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EUROPEAN REGION CONSULTATION ON THE IMPLEMENTATION AND ACHIEVEMENTS OF THE WHO EUROPEAN ACTION PLAN TO REDUCE THE HARMFUL USE OF ALCOHOL 2012–2020

ABSTRACT

This report summarizes the outcomes of two consultation meetings convened by the WHO Regional Office for Europe with Member States and civil society organizations in order to revisit the implementation of the policy areas for action defined in the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020. Additional aims of the consultations included discussing achievements, identifying obstacles for implementation, and outlining the way forward. Areas with the lowest policy implementation were linked to pricing policies, marketing, availability of alcoholic beverages, reducing the negative consequences of drinking and alcohol intoxication and alcohol labelling. Conclusions highlight the need for a roadmap to strengthen policy areas with lower levels of implementation in order to guide Member States towards implementation.

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Abbreviations

EAPA	European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020
EC	European Commission
EU	European Union
MLPA	minimum legal purchase age
MUP	minimum unit price
NCDs	noncommunicable diseases
WHO	World Health Organization
YLL	years of life lost

Introduction

This report summarizes the current status and the achievements of the implementation of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (EAPA),[1] endorsed by the 53 European Member States in 2011. It lists the major conclusions on ways forward that were reached at two consultations organized by the World Health Organization (WHO) Regional Office for Europe with selected Member States and civil society organizations.

The scope and purpose of the two consultation meetings was to revisit implementation of the policy areas for action defined in the EAPA where there was most room for improvement and to discuss both achievements and obstacles and the way forward. The consultation process was financed jointly by Germany, Sweden, Portugal, Norway and the Russian Federation.

The Member States meeting was hosted by the Swedish Ministry of Health and Social Affairs and took place on 21–22 January 2019 in Stockholm, Sweden. Thirty-four representatives from the ministries of health, finance, and enterprise and innovation (communications) attended the meeting, from Czechia, Estonia, Finland, France, Lithuania, Norway, Portugal, Romania, the Russian Federation, Slovakia, Slovenia, Sweden and the United Kingdom. The consultation meeting of civil society organizations took place on 28–29 January 2019 in Santo Tirso, Portugal, and was hosted by the city's mayor. Representatives from 20 international organizations participated in the meeting.

The structure of the two meetings involved group discussions and sharing of experiences, as well as presentation of updates on recent policy implementation in the areas of availability, pricing, commercial communication, and labelling.

Information gathered at the meetings was focused on implementation of four priority areas for action defined in the EAPA. The central part of the current report is structured around these priority areas.

The harmful use of alcohol

Alcohol-attributable deaths, injuries and diseases

Harmful use of alcohol is a leading risk factor for morbidity and mortality worldwide, and one of the most important risk factors for ill health and premature death in Europe. More than 3 million people died as a result of harmful alcohol use in 2016; 1 million of these deaths occurred in the WHO European Region[2].

There is a clear relationship between the harmful use of alcohol and over 200 diseases and injuries, such as heart disease, cancer and liver cirrhosis, and more than 40 three-digit ICD-10 codes are fully attributable to alcohol.[3] Overall in 2016, 10.1% of all deaths in the WHO European Region were caused by alcohol, equivalent to 928 000 people. Deaths were largely due to cancer (14.3% of alcohol-attributable deaths), liver cirrhosis (11.7%), cardiovascular disease (45.3%), and injury (17.4%). In the same year (2016), alcohol use caused 13.1% of years of life lost (YLL) in the European Region, representing 25.3 million years lost prematurely because of alcohol consumption.[4] [5]The European Region continues to have the highest level of alcohol consumption per capita globally, with proportionately higher levels of burden of disease attributable to alcohol use compared to other regions.[6]

Most worryingly, alcohol-attributable deaths in adolescents and young adults are unacceptably high in Europe; about every fifth death in the 15–19-year age group is caused by alcohol, and in the 20–24-year age group, this proportion is one in every fourth death.[6] In other words, a high proportion of alcohol-attributable harm occurs early in the life-course, making alcohol a leading cause of working years of life lost and hence of lost economic productivity and development. Moreover, the majority of deaths in these age

groups occur because of intentional and unintentional injuries and hence are due to causes of death that are preventable.

Alcohol is also one of the factors that have a significant impact on social inequality and health disparity. Across a number of European countries, people of low socioeconomic status have a mortality risk from alcohol that is several times higher than that of their more affluent counterparts, making alcohol an important driver of health inequalities.[4,6,6]

Alcohol consumption and production levels

Although alcohol per capita consumption has been decreasing across a number of European countries since the mid-1970s, Europe still stands out as the region with the highest alcohol per capita consumption, the highest proportion of drinkers, the highest prevalence of heavy episodic drinking, and the lowest proportion of abstainers.[4,6] In 2016 the average alcohol per capita consumption among adults (age 15+) in the WHO European Region was 9.8 litres of pure alcohol; men consumed an average of 16 litres of pure alcohol, women 4.2 litres.[6]

Europe also plays a significant role in the global production, marketing and trade of alcoholic beverages, with over a quarter of the world's alcohol beverages and over half the world's wine production emanating from Europe.[6,7] With regard to trade in alcoholic beverages, Europe's position is even more pivotal. Approximately 70% of all alcohol exports and just under half the world's alcohol imports involve countries in the European Union (EU)[7].

Policy strategies and action plans

In 2010, the 63rd World Health Assembly endorsed the Global Strategy to Reduce the Harmful Use of Alcohol.[8] To support countries in defining and implementing the 10 priority areas in the Global Strategy and in making new commitments to reduce alcohol-attributable harm, the WHO European Region adopted the EAPA, which was endorsed by the 53 European Member States in 2011.[1]

The EAPA contains a portfolio of recommended evidence-based policy options and interventions, collated into 10 specific action areas. It strengthens the monitoring and national public health responses needed to make progress in implementing the Global Strategy; it is also closely linked to the interventions in the European Strategy for the Prevention and Control of Noncommunicable Diseases (NCDs) (2012–2016)[9] and to the European health policy, Health 2020.[10] The WHO Regional Office for Europe has developed a tool for evaluating Member States' progress towards implementing the policy measures as outlined in the 10 action areas of the EAPA to allow for benchmarking analyses across countries.[11]

Another action plan that deserves special attention is the Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) (2014–2016), which was endorsed on 16 September 2014 by all EU Member States, represented by the Committee on National Alcohol Policy and Action (CNAPA).[12] This action plan complements the EU Strategy to Support Member States in Reducing Alcohol-attributable Harm; it provides a means to strengthen long-standing policy implementation work from Member States in the area of alcohol while also addressing key identified areas – namely, youth drinking and heavy episodic drinking. Other important areas covered in the action plan were accessibility and availability of alcoholic beverages to young people; exposure of youth to alcohol marketing and advertising; harm from alcohol during pregnancy; healthy and safe environments for youth; and increased monitoring and research in the field. The action plan was found to be beneficial to the countries covered as it contained a clear framework for action at EU level that reinforced other valid strategies and action plans.[13]

On 8 December 2017, the Employment, Social Policy, Health and Consumer Affairs Council adopted conclusions on cross-border aspects in alcohol policy. EU Member States were invited to continue to integrate the objective of reducing alcohol-attributable harm into all relevant national policies, including

policies likely to have an impact on the price of alcoholic beverages and policies aimed at regulating marketing and alcohol selling arrangements.[14]

Policy options

According to WHO, the most cost–effective policies available to Member States for reducing the harmful use of alcohol are the three so-called "best buys":

- increase excise taxes on alcoholic beverages;
- enact and enforce restrictions on the physical availability of retailed alcohol; and
- enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising.

Assessment of alcohol policies in the 10 action areas defined in the EAPA reveals huge variability in the implementation of the WHO best buys policies across countries in the WHO European Region.[5, 15]

Consulting Member States and civil society

Eight years after endorsement of the EAPA by Member States, alcohol per capita consumption and alcohol-attributable harm in the WHO European Region, including the EU, continue to be the highest in the world.[2] While working with the 2015 Global Alcohol Policy Questionnaire, European Region Member States shared with WHO the barriers they experienced in implementing effective alcohol policies. Commonly noted barriers were, among other things, limited or reduced financial resources, and lobbying and opposition from commercial interests in the alcohol area.

In 2018 the WHO Regional Office for Europe consulted the European Region Member States regarding alcohol per capita consumption and estimates of alcohol-attributable harm. During this consultation, the Regional Office provided support and guidance to participating Member States in order to improve estimates and overcome challenges in implementing effective alcohol policies.[16] It became obvious that, in order to improve implementation of the EAPA and reduce harmful use of alcohol, policies aimed at reducing harmful alcohol use must reach beyond the health sector and appropriately engage a broader range of policy areas. Moreover, as reported by Member States, and confirmed by research[17], efforts to introduce measures are diluted by trade agreements, economic interests, and exposure to issues such as cross-border advertising (including online advertising) and cross-border trade (including online sales).

Recent analysis of implementation across all 10 EAPA action areas shows that the ones linked to policies outside the health area, such as "Availability" (area 5), "Marketing" (area 6) and "Pricing polices" (area 7) – all three identified as best buys – had the lowest implementation rate; and that, for area 8, "Reducing the negative consequences of drinking and alcohol intoxication", only two countries had a legal requirement for warning labels on bottles or containers, despite alcohol being categorized by WHO as a class I carcinogen.[2,15, 18]

In this context, the purpose of the consultations was to revisit implementation of these four priority areas for action defined in the EAPA, to discuss both achievements and obstacles and appropriate ways forward (Annexes 1 and 2).

The invited Member States and civil society organizations were asked to include officials/organizations outside the alcohol policy/health area to allow the kind of cross-sector contributions that would be needed to overcome the barriers at country level identified by Member States in the policy questionnaire. The outcome of the consultations would also help WHO to develop a roadmap with examples and advice on the best ways forward. A total of 13 Member State representatives participated in the consultation meeting of Member States (Annex 3) and 20 civil society representatives attended the consultation meeting of civil society organizations (Annex 4).

During the two consultations, the WHO Regional Office for Europe decided to focus the discussions on implementation of priority areas that required cross-sector cooperation and on the best buys with a low implementation rate (Annexes 5 and 6). To facilitate discussions, WHO produced background documents for each of the two meeting sessions (Annexes 7 and 8).

