commercial or vested interest groups, or their representatives, in discussion on the development of alcohol policy. Input from these groups on implementation of policy must be critically evaluated in light of their vested interests

3 Producers

The alcohol industry has an ethical responsibility to minimise the harm caused by its products at all stages of the production chain, including product design and marketing. The ethical responsibility of the industry for the harm caused by its products cannot be regarded solely as a national issue. Multinational corporations have a responsibility for their behaviour all over the world, and should adhere to minimal ethical standards for responsible product design and marketing practices regardless of the country where their products are sold. In particular, we recommend that the global alcohol producers, their trade associations, and social aspect/public relations organisations:

Refrain from all marketing including sponsorship and product design (e.g., caffeinated alcohols, alcopops, sweetened alcohol beverages) in order to protect children, young persons, high risk alcohol users and females in their child bearing years

Refrain from further lobbying against effective public health measures

Refrain from further engagement in health-related prevention, treatment, and traffic safety activities, as these tend to be ineffective, self-serving and competitive with the activities of the public health community

Cease political activities designed to reduce or eliminate evidence-based alcohol control policies

Refrain from direct funding of alcohol research because of the potential for agenda setting and bias owing to conflict of interest

Respect the rules of science and the integrity of researchers and research organizations. They should quote and use the research in appropriate ways, and not use their sponsorship of scientific research for marketing or political lobbying purposes

Refrain from scientific publishing through their own publishers. If they produce through other channels publications that claim to be scientific, they should follow rules of open scientific peer review and otherwise meet the standards of academic publishers

Secure its own supply chains and cooperate with all aspects of the law when it comes to preventing the diversion of commercially produced alcohols to the informal market

4 Public health community, including research scientists, NGOs and other public interest organisations

Financial support from the alcohol industry and its third party organisations has the potential to affect professional judgment, and may strengthen the influence of private interests in the policy making process. Accepting alcohol industry support may adversely affect an individual's reputation and decrease public trust in an academic institution or nongovernmental organisation. Research scientists, NGOs and other public interest organisations are well advised to take these reputational issues into consideration. They should keep in mind that the evolution of ethical thresholds and

standards in recent decades has generally been towards more stringent standards, for instance in the case of tobacco.[61] The following actions are warranted by the public health community:

Avoid funding from industry sources for prevention, research and information dissemination activities. Refrain from any form of association with industry education programmes

Insist on industry support for evidence-based policies, and cessation of anti-scientific lobbying activities

Insist on rigorous adherence to Conflict of Interest principles

Support independent research in developing countries on noncommercial alcohol and alcohol marketing

Make all information and details relating to funding and/or partnership work transparent and available for public scrutiny

Conclusion

The global producers' activities in support of the WHO Global Strategy are compromising the work of public health experts, the WHO, its regional offices, and the NGOs working in the public health area to deal with the global burden of disease attributable to alcohol. Whereas some would argue that any efforts to promote alcohol control policies should be welcomed, it is clear that the global producers not only have a clear conflict of interest in the policies they promote, they also have no competence to do research, policy analysis or public health. Support for evidence-based policy and cessation of lobbying against effective policies should be a pre-condition for any dialogue with the WHO and the public health community. The misrepresentation by the global alcohol industry and their social aspect organisations of their role in the implementation of the WHO Global Strategy is interfering with important global health programmes, such as Non-Communicable Diseases initiative,[65,66] and should therefore be halted. Unhealthy commodity industries such as the global alcohol producers should have no role in the formation of national and international public health policies.

References

1. World Health Organization. Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010 (EB126/2010/REC/2).

2. Global Actions on Harmful Drinking. REDUCING HARMFUL USE OF ALCOHOL: BEER, WINE AND SPIRITS PRODUCERS' COMMITMENTS. October 8, 2012. Retrieved November 1, 2012 from, http://event.global-actions.org/Reducing%20Harmful%20Use%20of%20Alcohol.pdf

3. World Health Organization . WHA resolution 65.6 action 3(3)

4. World Health Organization and the World Economic Forum. Reducing the economic impact of NCDs in low- and middle-income countries. Executive Summary. 2011. Available at: http://www.who.int/nmh/publications/best_buys_summary/en/index.html.

5. Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingstone, M., Österberg, E., Rehm, J., Room, R., Rossow, I. Alcohol: No Ordinary Commodity - Research and Public Policy. 2nd edition, Oxford: Oxford University Press, 2010.

6. Stockwell T, Gruenewald P, Toumbourou JW, Loxley W, eds. Preventing Harmful Substance Use. The Evidence Base for Policy and Practice. West Sussex, UK: John Wiley & Sons; 2005.
7. Chikritzhs, T., Catalonao, P., Pascal, R. Predicting alcohol-related harms from licensed outlet density: a feasibility study. National Drug Law Enforcement Research Fund, Monograph, Series No 28. 2007. http://www.ndlerf.gov.au/pub/Monograph_28.pdf.
8. Room R, Babor TF, Rehm J. Alcohol and public health. Lancet. 2005;365 (9458):519-530.
9. Anderson, P, Chisholm, D,Fuhr, D. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol, The Lancet 2009;373(9682):2234-2246
10. Babor TF, Robaina K, Nilsen P, Kaner E, Li Q. Rapid Review of Current Evidence for Health Promotion Actions for Hazardous and Harmful Alcohol Use, With Specific Reference to Low- and Middle-Income Countries. Geneva, Switzerland: World Health Organization, Mainstreaming Project, Division of Noncommunicable Diseases; 2011.
11. Lachenmeier, DW, Taylor, BJ, Rehm, J. Alcohol under the radar: Do we have policy options regarding unrecorded alcohol?, International Journal of Drug Policy 2011; 22(2) 153-60.
12. International Center for Alcohol Policy. Initiatives Report 2012. 2012. Available at: http://epublishbyus.com/icap_-_initiatives_report_2012/10028069
13. Chaloupka F, Grossman M, Saffer H. Effects of price on alcohol consumption and alcohol-related problems. Alcohol Research and Health. 2002;26:22–34.
14. Carlsberg gives out school bags, raincoats to rural pupils. The Bourne Post. April 19, 2012. Available at: http://www.theborneopost.com/2012/04/19/carlsberg-gives-out-school-bags-raincoats-to-rural-pupils/
15. Hastings G, Brooks O, Stead M, Angus K, Anker T, and Farrell T. Failure of self regulation of UK alcohol advertising. BMJ 2010; 340, doi:10.1136/bmj.b5650.
16. Fortin, R.B. and Rempel, B. The effectiveness of regulating alcohol advertising: Policies and public health. Paper presented at the alPHa OPHA “Determining Health Through Public Health Action” Conference, November 2005, Toronto, Canada.
17. Dring, C. & Hope, A. The impact of alcohol advertising on teenagers in Ireland. Ireland, Dublin: Health Promotions Unit. 2001.
18. Vendrame, A., Pinksy, I., Souza e Silva, R., & Babor, T.F. Assessment of self-regulatory code violations in Brazilian television beer advertisements. Journal of Studies on Alcohol and Drugs 2010;71(3), 445- 451.
19. Donovan, K., Donovan, R.J., Howatt, P., & Narelle, N. Magazine alcohol advertising compliance with the Australian alcoholic beverages advertising code, Drug and Alcohol Review 2007; 26:1, 73-81.
20. Jones, S. C. and Donovan, R. J. Self-regulation of alcohol advertising: is it working for Australia? J. Publ Aff 2002; 2:153–165.
21. Marin Institute. Why big alcohol can’t police itself: A review of advertising self-regulation in the distilled spirits industry. San Rafael, CA. 2008. Available from: http://alcoholjustice.org/images/stories/pdfs/08mi1219_discus_10.pdf
22. Evans, J. M., & Kelly, R. F. Self-regulation in the alcohol industry: A review of industry efforts to avoid promoting alcohol to underage consumers. Federal Trade Commission Report. 1999. Available at: http://www.ftc.gov/reports/alcohl/alcoholreport.htm

