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Alcohol and the World Health Organization: The ups and downs of two decades

Introduction

There is presently an upsurge in activity on alcohol issues at the World Health Organization. Energetic new staff are in place in two of WHO's regional offices – Maristela Monteiro at WHO's regional office for the Americas, the Pan American Health Organization in Washington (transferred from Geneva), and Dag Rekve at WHO-Euro in Copenhagen. An upturn in activity is planned at WHO headquarters in Geneva, too, to augment the present professional staff of Vladimir Poznyak and Isidore Obot, and funding has been allocated for an alcohol position in each of the African, Eastern Mediterranean, and Western Pacific regional offices.

The policy decision which has made the upsurge in Geneva possible is a resolution on alcohol adopted in May, 2005 by the World Health Assembly (WHA 58–26, http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_26-en.pdf), the first specifically on alcohol since 1983 (http://www.who.int/substance_abuse/en/WHA36.12.pdf). Among other actions, the resolution calls for a report to the WHA in 2007 "on evidence-based strategies and interventions to reduced alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol". Initiating work towards this report, in early June WHO's Department of Mental Health and Substance Abuse held the first in a series of consultative meetings "to discuss priority areas for the review of evidence, and to explore ways of accelerating the global response to public health problems associated with alcohol" (http://www.who.int/nmh/a5818/meeting_june05/en/index.html).

Revised from a presentation at the 31st Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, Riverside, California, 30 May – 3 June, 2005. The paper has benefited from comments by several participants in the history, though the conclusions are the author's own. The author has been at least peripherally involved in a number of the activities described. However, the paper is based on the public record. This work is supported by the Swedish Council for Working Life and Social Research (FAS).

Those with long experience with alcohol and WHO, however, will recognize that this is not the first moment when things have looked very hopeful at WHO. An earlier account of WHO and alcohol, written in 1983 (Room 1984c), chronicled a story of boom and bust which had already moved through two cycles, with peaks in the early 1950s and in 1975–1982. Since then, a third high point in Geneva occurred in the mid-1990s, and there was another aborted new start in 2001, followed by a relative lull. Meanwhile, there was a high point in activity in the WHO-Euro office in Copenhagen from 1995 to 2001, succeeded also by a relative lull.

The paper summarizes the history of alcohol at WHO in Geneva and Copenhagen over the last two decades, considers the other issues with which it has been linked at WHO and how they have affected it, and discusses the influence of some of the outside players on the WHO effort. Some tentative conclusions and lessons for the future are drawn.

What is the WHO?

WHO is an intergovernmental organization in its own right, independent of the United Nations (general accounts of the WHO are offered by Beigbeder 1997 and Burci & Vignes 2004). Its governing body is the World Health Assembly (WHA), composed of the Ministers of Health of member states. WHO is thus responsible to the governments of the member states, with the political influence slightly muted by the common interest of WHO and Ministries of Health in their particular area of competence. The WHA meets each year in May; its agenda is prepared by an Executive Board (EB), chosen by the WHA, which meets regularly twice a year. The head of the WHO staff is a Director-General, elected to a 4-year term by the WHA. Each Director-General sets their own overall direction for the organization, and makes their own choices about staffing top positions, somewhat like a head of government (this analogy was particularly apt for the Director-General in 1998–2003, Gro Harlem Brundtland, who had been a prime minister).

On the other hand, there are many sources of considerable continuity in the organization. There is a staff of international civil servants, who often spend a considerable part of their career at WHO; efforts are made to balance the staff in terms of nationality and gender. The permanent staff, however, are considerably less than half the employees: many staff are on short-term appointments, which have sometimes been renewed for years. Given WHO's topical emphasis, physicians were long the dominant profession in its staff hierarchy, although the domination has now somewhat lessened.

Other sources of continuity are the particular topical areas of disease and health with which WHO deals, the framing of which changes only slowly or not at all. However, this continuity is often disguised by WHO's frequent administrative reorganizations and a shifting jungle of acronyms for units. Staff in each of the topical areas are in contact with a dense network of professional and nongovernmental organizations, many "in official relations with" WHO, and with relevant industries and commercial groups – all of which are likely to take a deep interest in WHO's work and policies in the particular topical area. Individual experts who have worked with WHO are often appointed to continuing Expert Advisory Panels, from which Expert Committee members are drawn, or to ad-hoc committees. Research centres are named as WHO Collaborating Centres, with a periodically renegotiated program of collaborating work. In each topical area there is also a wider network of professionals and researchers connected to WHO projects or activities.

In addition to the WHO headquarters in Geneva, there are six regional offices, each with its own Regional Director and a Regional Committee with a function equivalent to the WHA, and with considerable functional independence from headquarters. (One of these, the regional office for the Americas, had a prior existence as the free-standing Pan-American Sanitary Bureau, and continues to have a double identity.) WHO also has

subregional offices and country offices, particularly in developing countries.

WHO's regular budget is funded by assessments on member states, analogous to how the UN is financed. Rich countries, notably including the US, account for much of the regular budget. In addition, much of the work of WHO is done with "extrabudgetary funds" which may come from national governments or from other sources. WHO works on a 2-year budgetary cycle, to which plans of work are often tied.

