



**Meeting report
Regional consultation on
alcohol and health**

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CONTENTS

Page

Part I – Alcohol and Pregnancy.....	1
Part II – Alcohol and Health in the European Region	12

CHAIR: DR LARS MØLLER

Part I – Alcohol and Pregnancy

Dr Lars Møller (WHO Regional Office for Europe) officially opened the Regional consultation on alcohol and health, after which he gave the floor to **Dr Marijan Ivanusa, Head of Country Office, Slovenia.**

Dr Ivanusa welcomed all participants to Ljubljana, the 2016 winner of the European Green Capital Award. Dr Ivanusa specified that much more can still be done to address alcohol-related issues, which are a big concern in Slovenia. That was one of the reasons why Slovenia was eager to host the 7th European Alcohol Policy Conference. Dr Ivanusa stated that he was pleased to see nearly all Member States represented at the conference and that the work will contribute to alcohol policies and to establishing resilient communities.

Dr Møller specified that a regional consultation has traditionally been held every year, but due to funding limitations, the last conference was two years ago. Thanks to funding from the European Commission, however, meetings for 2016, 2017 and 2018 are secured as part of the Monitoring of national policies related to alcohol consumption and harm reduction (MOPAC) project. Dr Møller stressed that these meetings require the support of the ministries of health and that the meetings are important for the exchange of ideas and sharing of good practices in the Region.

Dr Møller stated that, together, Member States can be very strong. Permission was granted to send out the 2016 Global survey on alcohol and health to Member States, and in spring 2015, country profiles were submitted for review and update. Lastly, Dr Møller requested that participants complete the satisfaction survey that will be distributed following the meeting.

Dr Møller introduced the first session on alcohol and pregnancy and the first presenter, Ms Lisa Schölin.

Ms Lisa Schölin (WHO Regional Office for Europe) – Overview of alcohol and pregnancy in the WHO European Region

Ms Schölin introduced her presentation by stating that she wrote her PhD thesis on the topic of alcohol and pregnancy. She is also the author of the new WHO/EC report published in September 2016 entitled *Prevention of harm caused by alcohol exposure in pregnancy - Rapid review and case studies from Member States*.

Ms Schölin remarked that it is well known that people in the WHO European Region drink more than in other regions. Overall, consumption is higher among men than among women. The high proportion of unplanned pregnancies relates to the high level of alcohol consumption and to risky drinking patterns.

Alcohol exposure during pregnancy can result in irreversible harm to the fetus and may lead to fetal alcohol syndrome (FAS) or the more overarching fetal alcohol spectrum disorders (FASD). However, the mother's health is also important and factors including antenatal care and adequate nutrition are important for maternal health and fetal development.

Ms Schölin gave an overview of the 2016 report. She stated that the differing study designs and focus on different stages of pregnancy complicated the analysis and made comparing the studies difficult. For instance, the Screening for Pregnancy Endpoints (SCOPE) study showed that the first trimester was the period in which women drank most (the majority of women drank 1–2 or 3–7 units per week). According to a systematic review, one of the biggest factors that contributed to women continuing to drink was intimate partner violence and higher alcohol consumption prior to pregnancy. In addition, women may not know about the risks; social norms may prevent them from stopping drinking; and a partner who drinks increases the likelihood that the woman will drink.

Only five of the studies identified in the literature review were conducted in the European Region. Ms Schölin provided a summary of the findings of her report: pushing for effective contraceptive use can have an effect on alcohol-exposed pregnancies; it is essential to tailor prevention strategies; and involving the pregnant woman's partner and goal setting are important.

Ms Schölin specified that the report also included case studies from Member States describing recent prevention activities in the area of alcohol and pregnancy. These activities include raising awareness among health care professionals; identification, treatment and family support; and awareness campaigns. Furthermore, she highlighted the importance of the WHO *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. Identified challenges include the following: preparedness of health services to talk about pregnant women and alcohol use; stigmatization – also in relation to health professionals' attitudes; social norms and attitudes; lack of knowledge; legal implications of reporting alcohol or substance abuse – for instance, whether it is recognized as child maltreatment to be drinking during pregnancy.

Finally, Ms Schölin specified that the work plan for 2017 includes the organization of workshops on alcohol and pregnancy for health professionals. A Russian version of the report on alcohol and pregnancy will be available in early 2017.

