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Meeting report

Editorial meeting of the EC/WHO report on Alcohol and Technical Consultation on the European Information System on Alcohol and Health

8–9 October 2018
Moscow, Russian Federation



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Abbreviations

APC	alcohol per capita consumption
EC	European Commission
EHIS	European Health Interview Survey
EISAH	European Information System on Alcohol and Health
EU	European Union
GISAH	Global Information System on Alcohol and Health
HED	heavy episodic drinking
NCD	noncommunicable disease
SDG	Sustainable Development Goal
STEPS	WHO STEPwise approach to surveillance
WHO	World Health Organization

Scope and purpose

MOPAC (Monitoring of national policies related to alcohol consumption and harm reduction) is a three-year project funded by the European Commission (EC) that aims to support the European Union (EU) and the World Health Organization (WHO) European Region in monitoring and surveillance of progress achieved by Member States in reducing the harmful use of alcohol. Through this direct grant agreement, the EC and WHO have cooperated in collecting data to update the shared alcohol information system for the EU and the WHO European Region – the European Information System on Alcohol and Health (EISAH). Data collected and validated by Member States can be used to assess implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol, the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020, and the Action Plan on Youth Drinking and on Heavy Episodic Drinking of the Committee on National Alcohol Policy and Action (CNAPA action plan). These data also inform the WHO’s reporting on Sustainable Development Goal (SDG) Indicator 3.5.2 (“Alcohol consumption per capita”), on indicators included in the Global Monitoring Framework for Prevention and Control of Noncommunicable Diseases (NCDs), and on progress achieved in implementation of national commitments as elaborated in the 2011 United Nations Political Declaration and the 2014 United Nations Outcome Document on NCDs.

The latest (2016) iteration of the WHO Global Survey on Alcohol and Health collected data in Europe in collaboration with, and with the support of, the EC to produce the *Alcohol status report 2019: alcohol consumption, harm and policy responses in 30 European countries*. The Global Survey identified variations in countries’ national information systems. It is important to address these variations in order to improve WHO estimates; opportunities for improvement have been identified and should be taken. In some countries, there is a need for better understanding of WHO methodology in calculating alcohol consumption and harm attributable to alcohol consumption; in other countries, WHO support can help to improve national indicators and the quality of data, thereby allowing national monitoring and information systems on alcohol and health to advance.

To support Member States, the WHO Regional Office for Europe brought together 23 representatives from 11 selected European countries to gather feedback on the current sets of indicators and their use in producing and disseminating estimates at regional and national levels. The invited Member States were Austria, Belarus, Estonia, Kazakhstan, Lithuania, Poland, Portugal, the Republic of Moldova, the Russian Federation, Slovenia and Sweden (see Annex 1 for a full list of participants). Several discussions, explanations of the underlying methods and indicators, and a software demonstration provided countries with instruments that should help to improve national processes for estimating alcohol exposure and alcohol-attributable disease burden (see Annex 2 for the full programme). The overall aim of the meeting was to improve national and regional monitoring and reporting on alcohol and health.

Introduction to the meeting

The “Editorial meeting of the EC/WHO report on Alcohol and Technical Consultation on the European Information System on Alcohol and Health” was held on 8 and 9 October 2018 in Moscow, Russian Federation.

The meeting was opened by *Dr João Breda, Head of the WHO European Office for the Prevention and Control of Noncommunicable Diseases (NCD Office)*. He expressed his gratitude for the opportunity to hold the meeting in the Russian Federation. He highlighted that alcohol use is still a major risk factor

for mortality and morbidity; even though the volume of drinking may be going down in some countries, there is still massive binge drinking in many countries.

Dr Breda applauded the Russian Federation for its great efforts to introduce effective alcohol regulations based on WHO recommendations. This has led to major success in reducing alcohol consumption and alcohol-related harm. He also highlighted that better alcohol policies are needed in many other countries. To improve policies, however, better data are needed at regional and country levels. The meeting is a step forward to enable countries to make progress in data collection.

Session I

Producing the EC/WHO European Report as a spin-off of the Global Status Report on Alcohol and Health

Dr Carina Borges, Programme Manager, Alcohol and Illicit Drugs Programme (NCD Office), gave a historical overview of EISAH, which at first developed in parallel with the European Union Information System on Alcohol and Health (EUSAH) but is today a joint collaboration with systematic updates since 2008. She then reported on the development of alcohol use in the WHO European Region – specifically, within the EU+, the 28 EU countries plus Norway and Switzerland.

