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The World Health Organization and Alcohol Control

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While other psychoactive drugs have been a focus for attention and action in a variety of intergovernmental agencies, alcohol has been a continuing concern of only one global intergovernmental agency, the World Health organization. The present paper is an interpretation rather than an exact history of WHO's concern with alcohol. While the author has been at times an adviser to WHO's alcohol programme, this account is a personal and unofficial impression; a fuller account would undoubtedly benefit from reactions from many of the participants in the programme. Since it is based on the public record, the present interpretation gives more attention to published materials than to the unpublished meetings, training courses, and other activities which form much of the day-to-day substance of WHO's activities.

Alcohol and International Organizations, 1889-1955

At the level of international governmental organizations and agreements, a concern with alcohol can be traced back almost as far as the inception a century ago of what has become the British Journal of Addiction -- specifically to the Brussels General Act of 1889-90, which, while primarily concerned with measures against the slave trade, included a chapter on "Restrictive Measures Concerning the Traffic in Spirituous Liquor".¹ The history of such international action has been described up to 1973 in The Gentlemen's Club.² In broad terms, alcohol issues were considered in the League of Nations during the 1920s, particularly in connection with colonial mandates in Africa, but also more generally in the Health Committee. With the shift of national priorities accompanying the Depression and the repeal of alcohol prohibitions in such countries as Canada, the U.S., and Finland, alcohol issues disappeared from the agenda of the League by the early 1930s.

In contrast, "alcoholism" was on the agenda of the World Health Organization from its first assembly in 1948, and was a program focus during the years -- 1950 to 1955 -- that E.M. Jellinek served as a consultant in Geneva. This burst of activity left some enduring marks on the alcohol field. The "W.H.O. definition" of alcoholism (until recent years perhaps the most widely invoked definition in the field), Jellinek's chart of the "phases of alcohol addiction", and the full form of the Jellinek estimation formula, all made their first appearance in WHO publications of this period. Less noted than these concrete artifacts was the effect that Jellinek's WHO experience had in changing his conceptualizations of alcohol problems. The diversified conceptualization of "alcoholism" as a

¹Pan, L. (1975). Alcohol in Colonial Africa. Finnish Foundation for Alcohol Studies, Helsinki, vol. 22.

²Bruun, K., Pan, L. and Rexed, I. (1975). The Gentlemen's Club: International Control of Drugs and Alcohol. University of Chicago Press, Chicago & London.

"genus" with many "species" presented in Jellinek's Disease Concept of Alcoholism³ and other late works⁴ reflected his recognition of the very different national traditions of conceptualization of and clinical experience with alcohol problems he had encountered in his WHO experience, and represented his attempt to accommodate them within a common nosological frame. Behind this reconceptualization lay an explicit recognition that the "Anglo-Saxon" focus on a narrow "alcoholism", as in his earlier chart of phases, tended to result in "the complete neglect of other important aspects of the problem"⁵

Though the publications resulting from developments in Jellinek's thought in his years at WHO certainly strained the limits of the developing orthodoxies about "alcoholism" (ironically oriented around his own earlier writings), more radical departures from the status quo had been edited out of the published versions. Anticipating the 1970s distinction between the broad field of "problems related to alcohol consumption", as defining the scope of public health concerns, and the narrower "alcohol dependence syndrome", as one "small part of the total of alcohol-related problems",⁶ Jellinek had proposed in his original formulation in 1954 that "alcoholism" should be seen as only a small part of the public health interest in alcohol, and that the term "problems of alcohol" should therefore be adopted as the subject of discussions in an international public health framework.⁷ Perhaps even more daringly, in his 1954 working paper Jellinek included an extended discussion of the "economic origin" of alcoholism -- a discussion which included an assertion of linkage between overall level of consumption and rates of alcoholism which would not appear again in publications under WHO auspices until the mid-1970s.

When the French speak of the "economic origin" of alcoholism, they mean that the viticultural interests and the industrial and trade interests related to the former are the decisive factors in the genesis of alcoholism. . . . In France viticulture constitutes a highly important part of the country's agricultural wealth and millions of its inhabitants earn their living through the production of the raw materials, and the processing and sale of alcoholic beverages. The interests of these groups do contribute toward a general acceptance of large consumption. . . . Furthermore, these interests demand a large number of outlets. . . .

