

Global Intergovernmental Initiatives to Minimise Alcohol Problems: Some Good Intentions, but Little Action

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While, historically, alcohol production and sale were local matters, commercialised and industrialised alcohol has supervened, globalised initially through European empires, transforming alcohol's place in everyday life. But alcohol was not included in the current international drug control system, initiated in 1912. In the current "UN system" of 35 intergovernmental agencies, alcohol has been a recurrent concern in the work only of the World Health Organization (WHO). Examples are given of the sporadic involvement in alcohol issues of other agencies, and the history of WHO's involvement between 1950 and early 2020 is briefly described. At WHO, the place of alcohol programming in its structure and which other topics it is linked with have been recurrent issues. Civil society support for alcohol initiatives has been comparatively weak, and alcohol industry counter-pressure has been strong. Alcohol issues have thus received less attention at the intergovernmental level than the harm would justify. Constraining factors have included not only lobbying by industry interests, but also the multi-sectoral nature of alcohol problems and the international cultural position of alcohol as a luxury good served at gatherings of political and media elites.

I. ALCOHOL, ANCIENT AND MODERN

Alcoholic beverages were widely prepared and used in tribal and village societies in most parts of the world from ancient times – in all parts except Australia, Oceania and North America roughly north of present-day Mexico.¹ In most parts of the world, these beverages were fermented from local fruit or grain at the level of the household or small community, with supply limited by the availability of raw materials. Preparation was often for specific festivals, and availability was often seasonal.

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¹ R Room, D Jernigan, B Carlini-Marlatt, O Gureje, K Mäkelä, M Marshall, ME Medina-Mora, M Monteiro, C Parry, J Partanen, L Riley and S Saxena, *Alcohol in Developing Societies: A Public Health Approach* (Helsinki, Finnish Foundation for Alcohol Studies and Geneva, World Health Organization 2002).

Vestiges of such home or craft production can be found in most parts of the world, but nearly everywhere commercially prepared and widely distributed alcoholic beverages have been superimposed on or have replaced traditional craft production. In the last five centuries, the advent of distilled spirits as a mundane beverage, industrialisation of production and globalisation in the wake of European empire-building combined to transform the forms of alcohol and its place in everyday life. Industrialisation, standardisation and globalisation of alcohol markets continue today, carried forward by increasingly oligopolised alcohol industries² and by trade agreements that treat alcohol as an ordinary commodity.³ Although most industrially produced alcohol is consumed in the same part of the world in which it is produced, global production and sale of alcoholic beverages is increasingly dominated by multinational oligopolies.

In the countries at the heart of the Industrial Revolution, the transformation of alcohol production and availability had happened already by the eighteenth century, resulting in a dramatic rise in alcohol consumption and corresponding increase in social and health problems.⁴ Alcoholic beverages had become important trade items, although governments often taxed imported beverages relatively heavily; such excise taxes were important elements in government finances before the twentieth century. In delayed response to the rise in consumption and problems, there were substantial popular temperance movements against spirits and eventually against all forms of alcohol; these were particularly strong in northern Europe, Britain and English-speaking settler societies.⁵ By the late nineteenth century, temperance sentiments were influencing European imperial powers, particularly focusing on the perceived iniquity of financing colonial governments by selling intoxicants to indigenous populations.

II. ALCOHOL AND INTERNATIONAL TREATIES

This was the context for a successful initiative to limit international trade in alcohol in the interests of what would now be called public health and welfare. In 1888–1889, the Brussels General Act, an agreement between European nations with African colonies, included a chapter on “restrictive measures concerning the traffic in spirituous liquor”, applying to sales to indigenous populations in most of Africa (not north of the Sahara or the southern region).⁶ This treaty, abandoned with the end of the

² DH Jernigan and TF Babor, “The Concentration of the Global Alcohol Industry and Its Penetration in the African Region” (2015) 110(4) *Addiction* 551.

³ P O’Brien, D Gleeson, R Room and C Wilkinson, “Marginalising Health Information: Implications of the Trans-Pacific Partnership Agreement for Alcohol Labelling” (2017) 41 *Melbourne University Law Review* 341. <https://law.unimelb.edu.au/_data/assets/pdf_file/0009/2494341/09-OBrien-et-al.pdf>.

⁴ See, eg, J Warner, M Her, G Gmel and J Rehm, “Can Legislation Prevent Debauchery? Mother Gin and Public Health in 18th-Century England” (2001) 91(3) *American Journal of Public Health* 375.

⁵ HG Levine, “Temperance Cultures: Alcohol as a Problem in Nordic and English-Speaking Cultures” in M Lader, G Edwards and DC Drummond (eds), *The Nature of Alcohol and Drug-Related Problems* (New York, Oxford University Press 1993) pp 16–36.

⁶ G Hayler, *Prohibition Advance in All Lands: A Study of the World-Wide Character of the Drink Question* (London, International Prohibition Confederation 1913); L Pan, “Alcohol in Colonial Africa” (Helsinki, Finnish Foundation for Alcohol Studies, vol. 22, 1975) <<http://www.diva-portal.se/smash/get/diva2:599789/FULLTEXT01.pdf>>.

colonial era, remains the only multinational treaty dealing specifically with alcohol from a public health perspective.

