The technical package

SAFER

A WORLD FREE FROM ALCOHOL RELATED HARMS

Five areas of intervention at national and subnational levels

World Health Organization

The SAFER technical package: five areas of intervention at national and subnational levels
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THE SAFER TECHNICAL PACKAGE

Five areas of intervention at national and subnational levels towards a world free from alcohol-related harms

Introducing SAFER

The World Health Organization (WHO), in collaboration with international partners, launched the SAFER initiative in 2018 alongside the United Nations third high-level meeting on prevention and control of noncommunicable diseases (NCDs). The objective of the initiative is to provide support for Member States in reducing the harmful use of alcohol by strengthening the ongoing implementation of the Global strategy to reduce the harmful use of alcohol[1] and other WHO and United Nations instruments – including WHO's Global action plan for the prevention and control of NCDs[2] and the United Nations' Sustainable Development Goals (SDGs) target 3.5 (i.e. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol).[3]

The technical package for the SAFER initiative focuses on five key alcohol policy interventions that are based on accumulated evidence of their impact on population health and their cost-effectiveness (see Table). Further, the SAFER initiative recognizes the need to protect public health-oriented policy-making from interference by the alcohol industry, as well as the importance of a strong and sustainable monitoring system to ensure accountability and track progress in the implementation of the SAFER interventions.

The SAFER interventions				
STRENGTHEN	**ADVANCE**	**FACILITATE**	**ENFORCE**	**RAISE**
restrictions on alcohol availability	and enforce drink-driving countermeasures	access to screening, brief interventions and treatment	bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion	prices on alcohol through excise taxes and other pricing policies

This SAFER technical package is aimed at government officials with responsibility for developing policy and action plans to reduce the harm done by alcohol. Given that alcohol-related harm extends beyond public health, and that preventing and reducing such harm requires multicomponent action that involves many stakeholders, this guidance should also be of use to those working in sectors other than health.

Sectors relevant to alcohol control include those responsible for:

- alcohol pricing and tax policy;
- licensing the production, distribution and sale of alcohol;
- regulating and monitoring commercial communications on alcohol;
- identifying and eliminating illegal production and trade in alcohol;
- transport and drink–driving policy;
- commissioning health services for early identification, brief interventions and treatment of alcohol use disorders if this is outside the health sector; and
- collecting and analysing data and reporting on alcohol-related indicators.

The breadth of this group of sectors also implies that persons with prime responsibility for an action plan on alcohol will need to coordinate and communicate their efforts with a wide range of colleagues from different government departments and institutions – some of which may have a different understanding of, and goals for, alcohol policy.

Jurisdictional responsibilities and competencies for different elements of alcohol policy vary from country to country. As a result, the contents of the technical package will be relevant not only to people working at national level but also for those working at subnational, municipal or local levels. This implies that persons with prime responsibility for a national action plan on alcohol will need to coordinate and communicate with colleagues from a wide range of jurisdictional levels to ensure that the overall policy is integrated seamlessly across the different levels, and that national legislation and regulations facilitate rather than impede action at the subnational levels, as well as the other way around.

Background

The harmful use of alcohol is one of the leading risk factors for disease, injury, disability and death worldwide; alcohol consumption contributes to 3 million deaths each year globally, as well as to the disabilities and poor health of millions of people suffering from chronic diseases and nonfatal injuries. Overall, harmful use of alcohol accounts for 5.1% of the global burden of disease, across low-, middle- and high-income countries.[4]

There are considerable age, gender and other sociodemographic differences in the level of alcohol-related harm. Alcohol accounts for 7.1% and 2.2% of the global burden for males and females respectively.

Alcohol is the leading risk factor for premature mortality and disability among those aged 15-49 years, accounting for 10% of all deaths in this age group.4 Disadvantaged and especially vulnerable populations have higher rates of alcohol-related death and hospitalization than more affluent populations, despite consuming the same amount of alcohol on average – or even a lower amount. Consequently, persons of low socioeconomic status bear a disproportionate burden of the harm, compounded by other health risks that include unhealthy diet, smoking, physical inactivity and less access to health education and health care.[5,6]

As an intoxicant, alcohol affects a wide range of structures and processes in the central nervous system; as such, it is a risk factor for intentional and unintentional injuries, harms to people other than the alcohol drinker, reduced job performance and absenteeism, alcohol poisonings, interpersonal violence, suicides, homicides, crime and drink-driving injuries. Alcohol is a potent teratogen with a range of potential negative outcomes to the fetus, including low birth weight, cognitive deficiencies and fetal alcohol spectrum disorders.[7]

