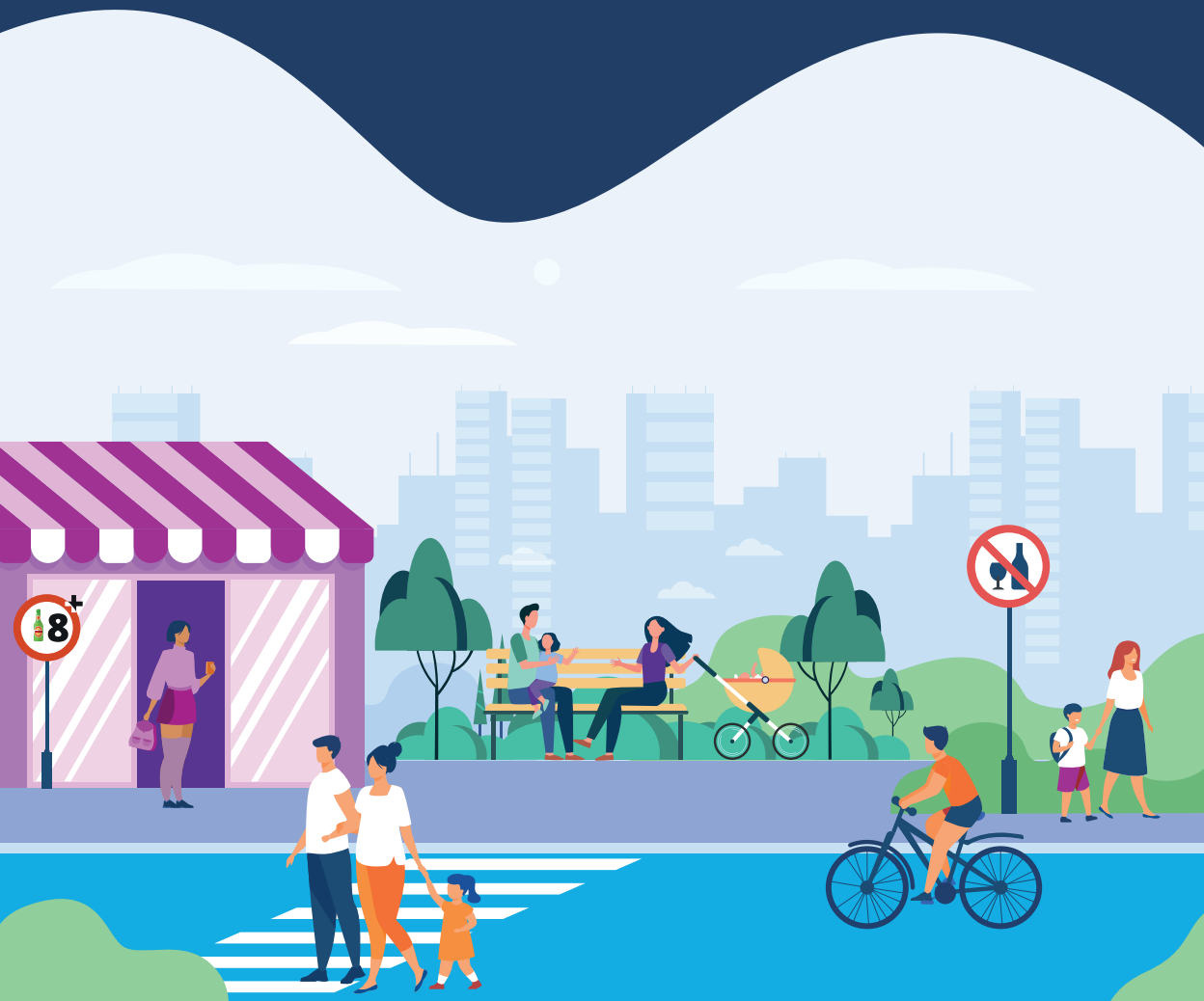
World Health Organization

European Region

Turning down the alcohol flow

Background document on the European framework for action on alcohol, 2022–2025



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The need for a renewed framework for action on alcohol in the WHO European Region

Our vision: the European framework for action on alcohol, 2022–2025 envisages a Region with improved health and social outcomes for individuals, families and communities and considerably reduced morbidity and mortality from alcohol consumption and ensuing social consequences. Our long-term strategic ambition is for a SAFER European Region free from harm due to alcohol.[1]

The European framework for action on alcohol, 2022–2025, draws on the latest evidence on alcohol-attributable harms and the best evidence to reduce such harms. It reflects the current issues faced by Member States, including dealing with the impacts of the COVID-19 pandemic, and highlights priority areas for action.

Alcohol consumption and its related burden of disease are responsible for some of the greatest health and societal challenges faced by Member States of the WHO European Region. Of the 10 countries that have the highest levels of consumption in the world, nine are located in the WHO European Region, where alcohol also makes the largest contribution to all-cause mortality *(3)*.

Total alcohol consumption per capita decreased by 2.5 litres (21%) between 2000 and 2019 in the WHO European Region; nevertheless, levels of alcohol consumption in the Region remain the highest globally *(4)*. Annually, every adult (15 years and older) in the Region drinks, on average, 9.5 litres of pure alcohol but there are large differences in estimated alcohol consumption across Member States, ranging from 0.9 to 14.3 litres of pure alcohol per capita per year in 2019. Since the Sustainable Development Goals (SDGs) were adopted in 2015, alcohol consumption levels have stagnated in the Region, with a small decrease of 0.3 litres (3.1%) per capita reported between 2015 and 2019. The most substantial decline reported at country level was 3.7 litres per capita and the most substantial increase was 2.1 litres per capita, while overall changes have been modest, and for some Member States, statistically non-significant *(4)*. Out of 51 Member States with available data, only six have reduced their alcohol consumption by more than 1 litre per capita *(4)*. In the WHO European Region, men drink approximately 3.5 times more alcohol than

1 See WHO, 2021 *(1)*, and WHO, 2022 *(2)*.

women, and there are large gender differences in the prevalence of alcohol use disorders (AUDs): 14.8% among men and 3.5% among women *(4)*.