23. Babor, T. F., Xuan, Z. and Damon, D. Changes in the self-regulation guidelines of the US Beer Code reduce the number of content violations reported in TV advertisements. J. Publ. Aff 2010, 10: 6–18.
24. deBruijn A, Wildenberg E, Broeck A. Commercial promotion of drinking in Europe: Key findings of independent monitoring of alcohol marketing in five European countries. Utrecht: STAP, 2012.
25. deBruijn, Avalon. Monitoring Alcohol Marketing Practices in Africa: Findings from the Gambia, Ghana, Nigeria and Uganda. WHO Regional Office for Africa: Brazzaville, Republic of Congo; 2011.
26. Alcohol Concern. Overexposed and Overlooked. London: Alcohol Concern. 2011. Available at: http://www.alcoholconcern.org.uk/assets/files/Publications/2011/Overexposed%20and%20overlooked.pdf.
27. National Committee for the Review of Alcohol Advertising. Review of the self-regulatory system for alcohol advertising. Report to the Ministerial Council of Drug Strategy. Minister for Health, Victoria, 2003.
28. Jones, S. C., Hall, D., & Munro, G. How effective is the revised regulatory code for alcohol advertising in Australia? Drug and Alcohol Review 2008; 27, 29-38.
29. Vendrame, Alan, & Pinsky, Ilana. Ineficácia da autorregulamentação das propagandas de bebidas alcoólicas: uma revisão sistemática da literaturainternacional. RevistaBrasileira de Psiquiatria, Epub May 13, 2011. Retrieved December 03, 2012.
30. Winpenny, E., Patil, S., Elliott, M., van Dijk, L., Hinrichs, S., Marteau, T., and Nolte, E. Assessment of Young People's Exposure to Alcohol Marketing in Audiovisual and Online Media. London: European Commission, Sep. 2012. Retrieved fromhttp://ec.europa.eu/health/alcohol/docs/alcohol_rand_youth_exposure_marketing_en.pdf
31. Jernigan, D.H., Ostroff, J., Ross, C. Alcohol advertising and youth: A measured approach. Journal of Public Health Policy 2005;26: 312–325.
32. Center on Alcohol Marketing and Youth. Plugged in 24/7: Alcohol Advertising & youth in the Digital Age. Washington, DC: CAMY, Georgetown University; December, 2011. Retrieved December 5, 2012, from http://www.camy.org/research/Summary_Brochures/CAMY_DigitalMedia2.pdf
33. Center on Alcohol Marketing and Youth.Youth exposure to alcohol advertising on television, 2001-2009. Washington, DC: CAMY, Georgetown University; December 15, 2010 (revised July 23, 2012). Retrieved November 30, 2012 from, http://www.camy.org/research/Youth_Exposure_to_Alcohol_Ads_on_TV_Growing_Faster_Than_Adults/_includes/TVReport01-09_Revised_7-12.pdf
34. Center on Alcohol Marketing and Youth. Youth Exposure to Alcohol Advertising in National Magazines, 2001-2008. Washington, DC: CAMY, Georgetown University; 2009.
35. Center on Alcohol Marketing and Youth. Striking a balance: protecting youth from overexposure to alcohol ads and allowing alcohol companies to reach the adult market. Washington, DC: CAMY, Georgetown University; July, 2005. Retrieved November 30, 2012, from http://www.camy.org/research/Striking_a_Balance_Protecting_Youth_From_Overexposure_to_Alcohol_Ads_and_Allowing_Alcohol_Companies_to_Reach_the_Adult_Market/_includes/striking.pdf

36. Center on Alcohol Marketing and Youth. Clicking for Kids: Alcohol Marketing and Youth on the Internet. Washington, DC: CAMY, Georgetown University; 2004, Available at: http://camy.org/research/internet0304/report-low.pdf.

