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Framework for alcohol policy in the WHO European Region

The WHO European Region is the region with the highest alcohol intake in the world and per capita consumption twice as high as the world average. Alcohol is the third largest risk factor for death and disability in Europe and the leading risk factor among young people. The disease burden from alcohol in the European Region is also twice as high as the world average.

A new phase of alcohol policy in the Region, as proposed in the attached document, is a timely response to the situation. The Framework for alcohol policy aims to encourage and facilitate the development and implementation of global, regional, national and local community policies and actions to prevent or reduce the harm caused by alcohol. It creates an overarching frame for existing WHO instruments and documents as well as addressing recent developments, new challenges and further research needs.

A draft resolution is attached for consideration by the Regional Committee.

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The need for a framework in the Region

1. The WHO European Region is the region with the highest alcohol intake in the world and per capita consumption twice as high as the world average. In 2002, alcohol was the third most important of 27 risk factors for burden of disease assessed in the Region, only surpassed by hypertension and tobacco, and the leading risk factor among young people. The disease burden from alcohol in the Region is also twice as high as the world average.

2. The health and social problems for those around the drinker are at least as important as the problems for the drinker himself or herself. The impact of alcohol on others besides the drinker is a very strong argument for taking effective action to reduce the burden of alcohol problems.

3. In 1992, the Regional Office for Europe was the first WHO regional office to take the initiative of launching a region-wide action plan on alcohol. The Office has played a substantial role over the past twenty years as a catalyst and facilitator of policy formulation and of health and welfare advocacy on alcohol-related issues in Member States.

4. Two consecutive regional action plans (1992–1999 and 2000–2005) and two ministerial conferences, resulting in the European Charter on Alcohol (1995) and the Declaration on Young People and Alcohol (2001), have all offered paths for the development and implementation of effective measures in Member States and therefore contributed to overall health policy in the Region.

5. Recent years have brought increased information on the size and nature of problems related to alcohol, and an increased understanding of which measures are effective and cost-effective[1] in reducing the burden of problems. Meanwhile, trade agreements, common markets and increased globalization have increased the difficulty of maintaining effective alcohol policies at the national level.

6. There is thus a need for concerted action at regional level. Strong expectations exist that WHO and other international and intergovernmental organizations will take effective initiatives to prevent or reduce alcohol-related problems. A renewal and strengthening of national and region-wide efforts is an opportunity to respond to the size of the problem and to put into practice the new knowledge available on effective strategies.

7. A new phase of alcohol policy in the Region, to be initiated and led by the WHO Regional Office, is a timely response. It should encourage and facilitate the development and implementation of global, regional, national and local community policies and actions to prevent or reduce the harm caused by alcohol.

Goals and objectives for the Framework

8. A framework for alcohol policy is proposed as a long-term strategy for the Region. It creates an overarching frame for existing WHO instruments and documents as well as addressing recent developments, new challenges and further research needs. The Framework is also consistent with other major health policy formulations, including the Health for All policy framework, WHO's general programme of work, the Millennium Development Goals and the Regional Office's Country Strategy. The Framework links ways, means and ends of an effective alcohol policy. Thus the Framework:

- represents a broad vision for alcohol policy developments in the WHO European Region and a common understanding of the need to prevent or reduce alcohol-related harm;

[1] For an overview of such measures see: *What are the most effective and cost-effective interventions in alcohol control?* Copenhagen, WHO Regional Office for Europe, 2004 (http://www.euro.who.int/document/e82969.pdf, accessed 22 June 2005).

- provides guiding principles and policy goals, and gives clarity with respect to objectives, roles, and responsibilities;
- reaffirms and creates continuity and a common platform for the existing instruments: the European Charter on Alcohol, the European Alcohol Action Plan (EAAP) and the Declaration on Young People and Alcohol, as the principal documents for alcohol policy development in the Region;
- facilitates consolidation and synergy with other international, national and local public health initiatives; and
- provides a rationale and guidance for the ongoing process of reviewing and realigning policies and programmes at local, national and international levels.

