EUROPEAN ALCOHOL ACTION PLAN

2000–2005

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EUROPEAN HEALTH21 TARGET 12

REDUCING HARM FROM ALCOHOL, DRUGS AND TOBACCO*

By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States

*(*Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)*

Keywords

ALCOHOLISM – prevention and control
ALCOHOL DRINKING – adverse effects
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FOREWORD

The European Alcohol Action Plan 2000–2005 was endorsed at the forty-ninth session of the Regional Committee for Europe of the World Health Organization, 13–17 September 1999 in Florence, Italy. It is the result of a long process of intense deliberation and consultation with experts from all over the Region and representatives of Member States, and internal discussions at the Regional Office. The fourth meeting of national counterparts for the European Alcohol Action Plan (EAAP) in Madrid in October 1998 and the meeting of the Standing Committee of the Regional Committee in April 1999 in Copenhagen made particularly significant contributions. National EAAP counterparts are designated by their ministers of health to liaise with the Regional Office on alcohol policy. They all play key roles in their own countries as policy-makers and advisers.

Evaluation of the previous phases of the EAAP has, of course, also been important in formulating this Plan. Evidence from many sources has been reviewed, in particular the counterparts' responses to a questionnaire to assess the impact of the EAAP in their countries. Reference is made to this evaluation in the Plan. Since the new Plan was drafted, additional information from a number of Member States has reached the Regional Office. The general summary remains unchanged and the full evaluation report is available from the Regional Office.

The Regional Committee unanimously endorsed the Action Plan, although some significant comments were made that need to be taken into account in its implementation.

The Action Plan aims to reduce the harm caused by alcohol. Nevertheless, alcohol use by individuals and in the community cannot and should not be isolated from other factors,

not least the use of other psychoactive substances. Although much more study is required of the relationships between the use of different psychoactive substances, at individual and community level, there is no doubt that such relationships play an important role in determining the extent of use and associated harms. In its Expert Committee reports and in World Health Assembly resolutions, WHO has always advocated a **combined approach** to reduce the harm resulting from the use of alcohol, drugs and tobacco. While this principle is not explicitly repeated in the text, it is important to keep it in mind when pursuing this Plan.

As clearly demonstrated by the evaluation of the previous phases of the EAAP, the opportunities for its implementation depend largely on economic, social and cultural factors in countries and communities. It must be kept in mind, therefore, that when strengthening national action and providing international support for the development of policies and programmes in line with this Plan, it is useful to **group countries** with similar geographical and cultural traditions and economic conditions.

Globally, much of the production of and commercial interest in alcoholic beverages is concentrated in the developed countries of the European Region, where consumption levels and related harm are higher than elsewhere. As economic development progresses in other parts of the world, however, levels of alcohol use and related harm increase as well. For example, alcohol consumption grew very rapidly in eastern and south-eastern Asia from the 1960s until very recently. The EAAP can serve as a model for action in other regions where, until now, this has not been urgent. There are other **global aspects** to this Action Plan. As efforts to control harm and consumption in the European Region succeed, industry and commerce may become increasingly keen to develop markets in other parts of the world. The need to strengthen global alcohol action is therefore urgent and plans to do so are well under way at WHO.

Throughout the preparation of this Plan, **relations with the industry** have been a particular concern, raised repeatedly in the Standing Committee of the Regional Committee and in the Regional Committee. The Plan contains some references to the role of industry and commerce. It proposes, for example, that the industry and the hospitality sector develop and implement programmes to reduce alcohol-related problems in the drinking environment. After the Regional Office held a meeting with the industry, through the so-called Amsterdam Group, the Group delivered an extensive critique of the Plan, explaining the industry's standpoint and offering suggestions for incorporating this in the text.

Although some of the proposals made by the Amsterdam Group were in accordance with the debate, there was no support from the Regional Committee for a global revision of the text. Communication with the Group to promote reciprocal information sharing was, however, encouraged. Although some form of cooperation with the industry, commerce and the hospitality sector cannot a priori be ruled out, there was no support for recommending that local and national public health alcohol policies in general be developed in cooperation with them.

In line with the debate in the Regional Committee, implementation of this Plan should be viewed in connection with two further issues that require particular attention at all levels: information about consumption trends and patterns of drinking, and action directed at the protection of young people.

