



**Action Plan on Youth Drinking
and on Heavy Episodic Drinking (Binge Drinking)
(2014–2016)**

Endorsed by CNAPA

Progress evaluation report





Co-funded by
the European Union

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ABSTRACT

In September 2014, European Union (EU) Member States, represented by the Committee on National Alcohol Policy and Action (CNAPA), endorsed the Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) (2014–2016). The Action Plan was intended to complement the EU Strategy to Support Member States in Reducing Alcohol-related Harm and to provide a means to strengthen long-standing alcohol policy implementation in Member States while addressing key identified areas – namely, youth drinking and heavy episodic drinking. As agreed by CNAPA on 22 March 2017, the Action Plan was extended until 2020. This report documents progress made in the activities that took place during the first period of the Action Plan, i.e. 2014–2016. It focuses on the 20 operational objectives that make up the plan's six action areas, using nine different data sources. The report indicates that Member States progressed in most of the six action areas; it further suggests that there is a need for better monitoring and support in policy implementation to ensure that a coordinated European alcohol policy with impact at country level can be maintained. The Action Plan appears to have been beneficial to the countries covered as it contained a clear framework for action at EU level that complemented and reinforced other valid strategies and action plans, while addressing the needs identified by CNAPA members. Guided by the wealth of data and results in this evaluation, we identify priorities for future concerted action from EU Member States, as well as priorities for future research.

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KEYWORDS

ALCOHOL CONSUMPTION
BINGE DRINKING
ALCOHOL HARM
MONITORING AND SURVEILLANCE
ALCOHOL POLICIES
ACTION PLAN ON YOUTH DRINKING AND ON HEAVY EPISODIC DRINKING

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Acknowledgements

This report was produced by the Alcohol and Drugs Programme of the WHO Regional Office for Europe and the WHO European Office for the Prevention and Control of Noncommunicable Diseases, headed by Dr João Breda; the work was carried out under the leadership of Dr Bente Mikkelsen, Director of the Division of Noncommunicable Diseases and Promoting Health through the Life-course of the WHO Regional Office for Europe, and in collaboration with the European Commission.

The WHO Regional Office for Europe would like to thank Professor Kim Bloomfield, Maj Nygaard-Christensen and Line Helland Boelskifte, from the Centre for Alcohol and Drug Research, Aarhus University, Denmark, who prepared the first and second drafts of this report. We are greatly indebted to PD Dr phil. Ulrike Grittner for her invaluable help with extensive recoding of the 2014 and 2016 Global Surveys on Alcohol and Health and transfer into SPSS, as well as graphical illustration, of the survey data. Dr Carina Ferreira-Borges, WHO European Office for Prevention and Control of Noncommunicable Diseases, as well as Dr Lars Møller and Ms Julie Brummer, also provided comments and suggestions on the first draft.

The World Health Organization wishes to thank the Committee on National Alcohol Policy and Action (CNAPA) editorial group of experts for valuable comments and suggestions on the first full draft of the report, which was discussed at a meeting in Edinburgh on 18 November 2018. Members of the editorial group were: Mr Cees Goos, European Centre for Social Welfare Policy and Research, Vienna, Austria; Professor Emanuele Scafato, National Health Institute, Rome, Italy, and WHO Collaborating Centre for Research and Health Promotion on Alcohol and Alcohol-related Health Problems; Dr Manuel Cardoso, Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD), Lisbon, Portugal; Dr Peter Rice, Scottish Health Action on Alcohol Problems (SHAAP), Edinburgh, United Kingdom; Ms Triinu Täht, Estonian Ministry of Social Affairs, Tallinn, Estonia; Ms Mariann Skar, Eurocare, Brussels, Belgium; and Lisa Schölin, WHO consultant.

The final version was prepared by Dr Pi Högberg and edited by Dr Carina Ferreira Borges, Professor Emanuele Scafato and Dr Lars Møller.

This document was produced with the financial assistance of the European Union. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

The report was also made possible through the support from the Government of Norway and the Government of the Russian Federation within the context of the Office for the Prevention and Control of Noncommunicable Diseases.

Abbreviations

abv	alcohol by volume
AVMSD	Audiovisual Media Services Directive
BAC	blood alcohol concentration
Chafea	Consumers, Health, Agriculture and Food Executive Agency
CNAPA	Committee on National Alcohol Policy and Action
EAHF	European Alcohol and Health Forum
EC	European Commission
ECHI	European Core Health Indicators
EISAH	European Information System on Alcohol and Health
EPHA	European Public Health Alliance
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
EUSAH	European Union Information System on Alcohol and Health
FAS	fetal alcohol syndrome
FASD	fetal alcohol spectrum disorder
GISAH	Global Information System on Alcohol and Health
GSRAH	<i>Global status report on alcohol and health</i>
HBSC	Health Behaviour in School-aged Children
HED	heavy episodic drinking
HiAP	Health in All Policies
Joint Action RARHA	Joint Action on Reducing Alcohol Related Harm
ND–AE	neurodevelopmental disorder–alcohol exposed
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
SDGs	Sustainable Development Goals
SEAS	standardized European alcohol survey
SiE	STAD in Europe
SUD	substance use disorder
WHO	World Health Organization

Summary

On 16 September 2014, European Union (EU) Member States, represented by the Committee on National Alcohol Policy and Action (CNAPA), endorsed the Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) (2014–2016).¹ The Action Plan was intended to complement the EU Strategy to Support Member States in Reducing Alcohol-related Harm² and to provide a means to strengthen long-standing policy implementation work from Member States in the area of alcohol while addressing key identified areas, namely youth drinking and heavy episodic drinking (HED). In an EU-funded assignment to the World Health Organization (WHO) Regional Office for Europe to evaluate the activities that took place during the period of the Action Plan, this report focuses on the 20 operational objectives that make up the plan's six action areas, using seven different data sources. As there is a scarcity of specific data to assess the period 2014–2016, some actions described and assessed together correspond to a wider timeframe (predominantly 2010–2016). As agreed by CNAPA at its 20th meeting in Luxembourg on 22 March 2017, the Action Plan on Youth Drinking and on Heavy Episodic Drinking was extended until 2020. Hence, the present report may be regarded as a midterm or progress evaluation.

Action area 1. Reduce heavy episodic drinking (binge drinking)

Although many countries had already implemented a number of policies in the area of HED at the start of the Action Plan period, slight increases were observed in the number of countries that utilized further policy options set out in the plan. There was a slight increase in the number of countries using health information labels (from nine to 10 for advertisements, and from two to three for labels on containers) and an increase in the mean number of awareness-raising activities (from 3.2 to 4.5). Several countries reported alcohol tax rises during the study period, and there was also a slight increase in the number of countries using price policies other than taxation (from 10 to 11 countries). However, there was no change in the number of countries using server training to curb HED. Discussions in CNAPA during 2014–2016 on pricing and fiscal policies appear to have been limited.

Action area 2. Reduce accessibility and availability of alcoholic beverages for youth

Much of the policy in this area was already in place in 2014. There were increases in the legal age for purchasing spirits both on-premises (from 16 to 18 years) and off-premises (both from 16 to 18 years and from 18 to 20 years) in a small number of countries. Otherwise, most of these regulations were in place before 2012 and had not changed. The mean number of awareness-raising activities on accessibility and availability increased slightly. Eight countries reported specific activities in this area in the period 2014–2016; there were noteworthy new initiatives to curb accessibility and availability in Estonia, Ireland, Lithuania and Cyprus.

Action area 3. Reduce exposure of youth to alcohol marketing and advertising

A report from the European Commission (EC) on minors' exposure to alcohol marketing was published in 2015,³ and alcohol marketing in a broader perspective appears to have been a recurrent subject at CNAPA meetings during the Action Plan period. Seven EU countries reported increased scope and intensity of governmental policies and activities in the area of alcohol marketing in the period 2010–2015, and four countries reported new marketing and advertising regulations put in place during 2014–2016. It appears that more countries placed restrictions on alcohol advertising and sales sponsorship/promotion in 2016 than in 2012; however, with respect to alcohol sponsorship at youth events and sales promotion, there was a fall in the number of countries imposing bans that covered all beverage types.

Action area 4. Reduce harm from alcohol during pregnancy

A majority of countries reported that they had brief interventions to reduce or prevent drinking in pregnancy in place before 2014; only two countries added such programmes after 2014. Six countries reported that they had rehabilitation centres for alcohol-dependent pregnant women; all were initiated before 2014. No change was found in the number of countries that reported specific treatment options for pregnant women. As assessed by the publicly available meeting minutes from CNAPA meetings in the period 2014–2016, clinical guidelines for prevention, diagnosis and treatment of fetal alcohol spectrum disorders (FASDs) seem not to have been a subject for discussion at CNAPA meetings during this period. However, the number of countries reporting that they had awareness activities regarding alcohol and pregnancy rose from eight in 2012 to 17 in 2016. France was the only EU Member State in 2016 which had mandatory health information labels giving information about the dangers of drinking alcohol while pregnant. Lithuania has since followed suit.

Action area 5. Ensure a healthy and safe environment for youth

There was a slight increase in community support for alcohol-free activities and settings at an aggregate level. However, in parks and leisure environments, this development was slightly negative. One CNAPA meeting included a presentation given by Denmark in which preventive interventions for youth living in families with alcohol and substance abuse were addressed. Most efforts to provide treatment that promotes a family perspective and is family-centred were already underway in 2014. On the issue of drink–driving, a clear majority of countries reported increased scope and intensity of activities in 2015 compared to 2010.

Action area 6. Support monitoring and increase research

During the Action Plan period, the Joint Action on Reducing Alcohol Related Harm (RARHA) developed a standardized European alcohol survey, a toolkit on good practices for changing attitudes, and a comprehensive evidence base to support EU Member States on national low-risk drinking guidelines. Within the Third Health Programme, the EC provided funding of €3.3 million for six research, development and implementation projects on alcohol. At CNAPA meetings, monitoring was addressed on a number of occasions, with presentations from WHO and other monitoring actors. On the issue of government policies and activities in the area of monitoring and surveillance and their overall scope and intensity, a majority of countries reported that efforts had remained the same between 2010 and 2015. With respect to monitoring or research in the area of cross-border or online alcohol sales, two countries reported that they had conducted such activities, one before 2014 and one after. The EC co-funded an economic analysis on alcohol policy by the Organisation for Economic Co-operation and Development (OECD) published in 2015.

Conclusions

In principal, the Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) (2014–2016) is in line with other strategies and action plans in force within Europe and should therefore be seen as part of an ongoing effort from EU Member States, Norway and Switzerland to address harmful use of alcohol. The Action Plan seems to have been beneficial to the countries covered as it contained a clear framework for action at EU level that complemented and reinforced other valid strategies and action plans, while addressing the needs identified by CNAPA members. While acknowledging the Action Plan's important limitations, this evaluation report indicates that, generally speaking, countries moved in the same direction in determining their alcohol policy and activities in the six action areas; and that, for the most part, they moved in the desired direction, increasing regulations and establishing policies to discourage HED and underage alcohol consumption. However, the gains were very modest – there were no gains at all in some action areas, and mixed results in others (for example, in reducing exposure to marketing). The fact that

the policy gains were so small indicates the need for a stronger action plan. In future alcohol policy work – if more tangible progress in reducing youth drinking and HED is to be made – it will be essential to address more specifically commonly encountered barriers, such as limited or reduced financial resources, lobbying and opposition from stakeholders, and cultural resistance.

Finally, the wealth of data and results in this report was used to provide guidance for the remains of the extended Action Plan period (up to 2020) as well as for the planning of a possible follow-up action plan after 2020. As for policy, the following lessons can be learnt for more tangible results on the prevention of harm from HED and youth drinking:

- **Evidence-based actions.** Information campaigns and other awareness-raising or education activities were popular in Member States but are often costly and have not been shown, in isolation, to sustainably reduce HED or youth drinking. To maximize the impact of future action plans, information activities may be emphasized as a complement to, or component in, interventions with a stronger evidence base.
- **Implementation support.** Member States seemed to need more support in implementing Action Plan measures. Support can be facilitated at EU level through adequate funding and by using relevant, measurable indicators of achievement; by continuation of the strong EU/WHO monitoring system that is already in place; and through discussions in forums such as CNAPA, where country- or region-specific obstacles to implementation can be addressed.

As for research, the following priorities that can guide further policy-making were identified:

- **Support high-quality evaluations of interventions.** Scientific evaluations of any policy change to reduce HED and youth drinking should be supported, as such evaluations bring added value to the EU. A controlled stepwise introduction of new policy may be advisable to gain a good evidence base for possible effects.
- **Explore differential effects of alcohol policies on socioeconomic and demographic groups.** Research into the effects of alcohol prevention measures on equity in health in high-income countries is still scarce. By encouraging such studies in the EU, future alcohol action plans can be more specifically tailored to protect vulnerable groups and can contribute to a socially sustainable development in line with the Sustainable Development Goals (SDGs).
- **Explore correlations between policy and harm over time.** Policy initiatives in Member States during the Action Plan period have brought opportunities to examine the extent to which the presence and combination of alcohol policies account for national-level variations in related harm outcomes. An EU-wide approach is needed, and as policies continue to develop, Member States lagging behind in alcohol policy implementation can be provided with a better basis for evidence-informed decisions.

Introduction

The EU Strategy and its alcohol policy landscape

Already in June 2001, an EU Council Recommendation pointed out that changes in drinking patterns among adolescents, and especially binge drinking and heavy drinking among minors, were of particular concern.⁴ The Council Recommendation encouraged Member States and other relevant stakeholders to develop mechanisms designed to address the problems caused by alcohol abuse among young people. Despite positive trends in some EU Member States since that date, these concerns continue to be relevant.

In October 2006 the EC launched the EU Strategy to Support Member States in Reducing Alcohol-related Harm.² It focused on five priority themes, all of which were relevant to EU Member States and which were seen to benefit, or gain added value, from action at EU level:

- (1) protect young people, children and the unborn child;
- (2) reduce injuries and death from alcohol-related traffic accidents;
- (3) prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- (4) inform, educate and raise awareness of the impact of harmful and hazardous alcohol consumption, and of appropriate consumption patterns; and
- (5) develop, support and maintain a common evidence base.

Actions under the strategy were carried out at three levels: measures implemented by Member States at national level; coordination of national policies at EU level; and actions taken by the EC (including support for projects, research and cooperation with stakeholders). For each theme, the strategy identified good practices to be implemented at these various levels.⁵ The strategy was intended to run from 2007 to 2012, but it was still in force in 2018.

According to the first progress report on implementation of the EU Strategy, which was produced by EC services in 2009,⁶ it contributed to raising Member States' interest in developing a national strategy, supported the revision of already existing national strategies, and called for multi-stakeholder action in the EU. The progress report also concluded that the evidence base had continued to be refined, and that there had been a steady convergence of national actions towards good practices across Member States. An external evaluation of the EU Strategy carried out in 2012 confirmed the pertinence both of its comprehensive approach and of its priority themes; it also underlined the potential of the existing tools.⁵ Nevertheless, the evaluation made clear the need to improve the functioning of these tools and to target their action to ensure an increase in effectiveness.

It is important to note that in 2010 the 194 WHO Member States, including the EU Member States, approved the Global Strategy to Reduce the Harmful Use of Alcohol;⁷ and in 2012 the 53 Member States of the WHO European Region approved the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020.⁸ These three mechanisms – the EU Strategy, the Global Strategy and the European Action Plan, signed by all EU Member States – have created a framework for development of alcohol policies in individual countries.

The Committee on National Alcohol Policy and Action

CNAPA was one of three bodies established under the EU Strategy in 2007 and continues to play a major part in its implementation. In particular, its role is to support coordination between national and EU alcohol policy and to assist in further developing policy to reduce alcohol-related harm. CNAPA provides a platform for the exchange of information on Member State alcohol policies and for discussion of issues and measures across the five priority themes, as well as other issues, such as alcohol taxation and advertising. EU activities under the umbrella of the alcohol strategy and discussed in CNAPA have been seen to provide input to the development of national public health policies on alcohol.

The Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking), endorsed by CNAPA¹

The EU Strategy was not followed by a second one at the end of December 2012, despite the EU Council of Ministers acknowledging its importance and calling for a continuation (see, for example, the Council Conclusions on alcohol and health of 1 December 2009)⁹; the Council's view was shared by the 2012 external assessment of the strategy.⁵ In October 2013 the EC proposed to CNAPA the idea of an EU-wide action plan as a means to strengthen and reinforce the work of addressing specific areas of harmful alcohol consumption. Several discussions led to a decision to specify youth drinking and HED (binge drinking) as the two main objectives and to set a duration of two years.

The resulting Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) was developed within CNAPA through written consultations, phone conferences and an ad-hoc working group. The EC expressed its commitment to keep working on further development of EU alcohol policy in close cooperation with CNAPA. In order to seek broad support for the new plan, the European Alcohol and Health Forum (EAHF) – one of the other two bodies formed at the time of the establishment of the EU Strategy – was invited to comment and suggest actions for the Action Plan, to which EAHF stakeholders would be able to commit. Stakeholders across the EU were also invited to participate and to propose activities related to actions in the Action Plan. In 2013 a number of nongovernmental organizations (NGOs) at both national and European levels sent recommendations for actions for the Action Plan.

The Action Plan was intended to complement existing activities under the umbrella of the previous EU Strategy. It was also expected to help ensure that EU alcohol policy in general would be implemented comprehensively. It is important to point out that the Action Plan was complementary to the previous strategy, the five priority themes and aims of which remained valid. Furthermore, it was stressed that all stakeholders should continue to be encouraged to apply a comprehensive approach and to carry on the work of the EU Strategy and the Action Plan in tandem.

As one means of encouraging such “joined-up” activity, the EC launched the Joint Action on Reducing Alcohol Related Harm (RARHA) in 2014. The aim of this initiative was to devise a set of complementary tools to support development of both scientific evidence and policies – and, potentially, to encourage greater convergence of approaches to tackling alcohol-related harm.¹⁰

Main objectives, action areas and operational objectives of the Action Plan

The main objectives of the Action Plan were to address alcohol-related harm and HED (binge drinking) among young people; actions performed under the plan should support the goals of the EU Strategy to reduce alcohol-related harm. These objectives were selected to reflect Member States' “common concerns that significantly contribute to alcohol-related harm with long-term consequences”.¹ Ranged beneath these two main objectives were six action areas and a portfolio of

options in the form of operational objectives, which Member States could adjust as necessary to take account of national circumstances (such as cultural contexts and national public health priorities) and available resources, capacities and capabilities.

Action area 1. Reduce heavy episodic drinking (binge drinking)

- Operational objective 1.1. Encourage health-related information including alcohol-related risks on alcoholic beverages to help consumers make informed choices
- Operational objective 1.2. Encourage knowledge about health and social harm from heavy episodic drinking in relevant services and subgroups
- Operational objective 1.3. Ensure knowledge about health and social harm from heavy episodic drinking among youth
- Operational objective 1.4. Strengthen regulations and measures to minimize sale and serving practices and environments that promote heavy drinking and intoxication
- Operational objective 1.5. Support and implement fiscal and pricing policies to discourage heavy episodic drinking
- Operational objective 1.6. Promote and ensure implementation of screening, early identification and brief intervention in all relevant subgroups and settings

Action area 2. Reduce accessibility and availability of alcoholic beverages for youth

- Operational objective 2.1. Promote, ensure and enforce adequate level of controls in on- and off-premises, particularly for legal age checks
- Operational objective 2.2. Support multisectoral approaches to ensure compliance with national regulations

Action area 3. Reduce exposure of youth to alcohol marketing and advertising

- Operational objective 3.1. Ensure that all marketing and advertising is in compliance with the Audiovisual Media Services Directive and with national regulations and voluntary codes
- Operational objective 3.2. Limit the exposure of youth to alcohol marketing through the internet and new media, including sponsoring

Action area 4. Reduce harm from alcohol during pregnancy

- Operational objective 4.1. Encourage that information about the danger of alcohol during pregnancy, the breastfeeding phase and infant age is widely available
- Operational objective 4.2. Encourage knowledge about alcohol-related birth defects and developmental disorders such as FAS and FASD among health care professionals, and among personnel within social services and schools
- Operational objective 4.3. Encourage counselling and appropriate care and treatment for at-risk and affected children and families

Action area 5. Ensure a healthy and safe environment for youth

- Operational objective 5.1. Promote alcohol-free activities and environments for youth
- Operational objective 5.2. Provide support to children and families with alcohol-related problems
- Operational objective 5.3. Reduce alcohol-related traffic accidents

- Operational objective 5.4. Ensure counselling and appropriate care and treatment for the drinker, the partner and children in families with alcohol problems

Action area 6. Support monitoring and increase research

- Operational objective 6.1. Make data on alcohol-related harm available as basis for policy-making
- Operational objective 6.2. Target EU research funding at knowledge gaps already identified and at topics that need to be studied at European level
- Operational objective 6.3. Monitoring of the Action Plan

Priorities in the Action Plan

(1) Reduce heavy episodic drinking (binge drinking)

HED is described broadly in the Action Plan materials, but there appears to be a special emphasis on youth HED. The Action Plan uses the WHO definition of HED: consumption of 60 g or more of pure alcohol on at least one occasion in the past 30 days. For the purposes of this report, the data utilized in descriptions and assessments include those policy actions that are understood in the Action Plan operational objectives to influence HED. For policy measures as well as consumption measures, we used only those indicators that had information from at least two time points which could roughly correlate to the period of the Action Plan.

(2) Reduce accessibility and availability of alcoholic beverages for youth

According to the 2013 report *Eyes on ages*,¹¹ enforcement of age limits involves a whole chain of supervision, sanctions and communication required to uphold laws imposing age limits on selling and serving of alcoholic beverages. Alongside such legislation there of course has to be enforcement of the age limits.

(3) Reduce exposure of youth to alcohol marketing and advertising

There is general consensus that marketing and advertising of alcoholic beverages should not target children and young people and should not encourage HED (binge drinking). An important role for Member States in this area is enactment and enforcement of advertising bans, monitoring, and eventual prohibition of product promotion and product sponsorship of events. Effective enforcement and self-regulatory measures also play a role in this context.

(4) Reduce harm from alcohol during pregnancy

Alcohol exposure during pregnancy can increase risks of a range of permanent physical and neurocognitive abnormalities known as fetal alcohol spectrum disorders (FASDs); these include specific diagnoses of fetal alcohol syndrome (FAS), partial FAS, and neurodevelopmental disorder–alcohol exposed (ND–AE).¹² CNAPA has recognized that supporting pregnant women in reducing their drinking is especially important, as FASDs have serious impacts on family, society and health systems that may last many years; and that further work is needed in awareness raising, education and counselling. Reducing drinking during pregnancy also involves encouraging Member States and stakeholders to implement labelling schemes to inform consumers about the risks of alcohol to the unborn baby.

(5) Ensure a healthy and safe environment for youth

Settings where drinking often takes place are prime locations for targeting interventions and encouraging transition to alcohol-free status. Emphasis should be placed on encouraging the relevant stakeholders to develop alcohol-free environments for children and young people – for example, encouraging schools and universities to provide alcohol-free environments and alcohol-free beverage options for students when they socialize.

It is important that children and young people are able to move and act in a healthy and safe environment which is free from the harmful influence of alcohol. This includes safe traffic situations for both drivers and passengers. It is also important to focus on early identification and brief interventions targeting families and young people. Successful interventions can help to prevent risky behaviour, protect the health of young people who socialize in drinking environments, and prevent the broader impacts on communities and society. Such interventions include responsible beverage service training, increased surveillance and sanctions.

(6) Support monitoring and increase research

One of the most important actions for a society to take in an area of concern is to ensure continual development of scientific knowledge and continuous monitoring and surveillance. The EU Strategy launched in 2006 highlighted the need to carry out regular comparative European surveys, especially to monitor trends in young people's drinking habits. In this area, the European Monitoring Centre for Drugs and Drug Addiction has supported the European School Survey Project on Alcohol and Other Drugs (ESPAD), while WHO has supported the Health Behaviour in School-aged Children (HBSC) research network. Joint Action RARHA was implemented in 2014–2016, which mobilized EU Member States to produce a baseline for comparative monitoring of drinking levels, patterns and alcohol-related harms across the EU.¹³ These have been the first steps in a process to make alcohol-related information available in a coordinated manner to Member States and to complement their national data. Another effort has been the establishment of a single European information system on alcohol and health.

Through joint collaboration, the EC and WHO developed a shared alcohol information system for the EU and the WHO European Region – the European Information System on Alcohol and Health (EISAH)/European Union Information System on Alcohol and Health (EUSAH); it has the advantages of easing the workload for countries and avoiding discrepancies in key indicators.

Data and methodology

A variety of data sources were identified that could be used to assess the amount of progress made. The following were included in this report:

- (1) Global Survey on Alcohol and Health 2012
- (2) Global Survey on Alcohol and Health 2016
- (3) WHO survey of alcohol policy implementation in Europe 2015
- (4) Health Behaviour in School-aged Children (HBSC) surveys
- (5) European School Survey on Alcohol and Other Drugs (ESPAD)
- (6) WHO Alcohol Policy Timeline Database
- (7) CNAPA meeting minutes and presentations
- (8) Global status report on alcohol and health (GSRAH)
- (9) Consumers, Health, Agriculture and Food Executive Agency (Chafea) Health Programmes Database.

(1, 2) Global Surveys on Alcohol and Health, 2012 and 2016^{14, 15}

WHO has been collecting data on alcohol consumption and alcohol control policies from its Member States since 1996.¹⁶ The current survey instrument entitled “Global Survey on Alcohol and Health” includes three sections – alcohol policy, alcohol consumption and surveillance.¹⁷ The information provided is essential for preparation of the recurring *Global status report on alcohol and health* (GSRAH) and publications of the WHO regions; it is also used to update the Global Information System on Alcohol and Health (GISAH) and regional information systems, such as EISAH/EUSAH. In our evaluation, the 2012 survey results served as a baseline for any changes up to 2016.