Much of WHO's work is in the form of specific projects or activities, which cover the whole wide gamut of public health research and action. Since WHO's institutional goal is action-oriented – to improve global health – research, development or training projects in which it is involved are fairly directly related to that goal. WHO has a substantial publication program, with materials increasingly available also on the web, reflecting its research, information collation and dissemination, and standard-setting roles. Among the most newsworthy of WHO's activities is its leading role in organizing the global response to infectious diseases and potential epidemics. WHO also has a variety of technical roles in the international system, including, for instance, its management of the International Classification of Diseases, which countries are treaty-bound to follow in their death recording, and a technical role in the international drug control conventions, in deciding or recommending on which drugs should be controlled and to what extent. Recently, with the entry into force of the Framework Convention on Tobacco Control, WHO used for the first time its power to initiate international public health treaties.

As a public health organization with strong medical influence, WHO is committed to its work being evidence-based. The development of the research literature relevant to public health policy and action in a topical field is thus important. In particular, in recent years WHO has spent much energy on estimating the relative size of different health problems and risk factors for health on a comparable basis (e.g., Ezzati et al. 2004), and on comparable cost-effectiveness analyses of interventions to prevent or alleviate health problems (e.g., Tan-Torres Edejer et al. 2003; Chisholm et al. 2004). Such analyses have been seen as an aid to rational priority-setting, among other things in determining WHO's program of work. However, as an intergovernmental agency, WHO's program is inevitably also influenced by political considerations.

Alcohol in the acronymic jungle: the intra-institutional history

Alcohol in Geneva in the last 20 years

For the first four decades of the World Health Organization's existence, the Mental Health department had had custody over alcohol, along with illicit drugs, with the small effort on tobacco located elsewhere. In line with this institutional location, the primary framing of alcohol issues until at least the late 1970s had been psychiatric. There was attention, for instance, to alcohol's place in psychiatric nosology, and to developing training courses in alcoholism treatment for psychiatrists and allied professions. In the mid-1970s, the U.S. National Institute on Alcohol Abuse and Alcoholism recognized that supporting the build-up of an alcohol programme at WHO would serve the interests of the field in the U.S. by underlining the disease status of alcoholism and pointing to a health rubric for responses to it. U.S. support initially for work on nosology (Edwards et al. 1977) and later for a multi-country demonstration project on community response to alcohol problems (Rootman & Moser 1984; Ritson 1985) allowed Joy Moser, the permanent staff member responsible, to build up a programme beyond what it had been before – a fraction of her position.

In the meantime, public health thinking in the world outside WHO had been changing (Room 1984a). The "purple book" (Bruun et al. 1975), produced by an international group of scholars under the auspices of WHO-Euro, put forward a more classic epidemiological model, relating population

levels of alcohol consumption to rates of alcohol-related deaths. By the time an Expert Committee on alcohol met in 1979 (WHO 1980) – so far the only expert committee specifically on alcohol since the 1950s – the problem had been reformulated in terms of a population approach to "alcohol-related problems", with the psychiatric home territory of what was now the "alcohol dependence syndrome" as just one among the array of problems.

The Nordic countries moved into the breach left by the end of the U.S. funding with support for a new and more broadly-defined programme, led by Jan Ording, a Swedish civil servant. The shift in thinking brought into consideration the supply of alcohol, and the programme included a study, in collaboration with the United Nations Conference on Trade and Development (UNCTAD), on the public health implications of alcohol production and trade. The project was a partial implementation of the call in a 1979 WHA resolution for WHO to review "existing trade practices and agreements relating to alcohol" (WHA Resolution 32–40, http://www.who.int/substance_abuse/en/WHA32.40.pdf).

But the initiative proved unsustainable. Coincidental with a review of intergovernmental agencies by the US government under Reagan with an eye to "depoliticization", WHO's Director-General discontinued the project in 1983 (Jernigan & Mosher 1988). A report by the Heritage Foundation, close to the Reagan administration, noted shortly afterward that the Director-General "has played a key role in attempting to reassure the Reagan Administration that WHO's global health programs are in line with the principles of private enterprise" (Starrels 1985).

The discontinuation of the project, however, attracted adverse press attention (Vichniac 1983; Selvaggio 1983). The book the UNCTAD researchers had been working on was eventually allowed to be published without note of its WHO connection (Cavanaugh & Clairmonte 1985). Marcus Grant, who had been director of the Alcohol Education Centre in London, was brought to Geneva, initially to put together a substitute WHO report on the project's topic (Walsh & Grant 1985).

Grant stayed on for 10 years as the main staff member for alcohol programming, but for most of this period the alcohol programme in Geneva reverted to being a relatively minor activity of the Mental Health division. Activities pursued included some work on alcohol and casualties (Giesbrecht et al. 1989), an alcohol education trial (Perry et al. 1989), and the initiation of a project on biological markers of alcohol use and dependence (Glanz et al. 2002 and papers in the same issue), and a long and continuing series of projects on detection of and brief intervention in alcohol problems in primary care settings (Saunders et al. 1993; Babor & Grant 1992, http://www.who-alcohol-phaseiv.net). Work in the Mental Health division on classification and diagnosis (discussed below) also included some work on alcohol. The activities stayed away from any more general alcohol policy concerns, and thus were not likely to attract the opposition which had greeted the Canavaugh and Clairmonte project.