As with any other area of public policy-making, action on alcohol must be based on sound **information**. Although information about drinking and its effects on public health has greatly improved over recent years, it still leaves much to be desired. In most countries in the Region, policy-makers still lack sufficient information on alcohol consumption, on its patterns among the population in terms of gender, age and other relevant

population characteristics, as well as on alcohol-related harm in its various forms. Although average consumption levels and alcoholic liver cirrhosis continue to be important indicators of what is happening, they are insufficient and too crude for well targeted and well adapted policy measures. It will therefore be of the utmost importance to develop more refined data at local, national and international levels. The Regional Office has already started this line of action and will in future intensify its efforts in this direction.

There is accumulating anecdotal evidence that drinking among young people is changing. Reports from all over the Region refer to **young people** drinking more on more frequent occasions. There is growing concern over this phenomenon among youth organizations and youth policy-makers and in public health circles. Although there are several references to young people and drinking in the current Plan, we recommend that, based on the debate in the Regional Committee, special attention be paid to this group when developing programmes and plans. In line with this concern, the focus will be on this issue at the next European Ministerial Conference on Young People and Alcohol, which the Swedish Government has kindly offered to host in Stockholm, 12–14 December 2000, precisely five years after the previous one on Health, Society and Alcohol.

All these considerations offer a framework for and additional perspectives on the text of the Plan that follows. The endorsement of this Plan by the Regional Committee, within the context outlined above, is another milestone in making the alcohol issue a major item in public health policy-making and in contributing to the health and welfare of Europeans.

J.E. Asvall
Regional Director

SUMMARY

The meaning of drinking alcohol varies, and for many people having an alcoholic drink is part of social life. The harm that can be done by alcohol extends beyond the individual drinker to families and communities across the whole population. Alcohol products are estimated to be responsible for 9% of the total disease burden within the Region. They are linked to accidents and violence and are responsible for a large proportion of the reduced life expectancy in the countries of the former Soviet Union. Reducing the harm that can be done by alcohol is one of the most important public health actions that countries can take to improve the quality of life.

Since 1992, the European Alcohol Action Plan (EAAP) has provided a basis for the development and implementation of alcohol policies and programmes in Member States. The aim of EAAP for the period 2000–2005 is to prevent and reduce the harm that can be done by alcohol throughout the European Region.

The overall objectives are to:

- generate greater awareness of, provide education in, and build up support for public health policies that address the task of preventing the harm that can be done by alcohol;
- reduce the risk of alcohol-related problems that may occur in a variety of settings such as the home, workplace, community or drinking environment;
- reduce both the breadth and depth of alcohol-related harm such as fatalities, accidents, violence, child abuse and neglect, and family crises;

- provide accessible and effective treatment for people with hazardous and harmful alcohol consumption and those with alcohol dependence;
- provide greater protection from the pressures to drink for children, young people and those who choose not to drink alcohol.

The ten strategies set out in the European Charter on Alcohol provide the framework for EAAP during the period 2000–2005. The Action Plan indicates what should be achieved (outcomes) and how that can be achieved (actions). Each Member State is encouraged to implement the actions most likely to reduce the harm that can be done by alcohol in that country.

The WHO Regional Office for Europe will play an active role in supporting the Action Plan in five key areas:

(a) advocate the protection of health and identify alcohol-related policies and practices that harm health;

(b) provide a focus for information on health through its alcohol-related monitoring and evaluation systems and cooperate with its major partners such as the European Commission;

(c) give support to Member States in the development of effective alcohol policies, utilizing its research and science base;

(d) provide evidence-based tools and guidelines for turning alcohol policies into action;

(e) provide leadership, technical support and coordinated action through collaborative networks across Europe.

THE NEED FOR ACTION IN EUROPE

Introduction

1. Alcoholic beverages are used in most European countries. The meaning of drinking varies in different contexts, from cultures where traditional patterns are occasional, ritual and celebratory to those in which alcoholic beverages play a role as part of the diet.

2. Alcohol consumption can have significant adverse effects on the physical, psychological and social health of individuals, families and communities throughout the Region. The direct and indirect effects are diffuse and costly; they are not confined to a minority of easily identified heavier drinkers, but extend across the whole population. In all cultures in which alcohol has been freely available, policies, both formal and informal, have been developed to reduce alcohol-related problems and the negative consequences of alcohol use on individuals and society.