The present international drug control system, built around drug treaties adopted in 1961, 1971 and 1988, dates its inception from the Hague Opium Convention of 1912. It has never included alcohol (or, for that matter, tobacco) in its scope. Both would clearly qualify under the provisions of the 1971 treaty for including psychoactive substances. Thus, the official United Nations (UN) commentary on the 1971 treaty acknowledges that “alcohol appears to be covered by” its wording, but argues that the “public health and social problem” that alcohol presents is not of such a nature as to warrant it being placed under “international control”.⁷ An attempt at the 2012 World Health Organization (WHO) Expert Committee on Drug Dependence meeting to have alcohol considered for pre-review for scheduling under the treaties was quickly deferred for future consideration,⁸ which has not occurred. With the adoption in 2003 of the Framework Convention on Tobacco Control, alcohol is thus the only intoxicating substance in wide use that is not covered by an international health-orientated treaty.

However, alcohol is subject as an ordinary article of commerce to the provisions of trade treaties and to the disputes and other mechanisms by which the treaties are enforced. In general, alcohol is regarded as an ordinary article of trade under these treaties, with the result that alcohol control measures affecting public health are as likely as not to be disallowed in disputes under the treaties.⁹

III. INVOLVEMENT IN ALCOHOL ISSUES OF GLOBAL INTERGOVERNMENTAL BODIES OTHER THAN WHO

The second half of the twentieth century saw a multiplication of intergovernmental bodies with diverse concerns – to name a scattering of topics, about crime, food and agriculture, the workplace, drugs in sports, science and culture. The current list of “funds, programmes, specialized agencies and others” considered to be part of the “UN system” includes 35 agencies.¹⁰ Only one of these international organisations has fairly consistently had dealing with alcohol problems as a continuing concern: the WHO.

A number of other agencies have had more peripheral or passing interests. For instance, the International Labour Organization (ILO), a century-old specialised agency that brings together employers, labour unions and governments with a mandate “to advance social justice and promote decent work by setting international labour standards”, decided in 1994 to convene an international group of experts to draft a “code of practice on the

⁷ UN, “Commentary on the Convention on Psychotropic Substances, Vienna 21 February 1971” (New York, United Nations 1976) p 47 <https://www.unodc.org/documents/treaties/organized_crime/Drug%20Convention/Commentary_on_the_Convention_1971.pdf>.

⁸ WHO, “Expert Committee on Drug Dependence: Thirty-fifth Report.” WHO Technical Report Series 973 (Geneva, World Health Organization 2012) p 16 <https://apps.who.int/iris/bitstream/handle/10665/77747/WHO_trs_973_eng.pdf?sequence=1>.

⁹ D Gleeson and R Labonté, *Trade Agreements and Public Health* (Singapore, Palgrave Macmillan 2020) pp 76–77.

¹⁰ UN, “Funds, Programmes, Specialized Agencies and Others” (New York, United Nations n.d.) <<https://www.un.org/en/sections/about-un/funds-programmes-specialized-agencies-and-others>>.

management of alcohol- and drug-related problems at the workplace”.¹¹ A few years later, ILO published “Alcohol and Drug Problems at Work: The Shift to Prevention”,¹² based on the work of projects in several countries that had been supported by the UN International Drug Control Programme and donor countries. These two publications appear to reflect ILO’s main burst of activity in the alcohol problems area in recent decades.

For another example, the World Bank, headquartered in Washington, DC, and its associated agencies focus on poverty reduction and the improvement of living standards worldwide by providing low-interest loans and other financing. Around 2003, World Bank staff took an interest in the question of whether increased availability and use of alcoholic beverages had a positive or negative effect on economic development. They linked up with WHO staff and some relevant researchers and put together a convincing argument that increasing the alcohol supply was a net impediment to economic development. Still on the World Bank website is a four-page “Alcohol” note on alcohol problems and effective policies and interventions.¹³ Based on these discussions, the World Bank adopted a rule that it would not finance alcohol manufacturing. But since then, the rule appears to have been largely abandoned. Items referred to in the “Alcohol” note, including the “World Bank Group Note on Alcoholic Beverages” from 2000, have disappeared from the World Bank website, although they are archived on the website of a subsidiary.¹⁴ The International Finance Corporation (IFC), part of the World Bank Group, now states on its “IFC Exclusion List” a substantially weaker rule that it does not finance projects where the sponsor is substantially involved in spirits production or trade – the exclusion is stated as “production or trade in alcoholic beverages (excluding beer and wine)”, and a footnote further states that the exclusion does not apply where the “activity concerned is ancillary to a project sponsor’s primary operations”.¹⁵

A third example is the UN Office on Drugs and Crime (UNODC). Many of UNODC’s central concerns are thoroughly entangled with alcohol issues. At a national or local level, it is a commonplace, for instance, for drug education to be combined with alcohol education in school programmes, and for the treatment of alcohol and drug problems to be responsibilities of the same specialised agency, and it would not make sense for an international agency to ignore such intersections. There is some history, particularly in recent years, of collaboration between UNODC and WHO on programmes in such areas, although the primary emphasis has been on controlled

¹¹ ILO, “Management of Alcohol- and Drug-Related Issues in the Workplace” (Geneva, International Labour Office 1996) <https://www.ilo.org/global/topics/safety-and-health-at-work/normative-instruments/code-of-practice/WCMS_107799/lang-en/index.htm>.

¹² ILO, “Alcohol and Drug Problems at Work: The Shift to Prevention” (Geneva, International Labour Office 2003) <https://www.ilo.org/global/topics/safety-and-health-at-work/areasofwork/workplace-health-promotion-and-well-being/WCMS_108398/lang-en/index.htm>.