Although alcohol use has been decreasing in the WHO European Region since 1990, mostly (though not exclusively) led by eastern European countries, there has been little change since 2010 in the EU+ region, and wide variation between countries: alcohol per capita consumption (APC) decreased in 17 countries and increased in 13. While overall alcohol exposure was relatively constant, the alcohol-attributable burden of disease was still at a high level: 800 people in the EU+ region died from alcohol use every day (290 000 annually), accounting for more than one in every 19 deaths in the countries concerned. Four major categories – cancer, cardiovascular disease, liver cirrhosis and injury – accounted for 87% of alcohol-attributable deaths. More needs to be achieved through implementation and strengthening of cost-effective alcohol policies; pricing policies, in particular, are underdeveloped.

Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse (WHO headquarters), highlighted the objectives of global alcohol monitoring – to prompt, mobilize and frame appropriate and necessary actions to reduce harm; and he presented the progress that has currently been made in producing global WHO estimates on alcohol use and related harm in three domains: data collection, data validation and reporting procedures.

Monitoring trends in harmful use of alcohol involves four indicator domains:

- (a) **input and processes** (implementation structure, governance and resources at global, regional and country level);
- (b) **outputs** (WHO support in establishing policies, programmes and tools, and supporting Member States to set up monitoring systems);
- (c) **outcomes** (changes in alcohol consumption and drinking patterns);
- (d) **impact** (changes in alcohol-attributable mortality, morbidity and social costs).

The Global Monitoring Framework for Prevention and Control of NCDs has one target and three indicators. The target is at least 10% relative reduction in harmful use of alcohol, as appropriate, within the national context. The three potential indicators are:

- (a) total (recorded and unrecorded) APC (15+ years old) within a calendar year in litres of pure alcohol, as appropriate, within the national context (by far the most frequently used indicator);
- (b) age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context;
- (c) alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context.

The objectives of global monitoring are not only to capture change, establish trends at global and regional level, provide information on the impact of actions, and mobilize and frame appropriate actions; a further objective within the process of global monitoring is to enhance assessment and reporting. However, there are numerous challenges involved in achieving this, and if these are not dealt with, they can reduce the chances of implementing effective prevention policies. The biggest challenges are particularly significant outside Europe, which is far from perfect but still has the best data sources:

- data received from countries are in part invalid, unreliable or incomplete;
- unrecorded alcohol consumption, in particular, is difficult to measure and data are often not available;
- data are commonly not comparable across countries, as different assessment tools, indicators and time frames (for instance, consumption measured over past week or past 12 months) are used.

Given the WHO primary goal of producing a comprehensive picture with comparable data, there is a need for adjustment and statistical modelling of available data. The need for such adjustment and modelling is due to a number of factors: differences in measurement and availability of data; differences in quality of data, which may be subject to many biases (e.g. underreporting of alcohol use in surveys); differences in data points across countries with regard to point of reference (e.g. where countries do not produce annual statistics, extrapolations from older data may be needed); and, finally, the fact that some data may simply not exist and need to be estimated by modelling on the basis of relationships with existing data.

This need for adjustment and modelling requires strong reporting standards. This is achieved by interagency collaboration (e.g. with the Food and Agriculture Organization of the United Nations); by seeking independent advice and review (e.g. from the WHO Technical Advisory Group on Alcohol and Drug Epidemiology); by adhering to transparency standards (e.g. the Guidelines for Accurate and Transparent Health Estimates Reporting (GATHER)); by using freely available modelling software (see Session V below); and, finally, by country consultation (e.g. by following Executive Board Resolution EB107.R8, which requests that public releases of estimates at country level be preceded by consultation with WHO Member States).

Dr Alexandra Fleischmann (WHO headquarters) presented the Global Information System on Alcohol and Health (GISAH). This consists of three main categories: (a) consumption (patterns of drinking, levels of drinking, consequences); (b) alcohol control policies, and prevention and treatment; and (c) youth and alcohol use. Data gathering is an iterative process in which country profiles are sent out and countries are required to report back and react. This is a major opportunity for interaction with

countries. However, there is a deadline for data closure as reports must be produced. Reported data are essential to assess progress made towards achieving the SDGs, the WHO Global Strategy to Reduce the Harmful Use of Alcohol, and the Global Monitoring Framework for NCDs; they are also important in informing the WHO World Health Statistics.