3. Alcohol can bring some beneficial effects for particular individuals. Most of the scientific evidence about these effects derives from industrialized countries and cultures, where alcohol consumption is largely accepted. Any possible benefit from alcohol should therefore be considered in its sociocultural context and cannot be generalized to those cultures and societies where drinking is not acceptable and where abstention is the norm.

Health, society and alcohol

4. Alcohol can adversely affect a number of aspects of drinkers' lives, harming their health, happiness, home life, friendships, work, studies, employment opportunities and finances. Alcohol is a psychoactive drug that can lead to hazardous consumption and dependency which is associated with an increased risk of

morbidity and mortality. Alcohol consumption and the frequency of heavy drinking are associated with an increased risk of accidents, including road traffic accidents, intentional violence both towards self and others, suicide, family violence, violent crime, engaging in criminal behaviour and victimization, including robbery and rape.

5. Alcohol products are responsible for some 9% of the total disease burden within the Region. The harm done by alcohol is particularly high in the eastern part of the Region and is responsible for a large proportion of the reduced life expectancy that occurred here during the 1990s. Between 40% and 60% of all deaths in the European Region from intentional and unintentional injury are attributable to alcohol consumption. Alcohol use and alcohol-related harm, such as drunkenness, binge drinking and alcohol-related social problems, are common among adolescents and young people, especially in western Europe.

6. The harm done by alcohol imposes a significant economic burden on individuals, families and society through medical costs, lost productivity from increased morbidity, costs from fire and damage to property, and foregone income due to early mortality. The costs of alcohol to society are estimated at between 2% and 5% of the gross national product (GNP). There are also significant economic losses through failure to collect taxes on smuggled alcohol products, which are particularly prevalent in the eastern part of the Region, an area with scarce governmental financial resources. There have been different levels of taxation and excise duties on alcohol in the European Union. A proposal by the European Commission to harmonize taxes as part of the single market resulted in the setting of minimum rates of excise duty on alcohol products. This has limited the use of pricing and fiscal policy as an effective alcohol policy strategy and has the potential to curtail tax revenue.

7. Alcohol consumption has been found to reduce the risk of coronary heart disease (CHD) and ischaemic stroke, a finding supported by an understanding of plausible biological mechanisms. This beneficial effect applies in particular to middle-aged men. The reduced risk for CHD has been found at the level of one drink every second day, and there is little additional reduction of risk beyond consumption levels of about one to two drinks a day.

THE POLICY RESPONSE IN EUROPE

The policy response to date – Evaluation of the European Alcohol Action Plan, 1992–1999

8. The aim of EAAP during the period 1992 to 1999 was to help Member States achieve a significant reduction in the health-damaging consumption of alcohol. This was to be done by reducing overall alcohol consumption and taking steps to combat high-risk behaviour. An action plan in key areas such as public policies, settings that promote health, primary health care, support systems and international cooperation with a support network provided by WHO, was outlined for implementation in each Member State.

9. In 1995, the European Conference on Health, Society and Alcohol in Paris adopted the European Charter on Alcohol. The Charter, which sets out ethical principles and goals that countries can use to develop comprehensive alcohol policies and programmes, was endorsed by all Member States in the European Region of WHO.

10. The WHO Regional Office for Europe, based on its well documented research, advocates the implementation of an effective alcohol policy that should include health, social and fiscal policies. Strong and continued political commitment from Member States is needed to ensure effective implementation of

policy throughout the Region and, in particular, in its eastern part.

11. At the end of 1998, WHO made an evaluation of the implementation of EAAP during the period 1992–1998, based on responses to a questionnaire from 33 countries spread over the whole Region. The main findings are summarized below.