³**Jellinek, E.M.** (1960). The Disease Concept of Alcoholism. Hillhouse Press, New Haven.

⁴**Jellinek, E.M.** (1960). Alcoholism, a genus and some of its species. Canadian Medical Association J. **83**, 1341-1345.

⁵**Jellinek, E.M.** (1957). The world and its bottle. World Health **10** (4), 4-6. Abridged as: Cultural differences in the meaning of alcoholism, in D.J. Pittman and C.R. Snyder, eds, Society, Culture, and Drinking Patterns, 382-388. Wiley, New York, 1962.

⁶**WHO Expert Committee on Problems Related to Alcohol Consumption** (1980). Problems Related to Alcohol Consumption. WHO Technical Report Series, No. 650.

⁷**Jellinek, E.M.** (1954). International experience with the problem of alcoholism. WHO/MENT/58 & WHO/APD/ALC/12, 2 June. Prepared for the "Joint Meeting of Expert Committee on Mental Health and on Alcohol", Geneva, 27 September - 2 October 1954.

The ubiquitousness of alcoholic beverages is an undeniable factor in the magnitude of consumption, and while the proportion of alcoholics may be smaller in a country or area where the consumption is general than where it is limited, the absolute number of alcoholics increases as the number of consumers and the amount consumed increases.⁸ The true economic problem in France in relation to alcoholism is that, because of the pressures of vested interests, it is extremely difficult to establish legal and educational controls and even to launch a nation-wide campaign for the public care of alcoholics. (pp. 15, 16)

Whereas his background paper for a 1951 meeting had defined controls on alcohol availability out of the sphere of interest to a "public-health approach" and to "scientific workers",⁹ by 1954 Jellinek had substantially modified his position: a "socio-economic factor" such as the interrelation of "large vested interests" with public opinion's "readiness to accept large individual consumption" was a complex question which requires and merits thorough sociological and economic analysis and cannot be ignored by the student of alcoholism. In many countries scientific investigations of alcoholism have deliberately kept aloof from this aspect of the problem and have given the impression that these matters are not within the field of the scientist, but belong to quasi-political wrangling. It is understandable that the scientist is reluctant to enter a field which may easily involve him in "partisanship", but on the other hand it is hardly scientific to deny the relevance and scientific nature of these facts. These are facts of the social sciences and can be brought on to the same level of objectivity as physiological, psychological and psychiatric research.

It is of great practical importance to show the economic and social factors in their proper perspective. If public-health authorities are led to believe that the problems of alcohol are primarily economic and social problems, they will not see the cogency of incorporating the control of alcoholism and the rehabilitation of alcoholics into their programme of activities. On the other hand, if it can be shown that socio-economic factors are a contributing element to the etiology of the problems of alcohol they will not shy away from it, as socio-economic factors are to some extent elements of most or all health problems with which they have to cope.

⁸Jellinek's formulation could have been clearer. I believe this must be read as contrasting the "proportion of alcoholics" among heavy drinkers with the "absolute number" of alcoholics as a proportion of the total population; i.e., he is asserting that as consumption rises, although the proportion of alcoholics among heavy drinkers may fall, the rate of alcoholics in the overall population rises. Compare the 1975 report of a collaborative project under the auspices of the WHO Regional Office for Europe: "there is a tendency for the dispersion [of the distribution of alcohol consumption] to be somewhat higher in populations with low per capita consumption than in populations with high per capita consumption. . . . When the total consumption of alcohol in a country increases, the prevalence of heavy users in that country is likely to increase as well." [Pp. 32, 38 in: **Bruun, K., Edwards, G., Lumio, M., Mäkelä, K., Pan, L., Popham, R.E., Room, R., Schmidt, W., Skog, O.-J., Sulkunen, P., and Österberg, E.** (1975). Alcohol Control Policies in Public Health Perspective. Finnish Foundation for Alcohol Studies, Helsinki, vol. 25.]

⁹**Room, R.** (1981). A farewell to alcoholism? A commentary on the WHO 1980 Expert Committee Report. Brit. J. Addiction **76**, 115-123.

