

A Draft Framework to Reduce the Harm from Alcohol in the Pacific

Introduction

This framework provides a series of evidence-based objectives to reach a number of outcomes leading to a reduction in alcohol-related harm. It reflects shared concerns across the Pacific Islands Countries and Territories (PICT) and provides a framework for collaborative regional activity.

This framework has been developed to link with the Draft Pacific Plan to Strengthen Regional Co-operation and Integration. It also links with the regional Non-communicable Diseases Strategy which is calling for integrated approaches that involve government and communities in the development of effective policies and strategies to address the rise of non-communicable disease across the Pacific. Such approaches are being developed in a number of Pacific countries.

This framework is based on work undertaken at three recent meetings on alcohol in the Pacific. In September 2004 the Secretariat of the South Pacific (SPC) and World Health Organisation (WHO) held a meeting in Noumea for government representatives from the Pacific region. This was preceded by a meeting of Western Pacific non-government (NGO) and voluntary organisations sponsored by the NZ Ministry of Health and held in Auckland. As a result of the Noumea meeting, it was recommended that a working group comprising interested members of the 2004 meetings be convened by WHO and SPC to develop a draft Regional Action Plan to reduce the harm done by alcohol. This meeting was held in Auckland in June 2005 and the framework below is a result of the work done by Pacific government and NGO representatives at the Auckland meeting.¹

Framework Objectives

The Framework aims to reduce the harm from alcohol in the Pacific by:

1. Implementation of effective (sub) regional cooperative action
2. Implementation of effective regional and international cooperative action
3. Implementation of effective country level strategies

Outcomes

Reducing harm from alcohol in the Pacific region

The Pacific Islands region includes low mortality developing countries of the kind in which alcohol has been estimated to account for the largest proportion of disability adjusted life years lost (DALYs) among the twenty risk factors investigated.¹ Alcohol is an underlying cause of much injury, violence, premature deaths, mental ill-health, unintended pregnancy and STIs.² It is also strongly associated with social problems

¹ Technical support at the meetings was provided by the Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University, a World Health Organisation Collaborating Centre.

that seriously impact on families, communities and society as a whole, and contributes to social and health inequalities.¹

The second tier outcomes which this framework for action sets out to achieve are to:

Reduce alcohol related family violence

There is a linear relationship between alcohol consumption and the risk of involvement in violence. Recent Pacific studies reflect this relationship. A study in Samoa³ reported alcohol as the second most frequent cause of violence towards women. A 2002 study⁴ in New Caledonia reported that alcohol abuse was found in 88% of violent crimes and 70% of rapes and sexual aggressions, and in Papua New Guinea (PNG)⁵ about 85% of domestic violence and child abuse was alcohol related.

Reduce alcohol related traffic crashes

Drinking patterns in the Pacific tend towards episodic and often heavy drinking on each occasion. Intoxication is strongly linked to road traffic crashes and injury. For example, in Guam in 2000 over fifty percent of fatal crashes were alcohol or drug related⁶ as were 96% in PNG.⁵ Alcohol is also a principal cause of road traffic crashes in French Polynesia⁷

Reduce alcohol related injury

Injury accounts for the largest proportion of the alcohol-attributable disease burden in high income countries.⁸ Evidence from the Pacific suggests this is also the case for some Island nations. For example, in Papua New Guinea a survey of Accident and Emergency Departments found 50% of admissions were due to trauma (eg falls, fights, traffic crashes, family violence, accidents at home or work). In 96% of the cases alcohol was involved.⁵

Reduce physical and mental harm from alcohol use

Alcohol is a causal factor in more than 60 diseases including cardiovascular disease, mental disorders, road traffic injuries and death, and high-risk behaviours.¹ People with alcohol dependence problems are more likely to suffer from mental health problems.⁹ A failure to limit the increases in alcohol consumption will place a greater burden on health services and the community.

Increase the age of onset of regular drinking

There is evidence that the earlier young people start drinking, the greater the likelihood that they will experience alcohol related harm.^{10,11} Cross country analyses indicate that a global youth culture has developed that is being influenced and shaped in part by commodity marketing including that for alcohol.¹² There is concern across most Pacific countries about the decreasing age of youth drinking, and especially about binge drinking, for example in the Marshall Islands, Fiji, Cook Islands and New Caledonia.⁹

Reduce proportion of alcohol consumed in heavier drinking occasions

The levels of alcohol consumption vary considerably across Pacific countries. Statistics that report total alcohol as an average per head of population can be misleading. For example in 1993, average consumption in Fiji was 1.5 litres per head of population but only 21% of men and 2% of women were drinkers; so males who were drinkers consumed an average of 16 litres of alcohol per year, a very high

level.¹³ This supports the view that among drinkers, heavier drinking has become normalized in some sectors of Pacific communities with 20-30% being heavy drinkers and exhibiting problem drinking behaviours.⁹

1. Implementation of effective (sub) regional cooperative action

Creating a framework for alcohol policy for the Pacific will help create an appropriate Pacific region culture to support regulation of alcohol and reduction of harm. A Pacific wide approach can support alcohol issues being integrated into other Pacific region initiatives. For example, the Pacific region might aim to:

- Improve alcohol related focus of police training including projects such as the Police Regional Training Project (PRTTP)
- Consider whether alcohol should be excluded/continue to be excluded from regional free trade and economic agreements
- Support NGO networks by building links through the Global Alcohol Policy Alliance (GAPA)
- Attract funds from development agencies and explore other funding opportunities eg run donor meeting(s)
- Enhance policy knowledge and focus at sub regional level by means of appropriate workshops and knowledge dissemination
 - Ensure linkage to other relevant regional plans
 - Ensure close collaboration between SPC, WHO and other key agencies on policy, strategy and implementation at all appropriate levels.

