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European Alcohol Action Plan 2012–2020: Implementing regional and global alcohol strategies

This document contains the draft action plan for implementation of the European and global alcohol strategies. The Action Plan will be submitted to the WHO Regional Committee for Europe at its sixty-first session in Baku, Azerbaijan in September 2011 for discussion and potential endorsement.

The document is being developed through a consultative process with a core editorial board and a larger editorial group; a first consultation with Member States took place in Geneva, Switzerland on 9–10 February 2010.

Member States have asked for additional time to submit written comments and a deadline of 15 March 2011.

A new draft will be developed and presented at a second consultation with Member States in Zurich, Switzerland on 4–5 May 2011.

The final draft will be submitted to the SCRC on 14–15 May 2011.

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The need for strengthened action in Europe

1. Countries that take stronger action on alcohol will reap considerable gains in terms of better population health and well-being, enhanced employment and productivity, increased health and social welfare savings, greater health and economic equality, and greater social cohesion and inclusion.

The impact of alcohol on health and well-being

2. Alcohol is one of the world's top three priority public health areas. The evidence available to support this statement is large, diverse and persuasive. Even though only half the world's population drinks alcohol, it is the world's third leading cause of ill health and premature death, after low birth weight and unsafe sex (for which alcohol is a risk factor), and greater than tobacco. Alcohol impacts on both noncommunicable and communicable diseases. A reinvigorated European alcohol action plan is all the more important given that WHO's European Region remains the area of the world with the highest levels of alcohol consumption and alcohol-related harm. In the Region, 40% of poor health and premature deaths are caused by three avoidable risk factors: smoking, alcohol and traffic accidents (which are in turn frequently caused by alcohol). Alcohol-related cardiovascular and injury mortalities are a major cause of health inequalities between Member States.

3. Most alcohol is drunk in heavy drinking occasions, which worsen all risks. In particular, heavy drinking occasions are a cause of all types of intentional and unintentional injuries, and of ischaemic heart disease and sudden death. Alcohol harms people other than the drinker, whether through violence on the street, domestic violence in the family, or simply using up government resources, notably through the costs of providing health care and dealing with crime and disorder. Up to three in ten people may have someone in their life who is a heavy drinker.

4. Including the harm done by alcohol from someone else's drinking is likely to double the social costs of alcohol. Thus, the external impact and costs of alcohol are considerably greater than those associated with smoking (environmental tobacco smoke) and far greater than those of illicit drugs. Who you are and where you live are important. Socially disadvantaged people and people who live in socially disadvantaged areas experience more harm from alcohol than the better-off. Increased spending on social welfare policies can mitigate the impact of economic recession and unemployment on increased alcohol-related deaths.

5. Economic efficiency is impaired through diminished productivity due to alcohol. It used to be thought that individuals with low to moderate levels of alcohol consumption have higher earnings than abstainers. However, a fuller analysis of these results finds that this is an artefact and that there is no level of alcohol consumption that has a positive impact on wages. Rather, it seems that low to moderate alcohol consumption is a proxy for a range of personality traits that have a positive influence on human capital.

6. The real absolute risk of dying from an alcohol-related condition increases simply with the amount of alcohol consumed over a lifetime. There is no safe level, and in many societies, when combining all conditions, no difference in the risk between men and women. The regular drinking of six drinks (60g alcohol) a day over a lifetime gives an adult a 1 in 10 chance of dying from alcohol. Studies have shown that middle-aged and older light to moderate drinkers are less likely to die from ischaemic events (coronary heart disease, ischaemic stroke and type 2 diabetes) than abstainers. This effect is found to be equal for people who just drink beer or who just drink wine. However, more and more, it is understood that a large part of this effect is due to confounders, with low to moderate alcohol use being a proxy for better health and social

capital1. Thus, it seems that the real protective effect is lower and occurs at a lower dose of alcohol than previously thought. In any case, there is no protective effect for younger people, where any dose of alcohol increases the risk of ischaemic events. And, in older people, a greater reduction in death from ischaemic heart disease could be obtained by being physically active and eating a healthier diet than by drinking a low dose of alcohol.

7. Alcohol can diminish individual health and human capital across the lifespan from the embryo to old age. In absolute terms, it is mostly the middle aged (and men in particular) who die from alcohol. However, taking into account a life course view, exposure to alcohol during pregnancy can impair the brain development of the foetus and is associated with intellectual deficits that become apparent later in childhood. The adolescent brain is particularly susceptible to alcohol and the longer the onset of consumption is delayed, the less likely it is that problems and alcohol dependence will emerge in adult life. Alcohol is also an intoxicant affecting a wide range of structures and processes in the central nervous system which, interacting with personality characteristics, associated behaviour and sociocultural expectations, are causal factors for intentional and unintentional injuries and harm to people other than the drinker, and drink–driving fatalities. In the workplace, harmful alcohol use and heavy episodic drinking increase the risk of problems such as absenteeism, low productivity and inappropriate behaviour, and can also increase the risk of alcohol use disorders and alcohol dependence.

Building on a momentum of action

8. The important thing about alcohol is that effective measures and policies exist to reduce harms and achieve gains, with almost immediate effect. Europe has been at the forefront of action to reduce the harm done by alcohol. The European Region of WHO was the first region to approve an alcohol action plan, in 1992 and again in 2000. In 2001 a ministerial conference on alcohol and young people was organized in Stockholm, Sweden, with the adoption of a declaration on young people and alcohol. In 2005, at the fifty-fifth session of the WHO Regional Committee for Europe, the action plan was succeeded by the framework for alcohol policy, maintaining and reinforcing the core principles and measures in the action plan.

9. In 2006, the European Commission launched its Communication on an EU strategy to support Member States in reducing alcohol-related harm, with a focus on protecting young people, children and the unborn child; reducing injuries and death from alcohol-related road accidents; preventing alcohol-related harm among adults and reducing the negative impact on the workplace; informing, educating and raising awareness about the impact of harmful and hazardous alcohol consumption, and about appropriate consumption patterns; and developing and maintaining a common evidence base at EU level.

10. By adopting resolution WHA63.13 in 2010, the Sixty-third World Health Assembly endorsed the global strategy to reduce the harmful use of alcohol, urged Member States to adopt and implement the global strategy as appropriate, and requested the Director-General to give sufficiently high organizational priority, and to assure adequate financial and human resources at all levels, to the prevention and reduction of harmful use of alcohol and implementation of the global strategy; to collaborate with and provide support to Member States, as appropriate, in implementing the global strategy to reduce the harmful use of alcohol and strengthening national responses to public health problems caused by the harmful use of alcohol; and to monitor progress in implementing the global strategy. It is thus timely to build on this momentum and reinvigorate regional action with a new European alcohol action plan 2012–2020.

11. The European Alcohol Action Plan 2012–2020 is closely linked to the interventions in the action plan for implementation of the European Strategy for the prevention and control of noncommunicable diseases (2012–2016) but is more detailed in its targets and action. The

Action Plan is also closely linked to the new European health policy, Health 2020, where noncommunicable diseases and the risk factors behind them are a priority for WHO during 2012–2020.

