Technical Advisory Group (TAG) on Alcohol Policy

Meeting Report

Washington, D.C.
29 November – 1 December 2017

Pan American Health Organization

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List of acronyms and definitions

APC	alcohol per capita
AUD	alcohol use disorder
BAC	blood alcohol concentration (in g/dL)
CSR	corporate social responsibility
FAS	fetal alcohol syndrome
FASD	fetal alcohol spectrum disorder
FENSA	Framework of Engagement with Non-State Actors
GDP	gross domestic product
GSHS	Global School Health Survey
HED	heavy episodic drinking
ICD-10	International Classification of Diseases, 10th Revision
NCDs	noncommunicable diseases
NGOs	nongovernmental organizations
PAHO	Pan American Health Organization
PANNAPH	Pan American Network on Alcohol and Public Health
PWR	PAHO/WHO Representative
SAO	social aspects organization
SDGs	Sustainable Development Goals
STEPS	STEPwise Approach to Surveillance of Noncommunicable Diseases
UN	United Nations
WHO	World Health Organization

1 Executive summary

During the last quarter of 2017, the Pan American Sanitary Bureau established a new technical advisory group to assist the Pan American Health Organization (PAHO) on alcohol policy. The new Technical Advisory Group (TAG) on Alcohol Policy convened its first-ever meeting on 29 November to 1 December 2017 at the PAHO Headquarters in Washington, D.C., with the purpose of providing guidance and support to the work of PAHO in alcohol policy, to accelerate implementation of the Regional Plan of Action to Reduce the Harmful Use of Alcohol, as well as to achieve a measurable reduction in the harmful use of alcohol in the Region of the Americas.

This first Alcohol Policy TAG meeting focused on three main objectives:

1. reviewing the regional situation related to the impact of alcohol on health and policy responses in the Region and making recommendations on priority areas for technical cooperation aimed at reducing the harmful use of alcohol within the Region

2. advising the PAHO Director and Pan American Sanitary Bureau on optimal interventions to achieve the alcohol-related targets documented in the Strategic Plan of the Pan American Health Organization 2014–2019 nationally and regionally, through partnerships and collaborations with stakeholders

3. advising the PAHO Director and the Pan American Sanitary Bureau on short-term measures aimed at scaling up the political commitment to reduce the harmful use of alcohol at national and regional levels

To fulfill these objectives, the TAG received, analyzed, and discussed official documents, reports, and presentations prepared by the Secretariat and external experts who were invited to attend the meeting, as well as listened to advisors from several technical areas of PAHO.

The TAG made recommendations in five main areas: 1) the current situation regarding alcohol consumption, problems, and policies in the Region; 2) monitoring and surveillance of alcohol policies and plans; 3) political commitment and awareness raising; 4) technical cooperation, capacity building, and research; and 5) interprogrammatic collaboration and partnerships.

The TAG considered evident the need for declaring the reduction of alcohol consumption a public health priority in the Americas; promoting a human rights–based approach for alcohol policy; focusing on social determinants of health, harms to others, violence to women and children, and traffic injuries; and following the 10 alcohol policy areas and 3 "best buys" recommended by the World Health Organization (WHO).

Given the weaknesses identified under monitoring and surveillance of alcohol consumption and harms, the TAG recommended the creation of a TAG Working Group on Monitoring and Surveillance to review and expand on existing indicators, definitions, tools, and instruments for data collection. The TAG also called on countries to increase data sharing and transparency of available information, and to reach out to nonhealth sectors to access alcohol-relevant data.

On political commitment and awareness raising, the TAG highlighted the need to increase awareness raising through a strong social mobilization effort, including high-visibility events and dialogue with

different sectors, such as working with journalists. The TAG also considered it critical to increase the political support and policy coherence in the Region and within countries, by having PAHO leaders become a strong voice emphasizing the role of alcohol on the burden of disease in the Region; the need for urgent implementation of the WHO “best buys”; the adoption of a national alcohol policy in all PAHO Member States; and having alcohol as a public health priority in high-level agendas. This requires an increase in countries’ understanding of the nature and role of the alcohol industry, to ensure that public health interests are kept above and separated from commercial interests.

Regarding the technical cooperation provided by PAHO to its Member States, the TAG provided recommendations to strengthen PAHO’s ability to provide the needed support to countries through stable and well-trained focal points, to bolster national counterparts, and to increase collaborative projects and research in the Region.

The TAG also called on PAHO to increase interprogrammatic collaborations within PAHO and partnerships with external entities to maximize the implementation and the impact of alcohol policies in the Region. The TAG specifically outlined the need for increased collaboration with civil society and nongovernmental organizations (NGOs).

The TAG plans to meet on a yearly basis, and review the Region’s progress and the implementation of the recommendations of previous meetings. The 2018 TAG meeting will discuss challenges to implementing the 2017 TAG recommendations and potential solutions, review the work of the TAG Working Group on Monitoring and Surveillance, and identify critical evidence gaps on alcohol-related issues and potential sources of funding and collaborations.

2 Introduction

2.1 Purpose of the TAG

During the last quarter of 2017, the Pan American Sanitary Bureau established a new technical advisory group to provide guidance and support to the Pan American Health Organization (PAHO) on alcohol policy. The overall purpose of the new Technical Advisory Group (TAG) on Alcohol Policy is to assist PAHO in alcohol policy, in order to accelerate implementation of the Regional Plan of Action to Reduce the Harmful Use of Alcohol (until 2021), as well as to achieve a measurable reduction in harmful use of alcohol in the Region of the Americas, thus contributing to the global target of 10% relative reduction by 2025. The TAG will also guide the development of groundwork for a new regional plan that will follow the current one, for the period of 2021–2025, so it will to be aligned with other established global and regional strategies, goals, and targets.

The members of the TAG will act, collectively and individually, as advisors to the PAHO Director and Secretariat in the implementation of the Regional Plan to Reduce the Harmful Use of Alcohol, its evaluation, and in developing a new plan in 2021. In addition to this critical function, the TAG will recommend to the PAHO Director specific avenues aimed at strengthening the technical cooperation with Member States, and policy dialogue among key stakeholders in the Region. The TAG will also recommend priority actions to prevent and control harmful use of alcohol consistent and in line with the Sustainable Development Goals (SDGs).

The new TAG held its first-ever meeting at the PAHO Headquarters in Washington, D.C., 29 November to 1 December 2017.