2. Implementation of effective cooperative action at regional and international level

The Pacific Islands Countries and Territories are part of the WHO Western Pacific region. The Framework to Reduce Harm from Alcohol in the Pacific will be available to inform the development of the WHO Western Pacific Regional Strategy on Alcohol. The Pacific Strategy on Non-communicable diseases may also help to inform the WPRO Regional Alcohol Strategy.

Since the passing of the resolution "Public health problems caused by harmful use of alcohol" at the 58th World Health Assembly, WHO is encouraging regional offices to begin developing an action plan that can feed into the development of a global strategy on alcohol. This Framework is based on considerable input from the Pacific (sub) region and is likely via its contribution to the WPRO strategy to make a contribution to the global strategy.

3. Implementation of Effective Country Level Strategies

3.1 Principles for action

- *Enforcement of laws*

Many Pacific countries have a range of legislation and policy to reduce harm from alcohol. However, enforcement is mixed, often lacking due to limited resources. Advocacy for increased resources and prioritisation for police to enforce these regulations, with support from other government agencies and community based organisations is needed.

- *Cross government collaboration*

Inter-sectoral collaboration is essential to the development and implementation of effective alcohol strategies to reduce harm, including establishing and enhancing sustainable mechanisms for cross government engagement. This may involve sectors such as finance, customs, health, statistics, youth affairs, and business. As policies from different sectors shape the way we drink, it is important that knowledge and perspectives are shared across areas of government. In particular, police in the Pacific region have been identified as having a vital and under utilized role to play in monitoring and enforcing liquor laws. Collaboration between sectors with a role in alcohol regulation is essential.

- *Collaboration between NGOs, and between NGOs and government*

Non government organizations play a vital role in raising community concerns, health issues and advocating for effective strategies with policy makers. For this reason, building capacity in NGO, and community based organizations (CBOs) including church networks is important. Because NGOs and CBOs are uniquely placed to undertake an advocacy role, it is important they receive support to develop and sustain strong networks. Also, forums for information exchange between governments and NGOs, including collaborative policy development work need to be strengthened. Key stakeholder involvement can contribute to building effective public policy. For example, traditional structures and leaders can support reduction of alcohol harm within the family, village and in youth settings.

- *Resources for country level strategies*

To implement effective national alcohol strategies, resources are needed to cover the costs of regulating production and distribution, enforcement of alcohol and drink driving legislation, monitoring and regulating alcohol marketing, and primary healthcare/treatment services.

Some countries in the Pacific are establishing national health promotion foundations funded from alcohol and tobacco taxes.¹⁴ These can supply the much needed resources for community action, skills development, capacity building, knowledge sharing, data gathering, research and evaluation of alcohol policies and strategies.

- *Advocacy re effective strategies, consumption trends and harm*

Advocacy, including the use of the media to promote awareness and support for effective alcohol policies, has been shown to be an effective strategy in building public support for population focused environmental alcohol policy. NGOs and CBOs have an important role in media advocacy.

Data collection on consumption trends, patterns, externalities and economic costs can assist in targeting strategies and focusing advocacy.

The alcohol industry, particularly the retail sector, may have a role in the implementation of some strategies. However, experience and analysis from other countries have shown that where the alcohol industry has been involved in the policy making process, this has generally resulted in the adoption of weaker policies. The influence of the industry favours maintaining consumption levels and expanding sales into new markets.

3.2 Implementation of effective strategies

Research from high income countries provides strong evidence that effective strategies exist. These have been found to be policies that alter the environment in which drinking choices are made, such as limiting the physical and economic availability of alcoholic beverages, strengthening drink-driving legislation and restricting the marketing of alcohol. Evaluation is needed to assess whether similar strategies are as effective in low income countries, such as the Pacific Islands, and the ways in which implementation may need to differ. However, the current evidence provides a good basis for beginning to implement and develop strategies across the Pacific.

Effective strategies

- *Introduce/maintain taxation policies that support reduction of harm from alcohol*

Evidence suggests that, for both moderate and heavy drinkers, the price of alcohol has an effect on levels of consumption.^{8,15,16} In high income countries, young drinkers have been found to be especially sensitive to price increases^{17,18}, meaning that tax effects on price can slow recruitment of young people to drinking. In populations with a lower prevalence of heavy drinking, taxation may be less cost effective than other, more targeted strategies.¹⁵ However taxes on alcohol can both generate revenue for governments and reduce consumption and harm from alcohol. A useful aspect of tax policy is for tax to be automatically inflation adjusted annually to maintain the real price.¹⁹ Regulations on taxes and prices are relatively easy to establish and maintain, and low cost to implement.