One in every 10 deaths in the Region each year is caused by alcohol, amounting to almost 1 million in total, and many of these deaths occur at a very young age *(5)*. Alcohol consumption also has detrimental effects on many other health issues; it is a causal factor for more than 200 diseases, health conditions and injuries, and is a group 1 human carcinogen, causally linked to seven types of cancer *(6)*. Alcohol consumption, particularly heavy consumption, weakens the immune system and reduces its ability to cope with infectious diseases *(7,8)*. Addressing harms due to alcohol consumption exerts considerable financial pressures on social and health-care systems *(9)*, which are often very stretched. These pressures have been exacerbated by the COVID-19 crisis *(3)*. People with AUDs may be at increased risk of infection from COVID-19 and experience worse outcomes: evidence coming from over a million electronic records suggests that a recent diagnosis of an AUD increased the risk of COVID-19 infection by almost eight times compared with individuals without the diagnosis *(10)*.

Alcohol consumption contributes to health inequalities. It has been a consistent finding by various studies that harms from a given amount and pattern of drinking are higher for poorer drinkers and their families than for richer drinkers in any given context *(11–13)*. Alcohol-attributable conditions shape mortality trends across the Region as they contribute to gaps in life expectancy between men and women, as well as between countries in the western and eastern part of the Region *(14–17)*. Despite having similar or lower levels of alcohol consumption, countries in the eastern part of the Region have the highest indicators of alcohol-attributable burden *(5)*.

There is a robust evidence base for alcohol control measures to reduce alcohol consumption and harms *(18,19)* as well as broader health inequalities *(20)* and there is clear guidance on which measures can be considered as cost–effective, meaning that they reduce the most harm per resources invested *(21–23)*. This guidance and the tools needed to make the change have been captured in the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (EAPA), which was endorsed by the 53 European Member States in 2011 *(24)*. Since the adoption of the Action Plan, 32 countries have indicated that they have updated or developed a new national alcohol policy or strategy *(25)*. From 2010 to 2017, largely due to policy actions, adult alcohol consumption, alcohol-attributable deaths and disability-adjusted life years decreased in 67% of Member States, mainly in eastern Europe and central Asia *(26)*.

There are substantial returns on investment from alcohol control measures, with significant productivity gains and savings to health and social care *(27)*. The latest economic analysis undertaken under the auspices of WHO demonstrated high returns on investment for Best Buys in alcohol control *(28)*. Effective public health support can ensure their successful implementation, with health and social improvements as a result. The powerful tools of the Global strategy to reduce the harmful use of alcohol *(29)* and EAPA *(24)* have, however, been underutilized. According to the global Action Plan (2022–2030) to effectively implement the Global strategy to reduce the harmful use of alcohol *(30)*, barriers to implementation of effective

and cost-effective alcohol policies have varied sources, such as the complexity of the issue and the difficulties of a fragmented response as well as the influence and power of commercial interests in policy-making and commitments *(31)*. Interference by economic operators in alcohol production and trade has been identified as one of the most serious barriers to implementation of alcohol policies by the Member States of the WHO European Region *(32)* as well as in many academic reviews *(33–39)*.

Of the 10 EAPA action areas, only three have achieved relatively high implementation scores in 2016–2019: (i) drink–driving countermeasures; (ii) leadership, awareness and commitment; and (iii) actions to tackle unrecorded (informal or illicit) alcohol. Other areas received moderate or low scores *(5)*. The most high-impact and cost-effective policies are the three WHO Best Buys: increasing excise taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media), and enacting and enforcing restrictions on the physical availability of retailed alcohol (via reduced hours of sale). They are all implemented at a level that leaves much space for improvement. Pricing policies are the worst-performing policy area in the WHO European Region, and there is evidence that more use could be made of taxation policies to reduce harms due to alcohol consumption across the Region, since the relative contribution of tax to alcohol prices is very low, and alcohol is becoming more affordable in many countries since taxes and prices are often not adjusted for inflation *(40)*.

In January 2019, two preliminary consultations were held with Member States and civil society organizations. These consultations called for further strengthening of implementation of the EAPA at country level in the least implemented areas. In October 2019, the WHO Regional Office for Europe convened a regional consultation with Member States to determine the way forward. The outcome of the consultations highlighted the need to develop a framework for action focusing on the implementation of priority areas, including the Best Buy policies that currently have a low implementation rate, in order to further reduce alcohol consumption and attributable harm *(32,41)*. This need was further confirmed in the Final report on implementation of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020, presented at the 70th WHO European Regional Committee for Europe (document EUR/RC70/8(A)) *(25)*. A side event at the 71st session (EUR/RC71/SE/2) *(42)* also made clear the need for concerted action and stronger political commitment by Member States, along with greater engagement of public health-oriented nongovernmental organizations (NGOs), professional associations and civil society groups, to ensure the effective protection of populations from alcohol harm. A series of consultation meetings in 2022 with Member States and civil society organizations, as well as an online public consultation have informed this framework, which is submitted to the 72nd session of the WHO European Regional Committee for Europe *(43)*.

The European framework for action on alcohol, 2022–2025 operationalizes a joint vision to ensure that no Member State is left behind, providing the opportunity for all Member States to gain from innovation, share experience and together face emerging and cross-boundary challenges in the area of alcohol policy.

Strategic context and approach

The framework articulates an action-oriented approach, promoting and supporting Member State and WHO Regional Office for Europe actions together with those of civil society organizations and community groups, to reduce the harms that are caused by alcohol consumption. The framework also aims to reduce stigma and discrimination related to alcohol consumption, AUDs and other alcohol-attributable conditions and to support the recovery of individuals and communities.