9. Alcohol is a complex policy area with many issues that have long been disputed. Some of these are addressed by the Framework to an extent not possible in the European Charter, the EAAP or the Declaration on Young People and Alcohol. Future developments may raise additional issues and challenges which should be met appropriately by Member States and the Regional Office, and incorporated into future revisions of the Framework.

Guiding principles for the framework

10. Given that drinking customs and habits are deeply rooted in many European cultures, effective actions to prevent or reduce the harm caused by alcohol will require the development and application of evidence-based recommendations and strong political commitment. Building up public support for effective alcohol policies is thus an important part of public health action on alcohol.

11. Each Member State has not only the right but also the obligation to provide a high level of protection to its citizens from alcohol-related harm, particularly with regard to harm from others' drinking and harm to vulnerable groups such as children.

12. Alcohol policies and implementing actions should be based on the best scientific evidence about effectiveness and cost-effectiveness, and should be sensitive to cultural diversity. Where the science is uncertain, the precautionary principle should be applied, to give priority to protecting the health and welfare of the population.

13. In the face of increasing levels of cross-border trade and price differences in this area, regional and global solutions to the problems should be explored. In the meantime, it is important that Member States acknowledge, to the extent possible, other countries' laws and regulations which aim to prevent or reduce alcohol-related harm, as applied within their own jurisdiction.

14. While the diverse and multisectoral nature of alcohol problems requires a dialogue with and appropriate involvement of a wide variety of official, commercial and civic actors, public health approaches to alcohol problems need to be formulated by public health interests, without any formal or informal veto from other actors.

The situation regarding alcohol in the Region[2]

15. Alcohol consumption in northern Europe is at a historical high and is continuing to increase. The decline seen in the south-west of Europe over past decades seems to be coming to an end. In the eastern part of the Region, general consumption remains at a very high level, reached in the mid-1990s, although there are some differences between countries. Religious belief leads to very low consumption figures in some areas, but among those who do drink is about as high as in other similar countries of the Region. In

[2] A more thorough report on the situation regarding alcohol in Europe, including an assessment of the EAAP 2000–2005, can be found in the Report on alcohol in Europe, a background document for the fifty-fifth session of the Regional Committee.

some countries of the European Region, unrecorded consumption accounts for a substantial part of total consumption and this makes direct comparisons between countries difficult.

16. Even though women account for only 20% to 35% of overall consumption in the European Region, this proportion is the highest in the world. Youth intoxication continues to be at a very high level in the west and has increased to a similar level in the east. The trend in youth intoxication is also a matter of concern in the south.

17. The most recent data available shows that, overall, alcohol-related deaths increased by about 15% between 2000 and 2002, and now represent 6.3% of all deaths in the Region. Taking into account the years of life lost due to premature mortality as well as years of life lived with disabilities, the burden of alcohol is even higher, representing 10.8% of the disease burden in the Region.

18. Males have considerably higher alcohol-related mortality and disease burden than females. Young people are especially affected and, in the 15–30 age group, more than one third of the burden in men and about 14% of the burden in women is attributable to alcohol. The detrimental effect of alcohol seems also to be more pronounced in interaction with poverty and malnutrition.

19. The burden estimates presented here exclude social harm other than the intentional injury categories captured by the International Classification of Disease.[3] Alcohol also contributes significantly to social problems, including crime and problems in the family and at work.

20. There is some indication of a north-south gradient in western Europe, where a given increase in alcohol seems to be associated with more harm in the north than in the south for homicide, suicide and unintentional injuries. This gradient is consistent with surveys of drinking patterns which find a greater proportion of drinking on heavy-drinking occasions in the north than in the south. Findings of a similar gradient for some chronic diseases, such as liver cirrhosis, suggests that pattern of drinking may also be important in the development of these diseases.

21. The substantial reductions in mortality, not only from casualties but also from heart disease, cirrhosis and infectious diseases, during of the 1985–1988 anti-alcohol campaign in the former Soviet Union provide direct evidence of especially deleterious drinking patterns in much of the eastern part of the Region too.