Dr Elena Varavikova (Public Health Institute for Health System Organization and Information CNHIOIZ, Russian Federation) – Developing FASD prevention in the Russian Federation

Dr Varavikova explained that in the Russian Federation, there is a Federal Research Institute for Health Organization and Informatics within the Ministry of Health. Within this institute, a Coordination Council for the prevention of alcohol harm and FASD was been established, and a variety of institutions are dealing with different aspects of this issue. Also, there is collaboration with an international team of experts that take action when necessary.

Dr Varavikova stated that alcohol overconsumption is leading to deaths and that it is a stigmatizing factor.

Dr Varavikova specified that there are different issues to deal with in the Russian Federation: protecting the health of men and women in specific age groups; advertising (as it has a strong impact on consumption); low levels of contraceptive use and hence high rates of unplanned pregnancies (in the beginning of their pregnancies, women often do not know that they are pregnant and will continue to consume alcohol); and early assessment and diagnosis of children affected by

alcohol-related harm, as alcohol exposure during pregnancy may lead to neurological disorders and behavioural disabilities.

Dr Varavikova presented the outcomes of a project in Novgorod Province, which dealt with early interventions. The study found a high prevalence of binge drinking among the women (30%). There were a high proportion of immigrants, who usually have different drinking habits, but once settled in the Russian Federation adapted to the social norm of drinking alcohol. Moreover, not all women changed their drinking patterns once they found out that they were pregnant.

Dr Varavikova stated that even though some of the physical features of FASD may become less pronounced in adulthood, brain connections may be affected, which may show in later stages in life. In orphanages, approximately 10% of the children have FASD. Some children are adopted by foreign parents, and as a result, data on these children and FASD are incomplete.

Stigmatization against FASD is common, and general practitioners (GPs) are not allowed to ask questions regarding the issue. Besides, many doctors believe it is safe to use alcohol until the third month of pregnancy. However, a study in Irkutsk showed that about 50% of obstetricians were prepared to talk about FASD and alcohol use during pregnancy. Due to the fact that the issue is a relatively new area of focus in the Russian Federation, the preparation and drafting of methodologies on diagnosis and treatment are welcome. Besides focusing on education of pregnant women, medical professionals need to be trained on the issue, and collaboration with other institutes and organizations is key.

Dr Varavikova specified that the first responses to this issue were negative, particularly in areas where FASD appear to be a significant problem. Challenges that have been encountered include setting up appropriate FASD prevention programmes, as well as working together with the penitentiary system. WHO will be important in order to establish a solid platform for collaboration and in order to provide diagnostic guidelines.

Questions and points of discussion: No questions or points of discussion. Dr Møller suggested a quick roundtable for everyone to introduce him- or herself and respective institute or organization.

Dr Vladimir Poznyak (WHO headquarters) – Prevalence study of FASD

Dr Poznyak explained why activities related to FASD were recently initiated and stated that the harm that alcohol use can have on others – as specified in the WHO *Global strategy to reduce the harmful use of alcohol* – was an important starting point. Currently, WHO headquarters is carrying projects on three topics: FASD, harm to others, and alcohol and infectious diseases.

Dr Poznyak stated that there are still issues regarding the recognition of FASD among physicians and there are on-going discussions of the inclusion of FASD in the International Classification of Diseases (ICD) system. As a starting point, it is essential that it is recognized that alcohol affects the fetus.

Regarding the prevalence of FASD, many different studies were conducted in the period from 1987–2009. Prevalence rates differ enormously, but the pooled overall FAS birth prevalence is 0.5 per 1,000 live births. The different methods that are used have a large influence on the diverse prevalence rates.

Dr Poznyak specified that it is essential to mention that many studies are focused on adults and visible signs of FASD. However, facial changes and mild psychological and behavioural impairments are not the only symptoms of FASD; secondary disabilities occur as well, although they are more difficult to assess. Related to this are prevalence rates of FASD in prison populations; compared to the general population, prevalence rates are approximately 10 times as high among people in prison.

Dr Poznyak gave an overview of one of the latest research projects on child development and prenatal risk factors specifically focused on FASD. The goals of this study were to generate knowledge on the prevalence of FASD among children aged 7–9 years and the prevalence of prenatal exposure. Data collection took place in Canada, Poland, Namibia, Ukraine, Belarus, Moldova and the Seychelles. Secondary objectives were to raise awareness of FASD and strengthen the capacity for prevention and identification; promote treatment and support; monitor FASD; and create links to policy development. In general, the aim is to support international collaboration, networking

and partnerships for advancing FASD-related research globally. Dr Poznyak specified that the sample consisted of 2,500 children at each study site, that sampling was done in rural and urban areas, and that the sampling frames used were regular schools, orphanages, health care settings, mental health institutions, and special education institutions. Lastly, Dr Poznyak stated that there were two assessment instruments and procedures used in two phases: pre-screening and active case ascertainment.