The framework contributes to the realization of the European Programme of Work (EPW), 2022–2025 *(44)*, including the achievement of the target of 10% relative reduction in alcohol per capita consumption by 2025 (from a 2010 baseline) and to targets 3.4 and 3.5 of the SDGs *(45)*. These priority actions will also pave the way towards implementation of the global Action Plan (2022–2030) to effectively implement the Global strategy to reduce the harmful use of alcohol as a public health priority that was adopted by the World Health Assembly in May 2022 *(30)*. Implementation will be supported by WHO's SAFER European Region free from harm due to alcohol initiative, which is aligned to actions of the WHO global SAFER initiative *(2)*.

The framework also aligns with other regional strategies, including the proposals of the WHO Regional Director for Europe's Advisory Council on Innovation for Noncommunicable Diseases *(46)*. The EPW's Healthier behaviours: incorporating behavioural and cultural insights flagship initiative will be an important resource to inform activities across all priority areas *(47)*. The Empowerment through Digital Health flagship initiative *(48)* will particularly support priority areas five and six, health services' response and community action. Given the strong evidence that alcohol consumption presents serious health risks related to cancer and mental health, strategic links will be built and enhanced with the pan-European movement United Action Against Cancer and activities of the WHO European Framework for Action on Mental Health 2021–2025 *(49,50)*. The framework also supports achievement of targets laid out in the 2030 Agenda for Sustainable Development and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025 *(45,51)*. The framework will also align with and support the aspirations of the European Union's Europe's Beating Cancer Plan *(52)*.

Principles

The following principles underpin this framework:

A Gender-sensitive strategies and a commitment to reducing health inequalities

B Evidence-informed prioritization of public health interests without interference from economic operators in alcohol production and trade

C Protection of children within the realm of the right to health of children as defined in the United Nations Convention on the Rights of the Child *(53)*

D Leaving no one behind, aligning with the guiding principles of the EPW and supporting sustainable development

Focus areas: priorities for action

Using synergies in areas such as health taxes, labelling and restrictions of digital marketing, the European framework for action on alcohol, 2022–2025 addresses the gap between the potential of the EAPA and current achievements in different countries, and strikes a balance between recognizing the importance of a comprehensive and effective public health approach and driving forward key actions to improve implementation.

A portfolio of policy options is proposed, guided and formulated by public health interests, based on clear public health goals and the best available evidence, with areas one to three focusing on activities related to the NCD Best Buys *(22,23)*. In total, six areas are prioritized: alcohol pricing; alcohol availability; alcohol marketing; health information, with a specific focus on alcohol labelling; health services' response; and community action. These focus areas intersect, and thus a comprehensive approach is recommended to have the greatest impact.

The priorities for action and implementation at the national and subnational levels are at the discretion of each Member State. Additional measures to those outlined in the framework can be considered by Member States in response to their national circumstances and specific needs, including national and subnational social, economic, legal and cultural contexts, public health priorities, health system policies and available resources.

Policy implementation should include consideration of actions to reduce the impact and counteract production and trade of unrecorded alcohol, including monitoring systems for the whole alcohol supply chain, enforcement measures and regular reviews of regulatory frameworks on homemade alcohol production.

Successful implementation of actions will rely on collaboration between Member States, supported by WHO, including utilizing WHO's established focal point network. The framework also prioritizes engagement with the expertise, experience and connections of people with lived experience of alcohol problems, as well as non-State actors (including NGOs), recovery activists and mutual aid and self-help organizations.

Focus area 1.
Alcohol pricing

Background

Strong and consistent evidence shows direct correlation between the affordability of alcohol, how much is consumed and harms *(54–56)*. Increasing alcohol excise tax to reduce alcohol affordability is one of the three WHO Best Buys; that is, one of the most cost-effective policy measures which yields the most health gains for the least resources invested, since taxes generate direct and immediate revenue for countries *(22,57)*. This is the policy option with probably the largest and most comprehensive evidence base yet the lowest implementation rate across the WHO European Region *(57)*.

From a health perspective, a specific system of alcohol taxation (i.e. taxing the volume of alcohol in different beverages directly) is more preferable, as it automatically imposes higher rates of duty for stronger products *(56)*. However, other supporting and complementary pricing policies should be considered to ensure that the total price of the product is high enough to have an impact on public health. Tax increases do not necessarily result in higher prices at the point of sale, since producers, distributors and retailers may choose to adjust consumer prices and absorb tax increases without passing them on to consumers. Therefore, tax increases need to be high enough to translate to higher consumer prices. Alcoholic beverages are sometimes sold below cost unless prohibited by legislation. WHO has highlighted the huge gap in tax shares between alcoholic beverages and tobacco and between different alcoholic beverages, highlighting that the full potential to reduce alcohol use and its burden is far from being realized in the WHO European Region *(40)*. Over the past decades, alcohol affordability has been growing in various countries due to their failure to adjust taxes and prices for inflation over time *(58,59)*.

Minimum pricing is an additional pricing option that countries can consider to regulate alcohol affordability. This sets a minimum floor price below which alcohol cannot be sold by law, targeting the cheapest alcohol products that are typically consumed by the heaviest drinkers. These are therefore promising policies for reducing health inequalities *(57)*. Although minimum pricing policies are already in place in several countries of the Region, they are relatively underutilized and their overall potential for public health has not yet been fully explored *(40)*.

The setting of alcohol taxes and other pricing policies must be tailored to specific national contexts. Cross-border trade complicates tax considerations for some Member States, although various policy options exist to regulate cross-border trade and other forms of unrecorded alcohol and the overall evidence shows that unrecorded alcohol should not be considered as a barrier to

implementing tax *(60)*. Although, as stated in Article 168 in the Treaty on the Functioning of the European Union *(61)*, national health policies belong to the jurisdiction of Member States, many issues cannot be solved at national level. Both European Union (EU) countries and those outside the EU are exposed to cross-border issues, including on-line sales and travellers' allowances.