OUTCOMES OF THE CONSULTATIONS

Priority area I. Alcohol pricing

Scientific evidence

Numerous reviews of the scientific evidence have concluded that pricing policies are the most effective measure to reduce alcohol-attributable harm and are one of WHO's best buy policies.[19,20,21,22] Alcohol taxation and pricing policies can (i) generate tax revenue; (ii) reduce alcohol consumption; and (iii) reduce alcohol-attributable harms to the drinker and alcohol's harm to others.[23,24] Emerging evidence suggests that taxation may also delay the onset of drinking among adolescents and young adults,[25] which may be a particularly relevant preventive strategy in countries that have a high prevalence of lifetime abstainers. Across the European Region, alcohol is generally widely available and highly affordable. Typically, lower prices are associated with heavier drinking – something which is particularly true in lower socioeconomic groups.[26,27]

Cost–effectiveness

The costs of implementing pricing policies are extremely low – for example, the cost of increasing taxation was estimated to be less than $0.10 per capita;[28] as such, pricing policies are highly likely to be cost–effective, particularly if cost savings to health and social care, public services and workplace productivity are considered.[28,29] Despite the evidence available, pricing policies remain the most poorly implemented intervention; in the WHO European Region, less than 30% of countries reported that effective pricing policies had been implemented.[4,15] Across different types of alcohol, alcohol taxation levels and structures vary hugely between countries and even within countries. Three main approaches to alcohol taxation are (i) *specific taxation*, where alcohol duty is levied according to the alcohol content of a product; (ii) *unitary taxation*, where alcohol duty is levied according to the volume of the product; and (iii) *ad valorem taxation*, where alcohol duty is levied on the basis of the sales value of the product.[2] Hybrid systems are also possible – for example, specific taxation can be applied to a product and then an additional ad valorem tax (e.g. value added tax) applied on top. Not all taxation approaches are equally effective; relatively, a specific taxation approach is most effective in reducing alcohol consumption and is cost-saving compared to existing hybrid systems.[27,30,31,32]

Despite constraints created by EU directives that prevent countries from implementing a specific taxation approach to alcohol, EU countries have some flexibility in how they set their alcohol duty. Notably, this can be done through regularly reviewing prices in relation to the level of inflation and income in order to ensure that the effectiveness of existing taxes is maintained and not eroded over time. Such erosion can also be effectively mitigated by use of a duty escalator – namely, annual increases above inflation in alcohol excise duty. Moreover, policy-makers are generally free to adopt policies on alcohol provided they do not discriminate against individuals from lower socioeconomic strata and are not more trade-restrictive than is necessary to protect health.

Low prices contribute to inequalities in health

Typically, lower prices are associated with heavier drinking, particularly among lower socioeconomic groups, suggesting that cheap alcohol in particular may be contributing to socioeconomic inequalities in health.[31,33] Evidence also shows that increasing the price of the cheapest alcohol is better targeted at reducing health inequalities than policies that increase the price of all alcohol.[33] This can be done by imposing a minimum unit price (MUP) on alcohol, below which it cannot be sold. The evidence for MUP is robust [20,34] and comes from two major sources: a series of natural experiments in Canadian provinces and modelling studies across the United Kingdom, Ireland, Czechia and Germany.[21,31,32,33,35,36,37,38,39] Additional

evidence is provided by micro-level panel data from the Russian Longitudinal Monitoring Survey, which documented that an increase in MUP on vodka in the Russian Federation had led to a decrease in its consumption for the period 2010–2013, which was also adjusted for other factors.[40] Taken together, these studies consistently demonstrate that MUP is effective in reducing alcohol consumption, hospital admissions, deaths, criminal offences, and workplace absence. By effectively targeting the cheap alcohol that is purchased by heavy drinkers, MUP results in the greatest gains for the heaviest-drinking, least affluent groups. For instance, modelling studies from England estimate that high-risk drinkers in the lowest socioeconomic group experience almost double the gains, in terms of reduced mortality and hospital admissions, of any other population subgroup.[33] As such, MUP has huge potential to reduce health inequalities that are caused, maintained and reinforced by alcohol.

Cross-border trade

Cross-border issues should remain a key consideration across the WHO European Region since changes in taxation in one country may have an impact on purchasing in a neighbouring country. Measures to protect public health can be diluted by exposure to cross-border advertising, including online advertising, and cross-border trade, including online sales. The issue of cross-border trade calls for a holistic approach to alcohol taxation and price regulation, including enforcement, customs policies, cooperation and coordinated action between neighbouring countries.

Illicit informal market

The emergence of an illicit or informal market in alcohol should remain a key issue in considering taxation policy, since – depending on the scale and responsiveness of unrecorded alcohol (alcohol which is consumed, but not taxed, as beverage alcohol) – such policies could increase illegal imports as well as illegal production. It is important to keep this issue in an appropriate perspective, since the alcohol industry consistently overstates these concerns as a mechanism to lobby against effective policy actions on price.[41] Unrecorded alcohol is not inherently more harmful than recorded alcohol,[42] and there is never full substitution between recorded and unrecorded alcohol.[43]

Complex process

Legal challenges brought against governments by alcohol producers and retailers remain an obstacle to implementation of pricing policies, as was demonstrated by the (ultimately unsuccessful) challenge to MUP implementation lodged against the Scottish government by the Scotch Whisky Association.[44] Nonetheless, public health interests should prevail over private wealth interests, and this is generally the view taken by the public health community and citizens alike.

The setting of alcohol taxes and other pricing policies is a complex process which must balance many, often competing, considerations. Protection of health should be a priority in this process, particularly when account is taken of the burden that alcohol-attributable ill health places on health and social care services, other public services, and the economy more broadly through absenteeism, presenteeism and disabilities, as well as general life years lost in the working age population. The evidence supporting taxation and price regulation is extremely robust and should be considered a cornerstone of contemporary alcohol policy by all decision-makers.

The way forward: challenges

The participants of the consultation meetings identified the following as the main challenges:

- Pricing policy interventions are still perceived as a threat, given their potential to cause cross-border issues as well as substitution effects from unrecorded alcohol in general; thus concerted policies between countries are essential.

- Not all pricing policies are equally effective and national differences need to be considered. Also, different pricing policies affect different socioeconomic strata in different ways, with the existing evidence suggesting that MUP is most effective in improving the health of the least affluent consumers and therefore decreasing health disparities and social inequality.
- Alcohol tax structures that apply very unequal levels of duty to different products are less likely to be effective at reducing consumption than those that impose similar rates across all products.
- Among Member States and in civil society, understanding of the dynamics of indexing and cross-border issues is still low – specifically, the impact of the total amount charged to the final consumer.
- There is a need to improve cooperation and knowledge exchange between health and finance ministries. Health ministries need to improve their knowledge of the complexity of alcohol taxation, while finance ministries need to improve their knowledge of health issues and the impact of harmful use of alcohol on society, including lost productivity and economic development. Better multisectoral collaboration is needed in order to demonstrate the large return on investment from alcohol policies, including but not limited to alcohol pricing. The WHO best buys provide the necessary framework when making the financial case for collaboration between the relevant ministries and other state authorities.
- Failure to link pricing policies to inflation is likely to lead to an erosion in their effectiveness over time as the real-terms value of duty rates or MUP threshold falls. For this reason, a duty escalator (annual increase above inflation in alcohol excise duty) is a useful tool in reducing alcohol consumption and attributable harm and simultaneously generating state revenue.
- Use of new technologies is decisive in facing the challenges of the digital developments. An innovative intervention that has already been implemented in the Russian Federation is use of quick response (QR) codes in point-of-sale receipts as a tool to trace time of sales and products sold, to ensure payment of tax duties, and to enforce local time restrictions on alcohol sale.

The way forward: conclusions

The participants of the consultation meetings formulated the following main conclusions:

- Increasing the cost of alcohol is effective at reducing alcohol consumption and the harms caused by alcohol use, especially heavy episodic drinking and its consequences.
- There is no clear argument from a health perspective for taxing different products at different levels; in order to improve public health and reduce alcohol-related harm, the most effective approach to taxation is a fully specific tax system, potentially with higher rates of duty for products with higher alcohol volume.
- MUP and levying alcohol duty on the basis of a product's alcohol content are the most likely ways to reduce health inequalities.
- Country analysis and modelling of different scenarios is extremely important as impact assessments allow understanding of what works well in each country.
- More cooperation is needed between Member States so that they can learn from each other and exchange best practice and administrative experience of the legal implications of implementing pricing policy interventions.
- Economic studies on the impact of pricing policy interventions are needed.
- Guidance is needed (from WHO, for example) on how to implement price policies in effective and concerted ways.

- Member States must communicate very clearly the objectives of pricing policies; they should focus on health outcomes (on the link between reducing harm and increasing cost) and on the economic consequences of acting and failing to act (as, for instance, in examples involving return on investment cases).
- Civil society organizations working in the area of alcohol need to engage with other health and consumer organizations in raising awareness of the impact of price on health and on consumption.

Priority area II. Alcohol availability

Scientific evidence

Policies that reduce the physical availability of alcohol are one of the WHO best buy policies and include: reducing the number and density of licensed premises; limiting the days and hours of sale; implementing a government retail monopoly on sale of alcohol; and setting and enforcing a minimum legal purchase age (MLPA).[1,22] Place-based approaches to reduce the physical availability of alcohol can also be used, such as drinking bans in public spaces, workplaces or public transport; or event-based restrictions, such as during football matches. Such place-based and event-based restrictions may be relatively easy to implement and enforce, and Member States should aim to implement them as a matter of urgency. There are examples of Member States where such placed-based restrictions are already in force; for instance, prohibition of alcohol sale and consumption within a certain perimeter around medical and educational facilities.

Evidence shows that greater availability of alcohol is associated with greater levels of consumption,[19,45,46] and an association between density of licensed premises and violence, road traffic accidents, sexually transmitted infections, hospitalizations, suicide, and (more recently) liver cirrhosis morbidity and mortality.[3,47,48,49,50] Density of licensed premises tends to be higher in more deprived areas; for this reason, reducing the availability of alcohol has the potential to reduce health inequalities.

Minimum legal purchase age (MLPA)

Setting and enforcing an MLPA is highly effective in reducing sale of alcohol to minors and is the most commonly implemented policy to restrict availability across Europe.[2,4] Around 80% of EU countries have an MLPA of 18 years, so an obvious immediate action is to increase this to 18 years for all products across all countries. Such a measure can reduce youth intoxication and delay early onset of alcohol consumption; this in turn reduces the likelihood of heavy drinking in adulthood, since age of initiation is a predictor for heavy drinking later in life.[51] Moreover, delaying the onset of drinking might decrease the likelihood of injuries and subsequent mortality in young people, as well as other health-related outcomes such as unplanned and unprotected sex, illicit drug use and developing alcohol dependence.[52] Crucially, the effectiveness of this policy is contingent on adequate enforcement; this can be costly, yet even moderate increases in enforcement can lead to substantial reductions in sales to minors (by as much as 40%).[53] Given the burden of alcohol in young people described above and the associated losses in productivity and economic development, this is one of the areas that should be given high priority by Members States.