Alcohol is also an immunosuppressant, increasing the risk of communicable diseases, including tuberculosis and HIV. Alcohol can have considerable toxic effects on the digestive and cardiovascular systems. The International Agency for Research on Cancer has classified alcoholic beverages as carcinogenic, increasing the risk of several types of cancer.[8] Additionally, alcohol is neurotoxic to brain development, potentially leading, in childhood and adolescence, to structural hippocampal changes, and in adulthood to reduced brain volume.[9,10] Alcohol is a dependence-producing substance through its reinforcing properties and is associated with the development of tolerance due to neuro-adaptations of the brain.[10]

A combination of total volume of lifetime alcohol use, context of use, frequency of alcohol consumption and amount consumed per occasion increase the risk of the above range of health and social harms. The risks mainly increase in a dose-dependent manner according to the volume of alcohol consumed and the frequency of alcohol use, and also increase exponentially with the amount consumed on a single occasion.[11] Surrogate and illegal alcohols can bring extra health risks from a high concentration of alcohol and the presence of toxic contaminants.[12]

WHO's position is that any alcohol use is associated with some amount of risk – such as, for instance, the risk of alcohol dependence, or breast cancer (a linear relationship in women) or injury. Although the risk at the level of the individual may be low, from a public health perspective and at the population level there are no levels of consumption at which no risks are involved.

Governments have made commitments to reduce the harmful use of alcohol through several WHO and United Nations resolutions. WHO's Global strategy to reduce the harmful use of alcohol, adopted by the World Health Assembly in 2010, continues to be the most comprehensive international policy document with guidance on reducing the harmful use of alcohol at all levels. The harmful use of alcohol is referenced in several other global strategies and action plans and, most recently, in the Agenda 2030 SDGs – with a separate health target (3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol) – and in the context of NCD prevention and control, where the "best buy" framework identifies several cost-effective alcohol policy interventions.[13]

The SAFER strategies

The SAFER action package provides guidance to countries on evidence-based alcohol policy formulation and implementation in five areas. How can countries make these recommendations a reality?

Three strategies are essential:

IMPLEMENT

Several SAFER interventions require legislative or regulatory actions that may build on an existing framework or may require new action. Countries could take a systematic approach that includes the review of existing rules, drafting of new language when needed, and a thorough political strategy for the passage of new laws or rules.

In addition to legislative and regulatory reforms, all SAFER areas require some degree of operational programmes for successful implementation. Many such programmes will relate to enforcement – of taxes, traffic laws, marketing restrictions, regulations on availability, including legal age limit compliance and licensing. The programmes require dedicated and sustained financing and can be administered at national, regional or local levels. Excise and alcohol corporate tax revenues and licensing fees can all contribute to these costs. By introducing an earmarked levy on alcohol, the SAFER package could be self-funded.

Robust implementation of SAFER will require multisectoral collaboration within countries. For example, tax policy must involve finance ministries, and drink-driving prevention must involve transportation and law enforcement. Strong alliances need to be built outside the health sector.

The following are some recommended preparatory steps for an implementation process of the SAFER technical package:

- assess the level and extent of alcohol consumption and alcohol-related harm at national and subnational levels, including identifying within the country any inequities that worsen or result from alcohol-related harms;
- map existing policies and legislation as well as the competencies for drafting, implementing and monitoring them;
- map current implementation and enforcement structures and levels;
- assess development needs on the basis of the above mapping;
- assess political and institutional readiness, including available resources, to strengthen policies and interventions;
- identify potential key champions and drivers – internal and external – for the interventions;
- identify potential barriers and the means to overcome or bypass them; and
- create a roadmap for SAFER policy formulation, implementation and evaluation according to identified priorities and feasibility.

MONITOR

Regular and robust monitoring of policy and programme implementation is essential for maintaining quality, applying best practices, measuring impact and informing public communication. Countries that implement SAFER strategies should, where possible, develop a monitoring, evaluation and reporting system which includes the following elements:

- tracking of policy and programme implementation according to best practices;
- ongoing monitoring of key indicators of consumption and sales;
- measurement of health outcomes (both morbidity and mortality);
- measurement of social outcomes (e.g. violence) attributable to alcohol; and
- regular public reporting of the above metrics.

PROTECT

Several of the recommended SAFER interventions restrict commercial activity. Accordingly, governments have faced – and will face – opposition to putting these recommendations into action nationally. The focused nature of the SAFER recommendations require that public health objectives are safeguarded and that calls for alcohol-related interventions that are speculative, unproven and distracting are rejected. Involvement of the alcohol industry in the formulation of public health-oriented policies to reduce the harmful use of alcohol has many potential risks that need to be minimized. Ultimately, reliance on scientific evidence is the best protection for the integrity of the SAFER package.

Strengthen restrictions on alcohol availability

What to do?