(3) WHO survey of alcohol policy implementation in Europe 2015

The WHO Global Alcohol Policy Survey 2015 gathered data on implementation of the global strategy and related regional strategies and action plans between 2010 and 2015.¹⁸ It aimed to identify successes, obstacles, gaps and challenges in the formulation and implementation of alcohol policy.

The current report presents data collected with this questionnaire from all Member States in the WHO European Region in 2015. Data were collected between December 2015 and February 2016. Thirty-eight WHO Member States of the Region and 26 of the 28 EU Member States (Bulgaria and Luxembourg did not participate) took part in the survey. In addition to categorical variables indicating changes in alcohol policy, the 2015 alcohol policy survey contained questions that invited free-text, open-ended answers that generated qualitative data on perceived achievements and barriers to policy implementation. For evaluation of the Action Plan period 2014–2016, the free-text survey responses were grouped according to overall themes and trends corresponding with the six action areas.

(4) Health Behaviour in School-aged Children (HBSC) surveys

HBSC is a cross-national research and monitoring study that has been run in Europe and North America with collaboration of the WHO Regional Office for Europe since 1982. The study aims to gain new insight into adolescent health behaviours, health and lifestyles in their social context. The present study has been allowed access to completed analyses of several waves of the HBSC data in order to help assess trends in alcohol consumption among European youth.¹⁹ Calculations made available to this report cover the period 2002 to 2014.

(5) European School Survey on Alcohol and Other Drugs (ESPAD)

ESPAD has been conducting surveys on schoolchildren aged 15 and 16 since 1995 and currently surveys around 35 European countries. Data used in this report came from the two survey time points that most closely mirror the period of the Action Plan – 2011 and 2015.^{20,21}

(6) WHO Alcohol Policy Timeline Database

The WHO Regional Office for Europe launched a new database in 2016 that provides access to information on major steps taken or milestones reached in the development of policy and action to reduce alcohol-related harm in the WHO European Region from 2006 to the present.²² The Alcohol Policy Timeline Database includes descriptions of and links to legislation, alcohol strategies/action plans, major reports on alcohol, nationwide information campaigns to reduce alcohol-related harm, and regular surveys on alcohol consumption and alcohol-related harm, among other activities.

The database provides three options for viewing data: by country, by year and by action area. This means that database users can access profiles for individual WHO Member States, view all entries for the European Region for a particular year, and view all entries in a specific policy area of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020.⁸

The main purpose of the Alcohol Policy Timeline Database is to facilitate networking between Member States on alcohol policy and to provide a tool to assist them when they are revising, updating and drafting new policies on alcohol.

The establishment of the database was a part of a three-year (2016–2018) EU-funded project for monitoring of national policies related to alcohol consumption and harm reduction (MOPAC), which aimed to support EU and WHO collaboration in the monitoring and surveillance of EU and WHO European Member States' progress in reducing the harmful use of alcohol.

(7) Minutes and presentations from CNAPA meetings

Set up by the EC in 2007 as a forum for EU Member States, CNAPA facilitates cooperation and coordination of alcohol policy across EU countries and contributes to further policy development. National delegates appointed by their governments share information, knowledge and good practice on reducing harmful alcohol consumption. Minutes taken and presentations made at CNAPA's twice yearly meetings in Luxembourg are all publicly available on the EC website and have been used as a source of information and data for the present report.²³

(8) Global status report on alcohol and health (GSRAH)

Issued on a regular basis since 1999, WHO GSRAH reports pull together current knowledge of alcohol consumption and its risks to health on a global level, the health consequences of drinking alcohol, and policy responses globally and in major world regions.²⁴ The present report uses data from 2016 on HED among young persons aged 15–19 collected for the latest GSRAH.

(9) Chafea Health Programmes Database

The EC website for the Europe 2020 strategy states that it aims to make the EU a smart, sustainable and inclusive economy promoting growth for all;²⁵ one prerequisite for this is good health. The Third Health Programme, covering the period 2014–2020, is part of the Europe 2020 strategy and includes four specific priorities. Priority 1 aims to promote health, prevent disease and foster healthy lifestyles through a Health in All Policies (HiAP) approach.

We searched for research and development projects funded through the Third Health Programme in the EC's Chafea Health Programmes Database.²⁶ Our initial search with the word "alcohol" in titles or keywords revealed 33 projects; of these, only those that had started at some point between 1 January 2014 and 31 December 2016 were considered eligible as initiatives within the original Action Plan period (2014–2016).

Analyses

The present report is a purely descriptive assessment of the available data that have been judged to be relevant to the six areas of the Action Plan. A main tool used to identify data from the data sources outlined in the previous section was the "Areas for action" table found at the end of the Action Plan (see Annex 1: Overview table), which was transformed into a "crosswalk" across the three main surveys that were evaluated for the report – the WHO survey of alcohol policy implementation in Europe 2015 and the 2012 and 2016 Global Surveys on Alcohol and Health (see Annex 2: Survey crosswalk). The Action Plan table provided the operational objectives into which each of the six action areas is divided. Three categories of information that existed either practically or theoretically as criteria for measuring the named operational objectives are shown in Annex 1. The most readily available data were the variables named in the third category: the WHO Global Surveys on Alcohol and Health, and the majority of these data were used. The other two categories of criteria – "Options for action" and "EC proposed indicators" – either overlapped with questionnaire variables or were indicators whose data had not been systematically measured and collected over the course of the Action Plan period, and thus would have required extensive original data collection that was beyond the scope of the present report. Instead, we used the Chafea Health Programmes Database to identify larger EU-wide efforts funded by the EC. Projects that began between January 2014 and December 2016 were regarded as initiated within the framework of the Action Plan.

In addition to the construction of the crosswalk for identifying available data, an additional step to identify further indicators relevant to the action areas was to cross-reference them with the data sources that were available for the report. Table 1 illustrates this approach.

Table 1. Cross-referencing available data with Action Plan action areas for assessment

CNAPA Action Plan action areas	Global Surveys on Alcohol and Health, 2012 and 2016	2015 alcohol policy survey	HBSC	ESPAD	Alcohol Policy Timeline Database	CNAPA minutes	GSRH	Chafea Health Programmes Database
1 Reduce HED	X	X	X	X	X		X	X
2 Reduce availability	X	X			X	X		X
3 Reduce marketing	X	X			X	X		X
4 Harm in pregnancy	X	X			X	X		
5 Safe environment	X	X			X	X		
6 Support research	X	X			X			X

Based on the data sources listed in the previous section, basic descriptions of the relevant data for each operational objective in each action area are presented in the following chapters. They describe quantitative representations of changes in the identified indicators over two time points; for example, the change in the number of awareness-raising activities from survey year 2012 to survey year 2016 was measured. Where open-ended questions were posed in the surveys, results are presented as qualitative descriptions of any changes. For example, in the case of the 2015 alcohol policy survey, the questionnaire contained free-text questions where national experts could outline the major achievements and barriers to policy implementation. These submissions generated qualitative data on perceived achievements and barriers for each action area; these were then analysed and grouped into themes. Reflecting these design features of the 2015 questionnaire, the current report largely presents these data using subjective measures based on national expert opinions rather than quantitative measures. When possible, we have tried to quantify a change in the number of activities, or the number of countries engaging in such activities, over a particular period.

Results

Action area 1

Reduce heavy episodic drinking (binge drinking)

Heavy episodic drinking (HED), or binge drinking, is perhaps the most critical of all action areas, as it is a major determinant of alcohol-related harm.²⁷ This action area consists of six operational objectives, four of which concern youth and adults, two concern adults only, and one concerns youth only.

Operational objective 1.1

Encourage health-related information including alcohol-related risks on alcoholic beverages to help consumers make informed choices

The EC's report on alcohol labelling, one of the actions under operational objective 1.1 in the Action Plan, was adopted early 2017.²⁸ The report addresses whether alcoholic beverages should be covered by the requirement (included in Regulation (EU) No. 1169/2011) to provide a list of ingredients and a nutrition declaration. The report recognized the need for better alcohol labelling and asked the industry to make a self-regulatory proposal by March 2018. An earlier study funded by the EC, *State of play in the use of alcoholic beverage labels to inform consumers about health aspects*, was produced in 2014. From an audit of 60 retailers across 15 European countries, it found that a minority of alcohol labels included health-related messages and that there was a clear need for guidelines and standardization.²⁹ The subject of labelling appears to have been briefly discussed at recurrent CNAPA meetings during 2014–2016.

Based on the 2015 Global Alcohol Policy Survey, only one country (Portugal) reported that mandatory labelling of alcoholic beverages to indicate alcohol-related harm had been introduced at national level between 2010 and 2015. Sweden reported that such a policy was already in place before 2010 on advertisements for alcoholic beverages (since 2003), but not on beverage containers.³⁰ The remaining responding countries reported that no such policy had been introduced (Q78)*. Nonetheless, 50% of responding countries reported an increase in government policies and activities aimed at reducing the negative consequences of drinking and intoxication. Achievements in this policy area were related particularly to awareness-raising events, rather than training of catering and serving staff in responsible serving of alcohol. Respondents also pointed to an increased general awareness of the consequences of serving alcohol to intoxicated persons (Q80, Q81).

The two Global Surveys on Alcohol and Health revealed a slight increase in the number of study countries that required health warning labels in alcohol advertisements and on alcohol beverage bottles or containers in 2016 compared to 2012. In 2012 the number of countries was nine for advertisements and two for labels; in 2016 it was 10 for advertisements and three for labels.

Operational objective 1.2

Encourage knowledge about health and social harm from heavy episodic drinking in relevant services and subgroups

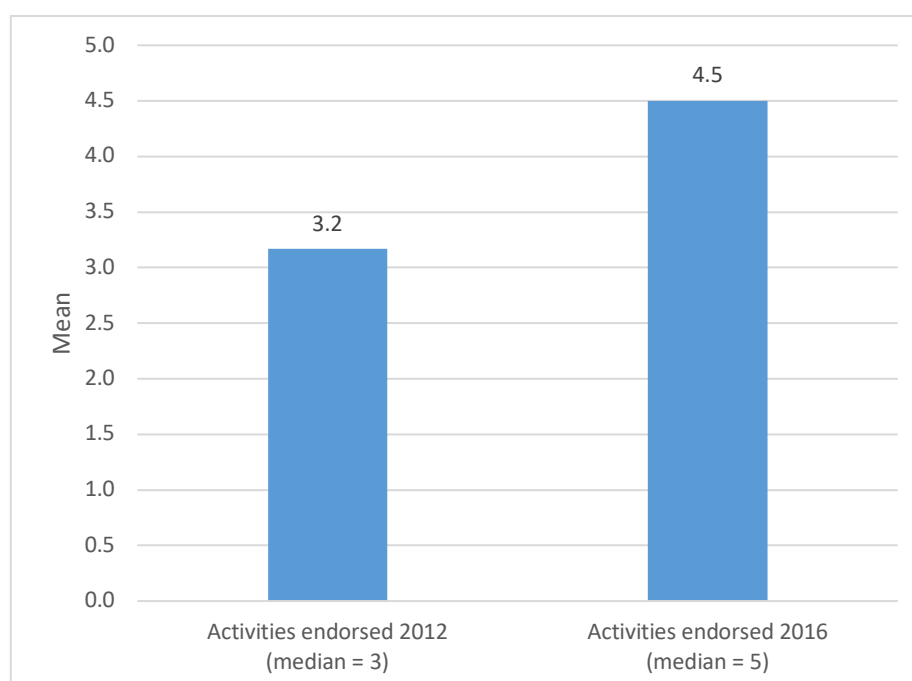
In 39% of responding countries, new nationwide awareness programmes on harmful use of alcohol were implemented between 2010 and 2015, while 21% of respondents reported that such programmes were already in place prior to 2010 (Q4). Achievements made between 2010 and 2015 in this policy area included:

* Q78 = Question 78 in Annex 2 (Survey crosswalk).

- Cyprus: new awareness week *
- Italy: alcohol prevention day
- Belgium, Lithuania, Poland and Slovenia: awareness campaigns to prevent drink-driving
- Croatia: campaign to prevent alcohol sale to underaged
- Netherlands: social norms campaign
- Latvia: educational events relating to alcohol use.

The Global Surveys on Alcohol and Health also showed an increase in awareness-raising activities. From a list of eight possible activities, the mean number endorsed by study countries in 2012 was 3.2 (median = 3) (Fig. 1). By 2016 the list of possible activities had grown to 15. However, a comparison of only those activities that appeared in both 2012 and 2016 surveys revealed the mean number of activities to be 4.5 (median = 5), indicating a slight increase. When considering the entire list of possible activities, the mean number increased to 5.8 (median = 6.5).

Fig. 1. Mean number of awareness-raising activities endorsed by study countries (n = 30) in 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

Additionally, minutes from the CNAPA meeting on 2 June 2016 indicate that Austria had developed a new strategy to raise awareness of alcohol. At the 2 November 2017 meeting, Portugal announced a new campaign to target parents on the issue of young people's consumption.²³

* Eurocare, a European NGO, together with a number of partners, organizes an Awareness Week on Alcohol-related Harm in the third week of November. It includes an event in the European Parliament and a breakfast meeting with health attachés, normally hosted by the presidency. During the Action Plan period, topics have included:

2014 Time for action – the need for an integrated EU alcohol strategy

2015 Alcohol – why is it a big thing?

2016 Audiovisual Media Services Directive (AVMSD): once in a decade opportunity to address alcohol marketing.

Operational objective 1.3. Ensure knowledge about health and social harm from heavy episodic drinking among youth

Unfortunately, there were no comparable data across the 2012 and 2016 Global Alcohol and Health Surveys to measure development of this objective. There were, however, a series of questions in the supplementary section for the WHO European Region in the 2016 survey. Here countries were asked:

“What have been the main activities/policy achievements in reducing heavy episodic drinking (binge drinking) since 2014?”

The specific question areas were as follows.

- (a) Raised awareness in the general public and relevant services on health and social harm from HED (e.g. through events, publications, information material)? Here, 19 countries had established awareness programmes before 2014; four did so in or after 2014.
- (b) Developed and integrated information on alcohol-related harm in academic curricula for professionals working with young people? Ten countries had information before 2014; five had incorporated such content in or after 2014.
- (c) Developed and implemented training and educational programmes to increase awareness of health professionals about health and social harm from HED among youth? Thirteen countries reported having such training before 2014; three had initiated programmes in or after 2014.
- (d) Promoted and developed community actions among groups of young people (students, universities, local communities, vulnerable groups)? Fourteen countries reported having promoted such actions before 2014; four did so in or after 2014.
- (e) Promoted and introduced standards for server training programmes, e.g. for those involved in selling and serving alcoholic beverages? Eleven countries introduced such standards before 2014; six did so in or after 2014.
- (f) Promoted and ensured implementation of screening, early identification and brief intervention in all relevant subgroups and settings, including expanding beyond primary health care? Sixteen countries reported that they had promoted implementation of screening and similar programmes before 2014; three did so in or after 2014.

The following countries reported additional activities under this objective from the supplementary section in the 2016 survey.

- **Denmark** ESPAD report, Report on the home pages for parties on high/secondary schools.
- **Finland** The Act on Organizing Alcohol, Tobacco, Drugs and Gambling Prevention (523/2015) came into force on 1 December 2015. This act and a new action plan on alcohol, tobacco, drugs and gambling aim to promote equality in health and well-being, to ensure the preconditions for preventive work in substance abuse and addictions across the country, and to support regions and municipalities, in particular, in intensifying their work. Prevention of harm related to alcohol, smoking, drugs and gambling is part of the statutory obligation of municipalities to promote well-being and health.
- **Malta** Publication of Draft Alcohol Policy in 2016; it is currently at the consultation phase.

- **Portugal** Portuguese Alcohol and Health Forum activities to raise awareness among youth, especially minors, of harmful use of alcohol as a starting point to promote discussion among stakeholders and stimulate public debate about recent law changes affecting the legal drinking age in the country.
- **Spain** In 2014, educational material on responsible alcohol services in student drinking settings was published. In the same year, a report on the possibility of using the Alcohol Use Disorders Identification Test (AUDIT) to screen for hazardous alcohol consumption in student health services was published.

Operational objective 1.4. Strengthen regulations and measures to minimize sale and serving practices and environments that promote heavy drinking and intoxication

In the 2015 WHO alcohol policy implementation survey,¹⁸ several responding countries (Cyprus, Estonia, Portugal, United Kingdom) reported an increase in government policies to prevent the sale of alcohol to intoxicated persons (Q47).

Server training is one approach used to discourage staff in bars and restaurants from serving minors or those who have begun to show signs of intoxication. Based on the 2012 and 2016 Global Surveys on Alcohol and Health, there was no change from 2012 to 2016 in the number of countries that had implemented server training. The question read: “In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis? If yes, organized by enforcement agencies, private sector, or other?” The answer at both time points was 14 countries, or 47%, that said yes to having server training (Q12a in 2012, Q13a in 2016).

On 1 May 2016 the EC provided a grant for the three-year project STAD in Europe (SiE), a local prevention method implemented in seven EU Member States (Czechia, Germany, Slovenia, Spain, Sweden, the Netherlands and the United Kingdom).³¹ Project aims were to test the feasibility of the method across the EU and across settings, and to reduce heavy episodic drinking by restricting the availability of alcohol in four drinking environments: nightlife server settings, festivals, public environments (such as streets, parks and beaches) and private environments. The STAD method has proved effective in nightlife server settings and contains three main components: community mobilization, training in responsible beverage service, and stricter law enforcement in the server setting. A manual in English was produced and pilot interventions in the seven participating countries were evaluated scientifically. The process evaluation suggested that the STAD model has the potential to be transferred across Europe and various public drinking settings. The short-term effect evaluation provided some evidence of reductions in factors that support harmful alcohol consumption, such as serving of alcohol to underage and intoxicated patrons, across a number of drinking settings.

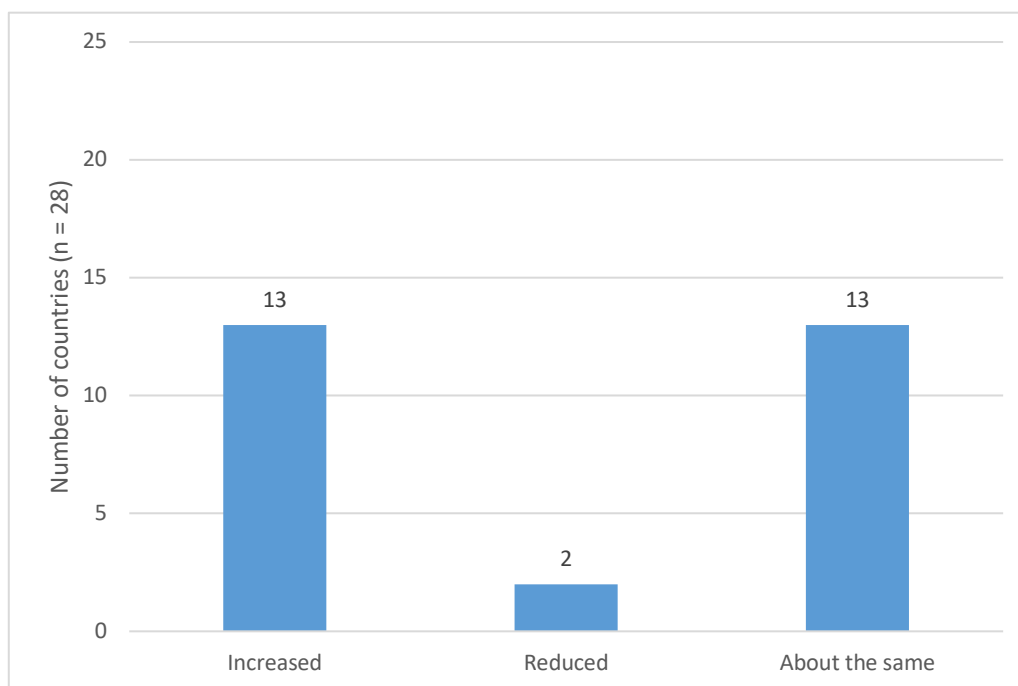
Operational objective 1.5. Support and implement fiscal and pricing policies to discourage heavy episodic drinking

The subject of pricing appears to have been discussed at three CNAPA meetings during 2014–2016. Two of these focused on developments concerning Council Directives 92/83/EEC (7–8 June 2016) and 2008/118/EC (27–28 September 2016); the third focused on denatured alcohol in 92/83/EEC (28–29 April 2015). No reports on the exchange of best practice were found in the CNAPA meeting reports.

In the 2015 alcohol policy implementation survey, all respondents, with the exception of one country, reported that no minimum price for alcoholic beverages had been established between

2010 and 2015 (Q69). In Slovakia, such a policy was already in place prior to 2010. Thirteen countries (46%) reported an increase in the overall scope and intensity of government policies and activities in the area of pricing policies with respect to alcoholic beverages (Q 71) (Fig. 2). Notable achievements were in the area of increased excise duty, with 20 countries reporting an increased excise duty tax between 2010 and 2015 (Q66). There were few reported difficulties in terms of implementing this policy area, although some noted opposition from the alcohol industry and disagreements regarding tax rates (Q72 +73).

Fig. 2. Overall scope and intensity of government policies and activities in the area of pricing policies with respect to alcoholic beverages, 2010–2015



Source: Global Alcohol Policy Survey 2015

With respect to price measures other than taxation, there was only a very slight increase in the use of such options. There were seven options that could be selected in both 2012 and 2016 surveys: minimum price; non-alcoholic option; ban on below-cost selling; ban of volume discounts; additional levy; underage drinking price measures; and other. All of these options have been recognized as policies that can be used to discourage the purchase of alcohol.³² In 2012 there were 10 countries that endorsed such additional measures; in 2016 there were 11. It should be noted, however, that mechanisms to increase prices on alcohol can often be counteracted by means of other strategies which may offset any possible price rise.³³

The WHO's Alcohol Policy Timeline Database identified a number of policy initiatives on alcohol pricing that were introduced in several countries between 2014 and 2015. Most of the initiatives mentioned below involved an increase in alcohol taxes. At the same time, it should be noted that some countries already had such policies in place and so are not listed here.

Thirteen countries reported changes in alcohol pricing; all but two of them clearly stated whether the increase was in price or tax. Other countries – for example, the United Kingdom – mentioned activities such as a publication, a risk analysis, and a consultation (on minimum pricing). Countries that reported actions or concrete plans to introduce clearly stated tax increases on all or some strengths of alcohol included Austria, Estonia, Finland, Greece, Latvia, Lithuania, Slovenia and

Sweden. Countries that reported modifications of the alcohol taxation system (leaving it unclear whether a tax increase was implied) included Hungary, Portugal, Spain and the United Kingdom. Only Romania reported a decrease in alcohol taxation.

Operational objective 1.6. Promote and ensure implementation of screening, early identification and brief intervention in all relevant subgroups and settings

The 2012 Global Survey contained one question (Q45) asking whether there were clinical guidelines for brief interventions; in response, 18 (60%) of the survey countries reported that they had such guidelines. Neither this question nor a comparable one could be found in the 2016 survey. However, responding to the 2015 alcohol policy implementation survey, 64% of countries reported an increase in the level of support for screening and brief interventions for hazardous and harmful drinking at primary health care and other settings (Q10).

The only vaguely related question in the 2016 Global Survey concerned FASD and asked whether development of guidelines for prevention, diagnosis and treatment of FASD had been initiated either before 2014 or in/after 2014. Responses included one country that had initiated such guidelines before 2014 and four that initiated such activities in or after 2014.

Data from the Alcohol Policy Timeline showed that in England, in 2014, implementation of health promotion actions for young people in the workplace, including alcohol risks, was developed and supported. Public Health England funded the Workplace Wellbeing Charter; an alcohol-specific toolkit has yet to be developed.³⁴ In Scotland, in 2014, a *Process evaluation of alcohol brief interventions in wider settings (Young People and Social Work)* was published by NHS Health Scotland.³⁵

Summary of action area 1

Although many countries had already implemented a number of policies in this area, a slight increase in the number of countries using further policy options to reduce binge drinking (HED or 5+ drinks) was observed. There was a slight increase in the number of countries using health information labels (from nine to 10 for advertisements; from two to three for labels on containers); an increase in the mean number of awareness-raising activities (from 3.2 to 4.5); but no apparent change in the number of countries using server training. The EU-funded project STAD in Europe (SiE) containing server training in seven Member States and across different drinking environments was ongoing at the end of 2016. The EC issued two reports on health-related labelling of alcohol beverages and the issue of labelling was discussed in CNAPA. Several countries reported alcohol tax increases during the study period, and some reported a modification. There was a small increase in the number of countries using price policies other than taxation (from 10 to 11 countries). Discussions in CNAPA on pricing and fiscal policies appear to have been limited during 2014–2016. In the area of screening, early identification and brief interventions for hazardous or harmful alcohol consumption, a majority of countries reported improvements in support, but it was not possible to assess if this increased support had reached all relevant subgroups and/or settings as indicated in the Action Plan's operational objective.

Action area 2

Reduce accessibility and availability of alcoholic beverages for youth

Addressing the accessibility and availability of alcohol encompasses such actions as introducing training of alcohol servers in drinking outlets and imposing legal age limits for buying alcohol in EU

Member States. Server training is one approach to ensuring that intoxicated persons and persons under the legal age for purchasing alcohol are monitored by server staff and denied service.

Operational objective 2.1. Promote, ensure and enforce adequate level of controls in on- and off-premises, particularly for legal age checks

Concerning distance sales, sales from automated tills, vending machines, and implementation of automated control measures for face-to-face sales to prevent purchase of alcohol by minors, the agenda of the CNAPA meeting on 7–8 June 2016 suggests that there may have been a discussion and/or exchange of best practices. However, the publicly available minutes do not describe such a focus or exchange of best practice.