To maintain their effectiveness, pricing policies need to be linked to inflation and regular adjustment is needed so that affordability of alcohol does not increase over time.

Priorities for action

ALCOHOL PRICING

A Pricing policies, based on best available evidence, that ensure that alcohol does not become more affordable for the whole population or for specific groups who may be especially at risk of harms

B Updating of all alcohol-related fiscal policies, including taxation, regularly and in line with inflation

C Intersectoral dialogue and planning on alcohol pricing across all government departments, including ministries of health and finance

D Transnational and intersectoral exchange of information and monitoring to plan collaboration in relation to pricing policies and cross-border trade

Focus area 2.
Alcohol availability

Background

Greater availability of alcohol is associated with higher levels of consumption and harms, and reducing availability is another of WHO's Best Buys *(22)*. Regulating availability includes paying attention to the number or density of premises, and the hours or days of sale. Interventions to reduce harms include restricting times and days of sale, limiting the number of outlets and setting a minimum legal age limit for both alcohol service on premises and sale of alcohol for consumption off premises *(62–65)*. In digital contexts, strategies to reduce the availability of alcohol need to adapt to the growth on several countries of online and telephone sales. In addition to reducing harms due to alcohol consumption, implementation of these strategies comes with a low cost and they are, therefore, cost–effective.

The most widely used measure to restrict alcohol availability in the WHO European Region is to set legal age limits for the purchase or serving of alcoholic beverages *(5)*. In these contexts, alcohol sales are sometimes also forbidden to people being visibly intoxicated or suspected of buying alcohol on behalf of underage people.

Regulations that restrict sales of alcohol to licensed outlets, including in some cases, government retail monopoly stores, are effective in reducing alcohol availability as infringements of the regulations can lead to revoking of licences *(18,19)*. Alcohol availability can also be reduced if bans are imposed on alcohol consumption in different places (such as parks, streets, hospitals and workplaces) or under specific circumstances (such as during football matches and music festivals). In 2016 complete or partial statutory bans were most commonly applied to educational buildings, followed by sporting events and health-care buildings.

Between 2012 and 2016, there was an increase in the use of statutory bans in health-care facilities, in educational buildings, at workplaces, on public transport, at sporting events, in places of worship and at leisure events. In 2016, 34 countries also reported restrictions on on-premises sales of alcohol to intoxicated people *(5)*.

As with other areas of intervention in consumer markets, the effectiveness of policies to restrict alcohol availability is influenced by having an effective legal system to monitor and enforce the implementation of regulations. Implementation of strategies should preferably be carried out in cooperation between national authorities, licensing officers, local governments such as city councils and the police. Availability restrictions also need to be supported by the public and efforts need to be made to inform the citizens of the public health and social benefits.

Priorities for action

ALCOHOL AVAILABILITY

A

National licensing systems, providing support for local licensing decisions, with effective consideration of public health impacts caused by alcohol availability, especially in areas of socioeconomic deprivation

B

Restrictions on the number and density of outlets and the days and hours of sale, and the regulation of drinking in outdoor public spaces

C

Minimum age restrictions on the sale of alcohol

D

Consideration of total restrictions on the sale of alcohol in and around sporting events and cultural events that include minors

E

Mandated server and salesperson training as conditions of licensing

F

Consideration of new measures, where there is evidence from different countries that these can be effective, including:

- restrictions on alcohol sales and consumption within transport settings;
- provision of sales data to public health agencies as a condition of licensing;
- provision of state-operated alcohol outlets;
- strategies, including data measuring, to respond to new modes of alcohol delivery, such as telephone and online sales; and
- data gathering on enforcement of measures to manage availability and how these can be improved.

Focus area 3.
Alcohol marketing

Background

Restricting marketing of alcohol is a third WHO recommended Best Buy – a cost-effective alcohol policy to reduce consumption and attributable burden, with clear evidence that it is an effective way of reducing harms due to alcohol consumption *(22)*. Marketing strategies include not only advertising and promotional activities, but also product development, price-setting, distribution, sponsorships and the targeting and segmentation of the market with different products *(66)*. Traditional methods of alcohol marketing, using broadcast media (such as television and radio) and non-broadcast media (such as print media, billboards and branded merchandise), are increasingly being replaced by digital and online marketing *(67,68)*.

There is a strong association between levels of exposure to alcohol marketing and alcohol consumption levels and harms, with increased risks of harms particularly, though not only, for young people *(66,69,70)*. Exposure to alcohol advertising makes it more likely that children and young people will begin alcohol consumption at an early age, as well as that they will drink more frequently and with drinking patterns that present more risks of harms to their health *(71–73)*. Marketing in online contexts presents special risks for young people, as in many countries across the WHO European Region, up to 92% of those who use the access the Internet every day are aged between 16 and 19 years *(73)*.

The fact that digital marketing operates beyond country borders means that consumers can access global content, but the responsibility for regulation does not sit rigidly within one country. Different countries have different regulations, so there is a lack of consistency at international policy level *(73,74)*.

With social media and other online apps, marketer- and user-generated content blur the boundaries between advertiser and consumer, with Internet users, often unknowingly, effectively becoming marketers of alcohol and other harmful products through their online activities *(73)*. Existing regulations may be inadequate, as they tend to focus on volume, placement and content, whereas in digital contexts it is predatory, data-driven models of profiling and targeting that seek to optimize attention and consumption *(67)*. The digital context also presents challenges in considering interventions into what is deemed to be private content and communication sharing, and consensual engagement. However, even within the context of such indirect marketing, there are adjustments that could be made, either voluntarily by actions of the platform providers or enforced by legislation *(73)*.

