WHO Regional Technical Consultation on a global strategy to reduce harmful use of alcohol

Meeting report

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ABSTRACT

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Introduction

Opening session

Dr Nata Menabde, Deputy Regional Director, welcomed participants from Member States and from the WHO secretariat in Geneva to this important meeting. She stressed her concern at the increased disease burden from alcohol. She said that alcohol consumption was far too high in the European Region and that harmful use of alcohol not only resulted in health problems but also negatively affected social cohesion with a high cost to society. Dr Menabde outlined the developments on alcohol policy in the WHO European Region, including the most recent document in 2005, the Framework for alcohol policy in the WHO European region.

Dr Menabde welcomed the Resolution WH61.4 which calls for the development of a draft global strategy to reduce harmful use of alcohol. She said that examining issues at the global level will add value to efforts at the regional level. Making good policy is a challenging process which needs political consensus and synergies with other complementary areas. She said policy options were necessary for the general population as well as for targeted groups and specific problems. There is ongoing co-operation between the WHO Europe office and the European Commission in collecting and sharing information and disseminating this information to Member States.

Dr Vladmir Poznyak, Coordinator, Management of Substance Abuse, Department of Mental Health and Substance Abuse, WHO- HQ, welcomed participants to the meeting and said this was the fifth technical consultation with representatives from Member States across the six WHO regions of the world. He said that harmful use of alcohol is a major concern and is related to a number of non-communicable diseases, cancers, injuries, violence, mental health, fetal alcohol syndrome, and communicable diseases, tuberculosis and HIV/AIDS. He said there is an increased demand to provide technical advice to Member States. However, strategies need to take into account cultural and religious differences.

Dr Poznyak praised the European Region for the long history in the development of alcohol issues including the first European Alcohol Action Plan, the setting up of a National Counterparts group, and the first information system to share with Member States.

Background and context of the regional consultation

Dr Poznyak said the disease burden attributable to alcohol consumption is significant and has increased. In 2004, the alcohol-attributable global disease burden was estimated at 3.7% of all deaths. He traced the World Health Assembly resolutions addressing alcohol related public health problems since the late 1970s and the process leading to the 2008 Resolution on alcohol at the World Health Assembly (WHA61.4: Strategies to reduce the harmful use of alcohol). The use of the word ‘harmful’ refers to the negative public-health effects of alcohol consumption. The resolution urges Member States to collaborate with the Secretariat in developing a draft global strategy on the harmful use of alcohol in order to support and complement public health policies in Member States. Member States are also urged to develop national monitoring and reporting systems and to strengthen national responses where appropriate.

Dr Poznyak outlined the requests of the WHO Director-General in the resolution which included; to prepare a draft global strategy, to put forward a set of proposed measures recommended for
States to implement, to detail ongoing regional processes, to collaborate with Member States and consult with other stakeholders and to submit to the Sixty-third World Health Assembly, through the Executive Board, a draft global strategy to reduce harmful use of alcohol.

Mr. Dag Rekve, Technical Officer, Department of Mental Health and Substance Abuse, WHO-HQ, explained the broad consultation process as part of implementing resolution WHA61.4. Stage one was an intensive consultation process with a broad range of stakeholders. A web-based public hearing was organized by the WHO secretariat (Oct/Nov ’08), with an open invitation to all stakeholders, including the public at large, to make submissions on ways to reduce harmful use of alcohol. A round table meeting with economic operators took place (6 Nov ’08) to discuss ways they could contribute to reducing harmful use of alcohol. A round table meeting also took place with health professional and nongovernmental organizations (24-25 Nov ’08) and a consultation with selected UN agencies and intergovernmental organizations is planned during 2009.

Stage two in the implementation of resolution WHA61.4 is the development of the draft global strategy which will be done in consultation and collaboration with Member States. Regional Technical Consultations with Member States have taken place in four WHO regions and the present meeting in the European Region is the fifth. Following this process, a draft global strategy will be developed by the WHO Secretariat and further consultation with Member States will take place, before the draft strategy will be submitted to the Executive Board (Jan 2010) and subsequently to the Sixty-third World Health Assembly in May 2010.

The reports from the public hearings, round table meetings, intergovernmental consultation and Member States Technical Consultations will be posted on the WHO website http://www.who.int/substance_abuse/

Objectives and scope of the meeting

Dr Lars Møller, Regional Advisor, Alcohol and Drugs, Division of Health Programmes, WHO Regional Office for Europe, welcomed everyone and invited participants to introduce themselves. There were 65 participants in attendance, representing 42 Member States, 2 intergovernmental organizations, and the WHO secretariat (Annex 3). The overall aim of the meeting was to ensure the effective technical consultation and collaboration with Member States of the region on developing a draft global strategy to reduce harmful use of alcohol. Specific objectives highlighted were

- To discuss major issues and challenges on possible areas for global action and coordination, taking into account the regional context, needs and priorities.
- To discuss the role of the different stakeholders.
- To discuss how the strategy can support and complement public health policies in the region and in Member States.
- To discuss the development of national and regional systems of monitoring alcohol consumption, its consequences and policy responses.
- To ensure that Member States share their technical expertise in the evidence of policy effectiveness, examples of good practice and ongoing national processes.
The most important working document for the meeting was the discussion paper prepared by the WHO Secretariat, ‘Towards a global strategy to reduce harmful use of alcohol’. The focus of the discussion paper was on the broad concepts and contained a number of questions which the WHO Secretariat requested technical input from Member States. A CD with relevant background information was also provided to the participants. During the course of the meeting, two presentations were made to update delegates on recent research developments in the European region. The first presentation covered some of the key public health issues relating to alcohol in Europe by Dr Peter Anderson and the second was on the economics of alcohol in Europe, from attributable burden to avoidable costs by, Dr Dan Chrisholm. The method of work agreed was plenary sessions and four small working groups. A Chair (Ms Ann Lévy, Switzerland, Co-chair (Dr Anatoliy Viyevskiy, Ukraine) and Rapporteur (Mr Ismo Tuominen, Finland) were appointed for the duration of the meeting. Within the small working groups, each had a chair and rapporteur. Work in small groups was preceded by an introduction at plenary and following group discussion, a report back from the groups to the plenary.