2.2 Terms of reference of the TAG

The TAG will:

1) review and/or use the scientific evidence available on alcohol-related topics, as appropriate, to advise the Director and Secretariat on policies, strategies, and interventions aimed at reducing harmful use of alcohol regionally and nationally

2) advise the Director and Secretariat concerning the optimal strategies and tactics to reach the alcohol-related targets of Strategic Plan of the Pan American Health Organization 2014–2019, the Plan of Action on Alcohol, United Nations (UN) declarations on noncommunicable diseases (NCDs) and SDGs, and other international commitments in this area

3) advise the Director and Secretariat on mechanisms to synergize efforts among technical institutions; civil society; bilateral, multilateral, and other non-State actors; and political leaders, in order to support effective public health policies and interventions for reducing harmful use of alcohol

4) advise the PAHO Director and Secretariat on how it can contribute to increasing national political commitment by government leaders and parliaments in addressing harmful use of alcohol, through population-based policies and effective, targeted interventions

5) advise the Director and Secretariat on the criteria, methodology, and research needed in order to meet alcohol-related targets and goals in the Americas

2.3 List of TAG members 2017

- Maria Elena Medina-Mora Icaza (chair). Psychologist, director of National Institute of Psychiatry Ramon de la Fuente, PAHO/WHO Collaborating Center, Mexico. Alcohol policy researcher; member of the Mexican Academy of Sciences; member of the WHO Expert Panel on Alcohol.

- Thomas Babor (co-chair). Professor and chair, Community Medicine and Public Health, University of Connecticut (United States of America). Expert on alcohol policy. Dr. Babor has collaborated with and consulted for several countries in Latin America and the Caribbean; member of the WHO Expert Panel on Alcohol; consultant to PAHO and WHO on several projects related to alcohol.

- Maria de la Paz Benavides. Institute of Women (ISDEMU- Instituto Salvadoreño para el Desarrollo de la Mujer), San Salvador, El Salvador. Works on prevention of violence against women and on gender equity.

- Alfredo Pemjean Gallardo. Professor of psychiatry and mental health, Medical School of the Diego Portales University (Chile). Previously responsible for mental health for the Ministry of Health in Chile.

- Rodrigo Guerrero. MD, DrPH, professor of epidemiology, elected twice as mayor of Cali, Colombia. Dr. Guerrero has enacted municipal policies to reduce hours of alcohol sales to reduce alcohol-related violence. Dr. Guerrero received the Roux Price in 2014 from the Institute of Health Metrics and Evaluation, for using data to address violence as a public health crisis in Cali.

- Paula Johns. Executive director of the Aliança de Controle do Tabagismo (ACT) of Brazil and a member of the executive board of the NCD Alliance and of the Global Alcohol Policy Alliance. Her recent work has been on alcohol policy advocacy in Brazil and internationally, in addition to her long career in tobacco control and advocacy.

- Rohan Maharaj. Policy advisor of the Healthy Caribbean Coalition, a civil society alliance established to combat noncommunicable diseases and their associated risk factors and conditions in the Caribbean; senior lecturer, The University of the West Indies.

- María Marta Rocche. Indigenous Kaqchikel, Sololá, Guatemala. Member of the Alliance of Indigenous Women of Central America and Mexico.

3 Regional situation of alcohol consumption and proposed strategies

Current alcohol consumption situation in the Region

The 2014 Global Status Report on Alcohol and Health of the World Health Organization (WHO) stated that alcohol kills 3.3 million people worldwide each year, that is, one person every 10 seconds. Data also show that younger people are killed proportionally more; in absolute terms, most of the alcohol-related deaths happen later in life but proportionately, they affect the young more.

Alcohol **consumption in the Americas** is higher than the global average and is only second to the European Region average. In 2012, alcohol contributed to more than 300,000 deaths in the Region—with more than 80,000 of those involving deaths that would not have occurred had alcohol not been consumed. The top 10% of drinkers consume more than 40% of all alcohol in the Americas on average. In particular, rates of heavy episodic drinking (HED)[1] have risen in the past five years, from 4.6% to 13.0% among women and 17.9% to 29.4% among men.

Alcohol use is a risk factor to more than 200 diseases and injuries, including cancers, HIV/AIDS, and various mental disorders. **Alcohol was the cause for more than 274 million years of healthy life lost in the Americas in 2012**. About 5.7% of the Region's population reported suffering from an alcohol use disorder, although the number is likely higher. Alcohol use disorders in the Americas have a lifetime prevalence of 12.4%, and the treatment gap is currently over 80%. Alcohol-related cancers even with light drinking have now been documented in more than 20 studies.

Intentional and unintentional injuries in the Americas are among the highest in the world. Alcohol consumption, especially heavy drinking, is a significant risk factor for suicide and intentional injuries, which include violence and self-inflicted injuries. Alcohol consumption is responsible for over one-third of all violence-related deaths; 10% of other intentional injuries; over 20% of all road traffic accidents; almost 20% of other unintentional injuries; over 10% of falls; and 8% of self-inflicted injuries.

Alcohol causes much harm, not only to those who drink to excess, but also to those around them. **Harms to others** include fetal alcohol spectrum disorders, violence (interpersonal and domestic), injuries (including traffic crashes or workplace injuries), emotional distress, and economic instability. There are also broader consequences, such as property damage, disturbance of neighbors, and colleagues working to compensate for the person who is either absent or present but not fully functional. Women or others in the family can be forced to miss work or quit work to care for the drinker, and children and others in the family can be neglected. Women appear to suffer more from the drinking of others.

Alcohol is the **leading risk factor** for death and disability among people aged 15–49 years, both in the Americas and worldwide. This is the age range in which people are typically most productive. One study estimated that the harmful use of alcohol in 2006 in the United States of America cost the country approximately US$ 224 billion (an average of US$ 750 per person), 72% of which was attributed to lost workplace productivity. Other substantial costs to society are incurred when drinking leads to arrest, property damage, job loss, or health service visits.

As countries in the Americas develop economically, an increase in alcohol consumption and related harms is expected, in the absence of effective policies to prevent them. Evidence also suggests that the socioeconomically disadvantaged often experience more harm from the same levels of consumption

[1] Heavy episodic drinking (HED) is the proportion of a population that has consumed at least 60 grams (approximately five standard drinks) or more of pure alcohol on at least one occasion in the past 30 days.

than their wealthier counterparts do, possibly due to the lack of access to health care resources and greater social exclusion.

There are multiple segments of the population that are particularly vulnerable to alcohol-related harm, including young people aged 15–24 years, for whom it is the leading cause of death and disability; indigenous populations; persons with a family history of alcohol dependence; pregnant women or women considering pregnancy; and persons who are impulsive or with conduct disorders.

Global Strategy and Regional Plan

To address the large burden of disease attributed to alcohol consumption, the WHO adopted the Global Strategy to Reduce the Harmful Use of Alcohol ("Global Strategy") in 2010, with the following 10 areas for policy action:

1. leadership, awareness, and commitment
2. health services' response
3. community action
4. drink-driving policies and countermeasures
5. availability of alcohol
6. marketing of alcoholic beverages
7. pricing policies
8. reducing the negative consequences of drinking and alcohol intoxication
9. reducing the public health impact of illicit alcohol and informally produced alcohol
10. monitoring and surveillance

In 2011, the Pan American Health Organization (PAHO) adopted a **Regional Plan of Action to Reduce the Harmful Use of Alcohol,** which is consistent with the WHO Global Strategy and includes all 10 policy areas of the Global Strategy. In 2016, a **midterm review** of the Regional Plan was undertaken and presented at the 55th Directing Council, showing a wealth of activities by the Secretariat and by Member States. However, the activities implemented at the country and regional levels did not result in significant reductions in alcohol consumption. Further, over a dozen countries drafted plans of action but were unable to finalize and implement them.