Policy response in Europe

Policy response to date

12. While there is extensive activity to reduce the harmful use of alcohol at the level of Member States, there is still considerable room for improvement. The *European status report on alcohol and health*,[1] which can act as a baseline for this action plan, notes that four out of ten countries did not have a written national alcohol policy in 2009, and only six out of ten countries produced regular monitoring reports, but on a diffuse range of non-standardized indicators. Of the 45 Member States which responded to the survey, 27 have adopted a national alcohol policy and two thirds of them have done this since 2005, when the latest WHO Regional Committee for Europe resolution on alcohol (EUR/RC55/R1) was adopted.

13. Almost all countries were implementing national awareness activities, and countries had generally taken effective action on drink–driving, with only a small number of countries arguably in need of reducing their legal maximum blood alcohol levels for driving. When it came to the more cost–effective policy options, the picture was less encouraging, with a significant number of countries imposing no restrictions on alcohol advertising, and enforcement generally considered to be in need of improvement. Overall, restrictions on availability remained poor, and in one third of countries adolescents under the age of 18 years could freely purchase alcohol. Generally, alcohol taxes represented a low proportion of the retail price and, relative to the consumer price index, alcohol prices were at the same level or had decreased in over half the countries during the previous five years.

14. Standing back, it can be said that alcohol policies still do not reflect the gravity of the health, social and economic harm resulting from the harmful use of alcohol; they fail to be properly integrated within overall health, social and development policies; and they fail to provide adequate capacity to ensure policy coherence and "joined–up" action between different government departments and sectors and at all levels of jurisdiction.

Policy for the future

15. There is no doubt that there is a rapidly building momentum for all countries, individually and collectively, to take more effective action to reduce the harmful use of alcohol, spurred on by the global strategy launched in 2010. Those countries that are most active in implementing evidence-based and cost-effective alcohol policies and programmes will profit from substantial gains in health and well-being, productivity, and social development. Given that many alcohol policy issues readily cross European borders, coherent action across countries will bring added value. Further, international frameworks should enable, rather than impair, individual countries to be bold and innovative in taking evidence-based approaches to reducing the harmful use of alcohol. Supporting the needs of the 53 Member States in the European Region, WHO's public health mandate affords the opportunity to propose a wide range of options for Member State action to reduce the harmful use of alcohol.

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[1] *European status report on alcohol and health 2010*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/en/what-we-publish/abstracts/european-status-report-on-alcohol-and-health-2010).

16. Effective alcohol policy over the coming years will have a number of attributes, reflecting the two way processes and interactions between effective alcohol policy, social development and social capital. In other words, it is not possible to have effective social development leading to improved human, health and social capital without effective alcohol policy and it is not possible to reduce alcohol-related harm without improved human, health and social capital. Further, adequate human, health and social capital are pre-requisites for the societal resilience necessary to mitigate future global stressors that will impinge on the health of the European Region as a consequence of, for example, climate change.[2]

17. Future effective alcohol policy will be that which ensures:

- integration of alcohol polices into broad economic and welfare policies, contributing to the effective development of societies' social, health and economic well-being;
- coherence and "joined–up" action between different government departments and sectors, identifying and implementing the necessary incentives that give gains to individual sectors and society as a whole;
- coherence and involvement of public and private actors alike, also identifying and implementing the incentives that benefit relevant public and private actors;
- integration of alcohol policy measures into all actions that promote well-being and healthy lifestyles and that reduce the burden of noncommunicable and communicable diseases;
- the capacity and opportunity for municipalities, local communities and civil society to implement effective alcohol policies and programmes that are aligned across all levels of society;
- the provision of incentives, as well as disincentives, for individuals and families to make more healthful choices when it comes to the use of alcohol;
- tackling the demand side and responding to the role alcohol plays alongside other factors in people's lives; and
- the recognition that everyone has a role to play whether individuals, communities, local health care and social care organizations, NGOs, the alcohol industry and government.

Objectives

18. Building on previous European alcohol action plans, the five main objectives of the present action plan are aligned with those of the global strategy to:

- raise awareness of the magnitude and nature of the health, social and economic burdens of harmful use of alcohol, and to foster increased government commitment to addressing those burdens;
- strengthen and disseminate the knowledge base on the size and determinants of alcohol-related harm and on effective interventions to reduce and prevent that harm;
- increase technical support to, and enhance the capacity of, Member States for reducing the harm done by alcohol, and managing and treating alcohol-use disorders and associated health conditions;

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[2] *Protecting health in an environment challenged by climate change: European Regional Framework for Action*. Copenhagen. WHO Regional Office for Europe (document EUR/55934/6 Rev.1) http://www.euro.who.int/__data/assets/pdf_file/0005/95882/Parma_EH_Conf_edoc06rev1.pdf.

- strengthen partnerships and improve coordination among stakeholders and increase mobilization of resources required for concerted action to reduce the harmful use of alcohol; and
- improve systems for monitoring and surveillance at subnational, national and European levels, and to ensure more effective dissemination and application of information for advocacy, policy development and evaluation.

Action and Outcomes

19. All European countries have some form of alcohol regulation or plan. However, the comprehensiveness of those regulations or plans varies, as does the experience of each country, area and municipality in implementing them. No matter how comprehensive or strict its alcohol action plan may be, every country is likely to benefit from reviewing, adjusting and strengthening it.

20. A national alcohol action plan or strategy is needed to establish priorities and guide action. National health goals can set priorities, express commitment to new action and allocate resources. Such goals and priorities should be based on epidemiological evidence, while the choice of strategies and interventions should be evidence-based. Measures to restrict supply (drink–driving policies and countermeasures, alcohol marketing policies, alcohol taxes, restrictions on outlet density and on days and hours of sale, a minimum purchase age,) and to reduce demand (early detection and brief interventions in health care and workplace, treatment and rehabilitation programmes) are some specific examples of how to reduce alcohol-related harm.

21. The ten action points below adhere to the titles and follow the order of the action points included in the WHO global strategy to reduce the harmful use of alcohol. Although they must all be addressed, the emphasis of some of them will vary from country to country. The main areas are:

- leadership, awareness and commitment;
- health services' response;
- community and workplace action;
- drink–driving policies and countermeasures;
- availability of alcohol;
- marketing of alcoholic beverages;
- pricing policies;
- reducing the negative consequences of drinking and alcohol intoxication;
- reducing the public health impact of illicit alcohol and informally produced alcohol; and
- monitoring and surveillance.

22. Each action point starts with a headline statement, and includes one or more outcomes and appropriate indicators. A brief background paragraph is followed by a discussion of strategies. A number of questions are then posed for each Member State to consider its own situation. Finally, a number of options for action are listed. For some action points, all Member States are encouraged to implement all the listed options; whereas, for other action points, Member States can find themselves in a continuum of action, following a journey along the

listed action points. The proposed actions and the evidence behind them are based on two WHO publications from 2009.[3]

23. Each Member State will need to consider the nature of the alcohol-related problems it faces and to determine which of the possible actions listed would prove to be most applicable and effective in its own circumstances. There is no single model that can be applied across the European Region. What matters most is that Member States take the actions most likely to reduce the harm that is caused by alcohol in their countries

Leadership, awareness and commitment

Headline

24. The substantial gains that can be achieved through the implementation of effective alcohol policy can only be achieved through adequate leadership provided by national and local government to ensure the full awareness and commitment of all sectors and levels of society to reap the gains through sustained and coherent action that reduces the harmful use of alcohol. This is best achieved through comprehensive action plans as agents of awareness and through well informed and supportive societies.

