



REGIONAL OFFICE FOR

**World Health
Organization**
Europe



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

25 April 2013, Istanbul, Turkey

Final report

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The one-day meeting was organized by the World Health Organization Regional Office for Europe (WHO Regional Office for Europe) in joint collaboration with the European Union (EU) and the Green Crescent Society.

Dr Lars Møller, Programme Manager, Alcohol and Illicit Drugs, WHO Regional Office for Europe, opened the meeting and welcomed the attendees to the 15th Meeting of the WHO National Focal Points for Alcohol Policy in the WHO European Region. The meeting participants included representatives from 43 Member States as well as expert speakers and other stakeholders.

Professor Ihsan Karaman, President, Turkish Green Crescent Society, also welcomed the meeting participants and provided background on the history of the Green Crescent Society, which was established in 1920 and is the oldest public health organization in Turkey. Professor Karaman thanked the WHO headquarters, the WHO Regional Office for Europe, and the WHO Country Office in Turkey for their assistance in organizing the conference and also provided logistical information regarding the Global Alcohol Policy Symposium.

Dr Maria Cristina Profili, WHO Representative and Head of Country Office, Turkey, thanked the hosts, organizers, and representatives of the Member States. She remarked on two recent relevant milestones, namely, the WHO global strategy to reduce the harmful use of alcohol adopted in 2010 and the *European action plan to reduce the harmful use of alcohol 2012–2020*. She noted that the meeting and symposium provide a forum for brainstorming, sharing best practices, and raising awareness of the harmful use of alcohol.

Dr Bekir Keskinliç, Deputy President, Public Health Institute of the Ministry of Health, Turkey, welcomed the meeting participants and stated that it is a great honour to host the meeting and symposium. He expressed appreciation for the work of the Member States in addressing alcohol-related harm in their countries. Harmful alcohol use is responsible for many deaths, which are largely avoidable. He noted that Turkey is late to take action to address this issue, but the symposium will help the country in developing alcohol policies.

Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, Department of Mental Health and Substance Abuse, WHO, welcomed the participants on behalf of the WHO headquarters. The events in Turkey reflect the increasing awareness of the public health problems associated with the harmful use of alcohol and the political commitment to addressing these issues. Both the Global Symposium and the Global Alcohol Policy Conference in Bangkok last year highlight the implementation of the WHO global strategy to reduce the harmful use of alcohol. In one month, the World Health Assembly will consider several documents relevant for the WHO's work on the harmful use of alcohol.

The three main objectives of WHO reform, which are applicable to activities aimed at reducing the harmful use of alcohol, include improved health outcomes with the WHO meeting the expectations of its Member States and partners in addressing agreed global health priorities; greater coherence in global health with the WHO playing a leading role; and an Organization that pursues excellence.

Dr Lars Møller chaired the morning session. All participants were asked to briefly introduce themselves.

Dr Vladimir Poznyak presented information on the implementation of the WHO global strategy to reduce the harmful use of alcohol. Following the adoption of the global strategy, several regions developed policy frameworks and adopted action plans consistent with the global strategy. As of December 2012, 53 Member States were in the process of developing a written national alcohol policy and 39 were in the process of reformulating existing policies for reducing the harmful use of alcohol.

The key priority areas for global action include public health advocacy and partnership, technical support and capacity building, production and dissemination of knowledge and resource mobilization. The key role in the implementation of the global strategy is collaboration with Member States, and, for this purpose, the global and regional networks of WHO national focal points, Coordinating Council and task forces were created. The WHO took a leadership role in co-hosting the Global Alcohol Policy Conference last year in Bangkok, which was attended by 1216 participants from over 50 countries. As regards technical support and capacity building, the WHO has conducted capacity-building workshops for government officials responsible for alcohol control and noncommunicable disease (NCD) prevention; additional workshops are planned for 2013. WHO Regional Offices and headquarters also provided direct country support for alcohol policy development and implementation.