Hours of sale restrictions

Some 64% of countries report restrictions on the location of licensed premises, and between 30% and 50% report restricting hours of sale.[4] Reducing on-trade premises opening hours in areas with the highest density of licensed premises, combined with appropriate enforcement, effectively reduces alcohol-attributable harm and is cost–effective.[19,54] Nonetheless, reported restrictions on hours of sale across the EU are low; only 10% of countries report restricting on-premises alcohol sales, rising to 20% for off-trade

premises[18]. All things considered, there is an urgent need for countries to better mirror the published evidence and to implement the best buy policies relating to availability regulations.

The need for accountability

Most availability policies occur at the local level and require concerted action and joint working between national and local authorities, licensing officers, the police, criminal justice systems, and the social and health care sectors. Monitoring and sufficient data collection, both before and after significant policy changes, are of the utmost importance to inform policy evaluations and practice.

The way forward: challenges

The participants of the consultation meetings identified the following as the main challenges:

- For the most part, cultural norms and public acceptance are not yet aligned with the need to establish, operate and enforce an appropriate system to regulate production, wholesale and retail selling, and serving of alcoholic beverages.
- Alcohol consumption age limits are considerably lower in some countries than others (20 years old *versus* 16 years old). Clear guidance from international agencies and exchange of best practices are both lacking. There is neither strong evidence nor clear support to support countries wishing to rise alcohol consumption age limits.
- Local economic and political interests strongly oppose any further restrictions on alcohol outlets or hours of sales.
- There is inadequate enforcement of existing alcohol consumption restrictions in most countries. In 20% of EU Members States, alcohol can be legally purchased and consumed by minors.
- There is a lack of mechanisms to make sellers and servers liable for breaches of national regulations.
- There is limited cross-sectoral cooperation, as the health sector often works in isolation.
- Additional support and guidance are needed on restricting the availability of alcohol in the vicinity of schools, during happy hours and at sports events.

The way forward: conclusions

The participants of the consultation meetings formulated the following main conclusions:

- Evidence shows that policies that reduce the physical availability of alcohol are one of the most cost–effective measures at local, national and international levels. However, consideration should be given to cultural norms, public acceptance, and measures that are based on best practice and evidence.
- Enforcement is an essential part of implementing alcohol availability policy. If countries are to improve effectiveness of policies on alcohol availability, priority must be given to enforcement. In order to do so, it is important to promote exchange of administrative experience on the legal implications of implementing availability policy interventions between countries that have successfully done so and others that have big margins for improvement.
- There is great need for guidance on policy interventions in internet sales; WHO has an essential role to play in supporting production of such information.
- Collaboration with other areas of public health research, including tobacco and obesity, should be explored.

- For effective implementation, there is a need to establish close cooperation and dialogue between government ministries responsible for health, finance and taxation, trade, and consumers in order to gain better understanding and knowledge both of the different roles involved and of the evidence base.
- It is necessary, as a matter of urgency, to set clear WHO guidelines, backed by scientific evidence, for local and national policies aimed at limiting drinking in public places and at official public agencies' activities and functions.
- Countries must focus on new and more effective ways of enforcing alcohol consumption age limits, such as making non-compliance with age controls an exclusion criterion for alcohol sales licensing. Tools that are usually used by the private sector to improve consumer experience and quality of service, such as mystery shopping, should be considered.
- Sport and public events attended by minors should be alcohol-free.
- There is a need for innovative and more effective policies aimed at reducing or eliminating availability of illicit alcohol production, cross-border sales and distribution of alcoholic beverages, and unrecorded alcohol sales.
- WHO stewardship is needed in the facilitation of experience exchange between countries, policy areas and civil society in order to promote international synergies and to save policies development time and national resources.

Priority area III. Commercial communications

Children and adolescents

Some of the most compelling evidence of the impact of marketing on alcohol consumption comes from reviews of longitudinal and cross-sectional studies that demonstrate that exposure to alcohol marketing increases the likelihood that children and adolescents will initiate drinking, or start drinking in greater quantities. [55,56,57,58] A recent cross-sectional study from four European countries also demonstrates an association between exposure to online alcohol marketing and binge drinking and increased odds of drinking initiation[59].

New boundaries

When properly and efficiently enforced, alcohol marketing restrictions constitute a cost–effective strategy for reducing harmful alcohol use and are included as a WHO best buy policy. Despite this evidence, in recent years there has been a general growth in citizens' exposure to commercial messages. The total annual marketing spend on alcoholic beverages is now estimated to have grown to a total of US$ 1 trillion globally.[20] Moreover, new marketing investments in the digital arena present new challenges from a regulatory and legislative perspective. Multiple marketing channels, techniques and platforms have turned alcohol marketing into a complex and ubiquitous phenomenon; a more correct term to describe alcohol marketing today would be commercial communication. As such, there is an urgency for current alcohol marketing legislation to correspond to these new realities. Part of this task concerns jurisdictions' articulation of the principles according to which commercial interests "plug into" the online lives of citizens, especially those of vulnerable populations. For example, one purpose of marketing regulation is to protect the rights of citizens to move freely around the internet without becoming unpaid marketers of harmful products.[60] Another important feature of marketing regulation is to protect children and adolescents from alcohol advertising, promotion and sponsorship.[61,62] The issue of digital marketing is not a marginal concern when, across many countries in the WHO European Region, over 90% of all citizens access the internet daily, rising to 92% of those aged 16 to 19 years.[63] This quickly evolving digital technology and new online "fishing" methods present challenges for authorities seeking to oversee and control marketing

activities.[61,64] Product branding and profiling are repeated and reinforced across a whole spectrum of channels and media platforms, including television, radio, printed media, the internet, apps and outdoor commercials, and they are synergized both with sponsorship and influencer deals and with product placements.[65]

The need to keep legislation up to date

Action is urgently needed as existing legislation and codes of conduct do not correspond to current advertising methods, particularly the emerging threat of digital marketing. Social media and other online and app-based marketing techniques can reach consumers in regions where alcohol-related content is prohibited in national law. All things considered, the complexity of contemporary synergized marketing techniques suggests that the simplest solution is a complete marketing ban; such a measure is supported by the evidence [20] and already in place in some Member States. Nonetheless, complete bans are often difficult to implement in the face of strong lobbying by the alcohol industry and a lack of political will. Thus, partial bans that operate at certain times (for instance, before a given watershed) or in certain places (such as at sports events), may be implemented as an alternative. On the digital landscape, besides total ban, WHO has proposed a three-step process to establish a system within which exposure of children to age-inappropriate marketing would be significantly curtailed comprised of 1) age verification of online users; 2) tagging of marketing campaigns to flag up material to which access should be restricted for a young audience; and 3) regulation to ensure that these data points are combined and consistently applied to prevent serving of restricted-category advertisements to underage ad impressions. [61]

Guarding and prioritizing the health and well-being of citizens, particularly children and adolescents, and protecting them from exposure to harmful products are in the interest of all governments. Most European countries have marketing regulation policies to protect the youngest and most vulnerable segments of the population; these range from complete bans to light-touch self-regulation – 63% of European countries report that they have statutory regulation, 34% self-regulation, and 3% co-regulation.[15] Countries across the WHO European Region should closely follow the good practice pursued by other countries. Countries are encouraged and advised to implement and enforce a total ban on alcohol advertising, or partial bans in cases where a complete ban is not feasible, while applying strict penalties for non-adherence. Researchers, civil society and public health officials need to focus more closely on developing and implementing new strategies to tackle digital marketing, since this represents a current and growing public health threat. Some aspects of regulation are still translatable from older media principles; for example, content can still be restricted and age limits enforced online. However, new product placement techniques, native advertising, dark social, and web influencer marketing, which cannot be understood under the guise of traditional advertisements, need to be tackled with effective new strategies. Proper enforcement should include clear-cut rules setting out the consequences of violations and effective penalty systems, such as shutting down web pages and social media profiles or imposing financial penalties. Most importantly, acceptance on the part of citizens is essential if restrictions on the market are to be implemented and enforced.

The way forward: challenges

The participants of the consultation meetings identified the following main challenges:

- Alcohol advertising and marketing is not a limited phenomenon. The last decade has seen a shift from traditional marketing to digital landscapes; the new merged repertoires of marketing channels, techniques and platforms make alcohol advertising a complex and ubiquitous phenomenon with many forms of expression.
- One of the biggest challenges faced by countries is to understand how to enforce current regulations in the digital space – for example, internet and social media advertising.

- Regulating private content/communication platforms, where most content is shared, is extremely challenging.
- As millions of posts are published daily on a multitude of platforms, active supervision and enforcement represent an extensive, costly yet crucial task.
- Total bans are most effective in minimizing the harmful use of alcohol but also the hardest to push through when facing the influence of the alcohol industry.
- There are serious doubts about the feasibility of enforcing partial bans on the multitude of channels currently in use.

The way forward: conclusions

The participants of the consultation meetings formulated the following main conclusions:

- There is a great need to develop a protocol for discerning native advertising, user-generated content and other difficult-to-grasp commercial messages, where the real message sender is invisible to consumers, especially young consumers and children.
- As many young people participate in social media environments as a natural part of their everyday life, age limits should be properly enforced by alcohol brands; implementing an age verification system (age-gating) on, for example, their Facebook and Instagram pages is not technically difficult.
- It is crucial to have cooperation between Member States over policy interventions in digital marketing, which are particularly difficult to enforce.
- There is a need for better evaluation, control and enforcement tools in the area of digital marketing and policy interventions.
- Support is needed in understanding which elements of existing legislation can be used and adapted for use in regulating digital marketing; there are many open questions concerning digital marketing, so Member States need support in order to gain some clarity about the most effective and cost–effective measures.
- A step-by-step approach should be considered; initially introducing partial restrictions on alcohol advertisement might be more appropriate in some countries, rather than moving straight to a total ban.
- As marketing bans are identified as one of the best buys, digital marketing must be included in the relevant toolkits used to implement them.
- Citizens and communities should be more fully included in calling for restrictions and total bans on advertising; surveys in several countries show that there is majority support for such policies.
- Self-regulation by the alcohol industry is clearly not working (despite claims to the contrary) and should no longer be considered a viable option.
- There is a lack of data on exposure, which offer essential support to policy-making.
- It should be mandatory for the alcohol industry to share its data on the behaviour of its target groups in the digital world.
- Gambling could be seen as a model for enforcing age regulation, which is a potential avenue for short-term action.
- It is necessary to set up an expert task force with a diverse pool of people (public and private sector) in order to better understand how brands use the internet and social media (especially dark social); in this area, it is important to involve young people and other stakeholders.

Priority area IV. Health information

Low public awareness

Although alcohol was the leading cause of ill health, disability and death in 2017 among those aged 15 to 49 years, and the seventh leading cause across all age groups,[66] public awareness of the harms relating to alcohol is low.[67] This is perhaps unsurprising as the information provided on alcohol products is woefully inadequate. At the very basic level, consumers have a right to information about the products they consume, particularly if they are harmful, and increased knowledge can be an important first step towards behaviour change.[20] Furthermore, improving public knowledge of the harms attributable to alcohol, particularly cancer, can increase public support for more stringent policies such as taxation.[67] Provision of health and consumer information therefore constitutes an important part of an overall policy approach to reducing alcohol-attributable harm. One easy way of providing information is by means of product labels on alcoholic beverages.