In 1990, alcohol and drugs were separated from the Mental Health division into a Programme on Substance Abuse, with an increase in the professional staff to 6, a development generally welcomed by the alcohol and drug field (Anonymous 1991). The Programme was directed until 1996 by another Swede, Hans Emblad, who had previously been an international civil servant at the United Nations Fund for Drug Abuse Control (now folded into the UN's Office on Drugs and Crime). The Programme set out in 1990 with an ambitious Strategy Document, outlining a number of areas for programmatic action (Caetano 1991). In 1994, tobacco was added to the Programme's responsibilities.

The independence from Mental Health lasted only until 1996, when the two programmes were brought back together in a "Division of Mental Health and the Prevention of Substance Abuse", headed by a psy-

chiatrist. Alan Lopez, an Australian epidemiologist who came to the Programme with the Tobacco or Health initiative, served as the Substance Abuse Programme's acting director 1996–1998 after Emblad's retirement. Eventually, Mary Jansen, a psychologist-administrator seconded from the U.S. Veterans Administration, was appointed the permanent head in 1998, shortly before Brundtland took office as Director-General. Lopez moved to the new Evidence and Information for Policy cluster at WHO, turning his full energies to the efforts at estimating the Global Burden of Disease (WHO 2002). Meanwhile, Brundtland's administration took tobacco back out of Substance Abuse and elevated it to a "cabinet level" activity, as WHO embarked on the negotiation of the Framework Convention on Tobacco Control. Resolving longstanding tension between the pharmacologist responsible for WHO's functions in the drug control system and other staff of the programme, these functions were also relocated elsewhere in WHO (now in the Quality Assurance and Safety of Medicines unit of Essential Drugs and Medicines Policy).

The idea of putting a U.S. civil servant in charge of a Programme under substantial pressure from the U.S. mission (see below) was not seen as a great success, and the position was abolished in 2000, merging alcohol and drugs back into the mental health programme. Most responsibility for alcohol and programming was taken by the Management of Substance Abuse Team, a small group headed by Maristela Monteiro. Responsibility for alcohol policy was taken by Leanne Riley, who had earlier worked in the Programme on Substance Abuse but was now in the Tobacco Free Initiative.

In early 2001, the Brundtland administration moved towards giving alcohol policy a higher priority. For the first time ever, a Director-General gave a speech on alcohol policy issues, at a joint WHO-Euro and EU ministerial conference in alcohol and young people in Stockholm (http://www.eurocare.org/who/youngpeople/bruntland.html), attacking the "large alcohol manufacturers" for "dangerous marketing techniques" directed at youth which try "to establish a habit of drinking alcohol at a very young age". The speech announced that WHO would set up an Alcohol Policy Strategic Advisory Committee "to address this serious public health problem". In a press release the following September, Cees Goos, responsible for the alcohol programme in WHO-Euro, noted that the Committee now had been set up, and stated that "as we work to protect the health of our young people and reduce the harm caused by alcohol, we look to this advisory group to set in motion an urgent review of transboundary broadcast and internet standards which threaten to undermine national control efforts" (http://www.euro.int/media-centr/pr/2001/20011206_1).

Such statements clearly got the focused attention of the alcohol industry, which immediately started efforts to meet with WHO to get information on and try to influence WHO's plans. The International Center for Alcohol Policies (ICAP), an industry-funded organization discussed below, suggested that WHO "consider inviting [ICAP] to interact with members of their alcohol policy scientific advisory committee, … and to be invited to participate in discussions on relevant topics … so that [ICAP] could contribute in a positive and collegiate way…" (Anderson 2002). The issue of how relations with the alcohol industry were to be managed became a primary task assigned to the Advisory Committee by WHO staff in the three meetings it held in the course of the next three years.

However, by 2002 the Brundtland administration had backed off from any priority for alcohol policy. A primary reason was the fear that a battle with another politically powerful industry would weaken WHO's fight for the Framework Convention on Tobacco Control and on the Global Strategy on Diet. As Derek Yach, the senior staff member responsible for both tobacco and alcohol under Brundtland, left his position in 2003, he admitted to a *Financial Times* reporter that the "WHO under Brundtland 'hasn't really

engaged substantially in the alcohol area' for fear of compromising WHO's work in cutting tobacco use" (Jones 2003).

Meanwhile, in 2003 a new effort to raise the profile of alcohol policy work at WHO got under way, this time from the external political level. Sweden, Norway and Iceland started pushing for a new resolution on alcohol at the WHA, the first since 2003. The result in 2004 fell short of this: some language about alcohol was included in a resolution on health promotion and healthy lifestyles (WHA 57/16, http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R16-en.pdf), including a call for a report in 2005 on "the Organization's future work on alcohol consumption". In October, 2004, the Nordic ministers of health decided on a renewed push for an alcohol resolution in 2005. With Iceland in the chair at the EB, a resolution was passed in January, and, as noted above, a slightly revised version of it was duly passed, after extended discussions, at the WHA in May. As also noted above, this has set the stage for a new burst of activity, building on the present base of two professional staff in Geneva – Vladimir Poznyak and Isidore Obot.