22. Recent decades have seen the development of a strong body of literature measuring the impact of different strategies for preventing or reducing rates of alcohol-related problems. The general conclusions for alcohol policy are twofold. First, the level of alcohol consumption in a population is an important determinant of health and disease. In any given society, levels of alcohol-related deaths and diseases tend to rise and fall with rises and falls in overall levels of consumption.

23. Second, there are substantial differences in drinking patterns between different parts of Europe, and these differences hold implications for the degree to which levels of disease and death will change with a given change in amount of drinking. This implies that appropriate public health-oriented alcohol policy interventions may differ for different parts of Europe.

Existing international alcohol policy initiatives

The WHO European Region

24. The WHO Regional Office has supported Member States through scientific publications, the regional action plans (EAAP), and two ministerial conferences resulting in the European Charter on

[3] *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*, Geneva, World Health Organization, 2003 (http://www3.who.int/icd/vol1htm2003/fr-ied.htm, accessed 24 June 2005).

Alcohol (1995) and the Declaration on Young People and Alcohol (2001). The annual meetings of the network of national counterparts for alcohol policy in the European Region, a valuable forum for exchanging information and best practice between nominated experts from all Member States, continue to discuss and support relevant developments in alcohol policy across the European Region.

25. Since 1992, the EAAP has provided a basis for the development and implementation of alcohol policies and programmes in Member States with a clear focus on preventing or reducing the harm caused by alcohol.

26. The European Charter on Alcohol, adopted by Member States in 1995, sets out ethical principles and goals for promoting and protecting the health and well-being of all people in the Region. The Charter calls on all Member States to draw up comprehensive alcohol policies and implement programmes as appropriate in their differing cultures and social, legal and economic environments. This can be done by implementing the principles in the Charter as aims of a national alcohol law.

27. The Declaration on Young People and Alcohol complements the Charter and the EAAP by developing specific targets, policy measures and support activities for young people. The Declaration aims to protect children and young people from the pressure to drink and reduce the harm done to them directly or indirectly by alcohol. The Declaration is the leading policy statement of the WHO European Region on young people and alcohol.

28. Recent developments in other areas of the Regional Office's work are also important for the Framework. Most notably, these include current developments towards a European strategy on noncommunicable diseases, the European strategy for child and adolescent health and development and the recently adopted European Declaration and Action Plan on Mental Health. The renewed focus on injuries and violence is an important linked domain. These and other related programmes in the Regional Office should be utilized in an integrated effort both by the Regional Office and by Member States to prevent or reduce alcohol-related harm at all levels of society.

WHO global developments and initiatives

29. *The world health report 2002* estimated that 4% of the global burden of disease is attributable to alcohol and, as such, alcohol was the fifth leading risk factor among the 26 selected risk factors for mortality and morbidity globally. As a response to this, the Fifty-seventh World Health Assembly in 2004 adopted resolution WHA57.16, in which it urged Member States to give attention to the prevention of alcohol-related harm and promotion of strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol.

30. The Fifty-eighth World Health Assembly considered a report and then adopted resolution WHA58.26 on Public health problems caused by harmful use of alcohol. The resolution, among other things, requested the Director-General to produce a report on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol, to be presented to the Sixtieth World Health Assembly in 2007.

European Union developments and initiatives

31. Developments and initiatives by the European Union, with its 25 member states, have important consequences for public health policy development in the Region. There have been several notable public health initiatives by the European Union (EU) in recent years: its partnership in the WHO Ministerial Conference on Young People and Alcohol (2001), Council Recommendation 2001/458/EC on the drinking of alcohol by young people, Council Conclusion 2001/C 175/01 on a Community strategy to reduce alcohol-related harm, reiterated in 2004, and the alcohol component of the Public Health Programme all show the growing and active role of the EU in preventing or reducing alcohol-related harm in Europe. Closer and more intensive cooperation has recently been established between the

European Commission and the WHO Regional Office. The aim is to coordinate developments and ensure synergy between initiatives to strengthen public health issues on alcohol policy in the Region.

