



**WHO Meeting of the National Counterparts for Alcohol Policy
in the WHO European Region**

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Final report

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The two-day meeting was organized by the World Health Organization Regional Office for Europe (WHO Regional Office for Europe) in joint collaboration with the European Commission (EC) and the State Agency for the Prevention of Alcohol-Related Problems (PARPA).

Dr Lars Møller, Programme Manager Alcohol and Illicit Drugs, WHO Regional Office for Europe, opened the meeting and welcomed the attendees to the 14th Meeting of the WHO National Counterparts for Alcohol Policy in the WHO European Region. The meeting participants included representatives from 38 Member States (MS) as well as expert speakers and other stakeholders.

H.E. Aleksander Soplinski, Undersecretary of State, Ministry of Health (MoH), Poland, also welcomed the meeting participants and provided background on the history of alcohol policy in Poland. Since the 1950s, there has been a continuous increase in the use of alcoholic beverages in Poland, with spirits as the most frequently consumed beverage. In 1982, the Law on Upbringing in Sobriety and Counteracting Alcoholism was passed, and, in 1993, PARPA was established. PARPA reports to the MoH. As the fundamental function of the agency is to engage in the prevention and resolution of alcohol-related problems, PARPA has served as co-organizer and participant in European alcohol-related meetings and has made participation in such meetings a priority of the MoH. Given that alcohol consumption in the European Region is the highest in the world, PARPA has undertaken prevention and education projects on a European scale. To emphasize the importance of the topic, in the course of the Polish Presidency in the Council of the European Union (EU), PARPA organized an international expert conference entitled the "Alcohol Policy in Poland and around Europe: Medical and Economic Disadvantages of Using Alcohol," the purpose of which was for experts to draft a position in the area of alcohol-related policy. Comprehensive and effective action and programs are needed to prevent the harmful use of alcohol at the country and regional levels. The Meeting of the WHO National Counterparts for Alcohol Policy will contribute to expanding knowledge of this important social issue by establishing and extending international cooperation.

Ms Marjatta Montonen, National Expert, DG Health & Consumers, EC, thanked the hosts and organizers for providing an opportunity to exchange information and views on issues that are at a turning point in terms of the development of public health policies at the international level.

In regard to the development of public health policies on alcohol, a two-track approach has worked well; that is, the two mutually supporting processes of the development of the strategy on alcohol-related harm from the EU on the one hand and the development by the WHO of a European framework and, eventually, a Global Strategy on the other hand.

Cooperation and exchange between the EC and WHO, between DG SANCO and the WHO Regional Office for Europe, is extremely important not just in terms of practical matters, such as monitoring and information systems, but also at the more principal level to clarify perspectives since, along with many similarities and concerns shared by all European countries, there are also issues that are specific for EU MS.

There has been unprecedented political attention at the international level on the challenge of noncommunicable diseases (NCDs), as exemplified by the United Nations high-level meeting, which called on nations to address the common risk factors for the major NCDs. This provides a new framework that will influence the way public health policies on alcohol are formulated. In the EU, there is an ongoing reflection process on chronic diseases between the EC and MS, with input from stakeholder consultations. This process builds on

the United Nations Declaration and is a response to a call from the EU Council for innovative approaches to tackle chronic diseases in public health and health care systems. The purpose of the reflection process is to identify gaps and opportunities in the EU response and to clarify priorities and needs for future action; hopefully, the discussions will lead to a consensus statement and, ideally, a policy document. The outcome of this reflection process is likely to influence the discussion on the continuation of the EC's work on alcohol and health after the current strategy has been evaluated. The international political attention to chronic NCDs gives new impetus for work on alcohol as a key risk factor. The Meeting of the WHO National Counterparts for Alcohol Policy will provide updates and new information on the WHO's scope of activity in Europe and globally and on the developments in European MS.

Ms. Paulina Miśkiewicz, Head of Country Office, WHO Country Office, Poland, welcomed the meeting participants to Poland and expressed appreciation for the work of the MS in developing the European Action Plan adopted last year in Baku. The WHO Country Office in Poland pledges to prioritize alcohol policy and programmes in the country work and will support national counterparts within the work plan and in collaboration with the MoH and partners in Poland.

Mr Dag Rekve, Technical Officer, Mental Health and Substance Abuse, WHO, thanked Drs Brzozka and Klosinki and PARPA for their efforts in the area of alcohol issues, which demonstrate how a country can play an important role both at the European and global levels, and discussed the development of the WHO Global Strategy to Reduce the Harmful Use of Alcohol. The Global Strategy can be used as a steering guide for countries, as is evidenced by several recent processes at the national level, which have been influenced by the Global Strategy.

Involvement of the EC has been crucial not only for the process in Europe but also at the global level in terms of policy formulations, research, and technical document developments.

Currently, there are many challenges in terms of the implementation of the Global Strategy, as it was adopted in the midst of a financial crisis. Despite these challenges, progress is being made, including in the areas of the global and regional networks of counterparts and collaborations between WHO and MS through workshops and technical tools to build up national capacity to formulate policies.

Dr Anatolii Viyevskiy, Director, Ukrainian Medical and Monitoring Centre on Alcohol and Drugs, MoH, chaired the morning session.

Dr Lars Møller, Programme Manager, Alcohol and Illicit Drugs, WHO Regional Office for Europe, presented information on alcohol consumption and harm in the EU based on the new publication launched in March 2012 entitled *Alcohol in the European Union. Consumption, harm and policy approaches*.

Alcohol consumption in Europe has remained stable, at a high level, and is double the world's average. Alcohol consumption in the EU is comparable with consumption in the WHO European Region. Recorded adult per capita consumption of alcohol is approximately 11 litres. There has been a slight decrease from 2008 to 2009. Beer is the most consumed product in terms of litres of pure alcohol. Overall in southern Europe, alcohol consumption has decreased, and some countries (for example, Spain) now get most of their alcohol from beer products rather than wine.

Overall, unrecorded alcohol consumption is not as significant as in other parts of the world (13% of total per capita consumption is unrecorded in Europe compared to 30% globally).

What is considered unrecorded alcohol (for example, cross border shopping, surrogate alcohol, undeclared wine production, moonshine, etc.) varies among European countries.

There are large differences in levels of consumption both between countries and between regions in Europe. The Central-Eastern and Eastern parts of Europe have the highest level of consumption (with a total adult per capita consumption of approximately 14.5 litres), and there is an increasing trend in these regions. In Central-Western and Western countries, there is a high level of consumption (12.4 litres per capita), but there is a decreasing trend. The Nordic countries consume the least amount of alcohol; however, adult per capita consumption has been increasing in recent years. Overall, in southern Europe, per capita consumption has been falling for the last 30 years. The average total adult per capita consumption in the EU (recorded + unrecorded) is 12.4 litres.

The most recent available figures for the global burden of disease (GBD) are from 2004; however, it is expected that within the next few months, the 2010 estimates will be released.

In the publication *Alcohol in the European Union. Consumption, harm and policy*, Professor Jürgen Rehm and his team used consumption data from 2009 but harm data from 2004, so some new estimates were produced in the report.

The alcohol burden of disease classification includes chronic diseases, such as cancers (e.g. mouth and oropharyngeal, esophageal, liver, and female breast), and neuropsychiatric diseases (alcohol use disorders, unipolar major depression, and primary epilepsy). Alcohol has some protective effects on diabetes type I (incidence). In terms of cardiovascular diseases, although there is some protective effect in the group of ischaemic heart disease and ischaemic stroke, alcohol has a detrimental effect on hemorrhagic stroke and hypertensive diseases. Alcohol has a detrimental effect on some gastrointestinal diseases (liver cirrhosis), conditions arising during the perinatal period (low birth weight, fetal alcohol syndrome), unintentional injury (motor vehicle accidents, drowning, falls, poisoning) and intentional injury (self-inflicted injuries, homicide).

There have been new developments with respect to causality and inclusion in alcohol-attributable disease categories. Colon/rectal cancer, pancreatitis, and some new injury categories will be included in the new GBD estimates; tuberculosis/pneumonia incidence is worsened by alcohol and will be included in the new estimates. HIV incidence is discussed but not included.

In the EU region, for men between 15 and 64 (premature mortality), 1 in 7 deaths were attributable to alcohol in 2004. For women in the same age category, 1 in 13 deaths were caused by alcohol. In the countries in Eastern and Central-eastern Europe, the figures are nearly 1 in 5 for men and 1 in 10 for women. Approximately 110 000 deaths among males per year in the EU are caused by alcohol and approximately 15 000 deaths are avoided due to the beneficial effects.

Conservative estimates of harm to others (based mainly on drink-driving, homicides and fetal alcohol syndrome) show that between 3-4% of the overall alcohol-attributable deaths in the EU are caused by harm to others.

In summary, alcohol consumption is stable in the EU and causing considerable harm. Overall, harm is higher in the Central Eastern part of Europe. This area of Europe drinks the most and drinks in the most detrimental way. In the Nordic countries, alcohol-attributable years lost due to disability are relatively high, especially given the consumption (mainly due to the higher toll of alcohol use disorders). Harm to others due to alcohol is considerable.

Dr Nick Sheron, Head of Clinical Hepatology and Senior Lecturer, University of Southampton, Faculty of Medicine, NHS Foundation Trust, presented information on alcohol and liver diseases from a clinical viewpoint.

Liver disease survival figures of patients admitted to the liver unit at Southampton General Hospital indicate no advances over the last 15 years due to the fact that by the time patients are admitted, it is too late to affect any change; interventions need to occur much earlier.

