

# Possibility of Developing a Framework Convention on Control of Harm from Alcohol Use

*Report of an Intercountry Consultation  
SEARO, New Delhi, 5-6 January 2009*



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## 1. Opening session

An intercountry consultation on the Possibility of Developing a Framework Convention on Control of Harm from Alcohol Use was held in the WHO Regional Office for South-East Asia, New Delhi, on 5-6 January 2009. The message at the inaugural session by Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, was delivered on his behalf by Dr Poonam Khetrpal Singh, Deputy Regional Director. The full text of the message is in Annex A.

Dr Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse, WHO/SEARO, welcomed and introduced the delegates.

Mr Vineet Chawdhry, Joint Secretary, International Health, Ministry of Health and Family Welfare, Government of India was elected Chairman. Dr Samarn Futrakul, Director, Office of Alcohol Control Committee, Department of Disease Control, Ministry of Public Health, Thailand, was nominated as the Deputy Chairman and Dr Swe Win, Director (Administration), Department of Health, Ministry of Health, Myanmar, was nominated as the Rapporteur.

In the absence of the Chairman due to unavoidable circumstances, the Deputy Chairman chaired the meeting.

## 2. Technical presentations (Day 1)

### **Harm from alcohol use in the South-East Asia Region: Dr Vijay Chandra**

The harm related to alcohol use is being widely recognized by governments worldwide including those of the Region. Several resolutions on the subject have been adopted by the Regional Committee for South-East Asia and the World Health Assembly. Research findings related to alcohol use in the Region were summarized in the presentation and some of the estimates of

the prevalence of alcohol use were highlighted: 67% of males between 15 and 60 years of age in Nepal, 53.1% of males and 6.4% women above 15 years in Sri Lanka, 56% of adult males and 10% of adult females in Thailand, 20-30% of adult males and 5% of adult females in India used alcohol.

No quantity of alcohol can be deemed as “safe”, as harm is related to the context of use. Alcohol use is higher in poorer communities. The average age of initiation has reduced from 28 years during the 1980s to 20 years in recent years in India. Traditionally, alcohol is used by men. Now, use by women is increasing. Even among men, a significant proportion are life-time abstainers. Frequent use of small quantities of alcohol is not the predominant pattern of use as is common in Europe. Issues unique to the Region were also highlighted: pay-day drinking, violence (including domestic violence), alcohol as a contributor to poverty, illicit and home-brewed alcohol (“unrecorded alcohol”) and heavy use of alcohol on special occasions.

The initiatives of the Regional Office for South-East Asia to address harm related to alcohol in the Region were outlined. These include highlighting the issue in high profile meetings – e.g. Regional Committee and the Parliamentarians meeting, publication and distribution of technical material, multisectoral technical workshop, incorporation of harm from alcohol into the adolescent mental health programme, community assessment and development of community interventions. Future plans include testing of community interventions, advocacy and addressing Region-specific issues.

### ***Discussion***

A question was raised whether the “belief” that alcohol use protects from heart disease was true. It was pointed out that this “protective effect” had been observed in European and North American studies among alcohol users who drank small quantities of wine on a regular basis. Such evidence is not available from other parts of the world where the drinking patterns were substantially different. Therefore, it was emphasized that the above observation cannot be used to “justify” alcohol use in this Region. Participants also raised the necessity of advocacy among doctors on the current evidence on harm from alcohol use.

**Why consider a Framework Convention on Control of Harm from Alcohol Use? Dr Sharat Chauhan, Director, International Health, Ministry of Health and Family Welfare, Government of India**

The impact of alcohol on global public health was highlighted. Current statistics quantifying global harm from alcohol were presented. The various facets of alcohol-related harm which include health, social and economic harm were discussed. Recent statistics from India relating to alcohol use and harm, and the responses were outlined. The rationale for a Framework Convention on Alcohol Control was presented. It was shown that harm from alcohol use adversely impacts achievements of global social and development goals such as elimination of poverty, violence and prevention of injuries, gender-based violence and child abuse. Some issues related to alcohol such as production, sales and marketing are governed by sectors other than health. Therefore, there is a need to support multilateral bodies like WHO and other UN agencies and the need for association with NGOs and civil society groups to develop synergies for effective action.