Introduce/maintain taxation policies that support reduction of harm from alcohol	Recommendations
<p>Disseminate existing research evidence</p> <p>There is a lack of knowledge in relevant sectors on the role of tax in reducing alcohol harm.</p>	<p>Treasuries, key government offices and other relevant agencies in the Pacific be made aware of the evidence on tax and harm in high income countries.</p>
<p>Undertake regional research on tax and harm reduction</p> <p>There is a need to ascertain whether excise tax creates similar levels of harm reduction in Pacific countries as high income countries.</p>	<p>Econometric studies on tax in low and mid income countries be undertaken.</p>

<p>Inflation adjust excise tax as a tool for achieving public health</p> <p>Some jurisdictions may not have considered inflation adjustment as a way of ensuring that alcohol becomes no easier to afford.</p>	<p>Any alcohol excise tax be automatically adjusted annually for inflation.</p>
<p>Protect pricing from impact of any trade agreements</p> <p>While tariffs may be removed in some instances, this does not mean alcohol needs to be more affordable.</p>	<p>The price of alcohol be protected from the impact of any economic and trade agreements (by setting excise taxes as least as high as any tariff removed).</p>

▪ *Reduce/change access to alcohol*

There is good evidence that policies restricting alcohol availability such as restricting hours of sale and density of liquor outlets are effective in reducing drinking and alcohol-related problems.^{8,16} Recent studies^{20,21} have shown increased problems such as drink-driving and injuries, with longer trading hours.

Evidence gained from countries that have increased their minimum purchase age indicates that this is also one of the most effective measures to reduce alcohol-related harm.^{22,23}

A recent assessment of the most likely cost effective policies for different world regions concluded that for the Pacific Islands region, (which is classified as a low income area with low premature mortality) would benefit from policies aimed at restricting supply including restricted access at weekends, along with restrictions on marketing.¹⁵

Reduce/change access to alcohol	Recommendations
<p>Enforce minimum purchase age</p> <p>Most Pacific countries have a minimum purchase age which is very commonly not enforced.</p>	<p>Strategies for enforcement of the minimum purchase age be developed both at the local and national levels.</p>
<p>Reduce hours of access and separate from risk situations</p> <p>Some countries have reduced opening hours and restricted alcohol sales on pay day.</p>	<p>Hours of access be reduced and other types of barriers created to accessing alcohol.</p>
<p>Limit number of outlets to control density and to limit access in villages</p> <p>While the effects of an extra premise may be minor where there is already considerable availability of alcohol, large changes in outlet density, such as allowing alcohol in grocery stores, can have a substantial influence on consumption and problems.²⁴</p>	<p>Number and density of outlets, be limited (including small, family outlets at the village level).</p>
<p>Review licensing laws</p> <p>Some Pacific countries have limited regulation of alcohol.</p>	<p>Policies and laws be reviewed to identify priorities for developing an effective liquor licensing framework.</p>

<p>Work collaboratively with police and traditional policing systems</p> <p>Police in some countries are not resourced and supported by other sectors to undertake enforcement. Traditional policing systems exist and can also be utilized in reducing harm.</p>	<p>Police be adequately resourced and trained to undertake enforcement, with support from other sectors.</p> <p>Collaboration with traditional leaders and police be enhanced.</p>
<p>Regulate home brew/illegal production of alcohol in order to facilitate control of physical availability and price.</p> <p>Home brewing or illegal production of alcohol is widespread in Pacific countries.</p>	<p>Regulations on informal/illegal production be introduced or strengthened.</p>
<p>Reduce smuggling in order to facilitate control of physical availability and price.</p> <p>There is some illegal sale of commercial alcohol in the Pacific.</p>	<p>Smuggling be reduced.</p>
<p>Strengthen/support traditional controls on alcohol</p> <p>Traditional controls on use of informally produced alcohol have commonly been developed and implemented.</p>	<p>Traditional controls be strengthened and supported to ensure a continued reduction in harm.</p>
<p>Monitor/respond to kava and other substance use</p> <p>There is increasing concern about non-traditional use of kava often in combination with alcohol, in countries such as Fiji, Vanuatu and New Caledonia.</p>	<p>Use of other substances (eg kava, cannabis) be monitored.</p>

▪ *Drinking contexts*

Strategies that focus on the context in which alcohol is consumed are increasingly being used in high income countries. Licensed premises have particularly been the target for policies aimed at reducing alcohol related problems. The most effective strategies in high income countries have involved active enforcement of regulations around serving and legal liability of bar owners.⁸

Drinking contexts	Recommendations
<p>Fully enforce current and new alcohol laws</p> <p>Countries in the Pacific have reported that laws regulating alcohol have been passed (eg laws against selling to intoxication or a minimum age of purchase), but they were not well known and were not being enforced.²⁵</p>	<p>Laws against serving to intoxicated patrons or underage patrons be introduced and/or enforced.</p>