37. Gordon, R. An audit of alcohol brand websites. Drug and Alcohol Review 2011;30: 638–644.

38. FDA. FDA Warning Letters issued to four makers of caffeinated alcoholic beverages [Press Release]. November, 2010. Retrieved from http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm234109.htm

39. O'Brien MC, McCoy TP, Rhodes SD, Wagoner A, Wolfson M. Caffeinated cocktails: energy drink consumption, high-risk drinking, and alcohol-related consequences among college students. Acad Emerg Med 2008;15 (5): 453–60.

40. American Medical Association. AMA warns teenage girls about dangers of drinking "alcopops". American Medical News.January 17, 2005. Retrieved December 5, 2012, from http://www.ama-assn.org/amednews/2005/01/17/hlsd0117.htm

41. Mosher, J & Johnsson, D. Flavored Alcoholic Beverages: An International Marketing Campaign that Targets Youth. J of Pub Heal Policy 2005;26, 326–342.

42. Center for Science in the Public Interest. What Teens are Adults are Saying About "Alcopops". Washington, DC: CSPI; 2001, Available at: http://www.cspinet.org/booze/alcopop_summary.PPT

43. Endal, D. Conflict over liquor sachets in Malawi. Alcohol, Drugs and Development. March 7, 2011. Retrieved December 5, 2012 from, http://www.add-resources.org/conflict-over-liquor-sachets-in-malawi.4891972-76188.html

44. White, A. Kids can get alcohol for as little as 25c online. Sunday Herald Sun.October 16, 2011. Retrieved December 5, 2012, from http://www.heraldsun.com.au/news/victoria/kids-get-booze-at-a-click/story-fn7x8me2-1226167539958

45. Uganda Youth Development Link. State of Alcohol Abuse in Uganda: Young people drinking deeper into poverty. June 2008. Retrieved December 5, 2012 from http://www.uydel.org/downloads/State%20of%20Alcohol%20Abuse%20in%20Uganda-20110706-161512.pdf

46. Stockwell TR. A review of research into the impacts of alcohol warning labels on attitudes and behaviour. British Columbia, Canada: University of Victoria, Centre for Addictions Research of BC, 2006.

47. Toomey, T.L., Erickson, D.J., Lenk, K.M., Kilian, G.R., Perry, C.L. and Wagenaar, A.C. A randomized trial to evaluate a management training program to prevent illegal alcohol sales. Addiction 2008;103: 405–413

48. Grant M. and Martinic, M. Harmful alcohol consumption, NCDs and post-2015 MDCs. ICAP: Washington, DC. 2012.

49. Stockwell, T., Auld, M. C., Zhao, J. and Martin, G. Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. Addiction 2012;107: 912–920.

50. Beer 'must be sold' at Brazil World Cup, says Fifa. January 19, 2012. BBC News. Available at http://www.bbc.co.uk/news/world-latin-america-16624823