In conclusion, Dr Poznyak stated that ethical challenges will need to be addressed in the study, and, thus, substantial training of staff will be necessary. Related to this are the *WHO recommendations on antenatal care for a positive pregnancy experience*.

Questions and points of discussion: Dr Møller stated that the study will be very valuable and afterwards gave the word to Dr Petrič. Dr Petrič inquired about the ways in which information and outcomes of studies will be disseminated. Dr Poznyak acknowledged that this is indeed an important issue; two formats of training will be offered, and WHO regional offices can widely disseminate material. The active dissemination of information is not possible due to a lack of capacity for it. The representative of Croatia inquired about what specific contraceptive methods are being recommended. Dr Poznyak stated that he is not able to recommend specific forms of contraception, as he is not an expert on this; he, however, does refer to international standards regarding contraceptive use and drinking.

Case studies on prevention of FASD in the WHO European Region – panel discussion

Dr Møller invited Ms Kit Broholm, Dr Marianne Virtanen, Ms Nasia Fotsiou, Dr Magdalena Borkowska, and Dr Emanuele Scafato to offer some country-specific examples.

Ms Kit Broholm (The Danish Health Authority) – Alcohol and Pregnancy in Denmark

Ms Broholm stated that it is known in Denmark that alcohol, even in small quantities, is poisonous. Although the position of the Danish Health Authority has been the same for many years (no alcohol during pregnancy or when planning to become pregnant), in 2009, only half of the GPs offered this advice to pregnant women.

Ms Broholm specified that, currently, new guidelines state that if a woman drinks no more than three units of alcohol per week, no additional information about risks is required; if a woman drinks four to six units of alcohol per week, additional information is provided; and if a woman drinks seven units or more, she will need to be referred to a special treatment centre.

Throughout Denmark, there are five regional family centres for pregnant women with problems with alcohol or drugs, or for those women who are exposed to these issues. An inpatient facility was established for pregnant women using alcohol and drugs, and advisory materials for GPs, midwives and obstetricians were created. Ms Broholm stated that it would be a major step forward if physicians actually started believing that alcohol is harmful to pregnant women and offered women the support they need and wish for.

Dr Marianne Virtanen (Norwegian Directorate of Health) – Prevention of FASD in Norway

Dr Virtanen offered a short overview of the Norwegian FASD prevention campaign. In 2005, an expert group on alcohol and pregnancy was established. National guidelines were then created, and in 2007, a Norwegian action plan on alcohol and drugs was published. Following the new guidelines, a national campaign was also launched. The overall aims of the campaign were to promote abstinence from alcohol use during pregnancy, to enable pregnant women to make informed decisions, and to change social norms (from acceptance of drinking during pregnancy to supporting no consumption of alcohol).

Dr Virtanen described results of the campaign evaluation. Annual surveys (results from 2010–2013 was presented) showed that 52% of women drank a little alcohol before they knew they were pregnant, 17% were drunk before they knew they were pregnant, and 2% started to drink alcohol while pregnant. From 2008 to 2013, the overall proportion of people believing that consuming small quantities of alcohol during pregnancy is ‘ok’ decreased. The campaign included the following elements: seminars for journalists; interviews and articles in media; advertisements; informational posters disseminated to health centres and GPs; and three versions of an animated film. Lastly, Dr Virtanen stated that in 2015, a centre for children with prenatal alcohol and drug exposure was established.

Ms Nasia Fotsiou (Cyprus Antidrug Council) – National developments in alcohol policy in Cyprus for pregnant women and the unborn child: New goals and actions 2017–2020

Ms Fotsiou reported that the existing action plan runs until the end of 2016, and a new plan is being developed. The new action plan includes the aim of preventing substance use in vulnerable groups and the delivery of programmes in high-risk areas, including the identification of pregnant women using alcohol and referral to relevant services and dissemination of informational material. New actions include the following: reducing negative alcohol-related consequences during pregnancy and breastfeeding, including, for instance, systematic monitoring of maternal health indicators; investigation of attitudes, beliefs and levels of alcohol consumption; promotion of greater awareness of FASD among health care professionals; and referral systems.

