

Global intergovernmental initiatives to minimise alcohol problems: some good intentions, but little action¹

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Abstract

While historically, alcohol production and sale was a local matter, 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 the 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 multisectoral 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.² In most parts of the world, they were fermented from local fruit or grain at

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² Room, R., Jernigan, D., Carlini-Marlatt, B., Gureje, O., Mäkelä, K., Marshall, M., Medina-Mora, M.E., Monteiro, M., Parry, C., Partanen, J., Riley, L. and Saxena, S. (2002) *Alcohol in Developing Societies: A Public Health Approach*. Helsinki: Finnish Foundation for Alcohol Studies & Geneva: World Health Organization.

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.

Vestiges of such home or craft production can be found in most parts of the world, but nearly everywhere alcoholic beverages prepared commercially and widely distributed 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 continues today, carried forward by increasingly oligopolised alcohol industries,³ and by trade agreements which treat alcohol as an ordinary commodity.⁴ Though 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 countries at the heart of the industrial revolution, the transformation of alcohol production and availability had happened already by the 18th century, resulting in a dramatic rise in alcohol consumption and corresponding increase in social and health problems (e.g., ⁵). Alcoholic beverages had become an important trade item, although governments often taxed imported beverages relatively heavily; such excise taxes were an important element in government finances before the 20th 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.⁶ By the late 19th century, temperance sentiments were influencing European imperial powers, in particular 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 1888-89 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

³ Jernigan, D.H. & Babor, T.F. (2015). The concentration of the global alcohol industry and its penetration in the African region. *Addiction* 110(4): 551-560.

⁴ O'Brien, P., Gleeson, D., Room, R. & Wilkinson, C. (2017) Marginalising health information: Implications of the Trans-Pacific Partnership Agreement for alcohol labelling. *Melbourne University Law Review* 41:341-391. https://law.unimelb.edu.au/data/assets/pdf_file/0009/2494341/09-OBrien-et-al.pdf

⁵ Warner, J., Her, M., Gmel, G., & Rehm, J. (2001) Can legislation prevent debauchery? Mother Gin and public health in 18th-century England. *American Journal of Public Health* 91(3): 375-384.

⁶ Levine, H.G. (1993) Temperance cultures: alcohol as a problem in Nordic and English-speaking cultures. In: Lader, M., Edwards, G. & Drummond, D.C., eds., *The Nature of Alcohol and Drug-Related Problems*, pp. 16-36. New York: Oxford University Press.

most of Africa (not north of the Sahara or the southern region).⁷ This treaty, abandoned with the end of the colonial era, remains the only multinational treaty dealing specifically with alcohol in 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 UN commentary on the 1971 treaty (UN, 1976, p. 47) 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”.⁸ An attempt at the 2012 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,⁹ 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 which is not covered by an international health-oriented 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.¹⁰

III. INVOLVEMENT IN ALCOHOL ISSUES OF GLOBAL INTERGOVERNMENTAL BODIES OTHER THAN W.H.O.

The second half of the 20th 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.¹¹ Only one of these international

⁷ Hayler, G. (1913) *Prohibition Advance in All Lands: A Study of the World-Wide Character of the Drink Question*. London: International Prohibition Confederation; & Pan, L. (1975) *Alcohol in Colonial Africa*. Helsinki: Finnish Foundation for Alcohol Studies, vol. 22. <http://www.diva-portal.se/smash/get/diva2:599789/FULLTEXT01.pdf>

⁸ UN (1976) *Commentary on the Convention on Psychotropic Substances*, Vienna 21 February 1971, p. 47. New York: United Nations. https://www.unodc.org/documents/treaties/organized_crime/Drug%20Convention/Commentary_on_the_Convention_1971.pdf

⁹ WHO (2012) *Expert Committee on Drug Dependence: Thirty-fifth Report*. p. 16. WHO Technical Report Series 973. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/77747/WHO_trs_973_eng.pdf?sequence=1

¹⁰ Gleeson, D. & Labonté, R. (2020) *Trade Agreements and Public Health*, pp. 76-77. Singapore: Palgrave Macmillan.