Alcohol at WHO-Euro

There has been a limited amount of activity over the years in the regional office for the Americas in Washington (e.g., Kaplan 1982) and the Western Pacific regional office in Manila (e.g., Marshall 1990). But the regional office which has had the strongest program of activity over the years is the European office, located in Copenhagen. The effort began with the "purple book" of 1975 (Bruun 1975), with Anthony May as the responsible WHO staff member. This project established the style which was successfully followed for a quarter-century in the alcohol activities at WHO-Euro: an agreement concerning a project was made with the coordinator of an international collaborative group of scholars, under which it was agreed that the project was a WHO-Euro activity, but that the groups of scholars would retain control over the content of the project's publications. The initial agreement involved the Finnish Foundation for Alcohol Studies and the Addiction Research Foundation of Ontario, as well, eventually, as scholars from several other countries. The "purple book" was succeeded by the International Study of Alcohol Control Experiences (ISACE), in a period when Jens Hannibal was the responsible WHO staff member. As a social history of the development of alcohol consumption and alcohol controls in the postwar period (Mäkelä et al. 1981; Single et al. 1981), ISACE was less directed to immediate alcohol policy questions than the 1975 volume, as was also true of a later international collaborative study of Alcoholic Anonymous (Mäkelä et al. 1996) under WHO-Euro auspices.

The next volume in the spirit of the 1975 book, *Alcohol Policy and the Public Good* (Edwards et al. 1994), appeared nearly two decades later. It was followed in 2003 by *Alcohol – No Ordinary Commodity* (Babor et al. 2003), also a review of the epidemiology on alcohol-related problems and of the evaluation literature on alcohol prevention strategies. However, by 2003 the alcohol programme at WHO-Euro was at a low ebb. WHO-Euro, in fact, declined to allow the WHO logo to appear on the book, requiring that Geneva step in to authorize the copublication.

In 1985, Cees Goos joined the WHO-Euro staff, working on alcohol and drugs and eventually becoming the Program Manager for "substance abuse". In 1992 an ambitious European Alcohol Action Plan was initiated, with some contribution from Ron Draper and a major contribution from Peter Anderson, who also organized a broad range of preparations for a 1995 European conference in Paris on Health, Society and Alcohol (Anderson 1997). Goos was responsible also for the joint WHO-EU Ministerial Conference on Young People and Alcohol in Stockholm in 2001, mentioned above. In the wake of the Stockholm Conference, two resolutions were passed by the European Commission, one on youth and alcohol, and the other providing

for the development of a European alcohol strategy (http://www.eu2001.se/eu2001/news/news_read.asp?iInformationID=15687).

Unfortunately, the active WHO-Euro program of the 1990s was allowed to dwindle in the wake of Goos' retirement in 2001. An administrative decision was apparently taken to de-emphasize alcohol, even to the extent that much of the material on alcohol disappeared from the WHO-Euro webpage. In late 2004, the administrative signals changed, and Dag Rekve was hired to revivify the program, in preparation for taking the renewal of the European Alcohol Action Plan to the Regional Committee, WHO-Euro's governing body, in September 2005.

Sibling issues in Geneva

Alcohol at WHO has always been linked organizationally with one or more related topics. Both in terms of the logic of the linkage, and in terms of the politics and professions involved, each of the topics has had a major influence on the WHO alcohol programme.

■ Mental Health

The spate of activities concerning alcohol in WHO's early days were under the auspices of WHO's mental health office (Room 1984c). The primary frame in the 1950s, and indeed until the late 1970s, was "alcoholism", defined as a mental disease; advisers on alcohol were primarily psychiatrists until the mid-1970s, and activities in the early 1970s were primarily directed at training in a psychiatric frame. However, alcoholism had relatively low prestige within psychiatry everywhere, so that WHO's activities on alcohol were never seen as a leading and prestigious part of its work in mental health. Thus the WHO staff with primary responsibility for alcohol programming, until very recently, have rarely been psychiatrists.

However, there was a spirit of entrepreneurship in the Mental Health Division under Norman Sartorius' leadership (from 1977 to 1999), with an openness to expanding international research activities with extrabudgetary funds. One activity which seemed to fit easily within an alcoholism frame was the clarification of diagnosis and classification in an international perspective, and this was the first substantial activity in the mid-1970s, supported by the U.S. National Institute on Alcohol Abuse and Alcoholism (Edwards et al. 1977). In the course of that activity, however, it became clear that health problems associated with drinking were not limited to those which comfortably fit within an alcoholism frame. By the late 1970s, the alcohol programming involved aspects which reached outside the usual constraints of a program dealing with a mental disorder.