Dr Magdalena Borkowska (The State Agency for Prevention of Alcohol Related Problems (PARPA), Poland) – PARPA in the field of FASD

Dr Borkowska outlined activities carried out by PARPA. In 2012, a population-based prevalence study on FASD in Poland was conducted (the ALICJA study). The main goal of the study was to estimate the prevalence of FASD among children aged 7–9 years, using an active case ascertainment approach. Sampling was done in selected schools, both ordinary and schools for children with special needs. Children with genetic diseases were excluded from the study. The assessment process included screening, neuropsychological and medical assessment, and verification of the given diagnosis. Initially, a total of 2,500 children were sampled, and the final study population included 280 children. The lowest prevalence rates found were 4 per 1,000 population for FASD, and 8 per 1,000 population for partial FAS. More information about the study can be found in the academic article titled *FASD prevalence among schoolchildren in Poland*.

Dr Borkowska specified that a special 3D scanning system was developed for the diagnosis of facial features related to FASD. In collaboration with the Jagiellonian University Medical College, a pilot workshop on the use of the 3D scanning system was offered to physicians.

Lastly, Dr Borkowska stressed the importance of further cooperation with physicians, psychologists, teachers, and other professionals to continue the work on FASD.

Dr Emanuele Scafato (National Health Institute, Italy) – Fetal alcohol syndrome prevention in Italy: awareness and information for prevention

Dr Scafato provided background figures and stated that an estimated 7% of newborns are exposed to alcohol during pregnancy. The prevalence rate of FASD is 8 per 1,000 newborns; 6% have partial FAS features. However, Dr Scafato emphasized that diagnosis is difficult for physicians and that there is a lack of training in assessing children for FASD.

Currently, there is an Italian campaign which is encouraging women to avoid alcohol during pregnancy, with the focus on that there is no safe limit of drinking during pregnancy. The campaign's message is disseminated through booklets, leaflets, and educational materials in schools targeting parents; in addition, the Minister of Health offers her advice through videos at public events. Dr Scafato stated that there is an international campaign focused on FASD and avoiding stigma titled *Too young to drink*. Health units and the national health system were involved in the Italian version of the campaign. The main commitment of the Italian Government was to spread information to the general population and to medical professionals.

Questions and points of discussion: Ms Schölin inquired about why the recommendation in Denmark is to drink less than three units per week, as this recommendation conflicts with the official international recommendation. Ms Broholm responded that the position of the Danish Health Authority is that it is okay to drink one alcoholic beverage per week mainly due to previous report by Danish alcohol researchers. Ms Broholm stated that she thinks it is essential for WHO to develop a curriculum for physicians and an international campaign.

The representative of the Russian Federation inquired about the best way for doctors to conduct consultations with pregnant women about alcohol use. Ms Broholm replied by stating that the authority behind the recommendations is very important, as it is difficult to let physicians make changes themselves. Official materials can be

combined with broader campaigns. Dr Møller confirmed that medical curriculum changes are very essential.

Dr Scafato commented that he thinks that the problem is a general population approach – GPs should be inquiring about the quantity of alcohol consumed, the frequency of alcohol consumption and the pattern of drinking (whether the woman is binge drinking). Primary health care services have an important role to play. The representative of Slovenia added that in Slovenia, work has been done in the area of FASD prevention, including public campaigns, lectures and workshops for health care professionals, and work with students; the campaign video presented by Dr Virtanen is used in Slovenia. The representative of Finland confirmed that public information campaigns are essential for educating not only pregnant women but also those people in their social environment. The representative of Slovakia stated that it is important to approach the general public by informing them about toxicity and the carcinogenic effects of alcohol and that awareness of health care professionals can be improved. The representative of Croatia welcomed and strongly supported the guidelines for medical doctors and stated that it would be good to use motivational interviewing as a tool to work with young people as well as collaboration with social workers. Dr Møller commented that there are guidelines available on pregnancy and alcohol and that those can be used at the national level. Dr Poznyak responded that it will be essential to have, in addition to guidelines, clear, concise messages for physicians on what to do when they face women with problems. Dr Møller stated that the WHO Regional Office for Europe is developing a brief intervention toolkit, which hopefully can be used at a national level for training purposes. A pilot workshop will be held in December 2016, and in spring 2017, it should be available on the WHO website. Furthermore, an application has been submitted for funding to hold an inter-country workshop in eastern Europe, where the need is the highest. Dr Scafato reacted by inquiring whether it should be taken as a challenge for countries to develop guidelines that in line with each other, in order to develop a common language.