The interplay between the digital marketing ecosystem and global platforms needs to be mapped and understood by policy-makers at local, national and international levels, with regulatory systems being established across borders and across platforms that can move quickly to protect public health and consumer rights. To support Member States, WHO's CLICK framework *(75)* supports monitoring of digital marketing of unhealthy products to children; the resulting tool is flexible and can be adapted to national contexts. The tool's use can be expanded to alcohol contexts, including exploring the expansion of the target groups that would benefit.

The United Nations Convention on the Rights of the Child *(53)* proclaims the right to health, including that children should be protected from exploitative marketing that can harm their health and well-being. Alcohol marketing fits clearly within this frame. Member States of the WHO European Region and the WHO–UNICEF–Lancet Commission have made clear their belief that self-regulation is insufficient to offer the protections that are needed *(32,76)*. Just as with tobacco, a global and comprehensive approach is required to remove alcohol marketing, as far as possible, from all contexts. The more comprehensive the alcohol control policies, the easier it will be to ensure clarity in communication and interpretation of the legal intention, as well as actions to monitor and enforce regulations.

Priorities for action

ALCOHOL MARKETING

A

Creation of multisectoral working groups to find the best ways to prevent and reduce the risks of harms associated with marketing of alcohol in traditional and digital contexts,recognizing that a global and comprehensive approach is required to remove it as far asv possible from all contexts; possible from all contexts

B

Intersectoral dialogue and planning on alcohol marketing across all government departments, including ministries of health and finance and ministries responsible for digital technologies

C

Restrictions on the content and volume of commercial alcohol communications, for example by limiting messages and images to factual content, without links to celebrities or influencers, or by banning all communications in television, radio, films and sports sponsorships

D

Regulatory codes that state what is permitted, rather than what is not, with the legal presumption that what is not named is not allowed

E

Establishment of relationships with Internet platform providers to support new innovative approaches that can measure, control and restrict alcohol marketing, with new regulations where necessary

F

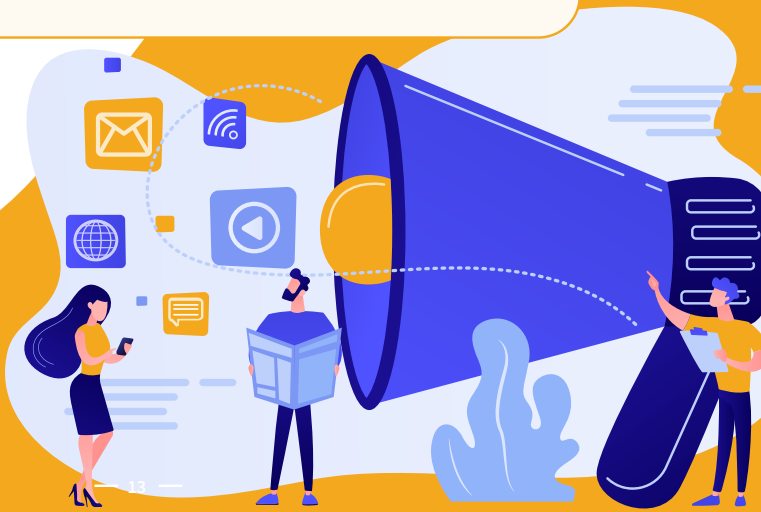
Actions to oblige alcohol producers to share their market data on consumers in different media for public health purposes

G

Partnerships and collaborations with other countries and with international agencies, with the intention of improving transnational cooperation on monitoring and enforcement

H

Consideration of new taxation systems, including e-commerce taxes, and ensuring that alcohol marketing activities are not tax deductible



Focus area 4.
Health information, with a specific focus on alcohol labelling

Background

Consumers have the right to be informed about the risks associated with products offered for consumption, including alcohol, which is no ordinary commodity, so that they can make informed choices. It is the obligation of governments to ensure consumers are provided with this information. There is substantial interest by Member States on improving policy implementation on the provision of health information using labels. While labelling of foodstuff and nonalcoholic beverages is relatively well regulated across the WHO European Region, labelling of alcoholic beverages is an area that has received little attention so far *(77)*.

Public awareness of the range of harms associated with alcohol consumption is low. Many people are unaware of the risks of developing a range of cancers due to even very low levels of alcohol consumption *(78)*. Despite the known causal link between alcohol and cancer, no country in the world has the mandatory provision to display this information on the label of alcoholic products, although Ireland and Norway have recently initiated the process of exploring this measure and Europe's Beating Cancer Plan has made the commitment to implement health warnings on alcoholic beverages *(52)*. There are various other causal links between alcohol consumption and health outcomes where public awareness is still quite low. For instance, fetal development is affected by drinking during pregnancy, which might lead to lifelong developmental difficulties for children, specifically the development of fetal alcohol spectrum disorders, yet awareness of these conditions remains quite low, even among health specialists *(79,80)*. The provision of labelling that increases knowledge and awareness of the risks associated with alcohol consumption may lead to an increase in public support for other policy measures to reduce harms due to alcohol consumption, even where these might be perceived as intervening in consumer contexts which have previously been less regulated, such as pricing policies and marketing restrictions.

According to the latest available data, 21 Member States (40%) have some legislation on the listing of ingredients, 10 (19%) have some legislation on inclusion of nutritional values and 15 (28%) have some legislation on health warnings. However, with regard to health information and health warnings, only nine countries (17%) have legislation specifying the size and content of the message *(81)*. The WHO European Region has seen some progress on calls for nutritional and ingredients information as well as health warning labels. The Eurasian Economic Union

(EAEU) Technical Regulation 047/2018 "On safety of alcoholic beverages" is, to date, the first and only international document to impose binding provisions on alcohol labelling for its Member States. The regulation applies to all types of alcoholic beverages intended for human use in the territory of the EAEU Member States, i.e. Armenia, Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation *(82)*. At the EU level, in Europe's Beating Cancer Plan, the European Commission indicated that it will review its promotion policy on alcoholic beverages. The Commission also initially indicated a proposed mandatory indication of the list of ingredients and the nutrition declaration on alcoholic beverage labels before the end of 2022, and of health warnings on labels before the end of 2023 *(52)*.