Where alcohol is legal, the government has several restrictions at its disposal to reduce the physical availability of alcohol, namely:

- to implement licensing systems to monitor the production, wholesale, sales, including delivery, and serving of alcoholic beverages;
- to regulate the number, density and location of retail alcohol outlets;
- to regulate the hours and days during which alcohol may be sold;
- to establish a national legal minimum age for purchase and consumption of alcohol; and
- to restrict the use of alcohol in public places.

In addition, the 2018 United Nations Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases invites the private sector to take concrete steps towards eliminating the sale of alcoholic products to minors.

Why do it?

Public health strategies that seek to regulate the commercial or public availability of alcohol through laws, policies and programmes are important ways to reduce the general level of harmful use of alcohol. Such strategies provide essential measures to prevent easy access to alcohol by vulnerable and high-risk groups. Commercial and public availability of alcohol can have a reciprocal influence on the social availability of alcohol and can thus contribute to changing social and cultural norms that promote the harmful use of alcohol. Restriction of availability has been assessed as a highly cost-effective best-buy intervention for NCD prevention. Countries are recommended to enact and enforce regulations on the physical availability of alcohol by reducing the hours of sale (a highly cost-effective measure), by fixing an appropriate minimum age for purchase or consumption of alcoholic beverages and by reducing the density of outlets.

How to do it?

The level of regulation of the availability of alcohol will depend on local circumstances – including social, cultural and economic contexts – as well as on binding international obligations and the delegation of authority at national level. In some low- and middle-income countries, informal markets are the main source of alcohol; consequently, in such situations, the regulation of industrial alcohol should be complemented by actions either to abolish illicit or informally produced alcohol or to bring it under government control.

Where a government monopoly for the retail sale of alcohol exists, there is a strong argument for preserving it because such a monopoly can effectively limit the availability of alcohol and reduce alcohol-related harm. Where a monopoly of this kind does not exist, and where it is not feasible to introduce one, a licensing system for alcohol sales should be introduced or maintained. A licence should be issued to a specific business or individual owner for a defined time period and with annual renewal dependent on compliance with obligations related to public health and safety, sanitary conditions and business practices.

Effective enforcement of licensing regulations is a critical factor in compliance; the ability to revoke a licence for noncompliance is a strong deterrent. Enforcement may be undertaken by the police alone or by civilian inspectors or community coalitions that work in collaboration with the police. Licence renewals should be issued only to establishments that adhere to laws restricting sales to under-age alcohol users and intoxicated persons, that discourage patrons from being a public nuisance or engaging in violence, that sell only licit beverages and that adhere to the country's sanitary standards.

Steps should be taken to ensure that local communities and municipalities do not use licensing systems merely as sources of revenue because this practice can lead to excessive distribution of licences. Licensing authorities should be charged with maintaining and improving public health rather than simply responding to market forces. Similarly, national licensing regulation should permit local bodies to act to reduce and prevent alcohol-related incidence of violence, crime, public disturbance and harm to health.

Governments should regulate the density of alcohol outlets and limit it where there is undue harm. It is advisable to avoid extending the days and hours of alcohol sales, and to curtail them further when certain neighbourhoods or communities experience increased alcohol-related harm.

A minimum age established by law for the purchase of alcohol enjoys broad public support. Where the minimum age is set at less than 18 years, it is recommended to increase it to at least 18 for all beverage products in both off-trade and on-trade establishments. "Mystery shoppers" – in this case, under-age purchasers – can be used to ensure that establishments enforce the minimum age for purchase. In accordance with national legislation, mechanisms should be considered for placing liability on sellers and servers to prevent sales to intoxicated persons and those below the legal drinking age.

Secondary supply of alcohol – e.g. by parents or friends – should be taken into consideration in measures to limit the availability of alcohol – perhaps in the form of fines and/or criminal charges, depending on the circumstances. Alcohol consumption by minors in the presence of parents, family or friends in on-trade establishments undermines the purpose of the law on a minimum age for purchasing and is therefore not recommended.

An emerging challenge regarding alcohol availability is remote selling (e.g. selling online or by telephone) and associated delivery systems for alcohol. It is important to ensure that regulations regarding minimum age, selling to intoxicated persons and days and hours of sales are safeguarded in this regard.

Whom to work with?

The health ministry's main partner in this area of policy (if it is not within the Ministry of Health) is the ministry that is responsible for licensing regulation. The two ministries can undertake joint actions to review or introduce licensing regulation and to analyse how changes might affect levels of alcohol-related harm and public nuisance.

Other important partners are the government ministries and departments responsible for laws and regulations on alcohol sales, as well as the police departments or other enforcement agencies responsible for actual enforcement. Together they can discuss how to better monitor and implement enforcement.

In many countries some restrictions regarding availability of alcohol are delegated to local governments. Any changes at national level must secure good buy-in at the local level, especially if national standards are under consideration to replace local competencies. National governments can also support local governments in their attempts to restrict the physical availability of alcohol.