Other initiatives

32. Eurocare, a European alliance of nongovernmental organizations (NGOs) working in the field of advocacy for the prevention of alcohol-related harm in Europe, is carrying out a project entitled "Alcohol policy network in the context of a larger Europe: Bridging the gap", co-financed by the European Commission for the years 2004 to 2006. The project includes partners in 30 European countries and cooperates with other regional organizations. The main aims of the project are to create an alcohol policy network in the EU member countries and to strengthen the development of an integrated Community strategy to reduce alcohol-related harm in the context of a larger Europe. The network has produced a set of "Bridging the Gap Principles" for a policy on alcohol in Europe.[4]

Recent and re-emerging challenges

33. Alcohol is a part of everyday life in many parts of the Region. Drinking is valued for many reasons: as a medium of sociability, as part of nutrition and as a symbolic break, bringing relaxation from everyday responsibilities. Alcohol is something with which people are familiar and comfortable, and it is difficult to adopt the necessary distance and dispassion to recognize and act on the problems that come with its use.

34. The symbolism attached to alcohol and drinking often gets in the way of rational policy-making. Thus the policy challenge is at one and the same time to accept the comfortable familiarity and the perceived positive aspects of alcohol consumption, and yet to take effective public health action to prevent or reduce alcohol-related harm.

35. As well as having psychoactive properties, alcoholic beverages are also regarded as commodities. The production and sale of alcoholic beverages, together with the ancillary industries, are important parts of the economy in many European countries, providing employment for many people, export revenue for drinks companies and substantial tax revenues for governments. These economic and fiscal interests are often an important determinant of policies that can be seen as barriers to public health initiatives. Dissemination of public health research that can counterbalance these economic and fiscal interests is paramount.

36. Controls on the supply and availability of alcohol have proved to be amongst the most effective and cost-effective approaches to limiting the harm done by alcohol. Traditionally, such controls have been a function of national or subnational governments and have thus been the building blocks for the two consecutive European alcohol action plans. Within the European Union, very large traveller's allowances for personal use have restricted the ability of several national governments to control sales to residents and have forced down alcohol tax rates in some countries. Extensive region-wide marketing strategies by the drinks industry, many of which appeal to young people, demonstrate the trans-national nature of modern marketing.

37. The growth of trade agreements and common markets and, more generally, the processes of globalization, have substantially weakened the ability of governments to use some of the most effective tools to prevent and reduce alcohol-related problems as appropriate in their own cultures. There is thus a need, from the perspective of public health, for concerted international action to clearly recognize that alcohol is a special commodity in terms of the very substantial harms associated with its use.

[4] A policy on alcohol for Europe and its countries. Reducing the harm done by alcohol – Bridging the Gap principles. Brussels, Eurocare, 2004 (http://www.eurocare.org/btg/policyeu/pdfs/2004-eurocarepolicy.pdf, accessed 24 June 2005).

Key players and their role

38. **Member States** have, through WHO, committed themselves to preventing or reducing alcohol-related problems. This means that governments are working to develop effective and cost-effective alcohol policy measures across many sectors. The implementation of such measures requires active involvement, commitment of resources and action by all the stakeholders at national and local levels. There is also an evident need to disseminate research results about effective and cost-effective measures in an understandable way to civil society as a way to gain public support for such interventions.

39. **Local community** involvement is crucial in preventing or reducing alcohol-related harm. In order to empower local communities to take effective action, local needs, interests, resources and abilities, as well as the level of evidence, must all be addressed. Active involvement of local decision-makers, including elected officials and senior administrators, is vital for public health.

40. **Health care professionals and public health institutions** are important in providing health care services, including treatment and brief intervention, to problem drinkers and their families. In addition, they are natural allies in helping to tackle alcohol-related harm, given their respected roles in the provision of health care in society. A better understanding among health care professionals of the size and scope of alcohol problems and of the necessary effective policy responses would help in mobilizing and lobbying for change in society.

41. **The scientific community**: it is an important criterion in the work of the Regional Office and of Member States that policies to prevent or reduce alcohol-related harm should be evidence-based. This, in turn, imposes strong demands for independence of the research community from commercial interests and other vested interests. Besides their duties to scientific ethics, those in the research community have a public responsibility to bring into public discussion and policy consideration the emerging findings from the research literature on alcohol and public health.