Server training and legal age checks

Between 2010 and 2015, 54% of responding countries reported an increase in the capacity of communities to prevent selling of alcohol to, and consumption of alcohol by, persons under the legal age; in 39% of countries, the capacity remained about the same (Q18). In 2015, the current scope and intensity of government policies to prevent sales to those below the minimum legal age were somewhat or substantially increased in 46% of respondents when compared to 2010 (Q48). Advances in this policy area between 2010 and 2015 included new legislation reported by Sweden that enabled municipalities to conduct mystery shopping in grocery stores that sell medium-strength beer to investigate compliance with minimum legal purchasing age regulations. In the same period, Italy saw a ban on alcohol sales to minors; Belgium introduced a ban on sales of beer and wine to those under 16; and Denmark, Greece and Latvia introduced stronger penalties for serving alcohol to underaged customers.

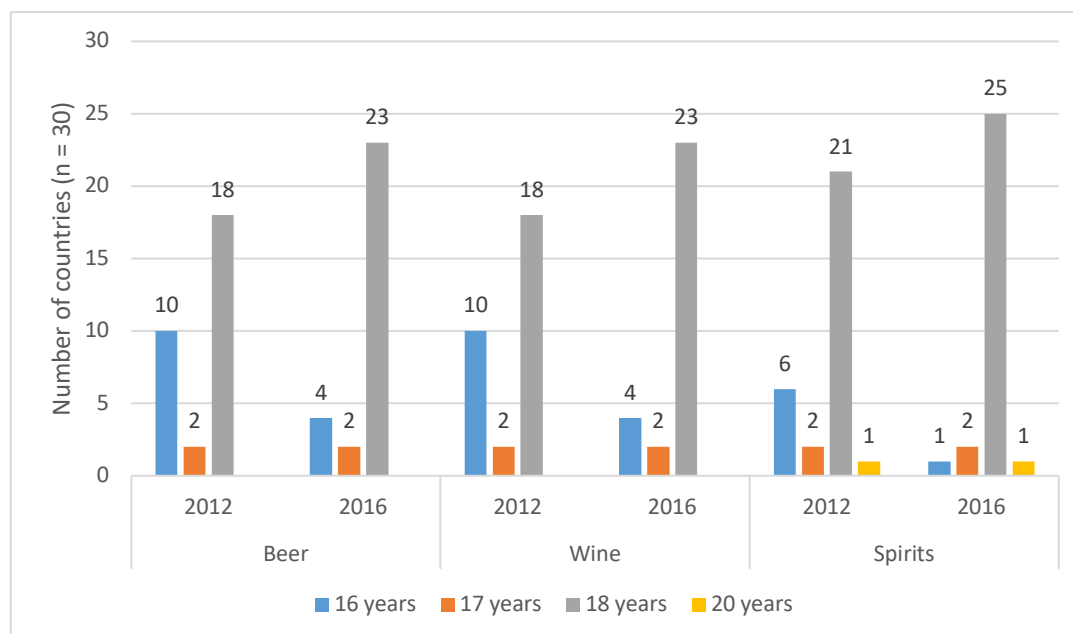
Data from the 2012 and 2016 Global Surveys on Alcohol and Health showed that there was no change in the number of countries that had implemented server training from 2012 to 2016. The question was: “In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis?” If yes, answer options were: “organized by enforcement agencies, private sector, or other?” The answer at both time points was 14 countries (47%) saying yes to having server training (Q12a in 2012, Q13a in 2016; data not shown).

The STAD in Europe (SiE) funded through the EC Third Health Programme started in June 2016 with the aim of piloting a local multicomponent method, the STAD model, in various server settings in seven Member States (see also operational objectives 1.4 and 6.2). In Germany the method was tested for feasibility to reduce the availability and provision of alcohol to minors in the home through educating and encouraging parents to be more restrictive over provision of alcohol. As there is no legislation in Germany covering adolescent alcohol consumption in the home under parental supervision, a significant departure from the original STAD model was the lack of an enforcement component. However, concerning education, parents were generally positive about the intervention, possibly because the information was disseminated by a health professional. The intervention included a paediatrician delivering information to parents about the risks associated with children and young people drinking alcohol.

Age limits on purchase of on-premises and off-premises alcohol

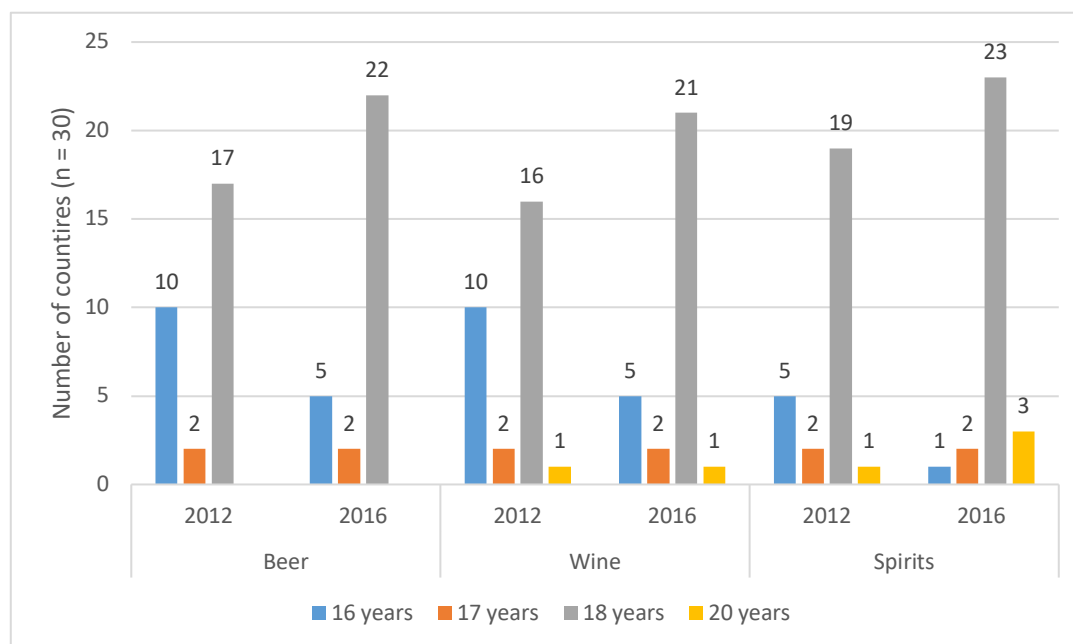
The 2012 and 2016 Global Surveys had comparable questions regarding the legal ages to buy on- and off-premises alcohol. Figs. 3 and 4 show the changes in legal ages between the two time points.

Fig. 3. Number of countries changing the legal age to buy on-premises beer, wine and spirits, 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

Fig. 4. Number of countries changing the legal age to buy off-premises beer, wine and spirits, 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

As Fig. 3 shows, the number of countries adopting a higher age limit for purchasing all types of beverages on-premises increased noticeably between 2012 and 2016. The number of countries with lower age limits decreased accordingly. A similar trend for off-premises age limits is also evident, with more countries adopting a higher age limit for all beverage types (Fig. 4).

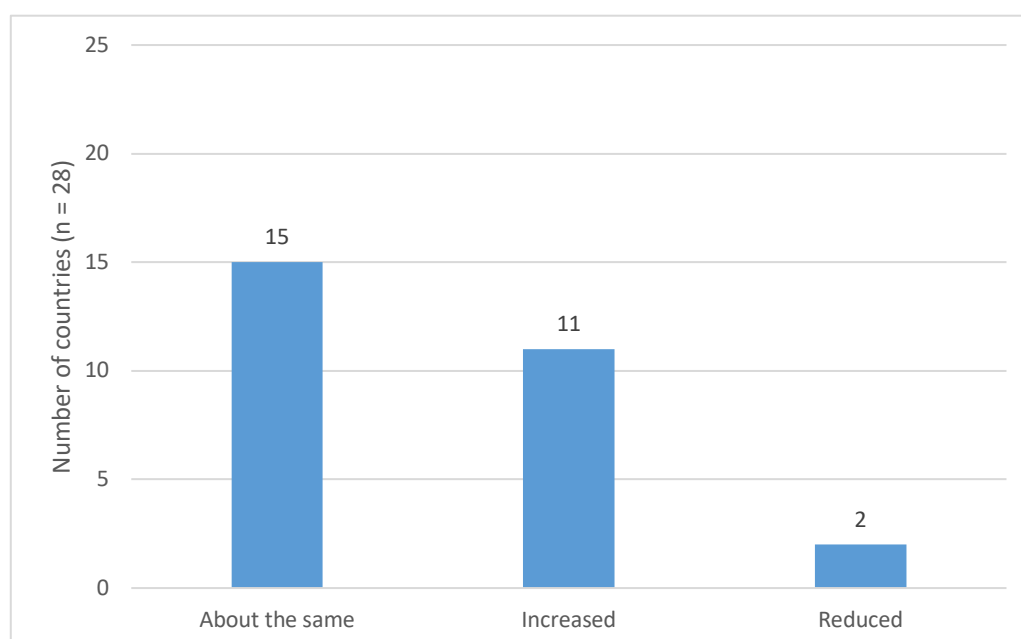
In sum, the number of countries engaging in server training programmes did not change between 2012 and 2016. However, age limits for on- and off-premises alcohol purchases moved noticeably in

the direction of older ages for all beverage types. In almost all cases, the age limit was raised to 18 years, with some countries also adopting a 20-year age limit for off-premises purchase of spirits.

Operational objective 2.2. Support multisectoral approaches to ensure compliance with national regulations

In 2015 the level of coordination of alcohol policy formulation and implementation across different sectors of government increased in 42% of responding countries, compared to 2010. For the remaining 58%, the level remained about the same (Q2). In the same period, the overall scope and intensity of government policies and activities in relation to availability of alcohol were somewhat or substantially increased for 39% of respondents (Fig. 5) (Q51).

Fig. 5. Overall scope and intensity of government policies and activities in the area of availability of alcohol, 2010–2015

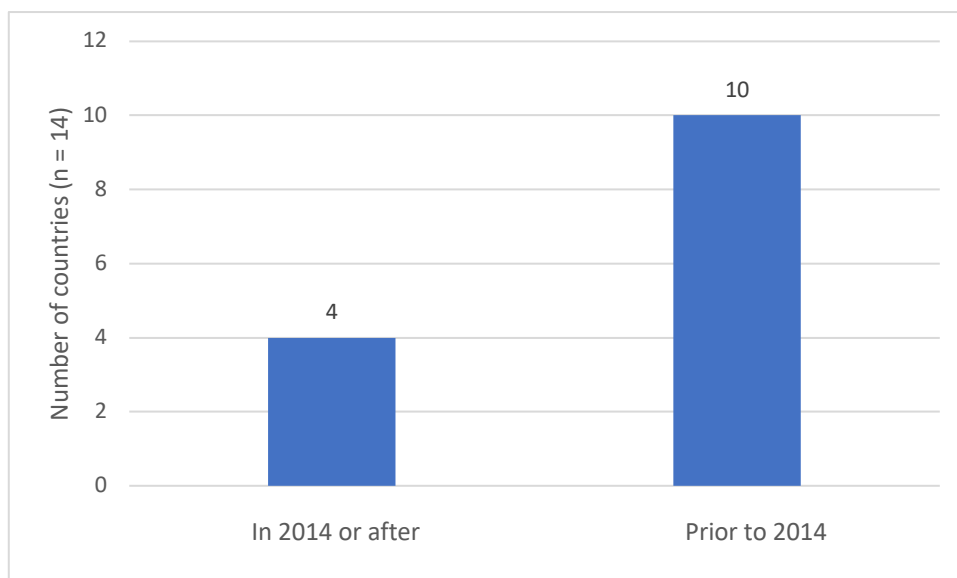


Source: Global Alcohol Policy Survey 2015

Little data were available from the 2012 and 2016 Global Surveys to assess this objective, although the 2016 survey had a special section for the WHO European Region which asked the following question (Q2): “What have been the main activities/policy achievements in reducing accessibility and availability of alcohol beverages for youth since 2014?” One response option (c) read: “Delivered national information campaigns to raise awareness of national legislation among sellers of alcoholic beverages and the general public, including carrying out Alcohol Awareness Day/Week.”

As can be seen from Fig. 6, 10 countries reported that they had initiated such campaigns before 2014; four had done so either in 2014 or later; 16 countries did not respond to the question.

Fig. 6. Number of countries initiating national youth alcohol access and availability awareness campaigns



Source: Global Survey on Alcohol and Health 2016

Data from the Alcohol Policy Timeline Database provided information on alcohol availability measures. Eight countries reported policy initiatives to tackle alcohol availability between 2014 and 2016. These initiatives (listed in detail below) included legal age legislation; guidelines to prevent sales to minors; stricter penalties for underage sales; server training; and various kinds of ban – on sales at public or sports events, on sales at petrol stations, and on advertising price reduction sales. In addition, legislation on changes to licensing systems was passed in the United Kingdom, where there were also a number of discussions, publications and proposals on licensing and underage sales.

Between 2014 and 2015 there was a mystery shopping programme in Cyprus to examine commitment to the legal age limit on sale and serving of alcohol, and to provide training for bar staff on responsible sale and serving of alcohol. In 2015 the Cyprus Anti-Drugs Council introduced revisions to the existing legislation on sales of alcoholic beverages; these included modifications specific to the legal age for consumption and access to alcohol (raising the legal age from 17 to 18) and introduction of measures and stricter penalties on sellers in order to minimize underage consumption and reinforce responsible selling/serving practices. Likewise, the Cyprus Anti-Drugs Council introduced guidelines on serving and selling of alcohol to facilitate training programmes to be implemented in the future, when training will be a legal requirement.

In Estonia, in 2014, voluntary guidelines to help prevent alcohol sales to minors were devised for retailers.

Also in 2014, legislative changes were introduced in Latvia; these included penalties for underage drinking and increased responsibility for illicit alcohol production, storage and distribution.³⁶

In 2015 several amendments were made in Lithuania to the law on alcohol control, including provisions covering availability of alcohol; in 2016 another amendment to this law was made, which prohibited advertising of alcohol price reductions. In 2014 Lithuania adopted a law which allowed municipalities to introduce bans on trading and consumption of alcohol at public events. By 2016 more than 30% of municipalities had adopted such bans. In the same year, a ban on the sale of alcoholic beverages in petrol stations was established.^{37,38}

In the Netherlands, in 2014, a new legal drinking age (18 years) was introduced.³⁹

Portugal announced major changes in 2015 to its licensing systems, age limits, and other matters pertaining to alcohol availability, banning consumption of all kinds of alcohol by minors (under 18 years). In 2016, a first amendment to Decree-Law No. 50/2013 was made, prohibiting provision, sale and consumption of all alcoholic beverages in the case of minors and those who appear to be drunk or to suffer from a mental disorder.⁴⁰

Slovenia introduced an Act Restricting the Use of Alcohol in 2015, which bans selling or offering alcoholic drinks at sports venues during sports events, including one hour before the start of such events. A parliamentary attempt to amend the act so as to reverse the ban on offering and selling of alcoholic drinks at sports events was not adopted since governmental, professional and nongovernmental organizations successfully defended the view that it would represent a risk and a backward step in the development of an effective alcohol policy in Slovenia.⁴¹

In the United Kingdom, the Scottish Qualifications Authority's Alcohol Licensing Qualifications were introduced;⁴² and Alcohol Focus Scotland's "Alcohol licensing in your community" toolkit was published.⁴³ Also in Scotland, in 2015 the Air Weapons and Licensing Act was introduced, which included amendments to the 2005 act with respect to alcohol licensing; the 2015 act included the creation of new offences for supplying alcohol to a child or young person for consumption in a public place.⁴⁴ In 2015 England and Wales set an unlimited maximum fine for persistent underage sales of alcohol.

There was also information from CNAPA meetings on activities undertaken by individual EU Member States. For example, at the 7 June 2016 meeting, Estonia gave a comprehensive overview of its alcohol strategy for 2015–2020.⁴⁵ From a variety of policy options, Estonia has chosen to focus primarily on two main areas: (1) availability of alcoholic beverages; and (2) marketing of such beverages. Cheap alcohol and the related issue of cross-border transport of cheap alcohol from Latvia were mentioned as major problems. Regularly increasing excise duties, which was already part of the Estonian government's package of measures, was not seen as being sufficient to tackle this issue, hence the need for other measures. So, focusing on these two main areas, on the issue of availability Estonia reported:

- from 1 January 2017 all alcoholic drinks would be separated from other products in stores;
- from 1 January 2018 all alcoholic drinks would be placed behind a screen or sold only from behind the counter with a salesperson (no self-service);
- alcoholic drinks would not be sold in petrol stations;
- no degustation (tasting) would be allowed in retail shops; and
- municipalities would be able to regulate on-sale hours (off-sale hours are already regulated by the state).

In the area of marketing, the following changes to the Advertising Act were proposed:

- advertisement of alcoholic beverages could contain only the name of the drink, the type of drink, the name of the producer, the brand, the state and region of origin, the ethanol content, an image of the sales packaging, and a description of its characteristics (colour, taste, aroma);
- TV advertisements could not contain any audio or visual elements apart from those listed above and a health warning, and the information should be presented on a single-coloured screen with no visual effects;
- all outdoor alcohol advertising would be banned;

- the alcohol advertising watershed would be moved from 21.00 to 22.00; and
- there would be a mandatory size for health warnings in or on printed media.

Ireland gave an update on the Irish Public Health (Alcohol) Bill (2015).^{*} The aim of the bill is to reduce alcohol consumption in Ireland to 9.1 litres per capita by 2020 and to reduce the harms associated with alcohol. The bill is part of a comprehensive set of measures to reduce excessive patterns of alcohol consumption. A standstill period was extended until 28 July 2016; however, the bill was turned into new legislation on 1 July 2018. The key provisions of the bill include:

- minimum unit pricing (to be set at €0.10 per gram ethanol)
- labelling of alcohol products
- notices in on- and off-licensed premises
- regulation of advertising and sponsorship of alcohol products
- structural separation of alcohol products in mixed trading outlets
- regulations on sale and supply of alcohol products (promotions).

These provisions demonstrate some concrete actions and fall into various areas of the Action Plan, including reducing consumption, reducing availability, reducing exposure to advertising and promotion, and reducing alcohol harm during pregnancy.

At the 7–8 November 2017 CNAPA meeting, Cyprus presented the Cyprus Alcohol Policy and Action Plan. Part I is on alcohol data and related actions (2013–2016), while Part II is on new proposed actions (2017–2020), using data on Cyprus from the ESPAD survey. Under the plan for 2013–2016 the main goals were: to increase control over the age limit for consumption; to reduce drink–driving incidents; to limit accessibility and availability of alcohol to vulnerable groups; and to reduce consumption among young people. A pilot mystery shopping programme was run in two cities.

In the plan for 2017–2020 the priorities are: to reduce HED among children and young people; to promote responsible selling and serving practices; to prevent FAS and FASD and provide appropriate care for affected children and young people in vulnerable groups; to create a dissuasive environment for use of addictive substances; and to implement early intervention programmes. Many amendments have been proposed in a wide collaboration with stakeholders and communities, and parliamentary discussions on legislative changes are underway. Important work has been done in cooperation with the municipalities.⁴⁶

At the same meeting, Lithuania reported on its alcohol control policy. Lithuania is one of the world’s heaviest alcohol-consuming countries, with very severe effects on public health. Consumption for people of 15 years and over decreased in the period 2011–2016 but remains high. Over the past 30 years, and especially in the last five, there have been many changes in alcohol regulations. Future plans included: a ban on alcohol advertising (which was due to come into force on 1 January 2018); setting up specialized alcohol stores (postponed); prohibiting alcohol sales online (postponed); limiting alcohol outlet density; and requiring installation of ignition interlock systems in the vehicles of those convicted of alcohol-impaired driving.⁴⁷

At the 20–21 March 2018 meeting, Poland reported that local authorities had recently been given authorization to limit availability of alcohol. They can now restrict opening hours and number of outlets and ban alcohol consumption in public places.

^{*} Information on the Irish bill was given in the form of slides presented at the CNAPA meeting.

PAKKA – the Local Alcohol, Tobacco and Gambling Policy Model in Finland

In Finland, the community action model PAKKA – the Local Alcohol, Tobacco and Gambling Policy Model (Paikallinen alkoholi-, tupakka- ja rahapelipolitiikka) – started as a development and research project in pilot communities. Since 2004 it has since been disseminated centrally by the Institute for Health and Welfare in cooperation with regional government offices.⁴⁸ In 2011 the project reached one third of the population, and the aim is that by 2020 the model will have been implemented in 50% of Finnish municipalities. In addition to substance use and gambling, the model focuses on alcohol availability and access to under-18s, as well as sale of alcohol to intoxicated people and minors. The PAKKA model involves cooperation between public authorities, inhabitants, businesses and NGOs.¹⁸

Summary of action area 2

Age limits had already been introduced in Europe over the last few decades. During the study period there was a rise in the legal age for purchasing spirits both on- and off-premises in some countries. For the most part, however, these regulations had already been put in place before 2012 and had not changed. The mean number of awareness-raising activities on alcohol accessibility and availability increased between 2012 and 2016. Eight countries reported specific activities in this area. Of particular note were initiatives by Estonia and Ireland to curb accessibility and availability, and by Lithuania and Cyprus, which reported major developments in their national alcohol policies at CNAPA meetings.

Action area 3

Reduce exposure of youth to alcohol marketing and advertising

Operational objective 3.1. Ensure that all marketing and advertising is in compliance with the Audiovisual Media Services Directive and with national regulations and voluntary codes

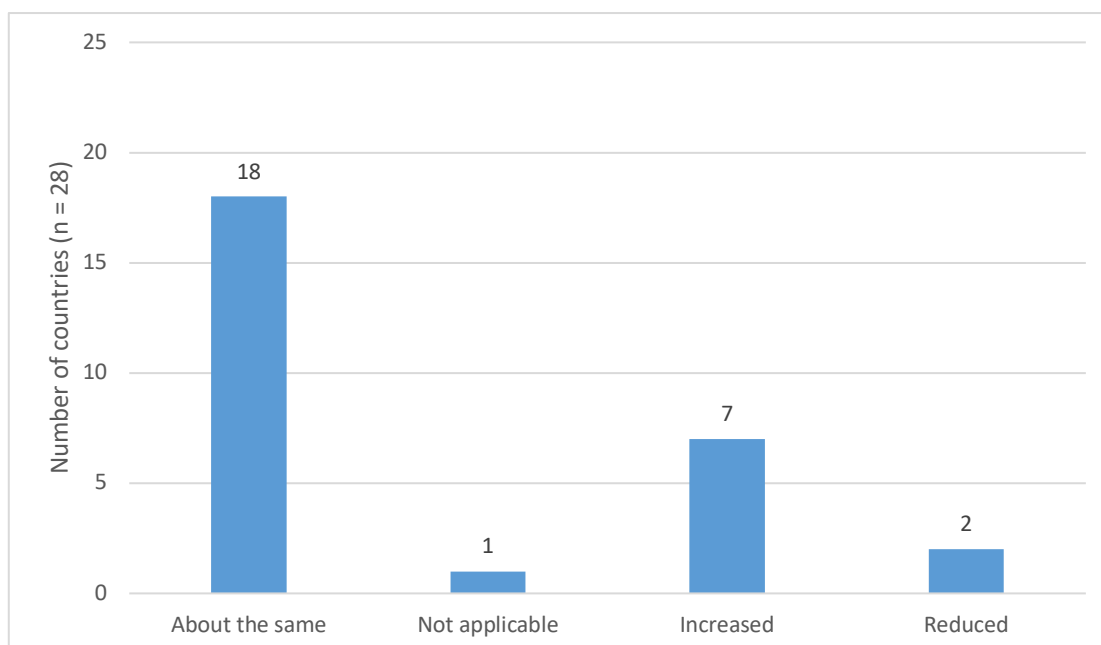
An EC report on exposure of minors to alcohol advertising on TV and in online services, published in 2015, was an option for action under this operational objective.³ Issues surrounding the EU's Audiovisual Media Services Directive (AVMSD), adopted in 2010, are complex, making further evaluation of this objective difficult.⁴⁹ In addition, a revision of the AVMSD took place in 2018, and there have also been challenges to it.⁵⁰ For these reasons and for the purposes of the current report, the focus of this chapter is on changes in alcohol marketing and advertising policies in general.

The European Public Health Alliance (EPHA) received funds from the EU Third Health Programme for work in 2016 to put the marketing of alcohol and unhealthy food to children on the policy agenda in the framework of negotiations on the AVMSD. The activities were coordinated with other organizations and aimed to raise political awareness of the impact of marketing on health, particularly for children. In October 2016, EPHA organized a conference in the European Parliament entitled "Self-regulation: a false promise for public health", which discussed the practical implications for the review of the AVMSD and the self-regulation and voluntary commitment schemes which – despite lack of evidence for a preventive effect – are often encouraged as tools to address youth drinking and HED.

Several countries, such as Norway, Sweden and France, have had strict regulations on the marketing of alcoholic beverages in place for many years before the start of the Action Plan. During the study

period 2010–2015, seven countries (25% of responding countries) reported an increase in the overall scope and intensity of government policies and activities in the area of marketing of alcoholic beverages (Q63) (Fig. 7).

Fig. 7. Overall scope and intensity of government policies and activities in the area marketing of alcoholic beverages, 2010–2015



Source: Global Alcohol Policy Survey 2015

The following achievements were recorded in this policy area (Q64).

- In Latvia, prohibitions on outdoor advertisement of alcoholic beverages and on alcohol sales on the internet were introduced.
- In Cyprus, partial statutory restrictions on radio and television advertising of beer, wine and spirits were provided for in legislation and enforced by the Cyprus Radio Television Authority. According to this regulation, alcohol advertising should not target those under 18 years, be associated with improved physical state or driving, or suggest positive social effects, sexual success or therapeutic qualities.
- In Finland, where there is already a total ban on advertising strong beverages (>22% abv), restrictions on advertising mild beverages were introduced in 2014. These included a ban on advertising in public places, both indoors and outdoors. On TV and radio, advertising of mild alcoholic beverages can only be aired after 22.00.