The WHO is working on a toolkit in support of the implementation of the global strategy (which includes technical tools, policy briefs and training materials) and fact sheets on key public health issues that can be disseminated through the network of focal points. With the support of the government of the Netherlands, the WHO has also developed web-based portals on alcohol and health that include web-based interventions. In terms of research, there are three ongoing activities: an international study on harm to others, a study on prenatal alcohol exposure and child development, and an international research project on alcohol and infectious diseases. Recent activities under the category of global monitoring include the *Global Status Report on Alcohol and Health* published in 2011 and the 2012 Global survey on alcohol and health. Future activities include an additional survey component to improve the estimates of unrecorded consumption, new WHO estimates for alcohol-attributable disease burden for 2010/2011 (to be produced in 2014), a new *Global Status Report on Alcohol and Health* (2014) and a revision of the alcohol module of the STEPS questionnaire. The NCD Global Monitoring Framework includes a set of nine voluntary targets for 2025, including a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context. In terms of resource mobilization, support has been provided by several governments, particularly the government of Norway, but the resources are still insufficient to address the magnitude of alcohol-attributable disease and social burden.

Professor Jorgen Rehm, Director, Social and Epidemiological Research Department, Centre for Addiction and Mental Health, Toronto, Canada, presented trends in the last 20 years for alcohol consumption in the EU and data on alcohol-related health harm (cancer, liver cirrhosis, and injury) in the EU. Overall in the EU (plus Croatia, Norway and Switzerland), recorded alcohol consumption has decreased over the past 20 years by more than 10%. However, this trend does not hold for all countries or all areas of the EU. The central-western and western country group is one of the groups responsible for the downward trend in recorded alcohol consumption in the EU. The central-eastern and eastern country group, however, has seen an upward trend in alcohol consumption at least in the past 10 years. The Nordic region has the lowest consumption in Europe but is still far above the global average, and there has been a slight upswing in consumption in recent years. The largest decline in consumption has been observed in southern Europe. In addition to differences between country groups in Europe, there are also different trends within a group; the United Kingdom, for example, which is part of the central-western and western country group, has had an increase in consumption. Consumption data are derived from a variety of sources; the data are collected from national focal points by the WHO, and the data and sources are entered into a database and compared with other data. If there are questions or inconsistencies, the focal points/country representatives are contacted. Thus, the data are approved by Member States and checked against other sources. Whenever there are country data which can constitute a time series, these data are given priority by the WHO. Other data sources include the Food and Agriculture Organization (FAO) of the United Nations. There are

special ongoing efforts to improve the process of collecting data on unrecorded alcohol consumption, and the WHO is implementing a pilot to study unrecorded consumption.

As regards alcohol-attributable health harm, there are three categories that cover 90% of the net mortality from alcohol, namely, cancer, liver cirrhosis and injury. There is a clear west–east gradient in alcohol-attributable liver cirrhosis, cancer and injury deaths, with much higher levels of health harm in the east, with a few exceptions. The west–east gradient is not as pronounced for alcohol-attributable cancer deaths and is most apparent for injury deaths; that is, there are the greatest differences between countries, and this may be due to the differences in style of drinking and the overall number of binge drinking occasions per time unit.

Ms Jean Nicol, Department of Health, London, United Kingdom, moderated a panel discussion on alcohol and brief intervention (BI). Panel members included **Ms Ranjita Dhital**, **Mr Dag Rekve**, **Ms Triinu Täht** and **Dr Simona Pichini**.

Ms Ranjita Dhital, King's College London, United Kingdom, presented information on the use of alcohol BI in pharmacies. There are two components of BI, namely, screening and a brief motivating discussion to assist the individual to reduce his/her consumption. General practitioner practices and accident and emergency departments are common locations for BI; however, there is other settings, such as pharmacies, are currently being investigated as potential settings for BI.