<p>Train security guards in licensing and enforcement</p> <p>Door staff or security guards are sometimes employed to control overcrowding, inappropriate behaviour and to enforce conditions of their employer's liquor license (for example not allowing sales to underage young people). However, evidence suggests that security guards may sometimes initiate aggression and/or increase levels of violence. Anecdotal evidence suggests this is occurring in the Pacific.</p>	<p>Security personnel be screened and trained in dealing with aggression from drinkers to reduce alcohol related violence in or near licensed premises.²⁶</p>
<p>Explore introducing community policing model to urban settings</p> <p>Community policing can play an important role in reducing harm from alcohol at the village level.</p>	<p>This model be adapted for use in urban settings if appropriate.</p>
<p>Remove 'happy hours' and other promotions</p> <p>Promotions may encourage people to drink heavily, especially when the price of alcohol is discounted. Such promotions are common in many Pacific countries.</p>	<p>Law that bans or restrict promotions be introduced or strengthened.</p>
<p>Investigate seller liability approaches</p> <p>Legislation exists in one high income country to enable a third party to sue staff who serve alcohol to an intoxicated person who then causes that person harm²⁷.</p>	<p>Seller liability be explored as a possible strategy for some parts of the Pacific.</p>

▪ *Regulated marketing environment*

Alcohol marketing is increasing in low and middle income countries.²⁸ Marketing practices are becoming increasingly sophisticated, and where controls are weak or not enforced, marketing pervades many different media and environments. Sponsorship is another powerful means of promotion which embeds the product in everyday activities of the consumer and reinforces links between alcohol brands and cultural identity.²⁹ Competitions with prizes of branded merchandise and large quantities of alcohol are an increasing phenomenon worldwide.^{30,31} While alcohol advertising on television is not permitted in some Pacific countries, visible marketing is common in many Pacific countries in the broadcast media, print media, bill boards, outdoor advertising, in promotional merchandise and at outlets. It is likely that younger people are particularly responsive to alcohol marketing. Pacific young people also see alcohol advertising and 'hidden' promotions on satellite television, videos and films.

Internationally alcohol marketers are increasing using new technologies such as telephone texting and web sites. This type of marketing gives marketers access to younger people and is not always noticed by older adults.

There is some evidence that bans on alcohol advertising and broadcast and other media can be effective and are low cost to implement. Bans are usually partial and may result in other marketing practices taking on greater importance, so to be effective policy should cover as many types of media as possible.³²⁻³⁵ Voluntary industry codes on the content of advertising are unlikely to be effective in countering the many ways that advertisers find to 'push the boundaries' in order to make alcohol advertising attractive to young people.^{36,37} An assessment of cost-effectiveness of a

selection of policies¹⁵ has identified comprehensive advertising bans, along with restrictions on supply, as likely to have the greatest health benefit for countries such as those in the Pacific region.

Regulated Marketing Environment	Recommendations
<p>Regulate alcohol advertising and marketing There is little comprehensive regulation of alcohol marketing in Pacific countries.</p>	Regulatory control on all forms of marketing and sponsorship in all media be introduced, maintained or strengthened, including consideration of bans.
<p>Document extent of use of existing and new marketing approaches There are many forms of advertising and marketing of alcohol across Pacific countries. Newer marketing approaches include use of email, cell phones, and viral marketing.</p>	Existing and new alcohol marketing be documented, monitored and methods of control explored.
<p>Ban industry branding/sponsorship Alcohol companies or retailers advertise the sponsorship of sport and cultural events in Pacific countries. Alternative funding sources like national health promotion foundations can allocate funding to replace alcohol industry sponsorship and enable links between alcohol brands and sports and cultural events to be weakened.</p>	All forms of branding of sports and cultural events via advertising and/or sponsorship by alcohol producers or retailers be banned.
<p>Ban competitions Competitions are used in the Pacific as a way of encouraging consumption.</p>	Bans on use of competitions be introduced, maintained or strengthened.

Treatment and Early Intervention

Brief intervention can be a cost-effective treatment for people with drinking problems. This involves advice being provided as part of primary health. One review of randomised control trials of brief intervention found a 22% net reduction in alcohol consumption in the intervention groups.³⁸ While treatment interventions are designed to reduce drinking in the individual drinker, they may also have impact at the community and population level.⁸ There are, however, considerable barriers to implementing brief intervention as there are sometimes few incentives for health professionals to take the time to include it in their consultations, for example when there is a fixed fee for service.³⁹

Treatment and Early Intervention	Recommendations
<p>Encourage brief intervention There is an opportunity to further utilise existing evidence on brief intervention and early intervention to enable existing primary health providers, community health workers and others to identify needs and deliver appropriate brief intervention.</p>	Health providers and community workers be encouraged to undertake brief intervention and early intervention.

<p>Provide training for health professionals</p> <p>Many health professionals are not aware of how to effectively intervene to reduce harmful drinking by patients</p>	<p>Training in brief intervention and recognizing alcohol related harm be included in health professional curricula.</p>
---	--

▪ *Drinking driving counter measures*

Measures to reduce drink-driving and associated injury and death have strong evidence for effectiveness. Random breath testing (RBT) is effective, especially if highly visible, and license suspension can have an impact. Breath testing equipment is used in Micronesia and the Philippines⁴⁰ Some other countries do not have access to RBT technology but may set up roadblocks as sobriety check points. There is strong evidence that a lower legal blood alcohol concentration (BAC) can reduce alcohol related harm.⁴¹ A lower BAC limit (near zero) for young drivers has been very effective in reducing alcohol-related crashes in some countries.^{42,43} Several countries in the Pacific already have .05% BAC eg French Polynesia, while some are at 0.08% and others have no BAC set by law.⁴⁰

Some Pacific countries are carrying out publicity campaigns about drinking and driving. There is little evidence that mass media campaigns on their own are effective, but hard hitting media messages can be effective in raising awareness of drink drive laws and enforcement, for example in supporting public awareness of random breath testing.^{44,45} Persuasive or emotional mass media campaigns (supported by consistent enforcement) have been found to be more effective than rational, informational style campaigns.⁴⁶

Drinking Driving Counter Measures	Recommendations
<p>Enable wider breath testing technology</p> <p>Many Pacific countries do not currently have breath testing technology widely available to their police. Provision of the technology would enable this monitoring and enforcement tool to be more widely adopted.</p>	<p>Appropriate breath testing technology and additional resources be provided and used.</p>
<p>Lower and harmonise blood alcohol concentrations (BAC)</p> <p>Countries need to move towards harmonization of allowable breath alcohol levels to those levels supported by research evidence. There is good evidence for lowering BACs towards 0.05mg/ml for adult drivers and zero tolerance for young/new drivers.</p>	<p>Blood alcohol concentrations be lowered/harmonized at 0.05mg/ml for adult drivers and zero tolerance for young/new drivers.</p>
<p>Provide resources for drink driving counter measures</p> <p>Provision of adequate administrative support and resources is required to implement effective drink driving countermeasures like random breath testing, road blocks etc.</p>	<p>Resources for drink driving countermeasures be provided and implemented.</p>

<p>Introduce license suspensions and graduated driver licensing Evidence shows that the immediacy of a penalty is important for effective graduated driver licensing.</p>	<p>Administrative license suspension and graduated driver licensing be introduced.</p>
<p>Utilise sobriety checkpoints While sobriety checkpoints are at risk of being less effective as drinkers avoid known checkpoint sites, this may be a useful strategy where resourcing for random tests is restricted.</p>	<p>Sobriety checkpoints be utilised where random breath testing technology and utilisation is limited.</p>
<p>Collaborate with police Participation from police and planning of complementary strategies across sectors will enhance effective drink-driving counter measures.</p>	<p>Collaboration between police and other relevant sectors be supported and community action be encouraged to support implementation and monitoring of alcohol policies.</p>

Conclusion:

The implementation of the measures outlined in this Framework will contribute within the Pacific to a lowered burden of disease from alcohol use and an enhanced community life.

Appendix One

Participants List for the NZ SPC/WHO/NZ MoH Meeting in Auckland

Working Group Participants

Dr Kai Dagaam	Papua New Guinea
Dr Christian Michel	New Caledonia
Dr Viliami Puloka	Tonga
Dr Solomon Qaranivalu	Fiji
Shelly Rao	Pacific Network on Globalisation
Andrew Peteru	Foundation for the People's of the South Pacific

Observers

Ross Bell	NZ Drug Foundation
Metua Fa'asisila	ALAC (NZ Alcohol Advisory Council)
Linda Hill	Global Alcohol Policy Alliance

Officials

Dr Chen Ken	WHO Representative in the South Pacific
Wang Xiangdong	WHO Manila
Dr Harley Stanton	Secretariat of the Pacific Community
Dr Ashley Bloomfield	NZ Ministry of Health
Ms Jo Bergi	NZ Ministry of Health
Bruce Wright	Australian Federal Government, Dept of Health and Ageing

WHO Collaborating Centre/SHORE staff

Professor Sally Casswell
Sally Liggins

Appendix Two

SECRETARIAT OF THE PACIFIC COMMUNITY
AND
WORLD HEALTH ORGANIZATION

SECRETARIAT GENERAL DE LA COMMUNAUTE DU PACIFIQUE
ET
ORGANISATION MONDIALE DE LA SANTE

MEETING ON ALCOHOL AND HEALTH IN THE PACIFIC
(28-30 September 2004, Noumea, New Caledonia)

CONFERENCE SUR L'ALCOOL ET LA SANTE DANS LE PACIFIQUE
(28 au 30 septembre 2004, Nouméa, Nouvelle Calédonie)

PARTICIPANTS

Cook Islands
Iles Cook

Mr Tuaine Teokotai
Chief Health Inspector
Department of Public Health
Ministry of Health

Federated States of Micronesia
Etats fédérés de Micronésie

Mr Kerio Walliby
Chief of Section for Substance Abuse
And Mental Health of the Dept of Health
Education and Social Affairs

Fiji
Fidji

Dr Odille Chang
Principal Medical Officer
St Giles Hospital
Suva

French Polynesia
Polynésie française

Dr Marie-Françoise Brugiroux
Médecin responsable de la consultation
spécialisée en alcoologie et toxicomanie
Direction de la Santé
Ministère de la qualité de la vie, de la
santé et de la solidarité

Guam

Mr J. Peter Roberto
Director
Department of Mental Health and
Substance Abuse (DMHSA)

Kiribati

Mr Marewe Tatau
Assistant Commissioner of Police
(Operations)

Marshall Islands

Mr Gerard Mejbon

<i>Iles Marshall</i>	Coordinator of Human Services Ministry of Health
Nauru	Ms Krystalmaine Dick Women's Development Officer Department of Women's Affairs & Culture
Niue	Mrs Minemaligi Asu Hetutu Pulu Public Health Nurse Charge Niue Health Department
Nouvelle-Calédonie <i>New Caledonia</i>	Dr Bernard Rouchon Médecin cadre territorial de la Santé et de la Prévention Service des Actions Sanitaires Direction des affaires sanitaires et sociales
	Dr Christian Michel Alcoologue Responsable de l'unité de prévention du risque alcool
	M. Jean-Pierre Bailly DASS Chargé de mission auprès du Directeur
Palau	Dr Sylvia Andres Chief of the Division of Behavioral Health, Bureau of Public Health Ministry of Health
Papua New Guinea <i>Papouasie Nouvelle Guinée</i>	Mr Kaii Len Dagam Director Department of Health
Solomon Islands <i>Iles Salomon</i>	Mr Albyy Lovi Director Health Promotion Services Ministry of Health
Tokelau	Dr Petelo Alapati Tavite Environment/ Public Health/ Policy Advisor Tokelau Department of Health
Tonga	Dr Viliami Puloka Senior Medical Officer Head of Promotion and Non Communicable Diseases
Tuvalu	Mr Fanoanoaga Patoro Chairman

Tuvalu National Alcoholic
Drinks Licensing Committee
Government of Tuvalu

Wallis & Futuna

Mademoiselle Géraldine Danigo
Cadre de santé, infirmière
Agence de Santé

OBSERVERS

Pacific Islands Forum Secretariat

Dr Helen Tavola
Social Policy Adviser

New Zealand, Ministry of Health

Ms Sally Liggins
Senior Portfolio Manager

**Australia, Commonwealth
Department of Health and Ageing**

Mr Bruce Wight
Director
Alcohol and Harm Reduction Initiative
Section
Drug Strategy Branch, Prevention Branch

SPEAKERS

Netherlands

Mr Peter Anderson
International Consultant in Public Health
Honorary Appointment to Oxford University

Massey University

Professor Sally Casswell
Director
Centre for Social and Health Outcomes
Research and Evaluation (SHORE)
Massey University

Ms Emily Rose
Research Associate
Centre for Social and Health Outcomes
Research and Evaluation (SHORE)

EUROCARE

Mr Derek Rutherford
Editor in chief
The Globe
Globe Alcohol Policy Alliance

FACILITATOR

**Allen and Clarke Policy
and Regulatory Specialists
Limited**

Ms Liz Price
Senior Associate

SECRETARIAT

WHO

Dr Chen Ken
WHO Representative in the South Pacific

Dr Vladimir Poznyak, M.D., Ph. D.
A/Coordinator
Management of Substance Abuse Unit
Department of Mental Health and Substance
Abuse (MSD)
WHO Geneva

Dr HAO Wei
Medical Officer
Mental Health and Control of Substance
Abuse
WHO/Western Pacific Regional Office

SPC - PUBLIC HEALTH PROGRAMME

Dr Mark Jacobs
Manager, Public Health Programme
Public Health Programme
Secretariat of the Pacific Community

Dr Harley Stanton
Health Promotion Adviser - Tobacco and Alcohol

Mrs Jimaima Tunidau-Schultz
Lifestyle Health Adviser

Mr Tony Lower
Team Leader
Pacific Action for Health, non communicable
diseases

Dr Dennie Iniakwala
HIV/AIDS/STI Adviser

Mrs Rolande Trolue
Women's Development Officer
Pacific Women's Bureau

Mr Tangata Vainerere
Youth Development Adviser
Pacific Youth Bureau

Appendix Three



Asia Pacific NGO Meeting on Alcohol Policy 23 September 2004 Auckland

LIST OF ATTENDEES

Speakers

Nau Epiha	SHORE/Whariki Kaumatua
Hon Damien O'Connor	Associate Minister of Health
Sally Casswell	Director, SHORE, Massey University
Peter Anderson	Public Health Consultant
Stanley Simpson	Pacific Network on Globalisation (PANG)
Linda Hill	Global Alcohol Policy Alliance (GAPA)
Lanuola Asiasiga	Centre for Social and Health Outcomes Research and Evaluation (SHORE)
Derek Rutherford	Global Alcohol Policy Alliance (GAPA)

Participants	
Viliamu Emanuele	Alcohol and drug co-ordinator, Sautiamai Catholic Family Ministry, Samoa
Tautala Mauala	Secretary General, Red Cross, Samoa
Thaksaphon Thamarangsi	Public Health Specialist, International Policy Program, Ministry of Public Health, Thailand
Ofa-Ki-Levuka Guttenbeil	United Nations Volunteer, Catholic Women's League, Tonga
Teurakai Ukenio	Senior Social welfare person in the Ministry of Internal Affairs (also works closely with Adolescent Reproductive Health and Pacific Action for Health project), Kiribati
Jiafang Zhang	Department of Epidemiology and Health Statistics, Tongji Medical College, Huazhong University of Science and Technology, China
Tuaine Teokotai	Chief Public Health Officer, Cook Islands
Ben Tanaki	Vice Chairman NUANGO, Niue Association of NGOs, Niue
Pamodinee Wijayanayake	Executive Director, Alcohol and Drug information Center (ADIC), Sri Lanka
Teurakai Ukenio	Senior Social Welfare person in the Ministry of Internal Affairs, active member of the HIV/AIDS task force, and the general

	registrar for NGOs, Kiribati
Drew Havea	Chairman of the Alcohol sub-committee, Tonga Family Health Association, Tonga
Suaree Borell	Te Ropu Whariki, Massey University
Stanley Simpson	PANG

Observers	
Tony Lower	Team Leader, Pacific Action for Health Project Secretariat of the Pacific Community (SPC), Noumea
Bill Stronach	Director, Australian Drug Foundation
Nemani Seru	Lecturer, Health Promotion Focal Point, School of Public Health and Primary Care, Fiji School of Medicine, Suva, Fiji
Ieti Lima	Macmillan Brown Centre for Pacific Studies, University of Canterbury
Rebecca Williams	Director, Alcohol Healthwatch
Ross Bell	Director, New Zealand Drug Foundation (NZDF)
Helen Hunter	Analyst, National Drug Policy, Ministry of Health
Chris Laurenson	Team Leader, National Drug Policy, Ministry of Health
Keith Robertson	Institute of Alcohol Studies, London, UK
Metua Fa'asisila	Pacific Manager, Alcohol Advisory Council
Anna Maxwell	Alcohol Healthwatch and SHORE
Sally Liggins	Workstream Leader:Alcohol and Drugs, New Zealand Ministry of Health

Appendix Four

References for A Framework to Reduce Harm from Alcohol in the Pacific

1. World Health Organization (2002) *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva. World Health Organization.
2. Peteru A (1997) *The Sexuality and STD/HIV Risk-Related Sexual Behaviours of Single, Unskilled, Young Adult, Samoan Males: A Qualitative Study*, Masters thesis.
3. United Nations Population Fund/Secretariat of the Pacific Community. (2000) Samoa Country Report, in: *Report from SPC/WHO Meeting on Alcohol and Health in the Pacific, Noumea, New Caledonia, September 2004*. Noumea: SPC
4. French Institute of Health and Medical Research. (2002) Health and living conditions of New Caledonian Women, in: *Report from SPC/WHO Meeting on Alcohol and Health in the Pacific, Noumea, New Caledonia, September, 2004*: Secretariat for the Pacific Community. Noumea: SPC
5. Secretariat of the Pacific Community. (2004) Papua New Guinea country report, in: *Report from SPC/WHO Meeting on Alcohol and Health in the Pacific, Noumea, New Caledonia, September*: SPC, Noumea.
6. Secretariat of the Pacific Community. (2004) Guam Country Report, in: *Report from SPC/WHO Meeting on Alcohol and Health in the Pacific, Noumea, New Caledonia, September*. Noumea: SPC
7. Secretariat of the Pacific Community. (2004) French Polynesia Country Report, in: *Report from the SPC/WHO Meeting on Alcohol and Health in the Pacific, Noumea, New Caledonia, September 2004*. Noumea: SPC.
8. Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, Grube J, Gruenevald PJ, Hill L, Holder H, Homel R, Osterberg E, Rehm J, Room R, Rossow I. (2003) *Alcohol: No Ordinary Commodity - Research and Public Policy*. Oxford: Oxford University Press
9. Secretariat of the Pacific Community. (2004) *Report from SPC/WHO Meeting on Alcohol and Health in the Pacific, Noumea, New Caledonia, September*. Noumea: SPC.
10. Chou SP, Pickering RB. (1992) Early onset of drinking as a risk factor for lifetime alcohol related problems. *Addiction*, 87:1199-1204.
11. Grant BF, Dawson DA. (1997) Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse*, 9:103-110.
12. Casswell S. (2004) Alcohol brands in young peoples' everyday lives: new developments in marketing. *Alcohol and Alcoholism*, 6:471-476.
13. Han S. (1998) Current problems of alcohol abuse in the Western Pacific Region and future prospects. *Alcoholism: Clinical & Experimental Research*, 22:177S-180S.
14. World Health Organization Regional Office for the Western Pacific (2005) *Health promotion infrastructure and financing (press release)*. Manila. Available at http://www.wpro.who.int/health_topics/health_promotion/
15. Chisholm D, Rehm J, van Ommeren M, Monteiro M. (2004) Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *Journal of Studies on Alcohol*, 65:782-793.