¹¹ UN (n.d.) Funds, Programmes, Specialized Agencies and Others [web page]. New York: United Nations. <https://www.un.org/en/sections/about-un/funds-programmes-specialized-agencies-and-others/> (accessed 15 May, 2020).

organisations has fairly consistently had dealing with alcohol problems as a continuing concern: the World Health Organization.

A number of other agencies have had more peripheral or passing interests. For instance, the International Labor Organization (ILO), a century-old specialised agency which 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 management of alcohol- and drug-related problems at the workplace”.¹² A few years later, ILO published “Alcohol and drug problems at work: The shift to prevention”,¹³ based on the work of projects in several countries which 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, and linked up with WHO staff and some relevant researchers, putting together a convincing argument that increasing the alcohol supply was a net impediment to economic development. Still on the WB website is a four-page “Alcohol” note on alcohol problems and effective policies and interventions.¹⁴ 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 archived on the website of a subsidiary.¹⁵ The International Finance Corporation, 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” (IFC, 2007).¹⁶

¹² ILO (1996) *Management of alcohol-and drug-related issues in the workplace*. Geneva: International Labour Office. https://www.ilo.org/global/topics/safety-and-health-at-work/normative-instruments/code-of-practice/WCMS_107799/lang--en/index.htm

¹³ ILO (2003) *Alcohol and drug problems at work: the shift to prevention*. Geneva: International Labour Office. https://www.ilo.org/global/topics/safety-and-health-at-work/areasofwork/workplace-health-promotion-and-well-being/WCMS_108398/lang--en/index.htm

¹⁴ World Bank (2003) *Alcohol (English)*. Public Health at a Glance; HNP notes. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/197651468182667049/Alcohol>

¹⁵ World Bank Group (2000) World Bank Group Note on Alcohol Beverages, March 7, 2000. <https://www.miga.org/sites/default/files/archive/Documents/arp.pdf> (accessed 17 February, 2020).

¹⁶ IFC (2007) IFC Exclusion List. Washington, DC: International Finance Corporation. https://www.ifc.org/wps/wcm/connect/topics_ext_content/ifc_external_corporate_site/sustainability-at-ifc/company-resources/ifcexclusionlist (accessed 16 February, 2020).

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 programs, and for 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 programs in such areas, although the primary emphasis has been on controlled 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",¹⁷ signed also by leading staff members at the 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 which 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 (for instance, in at least 40% of the violent incidents dealt with by the British police),¹⁸ 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 has much about the policing of illicit drug trafficking on its website, there is very little on alcohol -- the only website items on alcohol are concerned with "fake alcohol", i.e., alcohol containers which are mislabelled to mimic a legitimate brand (e.g.,¹⁹).

Most of the global international agencies on the UN list have no substantial history of involvement in alcohol problems 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

¹⁷ Volkow, N.D., Poznyak, V., Saxena, S., Gerra, G. & UNODC-WHO Informal International Scientific Network. (2017). Drug use disorders: impact of a public health rather than a criminal justice approach. *World Psychiatry* 16(2): 213-214.

¹⁸ Budd, T. (2003) Alcohol-related Assault: Findings from the British Crime Survey, p. 2. London: Home Office, Online Report 35/03. <http://www.dldocs.stir.ac.uk/documents/alcassault.pdf> (accessed 16 February, 2020).

¹⁹ Anonymous (2017) Alcohol tops list of EUR 230 million fake food and drink seizures in global operation. Lyon: Interpol. <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> (accessed 16 February, 2020); and Interpol (n.d.) Unsafe alcohol [web page]. Lyon: Interpol. <https://www.interpol.int/en/Crimes/Illicit-goods/Shop-safely/Unsafe-alcohol> (accessed 16 May, 2020).

program involving alcohol issues. Alcohol is left to the World Health Organization, 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 programs in particular.

IV. ALCOHOL ISSUES AT THE WORLD HEALTH ORGANIZATION

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. The director brought to Geneva E.M. Jellinek, a leader in the modern revival of alcohol research in the US, and for five years Jellinek was at the heart of WHO’s work in the area. In the US and other countries which 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” which 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.²⁰ The WHO interest in alcohol evaporated in 1955, with a change in the leadership of the mental health program.