Questions from participants focused on (a) whether other indicators such as ICD or DSM prevalence rates should be used instead of APC;¹ and (b) the difficulty in understanding the structure of the GISAH database and hence in its use for people outside WHO.

APC is clearly the best indicator, not least because it is available on an annual basis for most countries and is less biased compared to survey data.

Consideration is being given at WHO to installing a new system that would provide better representation of GISAH data in the future.

Session II

Producing estimates: alcohol exposure and burden of disease

The objective of this session was to improve understanding of the cycle needed to produce WHO figures for alcohol exposure (consumption and drinking patterns) and burden of disease; and to come up with suggestions for improving the process. As pointed out by *Professor Jürgen Rehm, Senior Director, Institute for Mental Health Policy Research, Centre for Addiction and Mental Health (CAMH), Toronto, Canada*, there are at least two important reasons to better understand and improve this process: (a) there are questions from almost 100 countries about the questionnaire used to obtain data; and (b) there are many complaints about the estimates derived for countries, commonly related to “league tables” that are used to rank countries. To estimate burden of disease, basically two sets of data are needed – namely, alcohol consumption measures and risk relations with disease.

Professor Rehm explained why survey data received from countries needs standardized and comparative processing. Among the challenges faced are low response rates, restricted age range, and missing hard-to-reach groups, particularly with respect to heavy drinking patterns. Also, for many countries the most recent surveys date back several years, so even large surveys – for example, in the USA, surveys with over 30 000 participants – may come to significantly different results with respect to alcohol exposure and trends in alcohol use disorders. As a result, surveys need statistical adjustment for year of survey, region of survey, age range, religion and economic status. Survey data are mainly used for estimation of (a) abstinence, (b) age- and sex-specific proportions of total volume (survey estimates are then scaled to APC data), and (c) prevalence of heavy episodic drinking (HED). *Jakob Manthey, TU Dresden, Germany*, later provided empirical examples, showing how data processing and quality checks used to calibrate survey data may lead to differences between a country’s own survey results and what is finally published in the Global Status Report on Alcohol and Health or in GISAH.

The second set of data that is relevant to monitoring concerns alcohol-attributable harm. Here, standard risk relations may be revised to country-specific risk relations, if there is evidence that such a revision is necessary. An example would be the Japanese population with the flushing gene, which results in a three times higher risk of oesophageal cancer compared to people without the gene.

¹ ICD = International Classification of Diseases; DSM = Diagnostic and Statistical Manual of Mental Disorders.

The basic elements of disease burden calculations are:

- (a) level of drinking (country's best operationalization of adult APC, proportion of drinkers in the population, and proportion of volume in groups of different age and sex);
- (b) pattern of drinking (country's best operationalization of percentage of heavy episodic drinkers);
- (c) risk per volume of drinking, per outcome;
- (d) risk associated with HED, per outcome.

Monitoring needs for countries are: monitoring of recorded and unrecorded consumption; surveys for proportion of drinkers and HED; and studies of country-specific risk relations.

Together with tourist consumption and country-specific outcome data on alcohol use disorders, these data would provide the best possible input for disease burden calculations.

In the subsequent discussion, moderated by Dr Poznyak, it became apparent that many countries need greater transparency and better understanding of how data are derived. There are discrepancies – for instance, in unrecorded consumption or proportions of HED, where WHO estimates may be two or more times higher than national estimates. Such discrepancies may cause a lack of trust in data, posing huge problems when it comes to convincing governments to take action. It is true, as Professor Rehm stated, that all data and programs can be downloaded and results verified, producing a level of transparency that is highly appreciated; however, such transparency is often not helpful, because many government officials are not able to use these programs and models and thus to translate the information into a form that can be used for decision-making.

There is a need for more intuitive presentations of the complex calculations that have been carried out, so that participants are better able to explain results (including deviations from national statistics) to their governments. More efforts need to be done in terms of pinpointing how much of the harm estimates comes from (a) original data, (b) data processing and adjustment, (c) calibration with APC data, and (d) estimation of HED.