Liver mortality over the last 30 years in the Europe reflects four patterns: countries that have maintained low levels of liver disease; countries that previously had high levels of liver mortality but have seen substantial decreases over the last 30 years; countries that have maintained high levels of liver disease (e.g. Poland); and countries that previously had low levels of liver disease but have seen increases in recent years (e.g. the United Kingdom).

As evidenced by data from two countries with the biggest decreases in liver mortality (France and Italy) and two countries with the biggest increases (United Kingdom and Finland), there is a direct relationship between liver mortality and population level alcohol consumption. Eighty per cent of the mortality from liver disease is alcohol related. Approximately 60% of the variation in liver mortality can be explained by population changes in alcohol consumption.

Problems associated with binge drinking tend to affect young people; liver disease mortality mainly occurs in middle age; the protective effect of alcohol on cardiovascular disease does not occur until individuals are in their 60s and 70s; cancers also tend to occur later in life. Thus, these are all age-mediated effects. The vast majority of deaths from liver disease are among people who are of working age.

Looking at the lifetime drinking history of Southampton liver disease patients, it is apparent that after age 20, there is an increase in drinking frequency. Deaths from liver disease among Southampton patients can be divided into three categories: one third of patients die early because the disease is too advanced; one third of patients die late because they cannot stop drinking; and one third of patients survive.

What determines long-term mortality is not the stage of damage to the liver but whether the patient stops drinking. This has implications for policy. For example, in the Russian Federation, when Gorbachev introduced reforms that reduced alcohol consumption overall by approximately 30%, there was a massive fall in mortality from alcohol-related diseases, and this occurred very quickly. This is because alcohol-related mortality is related to recent alcohol intake. This implies that, if a politician evokes a strategy that controls alcohol consumption, the public health results/payoff will be apparent within the political term (within two years).

The increase in liver disease deaths in the United Kingdom relates to the fact that alcohol is a commodity, which is sold. Changes in place of sales, changes in marketing practices, the introduction of alcopops (alcohol products that appeal to children), and increased affordability of alcohol (especially spirits) have contributed to increases in consumption.

The 20% of heaviest consumers in a population consume 80% of the goods (the Pareto principle). The alcohol industry is reliant on these hazardous/harmful drinkers.

Alcohol policies of the prior government in the United Kingdom were more in line with those of the alcohol industry than with evidence-based policies promoted by the health community.

Following the presentations, there was some discussion regarding the WHO procedures for collecting data on adult per capita alcohol consumption and the discrepancies between national figures and WHO figures. Dr Møller responded that a decision tree is used and that priority is given to national data if it is sound. In some cases, the WHO must rely on other sources. In these situations, there should be a dialogue and interactive process involving WHO and the country. Furthermore, much of the inconsistency between national total alcohol consumption data and WHO figures concerns unrecorded alcohol, on which there often is no national data, and WHO must use multiple sources to make estimations.

Professor Peter Anderson, Public Health Consultant, Substance Use, Policy and Practice, Newcastle University, moderated a panel discussion on alcohol price and minimum unit price. Panel members included **Mr Esa Österberg**, **Ms Kristina Mauer Stender**, **Ms Jean Nicol**, and **Dr Lesley Graham**.

Mr Esa Österberg, Senior Researcher, Department of Alcohol, Drugs and Addiction, National Institute for Health and Welfare, Finland, presented on minimum unit prices and experiences from the Canada and Sheffield models.

When other factors affecting alcohol consumption remain the same, an increase in alcohol price generally leads to a decrease in alcohol consumption, and a decrease in price usually leads to an increase in alcohol consumption. Price changes affect all types of beverage and all kinds of drinker, from light to heavy drinkers. Changes in alcohol taxes do influence the rates of problem drinking. Therefore, increases in minimum prices of alcoholic beverages should affect alcohol consumption.

Eight out of ten Canadian provinces have minimum pricing in government and private liquor stores and in bars, restaurants and hotels. There has been very little research on minimum pricing. However, data from Canada indicate that like price increases, minimum prices affect alcohol consumption. In Canada, minimum prices are defined separately for different beverage categories.

The Sheffield model shows that a minimum price per unit should have a stronger effect on hazardous and harmful drinkers than general price increases.

Minimum pricing especially targets heavier and younger drinkers because they mostly prefer cheaper drinks. Some have argued that this is ethically problematic because it places considerably burdens on those already most disadvantaged in society. On the other hand, minimum prices may have substantial health benefits on heavier drinkers and social benefits on younger drinkers. Moreover, all alcohol taxing and pricing strategies have most impact on heavier drinkers because of the amount of their alcohol consumption.

One question to consider is if minimum prices are in accordance with the EU's tax directives and other community rules.

Ms Kristina Mauer-Stender, Programme Manager, Tobacco Control, WHO Regional Office for Europe, presented lessons learned from pricing policies/taxation and tobacco products.

Taxation/pricing policy is the most effective single policy in tobacco control. In terms of smoking prevalence among adults, the WHO European Region has the highest rate in the world at 31%. WHO recommends that taxes constitute at least 70% of the retail price of tobacco products, applied equally to all tobacco products. As regards average price and excise tax per pack of cigarettes, the European Region has the highest total share of tax per pack at approximately 66% of the price.

In the European Region, 42% of countries report that >75% of the retail price of the most popular brand of cigarettes is tax. However, there is much variation – prices of the most sold brand of cigarettes (20-pack) in international dollars range from \$1.03 (in Kazakhstan) to \$9.51 (in Ireland)

South Africa, during the period of 1980-2005, provides an example of the consequences of changes in taxation and pricing policies. When taxes were reduced, cigarette consumption increased, and when taxes were increased, consumption decreased. The United Kingdom, over the period of 2003-2009, provides an example of how an increase in tobacco excise tax resulted in a decrease in smoking prevalence. Another example from France, over the period of 1980-2005, shows that an increase in price was associated with decreases in consumption of tobacco products and lung cancer rates.

Tobacco taxes raise revenues. For example, over the period of 2004-2010, when tobacco taxes were increased in Estonia, Latvia and Lithuania, revenues increased from €60 million to €115 million per year in Estonia; from €41 million to €130 million per year in Latvia; and from €63 million to €161 million per year in Lithuania.

There is no evidence that smuggling and illicit trade increase in countries that implement substantial increases in tobacco taxes.

Dr Lesley Graham, Associate Specialist, Public Health, Information Services Division, NHS National Services Scotland, presented the Scottish experience with minimum unit pricing.

The relationship between alcohol price, consumption and harm is the foundation on which the policy of minimum pricing is built. There is an extensive body of evidence demonstrating that as the price of alcohol falls, consumption rises and so does harm.

In Scotland, alcohol consumption, as measured by sales data, has risen by 11% since 1994. In 2010, for every adult in Scotland, 11.8 litres of pure alcohol were sold and consumption was 23% higher than in England and Wales. Off-trade sales have increased, while on-trade sales have decreased.

Alcohol has become both more available and affordable in recent years in the United Kingdom. The increasing affordability in the off-trade sales has been led by large retailers (e.g. supermarkets), which have been selling alcohol below cost. In Scotland, England, and Wales, 73% of pure alcohol sold off-trade was sold below 50p in 2010.

As consumption has risen, so has alcohol-related harm. Alcohol-related hospital admissions have more than trebled in the last 30 years, and alcohol-related mortality has more than doubled since the 1990s. Alcohol-related harms disproportionately affect those living in the most deprived areas.

In Scotland, the consumption is only 23% higher than England and Wales, but the mortality rates are double. This figure was pivotal when making the case for minimum pricing to politicians.

There are some ways in which governments might seek to affect the price at which alcohol is sold:

- Taxation: However there is no guarantee that increases in taxation are passed on to the consumer. Furthermore, the Scottish Parliament does not have taxation powers in this area.

- Ban on discounts: However, if discounts are tackled without also establishing a minimum price, it is likely that retailers will simply adjust their marketing model to reduce the price of an individual bottle or can.
- Prevent sales at below tax and duty: The difficulty is that the effect would be limited, having little impact on consumption and harm. It is not within the power of the Scottish Parliament to increase tax and duty to increase its effectiveness.
- Minimum price: This is what was recommended.

The proposal in Scotland specified that minimum pricing would effectively create a “floor” price below which a unit of alcohol could not be sold. It would be linked to alcohol content, not type of product, and would apply to all licensed premises. The minimum price would be set by Scottish Parliament, independently of retailers, producers or any group connected to the alcohol industry. It would be easy to vary price (likely linked to inflation) and easy to administer. In May 2012, legislation on minimum unit pricing was passed in Scottish Parliament.

Some of the elements for success are: having robust evidence; minimum unit pricing as part of a wider public health framed alcohol strategy; effective public health advocacy; political will and leadership; and ongoing monitoring and evaluation of policy implementation.

Ms Jean Nicol, Alcohol Policy Manager, Health Improvement and Protection, Department of Health, United Kingdom of Great Britain and Northern Ireland, presented on the plans of minimum unit price in the United Kingdom’s alcohol strategy.

The new United Kingdom alcohol strategy was launched in March 2012, and strong leadership has been extremely important in advancing the strategy. Despite a multi-component alcohol strategy, the United Kingdom has continued to have a high level of alcohol-related health harm. Minimum unit pricing is only one element of the new strategy.

The highest consuming 10% of the population are drinking more than 40% of all alcohol consumed in the United Kingdom. Those who drink above the low-risk guidelines are the target group for the alcohol policies.