42. **Civil society and NGOs**: the participation of civil society, in the form of parents, family members, peers, self-help movements and advocacy groups, among others, is essential in preventing, treating and reducing alcohol-related problems in society. Organized civil society groups can play an essential advocacy role to ensure that Member States develop and implement effective alcohol policies. They also provide a vital checks and balances by highlighting practices or policies of vested interests that can act as barriers to preventing or reducing alcohol-related problems in society.

43. **The individual**: adults choose whether and how much to drink in accordance with their own values, concerns and preferences. They also have the responsibility to avoid harming others by their choices about drinking. It is important to empower individuals to make significant lifestyle changes, but all choices are made and created in a cultural and situational context, and behaviour around alcohol is no different. Appealing solely to the individual to drink responsibly lacks contextual meaning, disregards the fact that decisions often have to be made when the individual is already intoxicated, and rarely yields a significant behavioural response.

44. **Young people** are important resources for changing existing harmful drinking cultures and patterns. They should be bettered mobilized and empowered to participate in shaping their own environments as well as in changing the harmful attitudes and practices of wider adult society.

45. **The WHO Regional Office for Europe,** as a public health agency, will provide leadership for action on alcohol at international level across the Region, including technical and other support for national plans and actions, and will stimulate international collaboration and action on alcohol-related public health alcohol issues. Epidemiological, policy impact and treatment system studies concerning alcohol have been carried out mainly in a limited number of countries in the Region. In consultation with the research community, the Regional Office can play a role of organizer and coordinator in identifying research gaps of high public health significance, in marshalling resources to support the necessary studies, and in reviewing and organizing a database of knowledge about effective policy measures.

46. **Other international and intergovernmental organizations** provide a multilateral platform for action to prevent or reduce alcohol-related harm in Europe. It is important that the European Commission, the Council of Europe, the World Bank and other organizations inside and outside the United Nations system, together with subregional organizations, become appropriately involved in the work to prevent or reduce the negative consequences of alcohol.

47. In addition to the key players and stakeholders in public health, the drinks industry and associated businesses and organizations have a primary role in ensuring that the production, distribution, promotion and selling of alcoholic beverages meet the highest possible standards of business ethics. Public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests. Involvement of the drinks industry and associated businesses and organizations in youth education or youth activities is subject to question because their support, direct or indirect, could be seen as an attempt to gain credibility with a youth audience.

Core areas and instruments for national action

National and local strategies and action plans

48. While alcohol policy initiatives can be carried out at various levels in society, the need for coordinated and strategic national efforts is evident. It is important to establish a national alcohol strategy and an action plan at the national and/or appropriate level within each Member State. In addition, there must be the infrastructure and capacity required to implement effective and cost-effective measures, as well as to monitor and follow up the action plan. Member States are called upon to develop or review their national strategies and action plans, taking into consideration the goal and objectives of the new Framework.

49. The ten areas for action and the identified outcomes in the European Alcohol Action Plan continue to be of central importance for the implementation of national alcohol policies and should be seen as an integral part of the Framework. These areas are: information and education; public, private and working environments; drink–driving; availability of alcohol products; promotion of alcohol products; treatment; responsibilities of the alcoholic beverage industry and hospitality sector; society's capacity to respond to alcohol-related harm; nongovernmental organizations; and formulation, implementation and monitoring of policy.

50. In order to effectively prevent or reduce alcohol-related harm, national alcohol action plans need to support local communities in the development and implementation of effective measures. Local communities need to adopt policies that set targets, identify responsible agencies and forms of accountability, and adequately involve NGOs. As serious public health threats, alcohol-related problems should be properly addressed in the health care system.

51. To enhance the effectiveness of action to prevent or reduce alcohol-related problems, a number of community sectors need to be empowered and coordinated. The coordination function can be likened to that of a spider in a web, where the task is to organize and coordinate different parts of the community. Advocacy is also necessary to raise public awareness of the extent of alcohol-related harm in the community and to gain public acceptance of effective policy measures.

52. A strong case can be made for restricting availability through an effective taxation policy, limiting the number of outlets for alcohol, and limiting the hours of sale. This applies to licensed premises such as restaurants, bars and pubs, as well as to shops where alcohol is sold. Programmes for responsible beverage service can also effectively reduce problems, if they are combined with active enforcement by police and licensing authorities.