Improvement of the economic factors is, of course, not within the sphere of the public-health authorities, but they can show other competent authorities how these factors interfere with the control of the health problem and engage their co-operation. (Ref. 7, p. 17; compare ref. 6, pp. 56-58)

The focus on alcoholism in the early 1950s which brought Jellinek to Geneva reflected an interest in the topic on the part of G.M. Hargreaves, the British psychiatrist who served as the founding head of the WHO Mental Health Unit. Jellinek's tenure at WHO did not long outlast Hargreaves' departure in 1955; it is reported that Jellinek and the new Mental Health Unit director did not get along well. It is possible that another factor may have been involved in the decision to terminate not only Jellinek's contract but also the programme focus on alcoholism: the direction in which Jellinek's thought had been moving may well have been seen as problematic by the permanent WHO staff. Many of the elements underlying the disintegration of the programme in the 1950s have remained problematic for alcohol programming in WHO: (a) Jellinek's appointment was as a temporary consultant, and thus there was no permanent staff commitment to the alcohol programme; (b) as a topical area with political implications which was peripheral to and between the "turfs" of established medical specialties, programming in the alcohol area depended on the patronage or displeasure of WHO senior staff; (c) judging by the disparities between Jellinek's original document (ref. 7) and the published versions (ref. 5), by the mid-1950s there was a developing rift between the direction of research thought and the politically acceptable definition of the problem.

In any case, Jellinek's departure marked the end of sustained programme interest in the alcohol area at the Geneva headquarters of WHO for about 15 years. As it was diplomatically expressed in 1966, "the Organization was able to give very little consideration to problems of alcoholism for several years, partly because of the pressure of other topics to be dealt with in the mental health programme".¹⁰

Alcohol and WHO, 1970-1983

Except for some regional Latin American meetings,¹¹ substantial WHO programme attention to alcohol did not resume until the late 1960s, and initially took the form of a "combined approach" which added alcohol as a topical emphasis to the already existing drug programme. In the wake of an Expert Committee report on Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs,¹² and with Griffith Edwards as the guiding consultant and with Joy Moser in Geneva and Anthony May at WHO-EURO as the responsible WHO staff, a

¹⁰Moser, J. (1970). World Health Organization activities concerning alcoholism. In R.E. Popham, ed, Alcohol and Alcoholism, 385-388. University of Toronto Press, Toronto.

¹¹Grupo de estudios sobre la investigacion epidemiologica del alcoholismo en **America Latina**. (1966) Informe Final. Pan American Health Organization, Washington. Excerpted as "Notes towards an epidemiological study of alcoholism in Latin America", Drinking and Drug Practices Surveyor 6 (1972), 9-10.

¹²WHO Expert Committee on Mental Health. (1967). Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs. World Health Organization, Geneva, Technical Report Series No. 363.

series of international meetings were organized between 1969 and 1972 on "national responses to problems of alcohol and drug dependence", on organizing prevention and treatment services, on compiling information for planning such services, and on the epidemiology of drug and alcohol dependence.^{13,14} Thereafter the programmes in the European Regional Office in Copenhagen and in the Headquarters Office in Geneva diverged somewhat in direction. With strong support from Leo Kaprio, the European Regional Director, WHO-EURO has built up a relatively small-scale effort, using regular budget resources, through a series of meetings and reports, with a consistent emphasis on a systematic public health policy approach to alcohol problems.^{15,16,17} While Jens Hannibal of the Copenhagen staff has devoted part of his time to alcohol issues for some time, there is now for the first time a full-time regular staff position budgeted for the alcohol programme. Underlying this budgeted programme at WHO-EURO was a much greater extrabudgetary research effort, carried out collaboratively and autonomously under WHO auspices by teams of investigators from a total of nine countries. The first phase of this effort, led by Kettel Bruun and supported by the Finnish Foundation for Alcohol Studies and the Addiction Research Foundation of Toronto, examined issues relevant to the potential importance of controls of alcohol availability in a public health approach to alcohol problems. In a progress report drafted by Griffith Edwards, the legitimacy in a public health context of studies of "the impact of trade policies and the economics of alcohol supply" was defended with a reference to and in a style reminiscent of Jellinek's approach of twenty years before:

There has so far been little published scientific work in this area and it may be that one reason is the obvious sensitivity of the issues involved, and the research worker's fear that his scientific intentions will draw him into an ideological arena. Those who have been trying to give alcohol studies a scientific basis have of course been much concerned to shake off the contentious moral overtones which have traditionally surrounded the subject of drinking, and to suggest that "the trade" should now be an object of study may seem to carry the danger of re-awakening all sorts of confusions and the accusation that the research worker has surrendered his impartiality. The Group felt, however, that although anyone treading this path should be aware of the dangers, there was in the present climate no real reason for

¹³**Moser, J.** (1974). Problems and Programmes Related to Alcohol and Drug Dependence in 33 Countries. World Health Organization, Geneva, Offset Publication No. 6.