Exempting alcohol products

Across Europe, there is little evidence on the information given on alcoholic beverages relating to nutrient, ingredient and health information.[68] At EU level, alcohol labelling is covered by Regulation 1169/2011 on the provision of food information to consumers, which became applicable in 2014. The only mandatory information required on labels includes listing of the most common allergens present in alcoholic beverages (Article 21, Annex II), such as sulphites added to wine; and labelling of the alcoholic strength by volume for beverages containing more than 1.2% of alcohol by volume (Article 9). Alcohol products are exempt from the requirement to provide information on ingredients or nutritional value, as is required for other food and soft drink products.

In March 2017, the conclusion of the European Commission (EC) report on labelling concluded that there were no objective grounds to justify the absence of ingredient or nutritional information on alcohol products; however, since the alcohol industry had shown greater willingness in its attempts to improve consumer information, it was given a year to further develop voluntary initiatives that would cover all alcoholic products.[69] In 2018, the industry submitted a self-regulatory proposal to the EC whereby it would voluntarily provide information on its products, including ingredients, energy and nutrient information per portion size as well as per 100 ml (energy, fat, saturated fat, carbohydrates, sugar, proteins and salt). However, the proposal does not require that this information is shown on a product label (it could be shown on a website, for instance), nor that the information should be presented in a standardized form (stipulating, for instance, font size, contrast, exact wording, etc.). The proposal has been criticized both by civil society organizations [70] and by members of the European Parliament,[71, 72] and it remains under assessment by the EC. In the event that it is deemed unsatisfactory, the EC will launch an impact assessment to review other options, both regulatory and non-regulatory.

The self-regulatory approach proposed by the EC does not accord with evidence from the United Kingdom, whose experience was that public–private partnerships involving a voluntary self-regulation approach to implementing labelling were ineffective and that the industry used deliberately obfuscatory tactics, such as putting the pregnancy logo on products more frequently consumed by males.[73, 74]

Progress in the WHO European Region

The WHO European Region has seen some progress in calls for nutritional and ingredient information and health warning labels. In 2011, the Eurasian Customs Union adapted the Technical Regulation on Food Products Labelling and on Food Safety for Armenia, Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation; by 2016, product manufacturing, ingredient listing, and nutritional information had become mandatory, requiring labelling in Russian as well as in the national language(s) of the country where the product was sold[75]. Moreover, mandatory health warnings covering at least 10% of the label area were

introduced as part of the technical regulation. These measures notwithstanding, progress has been observed only in a handful of countries; for the majority of Member States, implementation of alcohol labelling remains insufficient, especially in comparison to non-alcoholic beverages and tobacco.

Health warnings

Given that alcohol is a dependence-inducing drug, a teratogen and a class 1 carcinogen, there is a convincing case for inclusion of health warnings similar to those presented on tobacco and nicotine-containing products; and there is clear evidence giving guidance on the nature and format of these warnings.[76] Across Europe, the most commonly used health warning is a symbol relating to drinking during pregnancy, yet many of these do not comply with WHO label recommendations.

Health warnings for pregnant women are important. However, warnings should be more wide-ranging, extending to harms that are relevant to the general drinking population, such as the risk of cancer, hypertension and liver disease. Health warning messages currently displayed on labels are mostly directed at women and young people, but the groups where harm is highest consist of middle-aged men.[3]

Warnings and the provision of nutritional and calorific information on labels, seen as a standalone measure, are unlikely to directly contribute to a reduction in alcohol consumption and alcohol-attributable harm; rather, they should be viewed as a complementary component of a wider package of integrated policies. Labelling policy should be part of a broader policy package and can be supplemented by an integrated communication strategy that includes point-of-purchase information, advertisements and package inserts; at the same time, there should be broader communication actions, including social norm campaigns.[1, 19, 76]

Looking beyond the field of alcohol may present opportunities for implementation. Nutritional and ingredient labelling can be introduced either as part of food-related law or as part of alcohol control law. Health warning labelling can be introduced as part of general alcohol legislation, as part of alcohol advertising and marketing law, or as part of any other possible combination that is most feasible at a given moment (for example, the youth protection laws in Germany or the laws on the rights of disabled people in France).

The way forward: challenges

The participants of the consultation meetings identified the following as the main challenges:

- In comparison to labels on similar products (foodstuffs, tobacco), less evidence is currently available on different types of labels for alcohol products; more studies and research are needed.
- Labels relating to nutritional information have been discussed in many countries; however, most countries are passive, waiting for the EC to make its decisions before acting, and will be bound by the outcome.
- Voluntary self-regulation on implementing labelling has been found to be ineffective, with the alcohol industry deliberately using obfuscatory tactics to appear to comply with requirements.
- There is a need for technical experts' support and guidance in identifying the most important messages to include on labels, and which target groups to tackle first.
- The EC has not provided any clear or relevant information or guidance on the topic of labelling.

The way forward: conclusions

The participants of the consultation meetings formulated the following main conclusions:

- Introducing alcohol nutrition/ingredient labelling and health warning measures should be part of a comprehensive action to reduce alcohol consumption and related harm, including

evidence-based policy actions such as increased taxation, reducing availability and restricting advertising.

- WHO recommendations already available could provide guidance to foster country implementation.
- Alcohol nutrition/ingredient and health warning labelling will not by itself be the standalone policy that changes people's behaviour, but it can contribute to changing the cultural conversation and understanding about alcohol and allow consumers to make informed choices about the products they are buying.
- This policy area is also about the consumer's right to health information as it is commonly accepted in the case of tobacco products.
- Nutritional value and ingredient information for alcoholic beverages, including number of standard drinks, is a request among consumers; information about the calorie content of alcoholic beverages should be displayed on alcohol beverage containers, helping consumers to reduce their calorie intake if they so wish.
- The way forward seems to be closer cooperation between the health and other sectors (i.e. other Member States, consumer organizations, retailers, among others).
- Best practices on the most effective pictures/imagery on alcohol product labels would be seen as useful by Member States.
- Guidelines on the best ways to collaborate with the alcohol industry would be extremely useful to support Member States' action.
- It is important for Member States to learn from the tobacco experience and from how WHO spearheaded implementation of policy interventions in that area.

CONCLUSIONS OF THE CONSULTATIONS

In order to promote implementation of all the major suggestions discussed by the consultation participants, an integrated, country-focused approach is needed. It is essential to strengthen policy areas with lower levels of implementation, to address the challenges identified, and to build on the recommendations made during this process. The participants suggested, therefore, that the conclusions of the consultation meetings should be well documented so that they can inform a draft of a new roadmap to be presented in a wider consultation with the 53 Member States of the WHO European Region. The roadmap will aim to strengthen implementation of the EAPA at country level and to support Member States in achieving targets set in important public health commitments such as those related to reducing NCDs and achieving the Sustainable Development Goals. Furthermore, such a roadmap will contribute to aligning future actions with the overarching Global Strategy to Reduce the Harmful Use of Alcohol and to updating and refining priority actions based on the most recent data and evidence.

In addition, a roadmap of actions to strengthen implementation of the existing framework will identify specific focus areas and concrete actions that need to be taken by both Members States and the WHO Regional Office for Europe, in order to reduce alcohol consumption and alcohol-attributable harm in the WHO European Region. Ultimately, the roadmap can provide specific and evidence-based policy recommendations that are capable of meeting the current challenges, such as restrictions on digital marketing and adequate alcohol labelling regulations, in order to realize the vision of a world free of alcohol-attributable harm.

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Annexes

Annex 1. Member States consultation meeting: scope and purpose

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

/2

European Region Member States Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

Stockholm, Sweden **14 December 2018**

21–22 January 2019 **Original: English**

Scope and purpose

Harmful use of alcohol is a leading factor for mortality worldwide. More than 3 million people died as a result of harmful use of alcohol in 2016. One million of those deaths occurred in the WHO European Region. In the EU Member States, Norway and Switzerland in 2016, 23% of all injury deaths and 42% of all traffic deaths were due to alcohol. Several international frameworks identify the need for urgent action regarding the reduction of the harmful use of alcohol. The alcohol related harms done to adolescents and young adults are also unacceptably high in Europe. In the EU, Norway and Switzerland in 2016, about every fifth death in the 15-19-year age group was caused by alcohol and in the 20-24-year age group, this proportion was one in every forth death.

In 2010, the Sixty-third World Health Assembly endorsed the global strategy to reduce the harmful use of alcohol. In order to support countries in defining and implementing the 10 priority areas in the global strategy and make new commitments for reducing alcohol related harm, the WHO European Region adopted the European action plan to reduce the harmful use of alcohol 2012–2020 (EAPA). Fifty-three European Member States endorsed the EAPA in 2011.

On the 8th of December 2017, the Employment, Social Policy, Health and Consumer Affairs Council adopted conclusions on cross-border aspects in alcohol policy. EU Member States were invited to continue to integrate the objective of reducing alcohol-related harm into all relevant national policies, such as policies likely to have an impact on the prices of alcoholic

beverages as well as policies aimed at regulating marketing and alcohol selling arrangements, as recommended in the Council conclusions on Health in All Policies[2].

The EAPA is strengthening the monitoring and national public health responses needed to progress in implementing the global alcohol strategy, and is closely linked to the interventions in the European Strategy for the Prevention and Control of NCDs Diseases (2012–2016) and to the European health policy, Health 2020. The EAPA contains a portfolio of recommended evidence-based policy options and interventions, collated into 10 specific action areas.

After eight years since the EAPA endorsement by Member States, alcohol per capita consumption and related harm in the WHO European Region, including the EU, continues to be the highest in the world. Furthermore, across a number of European countries, people of low socioeconomic status have a several-fold higher mortality risk from alcohol compared to people with high socioeconomic status, contributing to social inequalities in health. Recent analysis of all the EAPA implementation areas linked to "WHO Best-buys" has shown that "Availability" (area 5), "Marketing" (area 6) and "Pricing polices" (area 7) had the lowest implementation rate, and that for the area "Reducing the negative consequences of drinking and alcohol intoxication" (area 8) only two countries have a legal requirement for warning labels on bottles or containers, despite alcohol being categorized as class I carcinogen by WHO. During the work with the 2015 Global Alcohol Policy Questionnaire, European Region Member States shared with WHO their experienced barriers to implementing effective alcohol policies to reduce harm. Commonly noted barriers were limited or reduced financial resources, lobbying and opposition from commercial interests in the alcohol area, a low level of cross-sectorial cooperation, lack of enforcement, slow political progress and lack of political willingness, cultural resistance and societal attitudes liberal to alcohol or intoxication.