53. Availability plays a particularly important role in youth drinking, where the enforcement of age limits on alcohol sales has proved to be an effective tool in reducing drinking. Some of the availability of

alcohol can, however, be social rather than commercial, with young people accessing alcohol from parents or older friends; this calls for wider community action programmes.

54. Education and information should be combined with other measures in a comprehensive strategy. Education of minors is best implemented by state agencies and other independent education agencies which have the necessary professional expertise and focus their activities on a healthy young generation. While research on the long-term effectiveness of school-based information on behaviour has been disappointing, parental programmes appear more promising. These programmes, addressing risk and protective factors, underline the importance of parental support for children, as well as the need to set limits and the importance of delaying the onset of drinking.

55. Drink-driving accidents, violence and public disturbance are common occurrences in local communities, requiring responses by community agencies. Local regulation and enforcement can effectively reduce rates of such alcohol-related problems. With respect to drink-driving, while legal blood-alcohol concentration levels are usually decided at the national level, enforcement is, to a large extent, a local responsibility. It is important that police authorities give priority to these issues.

56. Primary health care is an important part of the local community. The efficacy of screening and brief intervention for hazardous drinking is supported by a large body of international research literature. For such programmes to be implemented, the health professions need to play an active role and be supported by health authorities. Specialist services are needed for the care of severe cases of alcohol-related disorders and should be linked with other professional and nonprofessional approaches.

57. Many hazardous drinkers are employed and can thus be reached through workplace interventions. To achieve systematic activity in this field, it is necessary to adopt alcohol policies in the workplace. Such policies should set rules for alcohol consumption during and prior to working hours. They should also include guidelines for advice on and management of hazardous drinking and alcohol problems. Similarly, schools also need to adopt alcohol policies. These should include their responsibility to provide knowledge about alcohol; to improve the psychosocial climate in the school, as this can contribute to risky behaviour; and to provide health services where alcohol drinking and other risky behaviours are addressed.

Alcohol-free situations

58. Certain sectors of society and certain life circumstances should be alcohol-free. In particular, there should be no alcohol consumption during childhood and adolescence and in the environment surrounding young people. Other important situations and circumstances that should be alcohol-free are in road traffic, in the workplace and during pregnancy.

59. **Young people**: the earlier young people begin drinking, the worse the consequences are likely to be. Young people who begin drinking at the age of 14 or younger are more likely to develop alcohol dependence, to be involved in car crashes because of drinking or to suffer unintentional injury after drinking. Heavy use of alcohol during adolescence can impair brain development, causing loss of memory and other skills. Keeping children alcohol-free and delaying the onset of drinking is safer.

60. **Young people's environment**: pressures on young people to drink have increased while, at the same time, protective factors have become somewhat weaker. The sport and leisure environments, a central part of young people's social space, are strongly linked to drinking through extensive marketing practices, and this can result in unintentional injuries and violence. Youth sport and leisure environments free of alcohol and alcohol marketing could help reduce the pressure on and provide a safer social environment for young people.

61. **Road safety**: alcohol impairs psychomotor performance as well as judgement. There is no safe lower limit; driving skills are affected at very low levels of consumption. Research around the world has demonstrated large reductions in traffic crashes and fatalities when legal blood-alcohol levels have been

reduced. The effectiveness of legislation on blood-alcohol levels depends to a large extent on active enforcement and, in particular, on random breath testing.

62. **Workplace**: most workplaces are clearly dependent on their employees' ability to make judgements and perform qualified tasks. Many cater to the general public, in which case alcohol-impaired employees constitute a health hazard to others as well as to themselves. This particularly applies to the transport sector, but there are many other sectors where high demands are placed on employees. From a public health point of view, therefore, alcohol should not be a part of working life.

63. **Pregnancy**: alcohol crosses the placenta to the baby. It can cause problems during pregnancy and can also harm the foetus. It is not known whether or not there is any safe level of alcohol consumption during pregnancy. Nor is it certain if any particular stage of pregnancy is the most vulnerable to the effects of drinking. In the absence of demonstrated safe limits, abstinence from alcohol during pregnancy is recommended and should be encouraged.