The representative of Estonia specified that there are many good initiatives but that there should be more of a focus on moral values; it will be essential to change practices without making women or physicians feel guilty about what they have done in the past. The representative of the Alcohol Policy Network inquired as to whether

WHO could use its authority to address medical associations. Lastly, Ms Broholm commented that it is worrying that doctors only receive four hours of education on alcohol and related risks during their training, and that it will be essential to take responsibility for this to change.

Mr Dag Rekve (WHO headquarters) – Implementation of the WHO Global strategy to reduce the harmful use of alcohol

Mr Rekve summarized the WHO *Global strategy to reduce the harmful use of alcohol* and challenges in the implementation of the strategy. One of the key challenges in global thinking is the large variation in drinking patterns between countries; this creates difficulties in developing one strategy, as regional and cultural differences always need to be acknowledged. Global consensus was reached on actions that need to be taken on levels, patterns and contexts of alcohol consumption, and on the wider social determinants of health. The importance of addressing alcohol use as one of the risk factors for noncommunicable diseases (NCDs) can be also derived from the fact that Sustainable Development Goal (SDG) 3 includes a specific target on alcohol and drug use.

Mr Rekve furthermore stated that besides addressing equality in health, it is necessary to address equity in health. Revenues that are gained through taxation can be spent on attempts to solve some of existing health inequities.

Mr Rekve mentioned results of the 2015 Global Alcohol Policy Questionnaire: Of the reporting countries, 42 countries on the global level developed or revised a written national alcohol policy, 61 reported excise tax increases, and 19% established an institution to collect and disseminate data. “Leadership, commitment and awareness” was the action area with the largest challenges reported. Priorities reported by countries included to strengthen global coordination through the coordinating council and to develop a web-based site for the dissemination of information and data. Major challenges and opportunities were the increasing importance of drug policy issues with more emphasis on public health and acknowledgement of WHO’s role; the potential of the SDGs; and a stronger interest and engagement with other UN agencies and non-state actors. Mr Rekve finished his presentation by stating that he is looking forward to a stronger European network.

Questions and points of discussion: The representative of Slovenia commented that it is essential that Dr Møller is supported in his work regarding the network on alcohol and that focal points are clear and known to all stakeholders; the network that has been established is very important. The representative of EURO CARE stated that it is important to support non-state actors financially and to reconsider the current unequal distribution of funding. The representative of Norway mentioned that it is important to ensure that comprehensive approaches are taken in the communication between different parties, and this includes ministries as well, which usually do not have knowledge on the topic but rather on technical processes. Mr Rekve responded by stating that besides this, the mind-set of stakeholders and focal points – to be willing to work together with others – is essential.

CHAIR: MR BERNT BULL

Part II – Alcohol and Health in the European Region

Professor Jürgen Rehm (Centre for Addiction and Mental Health (CAMH) – Public health successes and missed opportunities: Trends in alcohol consumption and attributable mortality in the WHO European Region, 1990–2014

Professor Rehm began his presentation by stating that all data presented are public. Professor Rehm presented data on alcohol consumption, which has been analyzed for the period of the last 25 years. In this analysis, both recorded and unrecorded consumption were included. On a worldwide scale, consumption of alcohol has increased, but looking at the European Region, it has decreased over the past 25 years, largely within the past decade. The data show that patterns in alcohol consumption can be changed and that a culture of drinking can be influenced by policy measures.

Professor Rehm continued by stating that despite the overall decrease in consumption, alcohol-attributable mortality has increased. In the eastern part of the European Region, mortality due to alcohol has

increased by 22% since 1990. Moreover, for 90% of the countries, per capita consumption is the best predictor of mortality, especially if people drink in binge-like patterns. Four disease categories account for 95% of the alcohol-attributable deaths: cancer, cardiovascular diseases (CVD), gastrointestinal diseases and injury. The number of deaths due to liver cirrhosis is higher in eastern European Region countries as compared with the rest of the Region. In the eastern part of the Region, heavy episodic drinking has a significant impact for the trend in CVD as well. For the whole European Region, the number of injuries has been decreasing.