To improve the implementation of the EAPA, policies to reduce the harmful use of alcohol must reach beyond the health sector, and appropriately engage a broad range of policy areas, as Member States' efforts to introduce measures to protect public health can be diluted by trade agreements, economic interest or exposure to such cross-border issues like advertising, including on-line advertising, and cross-border trade, including on-line sales. In this context, implementation of the best buys should be in place, thereby contributing to the achievement of SDG3 aimed to ensure healthy lives and promote well-being for all at all ages and the 2030 Agenda for Sustainable Development as such.

The WHO Regional Office for Europe is then convening a series of meetings to revisit the implementation of the policy areas for action defined in the EAPA, discuss achievements as well as the obstacles and the way forward. The information gathered from the meetings will feed into the next European action plan on alcohol and health and will provide Member States a roadmap for improved implementation at country level during the period leading to the endorsement of a new action plan. Two Regional consultations are planned in January; one with Member States and one with key stakeholder's representatives.

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[2]Council conclusions adopted on 30 November 2006 (16167/06).

Hosted by the Swedish Ministry of Health and Social Affairs, the European Region Member States Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020 will take place on **21-22 January 2019** at the Centralposthuset, Mäster Samuelsgatan 70, Stockholm, Sweden.

Specifically, at the meeting the Member States representatives will:

- assess the progress to achieve target of 10% reduction in alcohol consumption;
- discuss the current implementation of the European action plan to reduce the harmful use of alcohol 2012–2020 (EAPA);
- discuss the implementation of the best buys;
- identify barriers, challenges and possible ways to advance the EAPA implementation, namely in the areas of cross border issues: availability, pricing, marketing and labelling of alcohol products;
- define priority areas, key actors and regional facilitation for the EAPA implementation at country level;
- showcase success stories and innovative practices.

The meeting structure will involve group discussions and sharing of experiences among the Member States representatives. The working language of the meeting will be English.

Annex 2. Civil society consultation meeting: scope and purpose

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

/2

European Region Civil Society Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

Santo Tirso, Oporto, Portugal **17 December 2018**

28–29 January 2019 **Original: English**

Scope and purpose

Harmful use of alcohol is a leading factor for mortality worldwide. More than 3 million people died as a result of harmful use of alcohol in 2016. One million of those deaths occurred in the WHO European Region. In the EU Member States, Norway and Switzerland in 2016, 23% of all injury deaths and 42% of all traffic deaths were due to alcohol and most worrying, about every fifth death caused by alcohol was in the 15-19-year age group.

Several international frameworks identify the need for urgent action from a broad range of actors to reduce the harmful use of alcohol. In 2010, the sixty-third World Health Assembly endorsed the global strategy to reduce the harmful use of alcohol. In order to support countries in defining and implementing the 10 priority areas in the global strategy and make new commitments for reducing alcohol related harm, the WHO European Region adopted the European action plan to reduce the harmful use of alcohol 2012–2020 (EAPA). Fifty-three European Member States endorsed the EAPA in 2011.

The importance of civil society and community involvement in health policies has been recognized in many international documents, some of which were issued more than three decades ago, namely the Declaration of Alma-Ata, in 1978, and the Ottawa Charter, in 1986. More recently, Non-Governmental Organizations and professional associations have played a major role in furthering the Global Strategy to reduce Harmful use of alcohol and actively participated in the consultations that lead to the creation of both the EAPA and the WHO Global Action Plan on the Prevention and Control of NCDs.

However, after eight years since the EAPA endorsement by Member States, alcohol per capita consumption and related harm in the WHO European Region, including the EU, still continues to be the highest in the world. Furthermore, across a number of European countries, people of low socioeconomic status have a several-fold higher mortality risk from alcohol compared to people with high socioeconomic status, contributing to social inequalities in health.

To improve the implementation of the EAPA and strengthen the next step forward, policies to reduce the harmful use of alcohol must reach beyond the health sector, engaging different stakeholders in a broad range of policy areas and representatives of the civil society. Civil society has a prominent role in this context as they can help to overcome different views and perspectives while giving a voice to communities, including vulnerable populations. Moreover, they can bring scientific knowledge to the political debate. In addition they can contribute to translate research into practical action and share experience from implementing

alcohol policy and preventive work at the local. Civil society and community monitoring of the progress is essential for strengthening the implementation of alcohol policies proven to have an impact. Synergies between the civil society, policy makers and professionals are essential in achieving the target of 10% reduction in alcohol consumption and alcohol-related harm.

The WHO Regional Office for Europe is convening a series of meetings to revisit the implementation of the policy areas for action defined in the EAPA, discuss achievements as well as the obstacles and the way forward.

To include the civil society in this consultation is key therefore, on 28-29 January 2019, the WHO Regional Office for Europe will gather selected civil society representatives working in the reduction of harmful use of alcohol and related policy areas in Santo Tirso, Oporto, Portugal.

Specifically, at the meeting, the Civil Society representatives are expected to;

- discuss the progress made to reduce the impact of the harmful use of alcohol on individuals, families and communities;
- identify what is needed to support the Member States in the implementation of the European action plan to reduce the harmful use of alcohol 2012–2020 **(**EAPA);
- identify barriers and challenges and possible ways forward in the areas of cross border issues: availability, pricing, marketing and labelling of alcohol products;
- define the contribution of civil society organizations for the EAPA implementation at country level and;
- showcase success stories and innovative practices.

The information gathered from the meetings will feed into the next European Action Plan on Alcohol and Health and will provide Member States a roadmap for improved implementation at country level during the period leading to the endorsement of a new action plan.

The meeting structure will involve group discussions and sharing of experiences among the civil society representatives. The working language of the meeting will be English.

Annex 3. Member States consultation meeting: list of participants

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

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European Region Member States
Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

Stockholm, Sweden
21–22 January 2019

18 January 2019
Original: English

Provisional list of participants

Member States

Czech Republic
Ms Eva Gajdošová
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Public Budgets
Ministry of Finance of the Czech Republic

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Inspectorate of Narcotic Drugs and Psychotropic Substances
Ministry of Health of the Czech Republic

Ms Jarmila Vedralová
National Drug Coordinator
Head of the Secretariat of the Government Council
for Drug Policy Coordination
Office of the Government of the Czech Republic

Estonia
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Ministry of Social Affairs

Mr Marek Uusküla
Head of Customs and Excise Policy Department
Ministry of Finance

Ms Anneli Sammel

Head of the Department of Disease Prevention
National Institute for Health Development
Ms Helen Noormets
Head of the Center for Health Marketing
National Institute for Health Development

Finland
Mr Ismo Tuominen
Ministerial Counsellor
Ministry of Social Affairs and Health

France
Mr Nicolas Prisse
National Drug Coordinator
Interministerial Mission for Combating Drugs and Addictive Behaviors

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Norway
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Royal Ministry of Health and Care Services
Member of the Coordinating Council for the implementation of the WHO Global Strategy to reduce the harmful use of alcohol

Portugal
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Directorate-General of Health

Dr. Manuel Cardoso
Deputy General-Director
Directorate-General for Intervention on Addictive Behaviours and Dependencies

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Alcoholic Beverages Taxation Department

Ministry of Finance

Mr Jorge Carvalho Quadros
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National Center for Mental Health and Anti-Drug Fighting

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Press Relations, European Affairs and International Relations
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Mr Viktor Zykov
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Federal Research Institute for the Organization and Informatization
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State Secretary Office

Ms Lucia Chromikova
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Undersecretary, Project Unit for the Implementation of Preventive Activities
Ministry of Health of Slovenia, Directorate for Public Health

Mr Marko Polocnlk
Undersecretary
Ministry of Finance of Slovenia

Sweden
Mr Mikael Lindman
Deputy Director
Ministry of Health and Social Affairs

Mr Johan Westlund
Legal Adviser
Ministry of Finance

Ms Karin Fuhr Lindqvist
Deputy Director
Ministry of Enterprise and Innovation

Ms Kajsa Kellerborg
Legal Adviser
Ministry of Finance

Ms Elisabet Aldenberg
Senior Adviser
Ministry of Health and Social Affairs

Ms Anna Bessö
Deputy Director-General
Public Health Agency of Sweden

United Kingdom of Great Britain and Northern Ireland
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Health Improvement: Drugs, Alcohol and Tobacco Division
Public Health England

Ms Louise Feeney
Alcohol Policy Team Leader
Scottish Government

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European Alcohol Policy Alliance

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Sheffield Alcohol Research Group
Health Economics and Decision Science
ScHARR, University of Sheffield

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ESADE Business School, Ramon Llull University

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Olga Oleinik
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and Control of Noncommunicable Diseases

Robyn Burton
Consultant

Rapporteur

David Cruz-e-Silva

Interpreter

Lyudmila Yurastova

Annex 4. Civil society consultation meeting: list of participants

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
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European Region Civil Society Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

Santo Tirso, Oporto, Portugal
28–29 January 2019

26 January 2019
Original: English

Provisional list of participants

Civil society organizations

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EU Policy Councillor
United European Gastroenterologists (UEG)

Stig Erik Sørheim
Head of International Department
Actis – Policy Network on Alcohol and Drugs
Norway
EURAD – Europe for Action on Drugs

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Public Health Associate
Youth Association No Excuse
Slovenia

Maria Sundelin
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Swedish Council of Information on Alcohol and Other Drugs - CAN

Eunan McKinney
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Alcohol Action Ireland
Mariana Almeida
Legal Adviser
Legal and Economic Department
Portuguese Association for Consumer Protection
North Delegation (DECO)

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Development manager
EHYT Finnish Association for Substance Abuse Prevention

Kristina Sperkova
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Peter Rice
Chair
Steering Group
Scottish Health Action on Alcohol Problems (SHAAP)

Patrick O'Sullivan
Chair of the Healthy Living Working Group of the CPME
The Standing Committee of European Doctors (CPME)

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VAD - Vereniging voor Alcohol- en andere Drugproblemen
(Association for Alcohol and other drug problems)

Rui Medeiros
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Association of European Cancer Leagues (ECL)
Member of the Board of Administration and Director of Research and Education Department LPCC-NRN Portuguese League Against Cancer

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Institute for Youth Participation, Health and Sustainable Development (IMZTR)

Wim van Dalen
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Dutch Institute for Alcohol Policy STAP

Nina Rehn-Mendoza
Director

Public Health
Nordic Welfare Centre

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João Romão
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Hosting institution

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Mayor of Santo Tirso
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Olga Oleinik
WHO European Office for the Prevention
and Control of Noncommunicable Diseases

Robyn Burton
Consultant

Rapporteur

David Cruz-e-Silva

Annex 5. Member States consultation meeting: agenda

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
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ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

European Region Member States
Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