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 the levels of consumption.²¹ The book arising from this study²² was followed by a 7-country project studying alcohol control experiences,²³ and inaugurated a tradition which continues today of independent

²⁰ Room, R. (1984b) The World Health Organization and alcohol control. *British Journal of Addiction* 79:85-92. <http://www.robinroom.net/who-alco.pdf>

²¹ Anonymous (1974) Alcohol control policy and public health: report on a working group. *Drinking and Drug Practices Surveyor* 9:1, 32-39.

²² Bruun, K., Edwards, G., Lumio, M., Mäkelä, K., Pan, L., Popham, R.E., Room, R., Schmidt, W., Skog, O.-J., Sulkunen, P. & Österberg, E. (1975) *Alcohol Control Policies in Public Health Perspective*. Helsinki: Finnish Foundation for Alcohol Studies, Vol. 25.
<http://www.alkoholitutkimussaatio.fi/core/wp-content/uploads/2013/06/Alcohol-Control-Policies-In-Public-Health-Perspective.pdf>

²³ Mäkelä, K., Room, R., Single, E., Sulkunen, P. & Walsh, B., with 13 others (1981) *Alcohol, Society and the State: I. A Comparative Study of Alcohol Control*. Toronto: Addiction Research Foundation.

scholarly studies under WHO auspices pulling together the alcohol epidemiology and policy impact literatures.²⁴

At WHO headquarters in Geneva, Joy Moser coordinated cross-national compilations on treatment responses and on prevention.²⁵ Extrabudgetary funds from the US supported a line of work on conceptualisation and diagnosis, finally bringing into play the broader concept of “alcohol problems” across the population at large which had been favoured by Jellinek,²⁶ and also financed a multicountry study of the “community response to alcohol problems”.²⁷

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 Consumption,²⁸ 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 1983.²⁹

By this time, with the Reagan administration in power in the US, 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.³⁰ At WHO, US extrabudgetary support for alcohol work had dwindled, and the main support was coming from Nordic countries. A WHO project on Public Health Aspects of Alcohol Availability was initiated, including a study of the global alcohol market and of the market

²⁴ Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Österberg, E., Rehm, J., Room, R. & Rossow, I. (2010) *Alcohol: No Ordinary Commodity - Research and Public Policy*. 2nd ed. Oxford, etc.: Oxford UP.

²⁵ Moser, J. (1974). *Problems and Programmes Related to Alcohol and Drug Dependence in 33 Countries*. Offset Publication No. 6. Geneva: World Health Organization; and Moser, J., compiler (1980). *Prevention of Alcohol Related Problems: An International Review of Preventive Measures, Policies and Programmes*. Toronto: Addiction Research Foundation.
https://apps.who.int/iris/bitstream/handle/10665/39050/0888680384_eng.pdf?sequence=1

²⁶ Edwards, G., Gross, M.M., Keller, M., Moser, J. & Room, R. eds. (1977) *Alcohol-Related Disabilities*. Geneva: World Health Organization Offset Publication No. 32.
[http://whqlibdoc.who.int/offset/WHO_OFFSET_32_\(part1\).pdf](http://whqlibdoc.who.int/offset/WHO_OFFSET_32_(part1).pdf)

²⁷ Rootman, I., Moser, J., Hawks, D., de Roumanie, M. & World Health Organization. (1984). *Guidelines for investigating alcohol problems and developing appropriate responses*. Geneva: World Health Organization. <https://apps.who.int/iris/handle/10665/39697>; and Ritson, E.B. (1985) *Community response to alcohol-related problems: review of an international study*. Public Health Papers No. 81. Geneva: World Health Organization.
<https://apps.who.int/iris/handle/10665/39160>

²⁸ 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.

²⁹ WHA (1983) Alcohol consumption and alcohol-related problems: development of national policies and programmes. Geneva: World Health Assembly, resolution WHA 36.12, 13 May.
https://apps.who.int/iris/bitstream/handle/10665/160567/WHA36_R12_eng.pdf?sequence=1&isAllowed=y (accessed 15 February, 2020).