Professor Rehm specified that the fact that mortality has increased over the past 25 years indicates that alcohol consumption and accompanying problems have not been managed well. Taxes may have gone up, but this is not a relative measure. Based on data from provinces in Canada, it could be assumed that minimum pricing of alcohol may be worth trying, as well as reductions in alcoholic strength. Professor Rehm concluded that to reduce alcohol-related harm, creative solutions for changing the environment related to alcohol consumption are needed.

Lastly, Professor Rehm stated that action is urgently needed, and in order to achieve results, it will be crucial to affect heavy drinkers and very heavy drinkers.

Questions and points of discussion: The representative of Slovakia inquired about the trends in alcohol consumption as compared with the growth of the population. Professor Rehm responded that, globally, consumption increases more steeply than the population. The representative of Denmark mentioned that it has been observed that consumption has decreased but that not everyone is aware of the carcinogenic potential of alcohol and asked Professor Rehm to comment on lessons that can be drawn from campaigns. Professor Rehm stated that this is one of the most difficult evaluation tasks; norms concerning drinking and driving are changing but are very complicated to evaluate.

The representative of Croatia inquired about the pit fruit hypothesis, which Professor Rehm mentioned in his presentation. Professor Rehm commented on the link between consumption of alcohol produced with fruits that still contain the pit and the prevalence of liver

cirrhosis, which appear to be the case in specific countries of the Region. The representative of the Russian Federation expressed interest in investigating the statistical relationship between mortality and the consumption of hard liquor more thoroughly and systematically. Professor Rehm responded by stating that it can be concluded that modelling country- and region-specific data is more useful. If an overview of a range of countries over a range of years is provided, it is more difficult to see specific trends; country-specific data are available at CAMH's website.

The representative of Slovenia commented that there are more possible policy areas than the three 'best buys', although the country is looking at the price measures that Scotland are aiming to implement. Slovenia is working on improving its traffic legislation and is looking into permitted levels of alcohol in beverages. Lastly, the representative of Slovenia stated that it would be useful to have available statistics on unregistered alcohol production. Professor Rehm affirmed this last point and stated that there needs to be more consideration of unrecorded consumption. Professor Rehm confirmed that the three best buys are good policy measures to implement but that, nevertheless, politicians may be very difficult to convince.

Mr Bull closed the session by stating that for the next conference, it would be useful to reserve time for information on new insights gained and thanked all speakers.

Dr Lars Møller (WHO Regional Office for Europe) – Current and future work on alcohol policy in the WHO European Region

Dr Møller stated that during the 66th session of the WHO Regional Committee for Europe, alcohol was not part of the official programme but was touched upon during a ministerial lunch session where Professor Rehm presented the new report on alcohol-attributable mortality. For the Regional Committee meeting in 2017, a progress report on alcohol-related activities will be produced. During the past year, the Regional Office has been collecting data that will be included in the European Information System on Alcohol and Health; however, at the moment, there are still 19 countries that have not submitted data for the 2016 survey (for the 2012 survey, there was a 100% submission rate).

Dr Møller showed a video highlighting the features one of the latest projects; the alcohol policy timeline database. The database provides information on alcohol policy milestones per year and per Member State and includes numerous links to other information. The database may have the potential to become a global tool.

Additional recent and ongoing activities include the following: a screening and brief intervention (SBI) train-the-trainer toolkit (with the aim of developing a toolkit that can be used by all countries), and reports on alcohol-attributable deaths and on alcohol and pregnancy. A workshop related to the topic of alcohol and pregnancy will be held in eastern Europe during 2017. Planned publications include reports on the following topics: alcohol-attributable mortality in the EU; alcohol policy scoring (focused on a scoring system for the 10 action areas and their indicators); and country-specific assessment reports (Croatia and Uzbekistan). Furthermore, there are 10 to 14 countries in which specifically funded projects on alcohol are being implemented. Dr Møller specified sources of funding: financing by the Ministry of Health of the Russian Federation in the context of the Project on the Prevention and Control of NCDs; voluntary contributions from Finland, Norway and Switzerland; and funding by the EC for the MOPAC project (2016–2018).

Questions and points of discussion: The representative of Finland inquired about Dr Møller's professional position next year. Dr Møller responded that in his contract the mandatory retirement age is 61 and that he will turn 62 in July 2017. He expects his position to be open for applications. The representative of Finland expressed concerns about the continuity of the work following Dr Møller's retirement. The representative of Norway thanked the representative of Finland for bringing up this matter.