In Ireland, the Public Health (Alcohol) Bill, passed in 2015, included provisions on marketing and advertising of alcohol to limit how alcohol is portrayed in advertisements in all media; to restrict advertising at certain events; to prohibit sponsorship by alcohol companies at certain events; to restrict advertising of alcohol in print media, depending on volume of alcohol and type of publication; and to limit advertising of alcohol in cinemas to films classified for 18-year-olds and older.

The primary difficulties or barriers reported in relation to this policy area were mainly due to pressure from the alcohol industry.

Turning to the 2012 and 2016 Global Surveys on Alcohol and Health, only four subsidiary questions in total, drawn from two main questions posed in 2012 (Q34) and 2016 (Q31), were directly comparable. These concerned the ways in which infringements of marketing restrictions are detected. The measure which showed the largest increase in this period was active surveillance: the number of countries using this approach rose from 18 in 2012 to 21 in 2016. The number of countries with a complaint system remained the same, at 22, while countries using case-by-case reports increased by just one – from 10 in 2012 to 11 in 2016. In all, the number of countries with no method for detecting infringements dropped from four in 2012 to two in 2016.

Operational objective 3.2. Limit the exposure of youth to alcohol marketing through the internet and new media, including sponsoring

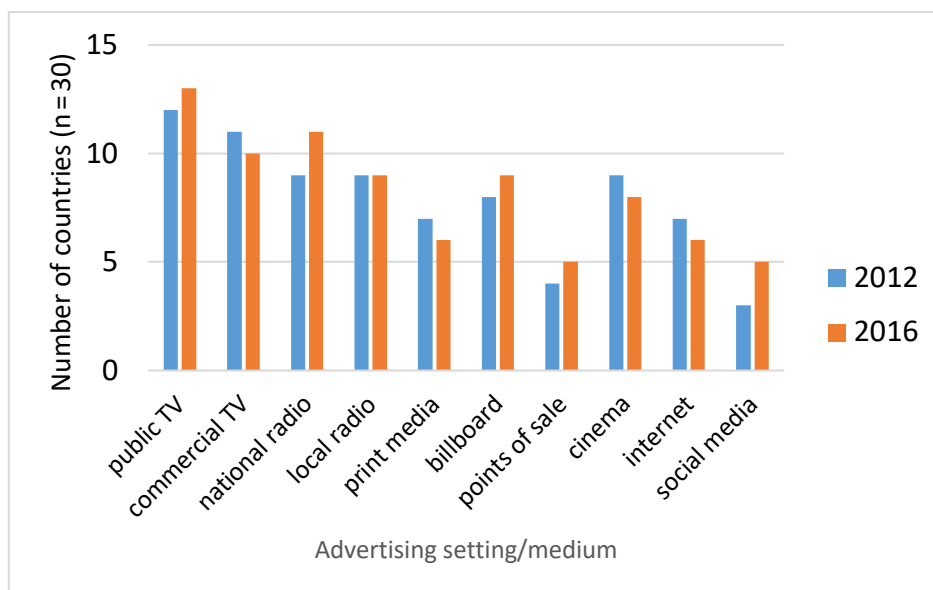
There were two options for action listed under this operational objective that encompassed discussions in CNAPA in the period 2014–2016 on marketing and young people's exposure and exchange of best practices or views. On product placement, no discussions took place in CNAPA, according to the publicly available CNAPA meeting minutes. Regarding sponsorship, the developments of the Irish Public Health (Alcohol) Bill, which included this issue, seem to have been presented twice in CNAPA. Alcohol marketing in new media and its impact on young people were addressed at the CNAPA meeting on 22 September 2015, where Finland presented its new regulation. Also at this meeting, Chafea presented an EU-funded research study on exposure of minors to alcohol advertising.³ Alcohol marketing in a broader perspective seems to have been discussed recurrently in CNAPA meetings between 2014 and 2016.

Based on the 2015 alcohol policy implementation survey data, two countries – Finland and Greece – reported an increase in statutory regulations regarding sponsorship activities that promote alcoholic beverages (Q58), while five countries reported an increase in the level of restrictions or bans on promotions in connection with activities targeting young people (Q59). Four countries reported an increase in regulations on new forms of alcohol marketing such as social media (Q60). In Finland, Estonia, Cyprus, Ireland and Latvia, alcohol advertising was either banned or restricted; in the case of Latvia, this included restricting advertisement on the internet. There were also bans or restrictions on the sale of alcohol, including a ban in Latvia on selling alcohol on the internet and a ban in Germany on selling alcohol in petrol stations and supermarkets at night.

Data on alcohol marketing and advertising in both the 2012 and the 2016 Global Surveys are based on complex matrix questions which were coded very differently in the two waves. This made direct comparisons extremely difficult. Nonetheless, through complex recoding, a basic level of comparison could be achieved, as is illustrated in Figs. 8–13.

As Fig. 8 shows, there were more countries in 2016 than in 2012 with a full advertising ban on at least one beverage type in the case of public TV, national radio, billboards, points of sale and social media. By contrast, in the case of commercial TV, print media, cinema and internet, the number of countries with a full ban on at least one beverage type decreased in the period 2012–2016.

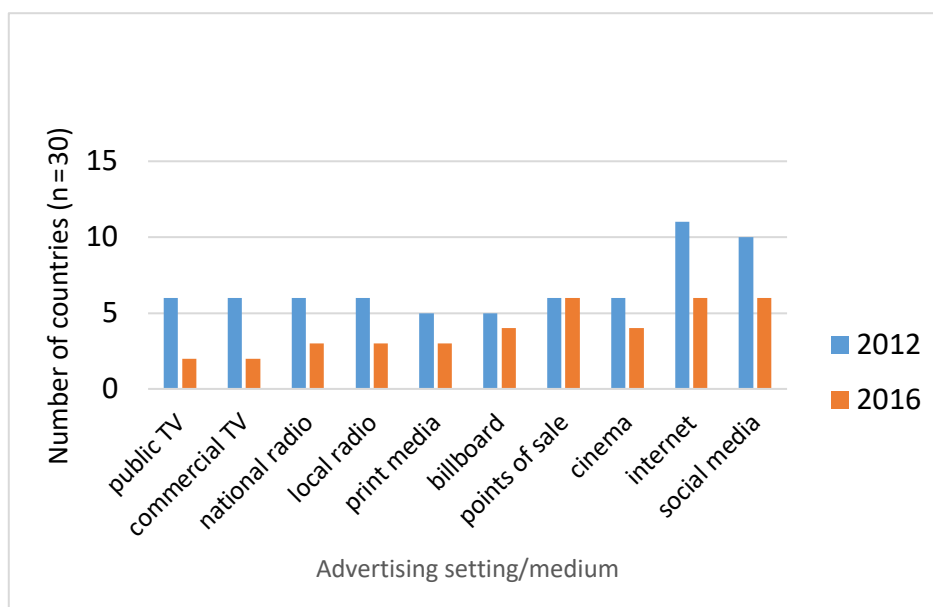
Fig. 8. Number of countries with a full advertising ban on at least one beverage (beer, wine or spirits), 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

The number of countries with no ban at all for at least one beverage type clearly decreased between 2012 and 2016 (Fig. 9). In no advertising setting was there an increase in the number of countries with no ban, and only in the case of point-of-sale advertising was there no change.

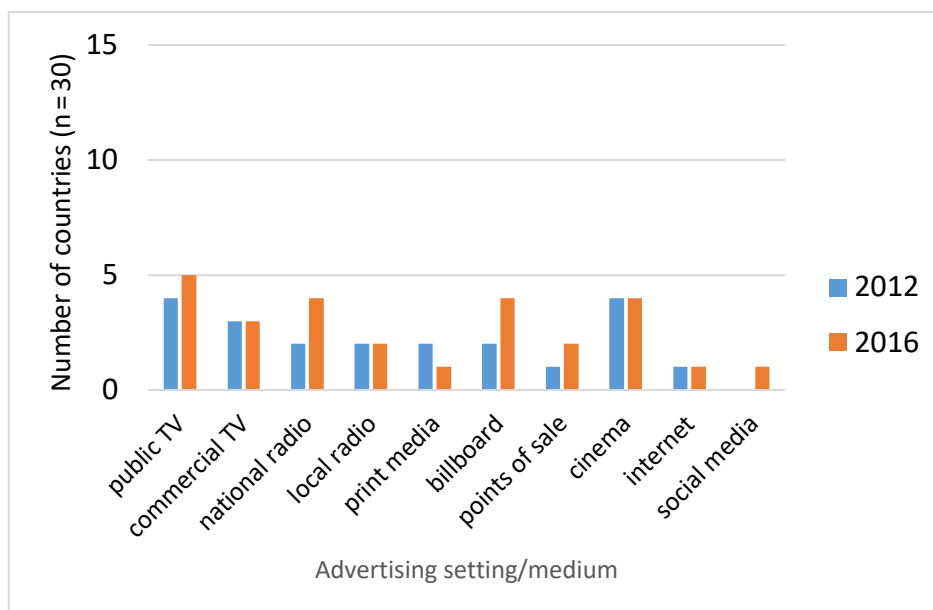
Fig. 9. Number of countries with no advertising ban on at least one beverage (beer, wine or spirits), 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

For all settings investigated, full advertising bans on all beverages are relatively rare. Such bans appear to have increased for particular settings in the period 2012–2016: public TV, national radio, billboards, points of sale and social media (Fig. 10). In print media, the number of full bans on all beverage types decreased.

Fig. 10. Number of countries with a full advertising ban on all alcoholic beverages, 2012 and 2016

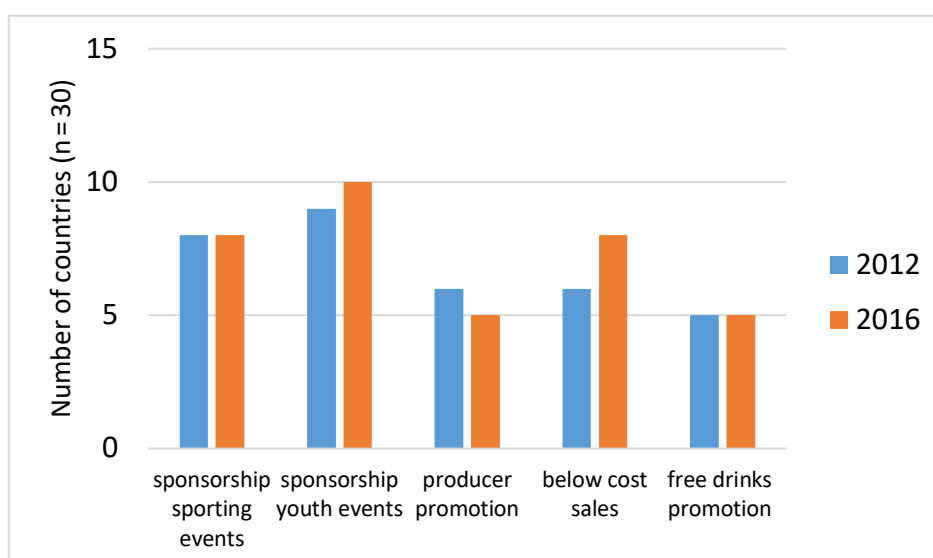


Source: Global Surveys on Alcohol and Health, 2012 and 2016

In the area of alcohol sponsorship and sales promotion, there was in general a lower level of progress in policy implementation than in the area of advertising.

There seemed to be little movement in increasing full bans on sponsorships at various settings and on sales-promoting activities. Only in the case of youth events and below-cost sales was there an increase in the number of countries adopting such bans between 2012 and 2016 (Fig. 11).

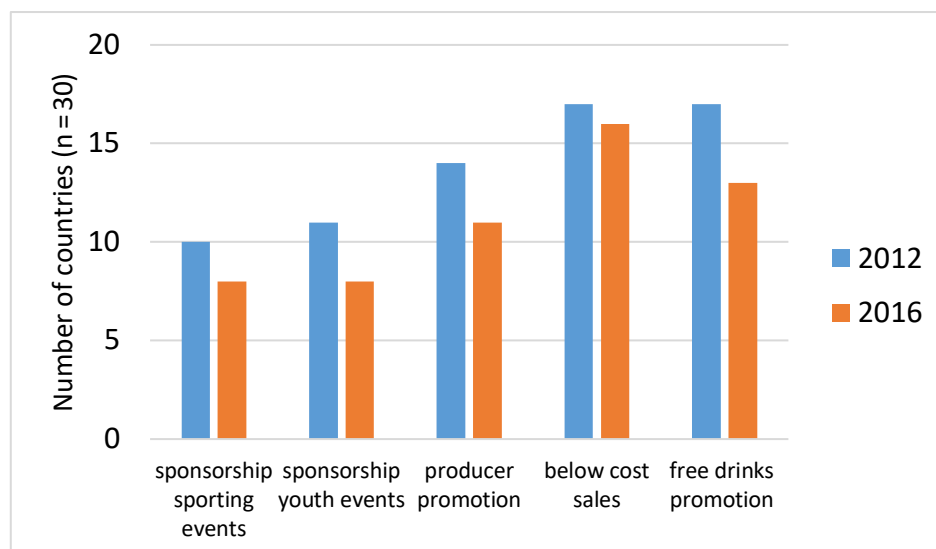
Fig. 11. Number of countries with a full sponsorship ban on at least one beverage (beer, wine or spirits), 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

Looking at the reverse case, it is easier to see that there are fewer countries with no ban at all on at least one beverage type (Fig. 12). The number of countries with such a situation had decreased for all settings since 2012.

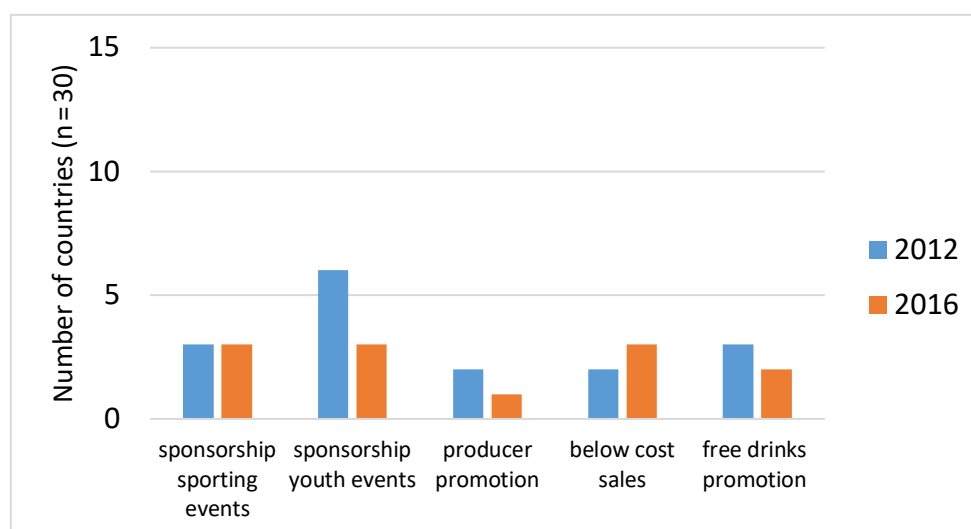
Fig. 12. Number of countries with no alcohol sponsorship ban on at least one beverage (beer, wine or spirits), 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

Interestingly, the number of countries with a full alcohol sponsorship ban on all beverages decreased in all sponsorship settings except for below-cost sales (where it increased) and sporting events (where it was unchanged) (Fig. 13). It might be informative to follow up more closely on what may lie behind the decrease.

Fig. 13. Number of countries with a full alcohol sponsorship ban on all beverages, 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

Searching the Alcohol Policy Timeline Database on initiatives related to alcohol marketing in the period 2014–2016, six WHO Member States reported either new regulations or reports related to

alcohol marketing. These included enactment of statutory restrictions on alcohol advertising in Finland, Latvia and Lithuania; an amendment clarifying an existing law in Sweden; and a report on children's exposure to marketing in Ireland. An agreement with the alcohol industry on responsible business practices and a code of conduct were developed in Portugal.

Specifically, in Finland there was a regulation on advertising introduced in 2014 and additional restrictions on advertising of beverages containing 1.2–22.0% abv (a total advertising ban on stronger beverages remains in place). The ban on TV advertising of alcohol was extended and now covers the period 07.00 to 22.00. Likewise, alcohol advertising on radio was banned for the period 07.00–22.00. A ban was introduced on alcohol advertising in outdoor and indoor public places; it applies to billboards, bus stops, public transport and commercial transportation vehicles, railway and bus stations, and public areas in shopping malls. Likewise, a ban on the use of games, lotteries and contests to advertise alcoholic beverages was introduced. Restrictions were imposed on alcohol advertising disseminated through electronic communication networks.

In 2014 Latvia introduced legislative changes in alcohol advertising, which prohibit outdoor advertising.⁵¹

In 2016 Lithuania prohibited advertisement of alcoholic beverage price reductions and running of competitions, games, discount campaigns or lotteries that could encourage purchase and/or consumption of alcoholic beverages (these restrictions came into force on 1 November 2016).⁵²

In 2016 Sweden amended its Marketing Act to clarify the way in which “aggressive” marketing should be assessed.⁵³

In 2015 Alcohol Action Ireland, funded by the Health Service Executive, commissioned the National University of Ireland Galway to produce a report on young people's exposure to alcohol marketing in the country.⁵⁴

In Portugal a code of conduct for advertising and other forms of commercial communication was introduced in 2014. And in 2015 an agreement was reached with the alcohol industry to develop responsible business practices in the selling, serving and marketing of alcoholic beverages.

Turning to CNAPA meeting minutes and presentations as a source of information on marketing policies: at the CNAPA meeting on 7–8 November 2017, Slovenia reported something of a setback in its alcohol policy, in that its parliament had agreed to allow alcohol sales at sporting events. This occurred in spite of opposition from a majority of health professionals, NGOs and legal services in parliament. At the 20–21 March 2018 CNAPA meeting, Sweden reported that it was working on a white paper proposing a ban on alcohol marketing on social media: the legislation would not cover the whole internet and producers would still be permitted to advertise their businesses and have websites; it was due to come into force on 20 September 2019. At the same meeting Estonia reported that its parliament had passed a new law that restricted/prohibited alcohol advertising on social media.

Summary of action area 3

An EC report on minors' exposure to alcohol marketing was published in 2016, and at CNAPA meetings alcohol marketing, broadly conceived, appears to have been a recurrent subject. Time trends for countries' policies on advertising, sponsorship and sales promotion were difficult to assess because of a lack of comparability between survey indicators, but for those indicators that could be made comparable, there were small increases in the number of countries with a total ban on at least one beverage type in public settings, and decreases in the number of countries with no restrictions at all on alcohol advertising (all settings/media except point-of-sale advertising), alcohol sponsorship

and sales promotion. In seven EU Member States, the scope and intensity of government policies and activities in the area of alcohol marketing increased between 2010 and 2015. Bans covering all alcoholic beverages were still very rare in 2016; this was evident for all settings or media types. Four countries reported new marketing and advertising regulations in the period 2014–2016. These regulations ranged from bans on advertising in various media (Finland) to bans on various locations (outdoors in Latvia), a ban on advertising price reductions (Lithuania), and an industry agreement on codes of conduct (Portugal).

In 2013, a new covenant on advertising and marketing of alcoholic beverages was signed in Belgium. In this agreement, alcoholic beverages are defined as beverages with a strength exceeding 0.5% alcohol by volume. The covenant addresses advertising on digital media targeted at minors and prohibits association of alcohol with a festive or welcoming atmosphere in marketing of alcoholic beverages.⁵⁵

Action area 4

Reduce harm from alcohol during pregnancy

Operational objective 4.1. Encourage that information about the danger of alcohol during pregnancy, the breastfeeding phase and infant age is widely available

In 2015 the extent to which harm to others is caused by someone else's drinking of alcohol was taken into consideration in alcohol policy formulation, and implementation had either increased somewhat or substantially for 43% of respondents compared to 2010. The remaining countries responded either that the level was about the same as in 2010 (54%) or that the question was not applicable (4%) (Q6). Lithuania reported that mandatory labelling on alcoholic beverages giving information about alcohol-related harm to pregnant women had been introduced.

For this analysis, the 2012 and 2016 Global Surveys on Alcohol and Health were less useful, as most of the questionnaire items dealt with public information in general and not specifically on pregnancy and breastfeeding. Also, there was no access to any reports from CNAPA members to the EC (this is also the case for operational objectives 4.2 and 4.3).

In the 2012 survey, the following question was posed (Q54): "Is there a comprehensive report on the alcohol situation drawn up and published regularly at the national level in your country?" Drinking and pregnancy was one of the topics that could be selected (tick option 7). Four countries responded that they had issued reports on drinking and pregnancy.

Under operational objective 1.1, we have already presented material on health information labels, which includes warnings about drinking during pregnancy. Also, in operational objective 1.6, we referred to the fact that the 2012 survey contained one question asking whether there were clinical guidelines for brief interventions. In response, 18 (60%) of the surveyed countries reported that they had such guidelines (Q45 (d): "In your country, are there clinical guidelines for brief interventions that have been approved or endorsed by at least one health care professional body?"). Neither this question nor a comparable one could be found in the 2016 survey.

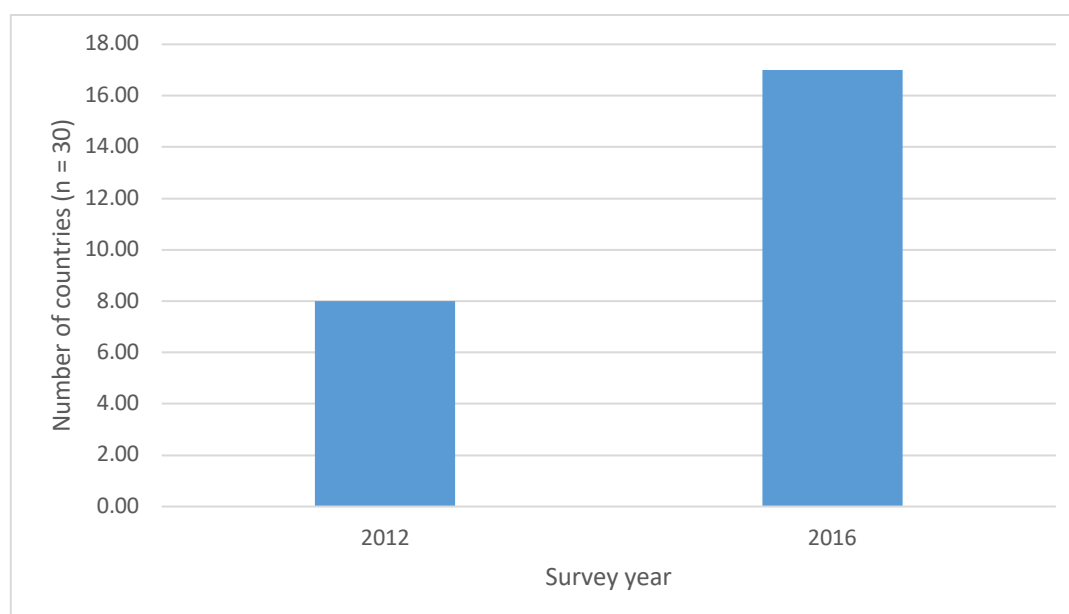
Operational objective 4.2

Encourage knowledge about alcohol-related birth defects and developmental disorders such as FAS and FASD among health care professionals, and among personnel within social services and schools

In 2015, 32% of responding countries reported an increased capacity for identification and prevention of FAS and for interventions on behalf of individuals and families living with FAS, compared to 2010. Poland reported increased training for FASD diagnostic teams, as well as increased interest in FASD in medical fields. In the case of two countries (Ireland and Estonia), such capacity was largely absent both before and after 2010 (Q11).

There was a considerable increase in the number of countries that reported having nationwide awareness-raising activities on alcohol and pregnancy. These data were based on direct comparison of responses to the question: “In the last three years, did you have any nationwide awareness-raising activities on alcohol and pregnancy?” (Q11 in 2012 Global Survey; Q12 in 2016 Global Survey). The number of countries with such activities grew from eight in 2012 to 17 in 2016 (Fig. 14).

Fig. 14. Number of countries that had nationwide awareness-raising activities on alcohol and pregnancy, 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

Operational objective 4.3. Encourage counselling and appropriate care and treatment for at-risk and affected children and families

According to the 2015 Global Alcohol Policy Survey, capacity to provide treatment services for alcohol use disorders in the health system increased to 43% of responding countries in 2015, compared to 2010. In 47% of countries, such capacity was reported to be about the same in 2015 as in 2010 (Q13).

Also according to the 2015 survey, many countries signalled progress in the area of treatment. Denmark reported a budget increase to support improved alcohol treatment and improved efforts to support pregnant women with substance use disorders (SUDs), including establishment of regional facilities to treat women with SUDs. Estonia similarly reported an increased budget in the area of treatment. In Belgium, Latvia and Cyprus, educational programmes for health workers and

other professionals on addiction issues and acute intoxication were established. New or improved treatment programmes and services were set up in Cyprus, Denmark, France, Germany, Greece and Hungary, while in France there were consultations with young people with addiction.

The 2012 Global Survey on Alcohol and Health contained a question on the incidence and prevalence of FAS among children within a year of birth, at national level and based on registry data (number of cases, number of births, year, and reference). Unfortunately, responses were patchy, with 11 countries answering the question on incidence and nine countries answering the question on prevalence in an unstandardized fashion. Data from 2016 could not be found.

Additional questions on alcohol and pregnancy were posed to EU countries in the special section of the 2016 Global Survey intended for the WHO European Region. These countries were asked about the existence and/or introduction of various activities before or after 2014. The questions mainly concerned various policy initiatives aimed at reducing harm during pregnancy. Unfortunately, this set of questions had a rather low response rate and a reassessment employing qualitative interviews in 2018 was not considered feasible.