Mr Rekve outlined the proposed structure of the draft strategy

- Background with a situational analysis
- Scope and aims of a global strategy, including 4 proposed objectives
- Basic principles for action
- Policy options and 10 priority target areas
- Implementation considerations
- Follow-up (e.g. assessment and re-examination of the actions taken)

**Situational analysis**

Mr Rekve said the purpose of the situational analysis is to bring together all relevant information and to synthesize the evidence base in terms of the size and magnitude of the alcohol-attributable harms and existing interventions and good practices. This analysis will show existing gaps and will help to identify needs and potential for action at all levels. The discussion paper identified two global challenges, namely: increased alcohol-attributable harm in developing countries and the need for actions in all relevant policy areas known as an intersectoral approach.

Participants identified a number of additional areas for inclusion in the situational analysis: Information on harm to others, FAS, cancer and the economic consequences for the health and social sectors. An analysis of the data by gender and by inequalities was suggested. Participants said the most important concept was that ‘alcohol is no ordinary commodity’. The world of work was seen as a way to build an intersectoral focus, given that harmful use of alcohol can impact on lost productivity and occupational accidents. A second recommendation was to identify the benefits in other policy areas when harmful use of alcohol is reduced.

Additional global challenges were identified by participants. Firstly, the challenge of trade issues where trade agreements and cross-border issues can undermine public health interventions to reduce harmful use of alcohol at national level. The second challenge was the lack of a health impact balance in the decision making process at international level, such as at the World Bank, International Labour Organization (ILO) and the World Trade Organization (WTO). The recommendation was that health impact assessment could be applied in the decision making
process at intergovernmental level to safeguard the health of the population. The third challenge was alcohol marketing, where participants expressed concern that alcohol marketing practices were transported not only between countries in the region but also to other regions of the world. The sustainability of policies was also highlighted as a challenge.

Participants suggested that a global strategy could address gaps and barriers at national and regional level by strong leadership from WHO, by the provision of recommended minimum standards for all States and by the encouragement of comprehensive effective policies relevant to the needs of Member States, based on the evidence of effectiveness and cost effectiveness. Building capacity is considered essential to help develop a common understanding of alcohol problems, to improve the evidence base across the regions, to advocate for effective alcohol policies and to develop a good monitoring and reporting system. In addition, tools for implementation, such as exchanges of good practice between Member States, resources to implement policies and adequate treatment for those in need of treatment were seen as very important. A global strategy should provide clear guidance on these issues. Participants also pointed out that a global strategy should support and complement the implementation of the recommendation we already have such as the framework for alcohol policy in the region.

**Scope, aims and objectives of the global strategy**

The proposed structure of the draft strategy with six main areas was accepted by all groups, with some suggestions for improvement to reflect adequately the intended scope and aims of a future global strategy. One group suggested that the area of follow-up could be renamed and widened to include the issue of governance for political commitment at the highest level and that monitoring and reporting should be an explicit part of the structure. It was also suggested that definition of key terms in the global strategy would be desirable. In defining the problem, alcohol should be recognized as a toxic substance and terms such as ‘alcohol related harm’ and ‘alcohol-attributable burden’ could be terms used in the strategy. The issue of risk is seen as a key concept.

Some groups suggested the scope could highlight the economic and others benefits gained by reducing harmful use of alcohol. The overall aim of the strategy could expand to improve quality of life and a longer life expectancy through reducing mortality from harmful use of alcohol. Suggested changes to the aims are that the issue is to create political awareness and will rather than political consensus and that public health policies should be comprehensive and occur at all levels. A further proposed change to the second aim is - ‘to support and complement health in public policies in Member States by seeking synergies and added value of action at all levels’. A proposed new aim is to reduce the alcohol-attributable burden.

**Objective 2:** Proposed changes are – to develop a set of relevant policies and interventions, at different levels, that address the general population, vulnerable groups, individuals, specific problems and harm to others caused by another’s drinking.

**Objective 3:** to define the role of different stakeholders, is considered problematic by some groups, given the wide range of stakeholders and could be more appropriately addressed in the implementation phase.

**Objective 4:** Suggested change is to be more explicit and include monitoring and reporting as well as to support international research and exchange of experience.
Objective 5: (new) - to coordinate and harmonize actions from other WHO global programmes and strategies that are capable of reducing the harmful use of alcohol.

**Guiding principles**

Participants observed that the proposed basic principles were somewhat different in nature, order and system. To have the basic principles reflect adequately the needs of a future global strategy, several changes are proposed.

Principle 1: (new) The protection and preservation of the health of the population from the harmful use of alcohol is a public health priority.

Principle 2: Public health policies, which aim at reducing harmful use of alcohol, should be formulated by public health interests and based on available evidence and good practice.

Principle 3: Public health policies to reduce harmful use of alcohol should not be the responsibility of the health sector only, and should be taken into account and supported by all policy making sectors and extend to be intersectoral, comprehensive and sustainable.

Principle 4: Interventions that are implemented should take into account, as appropriate, the different national, gender, religious, social and cultural contexts.

Principle 5: All involved parties have the responsibilities to act in ways that support public health interventions to reduce the harmful use of alcohol.

Principle 6: Children, young people and all those who do not wish to consume alcohol, or cannot do so for health or other reasons, have the right to be safeguarded from pressure to drink and be supported in their non-drinking behaviour.

Principle 7: Policies and interventions should have a special emphasis on the protection of individuals and communities, in particular on the unborn child and children growing up in families with alcohol problems, from the harmful effects of drinking by others.

Principle 8: Effective early interventions, treatments and care services should be accessible, available and affordable for all those affected by harmful use of alcohol.

Principle 9: Stigmatization and discrimination of groups and individuals with alcohol-related problems should be counteracted, to improve help seeking behaviour and the provision of needed services.

In addition, issues of transparency of policies and accountability of all those involved in reducing harmful use of alcohol were mentioned.