Outcomes

25. Throughout the duration of this action plan, all countries prepare, implement, review, and revise at least once, an identifiable national action plan or strategy on alcohol. All countries ensure that their populations are progressively informed about the harm that alcohol can do to individuals, families and communities and about the measures that can be taken to reduce that harm.

Indicators

26. Indicators would include the presence of a publicly accessible national action plan or strategy on alcohol, and measures of knowledge, attitudes and opinions about alcohol and alcohol policy through barometer surveys and opinion polls of random samples of the population.

Background

27. For an action plan on reducing alcohol-related harm to be effective, it is necessary to ensure that the requisite infrastructure for policy development, priority-setting, monitoring and surveillance, research and evaluation, workforce development and programme delivery is in place. Despite advances in building core infrastructure for action on alcohol, it can be argued that there continues to be insufficient political will and investment by both the private and the public sector in many Member States. Ensuring that this infrastructure is sufficiently large and capable remains a challenge.

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[3] *Evidence for the effectiveness and cost–effectiveness of interventions to reduce alcohol-related harm*. Copenhagen. WHO Regional Office for Europe 2009 (http://www.euro.who.int/__data/assets/pdf_file/0020/43319/E92823.pdf, accessed on 10 January 2011) *Handbook for action to reduce alcohol-related harm*. Copenhagen WHO Regional Office for Europe 2009 (http://www.euro.who.int/__data/assets/pdf_file/0012/43320/E92820.pdf, accessed on 10 January 2011).

Strategies

28. A national alcohol action plan or strategy is needed to establish priorities and guide action. National health goals can set priorities, express commitment to new action and allocate resources. Such goals and priorities should be based on epidemiological evidence, while the choice of policies and interventions should be evidence-based. Measurable outcomes make policy objectives more specific, allowing progress to be monitored and often inspiring partners to support policy initiatives. Accountability for the health impact of alcohol actions and programmes rests with all sectors of society, as well as the government officials who prepare action plans, allocate resources and initiate legislation. To enable transparency and accountability, measurable outcomes can be published nationally and, where possible, locally.

29. The responsibility of the national government for developing and implementing an action plan on alcohol is usually split among several government departments and levels. The departments involved can include those devoted to industry and trade, agriculture, employment, finance and health. The interests and priorities of these different sectors often need to be aligned to produce an agreed alcohol policy, and some sectors may wield power unequally. Coordination is needed to ensure that all levels of government and all affected sectors and stakeholders are considered when making decision on alcohol policy. A coordinating body, such as a national alcohol council, should include senior representatives of ministries, health professionals and other partners.

30. Public and political support for the content of alcohol action plans is crucial. National politicians have the authority to regulate and influence the environment in which alcohol is marketed. Politicians often have a particular interest in alcohol issues, which can vary according to their official roles as well as their personal views. Contacts with outside government players such as the alcohol industry or health groups may shape politicians' views on specific alcohol policies and possibly influence the forming or refining of policy proposals. Negative responses from civil society and public opinion have been identified as an obstacle to alcohol policy reform. In addition to governments, health and medical professionals and institutions supporting public health-oriented alcohol policy include independent, publicly funded institutions, insurance industry programmes, nongovernmental issue-based organizations and networks, and professional public health associations.

Options for action

31. All countries need to ensure adequate public health infrastructures for alcohol policy, including political will and a demand for good governance. They must also ensure that adequate resources are allocated to government officials responsible for preventing and managing the harmful use of alcohol, that capacity building measures are taken in alcohol policy and research, and that knowledge of evidence is introduced into policy and programme practice in all sectors and at all levels. Developed policies need to be comprehensive, minimizing any negative consequences. A lack of transparency and information, poor organization and preparation for the introduction of new policies and laws, a lack of financing, the presence of corruption, and public distrust of authority are all impediments to the acceptance, implementation, and enforcement of effective policy. As a minimum, all countries would be expected to have an identifiable national action plan or strategy on alcohol, including measurable health and policy outcomes; a coordinating body or mechanism to promote policy coherence and "joined–up" action across relevant government departments and sectors, and an adequately resourced nongovernmental sector, free of potential conflict of interest with the public health interest, to give voice to civil society.

Health services' response

Headline

32. The health sector, and through its support, the social welfare, education and workplace sectors, have real opportunities to reap both health gain and financial savings through the widespread but simple implementation of brief advice programmes that have been shown to reduce ill health and premature death subsequent to hazardous and harmful alcohol consumption.[4] This requires leadership from governments and health insurance companies to provide the incentives for primary care providers to take the required action.

Outcome

33. Throughout the duration of this action plan, all countries should progressively reduce the gap between the number of people who would benefit from alcohol consumption advice to reduce or prevent harm or treatment for alcohol use disorder and the number who actually receive such advice or treatment.

Indicator

34. Indicators would include the proportion of the adult population with hazardous and harmful alcohol consumption, and the proportion of the population with hazardous and harmful alcohol consumption who have received advice from a primary care provider to reduce their alcohol intake.

Background

35. Alcohol use disorders, including harmful alcohol use and alcohol dependence, are officially classified in the list of mental and behavioural disorders in the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10). In general, the prevalence of alcohol use disorders are quite high, with, in most countries, perhaps one in six adults drinking at least 40 g alcohol per day for a man and 30 g for a woman, and some 1 in 16 adults suffering from alcohol dependence in any given year. In almost every country studied, there is a considerable gap between the number of people who would benefit from alcohol consumption advice or treatment and the number of them who actually receive such advice or treatment. It has been estimated that only 1 in 20 of those with hazardous or harmful alcohol use are actually identified and offered brief advice by a primary care provider; similarly, less than 1 in 20 with a diagnosis of alcohol dependence have actually seen a specialist for treatment.

Strategies

36. Evidence strongly supports the benefits of widespread implementation of early identification and brief advice programmes for individuals with hazardous and harmful alcohol consumption in primary care, social welfare settings and accident and emergency departments, and offering programmes in the workplace and educational environments,. Governments can support identification and brief advice programmes and referral to specialist services by ensuring that clinical guidelines for such interventions are widely available; that primary care providers receive the training, clinical materials and advice they need to set up such programmes; and that they are adequately reimbursed for the interventions, either as part of quality improvement initiatives or with fee-for-service payments. Primary care providers find it

[4] Considered as consumption greater than 40g alcohol per day for a man and 30g alcohol per day for a woman.

easier to undertake this intervention when they are supported by specialist services to which they can refer difficult-to-manage drinkers. In the management of alcohol use disorders, the transition from primary to specialist care should ideally be seamless. Specialist services for managing alcohol withdrawal and treating alcohol use disorders using evidence-based behavioural and pharmacological treatments should be offered to those who have been assessed as likely to benefit. The trend has been to move away from lengthy inpatient treatment towards outpatient and community-based treatment. Compulsory treatment is no longer recommended, except in the case of court-mandated treatment for recidivist drink–drivers, which some evidence has shown can be effective.