On the issue of **education/information programmes, brief interventions and treatment**, countries were asked whether they had, before, during or after 2014:

- integrated the issue of alcohol-related harm to the unborn child into information-based prevention programmes targeted both at schools and at the general public (4 a);
- introduced and/or promoted comprehensive awareness-raising activities and education for the public at large, and young women in particular (4 d);
- delivered brief interventions and information on the need to avoid alcohol before and during pregnancy and the breastfeeding period (4 e);
- developed programmes to enhance the knowledge of health care professionals (for instance, were promotion of health prevention, awareness raising, screening and brief interventions included as compulsory modules in the curriculum for medical degrees? were continuous education and training implemented?) (4 f);
- ensured that containers of alcoholic products carry a health information message determined by public health bodies describing the harmful effects of drinking alcohol during conception and pregnancy (4 c);
- ensured adequate support for rehabilitation centres for pregnant women with alcohol dependence (4 k).

In response, seven out of 11 countries reported that they had begun education/information programmes in 2014 or after. The other four countries had established programmes prior to 2014. Only seven in all answered that they had health information labels on pregnancy; five of these already had such labels before 2014. Fifteen countries answered a question on awareness-raising campaigns targeted at younger women; 10 already had such programmes before 2014. On brief interventions to avoid drinking in pregnancy, 18 countries had such programmes; 16 of these had been initiated before 2014, two after. Eleven countries reported some sort of programme for medical professional and continuing education. Of these programmes, seven had been started before 2014, four after. Six countries reported that they had rehabilitation centres for alcohol-dependent pregnant women; in all six countries, these programmes were initiated before 2014.

On the issue of **programmes to tackle FAS and FASD**, countries were asked whether they had, before, during or after 2014:

- initiated research to develop and validate feasible methods to reliably assess the incidence of FASD at population level (4 b);
- promoted greater awareness among health care professionals of FASD and referral systems in order to improve diagnosis and management of children born with FASD (4 g);
- supported development of clinical guidelines for prevention, diagnosis and treatment of FASD (4 h);
- initiated provision of adequate diagnosis and treatment for children with FAS/FASD, including early detection and a referral mechanism to relevant structures (4 i);
- developed adequate support for children with FAS/FASD and their families outside the health sector, including preschool and school programmes (4 j).

In response, six countries reported research on FASD assessment; four research programmes began before 2014, two after. Initiatives to promote greater awareness of FASD among professionals was reported by 12 countries; seven of these had programmes before 2014, five after. Existence of clinical guidelines on FASD was reported by five countries, only one of which had such guidelines in place before 2014. Provision of adequate diagnosis and treatment for children with FASD was also reported by six countries, four of which had already started such initiatives before 2014. Four countries reported that they had developed adequate support for children with FASD, two before 2014 and two after.

Three countries mentioned other activities to reduce harm during pregnancy. These included the establishment of two treatment centres in Luxembourg. Lithuania had initiated research to develop and validate feasible methods to reliably assess the incidence of FASD at population level. Portugal reported a national awareness-raising campaign on the short- and long-term effects of alcohol consumption by women while pregnant and when breastfeeding.

Country-specific information on alcohol availability measures from the Alcohol Policy Timeline Database showed that a political agreement in Denmark in 2016 strengthened efforts to address substance use and disorders in pregnancy.⁵⁶

Germany issued national guidelines on diagnosis and screening of FASD and other related measures – the S3 guideline “Diagnosis of Fetal Alcohol Spectrum Disorders” appeared in February 2016.⁵⁷ There have been several measures in the field of FASD prevention, in both schools and communities, and the new pocket version of the S3 guideline has been distributed to and applied by experts in the health, social paediatric and social sectors.

In Portugal a number of initiatives have taken place during the study period. Actions in this area included a 2015 campaign to prevent consumption of alcoholic beverages during pregnancy and breastfeeding.⁵⁸ Likewise, a research project on alcohol use in pregnancy got underway; its aims were to describe patterns of alcohol use in a sample of pregnant woman who attended primary health care facilities in Lisbon and to identify risk/protective factors related to patterns of alcohol use.⁵⁹

In Slovakia, education of the general public (especially women) about FAS was carried out in 2015. A seminar entitled “Alcohol and women” was designed for the expert community; it is linked to health education activities for the general public in connection with International FASD Awareness Day. Activities are provided by staff from regional public health offices. The goal of the action is to raise awareness about the harmful use and effects of alcohol during pregnancy.

In Spain, media campaigns aimed at both minors and pregnant women were implemented in 2014 by the Spanish Federation of Spirit-based Beverages.

In the United Kingdom (Scotland), FASD clinical pathway and diagnostic guidelines were developed in 2016.

Material from the CNAPA meeting minutes and presentations showed that pregnancy and FASD were topics of discussion during a round table session at the meeting on 27–28 September 2016. Member States reported on national progress in implementation of best practices on prevention, diagnosis and/or treatment of FASD. However, it appears that the majority of reports covered recommendations or planned actions rather than implemented programmes or clinical guidelines in use.

- (1) Cyprus informed the attendees that FASD had recently been included in medical records and that guidance on FASD was currently being drafted.
- (2) Denmark mentioned an official recommendation that women should stop drinking when they wanted to get pregnant and a campaign of midwives and general practitioners to encourage women to avoid drinking before pregnancy.
- (3) Finland mentioned that the country had successful prevention programmes in place on alcohol harm during pregnancy and the first three years after birth; however, information about women who already had problems with alcohol was lacking.
- (4) France noted that there was an ongoing awareness-raising campaign targeting professionals and social media; health warnings were already on bottles.
- (5) Germany announced a meeting in December 2016 on measures related to FASD.
- (6) Greece mentioned that their doctors were currently being informed on FASD.
- (7) Hungary mentioned that more public discussion was needed on alcohol-related harm during pregnancy; the country already collected data on newborn infants, but the dangers of FASD were still underestimated.
- (8) Latvia stated that it was preparing a new action plan on alcohol, but there were no specific measures on FASD.
- (9) Lithuania mentioned that health professionals should be able to screen and identify use of alcohol; labelling was already in place, but beverages from other countries could be sold without health information labels.
- (10) Luxembourg announced that a new action plan on alcohol, including guidelines on FASD, had been approved by their parliament; self-reported alcohol consumption would be registered in electronic health records.
- (11) Malta noted that screening interviews for pregnant women were routine.
- (12) The Netherlands mentioned that it had a successful campaign in place which had resulted in a decrease in alcohol consumption during pregnancy. However, FASD diagnosis was still problematic (this was an issue for most countries).
- (13) Norway mentioned their successful nationwide campaign “Alcohol-free pregnancy”, which aimed to increase awareness in the general public and also to provide information to health professionals. It had been translated into many languages and received several awards in global competitions. Data from general population surveys showed some subsequent changes in attitudes towards drinking during pregnancy.
- (14) Portugal disseminated research results on alcohol harm during pregnancy; a campaign on this topic was currently being evaluated.

- (15) Slovakia mentioned the importance of increasing awareness even among gynaecologists and stated that during its EU presidency (in 2016) it would focus on cost-effective analysis, early detection of alcohol use disorders, and comprehensive treatment guidance.
- (16) Slovenia mentioned an awareness-raising campaign that had been in place since 2013 and announced that new material for future parents would be prepared.
- (17) Spain introduced its intention to include FASD as part of a new drug strategy, which also included alcohol.
- (18) Sweden mentioned its long history of monitoring alcohol abuse during pregnancy and its focus on children living in families with alcohol problems.

Of the 18 Member States participating in the round table, it appears that six countries reported that they had awareness-raising or screening campaigns that were currently running. All other Member States either reported that programmes were being planned or agreed that it was important to include FASD in future programmes.

Summary of action area 4

The number of countries reporting that they had awareness-raising activities on alcohol and pregnancy rose from eight in 2012 to 17 in 2016. About a third of countries reported increased activity in this area, based on the 2015 Global Alcohol Policy Survey. No change was found in the number of countries that reported specific treatment options for pregnant women. A majority of countries reported having brief interventions to reduce or prevent drinking in pregnancy in place before 2014; only two countries added such programmes after that year. Six countries reported that they had rehabilitation centres for alcohol-dependent pregnant women; all were initiated before 2014. Six countries listed specific programmes for pregnant women, and of 18 Member States participating in a CNAPA meeting round table, six reported that they had awareness-raising or screening campaigns that were currently running. All other Member States either reported that programmes were being planned or agreed that it was important to include FASD in future programmes. France was the only EU Member State in 2016 which had introduced mandatory health information labels giving information about the dangers of drinking alcohol while pregnant. Lithuania has since followed suit. Clinical guidelines for prevention, diagnosis and treatment of FASD seem not to have been a subject for discussion at CNAPA meetings in the period 2014–2016.

In the United Kingdom, the alcohol industry agreed to make commitments to provide consumers with information about alcohol and health; this included putting a warning about drinking during pregnancy on at least 80% of product labels by December 2013.⁶⁰

Action area 5

Ensure a healthy and safe environment for youth

Operational objective 5.1. Promote alcohol-free activities and environments for youth

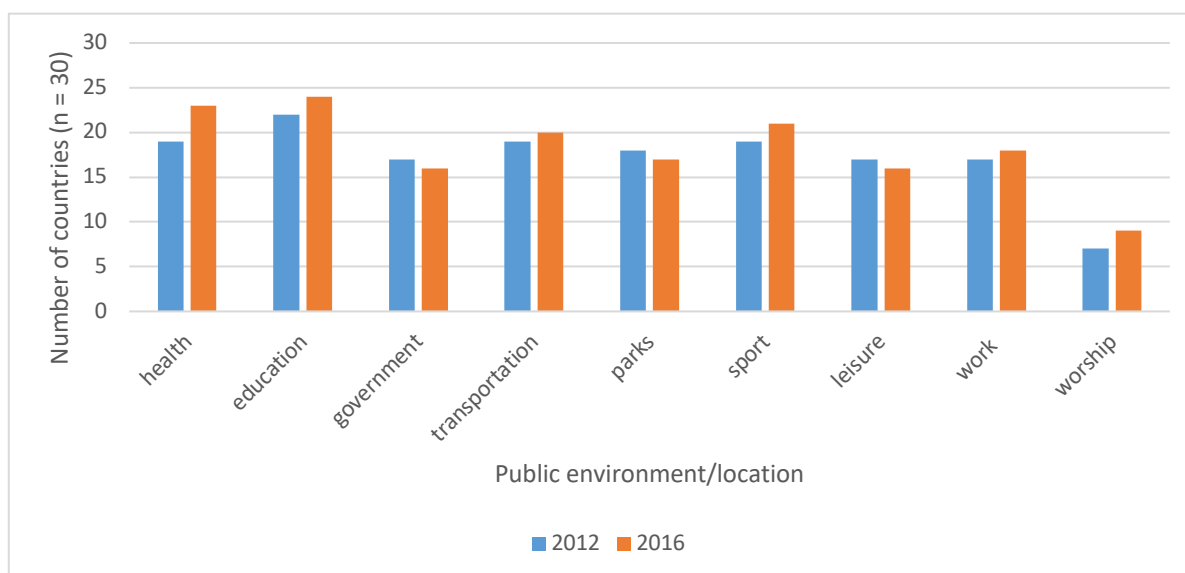
The CNAPA meeting on 28–29 April 2015 included a presentation given by Denmark in which preventive interventions for young people living in families with alcohol and substance abuse were addressed.

According to Global Alcohol Policy Survey 2015 data, 54% of responding countries reported an increase in the level of community support for alcohol-free environments and events for youth and other at-risk groups (Q19).

On the issue of alcohol-free environments in general (i.e. not just for youth), the 2012 and 2016 Global Surveys indicate that there was an increase in the number of countries that had national guidelines for alcohol problem prevention and counselling at workplaces. The number increased from 14 in 2012 to 16 in 2016 (Q45 d, e in 2012; Q15 in 2016).

Also in the Global Surveys, respondents were asked about a list of typical settings or locations where alcohol restrictions are often put in place (Q15 in 2012; Q19 in 2016). For the majority of locations, more countries had initiated partial or full alcohol bans in 2016 than in 2012 (Fig. 15). However, there was a slight decrease in the number of countries that had alcohol bans in government offices, parks or streets, and at leisure events.

Fig. 15. Number of countries with full or partial alcohol bans in various settings, 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

From the Alcohol Policy Timeline Database, we found that the United Kingdom had encouraged provision of alcohol-free leisure centres for young people, such as youth cafés and alcohol-free music, dance and sports venues. Public Health England’s drugs and alcohol capital funding funded several alcohol-free venue projects.

In 2014 the Efekt programme (a school-based programme to prevent minors’ drinking) completed its pilot project in Estonian schools on early identification and brief interventions for harmful use of alcohol in primary health care settings. The programme “Healthy and sober Estonia” was elaborated to increase availability of dependence treatment and improve its quality.

In Finland, guidelines for preschool and school-based prevention of problems that may affect a child’s development were provided in the core curricula issued by the National Board of Education; they were last updated in 2014. Schools are required to have a plan for prevention of tobacco, alcohol and other drug use and for intervention and referral as appropriate. In 2015 the Institute for Health and Welfare issued guidance to school health services on auditing the school environment’s health promotion and safety aspects at three-year intervals.

A broader initiative was identified in Hungary, where a general methodological tool entitled “Reducing alcohol-related harms in communities” was developed in 2015 within the framework of the Bilateral Cooperation Agreement (BCA) with, and on the initiative of, WHO. Based on scientific evidence and relevant national evidence-based health policies and good practices, the tool was developed to support local health care activists, professionals and decision-makers in policy-making and implementation of local plans to reduce alcohol-related harms.

Another broad-based initiative was identified in the United Kingdom, where it was announced that the second phase of the Local Alcohol Action Areas (LAAA) programme (part of the Modern Crime Prevention Strategy) would be launched by the end of 2016. The first phase ran from February 2014 to March 2015 as part of the 2012 Alcohol Strategy. The programme allows the areas involved to choose one or more of three aims: to reduce alcohol-related crime and disorder; to reduce alcohol-related health harms; and to promote growth by establishing diverse and vibrant night-time economies. It promotes multi-stakeholder programmes to ensure better enforcement of age limits. Within each of the three aims, LAAAs can also take community measures to tackle young people’s alcohol consumption.

Operational objective 5.2. Provide support to children and families with alcohol-related problems

No items could be found that specifically address this operational objective in any of the 2012, 2015 or 2016 survey questionnaires. Neither did we have access to any CNAPA members’ reports to the EC covering this subarea. However, some country-specific information could be derived from the WHO Alcohol Policy Timeline Database.

Germany issued national guidelines on diagnosis and screening of FASD and other related measures – the S3 guideline “Diagnosis of Fetal Alcohol Spectrum Disorders” appeared in February 2016.⁵⁷ There have been several measures in the field of FASD prevention, in both schools and communities, and the new pocket version of the S3 guideline has been distributed to and applied by experts in the health, social paediatric and social sectors.

In Ireland, *Alcohol-related brain injury: a guide for families* was published in 2015.⁶¹ The National Drug Rehabilitation Framework, funded by the Health Service Executive, includes a family protocol.

In Switzerland, in 2015, a study on the effectiveness of ambulatory counselling in cases of alcohol problems was published.⁶²

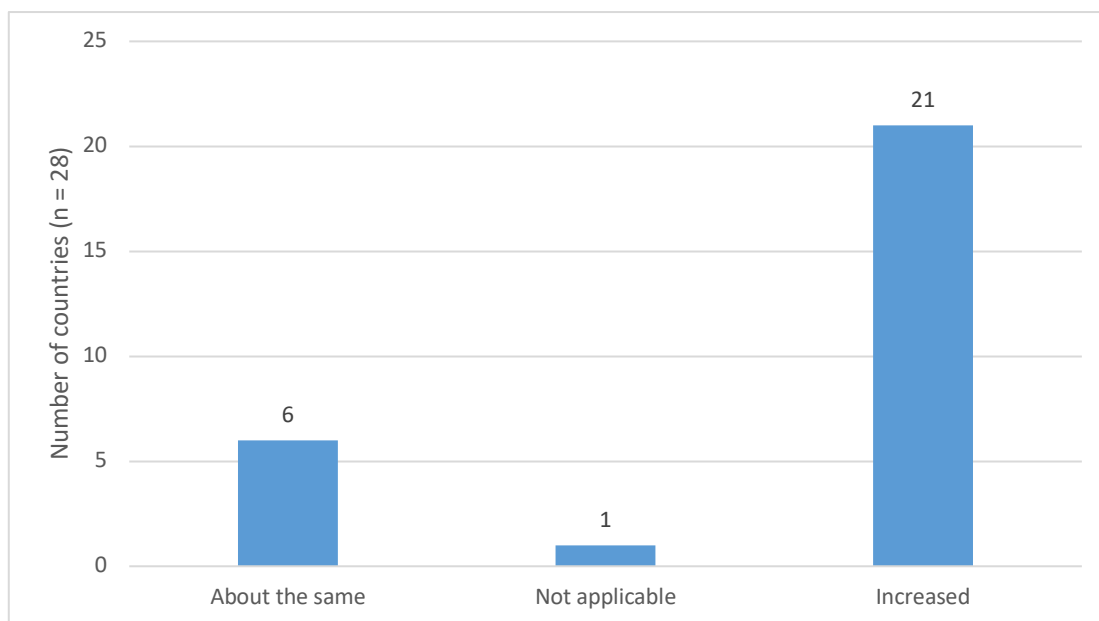
In 2015, as part of the Partnership Drugs Initiative (PDI), the Lloyds TSB Foundation for Scotland, with funding from the Scottish government, published *Everyone has a story*.⁶³ This project is designed to fill specific gaps in knowledge and evidence by using a participatory and consultative approach to improve the support for children and young people whose parents are in recovery. A number of recommendations were identified, some intended for the Scottish government, and the PDI is working with key partners to take these suggestions forward.

Operational objective 5.3. Reduce alcohol-related traffic accidents

According to Global Alcohol Policy Survey 2015 data, 14% of responding countries reported that mandatory driver-education programmes had been introduced for drink-driving offences between 2010 and 2015. 54% of respondents already had such programmes in place prior to 2010.

An increase in the overall scope and intensity of government policies and activities in the area of drink-driving countermeasures was reported by 75% of respondents (Q33) (Fig. 16).

Fig. 16. Overall scope and intensity of government policies and activities in the area drink-driving, 2010–2015

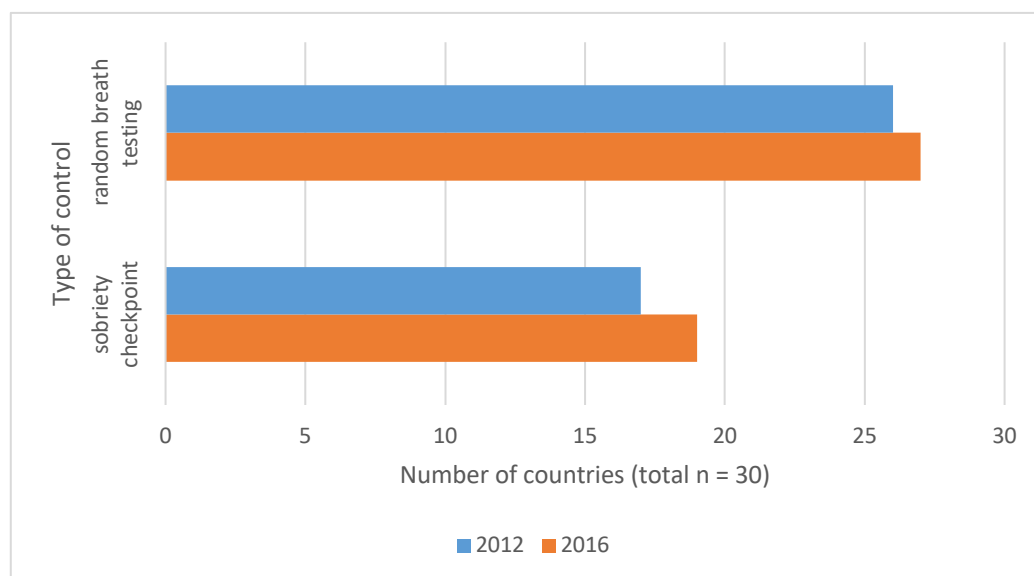


Source: Global Alcohol Policy Survey 2015

Achievements in this policy area included drink-driving prevention through mass media campaigns, ignition interlock systems, driver-education measures for novice drivers who had committed a drink-driving offence, re-education, and increased administrative penalties for drivers arrested for drink-driving (Q34). Other advances in this area included reduction of the permissible blood alcohol concentration (BAC) for new drivers, cyclists and professional drivers and stricter sanctions in Cyprus; a reduction of BAC in France; introduction of a zero BAC limit for new drivers with less than two years' experience in Italy; and lower BAC limits for young/novice and professional drivers in Switzerland.

Most of the questionnaire items concerning drink-driving and prevention of alcohol-related traffic accidents were not directly comparable across the 2012 and 2016 waves of the Global Survey on Alcohol and Health. One item, however, could be directly compared and showed slight increases in preventive drink-driving control measures (Fig. 17). The number of study countries that implement sobriety checkpoints increased from 17 to 19 between the two survey dates. Likewise, random breath testing increased slightly – one additional country had introduced use of this measure by 2016, bringing the total to 27.

Fig. 17. Number of countries with drink–driving controls, by type, 2012 and 2016



Source: Global Surveys on Alcohol and Health, 2012 and 2016

Some country-specific information was derived from the WHO Alcohol Policy Timeline. In Belgium, a national observational study on driving under the influence of alcohol (2012 data) was published in 2014.⁶⁴ In 2015, the Belgian Road Safety Institute (BRSI) had an article published in the journal *Accident analysis and prevention* investigating the impact of social norms and alcohol checks on driving under the influence of alcohol.⁶⁵ On 1 January 2015, the legal alcohol limit for professional drivers in Belgium was set at 0.2 g/L (the limit for ordinary, non-professional drivers remained at 0.5 g/L).⁶⁶

In Cyprus, in 2014, there was parliamentary discussion on revising road safety legislation and introducing lower BAC levels for novice and professional drivers.⁶⁷

Denmark introduced alcohol ignition interlocks as a penalty for drink–driving offenses in 2015.⁶⁸ In 2016, national clinical guidelines for screening and treatment of alcohol dependence and mental health were published.

In Scotland, in 2014, a lower drink–driving limit was introduced.⁶⁹

In Northern Ireland, in 2016, lower BAC levels were established for young drivers and professional drivers working in public transport services for children.⁷⁰

In 2015 France introduced Decree No. 2015-743 of 24 June 2015 concerning policy “against road insecurity”. The decree lowers the maximum permitted BAC limit from 0.5 g/L to 0.2 g/L for novice drivers.⁷¹

In Germany, in 2015, various actions involving youth groups (students, university students, local communities, vulnerable groups) were developed and promoted. Grants were awarded for pilot projects in the field of alcohol and drug prevention for students.

In Latvia, in 2014, changes in drink–driving legislation (tougher penalties for offenders) were introduced, and an information campaign warning against alcohol use and driving was organized.⁷² In 2016, Latvia conducted an audiovisual campaign giving information about the dangers of driving under the influence of alcohol.⁷³

In 2016, Lithuania introduced a zero tolerance (0.00 g/L BAC level) for drink-driving for novice drivers, professional drivers (taxis and other commercial transport vehicles) and drivers of mopeds, three-wheeled vehicles, all-terrain vehicles (ATVs) and motorcycles. Heavy drink-driving was criminalized.⁷⁴

In Portugal, a campaign to alert drivers to the dangers of driving under the influence of alcohol – “The decision of who takes you home is yours” – was conducted in 2015 by the Autoridade Nacional de Segurança Rodoviária (ANSR) (National Road Safety Authority) and the Guarda Nacional Republicana (GNR) (National Republican Guard).⁷⁵

In 2015 Spain made changes to the laws on alcohol and driving and imposed restrictions on alcohol consumption in public places (e.g. on public transport, in the street).⁷⁶

In Switzerland, an alcohol ban for novice and professional drivers ($\leq 0.01\%$) was introduced. Likewise, a mandatory “fitness to drive” check when drink-driving with a BAC of 0.05% or higher was introduced.⁷⁷

Operational objective 5.4. Ensure counselling and appropriate care and treatment for the drinker, the partner and children in families with alcohol problems

In the 2015 Global Alcohol Policy Survey, only four countries reported that mandatory counselling and/or treatment programmes had been introduced for drink-driving offences between 2010 and 2015. However, in 32% of responding countries such a programme had already been established prior to 2010 (Q31).

Unfortunately, we could find nothing directly comparable across the 2012 and 2016 Global Surveys. However, in the special WHO European Region section of the 2016 survey, there were a number of questions asking whether certain aspects of treatment and families had been instituted before, during or after 2014 (Q5k–n). Twelve countries introduced treatments that promoted a family perspective before 2014; two had done so in or after 2014 (Q5k). Thirteen reported that they had provided adequate support for family-centred treatment before 2014; only one had done so after (5l). Thirteen reported that they had ensured support/counselling for at-risk children and families before 2014; one had done so after (5m). Finally, 11 countries reported that they had begun to support the development of holistic alcohol treatment plans before 2014; none reported that they had done so in 2014 or later (5n).

From the WHO Alcohol Policy Timeline Database, we found that, in 2016, the Spanish Strategy on Health Promotion and Prevention was launched. Brief intervention programmes on alcohol in primary health care are part of comprehensive counselling on healthy lifestyles.⁷⁸ Furthermore, Switzerland published an updated study “Hospitalization due to alcohol intoxication or alcohol dependence of young people and adults” (2003–2012 data).⁶²

Summary of action area 5

There was a slight increase in the number of countries organizing and holding alcohol-free activities. The increases occurred in six of the nine settings listed. However, there was a decrease in the number of countries reporting alcohol-free parks and leisure areas in 2016 compared to 2012. There was some information on the availability of family-oriented treatment services (from the special European section of the 2016 survey). Fourteen countries reported that they had treatments promoting a family perspective (12 of these were prior to 2014); and the same number reported that they had instituted adequate support for family-centred treatment (all before 2014). At one CNAPA meeting, preventive interventions for young people living in families with alcohol and substance abuse were addressed in a presentation by Denmark. On the issue of drink-driving, a clear

majority of countries (21 out of 28) reported that the scope and intensity of activities had increased in 2015 compared to 2010. There was a slight increase in the number of traffic sobriety checks (random breath checks, random sobriety checks) over the 2012 and 2016 survey waves.