***Discussion***

The necessity for an international Convention was further reiterated. It was emphasized that such an instrument was necessary to address cross-border issues such as trade liberalization, foreign direct investment, global marketing and transnational advertising. It was noted that as negotiating and implementing such a treaty takes time, the process should start quickly. It was suggested that the name of the Convention should be one that most countries can accept. There was general consensus that the name should be "Framework Convention on Alcohol Control" (FCAC). This would include a wide range of activities which can all lead to "control" of alcohol resulting in reducing harm from alcohol use. It was pointed out that "control" did not mean "ban". It was controlling consumption so that it does not cause harm.

It was stressed that banning alcohol is impractical as it is a socially embedded and religiously sanctioned practice in several countries of the Region. The concept of "modifying drinking settings" was further discussed. The example given was the prohibition of live entertainment in venues selling alcohol in India.

The fact that issues related to alcohol were similar to that of tobacco was discussed. The need for a supranational tool to address issues such as free trade agreements which bring in new brands, weaken policy and reduce taxes was highlighted.

**Process of developing and lessons learnt from the WHO Framework Convention on Tobacco Control (FCTC):  
Dr Douglas Bettcher, Director, Tobacco Free Initiative,  
World Health Organization HQ**

The presentation highlighted the process of developing the WHO FCTC, the origins of which can be traced back 30 years. However, the actual negotiation, entry into force and preparations for the treaty's implementation occurred during a ten-year period. Three Executive Board (EB) and four World Health Assembly (WHA) consensus resolutions were needed over a long period of time in order to initiate the negotiations of the Framework Convention. Origins of the FCTC were traced, from its inception as a concept, to the EB and WHA resolutions that were required and the process of negotiation until the text was agreed upon. The post-agreement steps required such as signature, ratification, coming into force, setting up of the Conference of the Parties to administer the Convention were also described. The unique socio-political circumstances that led to the process and its success were highlighted. The costs incurred were also discussed.

***Discussion***

The possibility of the process of developing a FCAC to address harm due to alcohol use being shorter and easier than the FCTC was raised, as the FCTC process had already taken place. It was pointed out that a positive socio-political backdrop needs to be created with wide-ranging support for such a process to succeed.

It was stressed that the costs incurred in developing the WHO Framework Convention on Tobacco Control (FCTC), were small compared to the estimated cost of a Convention on harm due to alcohol use. Until the Convention's entry into force, the WHO FCTC negotiation process required an estimated 34 million USD which did not include staff secondments and other contributions in kind. It was accepted that the cost of negotiating a

new agreement would be considerably more. It was highlighted that the significant budget required to negotiate any treaty makes it difficult to reach a consensus decision to proceed with such negotiations. It was reiterated that in addition to funds, the convergence of views of countries was also needed.

The issues which were in favour of the FCTC were discussed. One such issue was that it was a high priority WHO cabinet project. As per current rules, a costing is required before presentation of resolutions to the World Health Assembly (WHA). This could make it more difficult to launch any treaty negotiation in the WHA given the large budget requirements. It was also stated that the second Convention to be developed by WHO is under negotiation now, which is the protocol on illicit trade in tobacco. However, this treaty is being negotiated under the auspices of the Conference of Parties to the FCTC, not the World Health Assembly. Generally, protocol negotiations are less costly than the negotiation of the parent Framework Convention and thus are less challenging to initiate.

Concern was raised on the issue whether the WHO FCTC was an issue of the "north" which was forced on the "south" and whether it took tobacco farmers into consideration. It was explained that it was not a north-south issue, but that it was the developing countries that had pushed the negotiations. Many countries in the South-East Asia Region played a leading role to ensure a strong treaty. It was noted that Brazil, who chaired the meeting was a leading tobacco growing country, but had also implemented strong tobacco control measures. It was also stated that the Conference of Parties to the FCTC had appointed a working group to address the issue of tobacco farming. The progress of similar cabinet projects such as Roll Back Malaria was also discussed.