Options for action

37. All the evidence suggests that the majority of hazardous and harmful drinkers are not receiving advice from primary care providers as a matter of course, and that many people with alcohol use disorders who would benefit from treatment are not currently receiving it. Leaving the situation unchanged might be viewed as costing nothing, but that is a false assumption. Investments in early identification and brief advice programmes not only improve health and save lives, but also save health systems money. Two levels of action can be taken.

38. The first would be to set a target of offering early identification and brief advice programmes to 30% of the population at risk for hazardous or harmful alcohol consumption. This target could be achieved by putting into place appropriate systems, including provider training, so that every patient who registers with a new primary care provider, receives a health check, consults a provider about particular disease categories (such as hypertension or tuberculosis) or goes to particular types of clinics is offered these interventions.

39. The second would be to set a target of offering early identification and brief advice programmes to 60% of the population at risk. This more ambitious target would require that every patient who receives primary care services would be offered these interventions, irrespective of the reason for the consultation. It would also necessitate a greater investment in training and supporting primary care providers.

Community and workplace action

Headline

40. Action at the local level, in communities, workplaces and educational settings, when delivered in a coordinated and aligned manner, can reduce the harmful use of alcohol by changing collective rather than individual behaviour. Public education campaigns and information about health risks given on alcoholic beverage labels can be used to support local action and alcohol policy measures. To be fully effective, local and collective action requires partnership and capacity building across different sectors and sustained leadership at different levels of society.

Outcomes

41. Throughout the duration of this action plan, all countries should, where appropriate, endeavour to progressively increase the number of schools implementing health-promoting action that includes action on alcohol; the number of municipalities with local action plans on alcohol; and the number of work-places and employing bodies that implement alcohol in the workplace policies and programmes.

Indicators

42. Indicators would include the proportion of schools, municipalities, and work-places implementing policies and programmes on alcohol that include specified criteria.

Background

43. Enacting alcohol policy at the community level has the advantage that alcohol problems have immediate local consequences to which a community must respond directly, such as dealing with injuries and deaths from road traffic accidents, providing hospital and emergency medical services and providing interventions for the harmful use of alcohol and alcohol dependence. Communities vary a considerably with respect to alcohol problems. An urban setting can be a risk factor for harmful levels and patterns of alcohol use, particularly when it is an area of low social capital, or when it develops a night-time economy and generates high levels of drinking-related nuisance and harassment.

44. In the workplace, harmful alcohol use and heavy episodic drinking increase the risk for absenteeism, presenteeism (reduced performance at work), arriving at work late, leaving work early, accidents, turnover due to premature death, low productivity, inappropriate behaviour, theft and other crimes that can require disciplinary action, poor co-worker relations and low company morale. Conversely, structural factors at the workplace, including high stress and low satisfaction, can increase the risk of alcohol use disorders and alcohol dependence.

45. Many national alcohol strategies and initiatives underscore the need to inform and educate the public. This may express a simple principle that consumers ought to be provided with information and that a population should know about and understand alcohol and its health risks, but it may also reflect the view, contradicted by evidence, that information and education alone can solve alcohol-related problems. In practice alcohol education rarely goes beyond providing information about the risks to promote the availability of help for alcohol use disorders or to mobilize public support for effective alcohol policies.

Strategies

46. Alcohol education should be considered as part of a wider policy approach. It should start with parenting support, and continue in schools as part of the holistic approach of the health-promoting and mental health promoting school. Given its limitations, it should be based on educational practices that have proven effective, such as targeting a relevant period in young people's development, talking to young people from the target group during that development phase, testing the intervention with teachers as well as members of the target group, ensuring the programme is interactive and based on skills development, setting behaviour change goals that are relevant for all participants, returning to conduct booster sessions in subsequent years, incorporating information that is of immediate practical use to young people, conducting appropriate teacher training for delivering the material interactively, and making any programme that proves to be effective widely available and marketing it to increase exposure. Family-based programmes could also be considered.

47. Community-based prevention programmes can be effective in reducing drink–driving, alcohol-related traffic fatalities and assault injuries. Community mobilization has also been used to raise awareness of problems associated with on-trade drinking (such as noise and aggressive behaviour), to develop specific solutions to them and to get establishment owners to acknowledge their community responsibility for addressing them. Evaluation of community mobilization efforts and documentation of grassroots projects suggest that community mobilization can reduce aggression and other problems related to drinking on licensed premises. The main characteristic of effective community programmes is that they implement and

mobilize support for interventions known to be effective, such as drink–driving laws or stricter enforcement of restrictions on alcohol sales to minors and intoxicated people.

48. Workplace efforts that can reduce alcohol-related harm include policies promoting alcohol-free workplaces, a managerial style that reduces job stress and increases job rewards, and optional workplace interventions that are available on request, such as psychosocial skills training, brief advice and alcohol information programmes.

49. Information-based public education campaigns about alcohol should be proportionate and should concentrate on providing information about the risks of alcohol and the availability of help and treatment to reduce harmful use. Public education programmes should also be used to support alcohol policy measures, particularly when new measures are introduced, such as a reduced blood alcohol limit for driving, an increase in the minimum age for purchasing alcohol or tax increases on alcohol.

50. Health warning labels should be placed on all alcoholic beverage containers as part of broader communication and point of purchase health campaigns to reduce the harmful use of alcohol. Once phased in, alcohol warning labels cost very little, and, at the very least, remind consumers, and society at large, that alcohol is no ordinary commodity. In line with the provision of information on ordinary foodstuffs, alcoholic beverage labels should state the alcohol content in an easily understood manner and list ingredients relevant to health, including calorie content, and in general introduce labelling like that used for other foodstuffs in order to ensure that consumers have access to complete information on the content and composition of the product for the protection of their health and interests.

Options for action

51. Failure to redirect and coordinate alcohol education initiatives risks a continued inappropriate and inefficient use of scarce resources, for instance by using poorly designed ineffective programmes. Likewise, failing to invest further in community programmes, an opportunity to mobilize public support for new alcohol policy efforts may be lost. In addition, it is likely that many existing community and workplace programmes have not been designed or implemented optimally, nor that they have been evaluated. A wide range of actions are possible:

52. Steps should be taken to redesign and reinvest in school-based education and public information campaigns on alcohol. These efforts should be financed in proportion to their potential impact. The redesigning should be based on needs assessments that are themselves derived from the results of public surveys on alcohol. The redesigned educational programmes should provide information on the risks of alcohol use, the availability and effectiveness of advice and treatment in reducing harmful alcohol use, and the evidence for effective alcohol policies.

53. Efforts should be made to support and help build the capacity of local communities and municipalities. Increasingly, local communities and municipalities are taking on a wider range of responsibilities to reduce the harmful use of alcohol. This requires increased locally generated training, capacity building and support of local action groups to ensure that the full range of potential evidence-based policies and actions are put to their full use at the local level.