**Policy options**

Ten proposed policy areas were outlined:

1. Raising awareness and political commitment
2. Health sector response
3. Community action
4. Drink-driving policies
5. Addressing availability of alcohol
6. Addressing the marketing of alcohol beverages
7. Pricing policies
8. Harm reduction
9. Reducing the public health impact of illegal and informal alcohol
10. Monitoring and surveillance

Participants agreed with the policy areas and the issues addressed in the discussion document. The group discussions which took place generated many suggestions on how a global strategy could support and complement national and regional policies and recommended measures for inclusion in the strategy.

**Raising awareness and political commitment**

To increase political commitment and sustainable policies, the groups stressed the importance of national co-coordinating mechanisms at the highest political level (Parliament/Government), where the health sector could take a lead role. A focus on the economic consequences of alcohol harm is of particular interest to politicians. Therefore, a broad evidence base is necessary. At the national level, a mechanism is needed to ensure an intersectoral strategy is in place to reduce harmful use of alcohol for the development and implementation of policy. Raising public awareness by strengthening advocacy with key NGOs and the establishment of a good networking system united around one common goal is seen as critical for long term sustainability. Some groups recommended that efforts to raise public awareness should be free from commercial interests to avoid conflict of interests.

Participants suggested a WHO global alcohol awareness day/week could provide good opportunities, at all levels, to discuss alcohol as an important public health issue and to showcase good practice. The use of the Health for All Principle was suggested as a means for a unified global strategy. At the global level, high-level mechanisms should be in place to discuss progress achieved, through monitoring and reporting, and the exchange of experiences. A call by WHO for political commitment at the national level is seen as carrying significant political weight. WHO can provide the solid evidence from the global level which is needed at the regional, national and local levels. The global strategy should pay particular attention to the national capacity building efforts, which is important to ensure political commitment and effective policy implementation. WHO has an important lead role in efforts to develop and strengthen advocacy and to build capacity.

**Health sector response**

To strengthen the health sector response, participants emphasized the importance of primary health care as a setting for screening and brief intervention (SBI) to reduce harmful use of alcohol. The role of the family doctor in screening and brief advice would expand and complement the treatment of alcohol-related problems and disorders. The need for trained people to implement SBI was stressed and a minimum level of basic knowledge on alcohol should be identified by WHO. Different settings could also be developed for SBI such as workplace, school and college. The groups recommended an increase in the role of alcohol prevention services in the public health system to strengthen the health sector response. Funding of the
health care response could be met by means of alcohol taxes. At the national level, incentives should be examined to facilitate the expansion of screening and brief intervention.

The global strategy should recommend a minimum level of basic knowledge on alcohol for effective implementation of screening and brief advice. The development of clinical protocols for diagnosis and treatment in outpatient and inpatient health facilities would also be helpful. A global strategy could help improve the health care response to harmful use of alcohol by developing the knowledge base, setting minimum standards for alcohol education in medical curricula and building capacity through shared international experiences in alcohol prevention and treatment.

**Community action**

Participants see local community action as essential to prevent and reduce harmful use of alcohol, where autonomy lies at the local level in deciding the policy options relevant to local needs. Some groups stressed that policy options decided at local level, in terms of stricter rules and regulations, should not be undermined at the national level. Community action should be supported at the national level. Different groups and settings can easily be reached and prevention activities delivered at local level such as youth, workplace, colleges and health clinics. Local community action provides opportunities to work with relevant partners such as the police on alcohol law enforcement issues. The development of networks and new communication tools such as the internet can increase accessibility to prevention and treatment services.

The global strategy could encourage communities to take local action and to strengthen intersectoral work in terms of partnerships and networks. Participants suggested the global strategy should link alcohol with other health areas such as nutrition, physical activity and HIV/AIDS. The groups recommended that WHO act as a clearing house for shared knowledge, good practice and evidence of effective strategies at community level. Efficient ways to transfer information between global and local will need to be developed.

**Drink-driving policies**

Participants stressed the importance of raising awareness in the general population and among all drivers of the risks relating to the use of alcohol. Some groups recommended that such awareness be part of all driver training programmes. The interaction between the health sector and traffic safety agencies at the national level could strengthen efforts to reduce alcohol related harm. Random breath testing should be effectively enforced at local and national level. Those convicted of drink driving offences could benefit from referral to treatment services. Several groups raised concern at the availability of alcohol at petrol stations which suggests a mixed message and a possible risk between driving and drinking. Some groups suggested that lower blood alcohol concentration (BAC) level can impact on reducing harm and on overall consumption.

The global strategy can best address drink driving policies by producing minimum standards for drink driving countermeasures in particular for professional drivers across the globe which could include shipping, boating, snow scooters, aviation, as well as professional drivers of motor vehicles. The global strategy could also set a clear maximum limit for BAC.
**Addressing the availability of alcohol**

Participants said that a leading principle for availability should be that alcohol is not an ordinary commodity, therefore restrictions are necessary to reduce the harmful use of alcohol. Of special importance is the enforcement of existing laws. Civil society, NGOs and the media could play a major role in monitoring the implementation of alcohol laws and restrictions. The groups suggested that legislation is important to control high risk areas such as sporting events and that alcohol free zones be designated to promote safer school, health and sporting environments.

Participants suggested it would be helpful for WHO to state the importance of ‘Health In All Policies’ in trade issues. The global strategy should report on the effectiveness of measures that restrict availability and clarify the evidence on density of outlets. Some groups said that effectiveness varies across cultures and greater monitoring of the impact of changes in legislation is needed in countries and regions where little research has taken place. Participants suggested the global strategy could highlight the benefits of higher age limits for alcohol consumption and purchase. The strategy could also bring forward ways to control internet sales, a cross border issue. Recommended measures for inclusion in the strategy were a minimum age limit for alcohol purchase and consumption and guidelines for license holders and licensing authorities.

**Addressing the marketing of alcohol beverages**

The need for a basic system of mandatory regulation alongside co-regulation was seen as vital at the national level by participants. Suggestions for meaningful restrictions on alcohol marketing were prevention of free alcohol distribution, warning label requirements and restrictions on socially attractive images promoting alcohol. Some groups called for a national ban on alcohol advertising.