The new alcohol strategy has a commitment to introduce a minimum unit price for alcohol, but there will be consultations on the price level. For the first time, it will be illegal for alcohol retailers to sell alcohol for less than a set price per unit. This intervention aims to end the sale of very cheap alcohol, drunk mostly by harmful drinkers, and aims to curb practices such as “pre-loading” before a night out.

The next steps will include consultations on the level of minimum unit price and an assessment of the impact on all types of drinkers as part of the Government’s impact assessment and consultation. The Government will consider any potential EU implications as part of this process.

Following the presentations, there was some discussion and questions regarding EU legislation and the EC’s position on minimum unit pricing. Ms Montonen provided information about previous discussions in the EC about this topic. There needs to be evidence to show that it is a necessary and proportionate measure. Furthermore, the measure needs to be non-discriminatory, and this depends on how the measure is implemented. Another issue is the competition aspect.

Dr Marina Kuzman, Director Associate Head, Youth Health Care and Drug Addiction, Prevention Department, Croatian National Institute of Public Health, chaired the afternoon session.

Professor Zbigniew Gaciong, Dean, the Medical University of Warsaw, Poland, presented on the topic of alcohol and heart disease.

There is a common belief that if one drinks a glass of red wine, one will live longer and avoid heart problems. Numerous studies have used a J-shaped or U-shaped curve to describe the relationship between alcohol use and total mortality. Fewer than 3 drinks per day in men and fewer than 2 per day in women appeared to confer benefit. Reductions in cardiovascular death and nonfatal myocardial infarction have been associated with light to moderate alcohol intake. The sources of this evidence include short-term trials analysing the effect of alcohol on physiological measures (participants usually include young healthy males) and observational studies comparing moderate drinkers with abstainers.

One important issue is whether there is an adequate control group for epidemiological studies on alcohol. Alcohol use is not distributed randomly among individuals. Non-drinkers may significantly differ from drinkers according to important parameters for cardiovascular risk. For example, people who are ill may stop drinking. There is also evidence that abstinence may be an indicator of underlying emotional or physical problems. Moderate alcohol use is a marker of socioeconomic status, and income is the best predictor of cardiovascular health. Non-drinkers may also have a higher number of other cardiovascular risk factors.

It is more important how you drink than what you drink, and binge drinking is particularly detrimental for health. Binge drinking increases cardiovascular mortality regardless of the amount of alcohol consumed. The “cardio protective” effect of alcohol disappears in irregular heavy drinkers.

Another issue is that when one can manage alcohol intake, one can also probably control other cardiovascular risk factors (e.g. these individuals smoke less, are less likely to be obese, etc.), and, therefore, there is a need to control for these other factors.

Observational epidemiological studies have compared drinkers with non-drinkers and have confirmed a “cardio protective” effect (U- or J-shaped relationship) in primary and secondary prevention and in low- and high-risk groups. Stroke is less sensitive to the “protective” effect of alcohol. There is no difference between the different types of drinks (i.e. not just red wine), and there is a gender difference such that females respond to lower doses of alcohol to “protect” the heart. There are no control or placebo studies.

In prospective studies, each subject can be used as his/her own control (e.g. drinking behaviour before and after a cardiovascular event). Based on data from a few studies, the evidence indicates that subjects who either decreased or increased alcohol consumption to a moderate consumption level after a myocardial infarction did not experience a significant change in mortality; however, these studies have low sample sizes.

There is evidence that that subjects with a permanent injury to the heart benefit from a reduction in alcohol use.

If alcohol can be considered a drug/medication, what is the effective dose? A meta-analysis shows that it is between 1 (perhaps less than 1) and 3 to 4 drinks per day; that is, there is a wide therapeutic range for beneficial effects of alcohol on cardiovascular outcomes. It is very unusual for a medication to have such a wide window.

There is the further problem of identifying the mechanism of action. Numerous mechanisms have been proposed to explain the benefit that light to moderate alcohol intake has on the heart, including an increase of high-density lipoprotein cholesterol, reduction in plasma viscosity and fibrinogen concentration, increase in fibrinolysis, decrease in platelet aggregation, improvement in endothelial function, reduction of inflammation, and promotion of antioxidant effects (resveratrol).

However, these explanations do not appear to be adequate. For instances, studies of administration of resveratrol in mice showed that beneficial effects were only apparent in extremely high doses (the equivalent of 1000 litres of red wine per day). Furthermore, results of clinical trials of natural antioxidants were either neutral or negative in terms of the effect on cardiovascular diseases. In addition, natural experiments involving people who are carriers of a gene that results in higher high-density lipoprotein cholesterol demonstrate that this does not translate into cardiovascular protection.

In summary, the epidemiological evidence does not support a causal relationship. The mechanism of the “protective” effect of alcohol has not been identified. Drinking cannot be recommended as a measure to reduce cardiovascular risk. Abstinence may improve prognosis in certain diseases.

Professor Peter Anderson, Public Health Consultant, Substance Use, Policy and Practice, Newcastle University, provided some comments on the topic of alcohol and heart disease. He noted that the issue of alcohol and heart disease is problematic because it disrupts many discussions on alcohol policy and advice and is the source of disagreement and criticism in the alcohol field. There is a need for a clear overview of the evidence, and it may be time to commission an expert review to provide a consistent message and professional consensus. Furthermore, there is the need to emphasize that if there is a protective effect, such protection disappears with one binge drinking episode per month.

Dr Lars Møller, Programme Manager a.i., Alcohol and Illicit Drugs, WHO Regional Office for Europe, presented an overview of the European Information System on Alcohol and Health (EISAH).

Since 2007, the EC and the WHO Regional Office have joined forces in gathering information on trends in alcohol consumption, health outcomes and public health policies to reduce alcohol-related harms and have made this information available in EISAH. This single system reduces the burden of reporting for MS and ensures the consistency and comparability of data across countries and over time

In 2011, an additional survey was carried out among EU MS, and the results were reported in the new publication *Alcohol in the European Union. Consumption, harm and policy approaches*. This survey was also used to provide input from MS on the continuation of the EU alcohol strategy. In this survey, there were some questions regarding changes in alcohol policy areas over the past five years (since 2006, when the EU alcohol strategy was introduced). In almost all areas, national counterparts reported that policies had become stronger. The same pattern was seen for price and tax measures, with most MS reporting an increase in the price of spirits and beer (but not wine) relative to the consumer price index. In terms of age limits for on- and off-premise sale of alcohol, the trend is moving toward an 18-year age limit. Improvements have been made in the area of drink-driving countermeasures globally, and the number alcohol-related traffic deaths has greatly decreased. Furthermore, an increasing number of countries have reduced the maximum legal blood alcohol concentration (BAC) level for driving.

The WHO is currently collecting data from MS; this is part of the ongoing global surveys on alcohol and health. For the European Region, there is an online data entry system. This will facilitate the input of data into the database and hopefully allow the data to be published and available in EISAH more quickly.

The WHO will draft a European status report for 2013 and will also update the country profiles, which were published in 2011. Greater focus will be placed on using national data and on discussions of consumption data with MS.

Establishing a good monitoring system and collecting accurate and comparable data are important components of the European Action Plan and the Global Strategy.

Ms Julie Brummer, Consultant, WHO Regional Office for Europe, presented some changes in the functionalities of EISAH and provided a brief demonstration of how to access and use the data.

This year, WHO updated the functionalities of EISAH to make the system more flexible and user-friendly and also added some new features, including an interactive map gallery. The web address for EISAH is <http://who.int/gho/eisah>. EISAH can also be accessed through the WHO European Region alcohol web site.

The indicators in EISAH are organized under six overarching subcategories: levels of consumption, patterns of consumption, harms and consequences, economic aspects, alcohol control policies and prevention, research and treatment. It is possible to filter data by region/country and by year and to export data tables to an Excel spreadsheet. Additional information about each indicator, including the definition, unit of measure, and method of estimation can also be viewed. Interactive maps for certain indicators can be accessed under the “analysis” section of the web site.

Ms Marjatta Montonen, National Expert, DG Health & Consumers, EC, discussed a new survey that will be conducted among EU MS.

Since 2007, there has been cooperation between the EC and the WHO Regional Office for Europe in developing a shared alcohol information system for the EU and the WHO European Region.

The EC and WHO have overlapping data needs, and, since 2008, have been engaged in joint data gathering on key indicators, such alcohol consumption, alcohol-related harm, and public health policies on alcohol. The advantages of this cooperation are that it eases the workload for MS in responding to surveys and prevents discrepancy in key figures. EUROSTAT gets data on total alcohol consumption from the WHO because it is important to refer to only one set of figures.

There are still challenges, including the coordination of information gathering on EU/European/global levels; coordination of reporting needs and timing (e.g. EU-specific survey questions should be incorporated into existing WHO surveys and data gathering processes).

Another challenge is the coordination of information needs and indicators. Common indicators are necessary for cross-country comparisons and for forming an overall view of important developments, especially alcohol consumption and alcohol-related harm. There is still a lot of variation between MS in original data collection; not all MS are collecting the same data, and not at the same pace; and MS may be using slightly different indicators. Therefore, there is still work to be done to establish a unified system.

A further challenge is the coordination with relevant research projects; a successful example of such coordination was the integration of additional questions from the AMPHORA project into the EC/WHO 2011 survey.

Ideally, when there are ad hoc information needs, or EU-specific information needs, these questions should be integrated into existing WHO surveys. However, there are still problems with timing, and, therefore, the EC plans to carry out a small-scale survey among EU MS. This survey will focus on emerging information needs related to recent discussions of the next steps of the EU work on alcohol and health.