In addition, the midterm review showed that, even though countries have increased efforts to develop and update national policies, plans, and programs, the most cost-effective policies have not been implemented to reduce the harmful use of alcohol. Such policies, which have been determined as the most cost-effective or the "**best buys"** by the WHO to reduce the harmful use of alcohol, include:

- increase taxes and prices on alcoholic beverages
- enact and enforce bans or comprehensive restrictions on exposure to alcohol marketing

- enact and enforce restrictions on the physical availability of retailed alcohol

Pricing and taxation regulation of alcohol products in the Americas are uneven. In most countries, those measures do not comply with the recommended practices of adjusting tax for inflation, equalizing based on alcohol content, establishing a minimum price, and determining whether the tax rate is high enough to reduce affordability and consumption.

Restrictions on exposure to alcohol marketing (includes advertising, promotions, and sponsorships) are largely nonexistent in the Region. Almost 70% of the Region's countries have no regulations in place on alcohol marketing on national television (the most common media used in most countries) or have only self-regulation by the alcohol industry. Evidence from several studies has shown that voluntary self-regulation codes are largely ineffective. The Internet and social media are the least restricted media outlets, as well the ones that young people use the most.

Restrictions on product availability differ among the countries of the Region. The most common restrictions implemented are minimum purchase age (29 countries); licensing and monopoly system on retail sale (25 countries); and regulating hours (21 countries), locations (19 countries), and days (6 countries) of retail sales. Restrictions on alcohol consumption in public places also differ significantly. The most common bans are implemented for educational buildings (21 countries), health care establishments (16 countries), and the workplace (15 countries). The least common bans are applied for leisure events (2 countries) and sporting events, parks, and streets (8 countries).

Drink-driving countermeasures (such as low blood alcohol concentration (BAC) for young and novice drivers of ≤ 0.02 g/dL, and BAC ≤ 0.05 g/dL for other drivers) are only implemented in five countries of the Region. Finally, enforcement is a critical element for the success of enacted alcohol regulatory policies; however, for most regulatory measures in place, enforcement is insufficient or very limited.

The lack of progress in the implementation of the best buys reflects the insufficient political commitment in the Region to addressing the problem of alcohol consumption. This is despite the mandate Member States committed to through the Directing Council resolution on the Regional Plan of Action to Reduce the Harmful Use of Alcohol, the WHO NCDs Global Monitoring Framework, and the 2030 Agenda for Sustainable Development (SDG).

Many **barriers** to this lack of progress were identified by the TAG. These include strong commercial interests, the cultural position of alcohol with various societies, and a relatively weak civil society mobilization that can help push for policy changes (regionally and nationally). There are also misperceptions about the relative benefits and harms from alcohol consumption, as well as about the effectiveness of population-based policies in changing consumption and alcohol-related harms. As documented by the midterm review of the Regional Plan, little progress has been made at the country level to enact policies with a population impact. This is particularly true for those related to pricing and taxation, regulation of the physical availability of alcohol, alcohol marketing control, and drink-driving countermeasures. Furthermore, alcohol is still more available and affordable in the Americas than it ever was before. Since alcohol control policies have not reduced availability and affordability, it is expected that the impact of alcohol consumption on health and well-being will be higher in years to come. Given that inequality is also expected to increase (a worldwide trend, in the absence of policy changes) and because inequality has a strong interaction with alcohol use, the resulting burden of disease from alcohol is likely to amplify health and social disparities.

It can therefore be concluded that **an integrated public health approach to alcohol policy is still lacking**, that is, one that recognizes that alcohol contributes to a range of health, social, and behavioral problems

in terms of its toxicity, its potential to create dependency, and its negative impact on human behavior. The overall level of alcohol consumption and the predominant pattern of drinking in the population are predictive of the incidence and prevalence of alcohol problems in any given society. Therefore, alcohol policy must take into account the total drinking population when defining the scope of public health action as well as targeting high-risk groups and individual high-risk drinkers. Additionally, while efforts seem to be concentrated on noncommunicable diseases (and alcohol has, of course, detrimental impact on noncommunicable disease mortality and disability), other causes of death attributable to alcohol play an even bigger role in the Americas (such as injuries and neuropsychiatric conditions), and should be also monitored and addressed.

Recommendations:

1. The TAG considers that reducing alcohol consumption in the Region to minimize the number of related healthy life years lost should be declared a public health priority in the Americas.

2. Given the significant impact of alcohol consumption on people other than the drinker, PAHO should develop and promote a human rights–based framework for alcohol policy.

3. The TAG recommends that the next PAHO regional report on alcohol be centered on the links between alcohol and social determinants of health, highlighting harms to others, violence to women and children, and traffic injuries.

4. The TAG recognizes that all the 10 alcohol policy areas of the WHO Global Strategy to Reduce the Harmful Use of Alcohol are policies with a strong evidence base and thus endorses their implementation in the Americas. The three most cost-effective policies (WHO best buys), should be considered essential to a public health response to alcohol in any country, and no single policy should be considered in isolation as the solution to reducing harmful use of alcohol. These policy areas have synergistic effects, and they should be part of an integrated and comprehensive approach to reducing harmful use of alcohol. Therefore, TAG recommends that these policies be implemented as a package, to the extent possible, to reduce alcohol consumption in the Region, instead of Member States relying on single isolated policies.

5. The TAG recognizes that there is a relative deficiency in funding for alcohol issues compared to the burden of morbidity and mortality created by this risk factor. The TAG recommends the Director work to correct this discrepancy.

4 Monitoring and surveillance of alcohol policies and plans

Background:

The WHO's Global Strategy to reduce the harmful use of alcohol includes specific monitoring objectives. These include strengthening the knowledge base on the magnitude and determinants of alcohol-related harm; improving systems for monitoring and surveillance; and more effective dissemination and application of information. Therefore, improved monitoring of alcohol consumption, harms, and policies is needed and, as a result, monitoring and surveillance efforts constitute one of the 10 areas of policy action of the Global Strategy.

The measurement of alcohol consumption is performed both at the individual and population levels. While surveys provide individual-level data by sex and age groups, they underestimate overall alcohol consumption, and comparisons may be difficult across countries, time, and surveys. In addition, data on sales, exports, and imports provide more accurate estimates of the total alcohol consumption, which can be triangulated with the survey data to provide more detailed information of the drinking patterns of the various groups of the general population.