- Over half of the countries developed a country alcohol action plan and had a coordinating body responsible for its implementation.
- Legislative measures which were deemed to have a helpful effect included more rigorous rules governing the marketing of alcohol, tax increases directed at prevention, and stricter drink–driving regulations in some countries.
- A reduction in alcohol tax, observed in some countries, was due in part to a move towards tax harmonization within the European Union and was seen as increasing the risk of alcohol-related harm.
- Overall, the alcohol and hospitality industry was considered to play an insufficient role in preventing alcohol-related harm. Intensive marketing by the alcohol industry was seen to be growing stronger and was noted as a major obstacle to implementation of EAAP.
- Young people and those who drank and drove were the main target groups towards whom programmes were directed. Primary health care facilities and general hospitals were indicated as key supports in identifying and treating individuals with alcohol-related problems in many countries.
- Of those countries where data were available at the time of the review, 11 had seen a decrease in per capita consumption and 3 (Italy, Poland, Spain) had achieved the European target under the health for all

(HFA) policy of a 25% reduction, but 11 countries had experienced an increase in consumption since 1992.

12. The impact of EAAP is difficult to measure at present, given its short time frame. Examining alcohol consumption levels and indicators of alcohol-related harm suggests that some changes took place in the decade 1985–1995. There was a decrease in alcohol-related traffic accidents in the western part of the Region, with the Nordic countries reporting the highest decrease of 31%. However, central and eastern European countries showed a marked increase of 32%. Indicators of the harm that can be done by alcohol, such as death from external injuries and poisoning, suicide and self-inflicted injury, decreased markedly in the European Union and Nordic countries but increased by 38% in the countries of the former Soviet Union. Chronic liver disease and cirrhosis death rates showed a decrease of 7% in European Union countries but an increase in all other countries, with the highest increase in the eastern part of the Region.

Policy for the future

13. HEALTH21, the health for all policy framework for the WHO European Region[1] sets 21 targets for health. Target 12 states that "by the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States".

14. The aim of EAAP for the period 2000–2005 is to prevent and reduce the harm that can be done by alcohol throughout the European Region. The European Charter on Alcohol sets out ten strategies that provide the framework for the Action Plan. In

[1] *HEALTH21: the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).

each of these ten strategy areas, the desired outcomes and most effective actions for achieving these outcomes are identified below. The rationale for these strategies, documented research evidence and successful examples of the actions recommended will be provided in a supporting document. The implementation process, having special regard to considerations of gender, age and ethnicity, should be in accordance with the differing cultures and social, legal and economic environments in each Member State.

OUTCOMES AND EFFECTIVE ACTIONS

15. The European Charter on Alcohol set out five ethical principles and ten strategies for alcohol action. For each of these strategies, the current Action Plan indicates what should be achieved (outcomes) in the period 2000–2005 and how that might be achieved (actions). Each Member State will need to consider the nature of the alcohol-related problems it faces and to determine which of the possible actions listed would prove to be most applicable and effective in its own circumstances. There is no single model that can be applied across the European Region. What matters most is that Member States take the actions most likely to reduce the harm that can be caused by alcohol in their countries.

16. The overall objectives are to:

- generate greater awareness of, provide education in, and build up support for public health policies that address the task of preventing the harm that can be done by alcohol;
- reduce the risk of alcohol-related problems that may occur in a variety of settings such as the home, workplace, community or drinking environment;

- reduce both the breadth and depth of alcohol-related harm such as fatalities, accidents, violence, child abuse and neglect, and family crises;
- provide accessible and effective treatment for people with hazardous and harmful alcohol consumption and those with alcohol dependence;
- provide greater protection from the pressures to drink for children, young people and those who choose not to drink alcohol.

Information and education

Outcomes

17. By the year 2005, all countries of the European Region should:

- develop public awareness of the harm that can be done by alcohol and the consequences on the health and wellbeing of individuals, families and communities;
- create support for public health policies that are in line with the European Alcohol Action Plan;
- provide children and young people with effective skills to make healthy choices and to be confident in their ability to withstand the pressures of under-age drinking.

Actions

18. Recommended actions to achieve these outcomes include the following:

– provide information about the harm that can be done by alcohol to the health and wellbeing of individuals, families and communities through public education or through the mass media;

- mount mass media campaigns to promote public support for existing or new policies to combat the harm that can be done by alcohol;
- provide all young people with the opportunity to experience skill-based learning through an integrated, holistic health education programme with a commitment to a safe and health-enhancing social and physical environment;
- ensure that school-based alcohol education, from pre-school upwards, is integrated into the concept of the health-promoting school and also into local community prevention coalitions.