Labelling policies should be supported by communication strategies that can include point-of-sale information and package inserts, as well as broader social norming campaigns. Once phased in, such initiatives can be cost–effective and, at the very least, warning labels can remind consumers and society at large, that alcohol is no ordinary commodity.

Priorities for action

ALCOHOL HEALTH INFORMATION, WITH A SPECIFIC FOCUS ON ALCOHOL LABELLING

A Independent mandating, monitoring and enforcement of what appears on all alcohol labels, working in the interests of public health and consumer rights and free from influence or interference from corporate interests

B Statutory labelling requirements informed by WHO guidance, with labels that include nutrition and ingredients as well as health warnings

C If Member States decide to permit self-regulation, requirements that alcohol producers demonstrate that they have sought and followed the advice of independent and nationally recognized public health agencies

D Consideration of the principle of a statutory "right to know" for consumers in relation to the content of alcoholic beverages and related risks

Focus area 5.
Health services' response

Background

The health sector provides a vital front line in prevention and early intervention to prevent and reduce harms due to alcohol consumption, as well as facilitating comprehensive support, wherever needed, to support individuals to recover, as well as their families. Health services should be considered as holistic, learning from people with lived experience and, if possible, including families as part of the recovery process, as well as engaging with external services, including mutual aid organizations to support long-term recovery. Evidence also supports engagement with families and carers to support recovery. Consideration should also be given to providing support for children and families affected by another person's alcohol consumption *(83,84)*.

Health service actions need to be aligned with community action in identifying risky drinking behaviours, providing early interventions before health and social problems become pronounced and severe forms of AUDs develop that require specialized medical care, as well as ensuring that specialized services are available for people with AUDs. There is robust evidence that the linkage of clinical services with well-articulated peer-led Alcoholics Anonymous Twelve-Step Facilitation interventions can achieve important outcomes for people with AUDs in relation to achieving and maintaining abstinence, with the additional outcome of substantial cost savings to health-care services *(85)*.

As with other substance use disorders *(86)* AUDs should be considered primarily as health problems, and people with these problems should be cared for as part of the health-care system. It is also important to note that people with alcohol problems are often grappling with many other health-related issues. For example, many people with alcohol problems face mental health issues and many people with mental health issues have alcohol problems, yet services still find it difficult to treat their co-occurrence effectively *(87,88)*. Evidence strongly supports the widespread implementation of screening and brief intervention (SBI) programmes in primary health care (PHC) settings *(89–91)*. There is also some evidence that similar programmes implemented in accident and emergency departments, as well as other specialized settings, can be effective *(92–94)*. In 2016 only 30 countries reported having clinical guidelines for SBIs that had been approved or endorsed by at least one health-care professional body. Estimated coverage was low, with only 15% of countries reporting coverage of more than 31% of the population for routine SBIs *(5)*. Primary care providers find it easier to undertake this intervention when they are supported by specialist services to which they can refer.

This framework encourages Member States to be aspirational, recognizing that national or local treatment services or systems will be at different stages of development and with differing resources to support them but that over time, progressive quality improvement, with evidence- based and ethical practice as an objective, can and should be expected to achieve better-organized, more effective and ethical systems and services for people with problems related to alcohol consumption, as with other substance use problems *(86)*.

Recovery-oriented systems of care constitute an approach to the long-term management of patients within the network of community-based support resources and services *(95,96)*. Professionally directed recovery management, as with the management of other chronic health disorders, shifts the focus of treatment from a model that seeks to "admit, treat and discharge" to a sustained health management partnership between services and the patient. In this model, post-stabilization monitoring, recovery education, recovery coaching, active linkage to recovery communities (including 12-step peer support), resource development and rapid access back to treatment, when needed, take the place of the traditional discharge process *(86)*. Processes should aim to be person-centred and rights-based. Evidence-based biomedical interventions should combine with psychosocial interventions in a flexible manner, making use of existing relationships with colleagues and people with lived experience of alcohol problems to co-produce plans and embed actions that support recovery over the long term for drinkers and their families. This is similar to the system of care for people with substance use disorders as well as those with other chronic diseases such as diabetes, asthma and cardiovascular diseases *(86)*.

Priorities for action

HEALTH SERVICES' RESPONSE

A

National guidance and investment to integrate health service information and screening and brief intervention services, and combine biopsychosocial treatment strategies with community support over the long term, maintaining contact, offering crisis interventions and support when needed and at different levels of intensity, with active linkages to recovery communities (including clinically related Twelve-Step Facilitation programmes)

B

Concerted actions to reduce the social stigma and discrimination that prevents people from accessing alcohol-related support services

C

Expanded provision of alcohol-related screening and brief interventions in primary health care settings and in other contexts based on evidence

D

Adequate provision of psychosocial treatment and pharmacological treatments, where these are required, including outreach services for vulnerable populations

E

National clinical guidelines for all alcohol-related services, paying attention to comorbidities related to other substance use and health conditions, with a rigorous and comprehensive evaluation structure and with services regularly reviewed and adapted according to findings

F

Awareness-raising among health and social care workers and in medical and health education contexts, about alcohol risks and harms, including harms to families and to children through fetal alcohol spectrum disorder

G

Raising public awareness about the community support and specialist services that are available and increasing their use through improved pathways and information sharing

Focus area 6.
Community action

Background

Alcohol consumption causes harm to communities, particularly those that are already disadvantaged *(97,98)*. As well as the immediate harms to health and social functioning of individuals, their families and friends, communities must deal with injuries and deaths from road traffic accidents, provide hospital and emergency medical services and provide interventions for people with problems related to alcohol consumption, including alcohol dependence *(91)*.

