



Launch of the WHO – European Union Evidence into Action Alcohol Project

Meeting report
Copenhagen, Denmark
6 December 2022





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Abstract

Public awareness of the cancer risk posed by alcohol consumption, even at low levels, is generally low. In 2016 about 80 000 people died of alcohol-attributable cancer in the European Union (EU). As part of the Europe's Beating Cancer Plan, the EU aims to reduce harms due to alcohol consumption by means of collaboration, coordination and support from the WHO Regional Office for Europe through the joint WHO/EU Evidence into Action Alcohol Project (EVID-ACTION). The project was formally launched on 6 December 2022 in Copenhagen, Denmark, along with the launch of the third edition of the book *Alcohol, no ordinary commodity*. Representatives of 18 Member States of the Region participated in the hybrid in-person and online event, along with expert advisors and representatives of the European Commission and WHO. The aims and objectives of the WHO/EU Evidence into Action Alcohol project (EVID-ACTION) project were introduced, and the research underpinning the third edition of *Alcohol, no ordinary commodity* and the report's main messages were summarized. The project is co-funded by the European Union.

Keywords

NONCOMMUNICABLE DISEASES
EUROPE
HEALTH POLICY
POLICY
ALCOHOL CONSUMPTION
CANCER

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Contents

Abbreviations	iv
Introduction and background	1
The EVID-ACTION formal launch	3
Official launch of the EVID-ACTION project	3
The global context and collaboration for reducing alcohol-related harm	4
EVID-ACTION	6
Launch of Alcohol, no ordinary commodity, third edition	9
The importance of evidence for alcohol policies	9
Why are alcohol control policies necessary?	9
Research in the service of public policy	14
Discussion	17
Annex 1. Provisional programme	18
Annex 2. List of participants	23

Abbreviations

EU	European Union
EVID-ACTION	WHO/EU Evidence into Action Alcohol project
NCDs	Noncommunicable diseases
WHO	World Health Organization



Introduction and background

Public awareness of the cancer risk posed by alcohol consumption, even at low levels, is generally low. In 2016 about 80 000 people died of alcohol-attributable cancer in the European Union (EU). As part of the Europe's Beating Cancer Plan, the EU aims to reduce harms due to alcohol consumption through collaboration, coordination and support from the WHO Regional Office for Europe through the WHO/EU Evidence into Action Alcohol Project (EVID-ACTION).

EVID-ACTION was formally launched on 6 December 2022¹ in Copenhagen, Denmark, along with the launch of the third edition of *Alcohol: no ordinary commodity*.² The aims of the meeting were to:

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- introduce EVID-ACTION, its aims and objectives; and
 - relate these aims and objectives to evidence from the newly published third edition of *Alcohol: no ordinary commodity*.
-

The meeting was a hybrid event, with participants attending both in person in Copenhagen, and online. Representatives of 18 Member States of the WHO European Region participated. Expert advisors also participated, along with representatives of civil society and the European Commission, and staff from WHO headquarters and the WHO Regional Office for Europe.³

The launch was followed by the first meeting of the EVID-ACTION Focal Point Network on Alcohol and a training session for national focal points on how to recognize and manage conflicts of interest.

1 See Annex 1.

2 Babor, Thomas F., and others, *Alcohol: No Ordinary Commodity: Research and public policy*, 3rd edn (Oxford, 2022; online edn, Oxford Academic, 19 Jan. 2023), <https://doi.org/10.1093/oso/9780192844484.001.0001>, accessed 17 Oct. 2023.

3 See Annex 2 for the list of participants.

PART ONE

An abstract graphic design featuring a dark blue background. The text 'PART ONE' is rendered in a light blue, sans-serif font. Below the text, there is a complex arrangement of overlapping triangles in various shades of blue and purple, creating a sense of depth and movement. The triangles are of different sizes and orientations, some pointing upwards and others downwards, creating a dynamic, crystalline structure.



The EVID-ACTION formal launch

The first session, which included the formal launch of EVID-ACTION, took place in a hybrid format, combining in-person participation with an online webinar.

Official launch of the EVID-ACTION project

Dr Carina Ferreira-Borges, WHO Regional Office for Europe, opened the session on behalf of Dr Nino Berdzuli, Director, Division of Country Health Programmes, WHO Regional Office for Europe, who was unable to attend.

Dr Ferreira-Borges formally announced the launch of EVID-ACTION. With this 4-year project, which has a budget of €10 million, the EU and WHO commit to a sustained partnership to support Member States of the EU, Iceland, Norway and Ukraine to implement evidence-informed policies to reduce alcohol consumption and harms.

The EVID-ACTION project supports the implementation of priority areas of WHO's European Framework for Action on Alcohol,⁴ which was adopted unanimously by the 53 Member States of the WHO European Region in September 2022. It also helps to deliver on the goals of the Europe's Beating Cancer Plan, which aims to tackle cancer across the entire disease pathway, covering prevention, early detection and diagnosis through to treatment, as well as improving quality of life for people with cancer.⁵

In 2016 cancer was the leading cause of alcohol-attributable deaths with a share of 29%. In the same year, about 80 000 people died of alcohol-attributable cancers in the EU and about 1.9 million years of life were lost due to premature mortality, or due to disability caused by alcohol consumption. All of these years lost are tragic, and all are preventable.

4 European framework for action on alcohol 2022–2025. Copenhagen: WHO Regional Office for Europe; 2022 (<https://iris.who.int/bitstream/handle/10665/361662/72wd12e-Alcohol-220604.pdf>).

5 Europe's beating cancer plan. Communication from the commission to the European Parliament and the Council. Brussels: European Commission; 2021 (https://health.ec.europa.eu/system/files/2022-02/eu_cancer-plan_en_0.pdf, accessed 6 June 2023).