It is common to consult alcohol producers and retailers when changes in availability or enforcement are contemplated, although the record shows that in general the industry does not support measures to reduce the availability of retail alcohol. Consequently, it will be important to protect the policy formulation process from undue influence. Governments must also be cognizant that regulation of informal production and sale will increase revenues to major commercial producers and will move revenues outside of the local communities; such producers should not be involved in planning these regulations. Efforts to stimulate alternative sources of income should be considered – especially for persons involved in informal production and sale of alcohol.

Advance and enforce drink-driving countermeasures

What to do?

Several measures are available for governments who want to take concrete actions to counter drink-driving.

For instance:

- blood-alcohol concentration (BAC) limits can be established and restricted (with lower limits for novice and professional drivers);
- sobriety checkpoints, random breath-testing, administrative suspension of licences, graduated driving licences for novice drivers and ignition interlocks are effective in reducing alcohol-impaired driving; and
- other complementary measures include mandatory driver education, provision of alternative transportation, counselling and, as appropriate, treatment programmes for repeat offenders and carefully planned, high-intensity and well-executed mass media campaigns.

Why do it?

Road traffic crashes are a major source of injury, disability and death throughout the world and road traffic injuries are the leading cause of death among people aged 15-29 years. Road users who are impaired by alcohol have a significantly higher risk of being involved in a crash. Driving under the influence of alcohol, or drink-driving, is a key risk factor for 27% of all road injuries. Thus, drink-driving is a significant public health problem that affects not only the alcohol user but also, in many cases, innocent parties such as passengers and pedestrians. Even at low blood-alcohol levels, drivers experience problems with concentration, coordination and identification of risks in the road environment. In addition, at a given blood-alcohol level, drink–driving crashes can be more severe or more common when high speed or poor road design are involved. Drink-driving laws and BAC limits have been assessed as effective interventions for NCD prevention.

How to do it?

An effective road safety transport policy should be in place to address drink–driving, together with road safety measures to reduce the severity and risk of drink–driving crashes. Such measures might, for instance, address infrastructure and speed limits.

Legislation should stipulate upper BAC limits for drivers at a maximum of ≤ 0.05 g/dL or lower for the general population, and at 0.02 g/dL or lower for novice and commercial drivers.

Legislation should specify the penalties for violation of such limits, allow for roadside testing (typically of breath) with approved and calibrated equipment, make it an offence for drivers to refuse a roadside breath test, and allow test results to be used as evidence in court. Penalties should include a combination of administrative sanctions (e.g. driving licence suspension) and criminal ones (e.g. mandatory minimum fines) of adequate severity.

BAC limits are most effective when enforcement is consistent and highly visible, when detection of violation results in penalties that are certain, swift and sufficiently severe, and when supported by effective public education campaigns.

The enforcement of drink-driving laws must be accompanied by strong public awareness campaigns, using mass media and other strategic communications, on the risks of drink-driving and the presence of enforcement activities.

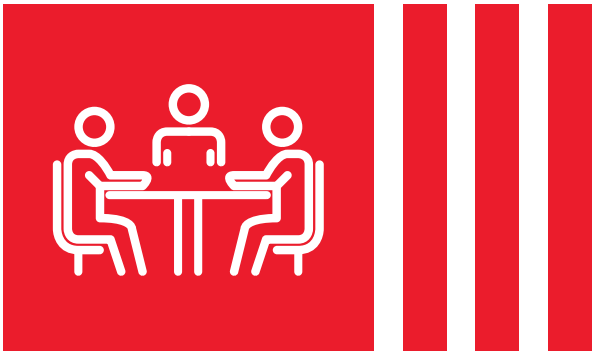
Effective enforcement of drink–driving laws requires a significant amount of police time for conducting and processing random breath-testing activities and sobriety checkpoints, and resources are required in the judicial system to process cases. Resources are also needed to pay for breath-testing equipment. It is important that the police and judicial system have adequate resources for effective enforcement. The fines collected could be used to finance police activity.

High BAC levels and repeated drink–driving can be both a sign and a symptom of alcohol use disorders. Resources need to be available for identifying cases and making treatment available for them.

Whom to work with?

The key stakeholders for reducing drink–driving accidents are the police; they are responsible for enforcing drink–driving laws and for generally stepping up drink–driving countermeasures. Such countermeasures require adequate resources.

Another important stakeholder is the department of transportation, which typically has responsibility for implementing drink–driving laws and other policies to improve road safety and health, and which often has expertise in communication to promote behaviour change.



Persons who serve alcoholic beverages are also stakeholders to the extent that they should be responsible for not serving excess alcohol to drivers.