54. Community and workplace resources for action on alcohol should be developed. These resources should include documentation of effective alcohol programmes and an analysis of the factors that contribute to success in the community and in the workplace. They should also include assessment tools to enable alcohol programme managers to ensure that these factors are incorporated into the design and implementation of community and workplace programmes.

55. A mechanism to evaluate and document programmes should be created and financed, in order to strengthen the design and implementation of both new and established programmes, and achieve the best results in the community and in the workplace.

56. Relevant national legislation should be revised with a view to potential amendment to ensure that it facilitates and supports community and workplace initiatives, rather than hindering them.

57. Measures should be taken to introduce a series of large warning labels on all alcoholic beverage containers and on all commercial communication materials for alcoholic beverages. The content of the warning messages should be determined by public health bodies. The focus for such messages might address issues of immediate concern such as drinking during pregnancy or while driving, or extend to cover the long-term risks of alcohol use, such as high blood pressure and cancer.

58. Product labelling similar to that used for foodstuffs, including alcohol and calorie content, additives, allergens etc, should be introduced.

Drink–driving policies and countermeasures

Headline

59. Any level of alcohol consumption impairs the ability to drive, and action to reduce drinking and driving receives widespread public support, particularly since many of the victims of drink–driving are not the drink drivers themselves. To be effective in reducing the unnecessary tragedy of drink–driving injuries and fatalities requires sustained "joined-up" action between government, traffic police, the criminal justice system, safety authorities, the health sector, local communities and other stakeholders.

Outcome

60. Throughout the duration of this action plan, all countries should progressively reduce, and maintain at as low a level as possible, drink–driving fatalities.

Indicator

61. The indicator for this section would be rink–driving fatalities.

Background

62. In general, drink–driving fatalities and accidents have been declining in most European countries, although there remains considerable room for improvement. Although young people are at the greatest relative risk of having a drink–driving accident, in absolute terms drink–driving and related accidents and fatalities are more common among the middle-aged. Most Europeans support tougher measures to reduce drink–driving, including greater enforcement by the police. Drink–driving laws, enforcement levels and sanctions might also need to consider the growing number of private and professional drivers that cross borders within the European Region. Repeated offences or very high blood alcohol levels can be an indicator of alcohol use disorders and alcohol dependence, for which treatment should be systematically made available.

Strategies

63. Action on drinking and driving, and indeed action on the use of other psychoactive substances and driving, not only reduces the risk of harm to the driver, but also the risk of harm to passengers, pedestrians and other drivers. One effective intervention is simply to reduce the legal blood alcohol content (BAC) limit for driving and the effectiveness of this can be improved if it is part of a combination of other measures. For any country with a BAC limit above 0.5 g/l, it could be beneficial to reduce the level to 0.5 g/l, while countries with a level of 0.5 g/l could benefit from reducing the level to 0.2 g/l. However, a lower legal blood alcohol level is only effective if combined with other measures and if it is actually enforced. The best method of enforcement is intelligent random breath testing that raises the fear of being caught by those who drink and drive rather than in the driving population at large, followed by sobriety checkpoints. Enforcement should be supplemented by public education campaigns to ensure that the public knows the consequences of being apprehended. Enforcement also works best when punishment has severe personal consequences, e.g., with on-the-spot fines, driving licence penalty points and, as appropriate, driving licence suspension. It can be further reinforced by court-mandated interventions and the use of alcohol ignition locks for specified periods. Alcohol locks can also be used as a preventive measure, notably for professional drivers.

Options for action

64. Very few countries would not benefit from lowering their existing BAC limits, or improving enforcement. Failure to do so may miss an opportunity to reduce preventable deaths and injuries among drink drivers and others. There are two particularly important actions that can be taken.

65. The first would be to reduce the legal BAC level for drinking and driving for all drivers. Whatever the present legal blood alcohol level, evidence suggests that more lives can be saved by reducing it closer to 0.2 g/l. This action sends a basic message and helps to establish “no drinking and driving” as a cultural norm. To be effective, however, a lower BAC limit must be part of a combination of other measures and must be backed up by enforcement.

66. The second action would be to enhance enforcement, either through increased random breath-testing or measures to increase the fear of being caught among those who drink and drive rather than among the driving population at large or greater use of sobriety checkpoints. In order for BAC limits to be effective, the drink driver, rather than the driving public, needs to know that there is a real risk of being stopped and breath-tested at any time.

Availability of alcohol

Headline

67. It is a simple fact that the more available alcohol is, the more it is consumed and the greater is the harm that results. Even only small reductions in the availability of alcohol, that can be easily and readily implemented, bring health gain and reduce violence and harm to people other than the drinker. To achieve this requires concerted action between licensing officers, the police, criminal justice systems and the health care sector.

Outcomes

68. Throughout the duration of this action plan, all countries should limit or reduce the availability of alcohol; and ensure that regulations on limiting the sale of alcohol to intoxicated and underage customers are increasingly enforced by all involved parties.

Indicators

69. Indicators would include a composite measure of alcohol availability, including an assessment of the number of outlets, size and density of outlets, and the days and hours of sale. Underage access to alcohol would also be measured by regular surveys of young people (for example the European School Survey Project on Alcohol and Other Drugs – ESPAD).

Background

70. A system of licensing for the sale of alcohol is crucial to enable governments to manage availability of alcohol, since it allows the government to restrict the number of licenses and require licensees to meet certain standards, revoking the license as a penalty for infringement. While strictly limiting the availability of alcohol may encourage the development of a parallel market in illicit alcohol, it can usually be controlled through enforcement. Situational bans on alcohol are another way to reduce harm, for example, bans on the use of alcohol in particular locations (such as parks, streets, hospitals and workplaces) and circumstances (such as during football matches). A few countries maintain government monopolies on alcohol sales, which tend to mean fewer stores and shorter opening hours than in countries with private sales.

Strategies

71. Encouragement should be given in all Member States to introducing or maintaining licensing systems for alcohol sales. Licences should only be renewed for establishments that adhere to laws restricting sales to underage drinkers and intoxicated people, and that discourage patrons from being a public nuisance or engaging in violence. Licensing authorities should be more closely involved in designing and where appropriate implementing measures aimed at reducing alcohol-related incidents of violence, crime, public disturbance and harm to health. Those countries with government monopolies for the retail sale of alcohol should consider preserving them.

72. Governments should take steps to control the availability of alcohol where nessesary, such as by regulating the density of alcohol outlets and controlling the sales hours. It is advisable to avoid extending the days and hours of alcohol sales, and to curtail them further when given neighbourhoods or communities experience excessive alcohol-related harm. Minimum purchase ages for alcohol should be enforced. Where it is less than 18 years, it would be advantageous to increase them to 18 for all beverage products in both off-trade and on-trade establishments. Effects could be envisaged to control the implementation, such as using young test buyers to ensure that establishments enforce minimum purchase ages.

Options for action

73. Most jurisdictions provide opportunities to control the sale of alcohol in ways that can reduce alcohol-related harm, notably through better enforcement. Enforcement appears to be a major deficiency in European alcohol efforts, particularly the enforcement of minimum age laws and laws against selling alcohol to already intoxicated customers. It is also worthwhile to review ways to control the density and sale hours of alcohol outlets by strengthening existing laws and regulations. Two important actions that can be taken are set out below.