There is no safe level of alcohol consumption. Alcohol is a Group one cancer-causing carcinogen, in the same category as arsenic and tobacco. Half of all alcohol-attributable breast cancer cases in the EU are the result of light-to-moderate alcohol consumption. However, most people are unaware of the many risks that alcohol consumption poses to their health.

In much of the EU, alcohol consumption and related harms have remained unchanged for many years. Where there have been reductions in the Region, these have occurred in contexts where effective and evidence-informed alcohol policies have been implemented over a prolonged period of time.

The scale of the investment in EVID-ACTION, therefore, reflects the scale of the challenges the Region faces. It also marks the commitment made by the EU and WHO to support policies that will reduce health and social harms as well as health inequalities using the best available evidence. There are substantial returns to be gained from such investment – there is strong evidence that alcohol control measures can lead to significant productivity gains and savings to health and social care.

As part of this launch, WHO welcomed representatives of the EVID-ACTION Member States to the first meeting of the EVID-ACTION Focal Point Network on Alcohol. Civil society partners also participated in the EVID-ACTION launch. Successful implementation of the project will rely on collaboration between Member States, as well as drawing on the expertise, experience and connections of civil society partners, including people with lived experience of alcohol problems and young people.

All alcohol harms are preventable. Through this landmark EVID-ACTION project, WHO will aim to stand alongside communities that are harmed by alcohol, supporting them to imagine and achieve a healthier future. By bringing evidence to policy action and working with, through and for Member States, this is a moment to be optimistic that real progress can at last be made to move closer to WHO's vision of a European Region free from harm due to alcohol.

The global context and collaboration for reducing alcohol-related harm

Dr Vladimir Poznyak, WHO headquarters, presented an overview of the global context and collaboration for reducing alcohol-related harm.

The global burden of alcohol-related harm is well known. The harmful use of alcohol results in around 3 million deaths every year globally, and the largest proportion of these deaths are among men. More than half of these deaths are due to noncommunicable diseases (NCDs) such as liver diseases, cardiovascular diseases or cancers. Almost 300 million people worldwide live with alcohol use disorders that are associated with premature mortality and multiple other health conditions. The alcohol-attributed disease burden is highest (per 100 000 people) in low-income and lower-middle-income countries when compared with upper-middle-income and high-income countries.

The Global strategy to reduce the harmful use of alcohol adopted in 2010, has a goal of considerable reduction in morbidity and mortality due to alcohol use.⁶ However, the progress achieved so far is very uneven and the overall health burden attributable to alcohol consumption continues to be unacceptably high. Many countries have no national alcohol policies and even if they have, their implementation and enforcement is often irregular or patchy.

The WHO-led SAFER initiative was launched at the side event of the 73rd United Nations General Assembly and the third High-level Meeting on NCDs in September 2018. The objective of the initiative is to provide support for Member States to reduce the harmful use of alcohol by strengthening the ongoing implementation of the Global strategy to reduce the harmful use of alcohol, the Global action plan for the prevention and control of NCDs and the United Nations' Sustainable Development Goals (SDGs). The SAFER initiative supports robust implementation of the following interventions:

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- strengthen restrictions on alcohol availability;
 - advance and enforce drink-driving countermeasures;
 - facilitate access to screening, brief interventions and treatment;
 - enforce bans or comprehensive restrictions on advertising, sponsorship and promotion;
 - and
 - raise prices on alcohol through excise taxes and pricing policies.
-

In addition, the SAFER Initiative's strategies aim to protect public health-oriented policy-making against interference from commercial interests, to establish strong monitoring systems and to track implementation progress and impact.

The Global alcohol action plan (2022–2030) provides further impetus and support for implementing the SAFER interventions. The goal of the action plan is to boost the effective implementation of the Global strategy to reduce the harmful use of alcohol as a public health priority and to significantly reduce morbidity and mortality due to alcohol consumption, over and above general morbidity and mortality trends, and associated social consequences. The key areas for global action identified include: implementation of high-impact strategies and interventions; advocacy, awareness and commitment; partnership, dialogue and coordination; technical support and capacity-building; knowledge production and information systems; and resource mobilization.

The objectives of the EVID-ACTION project are very much in line with the goal of the Global alcohol action plan (2022–2030). The action plan includes, for example, proposed actions for Member States and for the WHO Secretariat on three areas highlighted in EVID-ACTION; namely, alcohol beverage labelling, health literacy and screening and brief interventions.

⁶ Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789241599931>, accessed 6 June 2023).

EVID-ACTION

Dr Ferreira-Borges presented a brief overview of EVID-ACTION.

With this project, the WHO Regional Office for Europe, in close cooperation with the European Commission, will support 30 Member States (EU Member States, Iceland, Norway and Ukraine) to implement best practices and capacity-building activities and to disseminate knowledge in order to reduce alcohol consumption and harms in line with the targets of the SDGs.

As highlighted previously, alcohol is a major public health concern in the Region, with almost 1 million deaths every year. This is driven by affordability, wide availability and both lack and erosion of existing regulations. Eight of the 10 countries in the world with the highest alcohol per capita consumption are located in the EU.

The European Framework for Action on Alcohol 2022–2025 draws on best available evidence to reduce alcohol consumption and harms, with six priority areas that cover the three WHO best buys (alcohol taxes, availability restrictions and marketing controls), as well as better information, strengthening health system response and community action.