Participants identified the need for a global approach in this area, given international developments in commercial communication technology. The global strategy should set out the evidence on the impact of alcohol marketing on young people and other vulnerable groups. Participants recommended that the global strategy could identify a global minimum standard to protect young people and include on-going monitoring, with young people at the centre of the process. The groups suggested that warning labels and consumer information could be a global standard in public health.

**Pricing policies**

Participants suggested that cheap alcohol can contribute to harmful use of alcohol, in particular among high risk groups. National legislation could restrict free alcohol, happy hours and special offers. Some groups recommended a portion of alcohol tax revenue could be given towards the cost of prevention and treatment services.

The global strategy should give the evidence of the effectiveness of pricing policies and its impact on different groups, as it is not readily understood. To reduce cross-border sales fuelled by below cost selling (loss leaders), by some retailers in some countries and not others, participants recommended that a floor price could be considered, for example, only selling alcohol for more than the cost of the duty. Minimum price per unit of alcohol was considered as a way to impact on the consumption of products with the highest alcohol content by both those who drink the most and the young. Specific pricing policies can also have the effect of a switch...
to low alcohol products. The global strategy could include a basic rule that alcoholic drinks should not be cheaper than non-alcoholic drinks.

**Harm reduction**

Some groups suggested the definition of harm reduction should be to reduce the consequences of harmful drinking. Basic elements at the national level were seen as the provision of care to people in a state of acute intoxication, support for families and children affected and the protection of patient’s rights. Participants recommended that national legislation should prohibit the sale of alcohol to intoxicated persons. Responsible server training programmes could help reduce harm in the drinking environment when supported by law enforcement.

In the global strategy, the advice could be to ensure structures and services are in place to help children and families exposed to alcohol harm from others. WHO could recommend guidelines to ensure care services are developed and in place for problem drinkers. The groups suggested that standards should include protocols and procedures, access for all and the prevention of discrimination.

**Reducing the public health impact of illegal and informal alcohol**

Participants stressed the quality and safety of informal local alcohol production should be improved. The groups also agreed that creating conditions giving communities a role in the quality control process would be beneficial. The intended outcome should be to bring such informal production under the control of society. However, there is a delicate balance in countries where illicit trade is common and legal alcohol is expensive.

The global strategy could support the development of new methodologies to ensure safe standards in informal alcohol production and to monitor the development and impact on public health.

**Monitoring and reporting**

Dr Møller outlined the development of the European Alcohol Information System (EAIS) which was established in 2002 to monitor and evaluate the European Alcohol Action Plan. However, difficulties emerged as data did not cover several aspects in the new Framework (2005) and data was not comparable with other regions. A new EAIS is not in place with indicators similar to global database and a system for on-line data input. The development of the new database was a joint WHO /EU project which will yield results in 2010.

The Global Information System on Alcohol and Health (GISAH) was outlined and will form the central focus for the Monitoring and Surveillance of the global alcohol strategy. The GISAH will collect and analyse the global database on a range of alcohol indicators and provide valuable feedback to policy makers so that relevant action can be taken. The GISAH categories of indicators include

- Alcohol production and availability
- Level of alcohol consumption
- Patterns of alcohol consumption
The indicators and targets for 2009–2013 will be based on the number of Member States with a stabilized or reduced level of harmful use of alcohol, with outcome indicator based on trends in overall level of alcohol exposure supported by data on alcohol related mortality and morbidity.

The discussion among participants centered on how best to strengthen and coordinate, at all levels, the monitoring and surveillance area to support a global strategy on alcohol. Participants stressed the vital importance of reliable data and timely reporting to enable policy makers make informed decisions on effective alcohol policy to reduce alcohol-related harm. Participants said the data collection and monitoring system at national level was critical to the quality at global level. The quality of the data was interdependent on well defined indicators, comparability and a reliable collection process. The GISAH has provided clear indicators which will allow comparability at the regional and global level (www.who.int/globalatlas/alcohol). The Ministry of Health in each Member State should create a focal point by nominating a person who has responsibility for alcohol data collection. WHO could help build capacity by developing procedures and providing training on how to collect alcohol data. When capacity is limited within the Ministries of Health, participants from Member States gave examples of how they solved the issue. One Member State suggested outsourcing data collection when not related to policy to a quality research institute. The second suggestion is to request at the Ministerial level a nominated person in the relevant department to provide requested information when data collection is required from other government departments. The internet is an important link when gathering information and a system for on-line data input vital. Within the European Union, there are many alcohol-related projects where relevant information on infrastructure for alcohol policy (relevant laws, marketing regulation) can be sourced (www.europa.eu). Given the predicted increase in the older population, the lack of alcohol data on this segment of the population was raised by some groups.

For reporting, a global monitoring system was recommended and supported by a regional reporting system which could occur through the network of focal points. Participants also called for the monitoring and reporting of international agreements that influence alcohol policy regionally and globally. A world day on harmful use of alcohol could be used to report on progress to the general public. A follow-up conference every four years would help keep the global strategy on the political agenda.

**Implementing the strategy**

Three broad areas were discussed in implementation, the tools needed to help implement the strategy, how best to take account of the diversity and different contexts and the main stakeholders and their role in implementation.
Tools to help implementation

Participants identified a wide range of tools which can be summarized under three sub-headings; information, capacity building and reporting (Annex 1). The harmonization of monitoring and evaluation tools for different themes and areas on a national level to allow for comparability between Member States such as consumption, harms, good practice and the alcohol policy index were recommended. Guidelines on low risk drinking, policy briefs for different stakeholders and the integration of alcohol information into health information were discussed. Recommendations on capacity building called on WHO to develop tools on how best to put the global strategy in place, tools for networking and sharing experiences and practical links to other relevant WHO networks, in particular for community action. For the health sector, training guidelines for SBI in primary care was mentioned. Advocacy tools and better ways to involve and cooperate with NGOs at all levels were recommended. Participants recommended strengthening the role of National Counterparts in the implementation process.