The pharmacy workforce is the third largest health care professional group in the world, and, therefore, pharmacies have the potential to be a tool to prevent and reduce alcohol-related problems. Furthermore, the large number of pharmacies and frequent visits made by people suggest that the pharmacies may be used to influence public health. Pharmacists are already involved in public health services (e.g., smoking cessation and sexual health), and recent changes to the pharmacy environment (e.g., private consultation rooms, available computer/internet) will facilitate the delivery of BI. There are numerous opportunities in the pharmacy for BI, such as self-referral (through, for example, posters), pharmacy services (through, for example, health checks), counter purchases, and prescribed medications. There have been several recent feasibility studies as well as studies on customers' and pharmacists' perceptions, attitudes and knowledge of alcohol BI. In a recent study conducted in London, 29 pharmacists were recruited and trained to deliver alcohol BI. Nineteen of the pharmacists were categorized as active (they completed one or more BI), and 10 were less active (unable to complete a BI). Both groups had an overall significant increase in knowledge after the training, but the main difference between the groups concerned attitude – the active group was already motivated and had a positive attitude; the active group also had significantly increased role adequacy and work satisfaction, while the less active group had significantly reduced role legitimacy. There is currently an ongoing randomized control trial (RCT) assessing effectiveness of BI delivered by community pharmacists.

MrDag REKVE, Technical Officer, Mental Health and Substance abuse, WHO, presented an overview of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and linked BI. The ASSIST package contains three elements: the ASSIST manual, the ASSIST-linked BI manual, and a guide with self-help strategies. The development of the ASSIST was a long process, beginning the development of the Alcohol Use Disorders Identification Test (AUDIT) in the late 1980s. There were four further phases of development of the ASSIST extending from 1997 until 2011, including a feasibility and reliability study, international validity study, feasibility study of a linked BI, and an international RCT of a linked BI. WHO developed the ASSIST because of the need to create a tool that would be faster to administer than existing diagnostic tests, could be used in primary health care settings to screen for risky use of all psychoactive substances, would have cross-cultural relevance and

could be linked to a BI. The ASSIST is an 8-item clinician-administered questionnaire, which is cross-culturally neutral and can be administered in 5–10 minutes. The ASSIST questionnaire screens for hazardous and harmful use of a variety of substances, determines a risk score for each substance, provides an opportunity to start a discussion with a client/patient, and determines the most appropriate intervention depending on the level of use.

Ms Triinu Täht, Chief Specialist, Ministry of Social Affairs, Estonia, presented the Estonian experience in developing early identification and BI. Alcohol consumption in Estonia is high, in the range of 10–12 litres per capita per year over the past decade. A study investigating how Estonians evaluate their drinking habits found that many responded that Estonians in general drink “a lot” or “too much” but that they themselves drink “a little.” Early identification and brief intervention (EIBI) is one way to address this misconception. The national development project started in 2009 and was supported by the European Social Fund and aimed at integrating EIBI into primary health care, supported by a media campaign. The experiences of Finland and other countries were considered. Results of a pilot study of EIBI indicated that it is not time consuming (a fear expressed by many physicians); patients generally do not mind that physicians broach the subject, and most service providers find it easy to initiate a discussion on the topic. Providers reported that delivering the intervention is more difficult than asking the initial screening questions, but, still, 46% reported that it is “easy.” Based on AUDIT scores, half of the male patients in the pilot project were categorized as drinking at a risky level. The project also revealed that nurses are more interested in using EIBI than doctors. Future steps include the integration of EIBI into other health services (such as occupational health) and other settings (for example, for traffic offenders).

Dr Simona Pichini, Senior Investigator, National Institute of Health, Italy, presented the Italian experience with EIBI of alcohol-related problems during pregnancy. Most of the research on the prevalence of foetal alcohol syndrome (FAS) and foetal alcohol spectrum disorders (FASD) comes from North America and South Africa. The only Italian field study assessing prevalence was a retrospective cohort study conducted in a restricted area of Rome, which reported a FAS prevalence of 0.37% and a FASD prevalence of 2.3%. A survey of Italian and Spanish neonatologists and paediatricians found that between 60%–80% were aware of the dangers of alcohol consumption during pregnancy, but approximately half said that it is acceptable for pregnant patients to occasionally drink a glass of wine, and most of the physicians did not feel confident in their ability to diagnose FAS and FASD.

The joint Italian-Spanish Meconium Project found daily maternal ethanol consumption in 45% of the 1209 infants as measured by fatty acid ethyl esters (FAEEs) in meconium. An Italian multicentre study in 2010 found that 7.9% of newborns were prenatally exposed to ethanol.