The specific topics of interest include:

1. The definition of a standard drink used in EU countries (because currently there is wide variation)
2. The status of low-risk or sensible drinking guidelines in EU countries (to update findings from a small-scale survey that was carried out in 2009, which identified wide variation in guidelines, how they were delivered, the target groups for the guidelines)
3. Information related to risk factors for NCDs (how are the main risk factors for NCDs currently being addressed in MS's relevant national strategies and policies?). Ms Montonen welcomed feedback or suggestions from MS on the formulations of the question.
4. Information on the kinds of structures for multisectoral action that exist in EU MS in order to identify good practices; information on the experiences of MS from platforms/forums/partnerships to address alcohol, nutrition or other risk factors (the topics, sectors involved, levels [national/regional/local], and objectives/tasks).

Dr Lars Møller invited participants to provide any feedback or comments on the draft survey. The survey will be soon finalized and sent to EU MS.

Professor Peter Anderson, Public Health Consultant, Substance Use, Policy and Practice, Newcastle University, presented an overview of the cost-effectiveness of alcohol policy to reduce alcohol-related harm.

As background for the United Nations high-level meeting on NCDs last year in September, the Harvard School of Public Health and the World Economic Forum conducted a study of the global economic burden of NCDs. The cumulative world cost of NCDs and mental health over the next 20 years is estimated to be \$47 trillion. Quite a large portion of this cost is preventable. The WHO and the World Economic Forum presented a solution to reduce the economic impact of NCDs by outlining some "best buys" (i.e. policies that cost little to implement and result in huge economic and health gains). The best buys related to alcohol are: tax increases, restricted access to retailed alcohol, and bans on advertising.

Bans on advertising

Alcohol advertising consists of more than just mass media advertising (e.g. billboards, press, and television ads) and extends to all commercial communications by the alcohol industry, including marketing strategies/communications (e.g. sponsorship, packaging, free samples), consumer marketing (e.g. product design, price, and distribution), and stakeholder marketing (e.g. issues of corporate social responsibility).

In 2009, the Science Group of the European Alcohol and Health forum, after reviewing the evidence on the impact of marketing on alcohol, concluded that alcohol marketing increases the likelihood that adolescents will start to use alcohol and that they will drink more if they are already using alcohol. This finding has been consistently supported by more recent evidence.

Social media and web sites are now important marketing strategies for alcoholic beverages that appeal to minors. Social media also plays another role in that banned advertisements are still available through sites such as YouTube.

Restricted access to retail alcohol

A meta-analysis conducted by the Centers for Disease Control and Prevention in the USA showed that, in general, an extra day of alcohol sale results in an increase in alcohol consumption, assaults, and motor vehicle accidents. Regarding a change in hours of sale, it is very difficult to demonstrate an impact when the change is less than two hours; however, a change of more than two hours results in an increase in some negative outcome indicators. Therefore, days and hours of sales do matter. The more available alcohol is, the more likely there is to be increased consumption and harm.

Tax increases

Some issues have been raised about tax increases:

- *Shouldn't increase prices in economic crisis.* However, it is a way of gaining revenue for the Government. Furthermore, during an economic crisis, suicides and deaths from alcohol dependence increase. Thus, in times of recession, although overall consumption may decrease, people tend to drink in a more risky way and this indicates a need for effective alcohol policy as well as support systems.
- *Price increases unfairly harm lighter drinkers.* According to the Sheffield University estimates, a 10% price increase on alcohol in England would impact harmful drinkers much more than moderate drinkers in terms of consumption and cost.
- *Price increases unfairly harm the poor.* People in the lowest income group are less likely to drink alcohol than those in the highest income group; the people in the highest income group are also more likely to be drinking moderately, hazardously, or harmfully than those in the lowest income category. The lower income households are less likely to be purchasing cheap alcohol because less of them are drinking. Thus, an implementation of a minimum unit price on alcohol will have less impact on the lower income group than would be expected.
- *Highly targeted taxes are better.* This is not true. For example, when Germany introduced a tax on spirit-based ready to drinks (RTDs), there was an initial drop in annual per capita spending on RTDs; however, the German beer producers began producing beer-based RTDs, which were not part of the tax. The overall sales of RTDs then returned to the pre-tax level. The tax failed because of its specificity; it was not broad enough to cover the whole category.
- *Taxes do not necessarily increase prices.* When there is a tax increase, the producers or retailers may absorb some of the tax increase, and, therefore, there may not be a price increase. A way to avoid the problem of retailers selling the product below cost is to implement a minimum unit price.

As discussed in the publication *Alcohol in the European Union. Consumption, harm and policy*, over the past five years, the policies that have gotten stronger, such as awareness raising and community action, are not part of WHO's "best buys." Thus, there is an opportunity to reduce the burden of alcohol on individuals and societies, as well as the EU as a whole, by addressing the "best buy" policy options (i.e. affordability of alcohol, regulating, and marketing) over the coming years.

Dr Wojciech Klościński, Deputy Director, Department of Public Health, MoH, Poland, presented recent developments in the area of alcohol policy in Poland.

In Poland, the legal basis for addressing alcohol problems is the Law on Upbringing in Sobriety and Counteracting Alcoholism of 1982. This act of law has defined tasks in the area of prevention and addressing alcohol problems for government bodies, with the involvement

of NGOs and churches. The tasks specified by the law are consistent with EU and WHO guidelines on alcohol policy.

In the Polish system, the majority of spending is by local government/municipalities; in 2010, this was approximately €150 million.

2009 was the first year that alcohol consumption decreased in Poland, and this trend has continued. It is estimated that consumption is approximately 9 litres of pure alcohol per capita.

Since 2008, there has been a slight decrease in liver disease, and, as of 2007, there have also been decreases in mental conditions caused by the abuse of alcohol and in alcohol poisonings.

The latest figures from the European School Project on Alcohol and Other Drugs (ESPAD) show that most young people drink, and beer is the alcoholic beverage of choice among this group. Binge drinking is also a serious problem.

A large portion of resources is spent on prevention among young people, and the quality of prevention programs has been enhanced. A joint program of the National Office to Counteract Drug Addiction, the Centre for the Development of Education, the Institute of Psychiatry and Neurology, and PARPA introduced a system of prevention programs and health promotion.

Nearly 31% of Polish males and 6% of females drink to excess or misuse alcohol, and a recent study showed that 14% of adults (3.6 million people) exhibit signs of harmful consumption. In Poland, the prevalence of alcohol dependency is 3.3%

In Poland, the types of centres that treat alcohol dependence include outpatient clinics, residential centres, and centres for the treatment of alcohol withdrawal. Financing is provided from public funds, and the resources are increasing annually (in 2010, resources amounted to approximately €90 million). Support of local government over the last five years has been declining due to the recession.

Dr Mihail Magdei, Deputy Minister of Health, and **Dr Tudor Vasiliev**, Coordinator on Alcohol, Main Specialist in Narcology, MoH, Republic of Moldova, presented recent developments in the area of alcohol policy in the Republic of Moldova.

The Government policy on alcohol was adopted officially in 2007 and changes were introduced in the areas of education, transport/road safety, finance and taxation and trade.

At the initiative of the MoH, the Government has approved the national plan to reduce harmful alcohol consumption in the Republic of Moldova for the period of 2012-2020. There is a national council that will coordinate the implementation of the plan. The bases for the plan are the WHO guidelines, the European Action Plan to Reduce the Harmful Use of Alcohol 2012-2020, and the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol. In developing the plan, all relevant ministries and agencies were involved, and, for the first time, the alcohol industry was also involved. WHO has provided assistance and support; Dr Møller visited twice and participated in the development of the plan. The Government has approved a project for the complete ban on alcohol advertising, and the draft of the bill is currently in Parliament for consideration. Parliament is also working on a bill to recognize beer as an alcoholic beverage.

The excise tax on alcoholic beverages doubled over the last two years (in 2011, it increased by 50%, and in 2012, by an additional 25%). Minimum unit prices have been approved for

hard liquor (off- and on-premise sales). The Government has adopted an act on minimum age limits such that anybody under the age of 18 cannot legally buy alcohol; the act is novel in that salespersons can ask for proof of age from a buyer.

In May 2012, a law was passed that introduces limitations on the hours of sales in grocery stores and supermarkets (i.e. no alcohol can be sold between 22:00 and 8:00). There are penalties for shopkeepers that violate this law (fines and the revoking of liquor licenses).

The maximum BAC level while driving a car has been set at 0.02% for young and novice drivers. Alcometers were introduced in 2009. Figures show a reduction in injuries and fatalities from traffic accidents following the new laws.

Efforts are also being made to clamp down on the production of illicit alcohol. In the future, there will be studies on home-distilled alcohol (to better define the quantity and quality of such products).

Ms Iris Yogev, Director, Planning and Control Division, Israel Anti-Drug Authority (IADA), presented recent developments in the area of alcohol policy in Israel.

Since 1988, IADA has been the central body in Israel charged with managing drug-related issues, and, in 2005, the Israeli government extended IADA's mandate to include alcohol abuse. This mandate was part of a comprehensive government effort to address the public perception of increasing violence in the society.

An expert task force was set up at IADA to review the relationship between substance abuse and violence. The recommendations were to address the causes of violence by: enhancing awareness, education and prevention activities to increase the public awareness regarding dangers of drug use and alcohol abuse and to prevent abuse through didactic tools; enhancing enforcement; and reinforcing treatment infrastructure (to offer detoxification and rehabilitation to all).