¹³ World Bank, “Alcohol (English). Public Health at a Glance; HNP notes” (Washington, DC: World Bank 2003) <<http://documents.worldbank.org/curated/en/197651468182667049/Alcohol>>.

¹⁴ World Bank Group, “World Bank Group Note on Alcohol Beverages”, 7 March 2000 <<https://www.miga.org/sites/default/files/archive/Documents/arp.pdf>>.

¹⁵ IFC, “IFC Exclusion List” (Washington, DC: International Finance Corporation 2007) <https://www.ifc.org/wps/wcm/connect/topics_ext_content/ifc_external_corporate_site/sustainability-at-ifc/company-resources/ifcexclusionlist>.

drugs rather than alcohol. A recent example is a joint statement from the UNODC–WHO Informal International Scientific Network on “Drug Use Disorders: Impact of a Public Health Rather than a Criminal Justice Approach”,¹⁶ signed also by leading staff members at UNODC and WHO. However, the statement’s main emphasis, arguing for a shift from a criminal justice to a public health approach, was primarily about controlled drugs, with alcohol mentioned only once.

There are other international agencies with a mandate to address social issues and problems where alcohol is potentially a substantial factor that seem to have had little or no involvement in alcohol issues. For instance, the International Criminal Police Organization (Interpol) facilitates worldwide police cooperation and crime control. Alcohol is involved in a substantial proportion of everyday crime in a majority of countries (eg in at least 40% of the violent incidents dealt with by the British police)¹⁷ and is thus an important element in police work. It might therefore be expected to be a topic addressed by Interpol. But while the Interpol website highlights much about the policing of illicit drug trafficking, there is very little on alcohol – the only website items on alcohol are concerned with “fake alcohol” (ie alcohol containers that are mislabelled to mimic a legitimate brand).¹⁸

Most of the global international agencies on the UN list have no substantial history of involvement in alcohol problems and issues. For agencies that do get involved, other than WHO, the involvement is sporadic, often reflecting the impulse of a particular staff member. Where there is some concern with alcohol problems, the involvement seems to have usually included a link with WHO staff. There is thus a substantial gap at the international level in attention to alcohol problems. Many of these problems are in areas other than health – welfare, family functioning, crime, poverty and equity – but the international agencies relevant to these areas do not have any continuing commitment or programme involving alcohol issues. Alcohol is left to WHO, and by implication any problems associated with it are assumed to be about health. While WHO has defined “health” broadly, even in principle it would be problematic for it to try to cover the whole spectrum of problems. And in practice, as discussed below, the situation is much worse, in the light of WHO’s budgetary constraints in general and the difficulty in raising money for alcohol programmes in particular.

IV. ALCOHOL ISSUES AT WHO

1. The 1950s

Two years after its inception in 1948, WHO became quite deeply involved in alcohol issues, due to the interest of the founding director of its mental health programme.

¹⁶ ND Volkow, V Poznyak, S Saxena, G Gerra and UNODC–WHO Informal International Scientific Network, “Drug Use Disorders: Impact of a Public Health Rather than a Criminal Justice Approach” (2017) 16(2) *World Psychiatry* 213.

¹⁷ T Budd, “Alcohol-Related Assault: Findings from the British Crime Survey”, Online Report 35/03 (London, Home Office 2003) p 2 <<http://www.dldocs.stir.ac.uk/documents/alcassault.pdf>>.

¹⁸ See, eg, Anonymous, “Alcohol Tops List of EUR 230 Million Fake Food and Drink Seizures in Global Operation” (Lyon, Interpol 2017) <<https://www.interpol.int/en/News-and-Events/News/2017/Alcohol-tops-list-of-EUR-230-million-fake-food-and-drink-seizures-in-global-operation>>; Interpol, “Unsafe Alcohol” (Lyon, Interpol n.d.) <<https://www.interpol.int/en/Crimes/Illicit-goods/Shop-safely/Unsafe-alcohol>>.

The director brought to Geneva EM Jellinek, a leader in the modern revival of alcohol research in the USA, and for five years Jellinek was at the heart of WHO's work in the area. In the USA and other countries that had had a strong temperance movement and a generational reaction against it, the most acceptable framing of alcohol issues was in terms of "alcoholism as a disease", with a focus on providing treatment for those with the misfortune to have a "predisposing X factor" that made them unable to control their drinking, and this was the framing for WHO's work in the early 1950s. Although Jellinek himself tried to push for a broader "alcohol problems" perspective, this was edited out of the WHO documents of the time.¹⁹ The WHO interest in alcohol evaporated in 1955 with a change in the leadership of the mental health programme.

2. The 1970s–1980s

The next period of substantial WHO interest started in the early 1970s, both in the Geneva headquarters office and in the European regional office in Copenhagen. The European office, influenced by the social concerns and strong social alcohol research groups in Finland, Canada and Norway, sponsored a working group on "alcohol control policy and public health", which put forward for testing the ideas that alcoholism rates in a population were related to the per-capita level of alcohol consumption and that controls on alcohol availability could affect levels of consumption.²⁰ The book arising from this study²¹ was followed by a seven-country project studying alcohol control experiences,²² and this inaugurated a tradition that continues today of independent scholarly studies under WHO auspices pulling together the alcohol epidemiology and policy impact literatures.²³

At the WHO headquarters in Geneva, Joy Moser coordinated cross-national compilations on treatment responses and on prevention.²⁴ Extra-budgetary funds from the USA supported a line of work on conceptualisation and diagnosis, finally bringing into play the broader concept of "alcohol problems" across the population at

¹⁹ R Room, "The World Health Organization and Alcohol Control" (1984) 79 *British Journal of Addiction* 85 <<http://www.robinroom.net/who-alco.pdf>>.