Different contexts

Participants said that it was important to show respect for different strategies and to integrate differences into the global strategy. The added value of a global strategy included shared information and good practices as well as global monitoring. The global strategy creates an opportunity for worldwide solidarity in efforts to reduce harmful use of alcohol. A global alcohol conference with clear goals would help. The integration of global knowledge into the development of national policies would help support national needs and priorities. In the development and dissemination of the implementation tools, the different contexts should be taken into account. Technical support should be provided and access to international developments and programmes facilitated. Participants stressed that policies accepted at higher levels should not hinder ambitions at lower (local) levels. Participants affirmed ‘less is better’ as a guiding principle. The global strategy should help track trends across Member States and regions for rapid alerts (for example illegal production, marketing practices).

Stakeholders

Participants stated that governments have overall responsibility for the implementation of the alcohol strategy. The health sector was named as a very important and active collaborator in the implementation process, as was the nongovernmental sector (Annex 2). Many other stakeholders were also named as important to the implementation process, including trade unions, employers, religious organizations, youth organization, agricultural sector and the sports organizations. The alcohol industry with its many strands was seen as an important stakeholder. The alcohol industry role was to contribute to reducing alcohol related harm in the context of their role as producers, distributors and marketers of alcohol. Participants stressed that the alcohol industry should not undermine public health objectives. Participants said the alcohol industry had a limited role in prevention and that they should focus on what they can achieve in their business context. The mass media was also considered as a key stakeholder, where accurate and well balanced information on alcohol could make a significant contribution.
Conclusions

WHO thanked participants from the European Region for their active engagement in this Regional Technical Consultation with Member States on a Global Strategy to reduce harmful use of alcohol. Participants were asked to forward to WHO all relevant information on examples of good practice and evidence of effectiveness from their own country. The draft report will be circulated for review with a strict deadline for feedback. The report will then be finalized and available on the WHO website.

The next step for the WHO Secretariat will be to draft a global strategy, which will be done in continued consultation and collaboration with Member States. The draft will be submitted to the Executive Board in January 2010 and subsequently to the WHA in May 2010.
Annex 1

TOOLS AT THE GLOBAL LEVEL TO FACILITATE THE IMPLEMENTATION OF THE STRATEGY

Information

- WHO glossary, definition of terms, comparable indicators on consumption and harm
- WHO guide on cost/effectiveness, the evidence base.
- Harmonized evaluation tools for different themes or areas on a national level
- Tools for Global strategy to track trends on new developments
- Tools for monitoring illegal consumption
- Tools for monitoring capacity at all levels
- Alcohol policy control index (ECAS example)
- Non technical reports and policy briefs for different stakeholders
- Internet forum (something like Global-link) with simple information
- Alcohol information integrated into health information
- A world alcohol harm prevention day
- Guidelines on low risk drinking
- Guidelines for development of first treatment demand system (FTD)
- Guidelines on legislation to control availability of alcohol
- Guidelines on effective pricing mechanisms
- Global studies in countries with middle income
- Database on best practices in prevention and treatment for all regions
- Alcohol issues linked to development plans (Venice centre)
- Legislation on drink driving countermeasures policies (Rome office)
- Monitoring system for alcohol marketing
- Establishment of monitoring systems on availability and pricing policies
- Monitoring system for illegal and informal production

Capacity building

- Guidance on how to discover problem areas
- Guidance on ways to work with media, law enforcement and other sector
- Advocacy tools – benefits for other sectors, scope of the burden
- Models for delivery of alcohol strategy
- High level meetings
• WHO country office support
• Strengthening networks for National Counterparts
• Strengthening cooperation with NGOs and other relevant sectors
• Technical support for the development of national programmes
• Development of protocols, seminars and training for the prevention and treatment of alcohol disorders associated with alcohol
• Technical support for screening and short-term interventions
• Establishment of an international Advisory Board of technical support for the development and implementation of alcohol policies through a network of national coordinators.
• Technical support for strategic planning
• Financing and organizational tools for networking – between Member States, NGOs and health professionals (conference, etc)
• Strengthening of links to existing WHO tools for local community action (healthy cities, healthy schools, healthy hospitals)
• Forum to exchange good practice in all policy areas
• Forums for national and international debate among parliamentarians, executive level, and national co-ordinators

Reporting
• Use of World alcohol day to report to general public on progress
• Follow up conference every four years
• Responsibility at Regional level for reporting to global level.
• Sample of worldwide experiences, if possible every year
• Global monitoring System using GISAH
• Reporting system through network of focal points
• Report on World Trade Organization (WTO) agenda regarding alcohol issues
• Reports on international agreements that could influence alcohol availability.
Annex 2

**KEY STAKEHOLDERS AND THEIR ROLE IN IMPLEMENTING THE STRATEGY IN REDUCING HARMFUL USE OF ALCOHOL**

<table>
<thead>
<tr>
<th>Local Stakeholders</th>
<th>Global Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Producers, retailers, bars, clubs, restaurants etc.</td>
<td>- Parliamentarians</td>
</tr>
<tr>
<td>- Medical community</td>
<td>- Ministries</td>
</tr>
<tr>
<td>- Public health sector</td>
<td>- Economic operators in alcohol trade.</td>
</tr>
<tr>
<td>- Social services</td>
<td>- Medical professions</td>
</tr>
<tr>
<td>- Labor unions</td>
<td>- NGOs</td>
</tr>
<tr>
<td>- Transport authorities</td>
<td>- Mass media</td>
</tr>
<tr>
<td>- Treasury</td>
<td>- Education systems</td>
</tr>
<tr>
<td>- Police</td>
<td>- Trade unions</td>
</tr>
<tr>
<td>- Insurance</td>
<td>- Employers organizations</td>
</tr>
<tr>
<td>- Employers, workplaces</td>
<td>- Private and social insurance companies</td>
</tr>
<tr>
<td>- Settings – health networks</td>
<td>- Tax Authorities</td>
</tr>
<tr>
<td>- Media</td>
<td>- Church/religious organizations</td>
</tr>
<tr>
<td>- Consumer organizations</td>
<td>- Law enforcement</td>
</tr>
<tr>
<td>- Education</td>
<td>- Youth organizations</td>
</tr>
<tr>
<td>- Municipal administration</td>
<td>- Agricultural sector</td>
</tr>
<tr>
<td>- Abstinence movements and associations</td>
<td>- Sports organizations</td>
</tr>
<tr>
<td>- Scientific community</td>
<td>- Scientific community</td>
</tr>
</tbody>
</table>