Public, private and working environments

Outcomes

19. By the year 2005, all countries of the European Region should:

- reduce the occurrence of alcohol-related problems in public places, especially those associated with leisure-time activities and sporting events;
- reduce the risk of alcohol-related family harm and ensure a safe home environment for children;
- reduce the harm that can be done by alcohol in the workplace, in particular accidents and violence.

Actions

20. Recommended actions to achieve these outcomes include the following:

- control the availability of alcohol at major public events where alcohol-related harm occurs;
- prohibit alcohol at under-age leisure-time activities or sporting events and provide a wide range of food and non-alcoholic beverages;

- ensure that family-based prevention and treatment programmes are widely available and implemented;
- promote a workplace alcohol policy based on education, prevention, early identification and treatment that is integrated into workplace health programmes, in both the public and private sectors.

Drink–driving

Outcomes

21. By the year 2005, all countries of the European Region should:

- seek a substantial reduction in the number of alcohol-related accidents, fatalities and injuries resulting from driving after consuming alcohol.

Actions

22. Recommended actions to achieve these outcomes include the following:

- ensure high levels of enforcement of current drink–driving legislation;
- promote high-visibility breath testing on a random basis;
- review current blood alcohol limits and consider enacting legislation to adopt blood alcohol limits of 0.50 mg % or lower, and of close to zero for novice drivers and professional drivers of transport vehicles;
- encourage the provision of alternative transportation to their own vehicles for drivers who have consumed alcohol;
- consider mandatory driver education and treatment programmes for habitual drink–driving offenders.

Availability of alcohol products

Outcomes

23. By the year 2005, all countries of the European Region should:

- have a taxation policy that contributes to reducing the harm that can be done by alcohol;
- reduce the level of under-age drinking, especially among the very young.

Actions

24. Recommended actions to achieve these outcomes include the following:

– develop a taxation policy that ensures a high real price of alcohol, taxation based on alcohol volume (i.e. higher taxes on alcoholic beverages with a higher alcohol content), and the provision of non-alcoholic beverages at low prices;

– use alcohol taxes to fund alcohol control activities, including health education, research into alcohol policy, and support to health services at both local and national levels;

– control the availability of alcohol by restricting or at least keeping in check the number of outlets where alcohol is sold under licensing laws, limiting the number of licences and restricting hours or days of sale;

– control under-age drinking by setting a minimum age requirement, usually over 18 years, for the sale and public consumption of alcohol;

– have in place instruments, such as duty-paid stamps on alcohol products, to combat alcohol smuggling and ensure the implementation of effective price policies and the collection of all taxes.

Promotion of alcohol products

Outcomes

25. By the year 2005, all countries of the European Region should:

- adopt measures to protect children and young people from exposure to alcohol promotion.

Actions

26. Recommended actions to achieve these outcomes include the following:

– restrict advertising to product information and limit its appearance to adult print media, where a more comprehensive ban is not in force;

– develop an advertising code, in areas where advertising is permitted, that avoids glorifying the effects of alcohol and using young people in alcohol advertisements;

– develop a code of practice with the aim of preventing the promotion and advertising of alcohol products which may appeal in particular to children and young people;

– prohibit the drinks industry from sponsoring all young people's leisure-time activities;

– place restrictions on sponsorship of sports by the drinks industry;

– provide for strict regulations of events designed to promote alcohol consumption such as alcohol festivals and beer-drinking competitions.

Treatment

Outcomes

27. By the year 2005, all countries of the European Region should:

- ensure accessible and effective treatment to people (and their families) whose alcohol consumption falls within the range from hazardous or harmful to alcohol dependence.

Actions

28. Recommended actions to achieve these outcomes include the following:

– build a comprehensive treatment system based on needs assessment that is accessible, effective, flexible and accountable;

– ensure a coordinated approach that involves the social services, criminal justice bodies and self-help groups, as well as the health services;

– ensure that treatment is evidence-based, effective and flexible enough to respond to developments in scientific knowledge and treatment technology;

– ensure that treatment services cater for the complete range of problems and provide for detoxification, assessment, treatment matching, relapse prevention and after-care;

– provide for the training of primary health care professionals in identification of, and brief interventions for, hazardous and harmful alcohol consumption;

– allocate appropriate funding and adopt contractual strategies to ensure the widespread availability, accessibility and affordability of interventions based on primary health care;

– provide long-term treatment alternatives to a custodial sentence for offenders with chronic alcohol dependency problems who cooperate with a therapeutic programme.