Issues related to drinking guidelines and recommendations

64. Governments have differed on the advisability of publicizing low-risk drinking guidelines for the general population. Research has shown that they can be difficult to interpret and may be perceived as a "safe" baseline from which to range upward in setting personal limits. Region-wide specific drinking guidelines are not advisable and WHO continues to promote the message that "less is better". Should Member States consider formulating country-specific population-based drinking guidelines, existing drinking patterns and cultures need to be taken into account.

65. The health benefits of alcohol in the population on cardiovascular diseases appear at low or very low levels of drinking, at the most one standard drink per day for men at age 70, and less than half a standard drink per day for women at the same age. All consumption above these levels is associated with increased risk. Below the age of 40, no substantial beneficial effects of alcohol on health have been seen. Drinking to intoxication is always associated with increased risk.

66. There are no risk-free limits for drinking alcohol. On the other hand, there is no reason to discourage low-risk drinking in the adult population, provided that individual circumstances and situations have been taken into account. These include, but are not limited to, medical and social factors such as operating machinery, pregnancy, certain pharmacological treatments that may interact unfavourably with alcohol, and the risk of dependency. By low-risk drinking, it is meant that (a) regular consumption of alcohol is low and (b) drinking to intoxication does not occur.

67. Individual drinking guidelines for problem drinkers are best delivered by health professionals in the health care setting, by using available instruments and guidelines[5]. When discussing alcohol habits with patients, equal attention should be given to the pattern of drinking as to the volume of drinking. While there is evidence that light drinking on a regular basis in certain age groups is associated with reduced risk for cardiovascular disease and type 2 diabetes, controlled research does not support actively encouraging patients to drink alcohol as a means to reduce the risk of these diseases. Alcohol consumption can not be recommended as a preventive medicine.

A focus day on preventing alcohol-related problems

68. One possibility for raising awareness in society of the negative health and social consequences of alcohol is to initiate a national focus day on preventing or reducing alcohol-related problems. Used in combination with other more long-term measures, such a focus day could be an important instrument in

[5] See for example T.F. Babor et al; *The alcohol use disorders identification test. Guidelines for use in primary care*. Geneva, World Health Organization, 2001 (http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf accessed 22 June 2005).

increasing knowledge of the extent and magnitude of alcohol-related problems and thus stimulate support for effective alcohol policy options.

Key tools for international cooperation

Further research needs

69. There is enough evidence available for policies to be established and implemented, but there are still research gaps and a constant need to build up capacity for information gathering and analysis. Epidemiological studies should be carried out on a wider range of societies, mapping different drinking patterns and cultures. More needs to be known about the relation between pattern of drinking and the development of chronic health conditions. Better means of measuring unrecorded alcohol consumption, including flows between countries, should be developed and implemented on a regular basis.

70. The literature on the effect of alcohol policy interventions requires further development, with studies being conducted in a wider variety of societies and the capacity for better integrated health impact assessment being built up. This will improve our understanding of how the strength of policy effects may vary in different social and cultural conditions, with special attention paid to different target populations such as age, gender and ethnic groups.

71. In future studies, attention should also be paid to the differential costs of implementing new measures, to provide a basis for further cost-effectiveness studies. Since understanding the impact of alcohol policy measures is of general benefit to the Member States in the European Region, international mechanisms are required to encourage and finance such studies. WHO should serve as a clearing house for them and as an advocate for the further development of this health policy literature.

72. **Expert group on alcohol policy**: broad unity has been established in the public health community over the last twenty years on effective and cost-effective measures to reduce alcohol-related harm. Nevertheless, many controversies still exist concerning the right balance to be struck between different strategies and the best ways and means of achieving improvements in the field. To assist the Regional Office and the network of national counterparts for alcohol policy in implementing and following-up the Framework, an expert group comprised of high-level independent experts, should be established. The main tasks of the group would be to review current research and policy implementation and to advise on future development needs.

