World Health Organization
European Region

Regional Committee for Europe
72nd session

Tel Aviv, Israel, 12–14 September 2022

EUR/RC72/12
Provisional agenda item 10

16 August 2022 | 220604

ORIGINAL: ENGLISH

European framework for action on alcohol 2022–2025

The European framework for action on alcohol 2022–2025 draws on the latest evidence on alcohol-attributable harm and the best evidence to reduce such harm. It reflects the context that Member States find themselves in, including dealing with the impacts of the COVID-19 pandemic, and highlights priority areas for action.

The framework further contributes to the implementation of the European Programme of Work, 2020–2025, including the achievement of the target of a 10% relative reduction in alcohol per capita consumption by 2025 (from a 2010 baseline), and to meeting targets 3.4 and 3.5 of the Sustainable Development Goals. These priority actions will also pave the way towards implementation of the global Action Plan (2022–2030) to effectively implement the Global strategy to reduce the harmful use of alcohol as a public health priority, which was adopted by the World Health Assembly in May 2022.

This working document is submitted to the 72nd session of the WHO Regional Committee for Europe. The European framework for action on alcohol 2022-2025 is further elaborated in a separate background document.

Contents

THE NEED FOR A RENEWED FRAMEWORK FOR ACTION ON ALCOHOL IN THE WHO EUROPEAN REGION

1. Alcohol consumption and its related burden of disease are responsible for some of the greatest health and societal challenges faced by Member States of the WHO European Region. Globally, the European Region has the highest level of alcohol per capita consumption and the highest proportion of drinkers. One in every 10 deaths in the Region each year is caused by alcohol, amounting to almost 1 million in total, and many of these deaths occur at a very young age.

2. Alcohol is a causal factor for more than 200 diseases, health conditions and injuries and is a Group 1 human carcinogen, causally linked to seven types of cancer. Like COVID-19, alcohol harms exacerbate existing health inequalities; similar levels of alcohol consumption are associated with a more damaging impact on the health of more deprived individuals and their families than of wealthier drinkers.

3. Addressing harms due to alcohol consumption exerts considerable financial pressures on social and health care systems, which are often very stretched. These pressures have been exacerbated by the COVID-19 crisis. People with alcohol use disorders may be at increased risk of infection and harm from the virus and worse outcomes if infected. There is a robust evidence base for cost-effective alcohol control measures to reduce alcohol consumption and harms. The latest economic analysis undertaken under the auspices of WHO demonstrated high returns on investment for Best Buys in alcohol control.[1] However, the powerful tools of the Global strategy to reduce the harmful use of alcohol (2010) and the European action plan to reduce the harmful use of alcohol 2012–2020 have been underutilized.

4. This framework has been developed through consultations in 2022 with Member States and civil society organizations, as well as through an online public consultation. In these consultations, Member States reported that barriers to implementation of the most high-impact and cost-effective policies included significant and sustained opposition by economic operators in alcohol production and trade.

5. A side event at the 71st session of the WHO Regional Committee for Europe (EUR/RC71/SE/2) made clear the need for concerted action and stronger political commitment by Member States, along with greater engagement of public health-oriented nongovernmental organizations (NGOs), professional associations and civil society groups, to ensure the effective protection of populations from alcohol harms.

VISION AND PRINCIPLES OF THE 2022–2025 EUROPEAN FRAMEWORK

6. The 2022–2025 European framework envisages a Region with improved health and social outcomes for individuals, families and communities, and considerably reduced morbidity and mortality from alcohol consumption and ensuing social consequences. The long-term strategic ambition is for a SAFER European Region free from harm due to alcohol.[2] This vision is aligned with, and will contribute to, the implementation of the global Action Plan (2022–2030) to effectively implement the Global strategy to reduce the harmful use of alcohol as a public health priority, adopted by the World Health Assembly in May 2022.

7. The following principles underpin this framework:

(a) gender-sensitive strategies and a commitment to reducing health inequalities;

(b) evidence-informed prioritization of public health interests without interference from economic operators in alcohol production and trade;

[1] Saving lives, spending less: a strategic response to noncommunicable diseases. See https://apps.who.int/iris/handle/10665/272534.

[2] See https://www.who.int/europe/publications/m/item/a-safer-who-european-region-free-from-harm-due-to-alcohol-concept-note and https://www.who.int/initiatives/SAFER.