Stockholm, Sweden
21–22 January 2019

14 January 2019
Original: English

Provisional Programme

Monday, 21 January 2019

12:30-13:00	**Registration**
13:00-13:20	**Welcoming remarks**
	Anders Nordström, Ambassador for Global Health, Sweden
	Bente Mikkelsen, Director NCDs and Promoting Health through the Life-course, WHO Regional Office for Europe
13:20-13:40	**Overview: Implementation status of the European action plan to reduce the harmful use of alcohol 2012–2020 (EAPA)** *Carina Ferreira Borges, Programme Manager, Alcohol and illicit drugs,* WHO Regional Office for Europe
13:40-14:20	**Round Table on EAPA implementation: success stories** Moderator: *Francisco Goiana-da-Silva*, consultant, WHO Regional Office for Europe
	Countries: Estonia, Lithuania, Scotland, Russian Federation
14:20-14:50	**Current assessment, barriers and challenges in the EAPA implementation in the context of availability and pricing** Chair: *Maria Renström*, consultant, WHO Regional Office for Europe
	Alcohol availability; *Thomas Karlsson*, National Institute for Health and Welfare, Finland Alcohol pricing; *Colin Angus*, Sheffield Alcohol Research Group, UK

14:50–15:00	Coffee break
15:00 -16:30	**Breakout session– availability and pricing**
16:30-17:00	Plenary discussion and outcomes
17:00–18.00	**Visit to a Systembolaget (Swedish Alcohol Monopoly) retail store**
19:00-20:00	**Social dinner**

Tuesday, 22 January 2019

8:45–09:30	**Current assessment, barriers and challenges in the EAPA implementation in the context of commercial communications and labeling** **Chair:** *Triinu Täht,* Ministry of Social Affairs, Estonia*
	Marketing of alcoholic beverages; *Mikaela Lindeman*, University of Helsinki, Finland Review of labelling in WHO European Region *; Eva Jane LLopis*, World Health Forum, Spain *Labelling in the EU context; Mariann Skar*, EUROCARE
09:30–11:00	**Breakout session - marketing and labeling**
11:00–11:30	Plenary discussion and outcomes
11:30-11:45	**Coffee break**
11:45-12:45	**Round Table: Moving forward with "best buys" as priority areas for improved EAPA implementation** Moderator: *Nicolas Prisse*, Interministerial Mission for Combating Drugs and Addictive Behaviours, France*
	Sweden* United Kingdom* Portugal* Finland*
12:45–13:45	Lunch break
13:45–14:15	**Presentation of the consultation preliminary report** *Francisco Goiana-da-Silva*, WHO Regional Office for Europe
14.15-14:20	**Closing remarks** *Maria Renström*, consultant, WHO Regional Office for Europe *Carina Ferreira Borges* Programme Manager, Alcohol and illicit drugs, WHO Regional Office for Europe

Annex 6. Civil society consultation meeting: agenda

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
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ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

European Region Civil Society Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

Santo Tirso, Oporto, Portugal
28–29 January 2019

26 January 2019
Original: English

Provisional Programme

Monday, 28 January 2019

08:30-09:00	**Registration**
09:00-09:30	**Welcoming remarks** *Joaquim Couto*, Mayor of Santo Tirso, Portugal *João Breda,* WHO Regional Office for Europe *Manuel Cardoso,* on behalf of the Secretary of State for Health, Portugal
09:30-09:50	**Overview: implementation status of the European action plan to reduce the harmful use of alcohol 2012–2020 (EAPA)** *Carina Ferreira Borges,* WHO Regional Office for Europe
09:50–10:30	**Round table** The role of civil society in the EAPA implementation: interaction with governing bodies Moderator: *Manuel Cardoso,* SICAD, Portugal *Wim Van Dalen,* European Center for Monitoring Alcohol Marketing (EUCAM/STAP) *Mariann Skar,* European Alcohol Policy Alliance (EUROCARE) *Lukas Galkus,* International Youth Health Organisation (YHO) *Kristina Sperkova,* IOGT International

10:30–10:50	Coffee/tea
10:50-11:20	**Round table** The role of civil society in the EAPA implementation: contributions and hands-on experiences Moderator: Francisco Goiana-da-Silva, WHO Regional Office for Europe *Peter Rice*, Scottish Health Action on Alcohol Problems (SHAAP) *Helena Cortez-Pinto,* United European Gastroenterologists (UEG) *Eunan McKinney,* Alcohol Action Ireland (AAI)
11:20 -12:20	**Active break** Visit to the International Contemporary Sculpture Museum
12:20 -12:30	Group photo
12:30 -13:30	Lunch break
13:30–13:50	**Current assessment, barriers and challenges in the EAPA implementation in the context of commercial communications** Chair: *Maria Renstrom*, WHO Regional Office for Europe Background paper on alcohol marketing *Mikaela Lindeman*, University of Helsinki, Finland Commercial communication in social media: the actual reality *João Romão*, GetSocial, Portugal
13:50–14:50	Breakout Session
14:50–15:20	Plenary discussion and outcomes
15:20–15:40	Coffee/tea
15:40-16:00	**Current assessment, barriers and challenges in the EAPA implementation in the context of labelling** Chair: *Mariana Almeida*, Portuguese Association for Consumer Protection North Delegation (DECO), Portugal Background paper on labeling of alcoholic beverages *Eva Jane LLopis*, University of Maastricht, Netherlands
16:00–17:00	Breakout session
17:00–17:30	Plenary discussion and outcomes
19:00–20:00	**Social dinner**

Tuesday, 29 January 2019

09:00–09:20	**Current assessment, barriers and challenges in the EAPA implementation in the context of pricing** Chair: *Jan Peloza*, Institute for Youth Participation, Health and Sustainable Development (IMZTR) Background paper on alcohol pricing *Colin Angus*, Sheffield Alcohol Research Group, UK
09:20–10:20	Breakout session
10:20–10:50	Plenary discussion and outcomes
10:50–11:10	Coffee/tea
11:10-11:30	**Current assessment, barriers and challenges in the EAPA implementation in the context of availability** Chair: *Fernando Araújo*, Faculty of Medicine, Porto University, Portugal Background paper on alcohol availability *Thomas Karlsson*, National Institute for Health and Welfare, Finland
11:30–12:30	Breakout session
12:30 -13:00	Plenary discussion and outcomes
13:00–14:00	Lunch break
14:00-15:00	**Round table: main conclusions of the European Region Civil Society Consultation** Moderator: *Mariann Skar,* European Alcohol Policy Alliance (*EUROCARE)* *Lauri Beekmann,* Nordic Alcohol and Drugs Policy Network (NordAN) *Crispin Acton*, Institute of Alcohol Studies *Nina Rehn-Mendoza,* Nordic Welfare Centre *Patrick O'Sullivan,* European Doctors
15:00–15:30	Plenary Discussion
15:30–15:50	Coffee/tea
15:50–16:10	**Preview of the draft report** *Francisco Goiana-da-Silva,* WHO Regional Office for Europe
16:10-16:30	**Closing remarks** *Maria Renstrom,* WHO Regional Office for Europe *Carina Ferreira Borges,* WHO Regional Office for Europe

Annex 7. Member States consultation meeting: background documents

WORLD HEALTH ORGANIZATION
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ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

European Region Member States Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

I - Breakout session: Current assessment, barriers and challenges for EAPA implementation in the context of Pricing and Availability

Background information – Pricing Policies

Of all alcohol policy measures, the evidence is perhaps strongest for the impact of alcohol prices on alcohol consumption and alcohol-related harm. Yet it is still one of the most difficult interventions to implement. In the WHO European Region less than 30% of countries have implemented effective pricing policies, one of the WHO's "best buys" in alcohol control policies and widely considered to be the most effective policy measure.

One of the main reason seems to be linked to the involvement of several actors. They include those who are responsible for alcohol pricing and tax policy; for licensing the production, distribution and sale of alcohol; for regulating and monitoring commercial communications on alcohol; for identifying and stamping out illegally produced and traded alcohol; for transport. Cross-border trade can also complicate policy considerations for alcohol taxes. Although, the national health policies belong to the jurisdiction of Member States (Article 168 in the Treaty on the Functioning of the European Union) several problems are not easily solved at a national level. Countries' within the EU but also outside the EU's efforts to introduce measures to protect public health can be diluted by exposure to such cross-border issues like advertising, including on-line advertising, and cross-border trade, including on-line sales or acquisitions by private individuals. Fr example, lower prices in neighbouring countries attract cross-border shoppers and effectively reduce the average price of alcohol in the Member States with high taxation. The existence of a substantial illicit or informal market for alcohol can also complicate the policy considerations for alcohol taxes. One recent important document in this area is the Council conclusions on cross-border alcohol policy aspects, adopted by ministers at the meeting of the Employment, Social Policy, Health and Consumer Affairs Council on 8th of December 2017.

Tax increases do not necessarily result in higher prices, since producers, distributors and retailers may choose to adjust prices to compensate for higher taxes, sometimes even selling alcoholic beverages below cost. This tactic can be foiled by setting a minimum price per gram of alcohol. The

setting of alcohol taxes and other pricing policies is a complex process which must balance many, often competing, considerations. The protection of health should be a key consideration in this process, particularly when one also considers the burden which alcohol-related ill health places on healthcare services and the economy more broadly.

Instructions

1. Each group will be facilitated by a discussion leader and rapporteur. The group discussions should concretize both barriers, challenges and ways forward to implement the EAPA identified best buys – pricing policy.
2. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the way forward to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider on Pricing Policies

A. What has been done – and what can further be done to increase public health considerations when setting alcohol tax policies?
    - What is needed and possible at national level? And at European and/or global level?
    - What could be done in the short term and in the longer term?

B. What has been done – and what can further be done to reduce the availability of very cheap alcohol?
    - Are minimum unit prices an option? And if yes, what is needed and possible at national level? At European/Global level? And if not? Why not?
    - What other options recommended by WHO – besides minimum prices – have been introduced? For example, have taxes been adjusted to inflation?

C. How have alcohol pricing policies been balanced to meet the challenges from the illegal market, cross border trade or from private import?

D. To what extent is the barrier to implement effective pricing policies due to lack of better international evidence or lack of better evidence that is specific to your country?

Background information - Availability

Studies show that the more alcohol is available, the more it is consumed and the greater the harm that results. The implementation of even small reductions in the availability of alcohol can bring health gains and reduce violence and harm to people other than the drinker. The best available evidence, showing both reductions in alcohol use and alcohol-related problems, comes from studies regarding retail availability, such as restricting hours and days of sale, limiting the number of outlets restricting retail sales of alcohol and raising the minimum age limits. In addition of being effective, these strategies are also cost-effective as most of them are very cheap to implement. When implementing strategies to restrict alcohol availability, they should preferably be combined with concerted actions between the national authorities, licensing officers, the police, criminal justice systems and the social and health care sector. They should also be combined with actions to inform the citizens on the public health and social achievements gained by reducing the harmful use of alcohol.