In December 2009, the Government adopted the comprehensive national strategy to decrease irresponsible alcohol consumption over two years and allocated €5.4 million for its implementation. The first stage involved a national public awareness campaign on the dangers of irresponsible alcohol consumption. The strategy is multidisciplinary.

The main aim of the strategy is to decrease excessive and harmful alcohol consumption. This involves: promoting a national policy that publicly delegitimizes alcohol consumption among children/youth; emphasizing responsible and moderate alcohol consumption among adults; enhancing public awareness of the extent and dangerous consequences of alcohol consumption among youth; developing tools, research infrastructure and training programs to provide professional knowledge in the areas of public awareness, prevention, identification and treatment to ensure skilled and culturally sensitive responses; decreasing violence, delinquency and anti-social behaviour caused by irresponsible alcohol consumption; and decreasing mortality and disease related to alcohol abuse.

The Health Behaviour in School-aged Children (HBSC) survey results show that in 2009, 17% of 8th graders reported binge-drinking at least once in the last month, while this figure dropped to less than 10% in 2011 (after the implementation of the national program). Among 10th graders, the prevalence dropped from approximately 27% in 2009 to less than 20% in 2011, and among 11th graders, the prevalence dropped from approximately 34% to 25%.

The tools of the national program included:

- *Media campaigns* (internet, primetime TV, radio), with youths as the main target group
- *Legislation*
 - o Age limits (prohibition to sell, offer or serve alcoholic drinks to those under 18)
 - o Decreasing legal sales hours (prohibition to sell alcohol at stores between 23:00 and 6:00, except in restaurants, coffeehouses, and places serving alcohol for consumption on their premises [e.g., pubs, night clubs, etc.]).
 - o Limiting drinking in public places (prohibition to consume or possess alcohol in an open container in a public place or inside a car parked in a public place between 21:00 and 6:00; minors prohibited to consume or possess alcohol in an open container in a public place or inside a car parked in a public place during all hours).
 - o Enhanced law enforcement tools (police officers have the authority to confiscate the container and pour out its contents at all hours of the day if there is a perceived threat to the public safety).
 - o Warnings and labels (businesses selling alcohol must post warning notices noting health dangers, sale hours, prohibition to sell, offer or serve alcoholic drinks to minors, and prohibition to serve alcoholic beverages to intoxicated/drunken patrons; warning labels on containers and ads regarding health dangers of alcohol will be obligatory in approximately one year).
 - o Advertising and media (prohibition/limitations regarding advertising of alcoholic beverages in the mass media, including designated hours, use of role models, and limiting advertising to marketing information only). Self-regulated codes of practice in the Israel Press Council regarding alcohol advertisement are currently being developed.
- *Law enforcement*
 - o In 2011, police officers confiscated and poured out the contents of over 32 000 containers – five times more than in 2010.
 - o Closing venues which violate the law prohibiting sale to minors.
 - o Large fines for selling outside permitted hours.
 - o Zero tolerance (BAC) for new and professional drivers.
- *Other tools* include the establishment of early detection centres for youth, community actions, the establishment of a national drug and alcohol monitoring centre, and increased taxation

Currently, a focus is being placed on ongoing evaluation through regular epidemiological studies.

Dr Lars Møller, Programme Manager, Alcohol and Illicit Drugs, WHO Regional Office for Europe, opened the second day of the meeting.

Dr Krzysztof Brzózka, Director, PARPA, chaired the morning session.

Mr Dag Rekve, Technical Officer, Mental Health and Substance Abuse, WHO, presented the Global Strategy to Reduce the Harmful Use of Alcohol and the status of its implementation.

The WHO Global Strategy has five key objectives: *raised global awareness and increased commitment by governments; strengthened knowledge base; increased technical support to, and enhanced capacity of, MS; strengthened partnerships and better coordination among stakeholders and increased mobilization of resources; and improved systems for monitoring and surveillance.*

Achieving the objectives requires global, regional and national actions on four levels: levels of alcohol consumption, patterns of alcohol consumption, contexts of alcohol consumption, and wider social determinants of health. In addition, special attention should be given to

reducing harm to people other than the drinker and to populations that are at particular risk from harmful use of alcohol.

The Global Strategy recommends ten target areas for policy measures and interventions at the national level: leadership, awareness and commitment; health services' response; community action; drink-driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance.

The key components of global action include public health advocacy and partnership; technical support and capacity building; production and dissemination of knowledge; and resource mobilization. These were highlighted by MS as important areas for action.

Various regional strategies, action plans and frameworks are in place, and, therefore, the time has come for implementation. In addition to the Global Strategy, there is also the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs. Alcohol is a focus of the NCD Action Plan and is one of the four key risk factors for NCDs. This is a good example of the fruitfulness of horizontal collaboration.

The first WHO Global Counterparts Network Meeting in February 2011 was a milestone for the implementation of the Global Strategy. The role of the counterparts is to establish the working mechanisms and plans for the global network; elaborate priority areas and implementation plans; discuss priority areas and plans for implementation; and discuss monitoring and reporting.

In terms of advocacy, partnership, and resource mobilization, one of the key issues for WHO headquarters is to support the global network of WHO national counterparts and collaborative implementation mechanisms. An implementation action plan is currently being developed in collaboration with MS and will soon be published and disseminated. In addition, WHO is building different platforms for interactions with NGOs.

WHO is producing a new manual on screening and brief intervention and is developing modules on the identification and management of alcohol use disorders in health care settings. WHO is also developing e-health portals on alcohol and health, including web-based brief intervention, which will be launched this fall.

Technical support and capacity building is a priority to meet expectations at the national level. Plans in this area include conducting workshops for national counterparts on alcohol policy and implementation of the Global Strategy; trainings of health professionals on screening, brief intervention, and treatment of alcohol use disorders; strengthening/developing national monitoring systems on alcohol and health; and providing direct technical support to MS.

The aim of building capacity for national action will be achieved through three outputs: development of technical tools for the 10 different areas for alcohol policy development listed in the Global Alcohol Strategy, specially focused on the three best buys (pricing, availability, marketing) and on health systems response; regional capacity building workshops for training of national civil servants; and direct technical support in selected countries.

The Global Survey on Alcohol and Health 2012 has been completed by 19 European countries. It is very important that MS complete the surveys to provide WHO with national data.

The WHO supports the production and dissemination of the new Global Burden of Disease (GBD) estimates of alcohol-attributable burden. In the new GBD study, the disability rates have been reduced substantially for mental and neurological disorders, meaning that the overall ranking of alcohol will not be as high as it was previously. When these new data come out, it will be important to focus on the effect of alcohol on different age groups, especially the 15-to-55-year-old group. Furthermore, WHO is developing research projects on Alcohol, Health and Development.

Concerning global monitoring, the objectives are to capture change and establish trends (which is why WHO does not change the APC data from year to year); provide information on the impact of actions; prompt, mobilize and frame appropriate and necessary action; enhance assessment, reporting and re-programming; and ensure accountability. Challenges in the area of global monitoring include invalid, unreliable or lacking data; problems of unrecorded alcohol consumption; incomparable data across countries; coverage and level of implementation of policy measures; inadequate prioritization and resources for monitoring.

In terms of outcomes and impact measures, a focus is being placed on four areas: adoption and implementation of effective and cost-effective policy measures; a reduction in the level of alcohol consumption in populations (the most reliable and valid indicator); a reduction in hazardous patterns of drinking in populations; and a reduction in alcohol-attributable disease burden and mortality. WHO also has the GISAH, other surveillance activities and the global and regional reports on alcohol and health.

Effective global monitoring requires establishing and/or strengthening national surveillance and monitoring systems using indicators and definitions agreed at the international level. For global monitoring, regular reports to WHO regional and global information systems and production of national surveys are key.

There are few staff members in Geneva and at the regional offices available to work on the alcohol programme and the implementation of the global and regional strategies. There is a need to fill the resource and funding gap so that momentum can be kept at a global level, the urgent need for capacity building at the country level can be met, and new WHO estimates of alcohol consumption and alcohol-attributable disease burden at global and regional levels can be produced. Filling the gap also means that the WHO Global Status Report on Alcohol and Health 2013/2014 can be produced and disseminated with new country information, national monitoring systems can be improved, and substantial research can be done on critical areas like harm to others, child development, HIV and TB.

Ms Frederiek Mantingh, Technical Officer, NCDs, WHO Regional Office for Europe, presented the Action Plan for implementation of the European Strategy for the Prevention and Control of NCDs 2012 – 2016.

The burden of NCDs is the predominant challenge in each of the MS of the WHO European Region. The launch of new WHO estimates within the Global Status Report on NCDs illustrates the size of this challenge.

Among the six regions of the WHO, Europe and the Americas have the highest proportion of deaths from NCDs and injuries. Europe has the highest overall smoking rate, the highest per capita consumption of alcohol, the highest proportion of dietary fat intake, the highest rate of raised total cholesterol, and the second highest rate of overweight and obesity.

Over the last three decades, there has been a rapid fall in age-standardised coronary mortality in many European countries. This builds on evidence accumulating across the world that the burden of NCDs is not a chronic burden at a population level and can fall rapidly.

The NCD Action Plan adopted in Baku last September addresses diseases, risk factors, and social and environmental determinants in an integrated and comprehensive way. It identifies specific action areas and deliverables for MS, WHO and partners. The Action Plan is organized in priority actions, priority interventions, and supporting interventions.

The four main pillars of the United Nations Political Declaration on NCDs are surveillance, prevention, management, and partnership. These are very much in line with the European NCD Action Plan.