74. The first is that if the minimum purchase age is less than 18 years, consideration should be given raising it to 18 years for all beverage categories, including beer and wine, at all sales outlets, including supermarkets, bars and cafes. Any such change in the purchase age should be supported by increased enforcement.

75. The second important action would be to weigh the political and public support for strengthening existing laws and regulations to reduce the density and opening hours for alcohol sales outlets, and, where they exist, for maintaining a government retail monopoly.

Marketing of alcoholic beverages

Headline

76. The extent and breadth of commercial communications on alcohol and their impact, particularly on young people's drinking, should not be underestimated. There are many ways to limit exposure to commercial communications, ranging from avoiding the use of humour and glamour and other youth appealing aspects, to avoiding sponsorship and television and cinema advertising, all the way up to a complete ban. Whatever system is adopted, joint work is essential between health systems, the media and all forms of telecommunications. More than this, international coherence is needed, since communications cross borders.

Outcome

77. Throughout the duration of this action plan, and, in particular to protect children and young people, all countries should have systems in place to prevent inappropriate and irresponsible alcohol adverting and marketing targeting children and young people.

Indicator

78. The indicator here would be children's and young people's reported exposure to the full range of alcohol marketing, assessed using surveys conducted every one or two years.

Background

79. The marketing of alcohol is an enormous activity in itself, and continues to expand through different communication channels. A full marketing strategy includes not only advertising and promotional activities, but also product development, price-setting and targeting different market segments with different products. Moreover, alcohol is no longer marketed only through traditional broadcast media (such as television and radio) and traditional non-broadcast media (such as print media, billboards and branded merchandise). It is also promoted by linking alcohol brands to sports and cultural activities through sponsorship and product placement, and by direct marketing using technologies such as the Internet, podcasts and text messaging. In addition, the entire entertainment sector plays a role in shaping the expectations of young people for the use of alcohol through its portrayal of alcohol in films, television shows, songs and other cultural productions. Any effort to regulate alcohol marketing should be comprehensive and address all these elements. Finally, given that commercial communications cross borders, international action is needed.

Strategies

80. Both the content of alcohol marketing and the amount of exposure to it are critical issues for young people, who are particularly susceptible to alcohol's harmful effects. Young people's interest in specific aspects of marketing materials, such as humour, animation, and popular music, contributes significantly to the materials' overall effectiveness. Generally, there is a dose–response relationship between young people's exposure to alcohol marketing and the

likelihood that they will start to drink or drink more.[5] Real-time studies have shown that marketing can have an immediate and substantive impact on how much young people drink, and that this impact is even greater on heavier drinkers.

81. Although many jurisdictions regulate the volume and content of alcohol advertisements, their regulations may not always reflect sufficient knowledge of how young people respond to advertising and the aspects of advertising they are drawn to. Many forms of marketing exposure often remain unregulated, for example the portrayal of alcohol use in films, product placement in films and on television shows, advertising on the Internet and through mobile communication devices. Some jurisdictions have restricted certain forms of alcohol marketing, such as prohibiting it from television and cinemas, or forbidding sports sponsorships, while others have actually banned all forms of alcohol advertising.

82. In some jurisdictions, the content and placement of alcohol marketing is controlled through systems of co-regulation and self-regulation by economic operators, including advertisers, the media and alcohol producers. To be effective, however, such regulation requires a clear legislative framework and sufficient incentives to succeed. Monitoring of alcohol marketing practices is best done when it is the responsibility of an independent body or a government agency, and when it is performed systematically and routinely. Because it can be quite difficult for advertising codes or laws to specify all aspects that should not be permitted in alcohol advertising, some countries (France) have chosen to specify what it can include, since that is much clearer to monitor and enforce.

Options for action

83. The impact of marketing on the use and heavy use of alcohol should not be underestimated. Systems for managing the marketing of alcohol can be made more efficient, reducing exposure for the benefit of public health. Given the cross-border nature of commercial communications on alcohol, also supra-national action is needed. The four progressive steps required are described below.

84. The first step is to undertake a thorough review and analysis of existing systems including the volume and content of exposure. Such a review should ensure that no alcohol marketing practices fall outside the control of regulatory systems and thus go unregulated.

85. The second step would be to streamline the existing marketing systems with the aim to cover all marketing channels and strengthen the enforcement.

86. The next step would be to further restrict the volume and content of commercial alcohol communications, for example by only allowing those that describe the product directly, or by banning all such communications for example on television, radio, films and in sports sponsorships.

87. The fourth step would be to ban all forms of commercial alcohol communications, with the exception of media such as trade journals.

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[5] Anderson P, de Bruijn A, Angus K, Gordon R, Hastings G. Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol and Alcoholism*, Advance Access published January 14, 2009, 44(3):229-243 doi:10.1093/alcalc/agn115.

Pricing policies

Headline

88. When other factors are held constant, such as income and the price of other goods, a rise in alcohol prices leads to reduced alcohol consumption and reduced alcohol-related harm, and vice versa. Price increases correlate with a reduction in the harm caused by alcohol, which also indicates that heavier drinking has been reduced

89. Taxes are one way to influence the price of alcohol, with immediate and greater impact on heavier drinkers. Strong relationships are needed between health departments (ministries) and tax departments (ministries) to make the continued case that tax may be able to play a role in reducing the harmful use of alcohol.

Outcome

90. Throughout the duration of this action plan, all countries should include pricing policies as part of a comprehensive strategy.

Indicator

91. The indicator in this case would be the affordability of alcohol (measured by comparing the relative alcohol price index against the real household disposable income index).

Background

92. Of all alcohol policy measures, the evidence is strongest for the impact of alcohol prices as an incentive to reduce heavy drinking occasions and regular harmful drinking. The gains are greatest for younger and heavier drinkers and for the well-being of people exposed to the heavy drinking of others.

Strategies

93. Alcohol taxes must address a number of objectives and reducing the harmful use of alcohol is a factor countries should consider when setting their tax rates. Increased taxes do not necessarily mean increased prices, since alcohol producers and retailers can offset tax increases by not passing on the tax increase to the consumer. One way to manage this is to introduce a legal minimum price per gram of alcohol. It can be argued that light drinkers are punished by tax increases and governments will consider the impact on this group seriously. However, it can be argued that raising taxes or introducing a minimum price hardly affects the alcohol consumption and out-of-pocket expenses of light drinkers. Since no level of consumption is entirely risk-free, if an individual chooses to consume less alcohol because of the cost, there is a health benefit. Reductions in the damage that drinkers inflict on others may also benefit light drinkers. While it has also been argued that tax increases cause job losses, in fact, the long-term effects of higher alcohol taxes on employment as a whole are likely to be neutral, with less unemployment if anything, although there may be some short-term adjustments in the hospitality sector. One of the main determinants of alcohol consumption and alcohol-related harm is alcohol affordability, a composite measure of the price of alcohol relative to the price of other goods, adjusted for income. In order to protect public health, alcohol taxes may need to be adjusted to ensure that alcohol does not become more affordable. The existence of a substantial illicit or informal market for alcohol can complicate the policy considerations for alcohol taxes. In such circumstances, tax increases should be accompanied by government efforts to control these markets. Cross-border trade can also complicate policy considerations for alcohol taxes,

although it is important to note that decreasing taxes tends to lead to more alcohol-related harm, rather than resolving cross-border issues.