Session III

Data collection at country level and opportunities for improvement

Dr Manuel Cardoso, Deputy General-Director of SICAD, Dr Daria Khalturina, Head of Department for the Prevention of Risk Factors, Central Institute of Health Care, and Dr Marta Zin-Sędek, Chief Expert of the Department of Education, Analysis and International Cooperation of the State Agency for Prevention of Alcohol-Related Problems (PARPA), presented for Portugal, the Russian Federation and Poland, explaining which alcohol indicators are used in their countries and how data are collected.

It became evident that each country not only has different sets of surveys but also different sources to calculate APC (both recorded and unrecorded). For example, in Poland APC is based on production, which may need to account for stocks. In the Russian Federation, since 2017 retail sales of spirits and wine have been recorded by means of an automated system using cash registers. However, the APC of beer, cider and other low-alcohol beverages is calculated by a complex methodology.

Dr Ivo Rakovac, Technical Officer, NCD Office, presented the WHO's NCD surveillance system, focusing in particular on alcohol consumption. He showed that alcohol use is (among other things) a major risk factor for cardiovascular disease, diabetes and cancer. This risk factor can be validly measured using appropriate measures. The information provided by the NCD surveillance system can be used to set up and evaluate NCD interventions and programmes.

The following alcohol indicators are needed for the NCD Global Monitoring Framework (and other monitoring frameworks such as the SDG targets):

- Indicator 3. Total (recorded, unrecorded and tourist) APC (aged 15+ years) within a calendar year in litres of pure alcohol, as appropriate, within the national context (also SDG, Health 2020).
- Indicator 4. Age-standardized prevalence of HED among adolescents and adults, as appropriate, within the national context (also Health 2020).
- Indicator 5. Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context.

There are basically two major multi-country surveys to measure behavioural and biological risk factors, health status and health care: the WHO STEPwise approach to surveillance (STEPS) and the European Health Interview Survey (EHIS).

Dr Rakovac stimulated the discussion by raising four questions:

- Are the currently used alcohol questions useful for monitoring of alcohol consumption at country level and production of estimates?
- Are relevant questions missing?
- Is comparability of questions between STEPS and EHIS an issue?
- Are there suggestions for improvement?

The discussion was centred around three main points:

- (a) use of autopsy studies, which many countries do in less than 10% of cases and without random samples, to complement surveys;
- (b) use of (European) standard drinks, a concept which does not actually exist (for example, a unit in the United Kingdom is 8 g; in Hungary, 20 g);
- (c) the need for more validation studies of EHIS and STEPS.

Standard drink questions are not useful because there is a wide variety of container sizes across Europe. The equivalent in grams of pure ethanol should be used, and then adapted to the country-specific number of drinks in the questions.

Validation studies are needed in order to improve the quality of data collected through surveys, such as STEPS and EHIS, that are done at national level.

Session IV

Models to improve data: the case of unrecorded consumption

Dr Charlotte Probst, Centre for Addiction and Mental Health (CAMH), Toronto, Canada and Consultant for the WHO Regional Office for Europe, presented the global modelling study for unrecorded alcohol consumption. Types of unrecorded alcohol are: (a) homemade or informally produced alcohol (legal or illegal), (b) private imports, (c) travellers' imports, (d) smuggled alcohol, and (e) counterfeit alcohol. Unrecorded alcohol causes additional harm because it is not subject to regulations such as taxation, is sometimes of poor quality or has toxic ingredients, and is more often consumed in risky drinking patterns (high quantities) and by vulnerable groups.

The statistical model (a mixed-effects fractional response model) to estimate globally unrecorded consumption used three data sources: nominal group expert assessment in 91 countries, STEPS data from 16 countries, and WHO interim estimates for NCD reporting from 189 countries. Statistical models are needed because of incomplete data (not all countries provide data), different data sources, and disadvantages in each possible method, which have to be taken into account. For example, classical problems using survey data are lack of representativeness, memory bias of respondents, stigma, fear (illegal behaviour) and underreporting.