Instructions

1. Each group will be facilitated by a discussion leader and rapporteur. The group discussions should concretize both barriers, challenges and ways forward to implement the EAPA identified best buys – restrictions on availability.
2. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the way forward to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider on Availability Policies

A. Most restrictions on availability are cost-effective and within countries own competence to implement.
   - What has been done – and can further be done to reduce alcohol availability? Is reducing the density and opening hours an option? If not, why not?
   - Is increasing the minimum purchase age to 21 years be a possible consideration? What other options?

B. What are the most common barriers and challenges restricting alcohol availability?

C. What kind of support from the research society, international organizations and policy makers would facilitate increased implementation in the area of availability?

II - Breakout session: Current assessment, barriers and challenges for EAPA implementation in the context of Labeling and Commercial Communications

Background information – Commercial Communications

The extent and breadth of commercial communications on alcohol and their impact, particularly on young people's drinking, should not be underestimated. There are many ways to limit exposure to commercial communications, ranging from avoiding the use of humour and glamour and other youth-appealing aspects, to avoiding sponsorship and television and cinema advertising, all the way up to a complete ban.

Although most countries in the region have some form of marketing regulation, very few have statutory bans to limit the marketing of alcohol beverages. In contrast with the work on tobacco control, there has not been an international or regional framework instrument with guidelines for implementation to underlay and support initiatives to regulate alcohol advertisement and promotion, including digital marketing.

A systematic review of longitudinal studies found associations between youth exposure to alcohol marketing and initiation of alcohol use, and others clear associations between exposure and subsequent binge or hazardous drinking. Albeit a less researched area, also sponsoring of sport-events has been shown to have an impact on young audiences. Most studies look at how exposure of alcohol advertising via traditional marketing channels (TV, print media) affect its audiences, but recently more focus has been directed towards internet milieus and Social Media with worrying

features in a new online reality. New marketing investments are made into subtler Internet-based advertising expressions, setting new challenges from a legislative and regulatory point of view. New marketing techniques undermine also the protection of citizens in their right to move freely on the internet without becoming free marketers of harmful products. Today, health policies must consider the protection of online whereabouts as a space of human communication and socialization. A tangible question for public health policies has become how to stay accountable to citizens in scenarios when digital technology creates advanced records and predictions of consumer behaviours and settings where personal information is increasingly a commodity that is traded – and exploited.

The new so called native advertising techniques makes restrictions on commercial communication to protect young people and restrict alcohol marketing an extensive, yet crucial task. The new techniques have revealed that there is a great need to develop a protocol for discerning native advertising, user-generated content and other difficult to grasp commercial messages whose real message sender are invisible to consumer, especially young consumers and children. As many young people partake in social media milieus as a natural part of their everyday life, the very least Implementation of age-limits on for example their Facebook and Instagram pages is a small and easy technicality. This is a minimal demand for ensuring that under aged followers will not get access to alcohol-related posts, and to protect children and teenagers.

Monitoring tools, like the one created by WHO for supervising marketing of foods and non-alcoholic beverages high in saturated fat, salt and/or free sugars that are directed towards children, are being developed by WHO. Protocols like these enable shared understandings among countries on what marketing is, and to get comparable datasets on the extent of the phenomena. The objective of alcohol marketing regulation is to substantially reduce or eliminate the exposure to alcohol advertising, promotion, and sponsorships as a means to reduce harms from drinking, particularly by reducing early initiation among young people and promotion of drinking to groups in conditions of vulnerability. The global nature of alcohol marketing, and the ease with which it transcends national borders, necessitates regional and global as well as national responses.

Instructions

1. Each group should select a discussion leader and rapporteur. The group discussions should concretize both barriers, challenges and ways forward to implement the EAPA policy options – commercial communications.

2. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the way forward to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider on Commercial Communications

A. Total ban VS partial bans. With the multiple channels, native advertising etc. is it possible to develop partial bans and enforce them? Would the only option today be a total ban?

B. Are there any plans to develop improved national legislation/regulations for separating native advertising from editorial material? For example, as in Finland where brands operating in social

media are not allowed to use user-generated content and are not allowed to produce content that is explicitly intended for sharing.

C. Are there any studies in your countries on what marketing techniques are used to market alcoholic beverages to children and young people?

D. Are there any plans in your countries to change alcohol marketing regulations? If, yes, what plans? If no, why?

E. Do you have any recommendations on what would be priority number one to protect citizens, especially children and young people from alcohol beverages commercial messages in all types of media?

Background information - Labelling

It is the right of the consumers to make informed choices about the products they purchase, and it is the obligation of public institutions to ensure consumers are able to do so. Labels could be considered as part of a comprehensive strategy to provide information and educate consumers to prevent and reduce alcohol-related harm. This policy option should be seen not as an initiative that will modify behaviour overnight, but as a way of bringing gradual change over time. As an option for action, WHO proposes that measures could be taken to introduce a series of health and ingredients and nutritional information on all alcoholic beverage containers providing information both on ingredients and on the risks associated with alcohol consumption.

In European surveys, most consumers agree that the same nutritional and ingredient information should be provided for all food and drink products, regardless of whether they contain alcohol or not. Consumers appear to be keen to receive more information the WHO European Region has seen some progress on these calls for both nutritional and ingredients information as well as health warning labels.

National food-labelling laws and regional and international conventions and agreements that are relevant to labelling of alcoholic beverages exist. In 2011, the Eurasian Customs Union adapted the Technical Regulation on Food Products Labelling and on Food Safety for Belarus, Kazakhstan and the Russian Federation, with product manufacturing, ingredients' listing and nutritional information, becoming mandatory by 2016, requiring labelling in Russian as well as in the national language(s) of the country where the product is sold. Additional marks of voluntary certification systems or voluntary health warnings may be featured on the label. In March 2017, the European Commission (EC) published its report on alcohol labelling, as required by Regulation (EU) No 1169/2011 which had at the time exempted alcoholic beverages containing more than 1.2% ABV from mandatory listing of ingredients and the nutrition declaration. The EC found no objective grounds to justify the continued absence of ingredients or nutritional information on alcoholic beverages (with greater than 1.2% ABV), nor differentiated treatment for some alcoholic beverages, such as 'alcopops'. The report gave alcohol producers one year to deliver a self-regulatory proposal that covers all alcoholic beverages. In March 2018, the alcohol industry produced a proposal (with three different sector annexes), allowing the possibility to provide this information either on label or off label in a non-standardized way, which does not seem to meet consumers' expectations. Health warnings were not considered in this proposal. The latest development is that with the discussions on the Common

Agricultural Policy the wine producers are proposing to introduce a separate labelling regime governed by DG AGRI. The proposal opens up a possibility for three different labelling schemes just for the alcohol products and could create fragmentation in the way information is given to the consumers.

Beyond the above industry non-alignment on how to move towards self-regulation, concerns remain given the lack of cohesiveness in the proposals, the differing levels of adherence to the suggested actions and the little attention to health warnings (but a few and scattered exceptions, such as warnings around drinking during pregnancy). Discussion of legislative and regulatory frameworks at national level that include both health warnings and nutritional information, might be of assistance to support further EAPA implementation.

Instructions

1. Each group should select a discussion leader and rapporteur. The group discussions should concretize both barriers, challenges and ways forward to implement the EAPA policy options – labelling (which includes both nutrition/ingredients information and health warnings).

2. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the way forward to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider on Labelling

A. Is this a topic of interest in your country?

   - Have there been any nutrition information/ingredients listing attempts (legislation -attempted or successful-, industry self-regulation, etc.) or are there plans to include in labels in alcoholic beverages in your country? If so, could you please provide any materials, reports or existing information?

   - Have there been any health warning attempts (legislation -attempted or successful-, industry self-regulation, etc.) or are there plans to include in labels in alcoholic beverages in your country? If so, could you please provide any materials, reports or existing information?

   - If any of the above is a yes, are there any insights on barriers and facilitators that made such attempts successful or unsuccessful? If yes, could you please provide any materials, reports or existing information?

B. Are there any follow ups of the Estonian Council Conclusions, which clearly asked for labelling to be solved within this Commission? If yes – give examples; If no – what could be done?
C. Is there a need to have an internationally agreed product information and health warning messages that should be included in alcohol beverages to ensure consumers can exert their right to product information?
D. What would facilitate / help advancements in the implementation of EAPA labelling in your country? What hinders or stops discussions on these issues in your country?

Annex 8. Civil society consultation meeting: background documents

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

European Region Civil Society Consultation on the implementation and achievements of the European action plan to reduce the harmful use of alcohol 2012–2020

Santo Tirso, Oporto, Portugal
28–29 January 2019

15 January 2019
Original: English

I - Breakout session: Current assessment, barriers and challenges for EAPA implementation in the context of Pricing Policies

Of all alcohol policy measures, the evidence is perhaps strongest for the impact of alcohol prices on alcohol consumption and alcohol-related harm. Yet it is still one of the most difficult interventions to implement. In the WHO European Region less than 30% of countries have implemented effective pricing policies, one of the WHO's "best buys" in alcohol control policies and widely considered to be the most effective policy measure.

One of the main reason seems to be linked to the involvement of several actors. They include those who are responsible for alcohol pricing and tax policy; for licensing the production, distribution and sale of alcohol; for regulating and monitoring commercial communications on alcohol; for identifying and stamping out illegally produced and traded alcohol; for transport. Cross-border trade can also complicate policy considerations for alcohol taxes. Although, the national health policies belong to the jurisdiction of Member States (Article 168 in the Treaty on the Functioning of the European Union) several problems are not easily solved at a national level. Countries' within the EU but also outside the EU's efforts to introduce measures to protect public health can be diluted by exposure to such cross-border issues like advertising, including on-line advertising, and cross-border trade, including on-line sales or acquisitions by private individuals. Fr example, lower prices in neighbouring countries attract cross-border shoppers and effectively reduce the average price of alcohol in the Member States with high taxation. The existence of a substantial illicit or informal market for alcohol can also complicate the policy considerations for alcohol taxes. One recent important document in this area is the Council conclusions on cross-border alcohol policy aspects, adopted by ministers at the meeting of the Employment, Social Policy, Health and Consumer Affairs Council on 8th of December 2017.

Tax increases do not necessarily result in higher prices, since producers, distributors and retailers may choose to adjust prices to compensate for higher taxes, sometimes even selling alcoholic

beverages below cost. This tactic can be foiled by setting a minimum price per gram of alcohol. The setting of alcohol taxes and other pricing policies is a complex process which must balance many, often competing, considerations. The protection of health should be a key consideration in this process, particularly when one also considers the burden which alcohol-related ill health places on healthcare services and the economy more broadly.

Instructions

1. Each group will be facilitated by a discussion leader and rapporteur.

2. The group discussions should concretize on how Civil Society Organizations (CSO) could support and contribute to the implementation of the EAPA identified best buys – pricing policies.

3. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the CSOs role and on the way forward, to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider on Pricing Policies

A. What has been the role of the CSOs to further increase public health considerations in the context of alcohol tax policies?
   - What is needed and possible at national level?
   - What is needed and possible at European and/or global level?
   - What could be done in the short term and in the longer term?

B. What has been done – and what can further be done to reduce the availability of very cheap alcohol?

C. What do you know of (and what have your organization contributed with) how alcohol pricing policies have been balanced to meet the challenges from the illegal market, cross border trade or from private import? How have economic operators' arguments influenced civil society positions and what has been done to mitigate this influence?

D. To what extent is the barrier to implement effective pricing policies due to lack of better international evidence or lack of better evidence that is specific to your country?

II - Breakout session: Current assessment, barriers and challenges for EAPA implementation on Availability

Studies show that the more alcohol is available, the more it is consumed and the greater the harm that results. The implementation of even small reductions in the availability of alcohol can bring health gains and reduce violence and harm to people other than the drinker. The best available evidence, showing both reductions in alcohol use and alcohol-related problems, comes from studies regarding retail availability, such as restricting hours and days of sale, limiting the number of outlets restricting

retail sales of alcohol and raising the minimum age limits. In addition of being effective, these strategies are also cost-effective as most of them are very cheap to implement.

When implementing strategies to restrict alcohol availability, they should preferably be combined with concerted actions between the national authorities, licensing officers, the police, criminal justice systems and the social and health care sector. They should also be combined with actions to inform the citizens on the public health and social achievements gained by reducing the harmful use of alcohol.

Instructions

1. Each group will be facilitated by a discussion leader and rapporteur.

2. The group discussions should concretize on how Civil Society Organizations (CSO) could support and contribute to the implementation of the EAPA identified best buys – reducing availability.

3. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the CSOs role and on the way forward, to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider on Availability Policies

A. Most restrictions on availability are cost-effective and within countries own competence to implement. For example, hours and days of sale, limiting the number of outlets restricting retail sales of alcohol and raising the minimum age limits are even relatively cheap to implement. Even so, several countries have not yet fully done so. Why? Identify the most common barriers and challenges for the implementation.

B. Identify possible ways forward, what is needed to improve, and what would be the role of CSOs to improve the implementation of policies that restrict availability. Would increasing the minimum purchase age to 21 years be a possible consideration? What other options?

C. What kind of support from the research society, international organizations and policy makers would facilitate increased implementation in the area of availability?

III - Breakout session: Current assessment, barriers and challenges for EAPA implementation in the context of Commercial Communications

The extent and breadth of commercial communications on alcohol and their impact, particularly on young people's drinking, should not be underestimated. There are many ways to limit exposure to commercial communications, ranging from avoiding the use of humour and glamour and other youth-appealing aspects, to avoiding sponsorship and television and cinema advertising, all the way up to a complete ban. Although most countries in the region have some form of marketing regulation, very few have statutory bans to limit the marketing of alcohol beverages. In contrast with the work on

tobacco control, there has not been an international or regional framework instrument with guidelines for implementation to underlay and support initiatives to regulate alcohol advertisement and promotion, including digital marketing.

A systematic review of longitudinal studies found associations between youth exposure to alcohol marketing and initiation of alcohol use, and others clear associations between exposure and subsequent binge or hazardous drinking. Albeit a less researched area, also sponsoring of sport-events has been shown to have an impact on young audiences. Most studies look at how exposure of alcohol advertising via traditional marketing channels (TV, print media) affect its audiences, but recently more focus has been directed towards internet milieus and Social Media with worrying features in a new online reality. New marketing investments are made into subtler Internet-based advertising expressions, setting new challenges from a legislative and regulatory point of view. New marketing techniques undermine also the protection of citizens in their right to move freely on the internet without becoming free marketers of harmful products. Today, health policies must consider the protection of online whereabouts as a space of human communication and socialization. A tangible question for public health policies has become how to stay accountable to citizens in scenarios when digital technology creates advanced records and predictions of consumer behaviours and settings where personal information is increasingly a commodity that is traded – and exploited.

The new so called native advertising techniques makes restrictions on commercial communication to protect young people and restrict alcohol marketing an extensive, yet crucial task. The new techniques have revealed that there is a great need to develop a protocol for discerning native advertising, user-generated content and other difficult to grasp commercial messages whose real message sender are invisible to consumer, especially young consumers and children. As many young people partake in social media milieus as a natural part of their everyday life, the very least Implementation of age-limits on for example their Facebook and Instagram pages is a small and easy technicality. This is a minimal demand for ensuring that under aged followers will not get access to alcohol-related posts, and to protect children and teenagers. Monitoring tools, like the one created by WHO for supervising marketing of foods and non-alcoholic beverages high in saturated fat, salt and/or free sugars that are directed towards children, are being developed by WHO. Protocols like these enable shared understandings among countries on what marketing is, and to get comparable datasets on the extent of the phenomena.

The objective of alcohol marketing regulation is to substantially reduce or eliminate the exposure to alcohol advertising, promotion, and sponsorships as a means to reduce harms from drinking, particularly by reducing early initiation among young people and promotion of drinking to groups in conditions of vulnerability. The global nature of alcohol marketing, and the ease with which it transcends national borders, necessitates regional and global as well as national responses.

Instructions

1. Each group will be facilitated by a discussion leader and rapporteur. The group discussions should concretize on how Civil Society Organizations (CSO) could support and contribute to the implementation of the EAPA identified best buys – commercial communications.

2. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the CSOs role and on the way forward, to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider the context of Commercial Communications

A. Total ban contra- partial bans? Cons and pros. With the multiple channels, native advertising etc. is it possible to develop partial bans and enforce them?

B. Do you know of any/are you involved in any plans to develop improved national legislation/regulations for separating native advertising from editorial material? For example, as in Finland where brands operating in social media are not allowed to use user-generated content and are not allowed to produce content that is explicitly intended for sharing.

C. Do you know of any/are you involved in any studies at European level or in your countries on what marketing techniques are used to market alcoholic beverages to children and young people?

D. Do you know of any/are you involved in any plans at European level or in your countries to change alcohol marketing regulations? If, yes, what plans? If no, why?

E. Do you have any recommendations on what would be priority number one to protect citizens, especially children and young people from alcohol beverages commercial messages in all types of media?

IV - Breakout session: Current assessment, barriers and challenges for EAPA implementation in the context of Labelling

It is the right of the consumers to make informed choices about the products they purchase, and it is the obligation of public institutions to ensure consumers are able to do so. Labels could be considered as part of a comprehensive strategy to provide information and educate consumers to prevent and reduce alcohol-related harm. This policy option should be seen not as an initiative that will modify behaviour overnight, but as a way of bringing gradual change over time. As an option for action, WHO proposes that measures could be taken to introduce a series of health and ingredients and nutritional information on all alcoholic beverage containers providing information both on ingredients and on the risks associated with alcohol consumption.

In European surveys, most consumers agree that the same nutritional and ingredient information should be provided for all food and drink products, regardless of whether they contain alcohol or not. Consumers appear to be keen to receive more information the WHO European Region has seen some progress on these calls for both nutritional and ingredients information as well as health warning labels.

National food-labelling laws and regional and international conventions and agreements that are relevant to labelling of alcoholic beverages exist. In 2011, the Eurasian Customs Union adapted the Technical Regulation on Food Products Labelling and on Food Safety for Belarus, Kazakhstan and the Russian Federation, with product manufacturing, ingredients' listing and nutritional information, becoming mandatory by 2016, requiring labelling in Russian as well as in the national language(s) of

the country where the product is sold. Additional marks of voluntary certification systems or voluntary health warnings may be featured on the label. In March 2017, the European Commission (EC) published its report on alcohol labelling, as required by Regulation (EU) No 1169/2011 which had at the time exempted alcoholic beverages containing more than 1.2% ABV from mandatory listing of ingredients and the nutrition declaration. The EC found no objective grounds to justify the continued absence of ingredients or nutritional information on alcoholic beverages (with greater than 1.2% ABV), nor differentiated treatment for some alcoholic beverages, such as 'alcopops'. The report gave alcohol producers one year to deliver a self-regulatory proposal that covers all alcoholic beverages. In March 2018, the alcohol industry produced a proposal (with three different sector annexes), allowing the possibility to provide this information either on label or off label in a non-standardized way, which does not seem to meet consumers' expectations. Health warnings were not considered in this proposal. The latest development is that with the discussions on the Common Agricultural Policy the wine producers are proposing to introduce a separate labelling regime governed by DG AGRI. The proposal opens up a possibility for three different labelling schemes just for the alcohol products and could create fragmentation in the way information is given to the consumers.

Beyond the above industry non-alignment on how to move towards self-regulation, concerns remain given the lack of cohesiveness in the proposals, the differing levels of adherence to the suggested actions and the little attention to health warnings (but a few and scattered exceptions, such as warnings around drinking during pregnancy). Discussion of legislative and regulatory frameworks at national level that include both health warnings and nutritional information, might be of assistance to support further EAPA implementation.

Instructions

1. Each group will be facilitated by a discussion leader and rapporteur. The group discussions should concretize on how Civil Society Organizations (CSO) could support and contribute to the implementation of the EAPA identified policy option – labelling (which includes both nutrition/ingredients information and health warnings).

2. The discussion outcome should focus on some conclusions for the consultation report and concrete suggestions on the CSOs role and on the way forward, to be included in the final regional report on progress in the implementation of the EAPA.

Questions to consider on Labelling

A. Is this a topic of interest in your country? Is this a topic that engages NGOs at national, European of Global Level?
   - Have there been any nutrition information/ingredients listing attempts (legislation -attempted or successful-, industry self-regulation, etc.) or are there plans to include in labels in alcoholic beverages in your country? If so, could you please provide any materials, reports or existing information? If yes, is your organization involved?

   - Have there been any health warning attempts (legislation -attempted or successful-, industry self-regulation, etc.) or are there plans to include in labels in alcoholic beverages in your country? If so, could you please provide any materials, reports or existing information? If yes, is your organization involved?

- If any of the above is a yes, are there any insights on barriers and facilitators that made such attempts successful or unsuccessful? If yes, could you please provide any materials, reports or existing information?

B. Do you know of any follow ups of the Estonian EU Council Conclusions, which clearly asked for labelling to be solved within this Commission? If yes – give examples; If no – what could be done to support MS to do so?

C. Is there a need to have an internationally agreed product information and health warning messages that should be included in alcohol beverages to ensure consumers can exert their right to product information?

D. What would facilitate / help advancements in the implementation of EAPA labelling at national and/or European level? What hinders or stops discussions on these issues in your country/organization?

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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France
Georgia
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Hungary
Iceland
Ireland
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Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
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