The actions to be delivered through the EVID-ACTION project support the aims of this Framework, with a focus on three areas for action in the Members States in scope. These include:

-
- developing an evidence base to support implementation of effective alcohol health warnings, with a specific focus on cancer risks;
 - strengthening expertise and sharing of experience, supporting Member States' resilience in protecting public health interests in relation to alcohol policies, supporting national and transnational regulatory collaboration and developing public communications about links between alcohol consumption and cancer risks and policy options to reduce these; and
 - providing practical technical tools and training to support implementation of evidence-informed screening and brief interventions in primary health care, the workplace and social services contexts.
-

WHO thanks the EU for its support for this project and looks forward to this joint collaboration, ensuring that its actions move us closer towards the vision of a WHO European Region free from harm due to alcohol.



PART TWO



Launch of Alcohol: no ordinary commodity

The second session concerned the launch of the third edition of Alcohol: no ordinary commodity. The launch was also live streamed.

The importance of evidence for alcohol policies

Dr Ferreira-Borges provided opening remarks. The first edition of Alcohol, no ordinary commodity was published in 2003, cosponsored by the WHO Regional Office for Europe. The publication, which combines epidemiological evidence and policy research, is extremely important for academics, experts and policy-makers. This new edition is more relevant than ever, as countries are beginning to implement best practice policies.

Despite the longstanding evidence of the link between alcohol and cancer, the vast majority of consumers of alcohol are not aware that it is classified by WHO as a Group one carcinogen, in the same group as tobacco and asbestos. Indeed, only one Member State currently requires mandatory labelling relating to cancer risks on alcoholic beverages. There is a need for far stronger regulation, and this underlines the importance of Alcohol, no ordinary commodity as a guide for policy-makers and to shifting the narrative so that policies evolve to reflect up-to-date evidence.

Why are alcohol control policies necessary?

On behalf of all of the authors of the third edition,⁷ Professor Jürgen Rehm, Centre for Addiction and Mental Health, Canada and a member of the Regional Director of the WHO Regional Office for Europe's Advisory Council on Innovation for Noncommunicable Diseases, summarized why alcohol control policies are necessary.

Professor Rehm also provided some background to the publication, which is part of a tradition of collaborative, cross-national monographs on alcohol problems and policies. The third edition was published on 29 November 2022. Hard copies are available

7 Babor TF, Casswell S, Graham K, Huckle T, Livingston M, Österberg E, Rehm J, Room R, Rossow I, Sornpaisarn B.

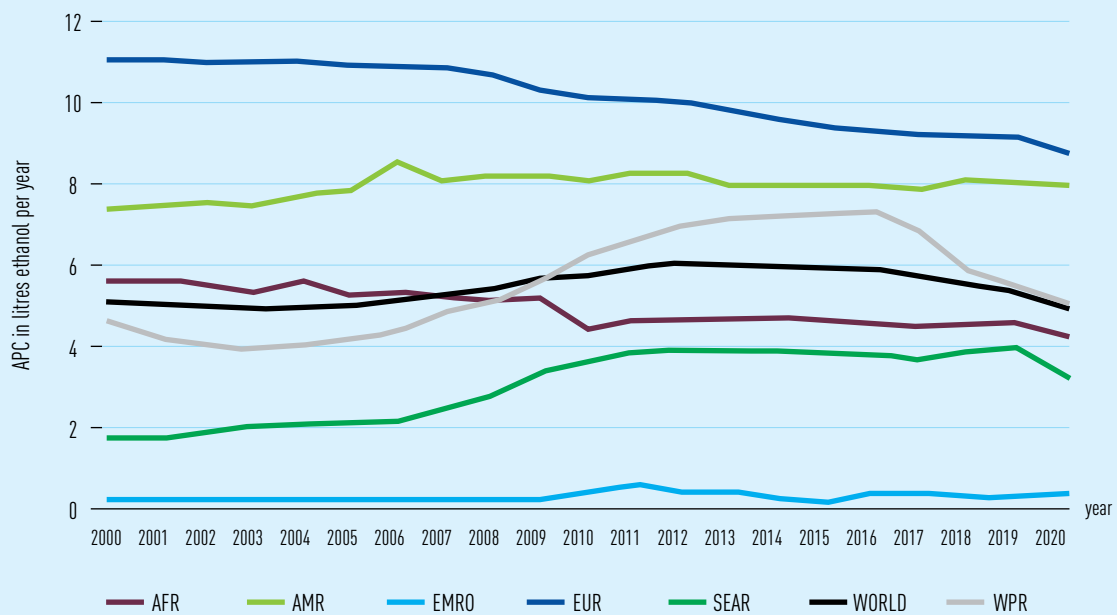


from Oxford University Press and the e-book is available open access thanks to support from the Norwegian Directorate of Health.⁸ The text is being translated into Chinese, Portuguese Russian, Spanish and Thai. It is available copyright-free to anyone wishing to translate it into other languages. Colleagues are also encouraged to contact the authors if they wish to translate the summary of the book and add material relating to the national context. A summary of the main findings is summarized in the December 2022 issue of the international journal, *Addiction*.⁹

Alcohol use around the globe

Alcohol use around the globe varies by region (Fig. 1), with most adults globally abstaining from drinking alcohol. Consumption also varies by level of drinking, the frequency of heavy episodic drinking and gender.

Fig. 1 Trends in alcohol consumption 2000-2020, by WHO Region



Note: AFR: WHO African Region; AMR: WHO Region of the Americas; APC: Total alcohol per capita consumption; EMRO: WHO Eastern Mediterranean Region; EUR: WHO European Region; WPR: WHO Western Pacific Region.