Maria Neufeld, NCD Office, explained the advantages and disadvantages of the various alternatives to survey methods. One such method is use of expert judgements by means of nominal group techniques or Delphi methods. This has the advantage of being relatively cost-effective, but its disadvantages include social and cognitive biases in judgement, conflicts of interest, and group effects. A second method is use of indirect assessments. Estimates can be based on mortality and morbidity data (for example, trends in 100% attributable mortality) or on other routine data such as production or sales data of raw alcohol other than for beverage alcohol (surrogate alcohol, illegal), confiscation numbers, and police records on illegal sales of homemade alcohol. The advantages of indirect assessments are cost-effective data collection and no response biases; however, there are several disadvantages, such as reliability and validity of data (for example, how much sugar is actually used for homemade alcohol?) and other complicating factors that require complex statistical modelling. A third alternative is based on autopsy data, as was demonstrated by A.V. Nemtsov for the Russian Federation; this method uses the ratio of observed deaths from external causes of individuals with and without alcohol in their blood. These estimates are linearly related to total APC (the difference to recorded alcohol consumption thus represents unrecorded consumption).

Dr Richard Henriksson, analyst at the Public Health Agency of Sweden, explained how, in Sweden, unrecorded alcohol consumption is measured in a continuously rolling telephone survey (1500 interviews per month). Calculations of unrecorded consumption include adjustments for both underreporting and the larger non-response among heavy drinkers. A growing problem is the non-response rates of more than 50%. As a result of policy change (such as the abolition of travellers' import quota in 2004), the proportion of unrecorded consumption has not reliably followed the time trend of recorded consumption.

Dr Elena Kukharevich, Vice-Chair, National Statistical Committee of the Republic of Belarus, presented a comprehensive modelling approach used in Belarus. First, the approach used the STEPS survey and adjusted the estimate by (a) calculating a subjectivity index from sociological surveys, and (b) using a coefficient reflecting the degree of impact of excessive drinking based on a survey of alcohol abusers under medical treatment in specialized health facilities. Second, the opinion of experts dealing with

the problem of the shadow alcohol market was used. Third, econometric regression modelling socioeconomic factors (income, educational attainment, percentage with secondary specialized education and with vocational education, and recorded vodka consumption) as independent variables was used. All three approaches yielded comparable results: 1.3–1.8 litres of unrecorded consumption, and an average proportion of total alcohol consumption of 13.4%.

Countries should be encouraged to add questions on unrecorded consumption to their surveys and to include vulnerable people in the sampling frame (for example, include institutionalized people or people in specialized care).

Unrecorded consumption should be measured by different types of unrecorded beverages (to avoid problems with standard drinks).

Unrecorded consumption should be measured as a proportion of total consumption, not in absolute terms (litres, grams), because of underreporting in surveys. If unrecorded consumption is measured in general population surveys, estimates should be upscaled. Recalibration can then be done with recorded APC.

Surveys on unrecorded consumption should be complemented by indirect methods – for example, they should be based on expert judgement or available indicators such as mortality and morbidity.

In the subsequent discussion the following points were dealt with, based on Maria Neufeld's presentation:

- What kind of guidance is needed to improve data collection in countries? Is a “short guide” enough to identify different types of unrecorded alcohol and the relevant (potential) data sources?
- What data can (realistically) be collected and is further assistance needed?
- Is it realistic to have regular data collection on unrecorded alcohol consumption, and if so, what is feasible?

It would be useful to have a toolbox offering guidance on devising estimates for unrecorded consumption. The toolbox should provide decision-making criteria allowing countries to choose the best option for their situation on the basis of their specific aims, data availability and resources. The toolbox should give countries clear guidance, accompanied by examples, on how they should perform their calculations. There should be no prescriptive document as each country has to decide for itself on the best available methodology with the resources at its disposal.

Session V

Using country exposure data to estimate alcohol-attributable burden: a practical demonstration

Jakob Manthey presented a conceptual overview of how to move from exposure data (APC, drinking status, HED) via data processing to burden of disease estimates. He did this by means of a worked-out example, using alcohol-attributable fractions derived from prevalence estimates and risk functions.

In a second step, he introduced a software program that allows calculation of alcohol-attributable burden using with one's own data. With this software, each country can do its own calculation, perform sensitivity analysis by changing certain parameters, carry out simulation studies (for example, reduction of APC by 10%), and check how WHO estimates are derived. The software is called the International Model of Alcohol Harms and Policies (InterMAHP); it needs no programming skills and is available for free download.²

In addition to population size and APC, exposure data (by sex and age group) are needed – i.e. prevalence rates of lifetime abstainers, former drinkers, current drinkers and HED. Then, relative consumption derived from surveys has to be entered – i.e. proportion of total alcohol consumption, by sex and by age group. In a second step, mortality and morbidity data, again by sex and by age group, are needed. Data are entered into Excel spreadsheets. The user can use default risk functions or change them on the basis of country-specific information.