¹⁴**(Hawks, D., ed.)** (1973). Epidemiology of Drug Dependence: Report on a Conference. World Health Organization Regional Office for Europe, Copenhagen, Publication EURO 5436 IV.

¹⁵World Health Organization Regional Office for Europe. (1979). Public Health Aspects of Alcohol and Drug Dependence: Report on a WHO Conference. WHO-EURO, Copenhagen, EURO Reports and Studies No. 8.

¹⁶**Walsh, D.** (1982). Alcohol-related Medicosocial Problems and Their Prevention. WHO-EURO, Copenhagen, Public Health in Europe Series No. 17.

¹⁷**Grant, M., ed.** (1985). Alcohol Policies. WHO Regional Publications, European Series No. 18, Copenhagen.

the supply side of the alcohol question not to be subjected to just as dispassionately objective enquiry as any other element in this complex interacting control system. . . . The general conclusion reached was that consideration of the social and economic determinants of alcohol consumption was a legitimate topic for objective research, and one which ought to receive more attention.¹⁸

While the Group's final report also recognized the inherent controversy of discussions of alcohol controls, the text was devoted to marshalling the evidence concerning a straightforward set of propositions, couched in terms of policy "in a public health perspective":

changes in the overall consumption of alcoholic beverages have a bearing on the health of the people in any society. Alcohol control measures can be used to limit consumption: thus, control of alcohol availability becomes a public health issue (ref. 8, pp. 12-13).

Over the next few years, the report, familiarly known as "the purple book", became the catalyst for research and debate in a variety of arenas. In the U.S., for instance, it played a role in convincing the National Institute on Alcohol Abuse and Alcoholism, under Ernest Noble's directorship, that influencing the national alcohol consumption level was a legitimate public health goal.¹⁹ At WHO Geneva, an initially sceptical Joy Moser came to rely on it as a benchmark in her synoptic project on the prevention of alcohol problems²⁰

The second extrabudgetary research effort under the auspices of WHO-EURO, known as the International Study of Alcohol Control Experiences, was organized as a collaborative enterprise of seven national research groups, each with their own national funding, with Klaus Mäkelä as the elected coordinator. While this study "found nothing that would require a revision" of the basic position of the earlier study, its emphasis was more social historical -- on understanding the interrelations of changes in the seven study sites in alcohol controls, consumption and consequences

¹⁸**World Health Organization Regional Office for Europe.** (1973). Alcohol Control Policy and Public Health: Report on a Working Group. WHO-EURO, Copenhagen, Publication WHO-EURO 5455 IV. Reprinted in The Drinking and Drug Practices Surveyor **9** (1974), 1, 32-39.

¹⁹**Room, R.** (1983). Former NIAAA Directors look back: Policymakers on the role of research. Drinking and Drug Practices Surveyor **19**, 38-42.

²⁰**Moser, J., compiler.** (1980) Prevention of Alcohol Related Problems: An International Review of Preventive Measures, Policies and Programmes. Addiction Research Foundation, Toronto.

in the postwar era. The results of the study have been presented in three volumes,^{21,22,23} two journal issues (Contemporary Drug Problems 10:1 & 2), and a variety of national reports. The study formed a major background to the recent WHO-EURO Symposium on Control of Alcohol Consumption (ref. 17).

In the meantime, the WHO programme in Geneva was built up in several different directions with the aid of extrabudgetary resources. This assistance began as an initiative of the U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1972. NIAAA support continued in various forms until 1981, and was followed by two years of support by the Nordic Council. Both for NIAAA and for the Nordic Council, a latent aim of the assistance was to build up a commitment on WHO's part to an ongoing alcohol programme; for NIAAA, the existence of such a programme at WHO enhanced the legitimacy of the field in its national political arena.²⁴ Given WHO's budget stringencies in recent years, however, the existence of extrabudgetary support, rather than evoking regular budgetary support, created the expectation that the programme would continue to draw support without regular budgetary allotments and positions. Besides Joy Moser's regular-budget position, which was extinguished on her retirement in 1981, the programme has had one senior staff position in the period of strong extrabudgetary support (from 1977 till June 1983), held by David Hawks, Irving Rootman, and Jan Ording on successive two-year appointments. As Pan and Bruun pointed out, these two WHO positions for alcohol, as of 1977 -- the only positions which were concerned with alcohol problems in any of the international agencies -- contrasted strongly with the total of 94 positions then existing for drug control in the international agencies.²⁵ At the moment of writing (October 1983), the programme is being supported with WHO budgetary funds on an interim basis, but without any regular programme staff positions.