Source: Babor et al., 2022.⁷

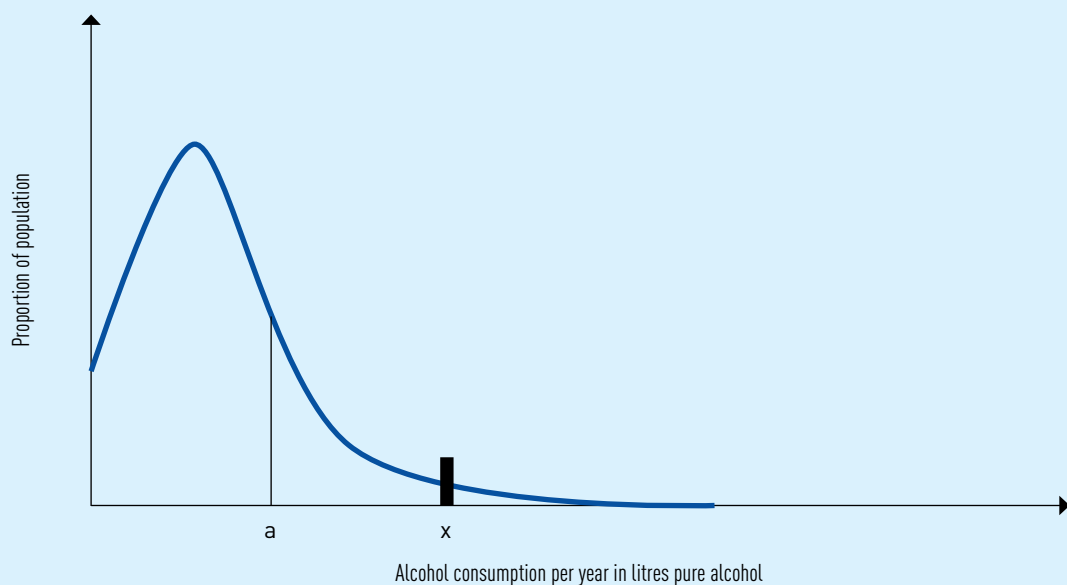
8 E-book available at: <https://global.oup.com/academic/product/alcohol-no-ordinary-commodity-9780192844484?q=babor&lang=en&cc=gb#>

9 Babor, Thomas F., and others, *Alcohol: No Ordinary Commodity: Research and public policy*, 3rd edn [Oxford, 2022; online edn, Oxford Academic, 19 Jan. 2023], <https://doi.org/10.1093/oso/9780192844484.001.0001>, accessed 17 Oct. 2023.

There are many important, often interrelated, factors that influence these variations across countries and over time. These include examples such as economic wealth, affordability, religious prohibition, changes in work life and leisure activities, alcohol policies and various other factors. In alcohol policy debates, this complexity is often ignored. Therefore, by comparing consumption levels between countries with different alcohol policies, erroneous conclusions about policy effects are often drawn.

Substantial literature exists from a wide range of countries all with varying consumption levels and drinking cultures showing a relatively fixed shape of the distribution of alcohol consumption (Fig. 2). The distribution is smooth and skewed to the right, and hence the majority of drinkers consume less than the average. Therefore, alcohol policies that effectively reduce total consumption by affecting the whole distribution, and effectively moving it to the left, will reduce harm risks among heavy drinkers and other drinkers (Fig. 3).

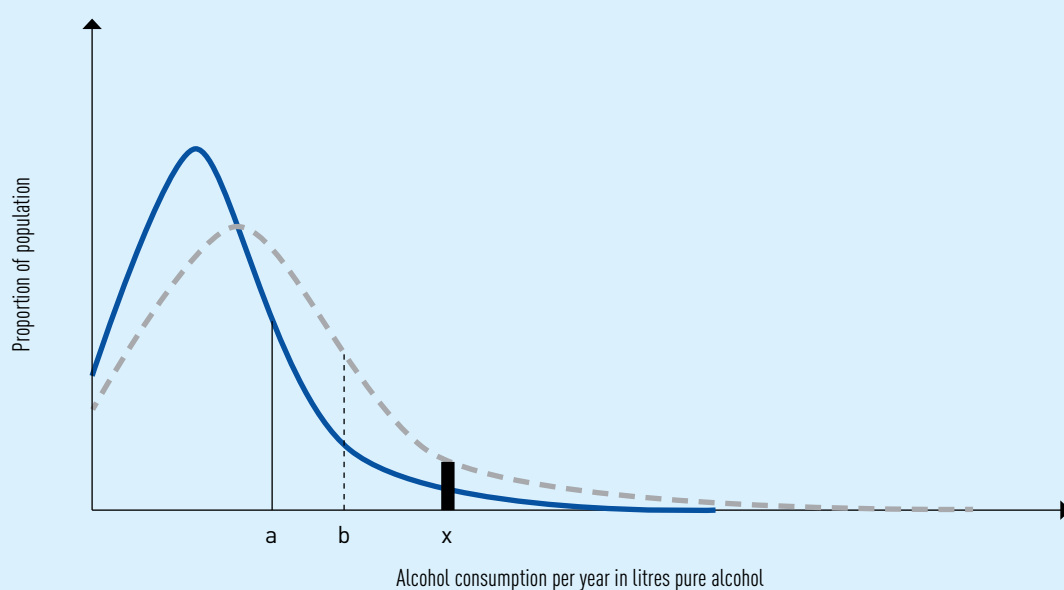
■ **Fig. 2** Typical distribution of alcohol consumption



a – average alcohol consumption
x – proportion of heavy drinkers in the population

Source: Babor et al., 2022.⁷

■ **Fig. 3** Changing the distribution of alcohol consumption



a – average alcohol consumption in a normal distribution,
b – average alcohol consumption in a distribution with more heavy drinkers,
x – the proportion of heavy drinkers in the population

Source: Babor et al., 2022.⁷

Alcohol-attributable harm

Alcohol use may cause health and social harm to the drinker and to others. For the drinker, there is a causal relationship between alcohol and more than 200 health conditions (as defined by the International Classification of Diseases, tenth revision). These include some which are 100% attributable to alcohol, such as alcohol use disorders and alcohol-related liver disease; and many which are partially attributable to alcohol. There are also causal relationships with a number of different social harms (e.g. financial harm, social drift downwards). For others, harms to health include fetal alcohol syndrome and injury. Social harms to others include forms of violence, public disorder, property damage, family and marital problems, child maltreatment, other interpersonal problems, financial problems, work-related problems, educational difficulties, social costs and productivity losses.