Alternative transportation (public and private) should be available. Mass media campaigns and police enforcement should not be limited to specific holidays since drink-driving behaviour occurs throughout the year. However, during holiday periods the frequency of enforcement and the visibility of media campaigns can be increased.

Facilitate access to screening, brief interventions and treatment

What to do?

Several concrete steps could be taken by governments to facilitate access to screening, brief interventions and treatment.

For instance:

- the capacity of health and social welfare systems can be increased in order to deliver prevention, treatment and care for alcohol use disorders, alcohol-induced disorders and comorbid conditions, including the provision of support and treatment for affected families and support for mutual help or self-help activities and programmes;
- initiatives for screening and brief interventions for hazardous and harmful alcohol intake can be supported in primary health care and other settings. Such initiatives should include early identification and management of alcohol use – especially heavy alcohol intake – among pregnant women and women of childbearing age;
- strategies and services can be developed and coordinated for integrated and/or linked prevention, treatment and care of alcohol use disorders and comorbid conditions – including drug use disorders, depression, suicides, HIV/AIDS and tuberculosis; and
- universal access to health can be provided – including through enhanced availability, accessibility and affordability of treatment services for groups of low socioeconomic status.

Why do it?

Access to health services is central to tackling alcohol-related harms at individual level. Health professionals have an important role in helping people to reduce or stop their alcohol use in order to reduce health risks, and health services must provide effective interventions both for those in need of help and for their families. There is extensive and consistent evidence that brief advice in health-care settings reduces alcohol-related

harm. Evidence strongly supports the widespread implementation of programmes of early identification and brief advice in primary care settings for persons with hazardous and harmful alcohol consumption. There is also some evidence that similar programmes implemented in emergency departments can be effective, as can programmes in reproductive health services for women (before and during pregnancy). However, there is not yet enough evidence to determine the effectiveness of such programmes outside primary care settings. There is consistent evidence that behavioural and pharmacological therapies are effective in treating alcohol use disorders. Brief psychosocial interventions have been assessed as an effective intervention for NCD prevention.

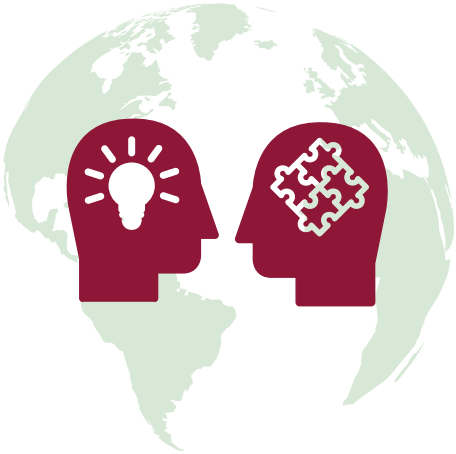
Comprehensive systems of screening, brief interventions and treatment have the potential not only to reduce but also to prevent alcohol-related harm (e.g. to spouses or children of parents with alcohol use disorders).

How to do it?

The health service response should be sufficiently strengthened and funded so that it is commensurate with the magnitude of the public health problems caused by harmful use of alcohol. Governments should support the widespread use of the health interventions listed above by promulgating guidelines, providing training, establishing quality assurance/performance metrics, providing services, and ensuring adequate reimbursement of providers where applicable.

Health-care professionals should use a structured and tested tool, such as the AUDIT (Alcohol Use Disorders Identification Test) questionnaire, to assess the level of risk for alcohol use disorders in all patients.

Patients scoring high on the AUDIT tool should be offered brief intervention in the form of motivational interviewing. This approach typically involves one or a few short sessions that focus on helping the patient to understand his or her pattern of alcohol consumption and to develop strategies to reduce consumption and risk. Health-care professionals should be given access to online and/or in-person training to familiarize them with motivational interviewing techniques.



Patients with alcohol dependence, or whose harmful consumption is persistent, may require referral for specialized treatment – which may include outpatient care, inpatient treatment, mutual self-help groups and supportive services. Governments should promote and support only those treatments with a strong evidence base, specifically recommended by WHO or by national governmental or professional associations following careful review of the scientific evidence of their impact.

Since comorbidities are common, screening and brief intervention should be delivered systematically in primary care and other frontline clinical settings (such as TB or HIV clinics, the emergency room in case of an injury, reproductive health clinics, or during prenatal care) by primary care professionals. Treatment for alcohol dependence can be provided by primary care practitioners with support from specialists (as in the “collaborative care” model), or directly by specialists, where available. Support services include social services, rehabilitation and self-help groups in the community.

It is necessary to decide whether to implement a universal and systematic screening programme to enable primary care providers to offer the identification and brief advice programme to every adult coming to a consultation, or whether to opt for an incremental programme whereby identification and brief advice are offered every time a patient registers with a new doctor, comes for a health check or comes with a new condition such as hypertension or tuberculosis.