In terms of the content of the Geneva programme, four main directions can be identified in the work of the last ten years. The initial support from NIAAA was for a study of "criteria for identifying and classifying disabilities related to alcohol consumption"; NIAAA was hoping to obtain a broadly-ranging nosology which would satisfy its domestic need for reimbursable but inclusive disease entities, in connection with its drive to gain health and social insurance coverage for

²¹**Mäkelä, K., Room, R., Single, E., Sulkunen, P., Walsh, B., with 13 others.** (1981). Alcohol, Society, and the State: 1. A Comparative Study of Alcohol Control. Addiction Research Foundation, Toronto.

²²**Single, E., Morgan, P. and de Lint, J., eds.** (1981). Alcohol, Society, and the State: 2. The Social History of Control Policy in Seven Countries. Addiction Research Foundation, Toronto.

²³**Giesbrecht, N., Cahannes, M., Moskalewicz, J., Österberg, E. and Room, R., eds.** (1983). Consequences of Drinking: Trends in Alcohol Problem Statistics in Seven Countries. Addiction Research Foundation, Toronto.

²⁴**Wiener, C.** (1981). The Politics of Alcoholism: Building an Arena around a Social Problem. Transaction Books, New Brunswick, NJ.

²⁵**Pan, L. and Bruun, K.** (1979). Recent developments in international drug control. Brit. J. Addic. 74, 141-160.

alcoholism. The Steering Group for the WHO study saw it as inappropriate for WHO to hew so closely to one nation's agendas. Instead, drawing on materials prepared by Griffith Edwards and Milton Gross, the eventual report of a "Group of Investigators" distinguished between "alcohol-related disabilities" -- defined broadly but not in terms of disease -- and a much more narrowly-defined "alcohol dependence syndrome" -- distinguished in fact from the older term, "alcoholism", by its narrower and thus more exclusionary definition.²⁶ In the ensuing years, this solution -- with "disabilities" replaced by "alcohol-related problems" -- has provided a fairly stable rapprochement between psychiatric traditions of insistence on the importance and entitativity of addictive phenomena and the emergent epidemiological and social science traditions of "disaggregation" of alcohol-related problems (see, for instance, 6). Further developments on the two sides of the distinction have tended to proceed in separate arenas: the newly-christened "alcohol dependence syndrome" quickly made its way into general nosology by adoption as code 303 in the Ninth Revision of the International Classification of Diseases, and has been further developed conceptually in the context of the WHO Mental Health Division's general concern with the classification of psychiatric disorders.^{27,28} "Alcohol-related problems", on the other hand, became the conceptual arena within which WHO's other programme components -- on prevention strategies and national policies, and on the measurement and improvement of community responses, and on action at the international level -- developed.

The second line of work, on prevention strategies and national policies, had actually been initiated by the earlier compilation on national responses to alcohol and drug problems (ref.13). With contractual support from NIAAA, and through several successive drafts in the period 1976-1979, Joy Moser assembled, wrote and edited into shape a wide range of conceptual and programmatic materials from 80 countries on the prevention of alcohol-related problems (ref. 20).²⁹ This work provided a major input into the 1979 Expert Committee on Problems Related to Alcohol Consumption (ref. 6) and was further extended in the materials prepared for the Technical Discussions on "Alcohol Consumption and Alcohol-Related Problems: Development of National

²⁶Edwards, G., Gross, M.M., Keller, M., Moser, J. and Room, R., eds. (1977). Alcohol-Related Disabilities. World Health Organization, Geneva, Offset Publication No. 32.

²⁷Edwards, G., Arif, A. and Hodgson, R. (1981). Nomenclature and classification of drug- and alcohol-related problems: A WHO memorandum. Bulletin of the World Health Organization **59**, 225-242.