The overall burden is high. According to the Global Burden of Disease survey 2019,¹⁰ more than 2.4 million deaths worldwide (of which 85% were men) would not have occurred without the use of alcohol. The overwhelming majority (76%) of these deaths were due to NCDs. A recent WHO-associated study also found high mortality, with a total of about 3 million attributable deaths, including much higher numbers of alcohol-attributable injury.¹¹ The social costs of

10 <https://www.healthdata.org/research-analysis/gbd>

11 Shield K, Manthey J, Rylett M, Probst C, Wettlaufer A, Parry CDH et al. National, regional, and global burdens of disease from 2000 to 2016 attributable to alcohol use: a comparative risk assessment study. *Lancet Public Health*. 2020;5(1):E51–61. doi 10.1016/S2468-2667(19)30231-2, accessed 6 June 2023).

alcohol use have been estimated to amount to about 2.6% of the gross domestic product,¹² a figure which underestimates the costs of harm to others.

The burden, however, is not evenly distributed. One litre of alcohol causes more harm to the poor than to the rich. This is true at individual level, but also between high-income and low- or middle-income countries. There are many reasons for this, in part due to the different disease categories and causes of death and in part due to the interactions between alcohol use and other risk factors (e.g. tobacco, overweight, air pollution and fewer medical services).

Given the heavy burden of harms to others, there is a need for effective policy actions. Globally, around 13% of road traffic deaths, between 50% and 80% of homicide deaths, a quarter of child maltreatment deaths and up to 45% of hospitalizations due to interpersonal violence are attributable to alcohol. In addition, fetal alcohol syndrome is the leading cause of preventable intellectual and neurodevelopmental disabilities.

There is also a need for effective policy action to prevent the economic burden of harm to others. Costs from others' use of alcohol was estimated at US\$ 19.8 billion in 2016.¹³ This is of the same order of magnitude as the costs that drinkers impose on themselves and on the response agencies serving them.

Harms to others also include impact on quality of life and well-being. Ratings of subjective quality of life and health status are lower among those with a heavy drinker in their life. The perceived well-being of those exposed to heavy drinkers is similar to that of those who care for people with disability.

The topic of harm to others is still a new and emerging area of research, compared with the 50–60 years of evidence generated relating to harms to the drinker. There is a need for further evidence to be produced to convince governments of the extent and severity of harm to others, in order to understand the overall harm attributable to alcohol.

The WHO European Region has the highest alcohol consumption and the highest alcohol-attributable proportion of burden of disease among the WHO regions. Good examples from the Region of how alcohol control policies can make a difference have now emerged, such as the marked increase in life expectancy in the Russian Federation and Lithuania associated with alcohol policies. There is now stronger evidence from Europe that alcohol control policies work; in four EU countries, increases in taxation and decreases in availability have been associated with a drop in the average alcohol per capita consumption of nearly one litre, as well as with decreases in all-cause mortality. A newly completed study has also shown that taxation increases have been associated with a narrowing of inequalities in death rates. There is, finally, greater realization that alcohol causes cancer, with no lower threshold. Furthermore, positive experiences with alcohol taxation have led to growing support from the general population, including from those that were originally opposed to such measures.

12 Manthey J, Hasan SA, Carr S, Kilian C, Kuitunen-Paul S, Rehm J. What are the economic costs to society attributable to alcohol use? A systematic review and modelling study. *PharmacoEconomics*. 2021;39(7):809–22. doi: 10.1007/s40273-021-01031-8, accessed 6 June 2023.

13 Jiang H, Doran CM, Room R, Chikritzhs T, Ferris J, Laslett AM. Beyond the drinker: alcohol's hidden costs in 2016 in Australia. *J Studies Alcohol Drugs*. 2022;83(4):512–24 doi: 10.15288/jsad.2022.83.512.

Building on these developments, the WHO Regional Office for Europe has started a signature initiative on alcohol taxation.

Research in the service of public policy

Professor Tom Babor of the University of Connecticut School of Medicine, United States of America, summarized the evidence from policy research in the third edition of *Alcohol, no ordinary commodity* and how this supports a public health approach.

Upstream sources of the damage caused by alcohol include affordable prices, easy availability, a culture of universal drinking supported by aggressive marketing, and a lack of regulatory controls. These elements combine with factors relating to individual differences in vulnerability to alcohol-related harm, such as genetics. Strategies and interventions to reduce alcohol-related harm, therefore, need to address both upstream and downstream factors.

The third edition of *Alcohol, no ordinary commodity* has a rating system for research evidence on policy strategies and interventions. This system classifies those which are high in effectiveness, supported by numerous studies, capable of reaching their target group and relatively low in cost as best practices. Interventions that have less than the maximum score for effectiveness and study support, but which nevertheless constitute a good investment, are classified as good practices.