Work did continue, however, on aspects of alcohol within the mental disorder frame, particularly under a long-running Cooperative Agreement initiated at the end of the 1970s with funding from the U.S. Alcohol, Drug and Mental Health Administration (and later from three components of the U.S. National Institutes of Health – NIMH, NIDA, NIAAA) to develop and test classifications and instruments for mental disorders. One-quarter of the US funding for this series of projects was for alcohol work, and the upshot of this was that alcohol and drugs were solidly entrenched and fully covered in the main vehicles by which WHO joined the shift towards symptom- and criterion-based psychiatric nosology – the various publications on the mental health chapter in the International Classification of Diseases, 9th and 10 revisions (ICD-9 and ICD-10), the Composite International Diagnostic Instrument (CIDI, http://www3.who.int/cidi/), and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (see Janca et al. 1994; Room 1997a). Alcohol diagnoses were thus included in the World Mental Health Survey (http://www.hcp.med.harvard.edu/wmh/). The Cooperative Agreement supported some specific work on classification and measurement of alcohol and drug disorders (e.g., Room et al. 1996; Schmidt & Room 1999; Üstün et al. 1997), and ensured that alcohol also received attention, where it would not have otherwise, in the development of the

International Classification of Functioning, Disability and Health (ICF; Üstün et al. 2001, http://www3.who.int/icf/). This work stayed with the mental health programme after the formation of the Programme on Substance Abuse, and was conducted separately from WHO's other alcohol and drug work. Except for occasional attention to comorbidity (e.g., WHO 2004c), in recent years activities within a psychiatric frame have been a relatively minor part of WHO's alcohol programming.

The distance between the main public health concerns in the alcohol field and in general mental health, and perhaps the relatively low prestige of alcohol disorders within psychiatry, meant that the part of the core budget of the WHO headquarters mental health division devoted to alcohol was always tiny before 1990, and has been small also since the reunion with mental health. Mental health has served as a kind of shelter when the winds of adversity have been chilliest for alcohol policy programming. But other than this, subordinating alcohol to mental health has been somewhat problematic as a base for a public health approach to alcohol issues.

Illicit Drugs

Under the 1961 and 1971 international drug conventions, WHO has the responsibility for providing medical and scientific advice on whether drugs should be included within the international control regimes, and in which schedule (i.e., with what degree of control). A series of WHO Expert Committees, usually with psychopharmacology as the main expertise, have been the main source of this advice, which technically comes from WHO's Director-General. The Expert Committees met annually for many years, but every two years after 1990. For a time in the 1990s, with the intention of using the Expert Committee also for broader public health agendas concerning drugs, every second Expert Committee (e.g., those of 1992 and 1996) included a broader range of expertise. Particularly during the 1990s, with Emblad's transfer from Vienna and the increase in funds available from what became the United Nations Drug Control Programme, the Programme on Substance Abuse was able to expand its work on public health approaches to drug problems, particularly in developing countries.

However, as a public health agency, WHO was bound to take a public health approach to drug problems, and public health has a proud and long-established tradition in such matters as sexuality and health of what in the drug field is termed a "harm reduction" approach. Given the opposition particularly of the U.S. to anything that smacked of harm reduction in this field (Room 1999; TNI 2005), the work in the drug area was bound to attract controversy sooner or later. Even the Expert Committee reports occasionally run up against determined opposition. An appendix to the 28th Expert Committee report (1993) dealing with the human rights of drug users was removed by the WHO Executive Board on technical grounds (Room 1997b), and more recently the Director-General, under pressure from the UN Office of Drugs and Crime, declined to transmit to Vienna the 33rd Expert Committee's recommendation for the reclassification of delta-9-tetrahydrocannabinol, the main psychoactive constituent of cannabis, to the lowest schedule of the 1971 Convention (WHO Expert Committee on Drug Dependence 2003).

The projects undertaken with extrabudgetary resources in the 1990s proved even more controversial. A large international project to collect information on cocaine use, initiated in 1991, was left unpublished after Emblad sent a briefing kit in 1995 on its results to the UN drug control agency, "where it caused a sensation". The U.S. representative expressed the dissatisfaction of the U.S. with the study's results and threatened to suspend payment of the U.S. dues to WHO if "activities related to drugs failed to reinforce proven drug control approaches" (TNI 2003). In 1998, WHO attracted unfavourable press attention from the other side of the ideological battle over drugs when the *New Scientist* charged that it had suppressed a commissioned report comparing the health effects

of cannabis with those of alcohol, tobacco and opiates (Concar 1998; the report was published as Hall et al. 1999). Meanwhile, WHO was pressed into conducting an evaluation of the Swiss heroin trials which failed to satisfy either side in the drug policy wars. At the end of the 1990s, projects on reducing the risk of HIV infection among drug users moved from WHO to a less vulnerable home in the UNAIDS agency, a separate UN agency for which WHO provides an administrative framework (Burci & Vignes 2004, 84–88). In the last five years, the main WHO-Geneva product on drugs has been a volume on the *Neuroscience of Psychoactive Substance Use and Dependence* (WHO 2004c), a volume which has so far escaped controversy. Currently, WHO can be described as taking a low profile on illicit drug issues.

There are some obvious commonalities between alcohol and drugs. But the institutional linkage with drugs has probably impeded WHO's work on alcohol. The vigorous U.S. objections in the drug field may well have played a role in the decision to bury psychoactive substance issues back in the mental health division.

Tobacco

The institutional histories of tobacco and alcohol within WHO-Geneva were largely separate until the Tobacco or Health programme was added to the responsibilities of the Programme on Substance Abuse in 1994.