³⁰ Room, R. (1984a) Former NIAAA directors look back: policymakers on the role of research. *Drinking and Drug Practices Surveyor* 19:38-42.

influence of multinational corporations, conducted in collaboration with the United Nations Conference on Trade and Development (UNCTAD). Substantial work was completed in the first year of the project,³¹ and the study was eventually published, though not under WHO auspices.³² 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.³³ While some work on alcohol at WHO's headquarters continued for the rest of the decade, it was primarily on issues relating to clinical populations, such as the development of the AUDIT screening test³⁴ and the reframing of alcohol diagnostic categories along with other mental disorder categories in the International Classification of Diseases.³⁵

3. The early 1990s. Alcohol again received increased attention at WHO 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.³⁶ 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; https://www.who.int/substance_abuse/activities/gisah/en/). 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

³¹ McBride, R. & Mosher, J. F. (1985). Public health implications of the international alcohol industry: issues raised by a World Health Organisation project. *British Journal of Addiction* 80(2): 141-147.

³² Cavanagh, J. & Clairmonte, F.F. (1985). *Alcoholic Beverages: Dimensions of Corporate Power*. London: Croom Helm & New York: St. Martin's Press.

³³ Vichniac, I. (1983). Le commerce mondiale de l'alcool est de plus en plus domine par les societes 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), pp. 1, 42; Selvaggio, K. (1983). WHO bottles up alcohol study. *Multinational Monitor*, 41 (11), 9-16; Jernigan, D. H., & Mosher, J. F. (1988). Research agendas on international trade in alcohol. *Journal of Public Health Policy*, 9(4), 503-518; and Schmitz, H.P. (2016) The global health network on alcohol control: successes and limits of evidence-based advocacy. *Health Policy & Planning* 31:i87-i97.

³⁴ Babor, T.F. & Grant, M. (1989) From clinical research to secondary prevention: International collaboration in the development of the Alcohol Disorders Identification Test (AUDIT). *Alcohol Health & Research World* 13(4): 371-375.

³⁵ WHO (1993) *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: World Health Organization. <https://apps.who.int/iris/handle/10665/37108>

³⁶ Anonymous (1991) Six horsemen ride out: WHO initiates a new programme on substance abuse. With commentaries. *British Journal of Addiction* 86: 1387-1403; and Room, R. (2005) Alcohol and the World Health Organization: the ups and downs of two decades. *Nordisk Alkohol- & Narkotikatidskrift* 22 (English supplement):146-162. <https://journals.sagepub.com/doi/pdf/10.1177/145507250602300603>

³⁷ WHO (2000b) *International Guide for Monitoring Alcohol Consumption and Related Harm*. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/66529/WHO_MS_D_MS_B_00.4.pdf

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

(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.

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

³⁹ Obot, I.S. & Room, R., eds. (2005) *Alcohol, Gender and Drinking Problems: Perspectives from Low and Middle Income Countries*. Geneva: World Health Organization.

http://www.who.int/substance_abuse/publications/alcohol_gender_drinking_problems.pdf; and Wilsnack, R.W., Vogeltanz, N.D., Wilsnack, S.C. & Harris, T.R. (2000). Gender differences in alcohol consumption and adverse drinking consequences: cross-cultural patterns. *Addiction* 95(2):251-265.

⁴⁰ Cherpitel, C.J., Borges, G., Giesbrecht, N., Hungerford, D., Peden, M., Poznyak, V., Room, R. & Stockwell, T., eds. (2009) *Alcohol and Injuries: Emergency Department Studies in an International Perspective*. Geneva: Departments of Mental Health and Substance Abuse & of Injuries and Violence Prevention, World Health Organization.

http://www.who.int/entity/substance_abuse/msbalcinuries.pdf?ua=1; and Cherpitel, C., Borges, G., Giesbrecht, N., Monteiro, M., Stockwell, T., eds. (2013) *Prevention of Alcohol-Related Injuries in the Americas: From Evidence to Policy Action*. Washington, DC: Pan American Health Organization. <http://apps.who.int/iris/bitstream/10665/173355/1/Prevention%20of%20alcohol-related%202013.pdf>

⁴¹ Jones, A. (2003) First the target was tobacco. Then burgers. So how has Big Alcohol stayed out of the lawyers' sights? *Financial Times*, 8 July. <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 (2000a) *European Alcohol Action plan 2000-2005*, p. iii. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/_data/assets/pdf_file/0004/79402/E67946.pdf?ua=1

⁴³ Gual, A. & Colom, J. (2001) From Paris to Stockholm: where does the European Alcohol Action Plan lead to? *Addiction* 96:1093–1096.