Options for action

94. In most countries, leaving alcohol taxes unchanged would mean that the relative price of alcohol falls, with a consequent rise in heavy drinking occasions, alcohol-related harm and lower productivity. There are four possible options for action.

95. The first option is to increase alcohol taxes. Elasticity and affordability data can inform the extent to which alcohol tax should be increased.

96. Proportionally higher taxes on products with a higher alcohol concentration or incentives on lower-alcohol versions of products could be instituted.

97. Special taxes could be added to products that are especially attractive to young consumers. Several countries have instituted such taxes for alcopops and related beverages.

98. A minimum price could be set per litre of pure alcohol. In countries that choose this option, this measure may be more likely to ensure that price changes result in a desired change in retail price, which tax increases may circumvent if they are not passed on to the consumer.

Reducing the negative consequences of drinking and alcohol intoxication

Headline

99. Most alcohol is consumed during heavy drinking occasions and this is the most risky form of drinking[6], which harms people other than the drinker, and can cause considerable harm to drinkers themselves, not only through accidents and sudden death, but also death from long term chronic conditions. All policy options proposed in this action plan are likely to reduce the frequency and size of heavy drinking occasions, but action in drinking environments is also fundamentally important. To be effective this requires a coordinated response between government, health systems, the police, criminal justice systems, licensing authorities, retailers and alcohol outlets, local communities and other stakeholders.

Outcome

100. Throughout the duration of this action plan, all countries should tackle death rates as a consequence of alcohol intoxication, and in particular alcohol-related intentional and unintentional injuries.

Indicator

101. Death rates from alcohol-related intentional and unintentional injuries will be the indicator for this section.

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[6] Baumberg B. How will alcohol sales in the UK be affected if drinkers follow government guidelines? Alcohol & Alcoholism 2009; 44 (5): 523–528. doi: 10.1093/alcalc/agp053

Background

102. Heavy drinking occasions and intoxication are particularly harmful to health and social well-being. While all action areas in this plan can impact on heavy drinking, this action area focuses on the consequences of intoxication that result from drinking environments. Ready availability of cheap alcohol from other retail outlets may result in many customers arriving at drinking environments already intoxicated. Nevertheless, drinking environments can be associated with drunkenness, drink–driving and aggressive and violent behaviours and some premises are associated with a disproportionate amount of harm. The relationship between drinking and alcohol-related harm can be both affected and mediated by the physical and social context of drinking. Interventions in drinking environments can be important in averting problems that often harm people who are not drinking, notably the problems of drink–driving and violence.

Strategies

103. Elements of bar environments that increase the likelihood of alcohol-related problems include serving practices that promote intoxication, aggressive enforcement of closing time by bar staff and local police, the inability of bar staff to manage problem behaviour, characteristics such as crowding, and a willingness to serve underage or intoxicated individuals. Adherence to bar policies for preventing intoxication has resulted in only modest reductions in heavy consumption and higher-risk drinking. Impact is greatly enhanced, however, when there is active, continual enforcement of laws prohibiting the sale of alcohol to intoxicated customers. For those countries that do not have one, introducing a licensing system for the sale of alcohol, and regulations for the issuance of licenses, can ensure that serving establishments meet certain standards to decrease the likelihood of alcohol-related harm. These regulations can be monitored regularly at the local level and sanctions imposed for violating them, including loss of license. Server training programmes could be a prerequisite for receiving and maintaining a license.

Options for action

104. Since all jurisdictions are likely to have serving establishments with poorly designed premises, or that violate laws against serving underage or intoxicated customers, there is always room to step up such efforts at the local level to reduce harm. Two important actions can be taken in that regard.

105. Guidelines and standards could be developed for the design of serving premises, server training and monitoring and enforcing licensing laws. These could be disseminated among licensing authorities and serving establishments. These guidelines and standards could reflect a public health orientation.

106. Existing licensing regulations should be reviewed and strengthened where appropriate. The regulations should ensure that serving premises meet established standards, that server training is considered for licensing, that the regulations are regularly monitored and enforced at a local level, that there are sufficiently severe sanctions (including license revocation) for violations by servers or serving establishments, and that there are sufficiently severe sanctions for licensing bodies that fail to regulate drinking environments effectively.

Reducing the public health impact of illicit alcohol and informally produced alcohol

Headline

107. Throughout Europe, although the exact amount of unrecorded alcohol consumed is not fully known, estimates suggest that overall it could be as high as between one third and two-fifths, being much higher in the eastern part of the Region than in the western part. Per unit of alcohol, unrecorded alcohol is considered to have a greater impact on health than recorded alcohol, although, the size of this potential problem is not known. The focus of alcohol policy should be to manage the harm from recorded alcohol, bring more unrecorded alcohol into the recorded and managed system, while at the same time undertaking a full assessment of the extent of potential harm from all forms of unrecorded alcohol.

Outcome

108. Throughout the duration of this action plan, countries with an identified problem should manage the chemical composition of unrecorded alcohols.

Indicator

109. The acetaldehyde, coumarin, phthalate and ethyl carbamate content of samples of unrecorded alcohols would serve as indicators in this case.

Background

110. The term unrecorded alcohol covers informal and homemade alcohols, illegally produced or smuggled alcohol products, as well as surrogate alcohol that is not officially intended for human consumption. Illegally and informally produced alcohol and surrogate alcohol can have health consequences when consumed owing to their higher ethanol content or contamination, which are toxic to the liver. Illegally traded alcohol can also pose health risks due to its lower cost, which encourages higher consumption, particularly among young and underage people.

Strategies

111. Despite concerns about potential health harms from the chemical composition of unrecorded alcohol, there are surprisingly few data on the problem in the European Region. A small study of samples collected from 17 European countries found that although samples frequently had higher ethanol concentrations than in recorded spirits most were generally free of contaminants. The exceptions were fruit spirits, which tended to have high levels of ethyl carbamate. Alcohol policy currently includes no evidence-based concept for managing unrecorded alcohol, with the exception of some successful past policy measures, including the prohibition of methanol to denature alcohol. Additional measures might range from legalizing unrecorded alcohol with subsequent quality control, to instructing the producers of unrecorded alcohol how to avoid the problems detected.

112. Although any heavily taxed product will be susceptible to fraudulent activity, that does not mean that reduced, uniform tax rates will reduce the level of alcohol smuggling. Two tools that could help monitor and combat smuggling are the computerization of surveillance data on the movement of excise products, and the issuance of tax stamps to show when and where duty is paid.

Options for action

113. The main focus of alcohol policy should continue to be reducing the harm done by recorded alcohol. Nevertheless, there remains a lack of knowledge about the extent of illegal trade and the potential health impact of unrecorded alcohol. Additional health gains can be achieved through a number of actions.