Primary care providers find it easier to undertake this intervention when they are supported by specialist services to which they can refer cases that are difficult to manage. In the management of alcohol use disorders, the transition from primary to specialist care should ideally be seamless but in many countries there is a scarcity of services that are available, accessible or affordable. Specialist services for managing alcohol withdrawal and treating alcohol use disorders should be offered to those who need them. The trend has been to move away from lengthy inpatient treatment to outpatient and community-based treatment. Compulsory treatment is no longer recommended. Court-mandated treatment can be considered for repeated drink–drivers, as some evidence has shown that it can be effective.

Whom to work with?

One key stakeholder is the clinical body or institute for clinical excellence that is responsible for developing clinical guidelines and which, therefore, can be asked to prepare guidelines for early identification and brief advice.

Another major stakeholder group consists of health professionals – and especially primary care providers, medical doctors, nurses, midwives and social workers. Their involvement will help to ensure that the guidelines reflect their professional perspective and will help to secure their endorsement and support for early identification and brief advice programmes.

A third stakeholder category in some countries encompasses the public bodies and private organizations that fund and provide primary care services. This category includes the national health service, local trusts and commissioning services, insurance companies and local communities and municipalities. These stakeholders need to be persuaded of the case for funding and managing early identification and brief advice programmes. To make this case effectively, it may be helpful to model the impact and cost–effectiveness of different scenarios for implementing these programmes.

A fourth stakeholder category includes civil society and community-based organizations that provide treatment and recovery programmes – often in underserved, low-resource settings – that play a key role in serving the most vulnerable and marginalized people and communities.

Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion

What to do?

Where alcohol is legal, governments can put in place measures through which alcohol advertising, sponsorship and promotion can be regulated.

For instance:

- bans or comprehensive restrictions on exposure to alcohol advertising can be enacted and enforced by setting up regulatory or co-regulatory frameworks, preferably with a legislative basis, and supporting them when appropriate by self-regulatory measures that contribute in particular to eliminating the marketing and advertising of alcoholic products to minors;
- public agencies or independent bodies can develop effective systems of surveillance of marketing of alcohol products; and
- effective administrative and deterrence systems for infringements of marketing restrictions can be set up.

Why do it?

Reducing the impact of marketing – particularly on young people, adolescents and children – is an important consideration in preventing and reducing the harmful use of alcohol. It is very difficult to target young adult consumers without exposing large numbers of adolescents under the legal age to the same marketing. The exposure of children and young people to appealing marketing is of particular concern, as is the targeting of new markets in developing and low- and middle-income countries that currently have a low prevalence of alcohol consumption or high abstinence rates.

Alcohol is marketed through increasingly sophisticated advertising and promotion techniques which include linking alcohol brands to sports and cultural activities, sponsorships and product placements, and new marketing

techniques (e.g. emails, text messaging, podcasts, social media and other communication techniques). The transmission of alcohol marketing messages across national borders and different jurisdictions via channels such as satellite television and the Internet is emerging as a serious concern in some countries.

Advertising restrictions have been assessed as a highly cost-effective best-buy intervention for NCD prevention. Because they generally cost little to implement, and since they can influence the initiation of alcohol use and risk behaviour at population level, advertising bans and significant restrictions have the potential to be substantially more effective than more labour-intensive interventions that seek to prevent or reduce alcohol use at the individual level.

The purposes of bans or comprehensive restrictions on alcohol advertising, promotion and sponsorship are:

- to prevent young people from being exposed (which is known to influence the decision to start consuming alcohol and to increase alcohol use);
- to reduce the presence of alcohol cues that can induce reactivity and craving in alcohol-dependent persons; and
- to prevent industry influence on social norms relating to consumption in general, given the negative public health, economic and social consequences of alcohol use.

How to do it?

The global alcohol strategy recommends considering a precautionary approach to protecting young people against these marketing techniques. Further, the political declaration of the 2018 United Nations third high-level meeting of the General Assembly on the prevention and control of NCDs invites the private sector to take concrete steps towards eliminating the marketing and advertising of alcoholic products to minors.

Restricting only one aspect of the marketing mix often results in an expansion of activity in other parts of the mix. In general, the more complete the regulation on marketing activities, the easier it will be to implement the regulation and the more effective it will be in reducing alcohol-related harm. That is why a comprehensive ban or set of restrictions is preferred.

Such frameworks should ideally incorporate all forms of new and emerging media as well as existing media and other promotional channels. The rapid pace of marketing innovation renders such comprehensive frameworks open to review and updates by regulatory bodies as new technologies and products evolve. Marketing of all types of alcoholic beverages should be regulated equally in all types of media.

Total bans are cost-effective and inexpensive to implement. They require fewer infrastructure for enforcement since violations are likely to be obvious, easy to identify and easy to sanction. The biggest barrier to enforcement is likely to be advertising that crosses national borders, for instance via television or the Internet.