What remains unchanged is WHO's global vision to reduce the toll of morbidity, disability and premature mortality related to NCDs. New aspects include the global baseline, country estimates, countries' capacities to respond to the NCD crisis, solutions and the "how to" tools. Other new components are calculations of the cost of inaction (\$7 trillion) versus action (\$11 billion) and "best buy" interventions to address NCDs.

Last week at the World Health Assembly, MS agreed to adopt a global target of a 25% reduction in premature mortality from NCDs by 2025.

At the global level, some of the next steps include further work by the WHO Secretariat in the area of technical work on targets and indicators and web-based consultations. MS are encouraged to participate in the web-based consultations in order to ensure that alcohol work is prioritized.

At the European Regional level, there will be additional meetings and activities directed towards the development and strengthening of NCD action plans, including the development of an NCD policy checklist and country assessment tool. There will also be work in the areas of strengthening NCD surveillance and monitoring; multisectoral action (including the development of guidance on fiscal policies, marketing, salt, trans-fat); and strengthening health systems.

Following the presentations, there was some discussion regarding the lack of prioritization of alcohol at the High-level Consultation in the European Region on the Prevention and Control of NCDs. It was noted that MS must be active and participate in the consultation process if they wanted anything to be changed. It was mentioned that it is useful for NCD and alcohol programme efforts to be coordinated and interlinked to conserve resources. The importance of cooperation between representatives in the NCD and alcohol fields was stressed to ensure that all representatives remain informed and aware.

The importance of harmonizing and obtaining consensus on definitions of indicators between MS, WHO, and EUROSTAT was acknowledged. There were some comments regarding the use of targets. It was clarified that the use of targets is part of the NCD process and of the implementation of the Action Plan and Political Declaration (to maintain consistency with other NCD risk factors) and is not a component of the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. However, if MS want to have a target on the harmful use of alcohol linked to the Political Declaration on NCDs, it is best to link the target to the indicator of adult per capita alcohol consumption because it is also a proxy for heavy episodic drinking and is a good indicator for NCDs.

There was some discussion regarding the phrase "harmful use of alcohol," which may be problematic because it is also a psychiatric diagnosis related to alcohol harm. Therefore, it is important to recognize that harm refers to *all* kinds of harm caused by alcohol.

Ms Marjatta Montonen, National Expert, DG Health & Consumers, EC, presented the implementation of the EU strategy to support MS in reducing alcohol-related harm.

The EU alcohol strategy is not interlinked with the other alcohol strategies at the international level, but the EU and other international processes are parallel and mutually reinforcing. The EU alcohol strategy focuses on priority themes that are relevant for all MS and for which action and coordination at the EU level has added value: protect young people, children and the unborn child; reduce injuries and deaths from alcohol-related road traffic accidents; prevent alcohol-related harm among adults and reduce the negative impact on the workplace; inform, educate and raise awareness (impact of harmful and hazardous alcohol consumption, appropriate consumption patterns); and develop and maintain a common evidence base. Coordination and mobilization at the EU level and exchange of good practice are important tools for implementation.

The pillars of the of implementation of the EU alcohol strategy include the European Alcohol and Health Forum, the Committee on National Policy and Action, and the Committee on Data Collection. These pillars involve mobilization of action across society, cooperation across MS, and synergy across EU policies and actions. There is a lot of action in the area of strengthening the evidence and knowledge base through cooperation with the WHO and funding provided for projects through the Health Programme.

The pillar involving development of the evidence base has many components. One strand of work relates to monitoring trends across MS (which is done in collaboration with the WHO) and the Committee on Alcohol Data, Indicators and Definitions (which identified common indicators for the priority themes of the EU strategy). Data collection is carried out through cooperation with WHO. Other important strands of the work include supporting publications that summarize the effectiveness of public health policies to reduce alcohol-related harm and supporting work on specific issues, such as the affordability of alcoholic beverages and alcohol, work and productivity. Marketing is another specific issue on which a lot of work has been produced and funded by the EC, including an ongoing assessment on the topic of young people's exposure to alcohol marketing conducted by RAND Europe and an upcoming overview of the market for alcoholic beverages of potentially particular appeal to minors (for example, alcopops). Dozens of research/development projects relating to alcohol have been funded through the EU. Since 2007, €49 million has been invested in research on alcohol and health through the EU Research Framework Programme. There has clearly been a change from a focus on specific diseases (for example, liver diseases) to public health-related research.

Currently, an independent evaluation of the added value achieved through the EU alcohol strategy is being conducted, and there is an ongoing discussion of the next steps of the EU alcohol strategy. Some of the angles of the discussion include synergies across public health topics (especially related to NCDs), added value from EU action (benefitting economic growth) and the division of labour between MS and the EC.

Dr Lesley Graham, Associate Specialist, Public Health, Information Services Division, NHS National Services Scotland, presented on alcohol problems in prisoners.

The link between alcohol and crime, particularly violent crime, is strong, with the consequences affecting individuals, their families, health and emergency services and wider society. There is not an international standard for measuring alcohol-related crime, but alcohol use is associated with crime in all European countries, particularly with violent crime. There is a range in terms of the percentage of alcohol-related crime, from 7% in Germany to 47% in Finland. Alcohol-related crime is estimated to cost Europe €33 billion (based on an estimate from 2003), and, in Scotland, the cost per year is £700 million.

The issue of alcohol problems in prisoners has been overshadowed by drug problems. There is limited evidence on the prevalence of alcohol problems in prisoners. A systematic review by Fazel (2006) found a prevalence of 18-30% for men and 10-24% for women; however, there was large heterogeneity in the studies. The prevalence of alcohol problems among prisoners in Scotland is three times that of the general adult male population, with nearly half of prisoners reporting an alcohol problem. It is important to note that not all alcohol problems in prisoners are directly linked to their offenses.

The prison setting is an opportunity for intervention. Prisoners are a population with a high prevalence of alcohol problems. Furthermore, in the prison setting, it is easier to reach the "hard to reach" population: predominantly the young and male, who are least likely to be in touch with primary care services. Over a third of prisoners reported that they would accept help if it was offered. There is also the potential to reduce re-offending and to have a positive effect on others (for instance, family members). There is the potential to reduce health inequalities, as many prisoners come from disadvantaged backgrounds.

However, the prison setting can also present challenges. Alcohol services delivery in prisons takes place within the constraints of a custodial regime where security and order are necessary. Overcrowding and churn can make access to treatment and continuity of care more difficult. Comorbidity is another challenge, as many prisoners have other complex needs, such as drug misuse and mental health problems, which can make treatment more challenging. Literacy problems can limit understanding.

There is a limited supply of alcohol in prisons (7% of prisoners have access to alcohol), and this, as well as the other pressures, can mask alcohol problems (accept among those who suffer from alcohol withdrawal). Prisoners may be unwilling to admit to alcohol problems, and there is the risk of relapse on release.

Recent research activities carried out in Scotland include a rapid review of international literature on screening tools and effective interventions; mapping of alcohol services across all Scottish prisons; and an in-depth case study of one prison. This work involved primary data collection (interviews with key informants, focus groups with prisoners, and screening of prisoners using AUDIT) in addition to literature reviews and resulted in a gap analysis with recommendations and a proposal of a model of care.

The rapid review showed that, in terms of screening, the AUDIT was the most promising, but there was no single superior screening tool. With regard to effective interventions, the evidence is limited in the prisoner population, although there is some suggestion that therapeutic communities may be effective. Alcohol Brief Interventions (ABIs) have the highest evidence base in the general population, and a recent study from England demonstrated the effectiveness of ABIs in a probation setting in reducing alcohol consumption and re-offending. There has been very little research on throughcare.

The results of screening using AUDIT from one prison (259 males), indicates that 73% of prisoners had AUDIT scores of 8+ (hazardous, harmful, or dependent use), with 36% possibly dependent (score of 20-40). The highest proportions of 20+ AUDIT scores were in the 18-24 and 40-64 age groups. The study found that the younger age group was scoring highly because of heavy binge drinking, whereas the older age group was more likely to score higher in dependency-focused questions. This highlights the need for tailored interventions. In addition, over one in four reported their current offence to be a violent crime. Four out of five had been in prison before, and many had social exclusion factors, such as unemployment.

Findings across the prisons (mapping) showed recognition from staff that prison provides an opportunity to detect and intervene for those with alcohol problems, that there was no use of

a validated screening tool, and that timing of asking about alcohol problems can be important. There were a range of interventions to address alcohol problems. Not all interventions were available to those on short sentences/remand, and low numbers of prisoners were accessing interventions. Furthermore, there was variation in the capacity of staff due to other demands (for example, methadone programs). There were problems reported in establishing continuity of care, and there was limited in-reach, though there were signs of development.

Results from a case study of one prison showed that prisoners and staff had a broadly convergent understanding of many alcohol issues and a perception that alcohol interventions are not as well resourced or as prominent as drug interventions (prisoners view alcohol problem assessment on admission as a “yes or no” question). Prisoners wanted more involvement of “outsiders” and those with experience of alcohol problems.

Based on the research findings and the Model of Care (MOC) for Alcohol Misuse developed by the National Treatment Agency in England, a MOC for alcohol services in prison was developed. The MOC utilizes AUDIT screening and AUDIT scores to recommend intervention; interventions are divided into tiers, with increasing intensity of intervention.

The elements of success include having a validated screening tool, timely access to effective interventions, partnerships, a standardised approach, a skilled workforce with capacity, advocacy (for example, peer support), in-reach from community services, a holistic approach, and adequate resources.