16. Loxley W, Toumbourou J, Stockwell T (2004) *The Prevention of Substance Use, Risk and Harm in Australia: A Review of the Evidence*. (National Drug Research Institute and the Centre for Adolescent Health). Canberra. Commonwealth of Australia.
17. Coate D, Grossman M. (1988) Effects of alcoholic beverage prices and legal drinking ages on youth alcohol use. *Journal of Law and Economics*, 31:145-171.
18. Chaloupka F, Grossman M, Saffer H. (2002) The effect of price on alcohol consumption and alcohol-related problems. *Alcohol Research & Health*, 26:22-34.
19. Zhang J-F, Casswell S. (1999) The effects of real price and a change in the distribution system on alcohol consumption. *Drug and Alcohol Review*, 18:371-378.
20. Chikritzhs T, Stockwell T. (2002) The impact of later trading hours for Australian public houses (hotels) on levels of violence. *Journal of Studies on Alcohol*, 63:591-599.
21. Ragnarsdottir P, Kjartansdottir A, Daviosdottir S. (2002) Effect of extended alcohol serving-hours in Reykjavik. In: Room R, (ed.) *Effects of Nordic Alcohol Policies: What Happens to Drinking and Harm When Alcohol Controls Change?* Helsinki, Finland: Nordic Council for Alcohol and Drug Research (NAD), 145-154.
22. Voas R, Tippetts A, Fell J. (2000) Relationship of alcohol safety laws to drinking drivers in fatal crashes. *Accident Analysis and Prevention*, 32:483-492.
23. Wagenaar A, Toomey T. (2002) Effects of minimum drinking age laws: review and analyses of the literature from 1960 to 2000. *Journal of Studies on Alcohol*, Supplement 14:206-225.
24. Noval S, Nilsson T. (1984) Mellanolets effekt pakonsumtionsunivn och tillvaxten hos den totala alkoholkonsumtionen (The effects of medium-strength beer on consumption levels and the rise in overall alcohol consumption). In: Nilsson T, (ed.) *Nar mellenolet forsvann (When middle-strength beer disappeared)*. Linkoping: Nar mellenolet forsvann, 77-93.
25. Jeffs BW, Saunders WM. (1983) Minimising alcohol related offences by enforcement of the existing licensing legislation. *British Journal of Addiction*, 78:67-77.
26. Wells S, Graham K, West P. (1998) "The good, the bad, and the ugly": responses by security staff to aggressive incidents in public drinking settings. *Journal of Drug Issues*, 28:817-836.
27. Mosher J. (1979) Dram shop liability and the prevention of alcohol-related problems. *Journal of Studies on Alcohol*, 40:773-798.
28. Riley L, Marshall M. (1999) *Alcohol and Public Health in 8 Developing Countries*. Geneva: Substance Abuse Department, World Health Organization
29. Buchanan D, Lev J. (1989) *Beer and Fast Cars: How Brewers Target Blue-Collar Youth Through Motor Sports Sponsorship*. Washington DC: AAA Foundation for Traffic Safety
30. Obot I, Ibanga A. (2002) Selling booze: alcohol marketing in Nigeria (A paper given at Drinking it in: Marketing and Promotion of Alcohol to Young People, WHO Valencia Conference, May, 2002). *The Globe New Series - (GAPA)*, No 2.

31. Madden N (2005) *Global News: Text messaging ads on fast track in Asia*. Available at <http://www.adage.com/paypoints/buyArticle.cms/login?articleId=1571&auth>, accessed 27 April 2005
32. Deeks J. (1992) Who's choking smoking? Advertising, Sponsorship and government regulation of the tobacco industry. In: Deeks J, Perry N, (eds.) *Controlling Interests: Business, the State and Society in New Zealand*. Auckland: Auckland University Press.
33. Saffer H. (1997) Alcohol advertising and motor vehicle fatalities. *Review of Economics and Statistics*, 79:431-442.
34. Saffer H. (1998) Economic issues in cigarette and alcohol advertising. *Journal of Drug Issues*, 28:781-793.
35. Saffer H. (2002) Alcohol advertising and youth. *Journal of Studies on Alcohol*, Supplement No.14:173-181.
36. Baggott R. (1989) Regulatory reform in Britain: The changing face of self-regulation. *Public Administration*, 67:435-454.
37. Jones S, Donovan R. (2002) Self-regulation of alcohol advertising: is it working for Australia? *Journal of Public Affairs*, 2/3:153-165.
38. Higgins-Biddle and Babor 1996, cited in, Babor et al. (2003) *Alcohol: No Ordinary Commodity - Research and Public Policy*, Oxford: Oxford University Press.
39. Seppä K. (2004) Towards a comprehensive treatment strategy - the role of primary health care. *Alcohol Policy Making in the Context of a Larger Europe: Bridging the Gap, Warsaw, Poland, 16-19 June*.
40. World Health Organization (2004) *Global Status Report: Alcohol Policy*. Geneva. Department of Mental Health and Substance Abuse, WHO.
41. Mann R, Macdonald S, Stoduto G, Bondy S, Jonah B, Shaikh A. (2001) Effects of introducing or lowering legal per se blood alcohol limits for driving: International review. *Accident Analysis and Prevention*, 33:569-583.
42. Voas R, Tippetts A (1999) *Relationship of Alcohol Safety Laws to Drinking Drivers in Fatal Crashes*. Washington, DC. National Highway Traffic Safety Administration.
43. Zwerling CJ, M.P. (1999) Evaluation of the effectiveness of low blood alcohol concentration laws for younger drivers. *American Journal of Preventive Medicine*, 16:76-80.
44. Homel R. (1988) Random breath testing in Australia: a complex deterrent. *Australian Drug and Alcohol Review*, 7:231-241.
45. Homel R. (1993) Random breath testing in Australia: getting it to work according to specifications. *Addiction*, 88:27S-33S.
46. Delaney A, Lough B, Whelan M, Cameron M (2004) *A Review of Mass Media Campaigns in Road Safety*. Victoria, Australia. Accident Research Centre, Monash University. Available at <http://www.monash.edu.au/muarc/reports/muarc220.pdf>