It was pointed out that in the case of tobacco there were almost 20 consensus resolutions adopted by the World Health Assembly from 1970 to 1999 before the negotiation of the WHO FCTC was initiated. These resolutions mapped out the key evidence-based, cost-effective interventions to reduce tobacco use, which were, in turn, endorsed by all of the Member States of WHO. The current situation with alcohol is not strictly comparable: two resolutions were adopted in the 1960s followed by a hiatus of 30 years where the World Health Assembly did not adopt any further resolutions until recently. Moreover, unlike tobacco control, the Member States of WHO have not all agreed on the evidence-based interventions to reduce alcohol

consumption. Furthermore, unlike tobacco control there is no global regulatory consensus regarding national measures to address alcohol use. There is a polarization of regulatory approaches ranging from prohibition to laissez-faire regulation. In this sense tobacco and alcohol control are not strictly comparable.

### **3. Country presentations and discussions (Day 1)**

#### **Nepal**

***Dr Y V Pradhan, Chief, Policy, Planning and International Cooperation Division, Ministry of Health and Population, Government of Nepal***

The prevalence of alcohol consumption among Nepalese adults is around 67% according to a National Survey conducted in 2006 and is showing an increasing trend (NCD Survey 2008). The degree of harm from alcohol use in the Nepalese community is still unknown as no study has been conducted. Looking at the large percentage of alcohol users, Nepal should introduce preventive, curative and rehabilitative activities to stop further deterioration of the situation. It was stated that whatever has been achieved in reducing harm from alcohol use should be further enforced and additional activities should be introduced at the earliest. The current requirement is a nationwide awareness campaign on harm from alcohol use to be organized involving civil society, physicians, media, vulnerable groups (teenagers) and women's groups. A community-based campaign to prohibit illegal alcohol production and sale, development and implementation of regulations to prohibit alcohol use in public places, public transport and cultural events and strict enforcement of law prohibiting drunk driving is also needed.

#### ***Discussion***

The discussions focused on the statistics presented. It was pointed out that the definitions of hazardous and harmful drinking used in the survey need to be clarified.

## **Indonesia**

***Dr Meinarwati, Secretary, Directorate General of Pharmaceutical Services and Medical Devices, Ministry of Health, Republic of Indonesia***

The problems related to alcohol in Indonesia were discussed. These included domestic and family violence, road traffic injuries, physical and mental health damage, social, criminal and economic problems. A drawback was that there were no data available on these issues, as there was no formal data gathering system. The currently published overall prevalence and the rates available from specific provinces were presented. Overall, the prevalence of alcohol use was quite low. The national programmes in place were outlined. The current regulations aimed at preventing alcohol-related harm in Indonesia were discussed in detail.

### ***Discussion***

The possible reasons for the low overall prevalence rate of 4.6% of alcohol use in Indonesia was raised. The response was that it was most probably due to Indonesia being a predominantly Muslim country.

The possible support by Indonesia to a FCAC also focused on the need for more information and research such as economic benefits of such an instrument will be needed to convince policy makers. The difficulty in providing national perspectives on FCAC while its contents were not clear were raised by the delegates of some countries.

It was stated that "control of harm" alone was not enough. The causes of harm need to be addressed. Despite some practices being historically sanctioned, it does not mean that they should continue. It was emphasized that alcohol use should also be viewed in the same light.

## **Bhutan**

***Mr Tandin Chogyel, Programme Officer, Mental Health Programme, Department of Public Health, Bhutan***

It is well known that both Bhutanese men and women consume alcohol. Consumption of alcohol is widely accepted and its use is culturally and

religiously permitted. At almost every occasion such as marriages, blessing ceremonies, rites of passage or offering to deities, receiving guests, or any other social gathering alcohol is served in any Bhutanese home. Many rural households brew various types of alcohol for household consumption and which may also be sold locally.