²⁰ Anonymous, "Alcohol Control Policy and Public Health: Report on a Working Group" (1974) 9 *Drinking and Drug Practices Surveyor* 32.

²¹ K Bruun, G Edwards, M Lumio, K Mäkelä, L Pan, RE Popham, R Room, W Schmidt, O-J Skog, P Sulkunen and E Österberg, "Alcohol Control Policies in Public Health Perspective" (Helsinki, Finnish Foundation for Alcohol Studies 1975) vol. 25 <<http://www.alkoholitutkimussaatio.fi/core/wp-content/uploads/2013/06/Alcohol-Control-Policies-In-Public-Health-Perspective.pdf>>.

²² K Mäkelä, R Room, E Single, P Sulkunen and B Walsh, with 13 others, *Alcohol, Society and the State: I. A Comparative Study of Alcohol Control* (Toronto: Addiction Research Foundation 1981).

²³ T Babor, R Caetano, S Casswell, G Edwards, N Giesbrecht, K Graham, J Grube, L Hill, H Holder, R Homel, M Livingston, E Österberg, J Rehm, R Room and I Rossow, *Alcohol: No Ordinary Commodity – Research and Public Policy* (Oxford, 2nd edn, Oxford University Press 2010).

²⁴ J Moser, "Problems and Programmes Related to Alcohol and Drug Dependence in 33 Countries". Offset Publication No. 6 (Geneva, World Health Organization 1974); J Moser, compiler, "Prevention of Alcohol Related Problems: An International Review of Preventive Measures, Policies and Programmes" (Toronto, Addiction Research Foundation 1980) <https://apps.who.int/iris/bitstream/handle/10665/39050/0888680384_eng.pdf?sequence=1>.

large that had been favoured by Jellinek,²⁵ and also financing a multi-country study of the “community response to alcohol problems”.²⁶

The capstones of this period of work, in terms of recognition within WHO prestige structures, were the first Expert Committee on Problems Related to Alcohol Consumption²⁷ and technical discussions on alcohol in 1982 at the WHO’s governing body, the World Health Assembly (WHA), followed by a WHA resolution on “Alcohol Consumption and Alcohol-Related Problems: Development of National Policies and Programs” in 1983.²⁸

By this time, with the Reagan Administration in power in the USA, a public health approach to alcohol problems was increasingly under attack from the alcohol industry; two of the first three heads of the US National Institute on Alcohol Abuse and Alcoholism later said that they were forced out by alcohol industry pressure.²⁹ At WHO, US extra-budgetary support for alcohol work had dwindled, and the main support was now coming from Nordic countries. A WHO project on the public health aspects of alcohol availability was initiated, including a study of the global alcohol market and of the market influence of multinational corporations, conducted in collaboration with the UN Conference on Trade and Development (UNCTAD). Substantial work was completed in the first year of the project,³⁰ and the study was eventually published, though not under WHO auspices.³¹ But the study had attracted press coverage and the attention of the Reagan Administration, which threatened to withhold general funding for WHO, and the WHO management shut down the project.³² While some work on alcohol at WHO’s headquarters continued for the rest

²⁵ G Edwards, MM Gross, M Keller, J Moser and R Room (eds), *Alcohol-Related Disabilities*. Offset Publication No. 32 (Geneva: World Health Organization 1977).

²⁶ I Rootman, J Moser, D Hawks, M de Roumanie and World Health Organization, “Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses” (Geneva, World Health Organization 1984) <<https://apps.who.int/iris/handle/10665/39697>>; EB Ritson, “Community Response to Alcohol-Related Problems: Review of an International Study”. Public Health Papers No. 81. (Geneva, World Health Organization 1985) <<https://apps.who.int/iris/handle/10665/39160>>.

²⁷ There had been two expert committees in Jellinek’s time, but they were technically an Alcoholism Subcommittee of the Expert Committee on Mental Health: <https://apps.who.int/iris/bitstream/handle/10665/40164/WHO_TRS_42.pdf?sequence=1> and <https://apps.who.int/iris/bitstream/handle/10665/40186/WHO_TRS_48.pdf?sequence=1>.

²⁸ WHA, “Alcohol Consumption and Alcohol-Related Problems: Development of National Policies and Programmes”. Resolution WHA 36.12, 13 May (Geneva, World Health Assembly 1983) <https://apps.who.int/iris/bitstream/handle/10665/160567/WHA36_R12_eng.pdf?sequence=1&isAllowed=y>.

²⁹ R Room, “Former NIAAA Directors Look Back: Policymakers on the Role of Research” (1984) 19 *Drinking and Drug Practices Surveyor* 38.

³⁰ R McBride and JF Mosher, “Public Health Implications of the International Alcohol Industry: Issues Raised by a World Health Organisation Project” (1985) 80(2) *British Journal of Addiction* 141.

³¹ J Cavanagh and FF Clairmonte, *Alcoholic Beverages: Dimensions of Corporate Power* (London, Croom Helm, and New York, St. Martin’s Press 1985).