Thanks to the documents available due to the U.S. tobacco industry lawsuits, we can draw on a consultant's report on the WHO and tobacco transmitted to British-American Tobacco in 1991 (CASIN 1991). At that point the Tobacco or Health (TOH) programme was still small and isolated within the WHO structure, "quite far removed from the Director-General's office", as the consultant report notes. "The programme's budget from regular sources is miniscule … hardly enough to pay for two secretaries". Short-term extrabudgetary funds received that year had allowed expansion of its staff from 1 to 4. "In terms of budget, resources, personnel, and access to the decision-making levels of WHO", the CASIN report notes,

> the TOH programme comes fairly low on the list of WHO's programmes and priorities.
>
> It would appear that WHO is unwilling to boost the programme significantly, either in terms of budget or status within the Organization for fear of offending its biggest budgetary contributor, the USA, whose pro-tobacco lobby is still powerful in Congress, a body that loses no opportunity to threaten the UN system with cuts in funding.
>
> Several other big contributing member states such as Japan, Germany and the UK derive large sums of money from the sale of tobacco products, and whereas they may be willing to place certain restrictions on advertising, they would not be ready to accept large-scale attacks on the tobacco industry. (CASIN 1991)

By the time the tobacco programme was transferred into the Programme on Substance Abuse in 1994, its staff had been strengthened with substantial expertise in epidemiology and policy work. Alan Lopez, in particular, brought to bear on alcohol, from his previous work in tobacco, a strong strategic sense of what would be important in terms of assembling and analyzing data to provide an underpinning for policy arguments and action. A crucial step, in his view, was assembling a global database on alcohol consumption, problems, and policies. The first fruit of this effort was the *Global Status Report on Alcohol*, with a first edition in 1999 (WHO 1999). With support from the International Order of Good Templars and later from the government of Switzerland, David Jernigan and then Nina Rehn put out a number of subsequent reports (Jernigan 2001; WHO 2004a; 2004b). The database provided an essential underpinning for estimating alcohol's role in the Global Burden of Disease (see below). Responsibility for the effort has now been picked up by the Centre for Addiction and Mental Health in Toronto. Under Lopez, the Programme also produced a guide to epidemiological data collection (WHO 2000) and

commissioned a book on *Alcohol Policy in Developing Societies* (Room et al. 2002), which applied to the context of developing societies the WHO-Euro model of a review of epidemiology and policy research by an independent collaborative research group.

As noted above, the link between alcohol and tobacco work was broken again in 1998, with the new Director-General's decision to make the tobacco programme a central priority of WHO's work, and a concurrent decision to downgrade the remainder of the Programme on Substance Abuse. However, the last of the work initiated in that period has only recently been published (WHO, 2004a; 2004b), and in his subsequent role Lopez provided a crucial link to ensure that alcohol was taken seriously in the Comparative Risk Analysis for the Global Burden of Disease effort (Rehm et al., 2004).

We have already noted the downside of the parallels between tobacco and alcohol: during Brundtland's tenure the WHO management was unwilling to pursue a vigorous alcohol programme for fear that it would detract from the tobacco effort. The unwillingness of WHO to draw any policy parallels between tobacco and alcohol continues today, with the Director-General noting at the January 2005 EB, in response to a request for an assurance from the US delegate, that the situation for alcohol differed from that regarding the tobacco industry, and that it was premature to discuss a framework convention on alcohol (www.who.int/gb/ebwha/pdf_files/EB115-REC2/e/7.pdf, p. 121).

Outside players

The alcohol industry

No record concerning the political and policy involvement of the alcohol industry is available equivalent to what is available for tobacco because of the U.S. tobacco litigation. Thus what is available is sketchy and anecdotal – rather like occasional sightings of a rare woodpecker in dense forest. It is clear that the alcohol industry watches over WHO's activities with care and concern, and industry actors at national levels probably play a role in keeping down the supply of extrabudgetary funds for WHO alcohol programming.

There has been considerable effort by industry firms or "social aspects" organizations funded by the industry (Anderson 2002) to engage in dialogue with WHO, and to influence WHO's alcohol programme. The response from the WHO side has been cautious, with an effort to establish ground rules for interactions. The effort by the US Executive Board delegate in January 2005 to get an assurance of WHO's willingness to engage the industry in a serious way on a partnership basis (Room, in press) can be seen as a signal of the industry's dissatisfaction on this. So can two sections in the proposed alcohol resolution as it was presented to the Executive Board. One of these, dropped after the delegate from Tonga had noted that it sounded like a complaint from the alcohol industry, asked for "transparency, impartiality and balanced regional and gender representation" in selecting experts, specifically mentioning the Alcohol Policy Strategy Advisory Committee. The other section, a compromise between the US who felt it was too weak, and countries like Tonga who felt that, as for tobacco, the alcohol industry should have no place at the discussion table, called for organizing "open consultations with representatives of industry and agriculture and distributors of alcoholic beverages in order to limit the impact of harmful alcohol consumption".

The dropped paragraph, with its specific mention of the Strategy Advisory Committee, is evidence of the extent and persistence of alcohol industry concerns about securing a place at public health policy discussions. Still on the website of the Amsterdam Group, the industry's social aspects organization oriented to the EU, is a slightly out-of-date reference to the Strategy Advisory Committee, stating that "the final shape of WHO's alcohol programme will be dependant [sic] on the recommendations of this Committee" (http://www.amsterdamgroup.org/main.html –> Key Areas: Alcohol and health –> WHO).