Due to excessive alcohol consumption by many Bhutanese people it is noticed that there is an increasing trend of liver diseases, accidents, deaths and many other legal and social problems. Alcohol has become a gateway to substance abuse for Bhutanese adolescents and youth. The Royal Government is concerned and has instructed relevant ministries and stakeholders to develop policy and control measures to discourage alcohol consumption. Statistics available on the harm from alcohol use were presented.

### ***Discussion***

The discussion focused on home-brewing of alcohol. It was pointed out that it is legal for people to brew alcohol at home in Bhutan, but it was illegal to sell such products.

## **4. Country presentations and discussions (Day 2)**

### **India**

***Mr Amit Mohan Prasad, Director, Public Health, Ministry of Health and Family Welfare, Government of India***

Data related to alcohol use from national surveys were presented. Around one third of males consume alcohol. Lowering of the age of initiation of consumption of alcohol was a cause for concern. The absence of data and annual reports of various state and national agencies were discussed. The guiding principles of the policies and programmes on alcohol were described and hinge mainly on Article 47 of the Constitution. Measures that have been taken to address alcohol-related harm were highlighted. These ranged from total prohibition in some States to prescribed minimum ages of drinking and a uniform minimum Blood Alcohol Concentration (BAC) level. One of the complicating factors with regard to alcohol control was that

taxation and other control measures vary across states, as India is a federal country and alcohol was a state subject. The legislative processes required for strengthening alcohol control were presented. The reasons why a global, legally binding Framework Convention to address alcohol-related harm was required were discussed in detail. These included issues such as cross-border trade of alcoholic beverages, global advertising and promotion, illicit trade and smuggling, packaging and labeling etc., which were international in nature.

### ***Discussion***

The minimum level of Blood Alcohol Concentration (BAC) and its implementation were discussed. The increasing trend of prevalence of alcohol use over the years, especially consumption of spirits over the last three years was highlighted. It was pointed out that some states in India (Gujarat, Manipur and Nagaland) impose prohibition of use of alcohol for various reasons.

The current global political support for a Framework Convention was discussed, and how such a process could be initiated under the current global political and social climate was deliberated on.

The definitions of harm reduction and sensible drinking were raised. It was pointed out that to have comprehensive harm reduction, “control” was necessary. It was also pointed out that in most instances, alcohol use is especially harmful to non-users, even when compared to tobacco.

It was noted that although all delegates seemed to agree on the need for a FCAC in principle, data on harm was needed for policy makers to initiate action. In response, it was pointed out that almost all countries had some measure of alcohol control in place such as BAC, minimum age for purchase and restrictions on advertising. Therefore, policy makers were already aware and there was some element of political commitment. The fact that there were many studies providing sub-national and precise data on alcohol-related harm was also highlighted. The Bangalore Study sponsored by SEARO also had a large amount of data on the social harm due to alcohol. It was also stated that using taxpayers’ money to address the costs of alcohol is a “harm” to non-using tax payers.

The fact that the term, “harm reduction”, had originated from the field of illegal substance abuse was emphasized. The discussion concluded that the application of this concept to alcohol needed adaptation. This was essential as consumption needed to be addressed to reduce harm from alcohol, which was not always the practice in reducing harm from illegal substances.

## **Myanmar**

***Dr Swe Win, Director (Administration), Department of Health, Ministry of Health, Myanmar***

The current statistics on alcohol-related harm in Myanmar were discussed. Data from Yangon Mental Health Hospital showed that there was a high level of alcohol dependence among patients admitted to the hospital. The prevalence rates of alcohol use showed that alcohol use among women was quite low. A recent community survey supported by WHO/SEARO showed that pay-day drinking was widespread, and exposure to violence following alcohol use, and drinking a large amount of alcohol on one occasion are matters of concern. The possibility of obtaining national support for a FCAC was also outlined.