³² I Vichniac, “Le commerce mondiale de l’alcool est de plus en plus dominé par les sociétés transnationales affirme un rapport des Nations Unies [The world trade in alcohol is more and more dominated by transnational corporations, says a UN report]”, *Le Monde* (15 February 1983), pp 1, 42; K Selvaggio, “WHO Bottles Up Alcohol Study” (1983) 41(11) *Multinational Monitor* 9; DH Jernigan and JF Mosher, “Research Agendas on International Trade in Alcohol” (1988) 9(4) *Journal of Public Health Policy* 503; HP Schmitz, “The Global Health Network on Alcohol Control: Successes and Limits of Evidence-Based Advocacy” (2016) 31 *Health Policy & Planning* i87.

of the decade, it was primarily on issues relating to clinical populations, such as the development of the Alcohol Use Disorders Identification Test (AUDIT)³³ and the reframing of alcohol diagnostic categories along with other mental disorder categories in the International Classification of Diseases.³⁴

3. The early 1990s

Alcohol again received increased attention at WHO's headquarters in the first part of the 1990s. Alcohol and drugs were shifted from the Mental Health division to a new Programme on Substance Abuse, with staff increased from two to six professionals.³⁵ With Alan Lopez as acting director, a cumulative database on alcohol, the Global Information System on Alcohol and Health, was started (now run for WHO by the Centre for Addiction and Mental Health in Canada).³⁶ An "International Guide for Monitoring Alcohol Consumption and Related Harm" was prepared and published as a guide to Member States on epidemiological monitoring and to improve the comparability of data "in order to improve monitoring and to facilitate research and risk assessment",³⁷ and the first in a continuing series of Global Status Reports on alcohol appeared.³⁸ Multinational research projects such as GENACIS (GENDER, Alcohol and Culture: an International Study)³⁹ and the Collaborative Study on Alcohol and Injuries⁴⁰ were initiated under the auspices both of WHO's Geneva office and the Pan American Health Organization, WHO's regional office for the Americas.

³³ TF Babor and M Grant, "From Clinical Research to Secondary Prevention: International Collaboration in the Development of the Alcohol Use Disorders Identification Test (AUDIT)" (1989) 13(4) *Alcohol Health & Research World* 371.

³⁴ WHO, *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research* (Geneva, World Health Organization 1993).

³⁵ Anonymous, "Six Horsemen Ride Out: WHO Initiates a New Programme on Substance Abuse. With Commentaries" (1991) 86 *British Journal of Addiction* 1387; R Room, "Alcohol and the World Health Organization: The Ups and Downs of Two Decades" (2005) 22(English Supplement) *Nordisk Alkohol- & Narkotikatidskrift* 146.

³⁶ WHO, Global Information System on Alcohol and Health (GISAH) <https://www.who.int/substance_abuse/activities/gisah/en>.

³⁷ WHO, "International Guide for Monitoring Alcohol Consumption and Related Harm" (Geneva, World Health Organization 2000) <https://apps.who.int/iris/bitstream/handle/10665/66529/WHO_MSD_MSB_00.4.pdf>.

³⁸ WHO, "Global Status Report on Alcohol" (Geneva, World Health Organization 1999) <https://www.who.int/substance_abuse/publications/en/GlobalAlcohol_overview.pdf>.

³⁹ IS Obot and R Room (eds), "Alcohol, Gender and Drinking Problems: Perspectives from Low and Middle Income Countries" (Geneva, World Health Organization 2005) <http://www.who.int/substance_abuse/publications/alcohol_gender_drinking_problems.pdf>; RW Wilsnack, ND Vogeltanz, SC Wilsnack and TR Harris, "Gender Differences in Alcohol Consumption and Adverse Drinking Consequences: Cross-Cultural Patterns" (2000) 95(2) *Addiction* 251.

⁴⁰ CJ Cherpitel, G Borges, N Giesbrecht, D Hungerford, M Peden, V Poznyak, R Room and T Stockwell (eds), "Alcohol and Injuries: Emergency Department Studies in an International Perspective" (Geneva, Departments of Mental Health and Substance Abuse and of Injuries and Violence Prevention, World Health Organization 2009) <http://www.who.int/entity/substance_abuse/msbalcinjuries.pdf?ua=1>; C Cherpitel, G Borges, N Giesbrecht, M Monteiro and T Stockwell (eds), "Prevention of Alcohol-Related Injuries in the Americas: From Evidence to Policy Action" (Washington, DC, Pan American Health Organization 2013) <<http://apps.who.int/iris/bitstream/10665/173355/1/Prevention%20of%20alcohol-related%202013.pdf>>.

4. Late 1990s–2004

However, WHO headquarters' work on alcohol dwindled again in the late 1990s. Focusing on tobacco and pushing through the Framework Convention on Tobacco Control, the WHO administration feared a battle with another politically powerful industry. The senior staff member responsible for both tobacco and alcohol when Gro Brundtland was Director-General, Derek Yach, admitted when he left his position in 2003, "WHO under Brundtland 'hasn't really engaged substantially in the alcohol area' for fear of compromising WHO's work in cutting tobacco use".⁴¹ The conflict between alcohol industry interests and the population-based public health approach continued. The WHO Regional Director for Europe noted, in his preface to WHO's European Alcohol Action Plan 2000–2005, that "throughout the preparation of this Plan, relations with the industry have been a particular concern, raised repeatedly" by national delegation representatives in WHO regional bodies. The industry's Amsterdam Group "delivered an extensive critique of the Plan, explaining the industry's standpoint and offering suggestions for incorporating this in the text".⁴² A 2005 commentary noted that industry pressure "is a likely factor behind the periodic crashes in WHO alcohol programming, both in Geneva and in Copenhagen. It explains the strong interest of industry representatives in being represented at the table in discussions of the WHO programme. And it undoubtedly lies behind the fact that 'population-based strategies ... disappeared as a specific strategy'⁴³ in the European Alcohol Action Plan for 2000–2005".⁴⁴