**Global Level Stakeholders**

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role/Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministries</td>
<td>- Acting at national level in cooperation across government sectors (legislation, public health, etc.)</td>
</tr>
<tr>
<td>NGO</td>
<td>- Advocacy</td>
</tr>
<tr>
<td></td>
<td>- Support the global strategy</td>
</tr>
<tr>
<td></td>
<td>- build networks and cooperate with other NGOs on join actions</td>
</tr>
<tr>
<td></td>
<td>- Forum</td>
</tr>
<tr>
<td>Mass Media</td>
<td>- Accurate and well-balanced information concerning alcohol</td>
</tr>
<tr>
<td></td>
<td>- Support social marketing</td>
</tr>
<tr>
<td>Industry</td>
<td>Primary prevention and sponsorship</td>
</tr>
<tr>
<td>Alcohol</td>
<td>- High business ethics (including health impact assessment and bearing the burden)</td>
</tr>
<tr>
<td>Producers</td>
<td>- Provide data on production, imports, exports to WHO.</td>
</tr>
</tbody>
</table>

- Encourage MS to build NGOs capacities
- network of networks
- Sharing information
- Consultate with industry on ways they can contribute to
<table>
<thead>
<tr>
<th>Category</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail/hospitality sector</td>
<td>Responsible Serving, no sales promotions or discounting</td>
</tr>
<tr>
<td>Advertising industry</td>
<td>Ensure advertising is not attractive to young people, self regulation – have to evaluate results</td>
</tr>
<tr>
<td>Education system</td>
<td>Deal with risks, prevention information, co-operation with parents</td>
</tr>
<tr>
<td>Employers organizations</td>
<td>Situational abstinence while working, prevention, counseling and treatment services</td>
</tr>
<tr>
<td>Private Insurance companies</td>
<td>Support measures such as to avoid drink driving, work against stigmatization of addicted people</td>
</tr>
</tbody>
</table>
### Annex 3

**PROVISIONAL PROGRAMME**

**Day 1: 20 April 2009, Monday**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00–13:30</td>
<td>Registration – lunch served in the WHO canteen from 11:30-13:30</td>
</tr>
<tr>
<td>13:30–14:00</td>
<td>Opening Session:</td>
</tr>
<tr>
<td></td>
<td>Welcome by Dr Nata Menabde, Deputy Regional Director</td>
</tr>
<tr>
<td></td>
<td>Welcome from Dr Vladimir Poznyak</td>
</tr>
<tr>
<td>14:00–15:00</td>
<td>Introduction of participants -Dr Lars Møller (15 minutes)</td>
</tr>
<tr>
<td></td>
<td>Appointment of rapporteur Objectives and scope of the meeting</td>
</tr>
<tr>
<td></td>
<td>-Dr Lars Møller and Dr Vladimir Poznyak (10 minutes) Background</td>
</tr>
<tr>
<td></td>
<td>and context of the Regional Consultation -Dr Vladimir Poznyak (15</td>
</tr>
<tr>
<td></td>
<td>minutes) Outcomes of the previous consultation process</td>
</tr>
<tr>
<td></td>
<td>and introduction of a discussion paper -Mr Dag Rekve (15 minutes)</td>
</tr>
<tr>
<td>15:00–15:30</td>
<td>Tea/coffee break</td>
</tr>
<tr>
<td>15:30–16:30</td>
<td>Public health issues related to alcohol use in EURO – Dr Peter</td>
</tr>
<tr>
<td></td>
<td>Anderson. The WHO Process for a Global Alcohol Strategy and</td>
</tr>
<tr>
<td></td>
<td>introduction for plenary discussion – Mr Dag Rekve.</td>
</tr>
<tr>
<td>16:30–18:00</td>
<td>Scope, aims and objectives of the global strategy. Guiding</td>
</tr>
<tr>
<td></td>
<td>principles (with the work organized in four groups following a short</td>
</tr>
<tr>
<td></td>
<td>plenary introduction).</td>
</tr>
<tr>
<td>18:00–20:00</td>
<td>Reception in lobby</td>
</tr>
</tbody>
</table>

**Day 2: 21 April 2009, Tuesday**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00–9:15</td>
<td>Report from rapporteur of day 1</td>
</tr>
<tr>
<td>09:15–10:15</td>
<td>Plenary reporting from group work on Scope, aims and objectives of</td>
</tr>
<tr>
<td></td>
<td>the global strategy – 10 minutes from each group.</td>
</tr>
<tr>
<td>10:15–12:00</td>
<td>Policy options Part I (with the work organized in four small groups</td>
</tr>
<tr>
<td></td>
<td>following a short introduction in plenary) Raising awareness and</td>
</tr>
<tr>
<td></td>
<td>political commitment Health sector response Community action Drink-</td>
</tr>
<tr>
<td></td>
<td>driving policies Addressing the availability of alcohol</td>
</tr>
<tr>
<td>11:00</td>
<td>Tea/coffee served</td>
</tr>
<tr>
<td>12:00–13:00</td>
<td>Plenary reporting from group work on Policy options (10 minutes</td>
</tr>
<tr>
<td></td>
<td>presentation from each group).</td>
</tr>
<tr>
<td>13:00–14:00</td>
<td>Lunch</td>
</tr>
<tr>
<td>14:00–16:30</td>
<td>Policy options Part II (with the work organized in four small groups</td>
</tr>
<tr>
<td></td>
<td>following a short introduction in plenary) Addressing the</td>
</tr>
<tr>
<td></td>
<td>marketing of alcohol beverages Pricing policies Harm reduction</td>
</tr>
<tr>
<td></td>
<td>Reducing public health impact of illegal and informal alcohol</td>
</tr>
<tr>
<td></td>
<td>Monitoring and surveillance</td>
</tr>
<tr>
<td>15:30</td>
<td>Tea/coffee served</td>
</tr>
<tr>
<td>16:30–17:30</td>
<td>Plenary reporting from group work on Policy options (10 minutes</td>
</tr>
<tr>
<td></td>
<td>presentation from each group).</td>
</tr>
<tr>
<td>17:30</td>
<td>Bus leaves for boat trip followed by dinner in Copenhagen -</td>
</tr>
<tr>
<td></td>
<td>sponsored by the Finnish Ministry of Social Affairs and Health</td>
</tr>
</tbody>
</table>
### Day 3: 22 April 2009, Wednesday