As part of an Italian project to better inform health professionals about FASD, two instruments were developed: a training book for health professionals and guidelines for the diagnosis of FASD.

Since 2012, EIBI has been conducted with 1500 pregnant women attending a hospital in Rome.

A suggested strategy to detect maternal drinking during pregnancy would be to administer a questionnaire and urine Ethylglucuronide (EtG) test at the first antenatal visit, and, if the results were positive, to test for EtG in the hair. If both results were positive, staff would conduct a brief intervention or refer the patient to a detoxification centre. The suggested strategy to detect foetal exposure to alcohol would be to test for EtG in the meconium of newborns.

Dr Belinda Loring, Technical Officer, European Office for Investment for Health and Development, Venice, WHO Regional Office for Europe, presented a policy brief on inequities and alcohol-related harm. Efforts to reduce inequalities in health have become more prominent with the adoption of Health 2020. As part of the ongoing collaboration between the EU and WHO to address health inequalities, five policy briefs will be developed, including guidance on practical ways to reduce health inequities in relation to alcohol. The target audience includes policy developers, programme managers and policy advocates with a primary interest in the topic of alcohol. The brief should be applicable to EU member states and the European Region (high-, middle- and low-income countries with different forms of government). Inequities in alcohol-related harm in Europe do not follow a consistent pattern, and, therefore, the nature and distribution of health inequities need to be examined from a national perspective. The dimensions of disadvantage or variables interact and amplify each other (for example, ethnicity and gender). In general, there are higher levels of alcohol-related harm among lower socioeconomic status groups with the same level of consumption. Addressing this situation requires a stepwise approach that includes ensuring that policy choices do not make inequities worse. There must be awareness that strategies, such as education, have the potential to increase inequalities, and there is a need to evaluate the effects of policies on different social groups.

Inequities in alcohol-related harm can arise from factors at many levels, and this framework can be used as tool for identifying entry points for interventions. For example, at the level of exposure, poor neighbourhoods have an increased density of alcohol outlets, and, therefore, a potential intervention might be zoning restrictions in these disadvantaged areas. A comprehensive approach to reduce inequities in alcohol-related harm requires a combination of interventions with a short-term and long-term focus.

Focal points are encouraged to provide feedback on the draft of the brief.

Ms Triinu Täht moderated the afternoon sessions, which included panel discussions on alcohol prevention at the population/local level, alcohol labelling, updates on the European Information System on Alcohol and Health, and examples from WHO collaborating centres.

Dr Wojciech Klosiński, Deputy Director, Department of Public Health, Ministry of Health, Poland, presented an example of effective communication in alcohol prevention and social campaigns conducted by the State Agency for the Prevention of Alcohol-Related Problems (PARPA).

To address the issue of alcohol consumption during pregnancy, a campaign was implemented with the goal of limiting the number of women who drink during pregnancy and increasing knowledge about the negative impact of alcohol on the foetus. The campaign message was “Even the slightest amount of alcohol consumed during pregnancy can cause harm to the unborn baby. Total abstinence from alcohol use is recommended during pregnancy!” Campaign tools included television (TV) and radio spots, billboards, printed educational materials, press articles, TV programmes, a campaign web site, prevention and educational family picnics, local debates and conferences, basic training for health care workers, and cooperation with local authorities.

Another campaign (2009) “Find out if your drinking is safe!” aimed to reduce alcohol-related harms and the number of hazardous and harmful drinkers by encouraging consumers to examine their drinking patterns. Campaign tools included educational materials, billboards, TV and radio spots, web sites, local debates, trainings, school-based education and prevention programmes, training of health care staff and training for sellers. The campaign had a special focus on youth.

Dr Angela Ciobanu, Public Health Officer, WHO Country Office, Republic of Moldova, presented an example of an alcohol communication strategy in the Republic of Moldova.

Per capita alcohol consumption in the Republic of Moldova is among the highest in the world, with high levels observed among youth, mainly in the rural areas. Alcohol production, particularly wine making, is an important part of the economy and a source of national pride. With the financial support of the EU, the WHO has been expanding alcohol control activities in the Republic of Moldova.