5. 2005–early 2020

WHO's work on alcohol revived in the mid-2000s; pressure initiated by Nordic countries at WHA was finally successful in passing a resolution in 2005.⁴⁵ The resolution called for a report from the secretariat on alcohol and resulted in a substantial elevation of alcohol in WHO's prestige structures: a second Expert Committee met in 2006,⁴⁶ and a "Global Strategy to Reduce the Harmful Use of Alcohol and Health" was adopted in 2010.⁴⁷ The Strategy laid out and discussed ten areas for national action: (1) leadership, awareness and commitment; (2) health services' response; (3) community action; (4) drink-driving policies and countermeasures; (5) availability of alcohol;

⁴¹ A Jones, "First the Target Was Tobacco. Then Burgers. So How Has Big Alcohol Stayed Out of the Lawyers' Sights?" *Financial Times*, 8 July 2003 <<http://www.ias.org.uk/What-we-do/Publication-archive/The-Globe/Issue-2-2003/First-the-target-was-tobacco-Then-burgers-So-how-has-Big-Alcohol-stayed-out-of-the-lawyers-sights.aspx>>.

⁴² WHO, "European Alcohol Action Plan 2000–2005" (Copenhagen, WHO Regional Office for Europe 2000) p iii <http://www.euro.who.int/_data/assets/pdf_file/0004/79402/E67946.pdf?ua=1>.

⁴³ A Gual and J Colom, "From Paris to Stockholm: Where Does the European Alcohol Action Plan Lead to?" (2001) 96 *Addiction* 1093.

⁴⁴ Room, *supra*, note 35.

⁴⁵ B Bull, "The Nordic Countries and the WHO Resolution on Alcohol at the 58th World Health Assembly, May 2005" (2005) 22(Suppl. 1) *Nordic Studies on Alcohol and Drugs* 163.

⁴⁶ WHO, "WHO Expert Committee on Problems Related to Alcohol Consumption: Second Report". WHO Technical Report Series 944 (Geneva, World Health Organization 2007) <https://www.who.int/substance_abuse/expert_committee_alcohol_trs944.pdf?ua=1>.

⁴⁷ WHO, "Global Strategy to Reduce the Harmful Use of Alcohol" (Geneva, World Health Organization 2010) <https://www.who.int/substance_abuse/activities/gsrhua/en>.

(6) marketing of alcoholic beverages; (7) pricing policies; (8) reducing the negative consequences of drinking and alcohol intoxication; (9) reducing the public health impact of illicit alcohol and informally produced alcohol; and (10) monitoring and surveillance. But the recommendations in each area tended to be fairly general, without clear targets and specific goals. How different this situation for alcohol is from that for tobacco can be seen in WHO's Global Action Plan for non-communicable diseases (NCDs) for 2013–2020.⁴⁸ The “policy options for member states” on tobacco (pp 30–31) include concrete targets keyed to provisions in the Framework Convention on Tobacco Control, while the policy options for alcohol (pp 34–35) are at a much more general level. With its limited resources for alcohol, WHO headquarters pursued international collaborative projects in a few strategic areas, including alcohol in pregnancy and alcohol's harm to others, with financial support for national projects and international coordination mostly from the Thai Health Foundation and other national funds, and from the Pan American Health Organization.

WHO's work on alcohol was to a considerable extent swept up into two overarching priority agendas from 2008 onwards. The first of these was a heightened focus on NCDs, signalled by the decision by WHA in 2008 to adopt an Action Plan on NCDs.⁴⁹ The diseases focused on initially were cancers, respiratory diseases, diabetes and cardiovascular diseases; mental disorders were added in 2018. Alcohol consumption was identified as one of four major risk factors for NCDs, and it can be argued that this increased its priority among public health goals, not only in WHO, but also through such actors as the NCD Alliance,⁵⁰ a global alliance of more than 1000 non-governmental organisations (NGOs). On the other hand, a 2018 review of global progress on reducing NCDs by an “independent high-level Commission” found that such “progress has been limited”.⁵¹ In the specific area of alcohol, there was little change in resources at WHO for its alcohol work in an era of a reduced overall budget. Apart from this, to emphasise alcohol as a risk factor for specific NCDs included in the Action Plan tended to de-emphasise alcohol's role in other disorders – injuries, infectious diseases such as tuberculosis and other NCDs such as liver cirrhosis.

The other overarching agenda has been the UN's 17 Sustainable Development Goals (SDGs),⁵² adopted by the UN General Assembly in 2015, with WHO taking on special responsibility for Goal 3, to “ensure healthy lives and promote well-being for all at all ages”. Sub-goals include 3.4, concerning NCDs, and 3.5, to “strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of

⁴⁸ WHO, “Global Action Plan for the Prevention and Control of NCDs 2013–2020” (Geneva, World Health Organization 2013) <<https://www.who.int/nmh/publications/ncd-action-plan/en>>.

⁴⁹ WHO, “2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases 2000” (Geneva, World Health Organization 2008) <<https://www.who.int/nmh/publications/9789241597418/en>>.

⁵⁰ NCD Alliance <<https://ncdalliance.org>>.

⁵¹ WHO, “Time to Deliver: Report of the WHO Independent High Level Commission on Noncommunicable Diseases” (Geneva, World Health Organization 2018) p 14 <<https://apps.who.int/iris/bitstream/handle/10665/272710/9789241514163-eng.pdf>>.