⁴⁴ See Room, 2005 in footnote 36 supra.

5. 2005 - early 2020. WHO work on alcohol revived in the mid-2000s; pressure initiated by Nordic countries at the World Health Assembly 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; (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 noncommunicable diseases 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 PAHO.

WHO's work on alcohol was to a considerable extent swept up into two overarching priority agendas from 2008 onward. The first of these was a heightened focus on non-communicable diseases (NCDs), signalled by the decision by the World Health Assembly 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 (<https://ncdalliance.org/>), a global alliance of more than 1000 NGOs. On the other hand, a 2018 review of global progress on reducing NCDs by an "independent high-

⁴⁵ Bull, B. (2005). The Nordic countries and the WHO Resolution on Alcohol at the 58th World Health Assembly, May 2005. *Nordic Studies on Alcohol and Drugs* 22(Suppl. 1):163-166.

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

⁴⁷ WHO (2010) *Global Strategy to Reduce the Harmful Use of Alcohol*. Geneva: World Health Organization. https://www.who.int/substance_abuse/activities/gsrhua/en/ (accessed 16 May, 2020)

⁴⁸ World Health Organization (2013) *Global Action Plan for the Prevention and Control of NCDs 2013-2020*. Geneva: WHO. <https://www.who.int/nmh/publications/ncd-action-plan/en/> (accessed 17 February, 2020).

⁴⁹ WHO (2008) *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases 2000*. Geneva: World Health Organization. <https://www.who.int/nmh/publications/9789241597418/en/> (accessed 17 February, 2020)

level Commission” found that such “progress has been limited”.⁵⁰ 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 Strategic Development Goals (SDGs; <https://sustainabledevelopment.un.org/>), 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”. Subgoals 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 alcohol”.⁵¹ While 3.5 is the only specific mention of alcohol, an IOGT report argues in much more broadly relevant, indeed that “alcohol is a massive obstacle to achieving 13 out of 17 SDGs”.⁵² 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 sparse⁵³.

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 action⁵⁴ 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 (WHO, 2018b).⁵⁵

At the May 2019 World Health Assembly, an amendment to a motion called on WHO staff to conduct wide consultations to review progress under the Global Strategy and chart paths forward, reporting to the WHO Executive Board in February 2020. The tiny staff responsible for alcohol at WHO headquarters were thus swamped with consultations with every member state and each WHO

⁵⁰ WHO (2018c) *Time to Deliver: Report of the WHO Independent High Level Commission on Noncommunicable Diseases*, p. 14. Geneva: World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/272710/9789241514163-eng.pdf> (accessed 17 February, 2020)

⁵¹ Dünnebier, M. & Sperkova, K. (2016) *Alcohol and the Sustainable Development Goals: Major Obstacle to Development*. Stockholm: IOGT International. https://iogt.org/wp-content/uploads/2015/03/Alcohol-and-SDGs_new.pdf (accessed 17 February, 2020)

⁵² Ibid., p. 52.

⁵³ WHO (2019) *Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-Being for All*. Geneva: World Health Organization. <https://www.who.int/publications-detail/stronger-collaboration-better-health-global-action-plan-for-healthy-lives-and-well-being-for-all>

⁵⁴ WHO (2017) *Tackling NCDs: ‘Best buys’ and other recommended interventions for the prevention and control of NCDs*. Geneva: World Health Organization. <https://www.who.int/ncds/management/best-buys/en/> (accessed 21 February, 2020).

⁵⁵ WHO (2018b) *SAFER: Preventing and Reducing Alcohol-Related Harms*. Geneva: World Health Organization. https://www.who.int/substance_abuse/safer/msb_safer_framework.pdf?ua=1 (accessed 21 February, 2020).