Ms Nataša Blažko, Health Promotion and Healthy Lifestyle Division, Directorate for Public Health, MoH, Slovenia, presented recent developments in the area of alcohol policy in Slovenia.

The registered adult alcohol consumption, in litres per capita, was 10.6 in 1999, 13.5 in 2004, and 11.5 in 2009. Thus, in the past decade, there has been a small increase overall.

There have been several developments in the area of alcohol policy and legislation. The Act Restricting Use of Alcohol (2003) includes a ban on selling alcohol to those under age 18; a ban on the sale of alcoholic drinks between 21:00 and 7:00; a ban on selling and serving alcohol in educational, health care, sport facilities (one hour prior to the start of an event and during an event) and at workplaces during working hours; and a requirement to offer two different types of non-alcoholic drinks at equal or lower price than the cheapest alcoholic drink. The Act Regulating the Sanitary Suitability of Food and Goods and Substances Which Come into Contact with Food (2000, 2002) stipulates a complete ban on advertising of alcoholic beverages containing more than 15% alcohol by volume; a ban on advertising of other beverages on radio and TV between 7:00 and 21:30; and a ban on advertising in cinemas before 22:00. Additional legislation includes the Occupational Health and Safety Act (2011), Resolution on the National Road Safety for 2012 – 2021 and Road Traffic Safety Act (2004, 2011).

The excise duty on alcoholic beverages has increased since April 2012. The result of negotiations between the MoH and the Ministry of Finance was a 20% increase in the excise duties for intermediate products and ethyl alcohol and a 10% increase in excise duties for beer.

In the area of drink-driving, new traffic legislation went into effect in 2011, introducing stricter sanctions for drink-driving and counselling and rehabilitation measures. One new feature is screening and brief interventions for hazardous and harmful drinking carried out by a selected general practitioner. The MoH is leading the action plan on drink-driving

countermeasures, which include frequent and systematic random breath testing, supported by education and awareness raising campaigns involving all stakeholders.

The activities of NGOs and professional institutions working in the field of the prevention of harmful and hazardous alcohol consumption are expanding. The number of awareness raising campaigns among young people and for the prevention of drink-driving is also increasing. Activities are being carried out at national, regional, and local levels. In 2010, the web portal MOSA Project (mobilizing society for more responsible attitudes towards alcohol) was published, providing a hub for the exchange of information and the promotion of good practices in the field of alcohol policy.

The Occupational Health and Safety Act adopted in May 2011 prohibits workers to work and/or be at the workplace when under the influence of alcohol, illicit drugs or other psychoactive substances.

In the area of drinking environments, various NGOs participate in harm reduction efforts. As part of the EC co-financed project “Club Health – Healthy and Safer Nightlife of Youth” (2009-2012), health and security standards are being developed for nightlife drinking environments and guidelines and recommendations are being developed for local civil authorities’ actions and training of staff in nightlife premises.

Dr Simona Pichini, Senior Investigator, National Institute of Health, Italy, presented recent developments in the area of alcohol policy in Italy.

OSSFAD is the official organ for information concerning tobacco, alcohol and drugs of abuse (plus doping) in Italy. It was created in 2000 and provides health and legal information, scientific data, reviews, and updates. In addition, materials for schools, public services, and health professionals are supplied upon request.

There are two help lines for alcohol, one of which is called the “red nose telephone.” It was created as part of a project related to discotheques and provides a taxi service for people who have been drinking.

In Italy, the excise tax is zero for wine, but it is high for anhydrous alcohol and intermediate products. Workplace legislation includes random testing of at-risk workers. Drink-driving legislation is strict and includes random roadside breath testing.

From 2004 to 2010, per capita alcohol consumption slowly decreased. In 2011, the per capita consumption was 6 litres. This is in line with the Health for All in the 21st Century goal of a per capita alcohol consumption of no more than 6 litres by the year 2015.

Based on data from the National Institute of Statistics, in 2011, 13.6% of people under the age of 15 drank at least once a year and 0.8% drank every day (1.1% of males and 0.4% of females). Among people over the age of 14 years, 66.9% (53.5% of females and 81.4% of males) drank at least one alcoholic drink in the last 12 months, 25.7% were lifetime abstainers, and 7.4% were former drinkers. Wine is the most frequently consumed beverage, with 23% reporting consumption of wine every day (compared to 4.5% for beer and 0.7% for spirits).

There are two problem areas that need to be addressed: daily risky behaviour and binge drinking. Daily risky behaviour is defined as a drinking pattern in excess of the Italian Guidelines of the Italian Institute of Nutrition (more than 2-3 alcohol units for men, more than 1-2 alcohol units for women and more than 1 alcohol unit for the elderly). Daily risky behaviour is a problem among the elderly because they consume two meals per day at home

accompanied by wine. Binge drinking is defined as 6 or more alcohol units per occasion and is largely a problem of young adults.

In the past decade, there has been a decrease in the mortality index (deaths divided by number of road accidents). Since 1996, health services specific for people with alcohol use disorders have doubled.

Since 2007, there has been a National Alcohol Plan, and this plan has been integrated in the National Prevention Plan 2010-2012.

In presenting the 2011 report on the Alcohol Health Plan, the Minister of Health noted that, in the future, a focus will be placed helping young people overcome the social pressure to drink in schools and in places of entertainment and sports and on implementing appropriate interventions of support and motivation for the change. The MoH has plans to work together with the Ministry of Education and the Ministry for Youth Policies to investigate the role of educational agencies and schools in combating excessive alcohol use. Another area that requires additional support/funds and work is fetal alcohol spectrum disorders.

Ms Adriana Galan, Head of Health Status Evaluation Department, National Institute of Public Health, Romania, presented recent developments in the area of alcohol policy in Romania.

Since 2005, Romania has had a National Antidrug Strategy (2005-2012), which includes alcohol. The National Institute of Public Health is struggling to have a specific strategy for alcohol because in the comprehensive strategy, alcohol policy is not aligned with the European strategy documents. The last revision of the Action Plan for the Antidrug Strategy was made in 2010.

There are several other governmental programs that affect the alcohol field: the National Program of Medical, Psychological and Social Care of Drug Users (2009-2012), the National Program of Health Promotion and Health Education, and the National Program of Mental Health.

Legislation on alcohol has been developed; however, implementation is not monitored, and the impact is not evaluated. There is legislation referring to production and sales control, specifically informal production. There is an excise tax on beer/wine/spirits, as well as special taxes on beer and spirits and alcohol publicity that are earmarked for health. There is a minimum legal age for sales/consumption of alcohol (18 years old), some restrictions on sales (hours, public events, and intoxicated persons) and a zero BAC limit for all drivers (which is increasingly being enforced by police). Health warnings are legally required on alcohol advertisements (especially on TV), and there are partial restrictions on advertising hours.

There is a lack of an integrated monitoring system for alcohol and health in Romania. The information is fragmented across different institutions, and, thus, there is a need for increased cooperation and a coordinating body. Romania is not involved in many international research studies, but the country does participate in ESPAD and HBSC (so there are data on young people).

Beer is the most frequently consumed alcoholic beverage in Romania. Wine consumption is increasing, while consumption of spirits is decreasing. The total adult per capita consumption (on average during the period of 2003-2005) was 15.3 litres of pure alcohol (11.3 litres recorded and 4 litres unrecorded). This figure is higher than the European average of 12.2 litres during the same period. In 2010, the National Institute of Statistics reported that the

recorded adult per capita consumption was 9 litres of pure alcohol; this figure differs from the figure presented in the WHO's most recent report.

Alcohol-attributable deaths are rather high among males. According to findings from the 2009/2010 HBSC survey, Romania has the highest proportion of 11- and 13-year-old boys, 19% and 25% respectively, who drink alcohol at least once a week (an increase from 2005/2006, where the figures were 17% and 20%). Romania also has the highest proportion of 11-year-old girls consuming alcohol.

In 2011, the National Institute of Public Health proposed to the MoH a potential national Action Plan, specific for alcohol, which included the main strategic directions from both EU and WHO strategies. Nevertheless, the official Action Plan valid through 2012 is that one developed for the National Antidrug Strategy. There has been a change in government, and the lobby process will need to begin again.

In July 2011, the National Institute of Public Health implemented an information month dedicated to informing target populations (especially youth and pregnant women) about the effects of harmful alcohol consumption on health. This information campaign will be repeated each year.

In 2013, the National Institute of Public Health will produce the first comprehensive National Report on Alcohol and Health (included in the Annual Planning of the Institute and in the National Health Program for Health Promotion and Health Education).

Ms Jean Nicol, Alcohol Policy Manager, Health Improvement and Protection, Department of Health, United Kingdom of Great Britain and Northern Ireland, presented recent developments in the area of alcohol policy in the United Kingdom.

The United Kingdom has a new alcohol strategy, which was launched in March 2012, under the strong leadership of the Prime Minister. The new alcohol strategy is targeted explicitly at heavy drinkers, problem pubs and irresponsible shops. There is also a new antidrug strategy, which was launched 18 months ago. In the antidrug strategy, there is a special section targeting the most dependent drinkers (approximately 300 000 people), with an aim of having total wrap-around services (a recovery agenda) in order to ensure that all issues faced by these individuals are being addressed.

Alcohol consumption has been mostly stable since 2005 but has fallen a bit recently. However, the long-term consumption has risen. Over 9 million people (out of an adult population of 40 million) report drinking above the low-risk guidelines for regular drinking, which are 3-4 units per day for men and 2-3 units per day for women. One major problem area is the consumption of spirits by young people before they go out in the evening (pre-loading). One study found that two-thirds of 17-30-year-olds arrested in one city in England claimed to have pre-loaded before a night out, and a further study found that pre-loaders were 2.5 times more likely to be involved in violence than other drinkers.