Existing alcohol consumption indicators rely on multiple data sources, including population surveys; data on sales, mortality, and morbidity; and various estimates carried out with data from economic operators. They are analyzed by WHO and by PAHO in consultation with Member States and experts for the generation of country profiles and the preparation of the WHO Global Status Report on Alcohol and Health.

The PAHO Strategic Plan 2014–2019 included three outcome indicators and one process indicator related to reducing harmful use of alcohol. The first assessment made on the progress in relation to these indicators was done for the period 2014–2015, and it showed a disappointing lack of progress with the four:

1) total (recorded and unrecorded) **alcohol per capita (APC) consumption** among persons 15+ years of age within a calendar year in liters of pure alcohol, as appropriate, within the national context:

    - baseline: 8.4 liters/person/year (2010)
    - target 2019: 5% reduction
    - status: **no progress**

2) prevalence of **alcohol use disorders (AUDs)** among adolescents and adults, as appropriate, within the national context:

    - baseline: 6.0% for codes of the International Classification of Diseases, 10th Revision (ICD-10) (2.6% for harmful use and 3.4% for alcohol dependence) in 2010
    - target 2019: 5% reduction
    - status: **no progress**

3) age-standardized prevalence of **heavy episodic drinking (HED):**

    - baseline: 13.7% (2010)
    - target 2019: 5% reduction
    - status: **no progress**

4) number of countries and territories with a **national alcohol policy or plan** for the prevention and treatment of AUDs in line with the Regional Plan of Action/Global Strategy to Reduce the Harmful Use of Alcohol:

    - baseline: 10

- target 2019: 17

- status: **partially achieved (6 countries fully achieved, and 12 partially achieved)**

The NCD risk factors progress indicators related to alcohol include an assessment of policies on alcohol availability, advertising restrictions, and taxes. In the Americas, policies to reduce alcohol availability have only been fully implemented in 5 of 33 Member State; the same is true for policies on taxation of alcohol. Policies to restrict alcohol advertising were comprehensive for only one Member State. So far, 19 countries in the Americas have established an alcohol-specific target within the Global Monitoring Framework related to the reduction in the harmful use of alcohol. However, most countries fail to follow the recommended 10% relative reduction in harmful use, and instead establish a lower threshold for themselves.

Regarding the outcome indicators currently in place, several problems were identified:

- With the indicator related to APC consumption, the majority of countries do not access the necessary data on volume of sales, despite their availability. This leads countries to rely on WHO estimates instead of conducting their own monitoring.

- With the indicator related to HED, the use of the same definition for adults as for youth is confusing, as it seems to condone lower levels of consumption for children and adolescents. Also, in many countries, the data is not regularly and reliably collected.

- With the AUDs indicator, many countries do not assess AUDs in their national health surveys.

- With the indicator related to a national alcohol policy or plan, the definition of the indicator is imprecise. A better definition of a “good-quality” plan and policy is needed.

- The HED and AUDs indicators seem inappropriate as outcome indicators of the PAHO Strategic Plan, for various reasons. They are difficult to change within five years, even when good policies are enacted. They are not expected to change at the same pace at the national level. They require investments at the country level that are not reasonably expected to be available in most countries. They depend on major changes in national health systems. Finally, they require resources for technical cooperation that are unlikely to become available.

There are many other opportunities for improvement in the monitoring and surveillance of alcohol consumption, harms, and related policies. Standardization of data collection instruments and fostering a data transparency and data sharing culture in the Region will be very important to allow for data aggregation and interpretation. Additionally, the regular collection and aggregation of other pieces of information is needed to inform progress and define priorities for moving forward.

In that regard, the estimation of alcohol consumption by socioeconomic status and inequality is critical. While efforts to date concentrate on classic risk factor epidemiology and main causes of deaths (NCDs), alcohol also interacts with the social determinants of health in a complex way, socioeconomic status and gender inequality.

Another key piece of information is the availability of alcohol and its relationship with violence and harm to others. New algorithms have been developed to quantify the burden of disease and mortality for traffic injury, violence, and fetal alcohol spectrum disorders (FASDs). The systematic quantification of alcohol-attributable harm to others in terms of burden of disease and mortality is important as an advocacy tool, since reducing this harm is seen as a major task for public health policy. Thus, the impact

on alcohol on harm to others should be quantified and added to the overall comparative risk assessments for alcohol.

Finally, since the most effective policies are often delayed for several years due to industry lobbying activities, and since there is a strong correlation between industry's marketing spending and alcohol consumption, the industry's actions need to be monitored, and further research needs to be conducted in this area.

Recommendations:

1. The TAG recommends that PAHO create a TAG Working Group on Monitoring and Surveillance and charge its members to:

    a. review indicators related to alcohol in the context of NCDs and SDGs and make recommendations on their monitoring at country level

    b. propose a definition of a "standard alcohol consumption measure" ("standard drink") in grams of ethanol or pure alcohol, to be used in monitoring, surveillance, consumer information, clinical guidelines, and any educational or capacity-building activities

    c. propose a minimum set of standardized questions on alcohol consumption, to be used routinely in national surveys; these questions would include some on unrecorded consumption, on alcohol-related harms (including harms to others), on alcohol use disorders, and on social norms linked to alcohol policies

    d. review existing tools and instruments for data collection on alcohol that are being used nationally and regionally

    e. recommend mechanisms for national health authorities to access data needed to monitor APC consumption, as well as alcohol policies

    f. propose a composite alcohol indicator that could be used to better reflect progress on the three "best buys," as well as a single indicator that can reflect the status of national alcohol policies

    g. recommend a core set of alcohol indicators to form a national surveillance system (including injury surveillance) that could be pilot tested and evaluated in a few countries

    h. conduct a needs assessment of national capacity for alcohol surveillance to inform the development of capacity-building activities

    i. conduct a review of existing methodologies for rapid economic evaluations and return of investment on the implementation of alcohol policies, and for estimation of alcohol-related economic and social burden and impact at national level

    j. have this new TAG Working Group prepare a report of its activities to present at the next TAG meeting

2. PAHO should urge Member States to share their data and to foster data transparency for all health areas, including alcohol.

3. PAHO should urge Member States to reach out to sectors other than health (such as finance or trade) to access data on volume of alcohol sales, as well as imports and exports of alcoholic beverages, so that the Member States can calculate APC consumption independently of industry sources.