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 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 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 10 other countries, but progressively weakened by countries with strong alcohol industries over 5 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 World Health Assembly, 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.⁵⁶ Despite its positive points, the 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, the World Health Organization was the only multinational agency with a continuing concern with alcohol problems issues at the global level in the latter decades of the 20th 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 on 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*.⁵⁷

Recurrent issues for alcohol within WHO have been its place in the structure and the other topics with which it has been linked (see Room 2005 in footnote 36 supra). 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 for many years to harm reduction as a public health approach; and a linkage with tobacco overshadowed it in another way in the 1990s. More recently, its identification as a major risk factor in non-communicable diseases (NCDs) and as a subgoal in the Strategic Development Goals 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.

⁵⁶ WHO (2020) Accelerating action to reduce the harmful use of alcohol. WHO Executive Board, Agenda item 7.2, EB146/CONF./1 Rev1, 7 February. http://apps.who.int/gb/ebwha/pdf_files/EB146/B146_CONF1Rev1-en.pdf (accessed 20 February, 2020)

⁵⁷ Haworth, A. & Simpson, R., eds. (2004) *Moonshine Markets: Issues in Unrecorded Alcohol Beverage Production and Consumption*. New York & Hove: Brunner-Routledge.

A continuing problem for alcohol issues in the international sphere has been the scarcity of “civil society” interests in the area – nonstate organisations with a commitment to pushing forward policies and programs to counter alcohol problems. For many years, the main player at the international level was the International Council on Alcohol and Addictions,⁵⁸ originally an international peak organisation of the temperance movement, but reshaped in the 1950s to put a primary emphasis on societal response 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 were a growing influence in ICAA, and in conflict with a continuing base of Nordic-based temperance organisations, and ICAA went into decline. In the new millenium, multinational organisations such as the Global Alcohol Policy Alliance (<https://globalgapa.org/index.php/about-us/>), Nordic-headquartered neotemperance organisations such as FORUT (a Norwegian international aid organisation; <https://forut.no/english/>) and the IOGT (now renamed Movendi International; <https://movendi.ngo/about-movendi/meet-us/international-office/>), and Anglophone alcohol policy NGOs such as the Institute for Alcohol Studies in the UK (<http://www.ias.org.uk/Who-we-are.aspx>) have come to fore as a support constituency for WHO’s programs on alcohol issues, so that it now makes more sense to talk, as Schmitz does, of a “global health network” addressing alcohol policy issues (see Schmitz 2016 in footnote 33 supra). But the globally-oriented “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 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:⁵⁹ one in public, involving firms’ own public relations, industry peak organisations, and “social aspects” organisations particularly oriented to seeking a common dialogue with civil society organisations, professional groups, and government agencies,⁶⁰ 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 extrabudgetary 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,⁶¹ there are several factors which impede

⁵⁸ Room, R. (2007) A century of societal responses to alcohol, tobacco and drugs. Presented at the 50th International ICAA Conference on Dependencies, Stockholm, Sweden, 10-15 June. <https://www.robinroom.net/centurysocietal.pdf>; and www.icaa.ch (accessed 16 May, 2020)

⁵⁹ Room, R. (2006) Advancing industry interests in alcohol policy: the double game. *Nordisk Alkohol- & Narkotikatidskrift* 26: 389-402.

⁶⁰ Anderson, P. (2002) The beverage alcohol industry’s social aspects organizations: a public health warning. *The Globe* 3:3-30. <https://globalgapa.org/wp-content/uploads/2015/05/gl200203.pdf>

⁶¹ WHO (2018a) *Global Status Report on Alcohol and Health 2018*, pp. 128-131. Geneva: World Health Organization. https://www.who.int/substance_abuse/publications/global_alcohol_report/gsr_2018/en/

the kind of progress in public health action which 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 multisectoral nature of alcohol problems, in terms of government departments, institutions and professions which 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 the society. In the experience of the 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.⁶² Perhaps more importantly, alcohol has become an international symbol of luxury, offered gratis, for instance, in the first-class cabin of planes, and served at the parties and receptions of political and media elites. In this circumstance, acting to reduce harms from alcohol in the society may go against 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 organizations 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.

⁶² Schmidt, L., Mäkelä, P., Rehm, J. & Room, R. (2010) Alcohol: equity and social determinants. In: Blas, E. & Sivasankara Kurup, A., eds., *Equity, Social Determinants and Public Health Programmes*, pp. 11-29. Geneva: World Health Organization.
http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf