SUBMISSION TO THE WEB-BASED CONSULTATION ON THE WORLD HEALTH ORGANIZATION'S 'GLOBAL ALCOHOL ACTION PLAN 2022-2030'

The Australian Research Centre in Sex, Health and Society, La Trobe University, Australia

David Moore, Helen Keane, Suzanne Fraser, kylie valentine & Kate Seear

Professor David Moore is a Professorial Research Fellow in the Drugs, Gender and Sexuality Research Program at the Australian Centre for Sex, Health and Society at La Trobe University, Australia. Author of numerous publications on the social and cultural contexts of alcohol and other drug use, David has co-edited (with Paul Dietze) *Drugs and Public Health* (Oxford University Press, 2008) and (with Suzanne Fraser) *The Drug Effect: Health, Crime & Society* (Cambridge University Press, 2011), and co-authored (with Suzanne Fraser and Helen Keane) *Habits: Remaking Addiction* (Palgrave Macmillan, 2014). He is currently leading an Australian Research Council-funded project on the treatment of gender in research and policy on alcohol and violence in Australia, Canada and Sweden.

Professor Helen Keane is based in the School of Sociology at the Australian National University. Author of the highly cited book *What's Wrong with Addiction?* (2002, Melbourne University Press), she has published extensively on alcohol and other drug use, addiction, gender, the body, health and medicine, and feminist theory. She is a Chief Investigator on a current Australian Research Council-funded project on the treatment of gender in research and policy on alcohol and violence in Australia, Canada and Sweden.

Professor Suzanne Fraser is Director of the Australian Research Centre in Sex, Health and Society at La Trobe University, and a Visiting Professorial Fellow at the Centre for Social Research in Health, University of New South Wales, Australia. She has published widely on health, gender and the body.

Professor kylie valentine is the Deputy Director of the Social Policy Research Centre, University of New South Wales, Australia. Her research interests include the impact of human services policies and programs, and the application of methods and concepts from the sociology of knowledge to new areas and concerns.

Associate Professor Kate Seear is an Australian Research Council Future Fellow and an Associate Professor at the Australian Research Centre on Sex, Health and Society, La Trobe University, Australia. She has published widely on health, gender and the law.

This submission addresses a specific aspect of the World Health Organization's 'Global Alcohol Action Plan 2022-2030': its treatment of gender. Our concerns and recommendations for improvements are summarised below in four points.

1. The targeting of women

First, we recommend that more critical attention be paid to the recommendation that drinking be prevented 'among pregnant women and *women of childbearing age*' (p. 17, emphasis added). The singling out of the majority of women for special attention and restrictions is starkly inconsistent with data cited elsewhere in the Plan. For example, on page 2, the Plan notes that:

> in 2016, an estimated 2.3 million deaths and 106.5 million DALYs among men globally were attributable to alcohol consumption. For women, the figures were 0.7 million and 26.1 million, respectively.

This means that men are over three times more likely than women to die from alcohol-attributable consumption, and they lose over four times the number of disability-adjusted life years than women. Furthermore, men are over five times more likely than women to live with alcohol use disorders (237 million men versus 46 million women) (p. 2). These data suggest that if any gender should be the target of specific policy attention and initiatives, it is men.

In addition, the targeting of 'women of childbearing age' reduces women to their reproductive capacity and suggests that women matter only by virtue of their ability to produce children (Thomas & Bull, 2018, p. 34). This represents a devaluing and restriction of women's personhood, and is consistent with long and oppressive traditions that seek to control women's bodies as if they are public property. Moreover, it erases the many women who choose not to bear children, or indeed cannot become pregnant, reinforcing socially harmful stereotypes about women – the very same stereotypes known to be associated with intimate partner violence (WHO, 2021). Substance use by women is already highly stigmatised, and the framing of women in the Plan risks making them more vulnerable to discrimination and less likely to seek care (Campbell & Herzberg, 2017). The recommendation that women's alcohol use be prevented also seems inconsistent with the emphasis on empowerment, equity and human rights elsewhere in the Plan.

We also note that the Plan's very limited approach to gender is reinforced by the failure to consider any issues pertaining to non-binary, trans and gender diverse populations, and to acknowledge their needs or interests.

2. Alcohol and violence

Another related focus of the Plan in need of attention is its treatment of alcohol and violence (see pp. 3, 11, 17, 26). A recent review of the 'history and current state of interpersonal violence research and prevention', which cites WHO and UN global estimates, notes that '[m]en are overwhelmingly more likely than women to be both perpetrators and victims of interpersonal violence' (Fleming et al., 2015, p. 250). Fleming et al. (2015) also report the following statistics:

- '95% of persons convicted of homicide were male';
- 'between 25 and 38% of women [worldwide] experience some sort of violence perpetrated by male partners'; and
- '81% of interpersonal violence deaths were men' (pp. 250-51).

If the relationship between 'harmful alcohol use' and violence is to be genuinely addressed by the Plan, men's drinking (as well as masculinities in general) should be a prime focus of specific policy attention and initiatives.

The reluctance to identify masculinities and men's drinking is at odds with the Plan's willingness to identify other specific population or sub-population groups as requiring specific attention. In addition to singling out 'women of childbearing age', the Plan also identifies 'young people' (pp. 7, 8, 26) and 'young people [or 'youth' or 'children'] and adolescents' (pp. 7, 9, 17), as well as 'indigenous populations', 'unemployed persons' and 'family members of people with alcohol use disorders' (p. 26).

3. Addressing male gender

Taking a broader view, based on these and other issues in the Plan, we ask why male gender is overlooked. For example, in relation to violence, if reducing the availability of alcohol is an effective means of reducing violence, and men are by far most responsible for this violence, should men's access to alcohol be limited? Such a policy would be consistent with the 'evidence base', and, as noted above, with alcohol policy's willingness to single out specific 'priority groups' for special attention and restrictions. Instead, blanket measures to reduce violence (such as reducing alcohol availability across the whole population) are proposed. These not only unnecessarily limit the choices of those least likely to contribute to, and more likely to be the victims of, such violence (most notably women, especially in the case of sexual violence), but they also actively obscure the sources and of such harms (Moore et al., 2020; Moore, Keane, & Duncan, 2020). Additionally, imposing limits of this kind reiterates and lends support to socially harmful gendered forms of power in which women's freedoms and pleasures are understood to be readily dispensable in the service of others.

Along with other researchers, we argue that alcohol research and policy should 'probe the assumptions that result in gendered inequities' (Hearn and McKie, 2008, p. 83) and address configurations of masculinity – in health promotion, law reform, education and initiatives focused on licensed environments, and in broader efforts to address socioeconomic disadvantage – rather than place faith in blanket interventions that ban drinking at certain times in certain places (Moore et al., 2017). Common objections to calls for measures addressing men and masculinities include a lack of evidence for effectiveness and the long-term generational shifts required to achieve cultural change. Yet such objections have not stymied efforts to address men and masculinities in a range of other settings – for example, in relation to family violence or mental health (for Australian examples, see The Men's Project and Flood, 2018; VicHealth, 2020).

4. Taking gender seriously in health research and policy

In recent years, there have been growing calls to take gender more seriously in both health research and policy generally, and in alcohol research and policy specifically. For example, a goal of Health Canada's (2018) Sex and Gender Action Plan 2017-2020 is to 'establish Health Canada as an organization where sex and gender-considerations are systematically integrated in all our research, legislation, policies, regulations, programs and services'. In Australia, a recent article in the *Medical Journal of Australia* calls for the systematic implementation of sex and gender analysis in Australian health and medical research and policy (The Sex and Gender Sensitive Research Call to Action Group, 2020). The article includes an audit of the top 10 health and medical granting agencies, two of which had sex- and gender-specific policies; an audit of the policies of the top 10 peer-reviewed health and medical journals, six of which had such policies; and a lengthy list of recommendations for universities, learned and professional societies, governments, funding agencies, journals and industry. At an international level, Bauer (2014) has called for greater engagement with sex/gender (and race/ethnicity) to facilitate population health research on 'different

intersections of identity, social position, processes of oppression or privilege, and policies or institutional practices' (p.10). Recognising that gender is not a neutral binary but is embedded in material conditions and social relations would also generate insights into broader questions such as the unequal distribution of alcohol-related harm.

In relation to alcohol research and policy, a recent commentary in the *Drug and Alcohol Review* (Merlino, Clifford, & Smith, 2021) argues that Australian health promotion and public health should integrate gender more effectively into its research and policy on alcohol. At the international level, a recent analysis of systematic reviews of population-level alcohol policies (Fitzgerald et al., 2016) found that the gendered effects of policy changes were poorly reported, a situation the article's authors attribute to the systemic 'gender blindness' observed in other areas of health research (p. 1742). A commentary on Fitzgerald et al.'s analysis argues that the sustained lack of attention to gender means that 'differences in impact of policies by gender cannot be taken into account when policy choices are made, even if there was the political will to do so' (Connor, 2016, p. 1748). Connor further argues that '[t]o measure gendered impacts we will need to have tools to measure gendered benefits and harms' (2016, p. 1749). We advocate investment in resourcing the development and implementation of gender-sensitive quantitative tools to allow for the systematic integration of gender (not just 'women') into alcohol policy, and to track gendered effects when alcohol policy choices are made (Duncan, Keane et al., 2020; Duncan, Moore et al., 2020).

Future policy should recognise that alcohol consumption and related harm are heavily gendered, and that the evidence makes clear that much more policy attention needs to be paid to men if harms are to be tackled meaningfully. Although this insight is not new in the social sciences, it is strikingly absent from contemporary policy discourse and legal debates on alcohol. Unless the issues most directly associated with male drinking are addressed, little or no lasting progress will be made in reducing alcohol-related harm.

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