⁵² UN Sustainable Development Goals <<https://sustainabledevelopment.un.org>>.

alcohol”.⁵³ While 3.5 is the only specific mention of alcohol, an International Organisation of Good Templars (IOGT; now renamed Movendi International) report argues it is much more broadly relevant; indeed, that “alcohol is a massive obstacle to achieving 13 out of 17 SDGs”.⁵⁴ But on the other hand, in a 2019 “Global Action Plan” on goal 3, signed by 12 international organisations but coordinated and published by WHO, coverage of alcohol is sparse.⁵⁵

In the later 2010s, WHO staff put special emphasis on promoting “concrete cost-effective” measures within the Global Strategy. Thus, the “best buys” for alcohol listed in a NCD campaign for public health action⁵⁶ turned areas 7, 6 and 5 in the Global Strategy into action items: increase excise taxes; impose multimedia restrictions on alcohol advertising; and restrict availability by reducing hours of sale. The SAFER campaign, initiated in 2018, added to these actions under areas 4 and 2: enforcing drink-driving laws and providing brief interventions in the health system for hazardous drinkers.⁵⁷

At the May 2019 WHA meeting, an amendment to a motion called on WHO staff to conduct wide consultations to review progress under the Global Strategy and to chart paths forward, reporting to the WHO Executive Board in February 2020. The tiny staff responsible for alcohol at WHO’s headquarters were thus swamped with consultations from every Member State and each WHO regional office; submissions were also solicited from other parties, including NGOs and alcohol industry interests. A meeting of experts to consider and advise on the results of the consultations, convened in Geneva on 16–18 December 2019, agreed that the Global Strategy was not succeeding in terms of its goal of a global reduction in alcohol consumption; that measures more specific than spelled out in the Global Strategy should be recommended and implemented; and that the WHO staffing and resources for dealing with alcohol issues needed to be substantially increased.

In preparation for the Executive Board’s consideration of the issue, a draft resolution was put forward by Thailand and ten other countries, but progressively weakened by countries with strong alcohol industries over five days of negotiation. The final resolution, as passed by the Executive Committee, ordered the development of an Action Plan for 2022–2030 to be considered at the 2022 WHA meeting, a review of the Global Strategy in 2030, production of a technical report on cross-border alcohol advertising and marketing and that WHO’s work on alcohol should be “adequately” resourced.⁵⁸ Despite its positive points, the

⁵³ M Dünbier and K Sperkova, “Alcohol and the Sustainable Development Goals: Major Obstacle to Development” (Stockholm, IOGT International 2016) <https://iogt.org/wp-content/uploads/2015/03/Alcohol-and-SDGs_new.pdf>.

⁵⁴ *ibid*, p 52.

⁵⁵ WHO, “Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-Being for All” (Geneva, World Health Organization 2019) <<https://www.who.int/publications-detail/stronger-collaboration-better-health-global-action-plan-for-healthy-lives-and-well-being-for-all>>.

⁵⁶ WHO, “Tackling NCDs: ‘Best Buys’ and Other Recommended Interventions for the Prevention and Control of NCDs” (Geneva, World Health Organization 2017) <<https://www.who.int/ncds/management/best-buys/en>>.

⁵⁷ WHO, “SAFER: Preventing and Reducing Alcohol-Related Harms” (Geneva, World Health Organization 2018) <https://www.who.int/substance_abuse/safer/msb_safer_framework.pdf?ua=1>.

⁵⁸ WHO, “Accelerating Action to Reduce the Harmful Use of Alcohol”. WHO Executive Board, Agenda item 7.2, EB146/CONF/1 Rev1, 7 February 2020 <http://apps.who.int/gb/ebwha/pdf_files/EB146/B146_CONF1Rev1-en.pdf>.

resolution thus postpones for a decade any consideration of stronger international action beyond the Global Strategy, such as a binding agreement parallel to the Framework Convention on Tobacco Control.

V. DISCUSSION

Clearly, WHO was the only multinational agency with a continuing concern with alcohol problems and issues at the global level in the latter decades of the twentieth century, and this remains true today. Just about all attention and effort on alcohol-related problems at the level of global agencies has been either under WHO auspices or carried out in collaboration with WHO. As the Interpol example illustrates, the few exceptions tend to have focused on issues such as fake alcohol, which were fairly peripheral and were often in line with alcohol industry interests – thus, for instance, the multinational industry's International Center for Alcohol Policies sponsored a book about unrecorded alcohol, *Moonshine Markets*.⁵⁹

Recurrent issues for alcohol within WHO have been its place in the structure and the other topics with which it has been linked.⁶⁰ Most of the time, its primary place has been with mental health, a context in which it was hampered at least in the past by its low prestige in psychiatry. A linkage with drugs has often meant it was politically overshadowed by the politics of drugs, such as the US opposition in that context to harm reduction as a public health approach for many years; and a linkage with tobacco overshadowed it in another way in the 1990s. More recently, its identification as a major risk factor in NCDs and as a sub-goal in the SDGs has had ambiguous effects, on the one hand identifying alcohol as an important element in a priority area for WHO, and on the other hand tending to obscure alcohol's role in other public health areas and to subordinate it to factors where more concrete goals had been set.