### ***Discussion***

The statistics presented were discussed and further elaborated.

## **Thailand**

***Dr Samarn Futrakul, Director, Office of Alcohol Control Committee, Department of Disease Control, Ministry of Public Health, Thailand***

The alcohol consumption control legislation of Thailand was presented in detail. The alcohol control strategy of Thailand is classified under six groups. These are: price and taxation; physical availability and consumption context control (time and place of sales-drink/minimum purchasing age); drink-driving counter measures; advertising control; education and persuasion; and screening and treatment. It was stated that Thailand welcomed an international instrument to tackle alcohol-related harm, because it will

make it easier to enact a comprehensive alcohol control act or to enact rules and regulations.

### ***Discussion***

The practical difficulties of addressing indirect and surrogate advertising of alcohol through national laws were discussed.

It was explained that through national-level action, the consumption of alcohol had leveled off after several decades. In response to a question it was stated that Thailand conducts surveillance of problems related to alcohol use. The possible factors that attracted children to media portrayals of alcohol were discussed.

## **5. Technical presentation (Day 2)**

### **Regional cooperation on the control of harmful use of alcohol, Dr Thaksaphon Thamarangsi, Alcohol Policy Research Programme, International Health Policy Programme, Ministry of Public Health, Thailand**

This presentation covered the following issues related to a possible Framework Convention on Alcohol Control (FCAC): principles and challenges, comparing tobacco and alcohol, situation analysis, strategy to put FCAC on WHO's agenda and personal recommendations of the presenter.

The factors that led to the success of the Framework Convention on Tobacco Control (FCTC) were listed and discussed. The obstacles faced during the process were also outlined. The positive outcomes of the FCTC beyond the treaty itself were described. They included national policy development, broadening the perspectives of tobacco control, creating ownership of tobacco control at national and international levels and expanding programmes of work and involvement of new sectors in tobacco control.

The similarity and dissimilarities between tobacco and alcohol in the context of global policy development were outlined. The supportive scenarios for FCAC were described. This included the recommendation of the WHO Commission on Social Determinants of Health which urged

WHO to consider global governance mechanisms such as the Framework Convention on Tobacco Control to address health damaging commodities such as processed food and alcohol. The possible foci of resistance for the development of FCAC were listed. The advantages and disadvantages of possible strategies to put FCAC on the agenda of WHO were discussed in detail. Strategies to bridge the gaps in regional cooperation were identified.

## **6. Conclusions and recommendations**

It was decided that the proposed strategy will be called: Framework Convention on Alcohol Control (FCAC). The underlying principle of the framework convention will be to prevent and reduce harm from alcohol use.

The delegates suggested that a draft preamble for the FCAC be prepared for stimulation of discussion among WHO Member States. The text of the draft with was proposed is in Annex E.

### **Why should a Framework Convention on Alcohol Control be developed?**

The factors in favour for an FCAC were discussed and the following were agreed:

- Currently, there is no international legally binding instrument to tackle alcohol-related problems.
- Individual countries cannot address globalized and cross-border problems on a stand-alone basis.
- Countries face common challenges: e.g. free trade agreements, globalization.
- The benefits of the Framework Convention on Tobacco Control on development of national and international policy on tobacco control was substantial.
- Many issues related to alcohol such as production, sales and marketing are governed by sectors other than health, and thus can be addressed only in a comprehensive treaty.

- Efforts to effectively tackle alcohol-related problems require multi-sectoral collaboration at national and international levels beyond the health sector.
- Controlling harm from alcohol use requires the support of multilateral bodies like WHO, other UN agencies and WTO etc.
- NGOs, the media and civil society groups may have to be associated to develop synergies for effective action.
- A Framework Convention is needed for generating awareness and for highlighting concerns about the harm caused by alcohol use.
- Issues like cross border trade of alcoholic beverages, global advertising and promotion, illicit trade and smuggling, packaging and labeling etc., which are international in nature can be best handled through international efforts for which an international enabling environment and an instrument is required.