The Swiss road safety programme Via Sicura was initiated in 2012. The programme focuses on safe behaviour among all drivers, including a zero tolerance of drink–driving for novice drivers. The Swiss road mortality rate is among the lowest in Europe.⁷⁹

Action area 6

Support monitoring and increase research

Operational objective 6.1. Make data on alcohol-related harm available as a basis for policy-making

According to the Action Plan table of indicators for follow-up, Member States, together with the EC, had as an option for action to develop a standardized comparative survey on alcohol use, including HED. In March 2017, a report on a standardized European alcohol survey (SEAS) was published on the project website of Joint Action RARHA. RARHA recommended that the SEAS developed within the project should be replicated within four to five years to grasp trends in alcohol epidemiology and to monitor the impact of alcohol policies, as well as the influence of more general socioeconomic and cultural developments. It was also concluded that the sustainability of standardized alcohol surveys could be secured by establishing a European institutional framework.

Another option for action in the Action Plan on harmonized monitoring and reporting concerned the European Core Health Indicators (ECHI) for alcohol, for which the indicator of achievement was regular ECHI reports. Such reports were not openly available and so do not form part of this evaluation. However, the EC updates an online ECHI database,⁸⁰ and studies published in scientific journals have reported on the implementation of ECHI indicators and on the challenges encountered in a European country when working on harmonizing national data collections with international data delivery requirements.⁸¹

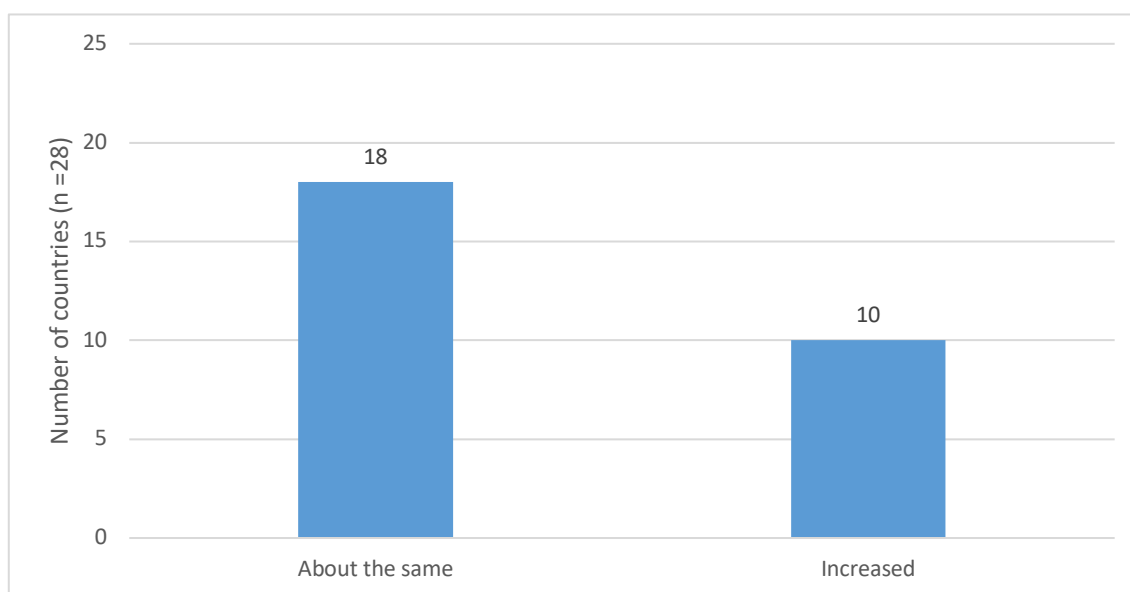
Two additional indicators in the Action Plan table for following up operational objective 6.1 were achieved through RARHA: a toolkit for evidence-based good practices to influence alcohol attitudes or behaviours; and work to seek consensus around low-risk drinking guidelines. Documents meeting this objective were published on the RARHA project website in 2016 and early 2017.⁸² Another indicator for operational objective 6.1 concerned the development of approaches with CNAPA and other relevant parties, such as WHO and the OECD, for more effective dissemination and better use of knowledge; such approaches focused, in particular, on cost–effectiveness of public health policies on alcohol, accumulated in EU-funded projects, through collaborative and commissioned work. To this end, the OECD published the report *Tackling harmful alcohol use: economics and public health policy*; this assessed the health, social and economic impacts of key policy options for tackling alcohol-related harms in three example countries (Canada, Czechia and Germany), extracting policy messages for a broader set of countries.⁸³

CNAPA meetings provided options to discuss methods and results of alcohol monitoring. Furthermore, the EC was given the option to report on developments of existing indicators for monitoring and data collection mechanisms – i.e. to work in collaboration with WHO and other relevant parties. In relation to the latter, the CNAPA meeting of 7–8 October 2014 agreed to include the European Monitoring Centre for Drugs and Drug Addiction in the list of CNAPA observers. Monitoring was discussed at several CNAPA meetings in the period 2014–2016, and WHO as well as the OECD gave presentations on this subject at the meetings. One example was the CNAPA meeting on 22 September 2015, at which the WHO Global Information System on Alcohol and Health (GISAH) was presented, including its databases, surveys and sources, and a presentation was given on OECD experience with data on alcohol.

According to the 2015 Global Alcohol Policy Survey, 61% of countries reported that an institution or other organizational entity responsible for collecting, collating, analysing and disseminating available data in their country was already in place prior to 2010. A further 29% of responding countries reported that such an institution/entity was established between 2010 and 2015 (Q90).

Thirty-six percent of participating countries reported that the overall scope and intensity of government policies and activities in the area of monitoring and surveillance had increased in the period 2010–2015 (Q95) (Fig. 18). The main barriers reported in this policy area were lack of funding and financial resources (Q97).

Fig. 18. Overall scope and intensity of government policies and activities in the area of monitoring and surveillance, 2010–2015



Source: Global Alcohol Policy Survey 2015

Entries in the Alcohol Policy Timeline Database seem to constitute the best documentation of monitoring and research initiatives that took place during the Action Plan period 2014–2016. Some of the studies and publications cited below are cross-posted in previous sections of this report.

In Belgium, in 2014, a national observational study on driving under the influence of alcohol (2012 data) was published.⁶⁴ Also published was a national survey of attitudes to driving under the influence of alcohol, drugs and medicines. In 2015, the Belgian Road Safety Institute (BRSI) had an article published in the journal *Accident analysis and prevention* investigating the impact of social norms and alcohol checks on driving under the influence of alcohol.⁶⁵

In France a report of the Court of Auditors on policies against harmful consumption of alcohol was published in 2016.

In Germany, *Alcohol consumption in adolescent and young adults in Germany 2012*, a representative study from the Federal Centre for Health Education, was published.⁸⁴ Also in Germany, in 2015, actions among youth groups – students, universities, local communities, vulnerable groups – were promoted and developed. In addition, grants were awarded for pilot projects in the field of alcohol and drug prevention for students.

The Greek REITOX Focal Point report on the drug and alcohol situation in Greece was published in 2014.⁸⁵

In 2014 Hungary started work in Joint Action RARHA. Work Package 4 (“Strengthening the monitoring of drinking patterns and alcohol-related harm across EU countries”) provided an unparalleled opportunity for a large-scope and population-wide examination of alcohol use habits as one of the most serious mental health risk factors in the country. Hungary also participated in both the evaluation of the project processes and the dissemination of the products of the project.⁸⁶ According to the project’s centrally recorded timeline, pilot testing of the questionnaire was completed and full-scale preparation for nationwide testing started in 2015.

In 2014, in Ireland, the report *Alcohol’s harm to others in Ireland* was published by the Health Service Executive.⁸⁷

In 2014, epidemiology and alcohol-related monitoring took place in Italy; a monitoring report from the National Observatory on Alcohol–CNESPS, focusing on the impact of the use and abuse of alcohol, was published in support of implementation of the activities of the National Alcohol and Health Plan.⁸⁸ The following year, *The use and abuse of alcohol in Italy* was published by Istat, the Italian National Institute of Statistics.⁸⁹

In Lithuania, in 2016, the Department of Statistics changed the methodology used to calculate alcohol consumption.⁹⁰

In Poland, in 2014, the *Report on the implementation of the Act of 26 October 1982 on upbringing in sobriety and counteracting alcoholism* was published.⁹¹ Also, in 2015, there was public funding for a major alcohol research project, or nationwide action project, on alcohol harm prevention and reduction.

In Portugal, in 2014, *General and family medicine and the approach to alcohol consumption: detection and brief interventions in primary health care* was published.⁹² In 2016 *A survey of addictive behaviour in young people in educational centres 2015* was published.⁹³ Also in 2016, another study of young people – *Addictive behaviour at age 18: survey of young people participating in National Defence Day 2015* – was published.⁹⁴ Annual reports on the state of the country with respect to alcohol were published in the study period by SICAD, the Portuguese intervention service for addictive behaviours and dependencies.^{95,96} A national study of alcohol, tobacco and drug use was carried out using representative samples of students from each age group from 13 to 18 years. The core questions of the ESPAD questionnaire were used, among others, and data from students aged 16 were included in ESPAD. The survey provides epidemiological characterization of alcohol, tobacco and drug use.⁹⁷

In 2015 Romania had a Governmental Decision published in the Official Monitor of Romania concerning the creation of the National Council for coordination of policies and actions aiming to reduce harmful use of alcohol in Romania. The Council acts under coordination of the Ministry of Health and has three bodies: the interministerial committee, the technical secretariat and the consultative committee. The Council is responsible for developing the national action plan to reduce harmful use of alcohol in Romania.

In 2015 Slovakia carried out a cross-sectional study of the influence and impact of health education on the prevention of alcohol dependence among people aged 15 to 29 years.

In Slovenia, in 2015, a report on the recorded alcohol consumption and health consequences of hazardous and harmful drinking in the country was published.⁹⁸

In 2015 Spain carried out a national health survey of the Roma population; a comparative study of national health surveys of the country's Roma population and general population was also conducted.⁹⁹

In Sweden, in 2015, two reports were published on the implementation and follow-up to the former strategy – Alcohol, Narcotics, Doping and Tobacco Policy (ANDT) 2011–2015.

In Switzerland, in 2015, the results of the country's 2014 HBSC survey were published. In 2014, the project "Alcohol intoxication with hospitalization: a systematic literature review on the effectiveness of psychosocial interventions in hospitals in case of alcohol intoxications and expert interviews on national practices" was carried out. Based on this, a follow-up project is due to focus on further knowledge exchange between the actors involved and on validation of established practices.⁶²

In the United Kingdom, in 2016, Public Health England commissioned research to develop methods to assess the physical and psychological health consequences for children living in families with alcohol problems. In the same year, *Monitoring and evaluating Scotland's alcohol strategy: final annual report* was published in Scotland.¹⁰⁰ In Wales the report *Reading between the lines: the annual profile for substance misuse 2014–15* was published.¹⁰¹

Operational objective 6.2. Target EU research funding at knowledge gaps already identified and at topics that need to be studied at European level

Our search for research, development and implementation projects under the Third Health Programme (2014–2020) in the Chafea Health Programmes Database revealed 33 projects on alcohol; of these, six were eligible, receiving €3.3 million in total EU funding. We also considered eligible an OECD report co-funded by the EU and published in 2015. The seven projects are summarized in Table 2.

Table 2. EU-funded research, development and implementation projects with starting dates in the Action Plan period 2014–2016

Chafea project number	Title	Project coordinator (project website) and short description	Start and end dates
709661	STAD in Europe (SiE)	Stichting Trimbos-Instituut, Netherlands Institute of Mental Health and Addiction (http://stadineurope.eu). The STAD in Europe (SiE) project aimed to tackle heavy episodic drinking by restricting the availability of alcohol in public and private drinking environments. Pilot implementation trials were performed and evaluated in Czechia, Germany, the Netherlands, Slovenia, Spain, Sweden and the United Kingdom.	1 June 2016–31 May 2019
710063	ALLCOOL Project	Raising Awareness and Action-Research on Heavy Episodic Drinking among low income youth and young adults in Southern Europe (ALLCOOL). Agencia Piaget para o Desenvolvimento (https://allcool.ausl.bologna.it). A consortium of research and collaborating stakeholders in Portugal, Spain and Italy aimed to build knowledge of HED among low-income young adults and the associations between alcohol use and economic downturn.	1 May 2016–31 July 2018
709876	EPHA SGA 2016	Specific Grant Agreement for the 2016 activities of the European Public Health Alliance (EPHA) (https://epha.org/epha-annual-review-2016). EPHA's Annual Work Programme for 2016 was drawn from the multiannual work programme 2015–2017.	1 Jan 2016–31 Dec 2016
20134204	6th European Alcohol Policy Conference (6EAPC)	European Alcohol Policy Alliance (Eurocare)* (https://www.nijz.si/sites/www.nijz.si/files/uploaded/mariann_skar_0.pdf). The overall objective of the conference is to support capacity-building and action in alcohol policy at the European, national, regional and municipal levels to invest in the health of Europe's citizens	27 Nov 2014–27 Nov 2015
20133206	Eurocare_ FY2014	Operating grant for Eurocare fiscal year 2014 (https://www.eurocare.org/media/GENERAL/docs/annual-reports/eurocareannualreport2014.pdf).	1 Jan 2014–1 Jan 2015
20132202	Joint Action on Reducing Alcohol Related Harm (Joint Action RARHA)	Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (http://www.rarha.eu/Pages/default.aspx). This Joint Action aimed to develop capacity-building and common understanding among Member State partners and in the wider public health community in order to address and reduce alcohol-related harm at European and local level.	1 Jan 2014–1 Jan 2017
20155101	<i>Tackling harmful alcohol use: economics and public health policy</i>	OECD (https://www.oecd.org/els/health-systems/tackling-harmful-alcohol-use-9789264181069-en.htm). ⁸³ This report gives a detailed examination of trends and social disparities in alcohol consumption in OECD countries and beyond and a wide-ranging assessment of the health, social and economic impacts of key policies for tackling alcohol-related harms in Canada, Czechia and Germany, with relevant policy messages for a broader set of countries.	

* Eurocare is an alliance of nongovernmental and public health organizations with around 55 member organizations across 24 European countries

The project STAD in Europe (SiE) is described briefly under operational objective 1.4 (and again under 2.1) as it was about implementing a method of limiting alcohol availability in on- and off-premise drinking environments in order to reduce youth drinking. The ALLCOOL project was a research-oriented joint action that aimed to improve scientific knowledge of HED among low-income, graduate and unemployed young adults living in southern European cities (Porto, Tarragona and Bologna) characterized by economic crisis. ALLCOOL also produced a toolkit on methodologies and implementation models that provides guidance and support to professionals who wish to address HED.

The European public health NGO EPHA received EC funding under an operating grant for 2016. In its annual report on activities in 2016, EPHA reported their progress in tackling the epidemic of noncommunicable diseases driven by commercial determinants in the era of globalized trade, particularly with respect to tobacco, alcohol, unhealthy food and pollution. Alcohol-specific actions highlighted in the report were in the area of marketing and in relation to the AVMSD; thus this project is further described under operational objective 3.1.

The NGO Eurocare was granted funds from the EU's Third Health Programme for activities during 2014. According to the Eurocare annual report for the fiscal year 2014, the main advocacy topic for Eurocare that year was a renewal of the EU Alcohol Strategy. The arrangement of the 6th European Alcohol Policy Conference in November 2014 was granted additional funding.

One of the major outputs from the RARHA research consortium was to develop EU-wide alcohol surveys using a joint methodology, described under operational objective 6.1 above. Addressing European-level knowledge gaps and topics, other main RARHA outputs were:

- **Guidelines.** These combine scientific knowledge of risks and experiences in the use of drinking guidelines to clarify their scientific basis and practical implications, offering good-practice principles for use of drinking guidelines as a public health measure.
- **Toolkit.** This provides health policy planners with a structured description of the effectiveness, potential for replication/adaptation, scalability, costs and critical success factors of collected examples of good practice in alcohol harm prevention in Member States.

An EC-funded OECD report, *Tackling harmful alcohol use*, published in May 2015, shed light on various dimensions of alcohol consumption, the economics of alcohol use, and the design of appropriate health policies to prevent alcohol-related harms.⁸³ The report focused on Canada, Czechia and Germany and considered the implications for the OECD region, providing a basis for a quantitative assessment of the impacts of alternative policy options. Heavy drinking was found to be associated with a lower probability of employment, more frequent absence from work, and lower productivity and wages; the overall value of production lost to harmful alcohol use was estimated at 1% of GDP in high- and middle-income countries.

The various survey data consulted in the current evaluation had little information that was relevant to operational objective 6.2. Neither were there any CNAPA members' written reports to the EC on this topic that were openly available. However, the 2016 Global Survey on Alcohol and Health had one relevant question in the special European section (Q6): "What have been the main activities/policy achievements in supporting monitoring and increasing research since 2014 ... on cross-border internet/online sale of alcohol, in particular on non-compliance on alcohol regulation, such as age limits?" In response to this question, two countries reported that they had initiated such research before 2014 and one country that it had done so during or after 2014. There was a follow-

up question asking about any other activities, which no country elaborated upon. Otherwise, there were no other relevant topics included in the special European section of the 2016 Survey.

Operational objective 6.3. Monitoring of the Action Plan

No indicators were found in any of the study material that makes reference to, or is related in some way to, this operational objective. Neither were there any CNAPA members' reports to the EC on this topic publicly available. Likewise, there was no publicly available summary report from the EC on EU achievements between 2014 and 2016 on monitoring of the Action Plan based on CNAPA members' reports to the EC. However, the present evaluation report can be seen as a first attempt to monitor the CNAPA Action Plan as specified in its main document endorsed on 16 September 2014.

Summary of action area 6

Data and monitoring were recurrently discussed at CNAPA meetings between 2014 and 2016. Two Joint Actions funded by the EC either ran or were started in the relevant period: RARHA, which ran from 2014 to 2016, and ALLCOOL, which started in 2016. During the Action Plan period, RARHA developed the standardized European alcohol survey (SEAS), a toolkit on good practices designed to change attitudes, and a comprehensive evidence base to support EU Member States in any revisions of national low-risk drinking guidelines or recommendations. To secure a sustainable European institutional framework for carrying out an SEAS at four to five-year intervals, two different options were suggested. Within the Third Health Programme, the EC provided funding of €3.3 million for six research, development and implementation projects on alcohol. Seventeen countries reported research or monitoring activities during the Action Plan period, and 14 countries listed a range of one to six publications and/or research projects occurring during the Action Plan period. CNAPA meetings were given a number of presentations on monitoring by WHO and other actors. Regarding the overall scope and intensity of government policies and activities in the area of monitoring and surveillance, a majority of countries reported that efforts had remained about the same in the period 2010–2015, while 10 said such efforts had increased. Regarding the only option for action mentioned in the Action Plan addressing knowledge gaps and EU-relevant topics – namely, support for research on cross-border or online alcohol sales – only two countries reported that they had conducted such activities before 2014 and one had done so after that date.

The Cyprus Anti-Drugs Council, Public Entity, was established under the “Prevention of the Use and Dissemination of Drugs and other Addictive Substances” Law 28 (I) 2000 and (Amendment) 142 (I) of 2002 and 222 (I) of 2014. The Cyprus Anti-Drugs Council is the supreme coordinating body in the field of substance dependency at three levels of prevention as defined by WHO (Cypriot Ministry of Health, 2018).¹⁰²

Discussion

Over the last two decades there has been increased awareness in the EU of the need to prevent and reduce alcohol-related harm. Focusing on the period 2014–2016, this report documents and assesses, at an aggregate level, the activities undertaken within the six action areas that are outlined in the Action Plan on Youth Drinking and on Heavy Episodic Drinking (binge drinking) (2014–2016), endorsed by CNAPA. It covers the work of the 28 EU Member States, Norway and Switzerland, which are members of CNAPA. A solid amount of work to decrease youth drinking and HED has been carried out in the countries covered by the Action Plan in the period 2014–2016. The data sources selected for the study showed that there has generally been a slow movement towards accordance with Action Plan aims and objectives. At the same time, and also at an aggregate level, the prevalence of binge drinking and drunkenness has decreased. Several scientific studies have documented this phenomenon, concerning young people in particular, which has not only taken place in Europe but in most of the developed world.

Importantly, this report does not represent an evaluation of the Action Plan in its true sense; rather, it gives a description based on a limited number of selected data that allowed comparisons to be made. As such, this report has significant limitations and should not be used to guide national alcohol policy. It should also be noted that, mainly as a consequence of insufficient specific data to assess the period 2014–2016, the actions described and assessed in this report correspond to a wider timeframe, 2010–2016.

In action area 1 – *Reduce heavy episodic drinking (binge drinking)*, slight increases in the number of countries using the policy options were seen. There was a slight increase in the number of countries using health information labels, and an increase in the mean number of awareness-raising activities, but no apparent change in the number of countries using server training. Several countries reported that alcohol tax increases had taken place during the study period, and some reported tax modifications. One country made use of price policies other than taxation. Discussions in CNAPA on pricing and fiscal policies appear to have been limited in the period 2014–2016. A majority of countries reported increased support for the method of screening, early identification and brief intervention in health care. At the same time, progress towards the action area aim – reduced HED – was favourable for both adults and young people at an aggregate level.

In action area 2 – *Reduce accessibility and availability of alcoholic beverages for youth*, a small number of countries reported increases in the legal age for purchases of spirits both on-premises (from 16 to 18 years) and off-premises (from both 16 to 18 years and from 18 to 20 years). Otherwise, most of these regulations were in place before 2012 and had not changed since. The mean number of awareness-raising activities on accessibility and availability increased slightly. Eight countries reported specific activities in this area in the period 2014–2016; of particular note were new initiatives to curb accessibility and availability by Estonia, Ireland, Lithuania and Cyprus.

In action area 3 – *Reduce exposure of youth to alcohol marketing and advertising*, the EC published a report on minors' exposure to alcohol marketing, and alcohol marketing in a broader perspective appears to have been a recurrent subject at CNAPA meetings during the Action Plan period. For those indicators that could be made comparable between surveys, there were small increases in the number of countries with a total ban on at least one beverage type in public settings, and decreases in the number of countries with no restrictions at all on alcohol advertising (all settings/media except point-of-sale advertising), alcohol sponsorship and sales promotion. In seven countries the scope and intensity of government policies and activities in the area of alcohol marketing had increased between 2010 and 2015. Marketing bans covering all alcoholic beverages were still very rare in 2016, and this was evident for all settings or media types. Four countries reported new

marketing regulations in the period 2014–2016, one of which was a voluntary agreement with industry.

In action area 4 – *Reduce harm from alcohol during pregnancy*, a majority of countries reported that they had brief interventions to reduce or prevent drinking in pregnancy in place before 2014; only two countries added such programmes after that year. Six countries reported that they had rehabilitation centres for alcohol-dependent pregnant women; all were initiated before 2014. The number of countries reporting that they had awareness-raising activities regarding alcohol and pregnancy rose from eight in 2012 to 17 in 2016. However, no change was found in the number of countries that reported specific treatment options for pregnant women. Clinical guidelines for prevention, diagnosis and treatment of FASD seem not to have been a subject for discussion at CNAPA meetings in the period 2014–2016. In 2016 France was the only EU Member State which had mandatory health information labels giving information about the dangers of drinking alcohol while pregnant. Lithuania has since followed suit.

In action area 5 – *Ensure a healthy and safe environment for youth*, slightly increasing support for alcohol-free activities and settings was revealed. However, importantly, this was not the case for parks and leisure environments. Concerning drink–driving, a clear majority of countries reported increased scope and intensity of activities in 2015 compared to 2010. In one CNAPA meeting, a presentation by Denmark addressed the issue of preventive interventions for young people living in families with alcohol and substance abuse. Most efforts to provide treatment that promotes a family perspective and is family-centred were already underway in 2014.

In action area 6 – *Support monitoring and increase research*, Joint Action RARHA developed a standardized European alcohol survey (SEAS) during the Action Plan period, a toolkit on good practices, and a comprehensive evidence base to support EU Member States on low-risk drinking guidelines and recommendations. Within the Third Health Programme, the EC provided total funding of €3.3 million for six research, development and implementation projects on alcohol. At CNAPA meetings there were a number of presentations from WHO and other actors on monitoring. Regarding the overall scope and intensity of government policies and activities in the area of monitoring and surveillance, however, a majority of countries reported that efforts between 2010 and 2015 had remained unchanged. The only option for action addressing knowledge gaps and EU-relevant topics in the Action Plan – namely, support for research on cross-border or online alcohol sales – was conducted by just two countries, one before 2014, the other after.

Limitations

The current report has several limitations.

First, the available sources of information cover only a selected range of alcohol policy activities based on the Action Plan and contain a modest quantification of those activities. Furthermore, indicator data for some options for action could not be found publicly available. This was an issue, in particular, for CNAPA members' reports to the EC, but there was also limited information in publicly available CNAPA meeting reports to judge the extent and quality of discussions of relevant topics. Regarding the survey information used in this report, it should be remembered that such information can represent a subjective assessment of policy gains or setbacks. It cannot be ruled out that some changes in policy reported here may be due to reporting bias, as one country representative might have answered the questionnaire at baseline and another at follow-up. Low internal response rate in some parts of the surveys used for this evaluation is another limitation. The set of questions used to evaluate actions addressing diagnosis and support of affected or at-risk groups for alcohol harm during pregnancy (operational objective 4.3) is a case in point. It is unclear

how to interpret the missing countries: do the missing values mean that the countries did not have relevant programmes or initiatives at all, did they refuse to answer, or were they simply unable to participate in this part of the survey? This problem affects the calculation (i.e. determination of the denominator) used to work out the proportion of countries that responded positively to a question.