Responsibilities of the alcoholic beverage industry and hospitality sector

Outcomes

29. By the year 2005, all countries of the European Region should ensure:

- a reduction in alcohol-related problems within the drinking environment;
- a reduction in the number of intoxicated persons leaving licensed premises and subsequently involved in assaults, violence and alcohol-related traffic accidents;
- the implementation of appropriate measures to restrict young people's access to alcohol.

Actions

30. Recommended actions to achieve these outcomes include the following:

– carry out health impact assessments, which evaluate the effect of the alcohol industry's social and economic policies and programmes on health, in order to ensure accountability;

– extend the concept of product liability to cover those who promote alcoholic beverages in an irresponsible and inappropriate way;

– ensure that regulations governing the alcohol content, packaging and marketing of alcoholic products lay down product safety standards, prohibit false claims

and provide relevant warnings (e.g. in the form of unit labelling);

- foster awareness of personal, ethical and legal responsibility by providing training programmes for those serving alcoholic beverages;
- draft legislation so that those who serve alcohol in an irresponsible manner are held accountable by means of server liability, licence withdrawal or other mechanisms deemed appropriate by the authorities;
- ensure that the best available technology is used to develop high-quality alcohol products with low alcohol content at low cost;
- ensure strict enforcement of existing licensing and drinking laws, mandatory training requirements and the placing of conditions on licences which prohibit irresponsible trading practices within the drinking environment.

Society's capacity to respond to alcohol-related harm

Outcomes

31. By the year 2005, all countries of the European Region should have:

- stepped up community actions aimed at reducing alcohol-related problems in local communities (such as traffic accidents involving alcohol use and under-age sales) through the provision of more responsible beverage service and the increased adoption of local laws;
- heightened awareness and increased competence among all government sectors that can have an impact on an effective alcohol policy.

Actions

32. Recommended actions to achieve these outcomes include the following:

- provide education and training in alcohol policy for professionals in other sectors such as education, social welfare and the judiciary, in order to ensure an effective multisectoral approach;
- support programmes that strengthen community mobilization, development and leadership for the prevention of alcohol-related problems;
- establish at least one coordinated and sustainable community demonstration project on the prevention of alcohol-related problems;
- ensure that a municipal alcohol policy is developed and implemented in all cities participating in the WHO Healthy Cities project.

Nongovernmental organizations

Outcomes

33. By the year 2005, all countries of the European Region should:

- support nongovernmental organizations and self-help movements that promote initiatives aimed at preventing or reducing the harm that can be done by alcohol.

Actions

34. Recommended actions to achieve these outcomes include the following:

- support nongovernmental organizations and networks that have experience and competence in advocating policies at international and country levels to reduce the harm that can be done by alcohol;

- support organizations and networks that have a specific advocacy function within their remit, such as associations of health care professionals, representatives of civil society and consumer organizations;
- support nongovernmental organizations and networks that have a specific role to play in informing and mobilizing civil society with respect to alcohol-related problems, lobbying for policy change and effective implementation of policy at government level, as well as exposing harmful actions of the alcohol industry.

Formulation, implementation and monitoring of policy

Outcomes

35. By the year 2005, all countries of the European Region should have:

- a comprehensive broad-based alcohol policy;
- a system for reporting on alcohol consumption and for monitoring and evaluating the implementation of alcohol policy and the harm that can be done by alcohol.

Actions

36. Recommended actions to achieve these outcomes include the following:

- in each country, develop a country programme containing an action plan on alcohol with clear targets;
- establish a body to coordinate the country programme and provide adequate funding for that function with a specific timetable to ensure implementation and monitoring of country-based action plans;
- establish an effective framework for monitoring and evaluating alcohol consumption and for tracking indicators of the harm that can be done by alcohol and

alcohol control policy responses (this process may require the development of appropriate standardized research tools).

ROLE OF THE WHO REGIONAL OFFICE FOR EUROPE

37. HEALTH21 provides a revised policy framework for the European Region of WHO. The main task of the WHO Regional Office for Europe is to work for better health, and it has a special mandate to promote closer cooperation for health development, both internationally and in its work to support individual countries. Health21 identifies roles for the Regional Office in actively supporting implementation of EAAP in five key areas.