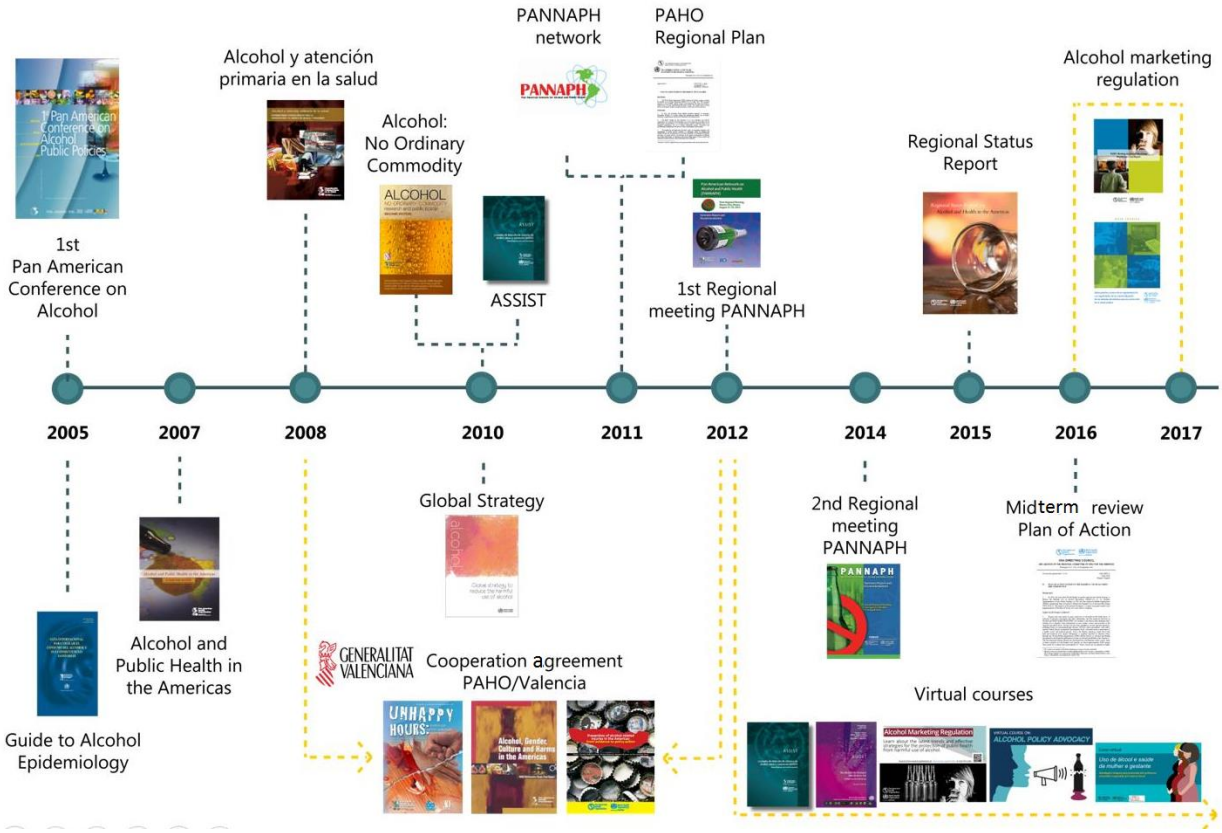
4. PAHO should continue to document, monitor, and disseminate information on the alcohol industry actions that delay alcohol policy implementation in the Region.

5. PAHO's and Member States' political commitment should be monitored by developing a set of progress indicators, and a report on this monitoring exercise should be presented at the next TAG meeting.

5 Political commitment and awareness raising

Background:

Below is a timeline showing alcohol policy strategies and activities implemented in the Region of the Americas over the past 13 years:



In 2005, the first-ever Pan American Conference on Alcohol Public Policies was held, with participation from 25 countries. The landmark **Brasilia Declaration** that stemmed from the meeting included the following recommendations:

1. reducing alcohol-related harm be considered a public health priority in all countries
2. regional and national strategies be developed
3. strategies should be evidence based and include improved information systems
4. creating a network of national counterparts
5. cost-effective alcohol policies should be implemented and evaluated in all countries
6. priority areas of action include heavy drinking occasions, overall consumption, women (including pregnant women), indigenous peoples, youth, other vulnerable populations, violence, intentional and unintentional injuries, underage drinking, and alcohol use disorders

In 2010, the WHO Global Strategy included leadership, awareness, and commitment as one of the 10 alcohol policy areas for action. Awareness in this context is to be distinguished from purely educational approaches about alcohol harms; awareness of policymakers at all levels should be the center. This awareness increases political support and policy coherence, which are indispensable components to advance the alcohol control policy agenda.

Since then, several regional networks have been established, including the Pan American Network on Alcohol and Public Health (PANNAPH)[2] and INEBRIA Latina. PAHO has cooperated in and supported those efforts in various ways. PAHO has prepared and disseminated multiple alcohol consumption and alcohol policy reports and capacity-building materials through conferences, webinars, and virtual courses. PAHO has also promoted the inclusion of alcohol policy advocacy activities during existing or new awareness days or campaigns on traffic safety, breast cancer, human rights, substance abuse, HIV, violence against women, and depression. Finally, PAHO has supported the creation of a specific alcohol awareness day in the Caribbean.

However, awareness raising and other advocacy activities were done in a nonsystematic way and in isolation (regionally and at national level), which made it difficult to create a consistent and integrated perception of the extensive harm that alcohol causes to society in the Region. These isolated activities were not accompanied by concrete national policy changes, suggesting a low level of political commitment from Member States.

Lack of awareness of the real magnitude of the problem and a perceived benefit from alcohol-producing countries are some of the key barriers for action, along with support from a strong alcohol industry that defends its commercial interests. With regards to the role of the alcohol industry, it is important to acknowledge that the industry's aim is primarily to generate profits through alcohol sales and related activities. The strategies of the alcohol industry include opposing any regulation that limits their operation or results, promising self-regulatory measures, funding biased studies on best policy options, encouraging public-private partnerships to influence policy-making towards deregulation, and defending isolated, individual-centered, nonregulatory alternatives such as providing information as the best policy options. Further, when regulations are already in place, the alcohol industry has worked to weaken them, challenge them legally, and delay their implementation. All these actions constitute important barriers to policy implementation, and they are symptoms of the insufficient political commitment in the Region.

[2] The Pan American Network on Alcohol and Public Health (PANNAPH) was created upon the adoption of the regional plan on alcohol in 2011 as a medium for bringing together national counterparts on alcohol.

There is a need for increased advocacy efforts and dissemination of the available evidence, health literacy, and the generation of new evidence such as cost and economic evaluations that will demonstrate the net negative impact of alcohol to a country's economy, given its high economic, health, and social burden.

Recommendations:

On awareness raising:

1. The TAG recognizes the need to create a strong social mobilization effort/movement to raise awareness of the need to implement and enforce effective alcohol policies. Also critical to building awareness and promoting social change in the Region is having a "champion" civil society organization, professional association, civil society group, and/or a recognized individual with a cause related to alcohol; a Member State committed to alcohol policy progress; and senior management at PAHO ready to speak up about the need to act on alcohol policies.