The Republic of Moldova implemented an alcohol communication strategy with the aim of reducing alcohol consumption among the population. The objectives of the strategy were to increase by 10% the target groups' knowledge about the effects of the harmful use of alcohol on health status, to decrease by 30% the perception of the general population that alcohol consumption is not harmful, and to increase by 10% the number of persons with positive behavioural patterns (for example, abstinence during pregnancy). Five different target groups were identified (general population, pregnant women, teenagers, drivers and lonely men), and different messages and channels for disseminating the messages were developed for each group. For example, for the pregnant women group, the proposed messages included "Don't drink for the health of your baby!" "Give your child the best start, be healthy and never drink alcohol during pregnancy!" and channels included video spots, posters, booklets, and individual and group discussions. For lonely men, the message was "Don't drink for the happiness of your children!" and the dissemination channels included flyers, social theatre, meetings organized with community leaders, and individual consultations. The general campaign logo was "With a sober mind!"

Ms Kit Broholm, Senior Consultant, National Board of Health and Medicines Authority, National Board of Health, Denmark, discussed evidence-based alcohol interventions at a local level.

The Health Packages in Denmark are evidence-based tools to assist municipal decision-makers and health planners in setting priorities and planning and organizing local health promotion and disease prevention activities. The Health Packages are structured with three parts: 1) facts (for example, prevalence and economic costs); 2) recommendations (for plans and policies, early detection, health promotion services, and information and education); and 3) implementation.

As regards recommendations on plans and policies on alcohol, municipalities are advised to make alcohol part of the municipal health policy (with separate measurable targets). The municipal policy should cover prevention, early detection, counseling and treatment, take a multisectoral approach, and include an action plan for implementation. It is also recommended that the municipality adopt policies for workplaces and institutions and that the principle of responsible alcohol serving inform alcohol licensing decisions. It is recommended that early detection include screening, BI and referral to treatment by frontline personnel (in the social services and health services, for example). Recommended health promotion services include brief counselling for people with excessive or harmful alcohol use and their families provided by the municipality and efforts to ensure cooperation between alcohol treatment, social services and family therapy.

The next step is for the Danish Government to support the municipalities in implementing the recommendations.

Ms Mariann Skar, Secretary General, Eurocare, discussed the topic of alcohol labelling. In the EU, consumer information/labelling is required on containers of milk, a beverage that does not cause cancer, is not addictive and is not a leading risk factor for chronic disease but is not required on alcoholic beverage containers. In approximately 20 countries in the world, health and safety warning messages are mandatory on alcoholic beverages; however, the

content, size, etc. vary. The United States requires a warning message; however, as implemented, it is often difficult to see on the packaging. Thailand specifies that the label must constitute no less than 30% of the total surface area of the package. A voluntary scheme in the United Kingdom was not very successful, as a study found that 85% of alcoholic beverages were not labelled, and, of those with labels, few use the recommended text.

Labelling is a low-cost tool to remind the public of alcohol-related health risks. The impact of the intervention would more likely be observed in the long-term rather than the short term, as it helps to change norms (for example, no alcohol during pregnancy) and develop the social understanding that alcohol is a hazardous product.

Alcohol labels should include the following components: ingredients, list of any substances with an allergenic effect, nutritional information, alcoholic strength (total grams), and a health and safety message. Furthermore, the location of the labels should be standardized, and the label should be positioned parallel to the base of the container, be clearly separated from other information on the label, be written in bold capital letters, and appear on a contrasting background. The size should be specified as a minimum percentage of the size of the container. Furthermore, it is recommended that a variety of rotating messages be used and that the messages be supported by other ongoing educational campaigns.

Dr Pierre-Yves Bello, Adjoint au chef de bureau, Bureau des pratiques addictives, Direction Générale de la Santé, Ministry of Health and Social Affairs, France, provided information on the French experience with health and safety warnings on alcoholic beverages and alcohol ads.