²⁸WHO/ADAMHA Joint Project on Diagnosis and Classification of Mental Disorders and Alcohol- and Drug-Related Problems. (1981). "Alcohol- and drug-related problems", in Current State of Diagnosis and Classification in the Mental Health Field, 45-66. WHO Division of Mental Health, Geneva, WHO/MNH/81.11.

²⁹Moser, J., ed. (1980). Prevention of Alcohol-Related Problems: National and Sub-National Profiles of Alcohol use, Alcohol-Related Problems and Preventive Measures, Policies and Programmes. World Health Organization, Geneva, Document MNH/80.18.

Policies and Programmes" held at the 1982 World Health Assembly.^{30,31}

The third line of work, and the most ambitious in terms of both resources and effort, has been the direction and coordination of collaborative studies on measuring and improving community and clinical responses to alcohol problems. The multifaceted WHO Study of Community Response to Alcohol-Related Problems, supported both by NIAAA and by the participating nations, and extending from 1976 to 1983, involved the collection and analysis of a variety of data from both rural and urban sites in Mexico, Scotland and Zambia, with associated studies in Canada and the U.S. In addition to assembling existing "background data", investigators in each participating country carried out a general population survey on drinking norms, behaviors and problems and on community responses to the problems, a qualitative study of community agency staff's perceptions and attitudes about alcohol problems, and a series of studies of alcohol-related problems as manifested in the caseloads both of alcohol-specific and of general community agencies. In a second phase, investigators attempted to intervene in and improve responses to alcohol problems both at community and national levels, while monitoring and reporting the success of the process. The study combined a number of conceptual and policy agendas: for instance, WHO's interest in practical work and training in developing countries, and in relating the response to alcohol problems to primary health care settings; an interest, deriving from work in Camberwell³² and California,³³ in the social ecology of alcoholism treatment and its relation to informal community processes; a desire, related to the first line of work above, to test the cross-cultural applicability of the alcohol dependence syndrome.³⁴ Besides reports from each country, products of the study have included a

³⁰**Moser, J., ed.** (1982). Alcohol Problems and National Policies: A Review Based on the Technical Discussions held during the Thirty-Fifth World Health Assembly, 1982. World Health Organization, Geneva, Document MNH/82.12.

³¹**Anonymous.** (1982). Alcohol problems: a growing threat to health. WHO Chronicle **36**, 222-225.

³²**Edwards, G., Hawker, A., Hensman, C., Peto, J. and Williamson, V.** (1973). Alcoholics known or unknown to agencies: Epidemiological studies in a London suburb. Brit. J. Psychiatry **123**, 169-183.

³³**Roizen, R.** (1977). Barriers to alcoholism treatment. Social Research Group, Berkeley, Report F145.

³⁴**Roizen, R.** (1983). Alcohol dependence symptoms in cross-cultural perspective: A report of findings from the World Health Organization Study of Community Response to Alcohol-Related Problems. Presented at a Symposium on Cross-Cultural Studies of Drinking Problems, Farmington, Conn. May 5-7.

variety of WHO documents, not yet in final published form^{35,36,37,38} and an ongoing collaborative cross-national analysis of the survey data. Some of the concerns of the Community Response Study, together with a clinical interest in operationizing the alcohol dependence syndrome and developing simple treatments appropriate for use in developing countries, have been carried further in a new 6-country collaborative study of early detection, diagnosis and treatment of alcohol problems.

The fourth line of work, on factors and collaboration at the international level, has primarily been developed since 1981. While there have been smaller efforts in this area, such an ongoing collaboration with the International Labour Organization and the International Council on Alcohol and Addictions on a review of existing national programmes for the handling of alcohol problems in the workplace, the major effort in this area has been the study of Public Health Aspects of Alcohol Availability. Part of this project, a study on the global market for alcohol and of the market influence of multinational corporations, was conducted in collaboration with the United Nations Conference on Trade and Development (UNCTAD). While summary reports on the project have been published,^{39,40,41} further WHO work on the project was halted by WHO senior staff in the wake of press coverage.⁴²

³⁵**World Health Organization.** (1981). Community Response to Alcohol Related Problems: Phase I Final Report, with 41 annexes. WHO, Geneva.

³⁶**Rootman, I.** (1982). WHO Project on Community Response to Alcohol-Related Problems: Phase II Report on Monitoring Responses to Alcohol Related Problems, with 4 annexes. WHO, Geneva. The substance of this and ref. 35 were published as: **Rootman, I. and Moser, J.** (1985). Community Response to Alcohol-Related Problems. NIAAA, Washington, DC.