2. PAHO should encourage Member States to raise national and local awareness about harmful effects of alcohol throughout the health system. Member States also need to reach out to other sectors to present the information available on why reducing harmful use of alcohol is necessary for sustainable development, makes economic sense, is a responsibility of the entire government, and can be done cost-effectively through health-related laws and the regulation of the alcohol market. Member States should consider using both mass media and alternative media outlets (such as the local press and television and radio broadcasts that target indigenous populations) to ensure the information reaches special populations as well. Such campaigns must be independent of any participation or funding from the alcohol industry and be well designed and evaluated.

3. PAHO should consider organizing a special awareness day or week dedicated to alcohol, which could be celebrated in all Member States. The focus could be on the harmful effects of alcohol consumption and on the progress being made on policies and other indicators, and on other specific topics, as appropriate.

4. PAHO should utilize the latest data of the WHO Global Survey on Alcohol and Health to prepare the second regional report on alcohol, to be disseminated at the upcoming 2018 Directing Council through a side event, and more widely in the Region.

5. PAHO should convene a high-visibility event, such as a high-level regional conference, to signal the public health impact of alcohol consumption as a high priority in the public health agenda regionally.

6. PAHO should increase dialogue with legislators and other politicians on the importance of addressing the problem of alcohol as a public health priority. This discussion should include presenting arguments for alcohol regulation, as these have the highest probability of getting the attention of the economic sector and generating public debate for policy changes.

7. PAHO should support a mechanism for working with journalists in the Region to make them more aware of the impact of alcohol on public health. These media representatives need to know which policies are effective and should be enacted and enforced, what the role of the industry is in maximizing the social acceptance of alcohol, and how the industry interferes in public policies that are beneficial to health and society. PAHO could provide informational

materials to journalists with an interest in alcohol issues and to nongovernmental organizations (NGOs) that regularly brief journalists, as well as support journalists in conducting investigations on the issue of alcohol. PAHO has an established network of journalists who receive regular updates, and alcohol could be included as a regular topic in those briefings. PAHO could also reinstitute a journalism award for outstanding articles focused on alcohol-related issues (done once in 2006).

On increasing political support and policy coherence:

1. Despite the economic importance of the alcohol industry in most countries, it is critical to recognize that selling and promoting alcoholic beverages is inevitably in conflict with the goal of reducing per capita alcohol consumption. According to Dr. Margaret Chan, the former Director General of the WHO, due to the alcohol industry's conflicts of interests, the industry should have no role in policy-making. Likewise, the alcohol industry should have no role in public health research or education, as these inform and shape policy-making, policy implementation, and key stakeholders' perceptions on alcohol issues. Those in the industry do have a role serving as producers, distributors, sellers, and marketers of alcohol; ensuring that their products meet minimum quality standards and that they comply with national policies aimed at protecting people from the harmful effects of alcohol; and informing consumers about what they are consuming.

2. PAHO should build the capacity of countries to develop policies without industry's influence and to recognize and face its interference.

3. The PAHO Director should become a strong voice emphasizing the role of alcohol in the burden of disease in the Region. The Director needs to convey a clear message on the detrimental effects of alcohol on the health and social welfare of individuals and families, including youth, women, and indigenous populations, as well as the need for urgent implementation of the "best buys" and the adoption of a national alcohol policy in all Member States.

4. The PAHO Director and the director of the PAHO Department of Noncommunicable Diseases and Mental Health should increase the visibility of alcohol as a public health priority, with a call to all Member States to do more to reduce the harmful use of alcohol. This should include promoting interprogrammatic, multisectoral, and interagency activities focused on alcohol, as well as a significant increase in resource mobilization efforts.

5. Alcohol should be included as a public health priority in the agenda of the Directing Council 2019. In that way, the commitments made by Member States on children and youth, NCDs, SDGs, and traffic safety at the global level can be included in a new regional plan of action with targets and indicators that reflect these commitments and require policy action to be met at country level. This will not only increase the evidence base for alcohol interventions, but also support immediate policy changes based on the current knowledge and expertise at regional and global levels.

6. PAHO should actively seek the inclusion of alcohol in the agenda of other sub regional cooperation mechanisms that exist in the Region, such as the Caribbean Community (CARICOM), the Common Market of the South (MERCOSUR), the Central American Integration System (SICA), the Council of Health Ministers of Central America (COMISCA), and the Union of South American Nations (UNASUR), as well as the United Nations Interagency Task Force (UNIATF) on the Prevention and Control of NCDs.

On advancing the "best buys" in the political agenda:

1. The PAHO Director should remind PAHO/WHO Representatives (PWRs) and respective countries of their commitments (globally and regionally) as they relate to alcohol, and that their duty to protect and promote the human right to health and life is a strong argument for the adoption of the "best buys" for alcohol policy.

2. PAHO should be actively involved in the UNIATF, to ensure that alcohol is fully considered and included in all decisions and negotiations.

3. PAHO should conduct a mapping exercise of countries' needs for and obstacles to implementing the "best buys," to gain knowledge of why policy action is not taking place, and thus better support Member States. There is a significant number of documents, training tools, and other materials that countries can take advantage of in their policy decisions and activities.

4. PAHO should promote the use of nontechnical language when developing materials and messages to policymakers.

7. The TAG recognizes the need for a "framework convention on alcohol control," similar to the one for tobacco, so that alcohol control measures (in particular marketing regulation) and a halt to alcohol industry interference can be achieved in the Region. However, given that this is a task that needs to be achieved globally, the TAG recommends that the Secretariat include activities that can facilitate this process into the next regional plan of action, as appropriate.

6 Technical cooperation, capacity building, and research

Background:

Since the adoption of the **PAHO Regional Plan of Action to Reduce the Harmful Use of Alcohol** in 2011, the following initiatives have been implemented:

- Technical cooperation for the development of alcohol-specific policies and plans has been provided to 25 countries, resulting in 6 adopted policies and plans and 13 policies and plans under development.

- PAHO has done much on the dissemination and application of knowledge. PAHO has created PANNAPH, a network of PAHO and ministry of health focal points, and with three face-to-face meetings held so far. PAHO has created an international network in Latin America called INEBRIA Latina, composed of researchers and clinicians interested in screening and brief interventions for alcohol problems in primary health care. This network has a dedicated website and an electronic newsletter to share new research information and disseminate activities at country level. PAHO has developed six courses on alcohol that are available in the PAHO Virtual Campus for Public Health: AUDIT and Brief Interventions, ASSIST and Brief Interventions, Alcohol Policy, Drug Policy, Alcohol Policy Advocacy, and Alcohol and Pregnancy. The courses are free of charge and are based on the best evidence available. PAHO has also organized webinars related to topics of interest to focal points. These include ones on alcohol and cancer, alcohol and adolescent health, alcohol and injuries, alcohol and gender, brief interventions for alcohol problems, alcohol policy and public health, the regional status on alcohol and health, alcohol

and pregnancy, alcohol marketing regulation, management of conflicts of interest, and alcohol epidemiology and burden of disease.