The legal framework on alcohol advertisement in France is mainly the *Loi Evin*, which specifies, among other restrictions, a total ban on TV advertising, a partial ban on radio broadcasting, and a total ban on advertising on newspapers, magazines and web sites targeting young people. A health warning message is mandatory on all advertisement for alcoholic beverages (except leaflets targeting professionals and menus/objects at points of sales). However, the size and colour, for example, are not specified in the law and are left to the discretion of the alcohol industry; this has led to difficulties with visibility and readability. There has not been a formal evaluation of this regulation; however, it may contribute to a change in perspective/mentality of new generations.

Legislation in 2005 and 2006 specified that alcoholic beverages must contain a warning message promoting the avoidance of alcohol by pregnant women and that the message must be a text or logo. As of 2007, this warning message has been mandatory in France. The implementation of the warning message was supplemented by additional measures, such as a communication campaign, information at schools and professional training. Studies show some evolution in the past five years of awareness of the dangers of consuming alcohol during pregnancy and high levels of recall and comprehension of the warning label.

Ms Maria Renström, Director, Department of Public Health, Ministry of Health and Social Affairs, Sweden, provided information on the Swedish experience with alcohol labelling. Sweden previously had a total ban on alcohol advertising, but, following a case in the Swedish courts, the legislation was revised. There is still a ban on alcohol advertising on TV and radio; however, advertising is now allowed in printed media and internet sites for alcoholic beverages below 15% alcohol by volume (that is, beer and wine). As part of the new legislation, it is specified that the advertisement must have a health warning label (similar to the one used for tobacco advertisements) and that the size of the label should be 20% of the advertisement. There are some lessons to be learned based on the experience of Sweden and the history of tobacco advertisement. Firstly, legislation should specify the size

of the labels as a percentage of the total space of the advertisement. Secondly, it should be noted that labelling is just one tool and should be used in combination with other regulations as part of a comprehensive strategy.

Dr Konstantin Vyshinsky, Lead Researcher, Department of Epidemiology, National Research Centre on Addictions, Russian Federation, presented recent developments in the labelling of alcohol products in the Russian Federation.

As regulated by Federal Law No. 171 (revised December 2012), all alcohol products sold in the territory must include various types of information, including the amount of alcohol product in the consumer packaging, the main ingredients, the content of potentially harmful substances, the ethanol concentration (and for beverages with less than 7% alcohol by volume, the concentration of alcohol in 100ml of the product and the full volume of the consumer packaging) and a health warning. There has been ongoing debate and recent initiatives to update the law and introduce stricter regulations, including a requirement for the warnings to be in a large and readable font occupying no less than 20% of the label and for the text to be modified.

Other recent changes in alcohol policy (effective January 2013) include restrictions on hours of sale (retail sales prohibited from 23:00 to 8:00 hours), the prohibition of the sale of beer in kiosks, a ban on alcohol advertising in printed media and an increase in the minimum retail price for a bottle of vodka.

Dr Lars Møller presented an overview of the European Information System on Alcohol and Health (EISAH) as well as information on the recent and planned activities of the WHO Regional Office for Europe. The WHO recently produced three publications: *The European action plan to reduce the harmful use of alcohol 2012–2020*, *Alcohol in the European Union. Consumption, harm and policy approaches*, and *Alcohol problems in the criminal justice system: an opportunity for intervention*.

Alcohol in the European Union. Consumption, harm and policy approaches updated the evidence base and presented data from the 2011 European survey on alcohol and health. There are plans to publish certain chapters individually on the WHO web site.

In June, the WHO will publish the *Status Report on Alcohol and Health in 35 European Countries 2013* using information collected in 2012 (the Global survey on alcohol and health). The report contains three sections: 1) trends in alcohol consumption and alcohol-attributable mortality in the EU in 2010, 2) an update on alcohol policies based on 2012 survey data, and 3) country policy timelines. The timelines are a summary of major steps or milestones in each country in the development of policy and action to reduce alcohol-related harm from 2006–2012 and include links to relevant documents, web sites, publications, etc. Such a tool could help Member States when they are revising, updating, and drafting new policies on alcohol and could facilitate networking between Member States in the area of alcohol policy. The report is financially supported by the EU and only includes EU member states, EU acceding and candidate countries, Norway and Switzerland. The report will not include country profiles, but these will be published for all countries in the *Global Status Report on Alcohol and Health* next year. Furthermore, there are plans to develop an online country timeline database for all WHO European Region Member States, which will be updated yearly.