114. Steps should be taken to make new estimates of the size of the illegal market, and extensive chemical testing of samples of unrecorded alcohol should be conducted to identify the riskiest products and their potential for harm. Where appropriate, work should be carried out with manufacturers of informal or surrogate products to reduce the risk of harm from manufacturing processes. Computerized tracking should be used to monitor the movement of alcoholic products, and tax stamps should be introduced to facilitate the tracking and identification of illicit products.

Monitoring and surveillance

Headline

115. An action plan is more effective if its implementation and impact in reducing alcohol-related harm is monitored and evaluated. This requires transparency and regular public reporting on progress. It also requires considerable leadership and adequate resources to ensure that the necessary data is available, and that many different government departments and sectors work together to produce regular and in depth monitoring and surveillance reports.

Outcome

116. All countries should publish regular comprehensive reports on alcohol that include information on drinking among adults, underage drinking, drinking-related ill health, and costs to society. All countries should present data for all the indicators of the WHO survey on alcohol and health.

Indicator

117. Public accessibility of annual (or at least biennial) comprehensive reports on alcohol would be the indicator in this case.

Background

118. As emphasized in the section on policy response, in order to be effective, national alcohol action plans and strategies should include objectives and outcomes that are publicized and worked towards. Process and outcome indicators should be developed, used and monitored, with regular reports to keep stakeholders informed. Regular evaluation allows tracking of progress in implementing the national action plan or strategy, helps identify what is working and what is not, and enables regular revision of the plan or strategy. The national instrument and monitoring reports should be made public, and public government sectors, NGO's and other stakeholders should be invited to provide comments and feedback on them at regular intervals.

Strategies

119. The European Commission's Committee on Alcohol Data Collection, Indicators and Definitions has recommended three key indicators for monitoring changes in alcohol consumption and alcohol-related harm. These indicators measure:

- *volume of consumption* (total recorded and unrecorded per capita consumption of pure alcohol in litres by adults (15 years and older), with subindicators for beer, wine, and spirits);
- *harmful consumption pattern* (intake of at least 60 grams of alcohol on a single occasion at least once per month during the previous 12 months); and
- *health harm* (years of life lost – YLL) attributable to alcohol, with subindicators for alcohol-attributable YLL from chronic disease and injury).

120. Regular reports on alcohol can be prepared each year addressing at least the following five topics:

- *drinking among adults*, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables, demographic characteristics, drinking and pregnancy, adults' drinking behaviour and knowledge of alcohol, and geographical patterns of alcohol consumption;
- *underage drinking*, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables and drinking among different ethnic groups, associations with other substance use, and drinking behaviour and knowledge of alcohol;
- *drinking-related ill health*, including hazardous, harmful and dependent drinking, consultations about drinking with health professionals, alcohol-related hospital admissions and alcohol-related mortality;
- *availability and affordability of alcohol*;
- *costs to society*, including expenditure on alcohol-related harm, alcohol-related crime and alcohol-related traffic accidents; and
- *policy responses*, including all the policy outcomes of this action plan relevant to a country related to leadership, awareness and commitment, health services' response, community and workplace action, drink–driving, availability, marketing, pricing, reducing intoxication, and reducing the impact of illicit and informally produced alcohol.

Options for action

121. Although a number of countries produce regular reports on alcohol that include collecting all the relevant data, it is likely that all countries can find ways to improve these data and strengthen their analytical and reporting systems. Moreover, it is difficult to improve existing action plans and strategies in the absence of extensive monitoring and evaluation. In that regard, a number of actions would be necessary.

122. The first action would be to assemble all the available data on alcohol in one report covering consumption, harm, social costs, and policy responses, and publicize the report widely. This report could also include on rotating basis more detailed information on a given topic.

123. The second would be to refine the analytical methods used in generating data on alcohol. Morbidity and mortality data should include the calculation of alcohol-attributable fractions. It is also important to estimate social costs, particularly avoidable social costs, which result from implementing specific alcohol policy measures.

Role of the WHO Regional Office for Europe

Leadership

124. The WHO Regional Office, together with its collaborating centres, will continue to play a leading role in coordinating a European response to the particular challenges of alcohol related harm in Europe. The Regional Office will work closely with WHO headquarters to support the European and global implementation of the global strategy to reduce the harmful use of alcohol. The Action Plan will be used for a publication that will include a check list or set of questions for Member States. The Regional Office will continue its close collaboration with the European Commission implementing common and joint actions. The Regional Office will assist countries in the implementation and evaluation and monitoring of alcohol policies, according to their needs, culture and socioeconomic make-up. It will liaise with appropriate intergovernmental agencies such as the Unite Nations Development Programme (UNDP), the World Bank, the International Labour Organization (ILO), the World Trade Organization (WTO), and Organisation for Economic Co-operation and Development (OECD) to seek inclusion of alcohol policies in relevant social and economic development agendas.

Capacity building

125. Within the context of a public health approach to alcohol-related problems, the Regional Office will support government bodies at national and subnational levels, and in particular in those countries with highest burden of alcohol-related disability and death to give high priority to the prevention of the harm done by alcohol, with an increased investment in the implementation of policies known to be effective. The Regional Office will support countries in continuing to review the nature and extent of the problems caused by alcohol in their populations, the resources and infrastructures available for reducing their incidence, prevalence and impact, and the opportunities and possible constraints in establishing new policies and programmes. It will also support countries' efforts to formulate, develop and implement adequately financed action plans on alcohol with clear objectives, strategies and targets, and to establish or reinforce mechanisms and focal points to coordinate the work of public health stakeholders. Furthermore, the Regional Office will assist Member States in implementing and evaluating evidence-based policies and programmes, utilizing existing structures where feasible.

Monitoring and surveillance

126. In view of the need to provide a sustainable system for monitoring and surveillance of progress in reducing the harmful consequences of alcohol use, the Regional office will continue in partnership with the European Commission and the WHO global office to maintain and further develop the European Information System for Alcohol and Health, with country-based counterparts, to bring together and analyse alcohol monitoring and surveillance information based on agreed and established comparable data and definitions. The Regional Office will support the integration of relevant data from international agencies such as the European Commission into this system to allow continuation of current monitoring efforts, as well as to provide information for countries which have not yet established an alcohol monitoring and surveillance system. The Regional Office will continue the function of integrating policies, laws and regulations and data on the effectiveness of policies and programmes into the information system, to help identify best practices and support the Member States in shaping effective programmes.

Knowledge dissemination

127. In order to take advantage of the large and growing body of knowledge, and to sustain and implement evidence-based measures to reduce the harmful use of alcohol, the Regional

Office will use its best efforts to communicate with Member States on a regular basis new findings on evidence-based alcohol policy measures and their implementation, and will establish a function to document, collate and disseminate practical experiences with the implementation of evidence-based alcohol policies in different societal circumstances and at different levels of governance.

Working with others

128. Recognizing the role that NGOs can play in supporting alcohol policy, the Regional Office will strengthen its processes of consultation and collaboration with NGOs and relevant professional bodies that are free of conflict of interest with the public health interest.

129. The Regional Office is guided by the principle that public policies and interventions to prevent and reduce alcohol-related harm should be guided and formulated by public health interests and based on clear public health goals and the best available evidence.