51. Global Actions to Reduce Harmful Drinking. Initiatives Reporting. http://initiatives.global-actions.org.

52. Babor, T.F and Robaina, K. Public health, academic medicine and the alcohol industry's corporate social responsibility activities. American Journal of Public Health, 2013;103,2:206-214.
53. O'Dowd, A. BMA and other health bodies walk out of "half hearted" national alcohol plan. BMJ 2011;342.
54. World Health Organization. Declaration on Alcohol and Young People. WHO European Ministerial Conference on Young People and Alcohol, Stockholm, Sweden, 21 February 2001.
55. Moller, L. The European Alcohol Action Plan. 2012 - 2020. 8th Meeting of the Committee on. National Alcohol Policy and Action. Luxembourg 1-2 March 2011. Retrieved December 27, 2012 from http://ec.europa.eu/health/alcohol/docs/ev_20110301_co14_en.pdf
56. World Health Organization Expert Committee on problems related to alcohol consumption. WHO Technical Report Series 944. 2007
57. Bakke O, Endal D. Alcohol policies out of context: drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. Addiction. 2010;105(1): 22-28.
58. CLARION Declaration. Nordic Studies on Alcohol and Drugs 2008; 25: 316.
59. Shepherd T. Alcohol chief reprimanded for conflict of interests. The Advertiser. March 18, 2010. http://www.adelaidenow.com.au/news/south-australia/alcohol-chief-reprimanded-for-conflict-of-interests/story-e6frea83-1225842056874
60. Channel Research. Evaluation of Global Actions on Harmful Drinking: A Stitch in Time. Ohain Belgium: Channel Research. May 23, 2011.
61. Stenius K and Babor TF. The alcohol industry and public interest science. Addiction. 2010;105 (2), 191-198.
62. Jernigan, DH. Global alcohol producers, science and policy: The case of the International Center for Alcohol Policy. American Journal of Public Health, 2012.
63. Matzopoulos, R., Parry, C., Corrigall, J., Myers, J., Goldstein, S. and London, L. Global Fund collusion with liquor giant is a clear conflict of interest. Bull World Health Organ 2012;90:67–69.
64. Adams, P. J. Assessing whether to receive funding support from tobacco, alcohol, gambling and other dangerous consumption industries. Addiction 2007;102(7),1027-1033.
65. United Nations, 2011. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, A/RES/66/2.
66. Moodie, R., Stuckler, D., Monteiro,C., Sjheron, N., Thamaerangsi, T., Lincoln, P., Casswell, S. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. Lancet. Feb. 12, 2013

Acknowledgement

Leadership for the drafting of this document was delegated to Professor Thomas Babor at a meeting of the AMPHORA international alcohol policy research project in Stockholm in October, 2012. The initial draft was reviewed and amended by the individuals listed below. Professional titles and institutional affiliations are provided for identification purposes only. The views expressed in this document do not necessarily reflect the views of the institutions with which the members of the drafting committee are affiliated. The dissemination of this Statement of Concern was coordinated by the Global Alcohol Policy Alliance. For more information visit www.globalgapa.org.

Professor Thomas F Babor, PhD, MPH, Dept of Community Medicine & Health Care, University of Connecticut School of Medicine, Farmington, CT, USA
Ms Katherine Brown, MSc, Director of Policy of the Institute of Alcohol Studies, London, UK
Professor David Jernigan, PhD, Department of Health, Behaviour and Society, and Director, Center on Alcohol Marketing and Youth, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA
Dr Nazarius Mbona Tumwesigye, Makerere University, School of Public Health, Kampala, Uganda
Professor Gerard Hastings, Founder/Director of the Institute for Social Marketing and Centre for Tobacco Control Research at the University of Stirling, Scotland, UK
Dr Ronaldo Laranjeira, Director of the National Institute of Alcohol and Drug Policies, Federal University of São Paulo (UNIFESP), Escola Paulista de Medicina (EPM), São Paulo, Brazil
Isidore Obot, PhD, MPH, Professor of Psychology, University of Uyo, Nigeria
Mr Sven-Olov Carlsson, International President of World Federation Against Drugs (WFAD) and President of IOGT International, Stockholm, Sweden
Dr Evelyn Gillan, Chief Executive of Alcohol Focus Scotland, UK
Professor Wei Hao, MD, Phd, Mental Health Institute, Second Xiangya Hospital, Central South University, Changsha, Hunan, China
Mr Øystein Bakke, FORUT, Oslo, Norway
Professor Mike Daube, Faculty of Health Sciences, Curtin University and Driector of the Public Health Advocacy Institute and the McCusker Centre for Action on Alcohol and Youth, Perth, Australia
Ms Kate Robaina, MPH, Department of Community Medicine and Health Care, University of Connecticut, USA
Peter G Millar, PhD, Associate Professor, School of Psychology, Deaking University, Victoria, Australia
Professor Peter Anderson, MD, MPH, PhD, FRCP, Institute of Health and Society, Newcastle University, England and Professor, Faculty of Health, Medicine and Life Sciences, Maastricht University, Netherlands
Dr Aurelijus Veryga, President, Lithuanian National Tobacco and Alcohol Control Coalition, Kaunas, Lithuania