Dr Peter Rice (Scottish Health Action on Alcohol Problems) – Building support for alcohol screening and brief interventions in the WHO European Region

Dr Rice started his presentation by explaining that as a psychiatrist, he ran a treatment service in Tayside, United Kingdom and currently works in the area of alcohol policy as a WHO consultant. Dr Rice stated that Dr Møller have identified the need for a toolkit that could provide Member States with easy access to brief intervention training. Next month, the WHO toolkit will be piloted in Moscow; this toolkit

is a multi-agency activity involving primary care practitioners, managers, emergency medicine and maternity care, policy makers, public health institutes and other researchers. However, the collaboration process between all of these professionals is an essential part of the work.

Dr Rice continued his presentation by identifying the three classic groups of issues in screening for alcohol use disorders: 1) role legitimacy (Is this my job? Why was this passed on to me? What is happening in other sectors?); 2) role adequacy (Do I have the skills? Theoretical models of alcohol harm are important to support practitioners, and practitioners will need to think in public health terms instead of from an individual perspective); and 3) role support (Are the circumstances right? Besides time, staffing and priority are two influential factors). A possible fourth dimension is confidence and motivation (Will this do any good for this major problem? SBI will only be part of a solution within an overall strategy). Dr Rice specified that a big remaining question is what needs to be done to make the 'policy world' important for primary care. In order to deal with this question, partnerships between higher political systems and local systems will need to be put in place.

Mr Bull confirmed Dr Rice's statements and added that this is a matter that also extends beyond the health sector.

Case stories on alcohol policy developments on the 'best buys' – panel discussion

Dr Eugenia Fadeeva (V.P. Serbsky Federal Medical Research Centre for Psychiatry and Narcology, the Russian Federation) – Prevention of drink-driving in the Russian Federation

Dr Fadeeva stated that drink-driving leads to considerable mortality and that the Russian Federation is using the following measures to reduce the number of road traffic incidents and road traffic mortality: a so-called zero threshold, fines for drink-driving (approximately €440) followed by withdrawal of one's driving license for 3–4 years, and the project Auto-sobriety.

Dr Fadeeva specified that in the period 2011–2015, injuries due to drink-driving increased. The project Auto-sobriety was developed, and in 2014, started with the training of trainers (students, doctors, and

teachers of driving schools). In 2015, the education project was implemented in 30 driving schools in smaller provinces. In October 2016, the project's materials were presented in Moscow. Materials are free of charge, and the project's slogan is "When you drink, you cannot drive". Dr Fadeeva explained that the aim of the project is to decrease the number of cases of drink-driving and that it consists of two parts. Training courses for students are shorter (1.5–3 hours) and include information on drink-driving and the law, the effects of alcohol on the human body, legal consequences of drink-driving, drink-driving and society, and statistics. The methodology used includes a guide with test sheets, hand-outs/stickers, and goggles simulating the effects of intoxication. Lastly, Dr Fadeeva showed one of the education videos.

Ms Marjatta Montonen (National Institute for Health and Welfare, Finland) – Alcohol policy developments in Finland

Ms Montonen provided an overview of alcohol policy developments in Finland since 1984. The level of alcohol consumption increased from 1984–2007; however, since 2008, the level of consumption has been decreasing. Developments such as in the areas of availability of alcohol in grocery stores and cross-border trade (purchasing of alcohol from Estonia) played a role in these trends. In the period 2008–2014, taxes were raised five times and special pricing advertising was banned. In 2015, further restrictions were implemented through the ban on outdoor advertising and restrictions on social media advertising.

Ms Montonen specified that there are different approaches to regulating alcohol advertising: prohibiting advertising, restricting the content of advertisements, and restricting the use of certain techniques (for instance, using games, social media and advertising together). By law, all advertisement and sales promotion activities are prohibited if they involve taking part in games, lotteries, contests, if they involve any textual or visual content produced by consumers, or if they involve any content which is intended to be used by peers.

Lastly, Ms Montonen stated that further issues to address are the following: content and techniques of advertising, cross-border advertising, and keeping up with the rapid pace of innovation and technological developments.