³⁷**Rootman, I. and Moser, J., eds.** (1982). Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses. WHO, Geneva.

³⁸**Ritson, B.** (1985). Community Response to Alcohol Problems: Review of an International Study. Public Health Paper No. 81. WHO, Geneva.

³⁹**Anonymous.** (1982). Public health aspects of international production, marketing and distribution of alcoholic beverages: Report of an 'informal consultation' held by the World Health Organization (WHO Geneva), 10-12 June 1981. Brit. J. Addic. **77**, 349-356.

⁴⁰**Cavanaugh, J.** (1983). The trade debate. In Grant, M. and Ritson, B. Alcohol: The Prevention Debate, 120-126. Croom Helm, London.

⁴¹**Mintz, M.** (1983). Alcohol, Inc: Bartenders to the world. Washington Post, Outlook section (4 September), C2.

⁴²**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. Le Monde (15 February), 1, 42. [note added in 2000: The study was eventually published outside WHO auspices: **Cavanagh, J. and Clairmonte, F.F.** (1985) Alcoholic Beverages: Dimensions of Corporate Power. St. Martin's

With the switch from extrabudgetary to interim regular-budget funds, the Geneva alcohol programmes is presently being reorganized under the direction of Norman Sartorius, as Director of the Mental Health Division, to concentrate on four major areas: (a) advocacy of the public health interest in the prevention and management of alcohol-related problems; (b) development and adaptation of technologies for the identification, prevention and management of alcohol-related problems found in the individual, the family and the community; (c) cooperation with countries in the development and implementation of national alcohol policies; and (d) international coordination and action.

Evaluating the Record

There are a variety of possible perspectives on the history of activities sketched in above. The record prior to 1970 is of sporadic and often ineffective activity. In comparison, the WHO alcohol programme as it has developed in the last ten years is a model of persistence, productivity and diversity. WHO staff have made imaginative use of limited resources in placing WHO in the forefront of discussions about many aspects of alcohol policy. And yet there are serious flaws in the contemporary picture. The programme has still not been institutionalized as a permanent activity at Geneva, let alone at regional offices other than WHO-EURO. The base of individuals and of professions whose talents have been drawn into the programme's activities remains small. Particularly at Geneva, the content of the programme has been considerably influenced by the happenstances of extrabudgetary funding and by the unwillingness of senior WHO staff to expend or risk political capital on alcohol issues.

The World Health Organization's activities with respect to alcohol can be seen as operating in three dimensions: in terms of symbolic activities, in terms of programmatic and coordinating activities, and in terms of the institutionalization of the program.

By symbolic activities is meant the panoply of arenas and channels available within WHO for emphasizing the importance of public health concerns about a topic. These activities often also carry a substantive meaning and implications, but an important thread connecting these activities is their potential value in increasing the salience of a topic on the policy and program agenda of a variety of audiences -- the WHO itself, its member governments, other international organizations, and the world community.

On the symbolic dimension, there has been substantial and cumulative activity in WHO in the last 10 years. Alcohol issues and programming have been the subject of two resolutions in the Executive Board and three resolutions in the World Health Assembly, of an Expert Committee, and of the "Technical Discussions" held during the 1982 World Health Assembly. Taken together, these resolutions and findings provide a broad legitimation for action by WHO's staff on alcohol problems, and embody much of the symbolic weight WHO can bring to bear on a topic.

There has also been a substantial record of activity, as detailed above, on information collation, definitional and conceptual development, and collaborative research. While not all the voluminous material which has been produced would find acceptance in a refereed journal, almost

Press, New York. Meanwhile, in a compromised position, WHO put out two substitute publications on the topic: **Walsh, B. and Grant, M.** (1985) Public Health Implications of Alcohol Production and Trade. WHO Offset Publication No. 88. WHO, Geneva; **Walsh, B. and Grant, M.** (1985) Alcohol trade and its effects on public health, World Health Forum 6, 195-199.]

all of it has been useful and apropos. With more resources, more could be done. For instance, the information exchange on prevention that operated informally during Joy Moser's prevention project might well be institutionalized as an international clearinghouse activity. The World Health Assembly's mandate to improve data on alcohol-related problem statistics will require substantial resources if such statistics are to be gathered in developing countries. Such coordinating tasks as bringing public health considerations to bear in trade discussions have yet to be faced.