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00–9:30</td>
<td>Report from rapporteur of day 2</td>
</tr>
<tr>
<td>09:30–12:00</td>
<td>Implementing the strategy (with the work organized in four small groups following a short introductory in plenary) Implementation at global, regional and national levels. Role of global, regional and national policy frameworks. Role of national contexts. Role of different stakeholders in policy development and implementation. Technical tools. Assessing and re-examining action, indicators and targets.</td>
</tr>
<tr>
<td>10:30</td>
<td>Tea/coffee served</td>
</tr>
<tr>
<td>12:00–13:00</td>
<td>Plenary reporting from group work on implementing the strategy (10 minutes presentation from each group)</td>
</tr>
<tr>
<td>13:00–13:45</td>
<td>Lunch</td>
</tr>
<tr>
<td>13:45</td>
<td>Tea/coffee served</td>
</tr>
<tr>
<td>14:00–17:30</td>
<td>Global Information System on Alcohol and Health (GISAH) National monitoring systems. Priority regional implications. Conclusions and next steps.</td>
</tr>
<tr>
<td>17:30</td>
<td>Bus leaves for Tivoli – dinner in Tivoli – Sponsored by the Finnish Ministry of Social Affairs and Health</td>
</tr>
</tbody>
</table>

### Day 4: 23 April 2009, Thursday

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30–10:00</td>
<td>Report from rapporteur of day 3</td>
</tr>
<tr>
<td>10:00–10:45</td>
<td>European Information System on Alcohol and Health and plans for 2009 and presentations of three planned publications on alcohol and health by Dr Lars Møller</td>
</tr>
<tr>
<td>10:45–11:15</td>
<td>Tea/coffee break</td>
</tr>
<tr>
<td>11:15–12:00</td>
<td>The economics of alcohol in Europe: from attributable burden to avoidable costs by Dan Chrisholm</td>
</tr>
<tr>
<td>12:00–12:30</td>
<td>Swedish EU Presidency Conference on Alcohol by Ms Maria Renström</td>
</tr>
<tr>
<td>12:30–13:00</td>
<td>Closure of the meeting</td>
</tr>
<tr>
<td>13:00–14:00</td>
<td>Lunch in the WHO canteen</td>
</tr>
</tbody>
</table>
ANNEX 4

LIST OF PARTICIPANTS

Albania
Dr Roland Shuperka
Chief, Section Substance Abuse (Tobacco, alcohol and drug), Institute of Public Health, Tirana

Andorra
Invited but unable to attend.

Armenia
Dr Karine Simonyan
Chief specialist, Health Care Organization Department, Ministry of Health, Yerevan

Austria
Dr Doris Kohl,
Expert on alcohol issues and non-substance addictions, Directorate III/B, Bundesministerium für Gesundheit (Federal Ministry of Health), Vienna

Azerbaijan
Dr Azad Hajiyev
National Coordinator programme healthy lifestyle, Ministry of Health, Baku

Belarus
Dr Ludmila Narojchik
Deputy Chief Doctor, Republican Centre for Hygiene, Epidemiology and Public Health, Minsk

Belgium
Mr Mathieu Capouet,
Political alcohol expert, D.G.4 Animaux, Végétaux et Alimentation SPF Santé publique, Sécurité de la chaîne alimentaire et Environnement, Bruxelles

Bosnia and Herzegovina
Dr Tatjana Maglov
Psychiatric Clinic, Clinical Centre Banja Luka Banja Luka

Dr Nermana Mehic-Basara
Director, Institute for Alcoholism and Substance Abuse of Canton Sarajevo, Sarajevo

Bulgaria
Invited but unable to attend.

Croatia
Dr Marina Kuzman
Head, Youth Health Care and Substance Abuse Prevention, Croatian National Institute of Public Health, Zagreb
Cyprus
Invited but unable to attend.

Czech Republic
Dr Hana Sovinova,
National Institute of Public Health, Praha

Denmark
Ms Kit Broholm
Centre for Prevention and Health Promotion, National Board of Health, Copenhagen
Ms Marianne Kristensen
Senior Adviser, National Board of Health, Copenhagen

Estonia
Dr Ülla-Karin Nurm
Head, Public Health Department, Ministry of Social Affairs, Tallinn

Finland
Mr Kari Esko Paaso
Director, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Helsinki

Mr Ismo Tuominen
Ministerial Adviser, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Helsinki

Dr Esa Österberg
National Research and Development Centre for Welfare and Health, Alcohol and Drug Research Group, Helsinki

France
Ms Juliette Guillemont
National Institute for prevention and health education (INPES), Saint Denis

Georgia
Dr Akaki Gamkrelidze
Deputy Head, National Center for Disease Control and Public Health, Tbilisi

Germany
Dr Tilmann Holzer
Federal Drug Commissioner, Bundesministerium für Gesundheit, Berlin

Mr Albert Kern
Federal Ministry of Health, Division Drug and Substance Misuse, Berlin

Greece
Invited but unable to attend.
Hungary
Dr Tamas Koos
Senior Consultant, National Institute of Addictions, Budapest

Iceland
Mr Rafn. M. Jonsson
Project Manager, Alcohol and drug prevention, Public Health Institute, Reykjavik

Mr Thorolfur Thorlindsson,
Director, Public Health Institute of Iceland, Reykjavik

Ireland
Mr Robbie Breen,
Health Promotion Policy Unit, Department of Health and Children, Dublin

Israel
Invited but unable to attend.