Alcohol-related harm has been increasing since the 1970s. There were 1.2 million alcohol-related hospital admissions in 2010-11. Liver deaths have risen by 25% over the last 8 years, and alcohol misuse costs the National Health Service (NHS) £3.5 billion per year.

The strategy includes a strong package of health measures that build on the introduction of the ring-fenced public health grant to local authorities and the new health and well-being boards, giving local areas the power to tackle local problems. The strategy encourages greater use of effective interventions for health professionals, brief interventions, specialist treatments for people dependent on alcohol, and alcohol liaison nurses at the accident and emergency departments (which is one of the biggest best buys). Starting next year, alcohol

checks will be conducted during health checks to screen for alcohol misuse disorders. Licensing authorities will also take local health harms into consideration, which is anticipated to reduce the density of shops, pubs, and bars that are causing health harm.

Drink-driving has been addressed in the United Kingdom since 1979, and deaths and injuries fell more than 75% between 1979 and 2009.

The desired outcomes of the strategy include:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others.
- A reduction in the amount of alcohol-fuelled violent crime.
- A reduction in the number of adults drinking above the NHS guidelines.
- A reduction in the number of people “binge drinking”.
- A reduction in the number of alcohol-related deaths.
- A sustained reduction in both the numbers of 11-15-year-olds drinking alcohol and the amounts consumed

The major areas of work to deliver on the ambitions include national action on promotions and cheap alcohol (minimum unit price, banning multi-buy discounts); enabling local areas to take action locally; working with industry in partnership; and informing and supporting individuals.

Mr Rafn Jonsson, Specialist, Alcohol and Drug Abuse Prevention, Directorate of Health, Iceland, chaired the afternoon session.

Dr Angela Ciobanu, Public Health Officer, WHO Country Office, presented on the cost-effectiveness of alcohol control strategies in the Republic of Moldova.

Hazardous use of alcohol is one of the most important social and health concerns at the national level. In the Republic of Moldova, it is the leading risk factor contributing to the total burden of diseases for men, and it is the third greatest risk factor for women. Compared to other countries in Europe, the alcohol-related mortality is one of the highest. A large proportion of the adult population consumes alcohol. According to the Global Status Report on Alcohol and Health (2011), total adult alcohol consumption was 18.2 litres per capita, over half of which was unrecorded alcohol. The results of the Republic of Moldova Demographic and Health Survey (2005) indicate that 59% of females and 81% of males had at least one drink during the previous month. As regards alcohol consumption by type of alcoholic beverage, the proportions are nearly equal, with 33% for spirits, 31% for beer, and 36% for wine; however, there are differences by age group.

The health ministry, with the support of the WHO Regional Office for Europe, initiated an analytical study to evaluate the effectiveness and cost-effectiveness of alcohol control strategies in the Republic of Moldova, and, based on the results, to build a national alcohol plan. The WHO-CHOICE methodology (**CHO**osing Interventions that are **Cost-Effective**) was utilized.

Resources (costs) included patient-related and programme costs, and results (effectiveness) were expressed in healthy years gained (or DALYs averted). Some of the features of the WHO-CHOICE methodology are that all interventions are evaluated against a “do nothing” option; the time of the intervention implementation is 10 years, but the model population is followed for 100 years; the intervention effects are discounted at a rate of 3% (age-weights); and cost calculations are made by using an “ingredients” approach.

The interventions analysed in the cost–effectiveness study (applied both separately and combined) were:

1. Increase in the tax rate on alcoholic beverages by 25% and by 50%
2. Reduced access to alcoholic beverages in commercial facilities
3. Comprehensive advertising ban
4. Roadside breath-testing for BAC in motor vehicle drivers
5. Brief interventions involving counselling to at-risk drinkers carried out by the primary care physician

The division of interventions into cost-effective and not cost-effective is determined by the norms and values of the society and the commonly accepted limits for those values. In accordance with the recommendation of the WHO Commission on Macroeconomics and Health, such division can be carried out based on GDP per capita. In Moldova, in 2010, this constitutes 20 171 Moldovan Leu (MDL). Highly cost-effective interventions are those where the cost of a healthy year of life gained is less than GDP per capita (up to MDL 20 171); cost-effective interventions are those where the cost of a healthy year of life gained is one to three times GDP per capita (MDL 20 171 – 60 513); and non-cost-effective interventions are those where the cost of a healthy year of life gained is more than three times GDP per capita (more than MDL 60 513).

Looking at effectiveness of interventions separately, the best result was an increase in the tax on alcoholic beverages of 25%, followed by increasing it by 50%. The least effective intervention was breath testing drivers for BAC. In terms of combined interventions, the best result was found from a combination of all interventions (saving 17 736 healthy years of life per year).

All of the evaluated alcohol control strategies were highly cost-effective. The most cost-effective intervention was the tax applied in 2010.

Based on the analysis, several recommendations can be made. There is a need to enforce legislation relating to pricing policies, reducing availability of alcoholic beverages, drink–driving and breath-testing, marketing, and advertising. Measures to reduce the quantity of untaxed alcohol produced should be developed and applied, and alcohol control strategies should be combined.

Based on the analysis, interventions should be recommended for implementation in the following order:

1. Increase taxes on alcoholic beverages
2. Combination of increasing taxes, comprehensive advertising ban, and counselling to at-risk drinkers
3. Combination of increasing taxes, comprehensive advertising ban, providing counselling to at-risk drinkers and restricting access to alcoholic beverages in commercial facilities
4. Implement all alcohol control interventions simultaneously

Dr Lars Møller, Programme Manager Alcohol and Illicit Drugs, WHO Regional Office for Europe, presented the update on the European Action Plan to Reduce the Harmful Use of Alcohol 2012-20, including the consultation process and plans for publication.

When the Action Plan was discussed last year at the national counterpart meeting in Zürich, there was a request from MS for WHO to develop and include two annexes. The first annex was a list of indicators that could be used to measure the baseline and impact of the Action Plan and would be linked closely with EISAH. The second annex was a checklist for policy-makers, which would be linked to the policy options in the Action Plan. In addition, in Baku last year, MS requested that a draft of the annexes be sent to MS for consultation before publication. WHO sent out a draft of the annexes to national counterparts by e-mail last

December and received approximately 20 responses requesting changes. After reviewing the comments, WHO determined that the annexes required substantial revisions. Thus, the annexes have been redone, taking into account the comments from MS. The indicator annex now includes definitions that are consistent with GISAH. The document is currently circulating at WHO for approval, and it is expected that it will be published within two months.

Dr Møller asked if there were any further comments from meeting participants on the procedure for finalizing the Action Plan, and there were no comments.

Dr Møller mentioned that, considering the feedback received from MS and the inconsistencies between national and WHO data, the 2012 draft country profiles will not be published. WHO will work with data provided by national counterparts as part of the 2012 Alcohol and Health Survey, and these data will be used to develop the country profiles that will be published in spring 2013.

Dr Sofia Ribeiro, Press and Communications Assistant, Alcohol Policy Youth Network (APYN), presented information on the APYN.

The aim of the APYN is to empower young people and youth organizations in Europe to become actors in the definition, promotion, implementation and evaluation of alcohol policies and programs at the national and European levels.

In 2011, APYN was established as an international NGO. APYN has been supported by many entities, including the EC, the MoH of Slovenia, and Eurocare, and has no connection to the alcohol industry. APYN currently works with 19 member countries.

It is important to include young people in all stages of planning, executing and evaluating policies and campaigns. The APYN also trains young people on advocacy.

Activities from 2010 included a training course on youth involvement on the alcohol topic (Hungary) and an advocacy school (Slovenia). Activities from 2011 included training for youth researchers (United Kingdom), training on how to lead projects on youth and alcohol (United Kingdom), training for trainers (Lithuania), and the publication of a report on the impact of marketing on alcohol consumption. In June 2012, the first General Assembly will be held, and, later in the year, a youth conference will be held in Slovenia.

An online survey (1095 respondents from 41 countries) was conducted by APYN on the impact of marketing. The findings showed that young people who had their first drink before the age of 15 years were more likely to report heavy episodic drinking. Approximately 75% believe that alcohol advertising influences youth perceptions of alcohol and should not be targeted to them, and 77% believe that alcohol advertisements should carry health warnings. More than 65% reported that they are influenced to buy alcohol when there is a special offer, and more than 85% claimed they do take price into consideration.

APYN provides general training courses on alcohol, peer education training, alcohol policy advocacy schools and training for youth researchers. All work is done by volunteers. MS are invited to contact APYN if they would like this work done in their countries.

Ms Lis Sevestre, Consultant, WHO Regional Office for Europe, presented a satisfaction survey.

The satisfaction survey includes questions on the meeting, EISAH, and the new online data entry system. Participants are encouraged to complete the survey to provide feedback that will be used in planning for the next year. The survey is also a requirement of the contract with the EC.

Dr Lars Møller, Programme Manager Alcohol and Illicit Drugs, WHO Regional Office for Europe, thanked PARPA, the EC, and the Norwegian MoH and Care Services for co-sponsoring the event. He also thanked the interpreters, the technicians, the photographer, the rapporteurs, and WHO staff, and all participants for their presentations and comments. The presentations, photos, meeting report and NCD documents discussed during the conference will be available on the SharePoint meeting web site.