### **Suggested mechanisms for alcohol control in a Framework Convention**

- Consumption control
- Prevention and reduction of harm from alcohol use, and
- Screening, early detection, treatment and rehabilitation.

### **General recommendations**

- (1) There should be proactive implementation of the Regional Committee for South-East Asia resolution RC59-R8.
- (2) Regional efforts should be encouraged to build up capacity and legal frameworks for alcohol control in Member States of the South-East Asia Region.
- (3) The development of a SEAR advisory group to effectively facilitate policy development at the national, regional, inter-regional and global levels should be initiated and strengthened. This partnership should consist of policy makers, implementing

agencies and regulators, academia, professionals and civil society who are free from commercial interests.

- (4) There should be active support by Member States in the South-East Asia Region in the development of the Global Strategy to Reduce Harmful Use of Alcohol.

### **Specific recommendations on FCAC**

- (1) Member States in the South-East Asia Region should propose for consideration of the 125<sup>th</sup> meeting of the Executive Board and the Sixty-third World Health Assembly, a request to the WHO Director-General to explore the feasibility of setting up a Framework Convention on Alcohol Control through WHO processes/mechanisms and report to the World Health Assembly.
- (2) Member States in the South-East Asia Region should request support from Member States of other WHO Regions for the proposal asking for a feasibility study on Framework Convention on Alcohol Control.

## **Annex A**

# **Message From Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region**

*(Delivered by Dr Poonam Khetrapal Singh, Deputy Regional Director)*

Distinguished Participants, Colleagues, Ladies and Gentlemen,

It is with great pleasure that I welcome you all to this important intercountry consultation. As you may be aware, the Hon. Minister of Health and Family Welfare of the Government of India had suggested the possibility of developing a framework convention on control of harm from alcohol use during the sixty-first session of the Regional Committee held in New Delhi in 2008. WHO is happy to host this meeting enabling Member States of the Region to discuss this issue further.

There is substantial evidence that alcohol use is a major contributor to morbidity and mortality in the community both within the South-East Asia Region and globally. For example, WHO has estimated that there are about 2 billion people worldwide who consume alcoholic beverages, and 76.3 million with disorders arising out of harmful use of alcohol. A causal relationship between alcohol use and over 60 types of diseases and injuries have been documented. Unintentional injuries account for approximately one third of the 1.8 million deaths due to alcohol.

In the South-East Asia Region, studies have indicated that health, social and economic harm from alcohol is widespread in several countries. On average, use of alcohol has been on the increase in the Region, imposing numerous challenges on policy-makers, professionals, civil society and on public health system. A study on the burden and the socio-economic impact of alcohol use, sponsored by the WHO Regional Office for South-East Asia, conducted by the National Institute of Mental Health and Neurosciences in Bangalore, India, published in 2006, estimated that the losses to the economy from adverse effects of alcohol was around 5 billion US dollars each year. Another study conducted by the same institute for the World Health Organization in 2001 found that the injuries of 80%

of males admitted to an emergency unit in a general hospital in Bangalore, India, could be related to alcohol use by the injured themselves or by others. The 2001 Demographic and Health Survey of Nepal found that 47.4% of males between the ages of 15-19 years consume alcohol. The Thailand National Household Survey on Estimation of Population of Alcohol Abuse in 2007 estimated that over 6 million alcohol users, which is more than half of all users, had a heavy drinking episode, also known as binge drinking, during the last 12 months. A community survey conducted in Myanmar by WHO showed that half of all alcohol users indulged in pay-day drinking, probably wasting a large proportion of their earnings on alcohol. All this information is well documented by the WHO Regional Office for South-East Asia in its series of publications on alcohol use.