People with alcohol problems and their families are part of communities. The lived experience that they have can help to inform strategies to prevent alcohol problems and to support recovery. Non-state actors, including NGOs and recovery activists, mutual aid and self-help organizations possess expertise, experience and connections that can inform strategies to support recovery, often at insignificant cost to the state, and should be regarded as essential partners in developing and implementing national and local alcohol plans. People recover when they are happy and fulfilled and able to contribute to society. Working within communities can help to reduce the stigma associated with having an alcohol problem, which can present barriers to seeking support for individuals and families, as well as leading to discrimination in the workplace and other settings *(99)*. Evidence also supports policies to reduce structural inequalities in society as contributing to preventing and reducing harms due to alcohol consumption *(100)*.

Local communities can help to create and sustain healthy living environments. Communities can be encouraged to mobilize public opinion, including using media and advocating with policy-makers, to address local determinants of increased alcohol consumption and alcohol problems; for example, by countering the attractiveness of the image of people drinking and of any acceptable level of drinking associated with driving; reducing unfair privileges attached to alcohol consumption; improving recognition of the nature and magnitude of the health and social consequences of alcohol consumption; identifying and countering the influences that encourage increased alcohol consumption; reducing the risk of young people developing social norms that always include alcohol consumption; encouraging people to stop drinking, reduce their consumption or change their patterns of consumption; and countering violence and aggression related to alcohol *(91)*. Community organizations can help to improve health literacy across populations, including providing information about where to obtain help and support in relation to alcohol problems. Policies that help to build the capacity of local action groups to ensure that the full range of potential evidence-informed policies and actions are put to their full use at the local level can have impact on decisions, such as licensing decisions that can reduce alcohol harms at local levels *(24)*.

In 2016, 43 Member States reported having community-based intervention projects involving stakeholders and 23 Member States reported having national guidelines for implementing effective community-based interventions *(5)*. A total of 22 Member States reported that they have national guidelines for the prevention of alcohol problems and counselling at workplaces *(5)*. However, the level of awareness remains low in various communities, particularly in relation to alcohol harms and the continuum of risks associated with alcohol consumption *(101–103)*. Evidence shows that knowledge of alcohol as a risk factor for various health outcomes, but specifically cancer, is a highly significant predictor of support for all alcohol policies and that community programmers are effective in providing knowledge and influencing the attitudes of the population *(104–106)*. Evaluation of real-life implementation of alcohol policies also shows changing attitudes of the public: once alcohol control mechanisms are implemented, they can gain public support and strengthen people's belief in the effectiveness of alcohol policies, increasing support for these measures *(107–111)*.

School and community interventions may usefully be combined, in part because community efforts can help restrict young people's access to alcohol, for example through enhancing the effectiveness of enforcement measures of the minimum legal drinking age *(91)*. There is evidence that it is possible to define and implement well-organized steps in promoting adolescent emotional well-being by capitalizing on opportunities at several community levels to reduce substance use of alcohol and other substances *(112)*. Programmes that encapsulate elements of life skills education and that involve parents suggest positive impacts, but evidence suggests that these may require substantial investments in time and resources in order to have successful outcomes *(113)*. School-based programmes should be part of a holistic approach of a health-promoting school. They should be based on educational practices that have proven effective, such as targeting important transition periods, conducting systematic needs assessments, ensuring an interactive approach based on skills development and embedding evaluation throughout *(114)*. Alcohol education and information programmes should be developed, delivered and evaluated without any involvement or influence from economic operators in alcohol production and trade *(91)*.

Priorities for action

COMMUNITY ACTION

A

Consideration of legislation that empowers local communities to inform and/or make decisions that affect their alcohol risk environments, such as enabling them to influence licensing decisions

B

Evidence-based school, community and workplace programmes, that include a focus on reducing stigma and discrimination, with no involvement or interference from economic operators in alcohol production and trade and with resources for evaluation and adaptation in response to findings

C

Awareness-raising about the harms that alcohol consumption can cause to others, including families and to children through fetal alcohol spectrum disorder, as well as alcohol-related violence and drink–driving

D

Engagement with young people to harness their energies and experiences to develop coherent strategies to reduce the risk of harms due to alcohol consumption for their peers and for future generations

E

Alignment of national and local strategies so that community resources – including professional organizations, NGOs, mutual aid and peer support agencies, people with lived experience of alcohol problems, faith-based organizations, and schools and other educational institutions – can contribute to the recovery of individuals, families and communities

Role of the WHO Regional Office for Europe

The WHO Regional Office for Europe will support the implementation of the priorities laid out in this 2022–2025 framework by:

A. Establishing action-focused networks to assess likely future developments and to develop strategies to prioritize public health approaches across all priority areas

B. Supporting intersectoral and transnational cooperation and the development of new national and transnational regulatory approaches, where appropriate, to support the implementation of coherent alcohol policies, including overcoming cross-border issues

C. Documenting and disseminating best-practice examples, including administrative and legislative approaches, across all priority areas

D. Working with other United Nations agencies to share best practices, technical knowledge and expertise in developing, evaluating and safeguarding evidence-based alcohol control policies

E

Providing technical guidance to Member States, including on:

- identifying and overcoming barriers to policy implementation;
- how to recognise conflicts of interest and counteract misinformation and interference with public health interests;
- supporting monitoring of alcohol consumption patterns;
- supporting the assessment of the potential health impacts of all alcohol control measures;
- facilitating intersectoral capacity-building through training and sharing of technical expertise; and
- establishing an interactive dashboard with available data on alcohol consumption, harms and alcohol control policies.