(a) Acting as the Region's "health conscience", the Regional Office will defend the principle of health as a basic human right, identify and draw attention to persistent or emerging health concerns and identify policies and practices that benefit or harm health.

(b) Being a centre for information on alcohol-related issues, the Regional Office will maintain and keep up to date the regional HFA monitoring and evaluation systems. It will promote the development of surveillance and other health information systems that combine ease of data collection and reporting for Member States with the technical requirements of standardization and responding to users' needs. In so doing, the Regional Office will strive to optimize its cooperation with WHO headquarters and with its major partners in the Region, in particular the European Commission, the Organisation for Economic Co-operation and Development and other United Nations bodies.

(c) Analysing and advocating EAAP, the Regional Office will provide guidance and support in the

development and implementation of alcohol policy at all levels to individual Member States (and particularly countries of eastern Europe), to organizations and to its networks. It will continue to advocate for effective alcohol policy through meetings and publications and through its network of counterparts.

(d) Providing evidence-based tools and guidelines for turning alcohol policies into action, the Regional Office will identify innovative tools, approaches and methods for reducing the harm that can be done by alcohol. This will be achieved by monitoring the results of international research, reviewing practical experience in Member States and, where necessary, promoting or undertaking special high-priority studies where these are not otherwise available.

(e) Working as a catalyst for action, the Regional Office will provide technical support and leadership in efforts to eliminate or control threats to public health that arise from alcoholic beverage products and it will coordinate action with its partners through collaborative networks across Europe.

CONCLUSION

38. Reducing the harm that can be done by alcohol is one of the greatest public health challenges facing the European Region of WHO. Ways of taking up this challenge are well known. What is needed now is to exercise political will, to mobilize civil society and carry out systematic programmes in every Member State. The European Alcohol Action Plan, by outlining effective actions which will result in clearly identified outcomes, creates a European movement to reduce the harm that can be done by alcohol and to promote health and wellbeing across the Region.

RESOLUTION

EUR/RC49/R8

EUROPEAN ALCOHOL ACTION PLAN – THIRD PHASE

The Regional Committee,

Recalling the health for all policy framework for the European Region for the twenty-first century which it endorsed in 1998 (resolution EUR/RC48/R5), and in particular target 12 dealing with reducing the harm from alcohol;

Recalling its resolution EUR/RC42/R8, by which it approved the first and second phases of the European Alcohol Action Plan, and the European Charter on Alcohol adopted at the European Conference on Health, Society and Alcohol, Paris, 12–14 December 1995;

Having considered document EUR/RC49/9, which contains proposals for the third phase of the European Alcohol Action Plan;

1. ENDORSES the third phase of the European Alcohol Action Plan as guidelines for European Member States to follow, taking into account their differing cultures and social, legal and economic environments;

2. URGES Member States:

(a) to formulate or reformulate national alcohol policies that are in line with the European Charter on Alcohol and to establish programmes that are in line with the outcomes and actions outlined in the third phase of the Action Plan;

(b) to recognize the importance of multisectoral action and the important roles which local communities and health systems have in promoting and in implementing the Action Plan;

(c) to support the implementation of activities designed to achieve the outcomes of the Action Plan in organizations that can assist in achieving the overall objectives;

(d) to adopt measures to protect young people from harm done by alcohol and to develop programmes involving young people;

3. URGES integrational, intergovernmental and nongovernmental organizations, as well as self-help movements, to undertake joint action with Member States and with the Regional Office to maximize the Region-wide efforts to reduce the harm resulting from alcohol consumption;

4. REQUESTS the Regional Director:

(a) to ensure support for the Action Plan from the Regional Office and its networks by using funds from WHO's regular budget and making efforts to raise more voluntary contributions;

(b) to cooperate with and assist Member States and other organizations in their efforts to reduce the harm resulting from alcohol consumption and thereby alcohol-related problems in the Region;

(c) to establish an information system for the European Region on alcohol-related problems in order to collect, analyse and distribute information relevant to the implementation of the regional Action Plan;

(d) to report, as part of the Regional Director's report, every two years to the Regional Committee on progress in implementing the Action Plan.