It is in terms of the third dimension, the institutionalization of the programme, that the picture appears most problematic, particularly in Geneva. As noted, a staff position has now been earmarked for alcohol in WHO-EURO, and there is a combined alcohol and drugs position in the Pan American Health Organization. Little alcohol activity is visible in the other regional offices. In Geneva, as mentioned, there is presently no permanent staff position on the alcohol programme. Joy Moser's long experience and wide range of contacts gave a continuity to the programme which can only be recaptured by stabilizing and institutionalizing the programme's staffing and activities.

Alcohol Control and Public Health Institutions

A public health agency can approach alcohol issues from a number of directions. It can seek to improve the treatment and other handling of those who need help with their own or another's drinking. It can embark on a programme of public education and persuasion concerning harmful features of the population's drinking customs. It can argue for the deterrence of behaviors that harm public health -- such as drunk driving -- by the application of criminal sanctions. All these have been common activities of public health agencies in the modern era at local, national and international levels, and the legitimacy of such activities is usually accepted without question. All are activities which, in the broad public health sense of the term, can be termed part of "alcohol control".

But there is also another, more specific meaning of "control" -- the use of regulatory measures affecting the marketplace, in what is sometimes termed "health protection" activities. Such controls are a traditional instrument in the armamentarium of public health, and "alcohol control" in this special sense -- meaning state regulation of the production, distribution and promotion of alcohol -- also has a long history in the alcohol field. In the alcohol field, the idea of alcohol control emerged in the latter part of the 19th century as an alternative to the temperance movement's advocacy of prohibition.⁴³ The idea of eliminating or at least controlling the agent of harm -- alcohol -- fitted well with general public health models, and leading public health figures were prominent in temperance movements and alcohol control reforms in many countries in the late 19th and early 20th centuries.

For a variety of reasons -- including a reaction against Prohibition in North America -- restrictions on the availability of alcohol fell out of favor with political progressives, except perhaps in Scandinavia, by the 1930s. For public health professionals, mostly recruited from the ranks of political progressives, alcohol control thus became an embarrassing subject, to be avoided. There was no way to invoke the public health paradigm of environment-host-agent without raising the

⁴³**Room, R.** (1984). Alcohol policies in industrial nations: Recent trends and alternative approaches. Journal of Primary Prevention, **4**, 189-198.

politically unacceptable issue of restrictions on the alcohol as the agent of harm.⁴⁴ Added to this problem, of course, is the fact that there are strong vested interests in the production and distribution of alcohol, and that these interests often have considerable influence at every level of government. To advocate the public health interest in alcohol controls, therefore, is necessarily a political act.

At the general level of government, as Jellinek suggested, it is perhaps the interplay of vested interests and popular sentiments which best explains the reluctance of governments, in the absence of an alcohol-oriented social movement or a national emergency, to tighten alcohol controls. But in the specific field of public health, the addition of the combination of paradigmatic attraction and political aversion may provide an explanation for the moth-and-flame approach of many public health institutions to alcohol controls. It is not only the World Health Organization which has commissioned and then shelved policy studies in this area; versions of this scenario have been played out in the last few years in Britain, Poland, the United States, Papua New Guinea, and Mexico, to my knowledge.

The issue has come up so frequently in the last few years because of the substantial revolution which has occurred in research thought on alcohol controls and their effectiveness (ref. 45). Studies and reports sponsored by WHO have played an important part in this change in consciousness among alcohol researchers. There is now no doubt that alcohol controls can reduce not only consumption but also alcohol-related problems, and that, contrary to common belief, they often most strongly affect the behavior of the heaviest drinkers (ref. 45). This does not mean that any alcohol control measure at any time will be effective; minimum conditions for the effectiveness of such measures are that they enjoy popular support, form a coherent programme. Nor does it necessarily mean that such measures should be invoked: that is a question for debate in the political process. But the new knowledge does mean that the political questions are there for debate -- the preemptive argument of ineffectiveness is no longer available. And the record so far suggests that attempts to sweep the new knowledge back under the rug -- to shelve the reports containing it -- is, for those motivated by a desire for a quiet life, often self-defeating.

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⁴⁴**Room, R.** (1984). Alcohol control and public health. Annual Review of Public Health **5**, 293-317.