(c) protection of children within the realm of the right to health of children as defined in the United Nations Convention on the Rights of the Child; and

(d) leaving no one behind, aligning with the guiding principles of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" (EPW), and supporting sustainable development.

STRATEGIC CONTEXT

8. This framework is aligned with and contributes to the realization of the global Action Plan (2022–2030) to effectively implement the Global strategy to reduce the harmful use of alcohol as a public health priority. Implementation will be supported by WHO's SAFER WHO European Region free from harm due to alcohol initiative, which is aligned to actions of the WHO global SAFER initiative.

9. The framework serves to promote and support actions by Member States and the WHO Regional Office for Europe (WHO/Europe), together with those of civil society organizations and community groups, to reduce alcohol consumption and alcohol-attributable harms.

10. The framework aligns with the core priorities of the EPW, as well as other regional strategies, including the proposals of the WHO Regional Director for Europe's Advisory Council on Innovation for Noncommunicable Diseases. The EPW's flagship initiative Healthier Behaviours: incorporating behavioural and cultural insights will be an important resource to inform activities across all priority areas.

11. The Empowerment through Digital Health flagship initiative will especially support priority areas five and six: health services' response and community action. Given the strong evidence that alcohol consumption presents serious health risks related to cancer and mental health, strategic links will be built and enhanced with the pan-European movement United Action Against Cancer, and activities under the WHO European Framework for Action on Mental Health 2021–2025.

12. The framework also supports achievement of targets laid out in the 2030 Agenda for Sustainable Development, including targets 3.4 and 3.5 of the Sustainable Development Goals, and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025.

13. As well as aiming to reduce harms due to alcohol consumption, the framework is intended to reduce stigma and discrimination related to alcohol use, and to support the recovery of individuals and communities.

14. The framework will also align with and support the aspirations of the European Union's Europe's Beating Cancer Plan.

FOCUS AREAS: PRIORITIES FOR ACTION

15. A portfolio of policy options is proposed, guided and formulated by public health interests, based on clear public health goals and the best available evidence.

16. Six areas are prioritized: alcohol pricing; alcohol availability; alcohol marketing; health information, with a specific focus on alcohol labelling; health services' response; and community action. These focus areas intersect. A comprehensive approach is recommended for the greatest impact in reducing alcohol consumption and alcohol-attributable harms.

17. The priorities for action and implementation at the national and subnational levels are at the discretion of each Member State. Additional measures to those outlined in the framework can be considered by Member States in response to their national circumstances and specific needs, including

national and subnational social, economic, legal and cultural contexts, public health priorities, health system policies and available resources.

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

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

Alcohol pricing

20. Evidence is strong and consistent on the links between the affordability of alcohol, how much is consumed and harms.

21. Increasing excise taxes on alcoholic beverages is considered a cost-effective noncommunicable disease (NCD) Best Buy intervention, which yields the most health gains for the least resources invested, and this is the policy option with the largest and most comprehensive evidence base. From a health perspective, a specific system of alcohol taxation (i.e. taxing the volume of alcohol in different beverages directly) should be in place in all countries, with higher rates of duty for stronger products. Minimum pricing policies target the cheapest alcohol products, which are typically consumed by the heaviest drinkers, and they are therefore promising policies for reducing health inequalities.

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

23. Priorities for action:

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

(b) uprating of all alcohol-related fiscal policies, including taxation, regularly and in line with inflation;

(c) intersectoral dialogue and planning on alcohol pricing across all government departments, including ministries of health and finance; and

(d) transnational and intersectoral exchange of information and monitoring to plan collaboration in relation to pricing policies and cross-border trade.

Alcohol availability

24. Greater availability of alcohol is associated with higher levels of consumption and harms, and reducing availability is another of WHO's NCD Best Buys. Evidence-based interventions include restricting times and days of sale, limiting the number and density of outlets, and setting minimum legal age limits for alcohol sales and consumption. Strategies to reduce availability need to adapt to the growth in several countries of online and telephone sales.