In relation to pricing and taxation policies, alcohol taxes that decrease affordability are classified as a best practice. Good practices include minimum unit pricing, differential pricing by beverage and special taxes on youth-oriented beverages. The experience of Lithuania, for example, resulted in demonstrable reductions in mortality and a dramatic increase in fiscal revenue following tax increases on beer, wine and spirits in 2017.

Regulating physical availability is a policy area that can increase the economic and opportunity costs of obtaining alcohol. Best practices include limiting hours and places of sale, sales of alcoholic beverages through public welfare-oriented alcohol monopoly and minimum purchase age laws. Good practices include rationing systems, restricting outlet density, individualized permit systems, post-conviction preventive bans, encouraging lower-alcohol beverages and total bans on alcohol sales where these are supported by religious or social norms. In Diadema, Brazil, for example, the implementation of a new closing time regulation for bars and restaurants in 2002 was followed by a decrease in homicide rates and a decline in other harms to others. Policies that increase outlet density and temporal and spatial availability are ineffective or potentially harmful.

In relation to restrictions on alcohol marketing, a complete ban on alcohol marketing is considered to be best practice, while partial bans on alcohol marketing are considered as good practice. Industry voluntary self-regulation of marketing, however, is ineffective or potentially harmful. Exposure to alcohol marketing increases the attractiveness of alcohol and the likelihood of drinking by young people and restrictions on marketing are likely to deter young people from early onset of drinking and from binge drinking. Exposure to alcohol images and messages can precipitate craving and relapse in people with alcohol dependence.

Drink-driving countermeasures also include some best practices. Namely, low blood-alcohol content (BAC) levels for young drivers, intensive breath testing (random where possible)

and intensive supervision programmes. Good practices include low or lowered BAC levels, graduated licensing for young and novice drivers, sobriety checkpoints, administrative licence suspension, comprehensive mandatory sanctions, courts specifically addressing driving under the influence offences and interlock devices. Policies that are ineffective include severe punishment, designated driver programmes, safe ride services, education programmes and victim impact panels.

Other good practices to help to address alcohol problems include education and persuasion, modifying the drinking environment, treatment services and early intervention. There are good reasons to apply such strategies but the effects on consumption levels and rates of harm in the population are, at best, mixed.

When these best and good practices are combined, there is huge potential for cumulative and aggregated effects at the population level. Experiences in countries such as Lithuania, the Russian Federation and Ukraine demonstrate that policies can achieve changes in alcohol consumption, alcohol-attributable mortality and life expectancy. The dramatic impact of policy action on life expectancy at the population level in countries with high consumption levels is underrecognized.

It is important to acknowledge the role of the alcohol industry and the dramatic recent changes to the way alcohol is promoted and distributed. Globally, the alcohol market is now dominated by a small number of transnational corporations controlling marketing chains across borders. These large and profitable corporations are politically influential in the area of alcohol policy. Furthermore, marketing is now carried out through transnational digital platforms and owners of global sporting events, or through public relations activities called Corporate Social Responsibility. The current threat to effective alcohol control from international trade and investment, cross-border marketing and other aspects of globalization is significant. These obstacles could be mitigated by purposive action at global level in the interests of public health and welfare. There is no international-level agreement to limit alcohol-related harms, in contrast to other psychoactive substances. A possible model for future international agreements on alcohol could be the Framework Convention on Tobacco Control,¹⁴ with adjustments to take into account the differences between tobacco and alcohol in terms of the nature of the product and its production and consumption, as well as alcohol's capacity to produce acute intoxication.

In the global landscape, the expanding economies of Africa, Latin America and Asia have observed increasing alcohol consumption, but opposition from the alcohol industry has prevented the adoption of policies likely to reduce consumption and prevent harm. While universal upstream measures are the most effective practices, many of the approaches targeted at high-risk groups also have something to contribute. According to the latest alcohol policy research, best practices and good practices are more numerous and more effective than ever. However, if alcohol policy is to use science in the public interest, there is a need for supranational mechanisms to address the consequences of increasing globalization of alcohol production, trade and marketing.

14 <https://fctc.who.int/who-fctc/overview>





Discussion

The growing evidence on the impact of conflicts of interest on policy-making was raised in a discussion of these findings. It is important to address the impact of economic operators' tactics and of pervasive digital marketing, particularly since the COVID-19 pandemic has expanded the practice of ordering alcoholic beverages online for home delivery. In relation to the alcohol industry, it was noted that the important role of the wine industry, which is increasingly well-organized at global level and is now undergoing rapid concentration within the overall alcohol industry, is not sufficiently highlighted or understood. Among EU Member States, 23 have set taxation levels for wine at 0% and increasing taxation (or minimum pricing) of wine has recently become a topic of discussion within the EU.

The clear messaging in the book about policies which are actually harmful was welcomed. The costs of harmful policies that will increase mortality and/or morbidity need to be clearly set out. Clarification was sought on the tension between considering education as a noneffective or minimally effective policy while, at the same time, fostering health literacy is promoted as a strategy. There was clarification that education alone is not an effective alternative to population-level interventions. There is some evidence that intensive education efforts involving teachers and parents directed at high-risk young people can have an impact, but in general education tends to have little effect on behaviour.

There was clarification that there are plans in the medium-term to produce advocacy kits for countries for the third edition of Alcohol, no ordinary commodity. There is also the intention to generate shorter policy briefs on specific topics from the policy chapters for advocacy purposes.