- With regards to building capacity in policy areas where regulatory legislation is needed, numerous workshops have been held, to supplement the regional virtual courses. Joint workshops with other risk factors (tobacco, nutrition) were organized. Workshops on taxation policies and on using the law to regulate risk factors were convened. There was a joint workshop with the CARMEN network on NCDs, as well as subregional workshops on alcohol policy development in the Caribbean and in Central America. Workshops for building capacity for the implementation of screening and brief interventions in primary health care settings were organized in countries that included Belize, Brazil, Cuba, the Dominican Republic, Ecuador, Guatemala, Guyana, Honduras, Nicaragua, Panama, Peru, and Uruguay. PAHO also collected alcohol-related laws from 19 countries in the Region, to be part of a repository on legislation.

- With regards to research efforts, PAHO coordinated the implementation of several regional studies by developing regional protocols that were adapted at country level. PAHO has also collaborated on secondary data analyses of data collected at country level, leading to various scientific publications. These publications have been disseminated through the regional networks, webinars and conferences.

- PAHO has developed principles for alcohol marketing regulation based on human rights.

- PAHO has strengthened alcohol surveillance in the Region through the implementation of STEPwise approach to Surveillance surveys (STEPS) and Global School Health Survey (GSHS) assessments, and is monitoring the health situation and assessing trends in the Region, in coordination with WHO.

Despite all these efforts and activities, the Secretariat's attempts to move the alcohol policy agenda forward have been insufficient to promote a positive change. The challenges have included the limited number of dedicated focal points in PAHO country offices, the lack of identified stable counterparts in the governments, inadequate funding to ensure continuation of the face-to-face PANNAPH meetings, and insufficient collaborations within PAHO areas and with external parties.

Regarding research activities, both WHO and PAHO had had successful experiences of collaborative research on prevention of alcohol-related injuries that could serve as a model for technical cooperation. Principal investigators from each of the countries included were given the opportunity to add more questions to the core questionnaire as they saw fit, which increased their investment and ownership in the study results. The data collected from these studies were integrated into a single database that contributed to the development of Global Burden of Disease (GBD) estimates and other endeavors. Even though collaborative research requires substantial resources, there are many regional and country-level benefits to be obtained. These include increased awareness and visibility of alcohol as a public health problem, as well as evidence on which to base recommendations for priority areas for reducing alcohol-related harm nationally and regionally. These data have the potential for improving monitoring and surveillance of alcohol-related injuries in the Region, for highlighting targets and providing justification for alcohol policies, for increasing political support and commitment, and for promoting policy coherence for achieving a reduction in alcohol-related harm. The more institutions and countries become involved in these kinds of collaborative efforts, the better the Region's data will be.

Recommendations:

1. All Member States should have a stable counterpart on alcohol policy at the ministry of health (across administrations) who is responsible for ensuring policy coherence at the national level; for coordinating activities across government sectors (including ministries of finance, education, governance, and environment), including monitoring and surveillance efforts; and for participating in multisectoral activities. Counterparts should become members of PANNAPH, and the Secretariat should contribute to providing those persons with opportunities for training on alcohol policy and public health, including on the "best buys," on alcohol policy advocacy, and on how to link topics that are relevant locally with the available evidence for policy action.

2. PAHO should strengthen the capacity of PAHO in-country focal points responsible for issues related to alcohol consumption to assist national counterparts in technical cooperation activities and in promoting initiatives free from commercial interests.

3. TAG calls on the PAHO Director to include alcohol as an agenda item of the next subregional meetings with PWRs, to encourage technical cooperation activities related to alcohol to advance the implementation of the Regional Plan of Action to Reduce the Harmful Use of Alcohol.

4. PAHO should require Member States that reported partial progress on a national policy and plan to finalize the process, by adopting the policy and plan with an identifiable budget to implement related activities.

5. PAHO should continue to promote regional collaborative research projects on priority alcohol-related areas. This would both generate data in support of alcohol policies and build capacity for alcohol-related health research. Such research should disaggregate data by sex, age, socioeconomic status, and special populations, as much as possible, to better inform future policy development.

6. PAHO should promote studies on the economic and social costs of alcohol consumption in key countries, to provide better arguments to policymakers on the need for policies to reduce these costs. These studies can be conducted in conjunction with research on other NCD risk factors, or independently.

7. PAHO should assist Member States in developing low-risk drinking clinical guidelines according to sex, age, vulnerable groups, and other factors. This should be done in collaboration with the respective national scientific societies and the best available evidence from the international scientific literature.

7 Interprogrammatic work and partnerships

Background:

The most relevant interprogrammatic work of PAHO in relation to alcohol has been a result of the integrated approach to risk factor prevention of NCDs. The WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 established common targets for NCD risk factors, including alcohol, tobacco, unhealthy diet, and physical inactivity. The most cost-effective policies to reduce consumption of the harmful products are related to their regulation (with fiscal policies, marketing control, and

limiting physical availability, at least for minors). Much could be achieved in an integrated way, thus saving resources and strengthening the response capacity of governments (within and outside the health sector). An integrated technical cooperation effort on these risk factors can:

- facilitate intersectoral dialogue for a better understanding of NCD issues, and generate economic evidence of the NCD epidemic
- facilitate dialogue specifically with the ministries of finance on fiscal policies on the best buys and their role in curbing the NCD epidemic
- raise awareness on the role of law as a powerful tool to prevent and control NCDs
- strengthen institutional capacity to regulate NCD risk factors and to manage conflicts of interest

As a result, PAHO developed the REGULA Initiative to tackle all risk factors and help support Member States in their efforts to implement regulatory policies and achieve the targets of the Global Action Plan for NCDs. REGULA has compiled and analyzed the laws and regulations related to each risk factor in 19 Member States and is now creating a repository that will be accessible through the Latin American and Caribbean Center on Health Sciences Information (BIREME) in 2018. Plans are underway to complete the compilation of laws in most Member States. Joint workshops were carried out, in the area of taxation and legislation, in several countries. Investment cases integrating all risk factors were also supported in Jamaica and Peru.

Beyond the overlap and commonalities between alcohol and other risk factors for NCDs, alcohol is associated with many other acute and chronic conditions (including injuries, violence, mental disorders, substance use disorders, HIV, hepatitis, TB, and suicide). As a result, there are many opportunities for interprogrammatic collaboration and benefit overall to public health. Alcohol affects all age groups and is related to social and gender inequities, and therefore could be integrated into nearly all technical areas within PAHO.

Civil society organizations have a key role in supporting alcohol policy and in advocating for policy development and implementation that is free from the influences of the alcohol industry. Civil society should be clearly distinguished from “social aspects organizations” (SAOs), which are entities created by the alcohol industry to manage issues that may be detrimental to its business. Civil society, on the other hand, aims to benefit the public good by working in the interest of the citizens, operating outside of the governmental and for-profit sectors. Civil society can become a strong, independent voice that can help advocate for policy changes regionally and nationally, when encouraged and enabled to play that role. Civil society also plays a critical role in generating population awareness about the real risks and negative impact of alcohol, and in changing the notion that alcohol is a normal and healthy part of our culture. Finally, civil society is key to shedding light on conflict of interest issues, including the interference of the alcohol industry in policy development, research, and education.