Session VI

Discussion of possible fast-track annual reporting mechanisms

The objective of this session was to consult with Member States on a proposal to introduce a fast-track annual alcohol reporting mechanism for NCD monitoring, while retaining the best possible surveillance. Suggestions were presented by Professor Rehm and the discussion was moderated by Dr Poznyak.

It was acknowledged that countries often receive too many requests for data reporting and validation – there were 60 questions in the previous year alone. Annual requests from WHO should therefore be short and simple. Professor Rehm suggested that there should only be four questions: (a) litres of recorded consumption; (b) proportion of unrecorded consumption; (c) survey data on prevalence of alcohol use; and (d) policy changes in the last year.

Requests will use an online interface. WHO will generate a first version of best current estimates, and countries will then be asked either to confirm or to provide better, more recent estimates, together with source references. There will also be an option to upload PDF reports of surveys. The new estimates provided will then go through a validation cycle.

Questions about alcohol policy changes will be posed in the following way:

Was there any change with respect to the three best buys in the last 12 months (for better or worse)?

- strengthen restrictions on alcohol availability
- enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
- raise prices on alcohol through excise taxes and pricing policies

If yes, please give a source where details are available.

It was noted that, every fourth year, the WHO Global Survey on Alcohol and Health would continue to require more comprehensive reporting to WHO than this fast-track procedure.

² International Model of Alcohol Harms and Policies. Canadian Institute for Substance Use Research, University of Victoria; 2018 (<https://www.uvic.ca/research/centres/cisur/projects/intermahp/index.php>).

Discussions mainly centred around the fact that not all data may be available on an annual basis. This, however, should not be a problem, as the most recent available data are already in the database and will be used for projections. Also discussed was the fact that it is often unclear who should be contacted. Usually focal points are used, but this is not always possible. However, it should be possible to find a solution as partners were found for the current estimates. Following a request from a Member State, WHO will also look into the possibilities of including SAFER-related indicators in the selection of policy measures on which Member States have to report.³

There was agreement that a fast-track approach needs the best possible coordination. There should be no duplication in what countries are asked so that in-country partners are not overburdened. Questions should be as simple as possible.

The fast-track approach should first be tested in a pilot of five or six countries selected from those attending the meeting; there should then be an extensive pilot before all countries are contacted.

Dr João Breda concluded the meeting by expressing his satisfaction that the aims of the meeting had been achieved – there had been constructive and open discussions of the system of reporting on alcohol and health to WHO and how to improve it. The meeting ended with a speech by *Mr Sergey Muraviev, Head of the Department of International Cooperation and Public Relations, Ministry of Health, Russian Federation*, who highlighted the importance of good data for correct political decision-making.

³ SAFER: a world free from alcohol-related harms [brochure]. Geneva: World Health Organization; 2018 (https://www.who.int/substance_abuse/safer/msb_safer_brochure.pdf).

Annex 1

Provisional list of participants

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WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

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on Alcohol and Technical Consultation
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on Alcohol and Health**

27 September 2018

**Moscow, Russian Federation
8–9 October 2018**

Original: English

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Annex 2

Provisional programme

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

**Editorial meeting of the EC/WHO report
on Alcohol and Technical Consultation
on the European Information System
on Alcohol and Health**

**Moscow, Russian Federation
8–9 October 2018**

21 September 2018

Original: English

Monday 8 October 2018

08:30–09:00 Registration and welcoming coffee

09:00–09:45 **Opening**

Welcome address, scope and purpose of the meeting

Dr João Breda, Head, WHO European Office for the Prevention and Control of Noncommunicable Diseases (WHO NCD Office)

Representative of the Ministry of Health of the Russian Federation

Dr Melita Vujnovic, WHO Representative to the Russian Federation, WHO Country Office, Russian Federation

09:45–10:45 **Session I. Producing the EC/WHO European Report as a spin-off of the Global Status Report on Alcohol and Health**