Annex 1. Provisional programme

Official launch of the WHO Regional Office for Europe / European Union Evidence into Action Alcohol Project (EVID-ACTION)

06 December 2022 08:30–17:30
(18:00–20:00 Reception)

07 December 2022 08:30–17:00
Mixed hybrid event: Copenhagen and online

02 December 2022
Original: English

Time zone: CET

PROVISIONAL PROGRAMME

■ 06 December 2022

08:30–09:00	Registration and coffee
09:00–09:30	PART ONE: WHO REGIONAL OFFICE FOR EUROPE / EUROPEAN UNION EVIDENCE INTO ACTION ALCOHOL PROJECT (EVID-ACTION) FORMAL LAUNCH: WEBINAR Opening of meeting 09:00–09:05 Moderator: <i>Dr Carina Ferreira-Borges</i> , Unit Lead <i>ai</i> . NCD Management and Regional Advisor Alcohol, Illicit Drugs and Prison Health, Division of Country Health Programmes Official Launch of EVID-ACTION project 09:05–09:15 <i>Dr Nino Berdzuli</i> , Divisional Director, Country Health Programmes, WHO European Region The global context and collaboration for reducing alcohol-related harm 09:15–09:25 <i>Dr Vladimir Poznyak</i> , Unit Head, Alcohol, Drugs and Addictive Behaviours, Department of Mental Health and Substance Use, WHO headquarters: online EVID-ACTION activities today and tomorrow and closure of session 09:25–09:30 Moderator: <i>Dr Carina Ferreira-Borges</i> , Unit Lead <i>ai</i> . NCD Management and Regional Advisor Alcohol, Illicit Drugs and Prison Health, Division of Country Health Programmes

09:30–11:00	<p>PART TWO: LAUNCH OF ALCOHOL, NO ORDINARY COMMODITY, THIRD EDITION – WEBINAR, STREAMED</p> <p>09:30–09:35 Moderator: <i>Maria Neufeld</i>, Technical Officer, WHO Regional Office for Europe</p> <p>09:35–09:45 The importance of evidence for alcohol policies</p> <p><i>Dr Carina Ferreira-Borges</i>, Unit Lead ai. NCD Management and Regional Advisor Alcohol, Illicit Drugs and Prison Health, Division of Country Health Programmes</p> <p>09:45–10:15 Presentations</p> <p><i>Professor Tom Babor</i>, Professor Emeritus, Department of Public Health Sciences, University of Connecticut School of Medicine</p> <p><i>Professor Jurgen Rehm</i>, Senior Scientist, Centre for Addiction and Mental Health</p> <p>10:15–11:00 Discussion, including questions and answers from Member States</p>
11:00–11:30	Coffee break and networking

■ 07 December 2022

Day 2: Training session for EVID-ACTION Member States on how to recognize and manage conflicts of interest

08:30–09:00	Registration and coffee
09:00–11:00	<p>Opening of meeting</p> <p>09:00–09:05 Moderator: <i>Dr Eric Carlin</i>, Consultant, WHO Regional Office for Europe</p> <p>Welcome from WHO - why this issue is important for Member States and WHO</p> <p>09:05–09:15 <i>Dr Nino Berdzuli</i>, Divisional Director Country Health Programmes, WHO European Region</p> <p>Structure for today's meeting</p> <p>09:15–09:20 <i>Professor Jeff Collin</i>, Professor of Global Health Policy, Global Health Policy Unit, University of Edinburgh</p> <hr/> <p>PART ONE: UNDERSTANDING CONFLICTS OF INTEREST</p> <p>Moderator: <i>Dr Eric Carlin</i>, Consultant, WHO Regional Office for Europe</p> <p>09:20–10:00 <i>Professor Jeff Collin</i>, Professor of Global Health Policy, Global Health Policy Unit, University of Edinburgh</p> <p>Live electronic survey: Conflicts of Interest and their significance in alcohol policy</p> <p>Followed by facilitated discussion, inviting comments and questions</p>

Moderator: *Dr Eric Carlin*, Consultant, WHO Regional Office for Europe

10:00–10:20 Presentation: Understanding Conflicts of Interest in the context of partnership and multi-stakeholder approaches

Professor Jeff Collin, Professor of Global Health Policy, Global Health Policy Unit, University of Edinburgh

10:20–11:00 *Exploring dilemmas in partnering with economic operators in developing alcohol policy* Small group exploration of a case study, followed by open discussion and questions

11:00–11:30 Coffee break and networking

Moderator: *Dr Eric Carlin*, Consultant, WHO Regional Office for Europe

11:30–11:50 Presentation: Strategic functions of industry-funded alcohol education charities

Dr Nason Maani, Lecturer in Inequalities and Global Health Policy, Global Health Policy Unit, University of Edinburgh.

11:50–12:30 *Assessing implications of industry-funded health promotion campaigns.* Small group exploration of a case study, followed by open discussion and questions

12:30–13:30 Lunch and networking

13:30–15:30 PART TWO: MANAGING CONFLICTS OF INTEREST

Moderator: *Dr Eric Carlin*, Consultant, WHO Regional Office for Europe

13:30–13:50 Presentation: Managing Conflicts of Interest in Alcohol Governance and the Contested Roles of Economic Operators

Professor Jeff Collin, Professor of Global Health Policy, Global Health Policy Unit, University of Edinburgh

13:50–14:35 *Facilitated discussion reflecting on experiences, challenges and available resources for managing Conflicts of Interest in alcohol policy*

14:35–14:50 Presentation: Policy instruments for managing Conflicts of Interest in NCD Governance

Professor Jeff Collin, Professor of Global Health Policy, Global Health Policy Unit, University of Edinburgh

Moderator: *Dr Eric Carlin*, Consultant, WHO Regional Office for Europe

14:50–15:30 *Assessing WHO tools in tobacco control and nutrition and their potential applicability in alcohol governance.* Small group assessment of policy instruments, followed by open discussion and questions

15:30–16:00 Coffee break

16:00–17:00 Moderator: *Dr Eric Carlin*, Consultant, WHO Regional Office for Europe