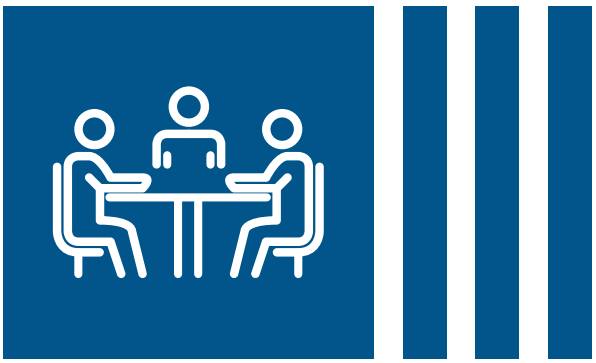
Content restrictions can establish important principles for what is and is not acceptable in alcohol marketing communications There is little disagreement that alcohol marketing communications should not target young people, should be in keeping with national and cultural standards of decency, and should avoid making health, curative or other claims for alcohol. It is common for marketing strategies to include messages related to “responsible or moderate drinking” or a form of health warning prepared by the alcohol industry. These messages are often vague and/or deceptive and should be developed and regulated by the government instead.

Surrogate marketing occurs when companies use products other than alcohol to build alcohol brand familiarity and loyalty among consumers. This has become common in the tobacco industry: as bans on tobacco advertising have proliferated, so have clothing stores and even travel services bearing tobacco brand names. Countries seeking to restrict this kind of activity should look at the tobacco experience for models of how this has been done for tobacco branded products and activities.

Governments should set up effective systems for administration and deterrence of infringements of marketing restrictions. In some jurisdictions, alcohol marketing is controlled through self-regulation by the relevant economic operators, including advertisers, the media and alcohol producers. To be effective, however, self-regulation requires a clear legislative framework. Furthermore, a self-regulatory system needs enough incentives to succeed; in general, self-regulatory systems are most prominent where pressure from the government or from lawsuits is greatest. As with government regulation, self-regulation should cover the entire range of marketing activity that reaches young people in order to prevent advertisers from simply using newer media to escape regulations. Sanctions and the threat of sanctions are needed to ensure compliance. Monitoring of alcohol marketing practices should be the responsibility of an independent body or a government agency and should be carried out systematically and routinely.

Whom to work with?

The Ministry of Health is the most important government stakeholder because it is responsible for ensuring that public health objectives are integrated into all efforts to regulate alcohol marketing. The health ministry's main partners are the ministries responsible for regulating commercial communications through broadcast media, non-broadcast media and telecommunications, including the Internet. In addition, the ministries responsible for culture, sports and children may need to be involved. To ensure that all forms of marketing are covered and that no marketing medium escapes regulation, it may be beneficial to establish a permanent task force to review and monitor the relevant regulations.



Other stakeholders include any bodies established by the government to oversee and monitor advertising standards. Again, if different bodies oversee different media, an overall task force is needed.

Alcohol producers, retailers and the marketing industry are normally consulted when the government makes changes in alcohol marketing regulations and practices. However, the published record indicates that, in general, these industry bodies do not support tighter statutory restrictions on marketing practices.

Raise prices on alcohol through excise taxes and pricing policies

What to do?

Where alcohol is legal, governments can try to influence the final price of alcohol by:

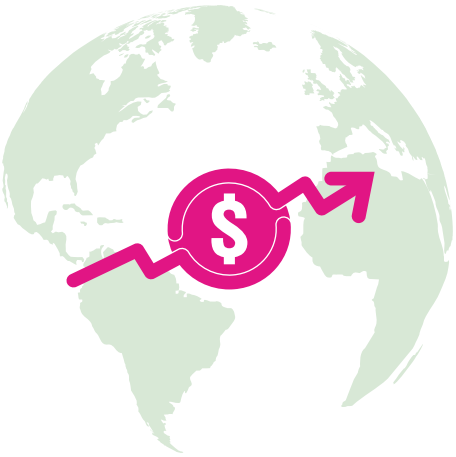
- establishing a system for specific domestic taxation on alcohol, accompanied by an effective enforcement system which may take into account, as appropriate, the alcoholic content of the beverage;
- increasing excise taxes on alcoholic beverages and regularly reviewing prices in relation to the level of inflation and income;
- banning or restricting the use of direct and indirect price promotions, discount sales, sales below cost, and flat rates for unlimited alcohol consumption or other types of volume sales;
- establishing minimum prices for alcohol, where applicable;
- providing price incentives for non-alcoholic beverages; and
- reducing or stopping subsidies to economic operators in the area of alcohol.

Why do it?