A continuing problem for alcohol issues in the international sphere has been the scarcity of “civil society” interests in the area – non-state organisations with a commitment to pushing forward policies and programmes to counter alcohol problems. For many years, the main player at the international level was the International Council on Alcohol and Addictions (ICAA),⁶¹ originally an international peak organisation of the temperance movement, but reshaped in the 1950s to put a primary emphasis on societal responses to alcoholism as a disease, and around 1970 to be as much about illicit drugs as alcohol. By 1995, groups sympathetic to alcohol industry interests represented a growing influence in ICAA, and in the wake of their conflict with a continuing nucleus of Nordic-based temperance organisations, ICAA went into decline. In the new millennium, multinational organisations such as the Global Alcohol Policy Alliance,⁶² Nordic-headquartered

⁵⁹ A Haworth and R Simpson (eds), *Moonshine Markets: Issues in Unrecorded Alcohol Beverage Production and Consumption* (New York & Hove, Brunner-Routledge 2004).

⁶⁰ Room, *supra*, note 35.

⁶¹ R Room, “A Century of Societal Responses to Alcohol, Tobacco and Drugs”. Presented at the 50th International ICAA Conference on Dependencies, Stockholm, Sweden, 10–15 June 2007 <<https://www.robinroom.net/centurysocietal.pdf>>; International Council on Alcohol and Addictions <www.icaa.ch>.

⁶² Global Alcohol Policy Alliance <<https://globalgapa.org/index.php/about-us>>.

neo-temperance organisations such as FORUT (a Norwegian international aid organisation)⁶³ and the Movendi International⁶⁴ and Anglophone alcohol policy NGOs such as the Institute for Alcohol Studies in the UK⁶⁵ have come to the fore as a support constituency for WHO's programmes on alcohol issues, so that it now makes more sense to talk, as Schmitz does, of a "global health network" addressing alcohol policy issues.⁶⁶ But the globally orientated "civil society" sector in the alcohol field remains tiny in comparison, say, to the fields of tobacco or illicit drugs.

As is evident from some of the instances cited above, global alcohol industry interests have long had a strong interest in multinational efforts to combat alcohol problems. Industry interests operate a double game:⁶⁷ one in public, involving the firms' own public relations, industry peak organisations and "social aspects" organisations, particularly orientated to seeking a common dialogue with civil society organisations, professional groups and government agencies;⁶⁸ and the second, behind closed doors, with the politically powerful. For tobacco, the US settlement agreements have meant that much of that industry's activity in this second game became visible, at least in retrospect. This has not been the case for alcohol; only occasionally have incidents in the game become visible. One may suspect that the paucity of extra-budgetary funds for WHO to work on alcohol issues may reflect industry actions in the second game: persuading a government not to spend money may not be a difficult task. But there is little evidence on this in the public record.

VI. CONCLUSION

A common complaint of those interested in alcohol issues is that the issues receive less attention and resources than the magnitude of the alcohol-involved social and health damage would justify. As the most recent WHO Global Status Report discusses,⁶⁹ there are several factors that impede the kind of progress in public health action that has been made, for instance, with tobacco. One already discussed above is the role of industries benefitting from alcohol production and sale and their lobbying against public health objectives. A second is the challenge of the multi-sectoral nature of alcohol problems, which means that there are multiple government departments, institutions and professions that need to respond. The third is the cultural position of alcohol in many societies. While cigarette smoking has increasingly become a habit of the poor, drinking is often more frequent – more an everyday behaviour – among those with higher status and political influence in society. In the experience of the

⁶³ FORUT <<https://forut.no/english>>.

⁶⁴ Movendi International <<https://movendi.ngo/about-movendi/meet-us/international-office>>.

⁶⁵ Institute for Alcohol Studies <<http://www.ias.org.uk/Who-we-are.aspx>>.

⁶⁶ Schmitz, *supra*, note 32.

⁶⁷ R Room, "Advancing Industry Interests in Alcohol Policy: The Double Game" (2006) 26 *Nordisk Alkohol- & Narkotikatidskrift* 389.

⁶⁸ P Anderson, "The Beverage Alcohol Industry's Social Aspects Organizations: A Public Health Warning" (2002) 3 *The Globe* 3 <<https://globalgapa.org/wp-content/uploads/2015/05/gl200203.pdf>>.

⁶⁹ WHO, "Global Status Report on Alcohol and Health 2018" (Geneva, World Health Organization 2018) pp 128–31 <https://www.who.int/substance_abuse/publications/global_alcohol_report/gsr_2018/en>.

affluent, their drinking may not carry a high risk of harm; for many structural and interacting reasons, the “harm per litre” is much greater for the poor than for the affluent.⁷⁰ Perhaps more importantly, alcohol has become an international symbol of luxury, offered gratis, for instance, in the first-class cabins of planes and served at the parties and receptions of political and media elites. In this circumstance, acting to reduce harms from alcohol in society may go against the personal inclinations and habits of those in these elites. Thus, while the original version of the 2020 resolution for the WHO Executive Board included action to set a standard by removing alcohol from WHO functions and lunchrooms, any mention of this was removed from the version that was passed.

Whatever explanations can be offered, the record of intergovernmental action on alcohol problems as of 2020 cannot be regarded as satisfactory. Only WHO among the intergovernmental organisations has taken alcohol issues on in any kind of sustained fashion. And, despite good intentions and impressive work, the WHO response to alcohol problems in the world has been clearly inadequate, reflecting an unwillingness on the part of governments and often of the organisation’s management to supply adequate resources.

⁷⁰ L Schmidt, P Mäkelä, J Rehm and R Room, “Alcohol: Equity and Social Determinants” in E Blas and A Sivasankara Kurup (eds), *Equity, Social Determinants and Public Health Programmes* (Geneva, World Health Organization 2010) pp 11–29 <http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf>.