F

Providing technical support and practical tools for Member States to facilitate implementation of screening and brief interventions in different contexts, including in primary health care, workplaces and social services, as well as extending opportunities for experience sharing between Member States

G

Supporting Member States to build their capacity to continue providing essential alcohol-related health and care services alongside emergency response measures in the case of future health emergencies

H

Expanding platforms for NGOs, civil society organizations, people with lived experience, and academics to:

- improve health literacy and public awareness and to build advocacy capacity for effective and cost-effective alcohol policies;
- extend opportunities for information and experience sharing about effective and cost-effective community- and workplace-based alcohol strategies;
- promote awareness of national and international initiatives that empower communities to make decisions in relation to alcohol policies; and
- make available evidence to counter misinformation and disguising of vested interests by economic operators in alcohol production and trade and provide information and guidance on how to identify and manage conflicts of interest.

Monitoring, targets and evaluation

This framework charts the way towards implementation of the global Action Plan (2022–2030) to strengthen implementation of the Global strategy to reduce the harmful use of alcohol as a public health priority and support the realization of commitments made under the United Nations 2030 Agenda for Sustainable Development, including achievement of targets 3.4 and 3.5 of the SDGs *(45)* and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025.

At the regional level, measures and milestones are being developed to track progress and to measure success, in line with those now in use, on the basis of data already collected by the WHO to avoid any additional reporting burden for the parties. The WHO EPW commits to further reduction in total alcohol per capita consumption, towards the target of a 10% relative reduction by 2025, with at least 35 Member States being below their baseline of 2010.[2] Besides this target, The WHO Regional Office for Europe will establish monitoring arrangements that will measure both overall alcohol per capita consumption in the national context within a calendar year in litres of pure alcohol and the extent to which recommended alcohol control policies laid out as priorities in this Framework have been implemented by Member States (Table 1).

The WHO Regional Office for Europe will work to ensure that the evidence gathered is as robust as possible. Tools used for measuring implementation progress will include the WHO Alcohol Policy Scoring Tool *(116)* and its indicators for measuring alcohol policy implementation. In addition to regular reporting of alcohol policy progress that is carried out every four years as part of the WHO global survey on alcohol and health, specific summary indicators are suggested to be included in this Framework to allow yearly fast track monitoring of the agreed priority areas. A final report on the implementation progress will be produced for the period 2022–2025.

2 More information on targets and milestones can be found in the Regional plan for implementation of the WHO European Programme of Work *(115)*.

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Annex 1. How the WHO Regional Office for Europe will measure progress

Table 1. Summary indicators to measure implementation progress of the European framework for action on alcohol, 2022–2025

Policy area	Proposed summary indicator	Definition of summary indicator
Pricing policies	Affordability of alcoholic beverages	Affordability: GDP PPP per capita divided by the price of 10 g pure alcohol (standard drink), weighted by the share of each beverage type (beer, wine, spirits) in total consumption Data for this summary indicator requires information on: • GDP PPP • average off-premises sale price of beer, wine and sprits • alcohol per capita consumption per beverage type in calendar year
	Alcohol tax share	Tax share: the proportion of excise tax in the final off-premises retail prices of beer, wine and spirits
Availability of alcohol	Restrictions on availability by time	Number of hours during which off-premises alcohol sales are allowed (working days) Number of hours during which alcohol off-premises sales are allowed (Saturdays) Number of hours during which off-premises alcohol sales are allowed (Sundays)
	Restrictions on availability by location	Restrictions by density of sale outlets by location (on and off premises) Restrictions by location of sale outlets by location (on and off premises)
	Alcohol-free public environments	Bans of alcohol consumption in the following public environments • public transport • parks, streets • sporting events • workplaces
Marketing of alcoholic beverages	Legally binding bans of alcohol marketing	Legally binding bans on alcohol advertising and marketing in all media Legally binding bans or partial restrictions on alcohol advertising and marketing on the Internet
	Legally binding bans on industry sponsorship	Legally binding bans of industry sponsorship of sporting events Legally binding bans of industry sponsorship of events for young people

Policy area	Proposed summary indicator	Definition of summary indicator
Reducing the negative consequences of drinking and alcohol intoxication – specific to labelling	Health information and warning labels	National legal requirements of health warnings on the containers/bottles of alcoholic beverages (separately for beer, wine, spirits) regarding: • overall health • cancer • pregnancy • underage drinking • drink-driving • other (specify the text(s) of the legally required health warning labels)
	Consumer information labelling (nutritional and caloric)	National legal requirement to display consumer information (separately for beer, wine, spirits) about: • ingredients • energy content (in calories or kilojoules or both) • additives • vitamins • number of standard drinks • national drinking guidelines (if in place)
Health services' response	SBIs for hazardous alcohol use and AUDs in PHC settings	Treatment of AUDs included in universal health coverage Legal frameworks for providing SBIs in PHC as routine practice SBIs are part of routine health check-ups in PHC Proportion of PHC facilities that provide SBIs as a routine practice of health service delivery
Community and workplace action	School-based prevention and reduction of harms due to alcohol consumption	Education on alcohol as a risk factor for health included in school curricula
	Workplace-based alcohol problem prevention and counselling	Proportion of employee assistance programmes where AUDs and alcohol problems are included
	Community-based interventions to reduce harms due to alcohol consumption	Continuum of care for AUDs includes community services as part of prevention and treatment, e.g. the availability of social workers and other professionals to refer individuals to services such as treatment, follow-up and support. Communities have the right to regulate density of alcohol outlets, i.e. the ability to legally regulate the availability of alcohol at the local level Communities have municipal alcohol policies, i.e. the ability to legally regulate alcohol at the local level

Note: GDP PPP: Gross Domestic Product based on Purchasing Power Parity.

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