Of all alcohol policy measures, the evidence is strongest that alcohol prices have an impact on alcohol consumption and alcohol-related harm. However, many countries underutilize alcohol taxes despite their great potential as tools to improve public health, earn revenue and redress the external costs of alcohol use – including the costs to society, the economy and health systems – as well as the cost of harm caused by alcohol to persons other than alcohol users.

When factors such as income and the price of other goods are held constant, a rise in alcohol prices leads to a reduction in alcohol consumption, and vice versa. Price increases reduce the harms caused by alcohol. Policies that increase alcohol prices delay the initiation of alcohol use, slow young people's progression towards consuming larger amounts, and reduce heavy episodic use of alcohol among them. At the same time, these taxes

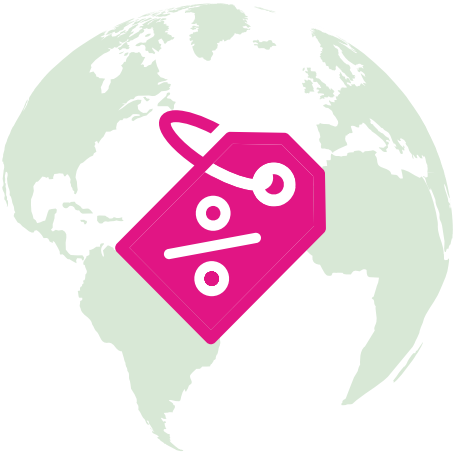
can continue to generate a positive revenue for governments. Pricing and taxation have been assessed as a highly cost-effective best-buy interventions for NCD prevention.



How to do it?

To protect public health and reduce the burden of alcohol-related harm, governments should raise taxes to make alcohol less affordable. A key factor for the success of price-related policies in reducing harmful use of alcohol is an effective and efficient system of taxation matched by adequate tax collection and enforcement.

National data can be used to estimate by how much taxes should be raised on the various beverage categories in order to achieve the desired change. These projections can be supplemented by standard economic modelling studies to estimate the potential impact of the change on the health and economic burden of alcohol and on crime and productivity. Alcohol taxes should be reviewed regularly and should be increased in line with inflation.



Increased taxes do not necessarily mean increased prices when alcohol producers and retailers – particularly large supermarket chains – offset tax increases by reducing prices. One way to control this outcome is to introduce a legal minimum price per gram of alcohol. This approach establishes a floor for the price of alcohol, thus preventing the sale of very inexpensive products. This strategy can be particularly effective in reducing the total alcohol intake of heavy consumers of cheap alcohol.

Influencing the prices of the cheapest and most consumed alcoholic drinks on the market by raising the lowest prices has a potentially larger impact on total consumption than increasing the prices of more expensive alcoholic drinks that have a limited market. However, this approach means that the revenue is gained by the industry rather than by the government.

Increased taxation may meet resistance from consumer groups and economic operators. Consequently, taxation policy will benefit from the support of information and awareness-building measures to counter such resistance and to clarify the real impact of alcohol on people and communities, on jobs and economies, and on society at large.

The existence of a substantial illicit or informal market for alcohol can also complicate policy considerations for alcohol taxes. In such circumstances, tax increases should be accompanied by government efforts to control illicit or informal markets through, for instance, tax policies that make low-alcohol and nonalcoholic variations of culturally preferred beverages more attractive. Tax stamps can also be introduced to show that duty has been paid on informal products.

Cross-border trade may complicate policy for alcohol taxes. However, it is important to note that lowering taxes does not necessarily resolve cross-border issues.

Direct and indirect price promotions, discount sales, sales below cost, and flat rates for unlimited alcohol consumption or other types of volume sales have the effect of reducing the price of alcohol. This in turn increases consumption and thus increases harm – particularly the consumption and harm that results from an occasion of heavy episodic drinking. These promotions should be restricted or banned.

Whom to work with?

The main partner of the health ministry in addressing alcohol prices is the ministry responsible for setting taxes. The two ministries can act jointly to obtain the best estimates for alcohol price elasticities, as well as to model the likely impact of tax changes on the consumption of alcohol in different population groups and on mortality, hospitalization, crime and productivity.

Other important partners include the ministries and government departments responsible for collecting taxes and monitoring smuggled and illicitly or informally produced alcohol. These partners can monitor any adverse consequences of tax changes and can institute taxes on alcohol that is currently untaxed.

Typically, alcohol producers and retailers are consulted when alcohol tax changes are contemplated. The industry tends to claim that tax increases do not reduce alcohol-related harm. The alcohol-related industry also tends to inflate the impact of taxes on its businesses and stresses the risk of unemployment. On the other hand, some parts of the industry may support minimum price measures; for instance, serving establishments may support minimum prices in order to reduce competition from off-trade establishments that practise price-cutting.

For more information about SAFER: https://www.who.int/activities/safer

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