One element in the background of the armwrestling on this issue is undoubtedly the industry's desire to influence WHO's programme in directions which do not conflict with its interests. At the national level in a number of countries, industry organizations have been very successful in such efforts, whether by persuasion (e.g., Room 2004), by threat or action (Room 1984c), or by some combination (Abrahamson 1998). Another element is probably the desire of the alcohol industry to avoid the tobacco industry's pariah status in the public health field. Burci and Vignes (2004,104) note that WHO will not, as a "consistent if unwritten policy", entertain relations "with the tobacco or arms industries", considering that their activities are "incompatible" with those of WHO.

ICAP

A special case of an alcohol industry player is the International Center for Alcohol Policies, set up in 1995 by 11 multinational alcohol producers. ICAP is the main example at the global international level of an industry "social aspects" organization; many other examples can be found at national levels (Anderson 2002), as well as such organizations as the EU-oriented Amsterdam Group. ICAP's founding and continuing director, Marcus Grant, went straight to ICAP from his job at the Programme on Substance Abuse, where he had worked on alcohol issues for 10 years. Grant took with him the extensive list of contacts in the field from his WHO service, and in the lists of authors of chapters in the various books ICAP has sponsored can be found many who have also worked with WHO. Names of various retired WHO staff – for instance, Norman Sartorius, Hans Emblad, Ilona Kickbusch and John Orley – show up as participants in ICAP activities (e.g., http://www.icap.org/download/all_pdfs/Other_Publications/dp_english.pdf).

Apart from making generous use of the contacts developed at WHO, ICAP tends to present itself as an alternative to WHO as an international public health agency in the field. A brochure produced on ICAP's 5th anniversary quotes Grant as stating "I believe that I have contributed more to public health in my five years at ICAP than in double that time at WHO" (ICAP 2000a). An even more direct effort to dress in WHO's clothes is ICAP's "global charter", entitled "The Geneva Partnership on Alcohol" (ICAP 2000b).

It is hard to imagine attitudes and activities which would be more alienating to the current staff of any intergovernmental organization in similar circumstances. The international alcohol industry seems to have learned this lesson finally, conducting contacts with WHO through other channels. However, in the absence of a wide-ranging alcohol programme at WHO, there is no question that ICAP is more of a presence than WHO in discussions about alcohol policy in a number of developing countries, and its presentation of itself as an agency for public health may often be influential there.

The United States

The US has played an important role in WHO's alcohol programme for the last 30 years. As noted, funding from the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) first established the alcohol programme as more than a fraction of the activities of one staff member. While funding for projects limited to alcohol ran out by the early 1980s, the long-running Cooperative Agreement with partial financing from NIAAA, as we have noted, continued to provide some finances, though with little connection to the WHO alcohol programme after 1990.

The other side of the US impact, also noted above, became apparent in 1983: as a source of pressure on WHO on behalf of alcohol industry interests. In recent years, the US has again taken on this role, in an apparent parallel to the activity on behalf of tobacco interests noted above for the early 1990s (CASIN 1991). The activity for alcohol can be glimpsed in the discussion in the January 2005 EB (Room, in press).

The Nordic countries

As noted above, the Nordic countries, and particularly Sweden and Norway, have made recurrent appearances in the history of the WHO Geneva alcohol programme. Nordic funding picked up from the US funding in the early 1980s, turning the program of work in a policy direction which proved unsustainable. Norwegian funding supported the first phase of the long-running projects on assessment and brief interventions in alcohol problems – the phase from which the well-known AUDIT instrument (Saunders et al. 1993) derives. During his time as head of the Programme on Substance Abuse, Emblad was able to secure some Nordic-related money, but primarily for drug programming. After 1995, however, the primary attention of Nordic countries turned to WHO's Regional Office for Europe.

As noted above, a new Nordic push for an expanded programme on alcohol began to gather steam in 2004. The meeting of the Nordic health ministers in October 2004 (Nordic Council 2004) specifically committed the Nordic states to "ensuring that alcohol is taken up as an independent resolution by WHA in May 2005", among other actions with respect to WHO both in Geneva and at the European office.

The research world

WHO programmes deal with multiple constituencies, among them politicians, civil servants, doctors and other professionals, and nongovernmental organizations (NGOs). As a public health institution, WHO has had a long-term commitment to its programmes being evidence-based. This means that researchers play an especially important role in the planning and often the implementation of WHO programmes. Frequently, a good deal of the programme is in fact composed of collaborative international research projects. A current example is WHO's substantial part in the GENACIS project, an international comparative survey project on gender, culture and alcohol (Wilsnack & Wilsnack 2002, http://www.who.int/substance_abuse/activities/genacis/en/; http://www.med.und.nodak.edu/depts/irgga/GENACISProject.html). Funding from WHO, both Geneva and PAHO (supported by the Spanish province of Valencia), has made possible the participation in the project of 10 developing countries.

In a field like alcohol, where commercial and often national interests are at stake, the most politically comfortable framing of the tasks of a public health agency is to arrange the provision of treatment for the "tiny fraction" of the population who are "alcoholics", and to mandate schools to provide alcohol education. Some symbolic activities around reducing drinking-driving and perhaps telling pregnant women not to drink are also usually acceptable.