The influence of the alcohol industry on public health in the Americas and worldwide is a critical consideration. The alcohol industry has interpreted from the Global Strategy that the WHO has given them a formal collaborative role, but this is clearly not the case. Producers, distributors, promoters, and sellers of alcoholic beverages have a role to play in ensuring the quality of their product, minimizing its environmental impact, and complying with all related marketing and legal regulations. However, they have no role in policy, research, education, or training, given that these are areas in which a conflict of interest in public health exists. In recent years, 13 leading global alcohol producers increased significantly their contribution to “the fight against the harmful use of alcohol” by funding the

implementation of “five global commitments”: (1) reducing underage drinking; (2) strengthening and expanding marketing codes of practice; (3) providing consumer information and responsible product innovation; (4) reducing drinking and driving; and (5) enlisting the support of retailers to reduce harmful drinking.

These commitments appear to be consistent with the WHO Global Strategy, but a more careful analysis has determined that they are unlikely to reduce the harmful use of alcohol at the population level. Some of these planned activities raise legitimate concerns about their effectiveness and consequences, while others may compete with activities under the responsibility of governments and public health institutions and organizations. The industry implements these activities through SAOs, which hold the industry’s interest at heart. SAOs focus heavily on promoting and implementing educational activities, which have been proven to be largely ineffective and which are appealing to countries for being the least controversial measures to implement. At their worst, some of these activities can neutralize or replace necessary government regulations. The alcohol industry promotes the concepts of “responsible drinking” and “smart consumption,” but without defining them. Further, “responsible drinking” is in direct contradiction with the goal of increasing profits, as it has been shown that over 45% of the industry profits come from “irresponsible drinking”; if eliminated, the survival of the industry would be at serious risk.

Recommendations:

On interprogrammatic collaborations within PAHO:

1. PAHO should foster interprogrammatic collaboration with a focus on alcohol, within the following priority areas: maternal, child, and adolescent health; indigenous health; mental health; NCD risk factors; violence (especially gender violence); traffic safety; infectious diseases (HIV, TB, hepatitis); and human rights.

2. PAHO should continue to expand the collaborative efforts and coordination between alcohol and the other NCD risk factors, particularly tobacco and sugar-sweetened beverages (SSBs), on the implementation of the “best buys.” For example, taxation as well as investment cases should be advocated for all three issues whenever possible, incorporating the cost of all alcohol harms in the model.

3. The Director should encourage those technical areas and units identified by the TAG as priority for interprogrammatic collaboration to include alcohol-specific activities in their workplans, in coordination with the PAHO Department of Noncommunicable Diseases and Mental Health, and to allocate funding for their implementation. The Secretariat should then monitor the workplans to identify interprogrammatic collaborations and report them at next TAG meeting, including resources allocated, and progress on products and services.

4. Country cooperation strategies must include an analysis of the situation related to alcohol consumption, harms, and policies, so that specific activities can be proposed and funded.

On partnerships with external entities:

1. PAHO should strengthen and support PANNAPH, including capacity-building activities. PANNAPH should continue to meet face-to-face at least every other year, to ensure that counterparts continue to have an active role nationally and are able to coordinate actions, including intersectoral dialogue.

2. The Secretariat should reach out to a larger number of PAHO/WHO Collaborating Centers in the Region to identify those interested in collaboration on alcohol-related topics. The Secretariat can create a regional network that can help strengthen the technical cooperation and assist PAHO with some of the tasks and recommendations made by the TAG.

3. PAHO should identify and reach out to relevant stakeholders and potential partners, including the World Bank, Inter-American Development Bank (IDB), Organization of American States (OAS), and potential donors, and convene a meeting at PAHO Headquarters to discuss areas for collaboration. The Secretariat could use the existing fora of strategic partners to identify and connect with relevant entities.

4. A pivotal point in the global community making the case against tobacco was the World Bank economic report on tobacco. The Director should advocate for a similar World Bank report on alcohol.

On the role of civil society organizations:

1. Civil society organizations need to be key partners of PAHO and Member States. To this end, PAHO should provide support to civil society organizations, including relevant NGOs and other community organizations, in their activities to advance the alcohol policy agenda, and urge Member States to encourage civil society participation in the development and implementation of such policies.

2. PAHO should conduct a landscape analysis of existing civil society organizations in the Region that include a focus on health issues related to alcohol consumption. A similar effort at national level should be conducted in collaboration with Member States.

3. PAHO should encourage and support civil society organizations to:

    - require that governments report all contact with industry (by means of "freedom of information" legislation);

    - document alcohol industry interference in policy-making, research, education, and other activities that are outside of the industry's realm of expertise and where conflicts of interest could play a role; and

    - conduct an analysis of marketing strategies (including types of products, messages, and implicit target audiences) to identify and document inappropriate practices.

On the role of the alcohol industry:

1. PAHO should develop and maintain a public directory of CSR/SAOs[3] linked to the alcohol industry to clearly distinguish them from civil society organizations.

[3] CSR/SAOs are corporate social responsibility/social aspects organizations, which are groups or organizations that are largely funded by the alcohol industry and represent or promote the industry's views and goals, including activities to improve the general public's image and perception of the alcohol industry, to lobby against proven policies, and to educate about what the industry calls "responsible drinking."

2. PAHO should ensure that commercial interests remain separate from those of public health at all levels, by educating PWRs, ministries of health, and programs within PAHO on the industry's tactics for influencing policy, and by applying Framework of Engagement with Non-State Actors (FENSA) principles[4] in all interactions with the private sector and CSR/SAOs.

3. Finally, given the concerns about the influence and interference of the alcohol industry in the alcohol policy agenda, the Secretariat should publish the currently drafted and approved report with regional findings on alcohol industry influence as soon as possible. This can provide NGOs, policymakers, and others with evidence to support more informed decisions regarding their collaboration with the industry on matters such as alcohol-related policy development and research.

8 Next steps

- The next meeting of the TAG is proposed for the first week of December 2018, in a location to be determined.

- The agenda of the next TAG will be prepared in consultation with TAG members and may include:

    - review of progress made on the implementation of the 2017 TAG recommendations

    - discussion of challenges faced to implement the 2017 TAG recommendations, and potential solutions

    - review of report of the TAG Working Group on Monitoring and Surveillance, as appropriate

    - identification of critical evidence gaps on alcohol-related issues, and identification of potential sources of funding and collaborations

    - generation of new or updated TAG recommendations, as needed

[4] FENSA principles: http://www.who.int/about/collaborations/non-state-actors/en/