When the Region is considered as a whole, there are also many unique features of alcohol consumption. For example, the relationship between alcohol and poverty is a major concern. A substantial proportion of income of the economically deprived is spent on alcohol rather than health, food or education. This, in turn, leads to many social problems such as malnutrition of children, chronic debt and disempowerment. There are many harmful patterns of alcohol use such as binge drinking, pay-day drinking, and driving while drunk. The consumption of illicit alcohol, home brewing of alcohol and domestic violence linked to alcohol is also found in several countries.

Governments of Member States of our Region have been very concerned about the harmful effects of the increasing use of alcohol in the community. They have requested WHO's support in developing plans, programmes and projects to reduce the harm. Resolutions adopted by the Regional Committee for South-East Asia and the World Health Assembly have given impetus to addressing harm related to alcohol use.

Ideally any approach to reduce harm from alcohol use should result in changing the behaviour of individuals and communities. To reach that end, the diversity of the context in which harm occurs should be taken into account. A myriad number of languages, religions, ethnicities, cultural norms, geographical regions, political ideologies and forms of government flourish in this Region. This leads to many variations in behaviour, perception and programmes related to the use of alcohol, not only between countries, but also within countries. Thus, any programme which is developed should be within the cultural context of the community.

Recognizing the need to address harm related to alcohol use in a sustained and effective manner, the WHO Regional Office for South-East Asia (SEARO) has initiated a two-pronged strategy. While working to strengthen alcohol policies and making them more comprehensive, SEARO is also giving priority to implement community-level interventions for the prevention of harm from alcohol use.

Alcohol production, distribution, marketing, retailing and use are complex issues involving many sectors. Thus, alcohol use is related not only to health, but also related to economics, trade, laws and employment. A paradoxical factor is the substantial revenue to governments from alcohol production sales, which is immediate and tangible, in contrast to the harm that ensues from alcohol which is often delayed and latent. There are also cross-border or international issues such as trade agreements, smuggling and cross-border media promotion. Such issues could be addressed by an international convention which is adapted by individual countries.

An example of a control strategy to consider is the Framework Convention on Tobacco Control, which has given worldwide impetus in reducing harm from tobacco use. This legally binding instrument has not only empowered governments, but has also enabled them to intensify action on comprehensive tobacco control.

Distinguished participants,

I am delighted to note that in this consultation you will discuss the issues that are pertinent to a possible framework convention on reducing harm from alcohol use, and discuss the process and the lessons learnt during the process of bringing the framework convention on tobacco control to life. It is a great privilege to host this meeting, and I will look forward to your recommendations on the way forward for the prevention of harm from alcohol use.

In conclusion, I wish you success in your deliberations and a very pleasant stay in New Delhi

Thank you.

## **Annex B**

### **Agenda**

- Opening address by the Regional Director
- Presentation on harm from alcohol use in South-East Asia Region
- Presentation on: "Why consider a Framework Convention on Control of Harm from Alcohol Use?"
- Presentation on process of developing and lessons learnt from the Framework Convention on Tobacco Control
- Country presentations and discussion on "National Perspective on Framework Convention on Control of Harm from Alcohol Use"
- Presentation on regional co-operation on "Framework Convention on Control of Harm from Alcohol Use"
- Discussion of World Health Assembly and Regional Committee resolutions on prevention of harm from alcohol use
- Process in developing the global strategy to reduce harm from alcohol use
- Recommendations and closing

## **Annex C**

# **Programme**

### **Day 1: 5 January 2009, Monday**

- |             |   |
|-------------|---|
| 1000 - 1030 | Registration  |
| 1100 - 1115 | Opening Address by the Regional Director  |
| 1115 -1130  | Introduction of participants, nomination of office bearers and group photograph   |
| 1130 - 1200 | Harm from alcohol use in South-East Asia Region: Dr Vijay Chandra   |
| 1200 - 1230 | Why consider a Framework Convention on Control of Harm from Alcohol Use: Representative of the Government of India  |
| 1330 - 1430 | Process of developing and lessons learnt from the Framework Convention on Tobacco Control: Dr Douglas Bettcher, HQ (presentation & discussion)            |
| 1430 - 1600 | Country presentations on "National perspective on a framework convention on control of harm from alcohol use" (presentation & discussion 45 minutes each) |
| 1615 - 1745 | Country presentations on "National perspective on a framework convention on control of harm from alcohol use" (presentation & discussion 45 minutes each) |
| 1745 - 1800 | Discussion and wrap up of day 1   |