In the 2012 survey, there were some questions regarding changes in alcohol policy areas over the past five years. The areas where the most countries reported positive developments were public awareness-raising, drink-driving policies and countermeasures and monitoring and alcohol research.

Upcoming activities include a small survey in 2014, which can be used to update the most relevant information among EU member states. This information will also be used to update country profiles, which will be ready for online publication in 2014. In addition, in 2016, a new Global survey on alcohol and health will be administered. There are plans to continue the network meeting on a yearly basis, funds permitting, and to organize a conference on FASD. Furthermore, if funding is available, the WHO Regional Office for Europe plans to produce a publication on brief intervention and/or treatment of alcohol use disorders.

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 database.

The web address for EISAH is <http://who.int/gho/eisah>. EISAH can also be accessed through the WHO European Region alcohol web site. Most of the overarching subcategories remain the same; however, an additional subcategory of youth and health has been added. Under this subcategory, there are data on abstainers and blood alcohol concentration (BAC) limits. The two other major changes concern the download and filter options.

It is possible to filter data by country and by year, among other options, and to export data tables to an Excel spreadsheet or in another format (such as CSV and HTML). Additional information about the database can be found in the EISH User Manual.

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

Professor Mark Bellis, WHO Collaborating Centre for Violence Prevention, discussed the activities of the Collaborating Centre.

There is a good evidence base linking violence and alcohol, and studies in this area include epidemiological studies and controlled experiments. Violence related to alcohol use can be compared to passive smoking in that, often, those other than the drinker are hurt. The term violence includes youth violence, child abuse, intimate partner violence, sexual violence, elder abuse and self-directed violence. The risk factors for all of these types of violence are similar, and this is important in terms of primary prevention. Another area that is much less discussed is that some people drink alcohol in response to violence; that is, alcohol can be a form of self-medication in response to violence.

The Collaborating Centre for Violence Prevention works with both the WHO Regional Office for Europe and WHO headquarters, and, within the United Kingdom, the Collaborating Centre works with the Home Office, Public Health England and the Department of Health. The Collaborating Centre is also a part of the Violence Prevention Alliance, which is a network of WHO Member States, international organizations and civil society organizations working to prevent violence. The activities of the Violence Prevention Alliance include lobbying and producing evidence, and its role is to tackle violence as a public health issue.

Currently, a global survey on violence is being conducted by the WHO, which will serve as a baseline and means of tracking progress with violence prevention. Within Europe, the Collaborating Centre has co-authored with the WHO Regional Office for Europe reports on youth violence and elder maltreatment and is currently preparing a report on child maltreatment. Internationally, the Collaborating Centre has co-authored evidence review series (for example, *Violence prevention: the evidence* and *Preventing and reducing armed violence: What works?*), hosted a World Safety Conference, and created a violence prevention web site with the most recent evidence on effective policy measures, among other

activities. The Collaborating Centre also worked with WHO to develop the TEACH-VIP (Training, Educating, Advancing Collaboration in Health on Violence and Injury Prevention) teaching materials, which includes a session on alcohol and youth violence.

An additional activity is the Adverse Childhood Experiences study, which investigates the relationship between abuse, neglect and household dysfunction in childhood (before age 18) and health outcomes later in life. Findings from the United States and the United Kingdom show that individuals experiencing four or more adverse childhood experiences have an increased risk of alcohol abuse, illicit drug use, and perpetrating violence as adults. Additional European studies are ongoing.

Much of the current evidence for primary violence prevention comes from studies in the United States, which is problematic because the systems, cultures, etc. may not be relevant in other parts of the world.

In summary, the problem with violence is that there is a cycle such that people who are exposed to violence and maltreatment as children are at an increased risk of becoming perpetrators themselves and developing a range of problems, including alcohol abuse. Therefore, there is a need to divert people from the cycle; intervention programs work best as part of an integrated approach.