Chair: Dr João Breda, Head, WHO NCD Office

Presenters: Dr Carina Ferreira-Borges, Programme Manager, Alcohol and Illicit Drugs Programme, WHO NCD Office; Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, WHO headquarters; Dr Alexandra Fleischmann (WHO headquarters)

- ✓ **EC/WHO European Region Report**
- ✓ **Producing WHO estimates: overview of data collection, validation and reporting procedures**
- ✓ **Global Information System on Alcohol and Health (GISAH)**

Objective: Global commitments, introduction to the WHO European (EUSAH/EISAH) and global (GISAH) information systems

- 10:45–11:15 **Coffee break**
- 11:15–12:30 **Session II. Producing estimates: alcohol exposure and burden of disease**
Chair: Dr Carina Ferreira-Borges, Programme Manager, Alcohol and Illicit Drugs Programme, WHO NCD Office
Presenters: Professor Jürgen Rehm, Senior Director, Institute for Mental Health Policy Research, CAMH, Canada; Jakob Manthey, TU Dresden, Germany
Discussant: Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, WHO headquarters
- ✓ **Current sets of indicators and their use for producing and disseminating estimates at regional and country levels**
 - ✓ **Methodology for analysis**
 - ✓ **Why are my numbers on per capita consumption and current drinkers different from the Global Status Report on Alcohol and Health?**
 - ✓ **Discussion: questions and suggestions for improvement of process (pre-prepared by countries)**
- Objective: Understanding the cycle of producing WHO alcohol exposure numbers and suggestions for improving the process
- Lunch**
- 13:30–15.00 **Session III. Data collection at country level and opportunities for improvement**
Chair: Professor Jürgen Rehm, Senior Director, Institute for Mental Health Policy Research, CAMH, Canada
Presenters: Dr Ivo Rakovac, WHO NCD Office; Portugal (Ministry of Health, Portugal); Poland (Ministry of Health, Poland); Russian Federation (Ministry of Health, Russian Federation)
- ✓ **NCD surveillance at country level**
 - ✓ **Data collection at national level: countries' national systems**
 - **Portugal**
 - **Poland**
 - **Russian Federation**
 - ✓ **Discussion**
- Objective: Presentation on national indicators and mechanisms for reporting; discussion of potential improvements to national monitoring systems for improvement of global estimates
- 15:00–15:30 **Coffee break**
- 15:30–17:00 **Session IV. Models to improve data: the case of unrecorded consumption**
Chair: Representative of the Ministry of Health of the Russian Federation
Presenter: Dr Charlotte Probst, CAMH, Canada; Maria Neufeld, WHO NCD Office; representatives from Sweden and Belarus

- ✓ **Global modelling study**
- ✓ **Monitoring unrecorded consumption at country level**
 - **Belarus**
 - **Sweden**
- ✓ **National systems for monitoring unrecorded consumption: proposal for multi-country pilot study**
- ✓ **Discussion**

Objective: Understanding unrecorded consumption; discussion of improvement of indicators; proposal of collaborative study

Tuesday 9 October 2018

09:00–10:30	<p>Session V. Using country exposure data to estimate alcohol-attributable burden: a practical demonstration</p> <p><i>Chair: Professor Jürgen Rehm, Senior Director, Institute for Mental Health Policy Research, CAMH, Canada</i></p> <p><i>Presenter: Jakob Manthey, TU Dresden, Germany</i></p> <p>From exposure to burden: A conceptual overview to calculate disease burden from alcohol exposure data</p> <p>Practical demonstration: Using the International Model of Alcohol Harms and Policies (InterMAHP) to calculate disease burden</p> <p>Application of InterMAHP for countries: A brief guide to producing country-specific estimates of disease burden using your own exposure data and risk functions</p> <p>Discussion</p>
10:30–11:00	Coffee break
11:00–12:00	<p>Session VI. Discussion of possible fast-track annual reporting mechanisms</p> <p><i>Presenter: Professor Jürgen Rehm, Senior Director, Institute for Mental Health Policy Research, CAMH, Canada</i></p> <p><i>Moderator: Dr Vladimir Poznyak, Coordinator, Management of Substance Abuse, WHO headquarters</i></p> <p>Objective: Proposal for best possible surveillance and fast-track annual reporting for NCD monitoring</p>
12:00–12:15	<p>Closing session</p> <p><i>Dr João Breda, Head, WHO NCD Office</i></p>
12:15–13:30	Lunch and departure

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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