### **Day 2: 6 January 2009, Tuesday**

- |             |   |
|-------------|---|
| 0900 - 1030 | Country presentations on "National perspective on a framework convention on control of harm from alcohol use" (presentation & discussion 45 minutes each)       |
| 1045 - 1215 | Country presentations on "National perspective on a framework convention on control of harm from alcohol use" (presentation & discussion 45 minutes each)       |
| 1215 - 1300 | Presentation and discussion of working paper on "Regional co-operation on a framework convention on control of harm from alcohol use" by Government of Thailand |
| 1345 - 1415 | Process in developing the global strategy to reduce the harmful use of alcohol: Dr Vijay Chandra  |
| 1415 - 1530 | Discussion on next steps  |
| 1545 - 1700 | Recommendations and closing   |

## Annex D

### List of participants

#### **Bhutan**

Mr Tandin Chogyel  
Programme Officer  
Mental Health Programme  
Department of Public Health  
Thimphu

#### **India**

Mr Vineet Chawdhry  
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Mr Debasish Panda  
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## **Annex E**

### **Text of draft preamble for the proposed Framework Convention on Alcohol Control**

WHO has estimated that there are about 2 billion people worldwide who consume alcoholic beverages, and 76.3 million with disorders arising out of harmful use of alcohol. A causal relationship between alcohol use and over 60 types of diseases and injuries have been documented. Unintentional injuries account for approximately one third of the 1.8 million deaths due to alcohol.

A study on the burden and the socio-economic impact of alcohol use, sponsored by the WHO Regional Office for South-East Asia, conducted by the National Institute of Mental Health and Neurosciences in Bangalore, India, published in 2006 estimated that the losses to the economy from adverse effects of alcohol was around 5 billion US dollars each year. Another study conducted by the same institute for the World Health Organization in 2001 found that the injuries of 80% of males admitted to an emergency unit in a general hospital in Bangalore, India, could be related to alcohol use by the injured themselves or by others. The 2001 Demographic and Health Survey of Nepal found that 47.4% of males between the ages of 15-19 years consume alcohol. The Thailand National Household Survey on Estimation of Population of Alcohol Abuse in 2007 estimated that over 6 million alcohol users, which is more than half of all users, had a heavy drinking episode, also known as binge drinking, during the last 12 months. A community survey conducted in Myanmar by WHO showed that half of all alcohol users indulged in pay-day drinking, probably wasting a large proportion of their earnings on alcohol. All this information is well documented by the WHO Regional Office for South-East Asia in its series of publications on alcohol use.

- Alcohol is responsible for considerable mortality and morbidity worldwide.
- Alcohol consumption is one of the ten leading risk factors for death and disease globally.

An intercountry consultation on the Possibility of Developing a Framework Convention on Control of Harm from Alcohol Use was held in the WHO Regional Office for South-East Asia, New Delhi, on 5-6 January 2009. The harm related to alcohol use is being widely recognized by governments worldwide including those of the Region. Several resolutions on the subject have been adopted by the Regional Committee for South-East Asia and the World Health Assembly. The impact of alcohol on global public health was highlighted by several speakers. Some issues related to alcohol such as production, sales and marketing are governed by sectors other than health. Therefore, there is a need to support multilateral bodies like WHO and other UN agencies and the need for association with NGOs and civil society groups to develop synergies for effective action. The rationale for a Framework Convention on Alcohol Control was discussed and the need for an international Convention was reiterated. It was emphasized that such an instrument was necessary to address cross-border issues such as trade liberalization, foreign direct investment, global marketing and transnational advertising. The SEAR Member States would take this proposal forward at appropriate forums.



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