Professor Emanuele Scafato, Director, WHO Collaborating Centre for Research and Health Promotion on Alcohol and Alcohol-Related Problems, discussed the activities of the Collaborating Centre. The Institute Superiore di Sanità (ISS) was founded in 1931 and funded by the Rockefeller Foundation. The Population Health and Health Determinants Unit (PHU), which is part of the National Centre for Epidemiology, Surveillance and Health Promotion (CNESPS) at ISS, conducts research in the areas of alcohol, ageing, Alzheimer's disease and dementia and assessment.

In addition to contributing to numerous reports at the European and international levels, the ISS assesses data for the reports of the Italian Ministry of Health to the Parliament on the health status of the country and collaborates in the status report on the Italian population. The ISS provides national alcohol-related public health campaigns and trainings and is responsible for organizing the Alcohol Prevention Day. The ISS is also involved in many alcohol policy-related EU projects.

As a WHO collaborating centre, the ISS has a mandate to be involved in activities related to the collection, collation and dissemination of information, the standardization of terminology and nomenclature, and the implementation of WHO programmes and activities at the country level. Two areas where ISS is particularly able to contribute include Bland ageing research areas.

Work on the implementation of early detection and BI began in 1984 in Italy, and research in this area has continued. A current project involves a randomized controlled non-inferiority trial of primary care-based facilitated access to an alcohol reduction web site.

The ISS has also been focused on the research area on alcohol and ageing. A recent European project, the VINTAGE project, had the objectives of providing the evidence base on the impact of alcohol on the health and well-being of older people (through a systematic review of the scientific literature and the publication of a report); collecting EU examples of best practice (through a survey and a grey literature review); and disseminating the findings to relevant stakeholders (through web sites).

Dr Esa Österberg, Senior Researcher, WHO Collaborating Centre on Alcohol Policy Implementation and Evaluation, discussed the history and activities of the Collaborating

Centre. In November 2012, the National Institute for Health and Welfare (THL) Department of Alcohol, Drugs and Addiction was designated a WHO Collaborating Centre; however, THL (and associated national organizations) has a long history of involvement with the WHO, including collaborating on several seminal publications, such as *Alcohol Control Policies in Public Health Perspective* and *Alcohol: No Ordinary Commodity*. THL was likely designated as a collaborating centre for two reasons: the strong leadership and will of the director of the institution (Pekka Puska) and the adoption of the WHO *Global strategy to reduce the harmful use of alcohol*, which increased the opportunities for WHO to take advantage of the experiences of THL.

Over the next four years, the activities of the Collaborating Centre will include systematizing alcohol policy measures in WHO Member States; assessing the impact of the WHO *Global strategy to reduce the harmful use of alcohol* on different actors' and stakeholders' activities to reduce the harmful use of alcohol; mapping policy system responses for reducing the availability of alcoholic beverages; mapping the different mechanisms used to influence the pricing of alcoholic beverages; mapping and strengthening knowledge-based local and community research and prevention measures to reduce harmful use of alcohol; and supporting the WHO Regional Office for Europe in implementing the alcohol action plan and research projects.

As part of the AMPHORA e-book, the THL is responsible for Work Package 5, which focuses on alcohol availability and pricing

Dr Manuel Cardoso, General-Directorate for Intervention on Addictive Behaviours and Dependencies, Portugal, made a brief presentation on joint action on alcohol. The purpose of joint action is to support EU member states in preventing harmful alcohol consumption and to improve the health of European citizens. The joint action aims to support member states in advancing work on common priorities consistent with the EU alcohol strategy. The focus is to improve the monitoring of drinking habits and alcohol-related harm, provide good practice information to protect children and young people and prevent alcohol-related harm among adults. The main objectives are monitoring, to have some consensus on guidelines for low-risk alcohol consumption and to develop a toolkit to share good practice.

Dr Lars Møller thanked the Green Crescent Society and the EU for providing financial support. He also thanked the interpreters, the technicians, and the WHO staff for their work, all participants for their presentations and comments, and the conference agency for their assistance in organizing the meeting. The presentations, photos, and meeting report will be available in a DropBox folder.