The second main limitation of this study is that the data used for the assessment cover various time periods. Thus, the Global Surveys on Alcohol and Health were conducted in 2012 and 2016; the WHO 2015 Alcohol Policy Questionnaire asks about the period 2010–2015; the HBSC survey compares data between 2002 and 2014; and the ESPAD survey compares data between 2011 and 2015. Although these periods do not match the Action Plan's period 2014–2016, the various data sources do cover part or all of it. Only one source of data explicitly covers the period 2014–2016 – the special section (D) of questions in the 2016 Global Survey. For these reasons the results of this report can only be seen as crude. However, because we have used several sources of data, in which the majority of results point in the same direction, we can be confident in our assessment that there was a modest increase in alcohol policy activities in the countries covered by the Action Plan.

A third major challenge is that the data used in this study were not data originally intended to be collected in conjunction and in synchronization with the Action Plan. To include all original Action Plan indicators would have required an original data collection for this report, as well as additional labour and time to complete it. For example, to have collected information on an indicator such as “quantity and quality of national events, publications, information material, percentage of population reached” (Annex 1, page 1) would have required not only operationalization but also additional national contact personnel, who would have been recruited to complete just this one task. This limitation raises an issue for future evaluations: those indicators that are declared for use in evaluations or assessments should be fully identified and operationalized at the outset and followed up continuously thereafter.

Our inability to operationalize and collect data on all proposed indicators shown in the table in Annex 1 also raises another major limitation of the report. Some of the information given in open-ended survey questions was provided in national languages. The languages the team assigned to draft the evaluation report could read were limited to English, the Scandinavian languages, German and a modest amount of Spanish. Funding to review documents and search literature in a variety of languages should be fully addressed in future work of this kind. Language barriers should be taken into consideration in any future serious assessments of Action Plan activities.

Finally, two operational objectives in the Action Plan (1.2 and 1.6) encourage actions targeted at “relevant subgroups”. With the exception of some easily identified regulations or activities which involved younger age groups (e.g. specific educational campaigns, age limits) and pregnant women (action area 4), it was often difficult to identify subgroups that were targeted or reached in activities carried out to meet these operational objectives. To allow evaluation, future Action Plan indicators should aim to specify subgroups or settings that are relevant on the basis of available evidence.

Conclusions

While acknowledging its several important limitations, the present report has served as a first attempt to document the progress made by EU Member States during the Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) (2014–2016), endorsed by CNAPA, up to and including the year 2016. Many of the activities in the Action Plan conform to other valid strategies and action plans in Europe and should therefore be seen as part of an ongoing effort from EU Member States, Norway and Switzerland to address harmful use of alcohol – an effort that started further back in time than 2014 and that continued to bear fruit after 2016. The Action Plan

seems to have been beneficial to the countries covered, in the sense that it contained a clear framework for action at EU level that complemented and reinforced other valid strategies and action plans, while addressing needs identified by CNAPA members.

This report indicates that countries moved in the same direction in determining their alcohol policy and activities in the six action areas outlined in the Action Plan and that, for the most part, they moved in the desired direction, increasing regulations and establishing policies to discourage HED and underage alcohol consumption. However, the policy gains were very modest, and for some options for action there was no apparent activity. There appear to have been few discussions in CNAPA on some of the policy options mentioned in the Action Plan, and none at all on others; and the quality of sessions is unknown. In view of this, this report also highlights the need for the EC to provide better and continuous monitoring of CNAPA meeting satisfaction and to improve its support for CNAPA members, so that a coordinated European alcohol policy agenda can be kept alive and on the table.

In some action areas – for instance, in reducing exposure of young people to alcohol marketing – the effects on policy were mixed. This suggests that future or revised action plans should address barriers that countries experience while trying to implement alcohol policy. Such barriers include lack of financial resources, low levels of cross-sectoral cooperation, opposition from stakeholders, insufficient political will, and drinking culture. Such obstacles must be addressed more specifically in future alcohol policy work.

Primary barriers to implementing alcohol policies

In the WHO Global Alcohol Policy Survey 2015, 11 countries noted limited or reduced availability of funding as a key barrier to implementing alcohol policies. Hungary, Germany and Romania pointed to inadequate cross-sectoral cooperation as a challenge. Seven countries listed lobbying and opposition from the alcohol industry as barriers to introducing changes in alcohol policy, while Ireland described lobbying by alcohol providers as undermining health reforms. Germany, Finland, Romania, Belgium, Latvia and Czechia described societal attitudes towards drinking and cultural resistance as barriers to successful implementation of alcohol policies. Additional barriers reported by responding countries included lack of enforcement, slow political progress and lack of political will to introduce reforms.

The process of national alcohol policy action is often troublesome and time-consuming. It is therefore likely to be beneficial for alcohol policy development in the EU the extended duration for the Action Plan, to 2020, as agreed by CNAPA in 2017. In any case, action plans need to be based on sound science to have a good chance to deliver their desired effects, they must be provided with adequate standards to monitor target achievements, and they should seek to overcome key obstacles to implementation.

As for policy, the following lessons can be learned for more tangible results:

- **Evidence-based actions.** Information campaigns and other awareness-raising activities were popular in Member States, but they are often costly and have not been shown, in isolation, to sustainably reduce HED or youth drinking. To maximize the impact of future action plans, information activities may be emphasized as a complement to, or component in, interventions with a stronger evidence base.
- **Implementation support.** Member States seem to need more support from the EU level in implementing the Action Plan. Examples of support:

- Adequate funding and relevant, measurable indicators of achievement, clearly associated with HED reduction or youth abstinence from alcohol, should be available; they should be followed up continuously during the Action Plan period, facilitated by the EU, and supported by the strong EU/WHO monitoring system on alcohol and health that is already in place.
- EU legislation and policies in other areas should not cancel out or make impossible preventive actions in the alcohol area; a Health in All Policies (HiAP) approach is advisable.
- As opposition and lobbying from commercial interests in the alcohol industry were identified by Member States as key obstacles to alcohol policy development,¹⁰³ Member States may benefit from guidelines that support achievements in reducing HED and youth drinking – for example, statutory regulation on industry disclosure of information on marketing expenditures, or strategies to handle initiatives in the area of prevention funded by commercial interests in alcohol production or marketing.

As for research, the following needs were identified:

- **High-quality evaluations of interventions.** As Member States are changing national alcohol policies, the EU level can encourage and collect scientific evaluations of national policy experiments to bring added value to the EU. Evaluations must be of high quality to allow unbiased conclusions about the effects of policy measures on HED and youth drinking, ideally in different socioeconomic groups. A stepwise introduction of new policy (for example, a difference-in-differences design) with matched unexposed controls is one example of a high-quality design, and the follow-up period should be long enough to inform on the sustainability of effect.
- **Research on differential effects of policies on socioeconomic and demographic groups.** Public health policy is about protecting the vulnerable, but there is still insufficient knowledge of the effects of alcohol interventions on HED or youth of various socioeconomic positions in high-income countries.¹⁰⁴ By encouraging more research in this area, the EU level can enlighten policy-making, protect vulnerable groups, and in the longer term contribute to a socially sustainable development of the EU in line with the SDGs.
- **Empirical knowledge of correlations between policy and harm.** As national policies to reduce HED and youth drinking develop in EU Member States, there are opportunities to examine the extent to which the presence and various combinations and interactions of alcohol policies account for national-level variations in related harm outcomes. An EU-wide approach is needed to see patterns. This research can inform and inspire Member States that are lagging behind in policy implementation.

Annex 1

Overview table

Action area 1. Reduce heavy episodic drinking (binge drinking)

Main priority: to reduce heavy episodic drinking (binge drinking) and its negative consequences, including harm to others in all age groups

Operational objectives	Options for action	EC-proposed indicators	Existing WHO survey questions (2012 and 2016 surveys)
1.1. Encourage health-related information including alcohol-related risks on alcoholic beverages to help consumers make informed choices.	EC report on application of the requirements to provide information on ingredients and nutritional information for alcoholic beverages (as requested in Regulation (EU) No. 1169/2011).	EC report.	
	Based on the EC report on application of the requirements to provide information on ingredients and nutritional information for alcoholic beverages, discussion on and exchange of best practices in CNAPA on health warnings and nutrition labelling on alcoholic beverages.	Quantity and quality of relevant topics discussed (based on CNAPA meeting reports).	<p>Are health warning labels legally required on the containers/bottles of alcoholic beverages in your country at the national level?</p> <p>Is there a national legal requirement to display consumer information about calories, additives, vitamins, microelements on the labels of alcohol containers?</p> <p>Is there a national legal requirement to display the number of standard alcoholic drinks in the container on the labels of alcohol containers?</p> <p>Is there a national legal requirement to display alcohol content on the labels of alcohol containers?</p> <p>What is the text/picture of the legally required health warning labels?</p>

1.2. Encourage knowledge about health and social harm from heavy episodic drinking in relevant services and subgroups.	Raise awareness of the general public and relevant services on health and social harm from HED.	Quantity and quality of national events, publications, information material, percentage of (targeted) population reached.	<p>In the last three years, did you have any nationwide awareness-raising activities [on the following topics]: young people's drinking; alcohol's impact on health; social harms?</p> <p>Are health warning labels legally required on alcohol advertisements in your country at the national level?</p> <p>3</p>
1.3. Ensure knowledge about health and social harm from heavy episodic drinking among youth.	Develop and integrate information on alcohol-related harm in academic curricula for professionals working with young people.	Quantity and quality of produced/adjusted curricula.	4
	Develop and implement training and educational programmes to increase awareness of health professionals about health and social harm from HED among youth.	Quantity and quality of programmes.	5
		Number of professionals trained.	6
	Promote and develop community actions among young people group (students, universities, local communities, vulnerable groups).	Quantity and quality of programmes.	<p>In your country, is there a legal obligation for schools to carry out alcohol (or broader alcohol and other substance use) prevention as part of the school curriculum or as part of school health policies?</p> <p>In your country, is there a legal obligation for schools to interact with parents regarding the education and well-being of students?</p> <p>In your country, do you have national guidelines for the prevention and reduction of alcohol-related harm in school settings?</p> <p>Does your national alcohol policy (or action plan) include steps to specifically involve young people in activities to reduce or prevent alcohol-related harm?</p> <p>7</p>

<p>1.4. Strengthen regulations and measures to minimize sale and serving practices and environments that promote heavy drinking and intoxication.</p>	<p>Promote and introduce standards for server training programmes, e.g. for those involved in selling and serving alcoholic beverages.</p>	<p>Number of Member States where server training is introduced/promoted.</p>	<p>In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis? If yes, organized by enforcement agencies, private sector, or other?</p>
<p>1.5. Support and implement fiscal and pricing policies to discourage heavy episodic drinking.</p>	<p>Discussion and exchange of best practices in CNAPA on fiscal and pricing policies to discourage HED.</p>	<p>Quantity and quality of relevant topics discussed (based on CNAPA meeting reports).</p>	<p>Please specify the average retail price of alcoholic beverages.</p> <p>Do you have any price measures other than taxation in your country? (options: minimum price policy; requirement to offer non-alcoholic beverages at a lower price; additional levy on specific products [e.g. alcopops]; ban on below-cost selling; ban on volume discounts; price measures to discourage underage drinking or high-volume drinking [please specify])</p>
<p>1.6. Promote and ensure implementation of screening, early identification and brief intervention in all relevant subgroups and settings.</p>	<p>Consider using the results of the EU-funded projects BISTAIRS (Brief Interventions in the Treatment of Alcohol Use Disorders in Relevant Settings) and ODHIN (Optimizing Delivery of Health Care Interventions) to revise national objectives concerning the implementation of screening and brief interventions in health care and social services.</p>	<p>Number of Member States where implementation of screening and brief intervention has expanded beyond primary health care.</p>	<p>Brief interventions used as a method of health promotion and disease prevention.</p> <p>In your country are there clinical guidelines for brief interventions that have been approved or endorsed by at least one health care professional body?</p> <p>Training of health professionals on a regular basis in screening and brief interventions for alcohol problems.</p>

Action area 2. Reduce accessibility and availability of alcoholic beverages for youth

Main priority: to prevent consumption among underage and harmful and hazardous use among young people

Operational objectives	Options for action	EC-proposed indicators	Existing WHO survey questions (2012 and 2016 surveys)
2.1. Promote, ensure and enforce adequate level of controls in on- and off-premises, particularly for legal age checks.	Use effective enforcement measures to reduce availability of alcoholic beverages to underage people.	Number of (legal and other administrative) interventions adopted or strengthened. 11	In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis? If yes, organized by enforcement agencies, private sector, or other?
		Age of first drinking. 12	
		Number of law enforcement officers or other relevant civil servants trained. 13	
	Introduce on voluntary basis 25 years or higher reference age for age controls.	Number of Member States with 25 or higher age as reference age for age controls. 14	
	Discussion and exchange of best practices in CNAPA on distance sales, sales from automated tills, vending machines, and implementing automated control measures for face-to-face sales to prevent the purchase of alcohol by minors.	Quantity and quality of relevant topics discussed (based on CNAPA meeting reports). 15	
2.2. Support multisectoral approaches to ensure compliance with national regulations.	Deliver national information campaigns to raise awareness of national legislation among sellers of alcoholic beverages and the general public.	Quality and quantity of mass media campaigns, information programmes. 16	In the last three years, did you have any nationwide awareness-raising activities on young people's drinking?
		Number of Member States carrying out Alcohol Awareness Day/Week. 17	
	Promote multi-stakeholder programmes including economic operators, police and local authorities to ensure better enforcement of age limits.	Quality and quantity of multi-stakeholder agreements. 18	
		Percentage of alcohol law compliance during inspection activities. 19	

Action area 3. Reduce exposure of youth to alcohol marketing and advertising

Main priority: to protect the most vulnerable age groups from exposure of alcohol marketing and advertising

Operational objectives	Options for action	EC-proposed indicators	Existing WHO survey questions (2012 and 2016 surveys)
3.1. Ensure that all marketing and advertising is in compliance with the Audiovisual Media Services Directive and with national regulations and voluntary codes.	Study on exposure of minors to alcohol advertising on linear and nonlinear audiovisual media services and other online services based on the Audiovisual Media Services Directive's restrictions (2010/13/EU).		<p>In which ways are infringements of marketing restrictions detected?</p> <p>What are the penalties for infringements of marketing restrictions?</p> <p>How many infringements of marketing restrictions occurred in the last calendar year?</p> <p style="text-align: right;">20</p>
3.2. Limit the exposure of youth to alcohol marketing through the internet and new media, including sponsoring.	Discussion and exchange of best practices in CNAPA on addressing alcoholic product placement and sponsorship on various media (TV, cinema, internet) taking account of young people's exposure.	Quantity and quality of relevant topics discussed (based on CNAPA meeting reports).	
	Discussion and exchange of views in CNAPA on alcohol marketing via new media and its impact on young people.	Quantity and quality of relevant topics discussed (based on CNAPA meeting reports).	
	Use existing legislation and co-regulation to reduce the exposure to advertising to which young people are exposed through media.	The number of countries that have strengthened their existing legislation or co-regulation to reduce exposure of young people to alcohol.	<p>Please specify the restrictions on alcohol advertising/product placement (on public service/national TV, commercial/private TV, national radio, local radio, print media, billboards, points of sale, cinema, internet, social media). (options: ban, partial statutory restriction on time/place, partial statutory restriction on content, voluntary/self-regulated, no restriction)</p> <p>Please specify the restrictions on industry sponsorship/sales promotion (on industry sponsorship of sporting events, industry sponsorship of youth events, sales promotions from producers, below-cost sales promotions from retailers, free drinks sales promotions from owners of pubs/bars). (options: ban, partial statutory restriction, voluntary/self-regulated, no restriction)</p> <p style="text-align: right;">23</p>

Action area 4. Reduce harm from alcohol during pregnancy

Main priority: to prevent Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD) and provide appropriate care for affected children and families

Operational objectives	Options for action	EC-proposed indicators	Existing WHO survey questions (2012 and 2016 surveys)
4.1. Encourage that information about the danger of alcohol during pregnancy, the breastfeeding phase and infant age is widely available.	Integrate alcohol-related harm to the unborn child into information-based prevention programmes in schools and targeting the general public.	Number of Member States integrating alcohol harm of the unborn child into prevention programmes. 24	
	Initiate research to develop and validate feasible methods for assessing reliably the incidence of FASD at population level.	Number of Member States initiating research. 25	Is there a comprehensive report on the alcohol situation drawn up and published regularly at the national level in your country? If yes, please indicate how often the report is published, by whom, and which topics are covered in the report (e.g. drinking and pregnancy).
	Ensure that containers of alcoholic products carry a warning message determined by public health bodies describing the harmful effects of drinking during conception and pregnancy.	Number of Member States requiring information on risks related to alcohol use on alcoholic beverage containers. 26	Are health warning labels legally required on the containers/bottles of alcoholic beverages in your country at the national level? What is the text/picture of the legally required health warning labels?
		Awareness of pregnant women and their partners. 27	
		Level of drinking before and during pregnancy. 28	
	Introduce and/or promote comprehensive awareness-raising activities and education for the public at large, and young women in particular.	Number of Member States and events/education activities. 29	In the last three years, did you have any nationwide awareness-raising activities on alcohol and pregnancy?

	Deliver brief interventions and information before and during pregnancy on the need to avoid alcohol before and during pregnancy and breastfeeding period.	Number of Member States delivering brief interventions and information. 30	In your country are there clinical guidelines for brief interventions that have been approved or endorsed by at least one health care professional body? Brief interventions used as a method of health promotion and disease prevention. Training of health professionals on a regular basis in screening and brief interventions for alcohol problems.
		Number of women giving up drinking alcohol during pregnancy. 31	
4.2. Encourage knowledge about alcohol-related birth defects and developmental disorders such as FAS and FASD among health care professionals, and among personnel within social services and schools.	Develop programmes to enhance knowledge of health care professionals such as inclusion of promoting health prevention, awareness-raising, screening and brief intervention as compulsory modules in the curriculum for medical degrees, and continuous education and training.	Number of Member States with special programmes targeting health care professionals. 32	
		Lower level of consumption during pregnancy. 33	
		Number of trained professionals. 34	Training of health professionals on a regular basis in screening and brief interventions for alcohol problems.
	Promote greater awareness among health care professionals of FASD and referral systems in order to improve diagnosis and management of children born with FASD.	Quality and quantity of awareness-raising activities. 35	
		Number of Member States with relevant activities. 36	In the last three years, did you have any nationwide awareness-raising activities on alcohol and pregnancy?
	Support development of clinical guidelines and exchange of good practices in CNAPA for prevention, diagnosis and treatment of FASD.	Quality and quantity of clinical guidelines. 37	
Quantity and quality of relevant topics discussed. 38			

4.3. Encourage counselling and appropriate care and treatment for at-risk and affected children and families.	Initiate provision of adequate diagnosis and treatment for children with FAS/FASD including early detection and referral mechanism to relevant structures.	Number of children with FAS/FASD diagnosed and treated.	Incidence of FAS (ICD-10 code Q86.0) among newborn children within a year, at national level based on registry data (number of cases, number of births, year, reference). Estimate of the prevalence of FAS per 100 000 in your country (include reference).
		39	
	Develop adequate support for children with FAS/FASD and their families outside the health sector, including preschool and school programmes.	Number of Member States with effective early detection/referral mechanisms.	
		40	
Ensure adequate support for rehabilitation centres for pregnant women with alcohol dependence.	Number of Member States with adequate preschool/school programmes.		
	41		
		Number of Member States providing adequate support.	Within the health system, counselling is provided to pregnant women with alcohol use disorders or alcohol problems. In your country, are there prenatal care services specifically for pregnant women with alcohol or drug problems?
		42	

Action area 5. Ensure a healthy and safe environment for youth

Main priority: to limit exposure of youth to harm caused by alcohol in all relevant settings

Operational objectives	Options for action	EC-proposed indicators	Existing WHO survey questions (2012 and 2016 surveys)
5.1. Promote alcohol-free activities and environments for youth.	Discussion of best practices and exchange of views in CNAPA on preventive interventions for youth living in families with alcohol and substance abuse.	Quantity and quality of relevant topics discussed (based on CNAPA meeting reports). 43	
	Develop methods to improve identification of particularly vulnerable groups.	Number of adequate methods identified. 44	
	Encourage provision of alcohol-free leisure settings for youth, e.g. youth cafés, alcohol-free music, dance and sports venues.	Quality and quantity of relevant initiatives. 45	Please provide information on the extent to which different public environments are alcohol-free in your country (e.g. health care establishments, educational buildings, government offices, public transport, parks/streets, sporting events, leisure events [concerts, etc.], workplaces, places of worship).
	Develop and support implementation of health promotion actions in the workplace for young people, also including risk of alcohol.	Number of Member States where alcohol is included in workplace health promotion targeting young people. 46	In your country, are there any national guidelines for alcohol problem prevention and counselling at workplaces?
5.2. Provide support to children and families with alcohol-related problems.	Encourage programmes to support children from families with existing and potential alcohol problems (e.g. through educational centres).	Quality and quantity of relevant initiatives. 47	Within the health system, counselling is provided to children in families with alcohol problems.
	Strengthen and disseminate evidence base for preventive interventions for youth living in families with alcohol and substance abuse.	New evidence built up during the action plan. 48	
	Facilitate early detection at local level and improve local cooperation among professional groups dealing with children who suffer neglect or mistreatment in families with alcohol/substance abuse.	Number of children detected. 49	

5.3. Reduce alcohol-related traffic accidents.	Establish lower BAC levels for young drivers and professional drivers for public transport services for children.	Number of Member States that lowered BAC level(s) in 2014–2016. 50	At the national level, what is the maximum legal blood alcohol concentration (BAC) when driving a vehicle for young/novice drivers and professional/commercial drivers?
	Enforce systematic police controls through alcohol testing.	Number of offences recorded. 51	Do you have sobriety checkpoints and/or random breath testing?
		Percentage of positive alcohol tests. 52	In your country, what are the usual methods for measuring BAC? (blood or urine analysis; breath testing; observational assessment; other)
	Develop structures for cooperation between police, municipalities and transport authorities, in particular to provide brief intervention and referral to treatment for drink–drive offenders.	Quality and quantity of relevant initiatives. 53	What are the penalties for drink–driving in your country (e.g. mandatory treatment, mandatory education and counselling)?
		Number of drink–drive offenders referred to treatment. 54	
	Awareness-raising programmes specifically targeting young drivers.	Quality and quantity of relevant programmes. 55	In the last three years, did you have any nationwide awareness-raising activities on drink–driving?
5.4. Ensure counselling and appropriate care and treatment for the drinker, the partner and children in families with alcohol problems.	Promote a family perspective in all alcohol treatment and care.	Number of Member States with effective early detection/referral mechanisms. 56	
	Ensure adequate support and treatment for the drinker, partner and children in families with alcohol problems in alcohol treatment centres.	Number of families treated. 57	
	Ensure support and counselling for the children and partner in alcohol treatment centres even if the drinker does not yet want alcohol treatment.	Number of partners and children supported. 58	Within the health system, counselling is provided to children in families with alcohol problems.
	Support the development of alcohol treatment methods directed towards the whole family: the drinker, the partner and the children.	Number of Member States with programmes for professionals in treatment centres. 59	

	Initiate research to develop and validate methods assessing how many children are living in families with alcohol problems.	Number of relevant research initiatives. 60	
	Initiate methods for assessing the physical and psychological health consequences for children living in families with alcohol problems.	Number of Member States with research programmes. 61	
	Integrate alcohol-related harm done to children in families with alcohol problems into information-based prevention programmes in schools and targeting the general public.	Number of Member States with such relevant prevention programmes. 62	
	Develop adequate special support for children in families with alcohol problems outside the health sector, including preschool and school, in the period where the family is under treatment.	Number of Member States with relevant support programmes. 63	

Action area 6. Support monitoring and increase research

Main priority: to maintain and reinforce a common knowledge base

Operational objectives	Options for action	EC-proposed indicators	Existing WHO survey questions (2012 and 2016 surveys)
6.1. Make data on alcohol-related harm available as basis for policy-making.	Through Joint Action RARHA, develop a standardized comparative survey on alcohol use, including HED.	Availability of the survey. 64	
	Ensure regular harmonized monitoring and reporting of the European Core Health Indicators (ECHI) on alcohol.	Regular reports on ECHI. 65	
	Discussion, exchange of views and best practices in CNAPA on monitoring, alcohol indicators, data collection and dissemination/evaluation of research (involving WHO).	Quantity and quality of relevant topics discussed (based on CNAPA meeting reports). 66	
	In collaboration with WHO and other relevant parties, continue developing the existing indicators and implement appropriate data collection mechanisms.	Number of indicators changed/added. 67	
	Develop approaches with CNAPA and other relevant parties such as WHO and the OECD for more effective dissemination and better use of knowledge, in particular on cost-effectiveness of public health policies on alcohol, accumulated in EU-funded projects, through collaborative and commissioned work.	Quality and quantity of relevant initiatives. 68	
	Strengthen capacity in alcohol survey methodology and comparative analysis and develop a standardized approach for monitoring drinking levels and patterns, including HED, and alcohol-related harms across the EU.	Availability of Joint Action RARHA reports, policy briefs documenting consensus-seeking. 69	

	Preparation of a tool kit of good practices on transferable interventions based on evidence of effectiveness in influencing alcohol attitudes or behaviours and guidance for health policy planners on use of information approaches, as part of wider public health policies on alcohol.	Availability of the tool kit.	70
	Based on science and experience, seek consensus on use of low-risk drinking guidelines, and work towards more aligned messages to the general population, subgroups and intermediaries.	Availability of Joint Action RARHA reports, policy briefs documenting consensus-seeking.	71
6.2. Target EU research funding at knowledge gaps already identified and at topics that need to be studied at European level.	Support research on cross-border internet/online sale of alcohol, in particular on non-compliance on alcohol regulation such as age limits.	Number of relevant studies initiated/supported.	72
6.3. Monitoring of the Action Plan.	Prepare a summary report on national achievements in 2014–2016 based on the Action Plan.	Availability of CNAPA members' reports to EC.	73
	Prepare a summary report on EU achievements in 2014–2016 based on the Action Plan and the CNAPA members' reports to EC.	Availability of EC report.	74

Annex 2

Survey crosswalk

Action area 1 (reduce HED). Crosswalk over all three surveys (2012, 2016, 2015)

Operational objectives	Global Survey on Alcohol and Health 2012	Global Survey on Alcohol and Health 2016	Global Survey 2016, special European section (pp. 35–8), since 2014	WHO Global Alcohol Policy Survey 2015
Questions	25 b–27	27 b,e–28 a-c	----	78
1.1. Encourage health-related information including alcohol-related risks on alcoholic beverages to help consumers make informed choices (warning labels).	<p>25 b. Are health warning labels legally required on the containers/bottles of alcoholic beverages in your country at the national level?</p> <p>26 a. Is there a national legal requirement to display consumer information about calories, additives, vitamins, microelements on the labels of alcohol containers?</p> <p>26 b. Is there a national legal requirement to display the number of standard alcoholic drinks in the container on the labels of alcohol containers?</p> <p>26 c. Is there a national legal requirement to display alcohol content on the labels of alcohol containers?</p> <p>27. What is the text/picture of the legally required health warning labels?</p>	<p>27 b. Are health warning labels legally required on the containers/bottles of alcoholic beverages in your country at the national level?</p> <p>28 a. Is there a national legal requirement to display consumer information about calories, additives, vitamins, microelements on the labels of alcohol containers? (BEV. SPECIFIC)</p> <p>28 b. Is there a national legal requirement to display the number of standard alcoholic drinks in the container on the labels of alcohol containers? (BEV. SPECIFIC)</p> <p>28 c. Is there a national legal requirement to display alcohol content on the labels of alcohol containers? (BEV. SPECIFIC)</p> <p>27 e. What is the text(s) of the legally required health warning labels?</p>	----	<p>(78) Since 2010, has mandatory labelling of alcoholic beverages to indicate the harm related to alcohol been introduced?</p> <ul style="list-style-type: none"> – <i>yes</i> – <i>policy was established prior to 2010</i> – <i>no</i> – <i>policy was discontinued after 2010</i> – <i>policy established prior to 2010, discontinued after 2010 and then re-established</i> – <i>N/A</i>

Questions	11, 25 a	12 a, 27 a	Q 1, p. 35	4, 20
1.2. Encourage knowledge about health and social harm from heavy episodic drinking in relevant services and subgroups.	<p>11. In the last three years, did you have any nationwide awareness-raising activities [on the following topics]: young people’s drinking; alcohol’s impact on health; social harms?</p> <p>25 a. Are health warning labels legally required on alcohol advertisements in your country at the national level?</p>	<p>12 a. In the last three years, did you have any nationwide awareness-raising activities [on the following topics]: young people’s drinking; alcohol’s impact on health; social harms?</p> <p>27 a. Are health warning labels legally required on alcohol advertisements in your country at the national level?</p>	<p><i>Since 2014</i></p> <p>Raised awareness of the general public and relevant services on health and social harm from heavy episodic drinking (e.g. through events, publications, information material).</p> <p>Developed and integrated information on alcohol-related harm in academic curricula for professionals working with young people.</p>	<p>(4) Since 2010, has/have new comprehensive nationwide public awareness programme(s) on harmful use of alcohol been implemented? Check one answer only.</p> <p>(20) Compared to 2010, how is the current level of community programmes and policies for subpopulations at particular risk, such as children, adolescents, women of child-bearing age, pregnant and breastfeeding women, indigenous peoples and other minority groups or groups with low socioeconomic status? Check one answer only.</p>
Questions	45 a–c, 45 j		Q1, p. 35	
1.3. Ensure knowledge about health and social harm from heavy episodic drinking among youth.	<p>45 a. In your country, is there a legal obligation for schools to carry out alcohol (or broader alcohol and other substance use) prevention as part of the school curriculum or as part of school health policies?</p> <p>45 b. In your country, is there a legal obligation for schools to interact with parents regarding the education and well-being of students?</p> <p>45 c. In your country, do you have national guidelines for the prevention and reduction of alcohol-related harm in school settings?</p> <p>45 j. Does your national alcohol policy (or action plan) include steps to specifically involve young people in activities to reduce or prevent alcohol-related harm?</p>		<p><i>Since 2014</i></p> <p>Raised awareness of the general public and relevant services on health and social harm from heavy episodic drinking (e.g. through events, publications, information material).</p> <p>Developed and integrated information on alcohol-related harm in academic curricula for professionals working with young people.</p>	

Questions	12	13 a	Q2, p. 35	36–53, 75
<p>1.4. Strengthen regulations and measures to minimize sale and serving practices and environments that promote heavy drinking and intoxication.</p>	<p>12. In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis?</p> <p>If yes, organized by enforcement agencies, private sector, or other?</p>	<p>13 a. In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis?</p> <p>If yes, organized by enforcement agencies, private sector, or other?</p>	<p>Adopted or strengthened enforcement measures (legal and other administrative) to reduce availability of alcoholic beverages to underage people.</p>	<p>(36, 37, 38) Since 2010, has the system for licensing retail sales of alcohol beverages changed for beer (Q36), wine (Q37), spirits (Q38)?</p> <p>(39) Since 2010, has the system for licensing retail sales of alcohol beverages changed for other alcoholic beverages such as fermented beverages, cider, alcopops and “Ready To Drink” beverages (RTDs)? Check one answer only.</p> <p>(40) Since 2010, have regulations changed regarding the density of alcohol on-premise outlets? Check one answer only.</p> <p>(41) Since 2010, have regulations changed regarding the density of alcohol off-premise outlets? Check one answer only.</p> <p>(42) Since 2010, have regulations changed regarding the days allowed for the sales of alcoholic beverages? Check one answer only.</p> <p>(43) Since 2010, have regulations changed regarding the hours allowed for the sales of alcoholic beverages? Check one answer only.</p> <p>(44) Since 2010, has the minimum legal age for purchase or consumption of beer increased, i.e. become more restrictive for beer?</p> <p>If yes, in what year did the new age limit(s) take effect?</p> <p>If the policy has become less restrictive in some or all instances regarding the legal age for purchasing, please describe the new situation.</p> <p>(45) Since 2010, has the minimum legal age for purchase or consumption of wine increased, i.e. become more restrictive for wine?</p> <p>If yes, in what year did the new age limit(s) take effect?</p> <p>If the policy has become less restrictive in some or all instances regarding the legal age for purchasing, please describe the new situation.</p>

			<p>(46) Since 2010, has the minimum legal age for purchase or consumption of spirits increased, i.e. become more restrictive for spirits? Check all that apply.</p> <p>If yes, in what year did the new age limit(s) take effect?</p> <p>If the policy has become less restrictive in some or all instances regarding the legal age for purchasing, please describe the new situation.</p> <p>(47) Compared to 2010, what is the current scope and intensity of government policies to prevent sales to intoxicated persons?</p> <p>(48) Compared to 2010, what is the current scope and intensity of government policies to prevent sales to those below the minimum legal age?</p> <p>(49) Compared to 2010, what is the current level of government policies regarding drinking in public places?</p> <p>(50) Compared to 2010, what is the current level of policies regarding drinking at official public agencies' activities and functions?</p> <p>(51) Compared to 2010, what is the overall scope and intensity of government policies and activities in this area (availability of alcohol)? Check one answer only.</p> <p>(52) What have been the main policy achievements/breakthroughs in this area since 2010?</p> <p>(53) What have been the main difficulties/barriers/setbacks in this area since 2010?</p> <p>(75) Compared to 2010, what is the current level of laws against selling alcohol off-premise to intoxicated people? Check one answer only.</p>
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Questions	10a, b	11a	---	66, 68, 69, 71
<p>1.5. Support and implement fiscal and pricing policies to discourage heavy episodic drinking.</p>	<p>10a. Do you have any price measures other than taxation in your country?</p> <p>[Price measures other than taxation mean e.g. by regulation of the price of non-alcoholic and alcoholic beverages, such as having a non-alcoholic beverage cheaper than an alcoholic beverage.]</p> <p>If yes, please specify: check all that apply.</p> <p>10b. If YES to minimum price policy, what is the minimum price for the following alcoholic beverages?</p> <p>[Minimum price policy for alcoholic beverages means a policy where a minimum price is set for a unit of alcohol, below which it cannot be sold.]</p>	<p>11a. Do you have any price measures other than taxation in your country?</p> <p>(options: minimum price policy; requirement to offer non-alcoholic beverages at a lower price; additional levy on specific produces [e.g. alcopops]; ban on below-cost selling; ban on volume discounts; price measures to discourage underage drinking or high-volume drinking [please specify])</p>	<p>---</p>	<p>(66) Compared to 2010, what is the current level of excise duties on alcohol? Check one answer only.</p> <p>(68) Compared to 2010, what is the current level of bans or restrictions on the use of direct and indirect price promotions, discount sales, sales below cost and flat rates for unlimited drinking or other types of volume sales? Check one answer only.</p> <p>(69) Compared to 2010, has a minimum price for alcoholic beverages been established? Check one answer only.</p> <p>(71) Compared to 2010, what is the overall scope and intensity of government policies and activities in this area (pricing policies of alcoholic beverages)? Check one answer only.</p>

Questions	45 d		Q 4 (re pregnancy)	10
<p>1.6. Promote and ensure implementation of screening, early identification and brief intervention in all relevant subgroups and settings.</p>	<p>45 d. In your country are there clinical guidelines for brief interventions that have been approved or endorsed by at least one health care professional body?</p>		<p>Delivered brief interventions and information before and during pregnancy on the need to avoid alcohol before and during pregnancy and breastfeeding period.</p> <p>Developed programmes to enhance knowledge of health care professionals such as inclusion of promoting health prevention, awareness-raising, screening and brief intervention as compulsory modules in the curriculum for medical degrees, and continuous education and training.</p>	<p>(10) Compared to the situation in 2010, what is the current level of support for screening and brief interventions for hazardous and harmful drinking at primary health care and other settings? Check one answer only.</p>

Action area 2 (accessibility/availability). Crosswalk over all three surveys (2012, 2016, 2015)

Operational objectives	Global Survey on Alcohol and Health 2012	Global Survey on Alcohol and Health 2016	Global Survey 2016, special European section (pp. 35–8), since 2014	WHO Global Alcohol Policy Survey 2015
Questions	12 a, 14	13 a, 18	Q2	18, 48
2.1. Promote, ensure and enforce adequate level of controls in on- and off-premises, particularly for legal age checks	<p>12 a. In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis? If yes, organized by enforcement agencies, private sector, or other?</p> <p>14. What are the legal age limits at the national level for the following? [six-part answer: [beer, wine, spirits; on- and off-premise]]</p>	<p>13 a. In your country, is there any systematic alcohol server training (for servers in pubs, bars, restaurants) on a regular basis? If yes, organized by enforcement agencies, private sector, or other?</p> <p>18. What are the legal age limits at the national level for the following? [six-part answer: [beer, wine, spirits; on- and off-premise]]</p>	<p>– Adopted or strengthened enforcement measures (legal and other administrative) to reduce availability of alcoholic beverages to underage people.</p> <p>– Introduced, on a voluntary basis, 25 years or higher reference age for age controls.</p> <p>– Promoted multi-stakeholder programmes to ensure better enforcement of age limits.</p>	<p>(48) Compared to 2010, what is the current scope and intensity of government policies to prevent sales to those below the minimum legal age? Check one answer only.</p> <p>(18) Compared to 2010, what is the capacity of communities to prevent the selling of alcohol to, and consumption of alcohol by, underage drinkers? Check one answer only.</p>
Questions	11	12 a	Q2	2, 51
2.2. Support multisectoral approaches to ensure compliance with national regulations.	<p>11. In the last three years, did you have any nationwide awareness-raising activities on young people’s drinking? [nine tick options]</p>	<p>12 a. In the last three years, did you have any nationwide awareness-raising activities on young people’s drinking?</p>	<p>Delivered national information campaigns to raise awareness of national legislation among sellers of alcoholic beverages and the general public, including carrying out Alcohol Awareness Day/Week.</p>	<p>(2) How has the level of coordination of alcohol policy formulation and implementation between different sectors of governments been developing since 2010?</p> <p>(51) Compared to 2010, what is the overall scope and intensity of government policies and activities in this area (availability of alcohol)? Check one answer only.</p>

Action area 3 (marketing/advertising). Crosswalk over all three surveys (2012, 2016, 2015)

Operational objectives	Global Survey on Alcohol and Health 2012	Global Survey on Alcohol and Health 2016	Global Survey 2016, special European section (pp. 35–8), since 2014	WHO Global Alcohol Policy Survey 2015
Questions	34, 35, 36	31 a, 31 b	Q3	54, 58–64
<p>3.1. Ensure that all marketing and advertising is in compliance with the Audiovisual Media Services Directive and with national regulations and voluntary codes.</p>	<p>34. In which ways are infringements on marketing restrictions detected? [five tick options]</p> <p>35. What are the penalties for infringements of marketing restrictions? [three tick options]</p> <p>36. How many infringements of marketing restrictions occurred in the last calendar year? [open answer]</p>	<p>31 a. In which ways are infringements of marketing restrictions detected?</p> <p>31 b. What are the penalties for infringements of marketing restrictions?</p>	<p>Conducted study on exposure of minors to alcohol advertising on linear and non-linear audiovisual media services and other online services based on the Audiovisual Media Services Directive’s restrictions (2010/13/EU).</p> <p>Strengthened existing legislation or co-regulation to reduce exposure of young people to alcohol.</p>	<p>(54) Since 2010, has a total ban on alcohol marketing been introduced?</p> <p>(58) Compared to 2010, what is the current level of statutory regulations on sponsorship activities that promote alcoholic beverages?</p> <p>(59) Compared to 2010, what is the current level of restrictions or bans on promotions in connection with activities targeting young people?</p> <p>(60) Compared to 2010, what is the current level of regulations on new forms of alcohol marketing techniques, for instance social media?</p> <p>(61) Compared to 2010, what is the current level of administrative systems for infringements of marketing restrictions?</p> <p>(62) Compared to 2010, what is the current level of systems for monitoring the content and placement of alcohol marketing and the audiences exposed?</p> <p>Possibly (63) on scope and intensity.</p> <p>(64) What have been the main policy achievements/breakthroughs in this area?</p>

Questions	28 a–c, 31 c	29 a, 30 a		
<p>3.2. Limit the exposure of youth to alcohol marketing through the internet and new media, including sponsoring.</p>	<p>28 a. Are there legally binding restrictions on alcohol advertising at the national level?</p> <p>28 b. Are there legally binding restrictions on alcohol product placement at the national level?</p> <p>28 c. IF YES to a/b, please specify the restrictions on alcohol advertising/product placement. [options: ban, partial statutory restriction on time/place, partial statutory restriction on content, voluntary/self-regulated, no restriction] [10 tick options for advertising; three tick options for product placement]</p> <p>31 c. Please specify the restrictions on industry sponsorship/sales promotion (on industry sponsorship of sporting events, industry sponsorship of youth events, sales promotions from producers, below-cost sales promotions from retailers, free drinks sales promotions from owners of pubs/bars). [options: ban, partial statutory restriction, voluntary/self-regulated, no restriction] [five tick options]</p>	<p>29 a. Please specify the restrictions on alcohol advertising/product placement (on public service/national TV, commercial/private TV, national radio, local radio, print media, billboards, points of sale, cinema, internet, social media). [options: ban, partial statutory restriction on time/place, partial statutory restriction on content, voluntary/self-regulated, no restriction]</p> <p>30 a. Please specify the restrictions on industry sponsorship/sales promotion (on industry sponsorship of sporting events, industry sponsorship of youth events, sales promotions from producers, below-cost sales promotions from retailers, free drinks sales promotions from owners of pubs/bars). [options: ban, partial statutory restriction, voluntary/self-regulated, no restriction]</p>		

Action area 4 (pregnancy). Crosswalk over all three surveys (2012, 2016, 2015)

Operational objectives	Global Survey on Alcohol and Health 2012	Global Survey on Alcohol and Health 2016	Global Survey 2016, special European section (pp. 35–8), since 2014	WHO Global Alcohol Policy Survey 2015
Questions	54, 25 b, 27, 11, 45 d	27 b, 27 e, 12 a	Q4	6, 20
<p>4.1. Encourage that information about the danger of alcohol during pregnancy, the breastfeeding phase and infant age is widely available.</p>	<p>54. Is there a comprehensive report on the alcohol situation drawn up and published regularly at the national level in your country? If yes, please indicate how often the report is published, by whom, and which topics are covered in the report [tick option: drinking and pregnancy]</p> <p>25 b. Are health warning labels legally required on the containers/bottles of alcoholic beverages in your country at the national level?</p> <p>27. What is the text/picture of the legally required health warning labels?</p> <p>11. In the last three years, did you have any nationwide awareness-raising activities on alcohol and pregnancy? [tick option on alcohol and pregnancy]</p> <p>45 d. In your country are there clinical guidelines for brief interventions that have been approved or endorsed by at least one health care professional body?</p>	<p>27 b. Are health warning labels legally required on the containers/bottles of alcoholic beverages in your country at the national level?</p> <p>27 e. What is the text(s) of the legally required health warning labels?</p> <p>12 a. In the last three years, did you have any nationwide awareness-raising activities on alcohol and pregnancy? [tick option on alcohol and pregnancy]</p> <p>-</p>	<p>Integrated alcohol-related harm to the unborn child into information-based prevention programmes in schools and targeting the general public.</p> <p>Initiated research to develop and validate feasible methods for assessing reliably the incidence of FASD at population level.</p> <p>Ensured that containers of alcoholic products carry a warning message determined by public health bodies describing the harmful effects of drinking during conception and pregnancy.</p> <p>Introduced and/or promoted comprehensive awareness-raising activities and education for the public at large, and young women in particular.</p> <p>Promoted greater awareness among health care professionals of FASD and referral systems in order to improve the diagnosis and management of children born with FASD.</p> <p>Supported development of</p>	<p>(6) Compared to 2010, to what extent is the harm to others from someone else’s drinking of alcohol taken into consideration in alcohol policy formulation and implementation?</p> <p>(20) Compared to 2010, how is the current level of community programmes and policies for subpopulations at particular risk, such as children, adolescents, women of child-bearing age, pregnant and breastfeeding women, indigenous peoples and other minority groups or groups with low socioeconomic status?</p>

			<p>clinical guidelines for the prevention, diagnosis and treatment of FASD.</p> <p>Initiated provision of adequate diagnosis and treatment for children with FAS/FASD including early detection and referral mechanism to relevant structures.</p> <p>Developed adequate support for children with FAS/FASD and their families outside the health sector, including preschool and school programmes.</p> <p>Ensured adequate support for rehabilitation centres for pregnant women with alcohol dependence</p>	
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Questions	13, 11			11
<p>4.2. Encourage knowledge about alcohol-related birth defects and developmental disorders such as FAS and FASD among health care professionals, and among personnel within social services and schools.</p>	<p>13. In which ways does the national government support community action? [training programme as tick option]</p> <p>11. In the last three years, did you have any nationwide awareness-raising activities on alcohol and pregnancy?</p>			<p>(11) Compared to 2010, what is the current capacity for prevention of, identification of, and interventions for individuals and families living with FAS?</p>
Questions	52 a, b		Q4	13
<p>4.3. Encourage counselling and appropriate care and treatment for at-risk and affected children and families.</p>	<p>52 a. Incidence of FAS (ICD-10 code Q86.0) among newborn children within a year, at national level based on registry data (number of cases, number of births, year, reference).</p> <p>52 b. Estimate of the prevalence per 100 000 of FAS in your country (include reference).</p>		<p>Incidence of FAS (ICD-10 code Q86.0) among newborn children within a year, at national level based on registry data (number of cases, number of births, year, reference).</p> <p>Estimate of the prevalence per 100 000 of FAS in your country (include reference).</p> <p>Within the health system, counselling is provided to pregnant women with alcohol use disorders or alcohol problems.</p> <p>In your country, are there prenatal care services specifically for pregnant women with alcohol or drug problems?</p>	<p>(13) Compared to 2010, what is the current capacity of the country to provide treatment services for alcohol use disorders in the health system?</p>

Action area 5 (environment). Crosswalk over all three surveys (2012, 2016, 2015)

Operational objectives	Global Survey on Alcohol and Health 2012	Global Survey on Alcohol and Health 2016	Global Survey 2016, special European section (pp. 35–8), since 2014	WHO Global Alcohol Policy Survey 2015
Questions	15	19, 15	ALL OF Q5	19, 32
5.1. Promote alcohol-free activities and environments for youth.	15. Please provide information on the extent to which different public environments are alcohol-free in your country. [tick nine categories with four kinds of bans]	19. Please provide information on the extent to which different public environments are alcohol-free in your country (i.e. health care establishments, educational buildings, government offices, public transport, parks/streets, sporting events, leisure events [concerts, etc.], workplaces, places of worship). 15. In your country, are there any national guidelines for alcohol problem prevention and counselling at workplaces?	What have been the main policy achievements/ breakthroughs in limiting the exposure of youth to harm caused by alcohol since 2014? Please check all that apply.	(19) Compared to 2010, what is the current level of community support for alcohol-free environments and events, especially for youth and other at-risk groups? (32) Since 2010, have high-intensity national mass media campaigns targeted at specific situations, such as holiday seasons, or audiences, such as young people, been introduced and carried out on a regularly basis?
Questions				11, 13
5.2. Provide support to children and families with alcohol-related problems.				(11) Compared to 2010, what is the current capacity for prevention of, identification of, and interventions for individuals and families living with FAS? (13) Compared to 2010, what is the current capacity of the country to provide treatment services for alcohol use disorders in the health system?

Questions	20–23, 11	23, 26, 25		24–30, 33–5
<p>5.3. Reduce alcohol-related traffic accidents.</p>	<p>20. At the national level, what is the maximum legal blood alcohol concentration (BAC) when driving a vehicle for young/novice drivers and professional/commercial drivers?</p> <p>21. In your country, what are the usual methods for measuring BAC (blood and urine analysis; breath testing; observational assessments; other)?</p> <p>22. Do you have sobriety checkpoints and/or random breath testing?</p> <p>23. What are the penalties for drink-driving in your country (e.g. mandatory treatment, mandatory education and counselling)?</p> <p>11. In the last three years, did you have any nationwide awareness-raising activities? [tick drink-driving]</p>	<p>(23) At the national level, what is the maximum legal blood alcohol concentration (BAC) when driving a vehicle for young/novice drivers and professional/commercial drivers?</p> <p>(26) In your country, what are the usual methods for measuring BAC (blood and urine analysis; breath testing; observational assessments; other)?</p> <p>Do you have sobriety checkpoints and/or random breath testing?</p> <p>(25) What are the penalties for drink-driving in your country (e.g. mandatory treatment, mandatory education and counselling)?</p>		<p>(24) Since 2010, has the limit for blood alcohol concentration while driving a vehicle been changed for the general population?</p> <p>If changed or established after 2010, in which year did the change take effect? What are the new and what was the old limit for the general population?</p> <p>(25) Since 2010, has the BAC limit while driving a vehicle been changed for professional drivers?</p> <p>(26) Since 2010, has the BAC limit while driving a vehicle been changed for young or novice drivers?</p> <p>(27) Compared to 2010, what is the current scope and intensity of sobriety check points and/or random breath-testing programmes?</p> <p>(28) Since 2010, has an administrative suspension of driving licences been introduced for drink-driving?</p> <p>(29) Since 2010, has the use of ignition interlocks been introduced for drink-driving?</p> <p>(30) Since 2010, have mandatory driver-education programmes been introduced for drink-driving offences?</p> <p>(33) Compared to 2010, what is the overall scope and intensity of government policies and activities in this area (drink-driving policies and countermeasures)?</p>

Questions			Q4	31
<p>5.4. Ensure counselling and appropriate care and treatment for the drinker, the partner and children in families with alcohol problems.</p>			<p>Developed adequate special support for children in families with alcohol problems outside the health sector, including preschool and school in the period where the family is under treatment.</p>	<p>(31) Since 2010, have mandatory counselling and/or treatment programmes been introduced for drink-driving offences?</p>

Action area 6 (monitoring/research). Crosswalk over all three surveys (2012, 2016, 2015)

Operational objectives	Global Survey on Alcohol and Health 2012	Global Survey on Alcohol and Health 2016	Global Survey 2016, special European section (pp. 35–8), since 2014	WHO Global Alcohol Policy Survey 2015
Questions			Q6	90–97
6.1. Make data on alcohol-related harm available as basis for policy-making.			What have been the main activities/policy achievements in supporting monitoring and increasing research since 2014?	<p>(90) Since 2010, has an institution or other organizational entity responsible for collecting, collating, analysing and disseminating available data been established or designated?</p> <p>(91) Since 2010, has a common set of indicators of harmful use of alcohol and of policy responses and interventions to prevent and reduce such use been defined?</p> <p>(92) Since 2010, has a repository of data at the country level been created?</p> <p>(93) Since 2010, have monitoring and evaluation mechanisms been put in place in order to determine the impact of policy measures, interventions and programmes to reduce the harmful use of alcohol?</p> <p>(94) Did your country sponsor or participate with the WHO Regional Office on any research study since 2010 focused on alcohol and its impact on health? Check one answer only.</p> <p>(95) Compared to 2010, what is the overall scope and intensity of government policies and activities in this area (monitoring and surveillance)?</p>

Questions				
6.2. Target EU research funding at knowledge gaps already identified and at topics that need to be studied at European level.				
6.3. Monitoring of the Action Plan.				

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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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