Surveillance and monitoring

73. Surveillance and monitoring are needed at national and international levels and will continue to be developed in close collaboration with Member States, WHO headquarters and the European Commission. The Regional Office will continue to improve the surveillance and monitoring of alcohol-related problems in the Region by systematically collecting, collating and analysing available data, and developing and improving the necessary indicators and disseminating relevant information in a timely fashion to Member States. There is an urgent need to harmonize measurements of alcohol consumption and related risk, to implement a common alcohol monitoring system and to measure social problems from drinking experienced by others as well as the drinker. Such measurements will also help to improve the basis for estimating the social costs related to alcohol consumption.

74. **The European Alcohol Information System (EAIS)**, established in 2002, is a web-based portal intended to collect, analyse and distribute information relevant to alcohol policy formulation and implementation. The EAIS will be an important instrument in monitoring the implementation of the Framework at national and regional levels. There is a need to expand the database to include systematic material on legislation and marketing practices in the Region. The EAIS should become the main clearing house for timely, relevant and objective information about alcohol policy research, formulation and implementation in the Region.

Training and capacity-building

75. Building and strengthening national and local capacity in Member States is an important part of a systematic multisectoral approach to preventing or reducing alcohol-related harm. The Regional Office will thus continue to assist Member States in developing training systems, building national coalitions and improving the dissemination of effective and cost-effective interventions to prevent or reduce alcohol-related harm. This includes sharing lessons learned from the experiences of different countries and offering advice to enable countries to put the principles of alcohol policy into practice.

76. **Biennial collaborative agreements (BCAs)** are an important tool for collaboration with Member States. They provide a platform for country-specific initiatives and support that complement regional and subregional actions. Strengthening national capacity, supporting and assisting in the development of national action plans, and setting up surveillance and monitoring systems are among the most important components of BCAs. BCAs could be a key tool for the implementation of the Framework in many Member States.

Advocacy, networking and policy development at the regional level

77. Effective public health advocacy must be evidence-based, ethical and credible. It must be able to package accurate, relevant and impartial information in ways which inform and ignite healthy personal and policy action. Communication, particularly popular communication, is often ignored and remains a weak area for public health advocates.

78. Potentially synergistic partners that could stand together at the frontline of health communications regarding alcohol-related harm are often unaware of what others are doing and may be mistrustful of their motives. Proprietary relations can hold back information-sharing. The Regional Office will work to strengthen information links between different actors involved in communication, including the media, government spokespeople, NGO advocates, scientists and educators, by creating training packages and relevant networking activities.

79. **A network of national counterparts for alcohol policy in the European Region**, nominated by the respective Member States, was set up a decade ago to exchange experiences, plan activities, evaluate actions and provide international support for action on alcohol at national and regional levels. It is expected that each counterpart should have relevant links and be able to build up capacity in the appropriate policy areas at the country level. When needed, ad hoc groups of national counterparts may be formed to advise on specific documents and events.

80. **European Coalition on Alcohol Policy Development**: the Regional Office is committed to allocating resources to follow up the intentions of the Framework. The task of attaining the ambitious goals of preventing or reducing the harm caused by alcohol in the Region needs a broad platform. Member States and international organizations and institutions will be invited to join a coalition that could create the necessary support for and achieve the implementation of effective alcohol policies in the Region.

The follow-up process

81. The progress achieved within the context of the Framework must be constantly assessed in order to measure success and shortcomings and adjust the Framework accordingly.

82. **Triennial Framework progress report**: a progress report on the Framework should be produced every third year. The purpose of the report should not only be to estimate the levels of implementation and success of the Framework, but also to alert Member States to emerging challenges and threats to public health and to identify any need for adjustment of the Framework. The progress report should be

produced in close collaboration with the network of national counterparts for alcohol policy and relevant collaborating centres.

83. **Triennial high-level forum on alcohol policy in the Region**: a special high-level forum on alcohol should be organized by the Regional Office every third year. The purpose of such a forum would be to discuss the outcomes and recommendations of the progress report and to deliberate on critical or challenging issues regarding alcohol policy, with a particular focus on issues with cross-border implications and other issues that are difficult to resolve in the context of a single Member State.