Italy
Dr Emanuele Scafato,
Istituto Superiore di Sanita, Centro Nazionale di Epidemiologia, Sorveglianza e Promozione dekka Saalute – CNESPS, Centro Collaboratore OMS Ricerca e Promozione della Salute, Su Alcol e Problematiche Alcol-correlate, Rome

Kazakhstan
Dr Aigul Tastanova
Chief Specialist of treatment-and-prophylactic work, Health Care Organization Department, Ministry of Health, Astana

Kyrgyzstan
Dr Tatiana Viktorovna Borisova
Deputy Director, Republican Centre of Narcology, Ministry of Health of Kyrgyzstan, Bishkek

Latvia
Dr Astrida Stirna,
Chief of Addiction Disorders Unit, Riga Centre of Psychiatry and Addiction Disorders, Riga

Lithuania
Dr Audrius Sceponavicius,
Director of Public Health Department, Ministry of Health, Vilnius

Luxembourg
Invited but unable to attend.

Malta
Mr Manuel Mangani
Manager of Alcohol Community Services, 'Sedqa', Ministry of Social Policy, Santa Venera

Mr Jesmond Schembri
Service Manager, 'Sedqa' – FSWS, Sta. Venera
Monaco
Invited but unable to attend.

Montenegro
Invited but unable to attend.

Netherlands
Mrs Sandra B. van Ginneken,
Senior Policy Officer Alcohol, Nutrition, Health Protection and Prevention Department, Ministry of Health, Welfare and Sport, The Hague

Norway
Mr Bernt Bull
Senior Advisor, Ministry of Health and Care Services, Oslo

Poland
Dr Krzysztof Brzozka
Director, State Agency for Alcohol-Related Problems, Warsaw
Dr Wojciech Klosinski
Deputy Director, Health Policy Department, Ministry of Health, Warsaw

Portugal
Dr Manuel Cardoso
Member of the Executive Board, Istituto da Droga e da Toxicodependência, Lisbon
Dr Ana Sofia Santos
Coordinator for International Relations Unit, Department on Monitoring, Training and International Relations, Institute on Drugs and Drug Addiction, Lisboa

Republic of Moldova
Dr Aliona Serbulenco
Head, Depart for Public Health Services, Ministry of Health, Chisinau
Dr Tudor Vasiliev,
General Director, IMSP Republican Dispensary of Narcology, Chisinau

Romania
Mrs Adriana Galan
Public Health Consultant, Institute of Public Health Bucharest, Bucharest

Russian Federation
Dr Natalia Sirota
Dean of Faculty of Clinicl Psychology, Moscow State University of Medicine and Dentistry, Ministry of Public Health, Moscow

Serbia
Dr Ivica Mladenovic
Head, Day Hospital for Addiction Disorders, Institute of Mental Health, Belgrade
Slovakia
Dr Lubomir Okruhlica
Chief expert, Centre for Treatment of Drug Dependency, Bratislava

Slovenia
Dr Vesna-Kerstin Petric
Head, Sector for Health Promotion and Healthy Lifestyles, Ministry of Health of the Republic of Slovenia, Ljubljana

Spain
Dr Vicenta Lizarbe
Head of the Preventive Department, Directorate General of Public Health, Ministry of Health and Consumer Affairs, Madrid

Ms Maria Librada
Head of Service of Preventive Department, Ministry of Health and Consumer Affairs, Madrid

Sweden
Dr Sven Andreasson
Head of Department, Swedish National Institute of Public Health, Östersund

Dr Pi Högberg
Public Health Planning Officer, National Institute of Public Health, Östersund

Ms Karin Nilsson Kelly
Head of Section, Ministry of Health and Social Affairs, Stockholm

Ms Maria Renström
Director, Department of Public Health, The Swedish Ministry of Health and Social Affairs, Stockholm

Switzerland
Ms Anne Lévy
Head of Alcohol Section, Swiss Federal Office of Public Health, Division of National Prevention Programmes, Bern

Tajikistan
Dr Oktam Bobokhojaev
Head, Department of Health Services Delivery, Ministry of Health, Dushanbe

The former Yugoslav Republic of Macedonia
Dr Pavlina Vaskova
Vice Director, Mental Hospital “Skopje”, Skopje

Turkey
Invited but unable to attend.

Turkmenistan
Nomination awaited.
Ukraine
Dr Anatoliy Viyevskiy
Director, Ukrainian National Medical and Monitoring Centre for Alcohol and Drugs, Kyiv

United Kingdom
Ms Jean Nicol
Team Leader for Alcohol, Department of Health, Wellington House, London

Uzbekistan
Ms Luiza Baymirova
Treatment and Prophylactics department, Ministry of Health of the Republic of Uzbekistan, Tashkent

Representatives of other intergovernmental organizations

European Commission
Dr Marjatta Montonen
Directorate General Health and Consumers, Health Determinants, Luxembourg

Mr Ceri Thompson
Directorate General Health and Consumers, Health Determinants, Luxembourg

Nordic Council of Ministers
Ms Matilda Hellman
Project coordinator, Nordic Council of Ministers, Helsinki, Finland

Temporary advisers

Dr Peter Anderson
Public Health Consultant, Girona, Spain

Dr Ann Hope
Co Wexford, Ireland

World Health Organization

Regional Office for Europe
Scherfigsvej 8, 2100 Copenhagen Ø, Denmark

Dr Nata Menabde
Deputy Regional Director

Dr Nedret Emiroglu
Director a.i., Division of Health Programmes

Dr Agis Tsouros
Head, Noncommunicable Diseases and Environment, a.i., Division of Health Programmes
Dr Lars Møller
Regional Adviser a.i. Alcohol and Drugs, Division of Health Programmes

Ms Mailis Jepsen
Programme Assistant, Division of Health Programmes

Ms Nina Blinkenberg
Programme Assistant, Division of Health Programmes

Headquarters
20, avenue Appia, CH-1211 Geneva 27, Switzerland

Dr Dan Chisholm
Department of Health System Financing (HSF), Health Systems and Services (HSS)

Dr Vladimir Poznyak
Coordinator, Management of Substance Abuse

Mr Dag Rekve
Technical Officer, Mental Health and Substance Abuse

Interpreters

Mr Aleksander Reshetov
Minsk, Belarus

Mr Andrei Reshetov
Minsk, Belarus