But a passive approach such as this is not in the general traditions of public health. And, as time has gone on, it has become clearer that it is not consonant with evidence-based practice, if the aim of the practice is to reduce rates of alcohol-related harm in the population as a whole. Even in the earliest days of alcohol programming at WHO, there is evidence of some strain between the politically comfortable framing and a scholar's alternative framing: Jellinek's effort to broaden the focus from "alcoholism" to "problems of alcohol" was not accepted (Room 1984c).

By the 1970s, the comfortable approach was losing its support among researchers with a public health orientation (Room 1984a). The "purple book" (Bruun et al. 1975) was both a signal and a carrier of this shift. In the U.S., after reading the book and taking on board its perspective, an NIAAA director found himself pushed out of office, as he tells it by the alcohol industry (Room 1984b). In the UK, an official report drawing on much the same literature was suppressed by an incoming government, and only found publication in Sweden, beyond the reach of the UK Official Secrets Act (Bruun 1982). Similar demonstrations of the discomfort caused by the "new public health" approach to alcohol can be found in other countries. The closing down of the Clairmonte and Cavanaugh project in 1983 can be seen as

WHO's version of the initial shocks which the new model met in place after place.

The drama has usually been more muted in later years, as powerful actors opposed to the "new public health" approach – in particular, alcohol industry interests – have moved further back into the forest. But the conflict between industry interests and the new public health approach continues. It 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 interests 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" in the European Alcohol Action Plan for 2000–2005 (Gual & Colom 2001).

While the publications of the industry's social aspects groups (e.g. Portman Group 2002) increasingly accept some parts of the public health approach, they dismiss, scorn or ignore the unacceptable parts: that changes in the level of alcohol consumption can affect rates of alcohol problems; that taxes and other limitations of supply can reduce problem rates; that the supply of alcohol is therefore a legitimate public health concern.

The research findings are not always in the same direction on these points of contention for industry interests. But the research underpinning for a higher public health priority for alcohol issues has become stronger in recent years. Some of this research comes, in fact, from WHO, though not from the alcohol programme. In the Comparative Risk Analysis carried out as part of the estimation of the Global Burden of Disease in 2000 (WHO 2002; Rehm et al. 2004), alcohol somewhat unexpectedly came out ranking fifth among risk factors globally, third in developed countries, and first in the fastest advancing parts of the developing world. Meanwhile, the WHO CHOICE study on the cost-effectiveness of strategies to reduce alcohol problems (Chisholm et al. 2004) underlined that cost-effective, though often politically difficult, prevention strategies are available. In an institution committed to setting priorities on the basis of evidence, such findings are a powerful argument for an increased attention to alcohol issues.

Research and researchers relevant to WHO's institutional roles, then, have often had a role of pushing towards the politically uncomfortable, in an era when commerce and trade have been politically dominant. It is not only for alcohol that this has been the case. To a greater or lesser extent, WHO has also found itself wrestling with a number of other industries on behalf of public health in recent decades – for instance, makers of baby formula, processors of sugar, pharmaceutical companies, and of course the tobacco industry. Understandably, the response of senior WHO staff has been to try to pick their battles, taking on only so many industries at a time. Thus, as noted above, it was acknowledged that the alcohol issue was subordinated to the interests of the tobacco issue during Brundtland's term. But the findings of the Comparative Risk Analysis may well be pushing alcohol up the priority list in the triage of battles to be taken on.

Conclusion

This paper is far from exhaustive about WHO activities in the alcohol field in the last two decades. Besides projects such as GENACIS which we have mentioned, work is ongoing, for instance, on other large collaborative projects – for instance, studies of alcohol's role in accident and emergency departments (e.g., Borges et al. 2004); and Phase IV of the early identification and brief intervention project (http://www.who-alcohol-phaseiv.net). With tiny regular budgetary resources, and with limited extrabudgetary ones, much has been accomplished. WHO's ability to draw on substantial goodwill and interest in international collaboration in the research community allows its staff to amplify the effect of the programme's work far beyond the apparent resources.

At the moment, WHO's alcohol programming stands at a cross-roads. Unusually, the cycles are synchronized: an upswing seems

under way in each of three offices – Geneva, Copenhagen and Washington. The evidence base assembled in recent years, much of it in work under WHO auspices, justifies a substantial increase in WHO's effort to assist member states in working towards effective strategies to reduce rates of alcohol problems. However, the evidence base often points in directions which are anathema to alcohol industry interests. On the other hand, directing the programme in directions which industry interests favour is a recipe for ineffectiveness.

A further element in the situation is the growing urgency of action at the international level as well as within member states. Globalization, common markets and trade agreements are all chipping away at possibilities to manage alcohol markets at the national or subnational level. The adverse impact of trade agreements on effective prevention measures to reduce alcohol problems (Grieshaber-Otto et al. 2000) adds a strong argument for action at the international level, in some form like an international framework convention on alcohol control. There is a role to be filled in promoting public health interests concerning alcohol in international trade and commerce, and WHO is the logical intergovernmental agency to take this on.

In this circumstance, understandably, the efforts of the alcohol industry and related interests to counteract effective programming seem to have increased. If the upswing in activity in the WHO alcohol programme is to be maintained, conflict over it may well increase. To build support for an effective programme may thus require efforts which reach beyond the research community. The question of building and marshalling public support for effective public health strategies to reduce alcohol problems, an important question in many countries, is also one for the international level.

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