Dr Vesna-Kerstin Petrič (Ministry of Health, Slovenia) – Case stories on alcohol policy developments on the “best buys” Slovenia

Dr Petrič started her presentation by stating that the level of alcohol consumption is decreasing in Slovenia. However, the level of consumption is still higher than the European average. Data from Slovenia indicated that even small increases in price directly affect alcohol consumption. Dr Petrič specified that a concern in Slovenia is the number of young people dying from alcohol poisoning; in the past 15 years, 48 young people died due to alcohol poisoning. In the three “best buy” areas – tax increases, restricted access to retailed alcohol, and bans on alcohol advertising – Slovenia is performing relatively poorly, compared with other countries in the European Region. Affordability of alcohol remains high and cheap wine is being imported into the country. The Excise Duty Act 2016 allows for increased quantities of wine and beer for personal use: 600 litres per person and year. The country imposes taxes on spirits (beer and wine, however, are taxed little), but less so in comparison with other countries in the Region.

Concerning the marketing of alcohol, advertising is allowed at certain hours; in cinemas, there is a ban on advertising before 22:00; and there is a ban on advertisements inside healthcare establishments, educational buildings and sports sites. However, the bans are limited, and there are still advertisements in which reference is made to an alcoholic beverage due to gaps in the law. Lastly, measures pertaining to the availability of alcohol are the following: a ban on sales to persons below age 18, prohibition of sales from vending machines, ban on sales of alcoholic drinks between 21:00 and 07:00, and requirement for every bar to have at least two beverages at equal or lower price than the cheapest alcoholic drink.

Ms Natalya Martynova (Ministry of Health, Russian Federation) – State policies to reduce alcohol abuse in the Russian Federation

Ms Martynova introduced herself by stating that she works in the Department of Public Health and Communications and that she would like to present a document adopted by the Government in 2009. Among others, the tasks defined in the document pertained to the reduction of the share of alcohol consumption in the Russian Federation (by 5% by 2020). Some of the defined key measures are an

increase in alcohol excise taxes; the introduction of minimal prices on spirits, ethanol and wine; a national ban on retail alcohol from 23:00 to 08:00; restrictions of online alcohol advertising; and stricter sanctions for illegal alcohol production and sales, as well as the sale of alcohol to minors.

Ms Martynova stated that according to the Ministry of Health, the Russian Federation reduced alcohol consumption from 18 to 12 litres per capita between 2008 and 2015 – a 33% decrease. Furthermore, between 2006–2014, the share of teenagers who drink at least daily decreased from 27% to 12% in boys and from 9% to 6% in girls.

In 2015, the Russian Federation had the highest reduction in mortality among high- and middle-income countries. In absolute numbers, the number of deaths decreased from 2.08 million in 2008 to 1.83 million in 2015 (over 200,000 people). In addition, during the period 2008–2015, the homicide rate decreased from 16.7 to 8.2 per 100,000; the prevalence of alcohol-related psychosis decreased by 39%; and the prevalence of alcoholism decreased by 19%.

Furthermore, Ms Martynova specified that from 2011 to 2014, alcohol excise taxes were increased considerably, and, as a result, the budget income increased from 178 to 300 billion roubles. Moreover, the Russian Federation now has a uniform state information system controlling all information on wholesale and retail purchases of alcohol. Lastly, Ms Martynova stated that legislative initiatives are being discussed but not supported by the Ministry of Health, such as an alcohol tax harmonization proposal within the Eurasian Economic Union and a ban on beer sales in kiosks. However, a ban on sales on the internet has been implemented.

Dr Møller commented that these presentations were very valuable and mentioned that the alcohol culture has greatly changed over the past years.

Questions and points of discussion: The representative of Estonia commented that it needs to be taken into consideration that Russian politics have a spill-over effect on neighbouring countries. For instance, when the Russian Federation restricted advertising on television, the Russian speaking youth in Estonia had better health outcomes as compared with the non-Russian speaking youth. The

representative of Kyrgyzstan proposed that people taking driving lessons could be provided with first aid information and inquired about data on the reduction of death rates. Dr Fadeeva responded by stating that first aid training is already part of school curricula, and in 2015, a pilot project was carried out to add information on prevention of drink-driving in addition to first aid.

Dr Møller closed the meeting by expressing that he is pleased to be back on track again and underlined the importance of networking for communicating, sharing information, and providing advice. The next year's conference will be held on 23 October 2017 in Lisbon, Portugal. Dr Cardoso specified that the meeting will precede and be connected with the Lisbon Addictions conference (24–26 October 2017). The last Lisbon Addictions conference in 2015 had more than 600 participants from 58 countries.

Dr Møller expressed his gratitude to Dr Petrič and Slovenia for hosting the conference and thanked all countries, all organizations present, and the WHO Regional Office for Europe staff, as well as the interpreters.

Copenhagen, January 2017