Towards effective management of Conflicts of Interest in Alcohol Control

Professor Jeff Collin, Professor of Global Health Policy, Global Health Policy Unit, University of Edinburgh

16:00–16:40 *Discussion of resources and support required to strengthen management of Conflicts of Interest in alcohol governance, including an electronic survey of participant needs and priorities*

16:40–16:55 Any other business

Moderator: *Dr Eric Carlin*, Consultant, WHO Regional Office for Europe

16:55–17:00 Thanks and closure of meeting

Dr Carina Ferreira-Borges, Unit Lead ai. NCD Management and Regional Advisor Alcohol, Illicit Drugs and Prison Health, Division of Country Health Programmes

Annex 2. List of participants

Austria

Rafling, Claudia
Ombudsman for the Protection of Non-Smokers, Legal and Technical Matters Tobacco and Related Products, Alcohol and Behavioural Addictions
Federal Ministry of Social Affairs, Health, Care and Consumer Protection
(online)

Bulgaria

Chileva, Anina
Chief Expert
Health Promotion and Disease Prevention Directorate, National Centre for Public Health and Analyses
(in person)

Czechia

Jarosikova, Hana
Drug Policy Coordination and Funding Unit
Office of the Government of Czechia
(in person)

Denmark

Friborg Madsen, Camilla
Head of Section
Office for Prevention and Radiation Protection
Ministry of Health
(in person)

Hussein Al-Yasiri, Sura Adnan
Student Workers
Office for Prevention and Radiation Protection
Ministry of Health
(in person)

Schriver, Noline
Team Leader
Office for Prevention and Radiation Protection
Ministry of Health
(in person)

Estonia

Brigitta Õunmaa
Advisors, Public Health Department
Ministry of Social Affairs
(in person)

Iceland

Jonsson, Rafn Magnus
Project Manager
Department of Public Health
The Directorate of Health
(in person)

Italy

Simona Pichini
Senior Investigator
National Centre for Addiction and Doping
National Institute of Health
(online)

Latvia

Zviedre, Elena
Senior Expert of Health Promotion and Addiction Prevention Division
Ministry of Health
(in person)

Lithuania

Talačkienė, Jelena
Advisors of Mental Health Division
Public Health Department
Ministry of Health
(in person)

Luxembourg

de Muysen, Catherine
Ministry/Directorate of Health
(online)

Kingdom of the Netherlands

Freriks, Jeroen
Senior Advisors
Ministry of Health, Welfare and Sport
(in person)

Norway

Dugstad, Herdis
Senior Advisors
Ministry of Health and Care Services
(in person)

Tsereteli, Zaza
International Technical Advisor
for the ASA EG
Northern Dimension Partnership in Public Health and Social Well-being (NDPHS)
(in person)

Portugal

Melo, Raul
General-Directorate for Intervention on Addictive Behaviours and Dependencies
Portugal
(in person)

Romania

Galan, Adriana
Head
Department Health Status Evaluation and Priority NCDs
National Institute of Public Health
(in person)

Slovakia

Chromíková, Lucia
Officer
Public Health Authority of the Slovak Republic
Department of Health Promotion and Health Education
(online)

Slovenia

Debeljak, Peter
Secretary
Ministry of Health of Republic of Slovenia
Directorate for Public Health
(in person)

Sweden

Ericson, Paula
Unit for Public Health and Health Care Ministry of Health and Social Affairs
Sweden
(in person)

Ukraine

Ivanchuk, Iryna
Ministry of Health
(in person)

Pivovarov, Oleh
Ministry of Health
(in person)

Pryhodko, Anna
Ministry of Health
(in person)

Temporary Advisors

Berteletti, Florence
Secretary General
The European Alcohol Policy Alliance (Eurocare)
(in person)

Babor, Tom
Professor Emeritus
Department of Public Health Sciences
(in person)

Collin, Jeff
Professor of Global Health Policy
University of Edinburgh
(in person)

Gilheany, Sheila
Chief Executive Officer
Alcohol Action Ireland
(in person)

Maani, Nason
Lecturer
Global Health Policy Unit
University of Edinburgh
(in person)

McCull, Karen
Rapporteur
(in person)

Yared, Wendy
Director
Association of European Cancer Leagues
(in person)

European Commission

Kozakiewicz, Agnieszka
Team Leader
Tobacco Control Law and International
Directorate-General for Health and Food Safety
Disease Prevention and Health Promotion
(online)

World Health Organization Secretariat

WHO headquarters

Poznyak, Vladimir
Unit Head
Alcohol, Drugs and Addictive Behaviours
Department of Mental Health and Substance Use
(online)

Tello, Juan
Unit Head, Less Alcohol Unit
(in person)

WHO Regional Office for Europe

Berdzuli, Nino
Director
Division of Country Health Programmes
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(director, in observance)

Ferreira-Borges, Carina
Regional Advisor Alcohol, Illicit Drugs and
Prison Health and a.i. Unit Lead, NCD Management
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Konovalova, Natalia
Programme Assistant
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Neufeld, Maria
Technical Officer
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Babaian, Aram
Information Technology Specialist
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Carlin, Eric
Consultant
WHO European Office for the Prevention and Control of Noncommunicable
(in person)

Kokole, Daša
Consultant
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Kryuchkov, Igor
Communication Consultant
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Olsen, Aleksandra
Communication Consultant
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Rehm, Jurgen
Consultant
WHO European Office for the Prevention and Control of Noncommunicable Diseases
(in person)

Tran, Alexander
Consultant
WHO European Office for the Prevention and Control of Noncommunicable
(online)

Videographer

Borgholm, Niels
(in person)

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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