25. Priorities for action:

Consideration of national alcohol strategies that prioritize managing availability, with measurable outcomes and support for enforcement, as well as recognizing the right for communities to have alcohol-free spaces, to include:

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

(b) restrictions on the number and density of outlets and the days and hours of sale, and the regulation of drinking in outdoor public spaces;

(c) minimum age restrictions on the sale of alcohol;

(d) consideration of total restrictions on the sale of alcohol in and around sporting events and cultural events that include minors;

(e) mandated server and salesperson training as conditions of licensing; and

(f) consideration of new measures, where there is evidence from different countries that these can be effective, including:

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

Alcohol marketing

26. Restricting marketing of alcohol is a third WHO-recommended NCD Best Buy. There is a strong association between levels of exposure to alcohol marketing and impacts on alcohol consumption levels and harms, with young people being especially at risk. The digital marketing context presents new risks and challenges. There is evidence that the more comprehensive the regulations and restrictions on marketing, the easier it is to ensure clarity in communication and interpretation of their legal intention, as well as to take action to monitor and enforce regulations.

27. Priorities for action:

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

(b) intersectoral dialogue and planning on alcohol marketing across all government departments, including ministries of health and finance and ministries responsible for digital technologies;

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

(d) regulatory codes that state what is permitted, rather than what is not, with the legal presumption that what is not named is not allowed;

(e) establishment of relationships with Internet platform providers to support new innovative approaches that can measure, control and restrict alcohol marketing, with new regulations where necessary;

(f) actions to oblige alcohol producers to share their market data on consumers in different media for public health purposes;

(g) partnerships and collaborations with other countries and with international agencies, with the intention of improving transnational cooperation on monitoring and enforcement; and

(h) consideration of new taxation systems, including e-commerce taxes, and ensuring that alcohol marketing activities are not tax deductible.

Health information, with a specific focus on alcohol labelling

28. Public awareness of the range of harms associated with alcohol consumption is low. For example, many people are unaware of the risks of developing a range of cancers due to alcohol consumption, even at very low levels. Consumers have the right to be informed about the risks associated with products offered for consumption, including alcohol, which is no ordinary commodity, so that they can make informed choices.

29. Priorities for action:

(a) independent mandating, monitoring and enforcement of what appears on all alcohol labels, working in the interests of public health and consumer rights and free from influence or interference from corporate interests;

(b) statutory labelling requirements informed by WHO guidance, with labels that include nutrition and ingredients as well as health warnings;

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

(d) research to understand the effects of health warning labels on alcohol products, including measurement of the impacts on public knowledge, awareness and drinking intentions; and

(e) consideration of the principle of a statutory “right to know” for consumers in relation to the content of alcoholic beverages and related risks.

Health services’ response

30. Evidence strongly supports the widespread implementation of screening and brief intervention programmes in primary health care settings, with evidence showing that these can also be effective in other settings. Alcohol use disorders should be considered primarily as health problems, which coexist and interact with other health conditions. Health services need to be holistic, learning from people with lived experience and, where appropriate, including families as part of the recovery process, as well as engaging with external services, including mutual aid organizations. Where possible, support services should be put in place for children and families affected by another person’s drinking.

31. Priorities for action:

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

(b) concerted actions to reduce the social stigma and discrimination that prevents people from accessing alcohol-related support services;

(c) expanded provision of alcohol-related screening and brief interventions in primary health care settings and in other contexts based on evidence;

(d) adequate provision of psychosocial treatment and pharmacological treatments, where these are required, including outreach services for vulnerable populations;

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

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

(g) raising public awareness about community support and specialist services available and increasing their use through improved pathways and information sharing.

Community action

32. Alcohol consumption causes harms to communities, especially those that are already disadvantaged. Community groups can mobilize to influence policies that can protect their environments from harms due to alcohol consumption. School and community interventions may be combined usefully, in part because community efforts can help restrict young people's access to alcohol. People with alcohol problems and their families are part of communities, and their lived experience can also inform strategies to prevent alcohol problems and to support recovery.

33. Priorities for action:

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

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

(c) awareness-raising about the harms that alcohol consumption can cause to others, including families and to children through fetal alcohol spectrum disorder, as well as alcohol-related violence and drink-driving;

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

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

ROLE OF WHO/EUROPE

34. WHO/Europe will support the implementation of the priorities laid out in this 2022–2025 framework by:

(a) establishing action-focused networks to assess likely future developments and to develop strategies to prioritize public health approaches across all priority areas;

(b) supporting intersectoral and transnational cooperation and the development of new national and transnational regulatory approaches, where appropriate, to support the implementation of coherent alcohol policies, including overcoming cross-border issues;

(c) documenting and disseminating best-practice examples, including administrative and legislative approaches, across all priority areas;

(d) promoting the exchange of experience and collaboration between Member States;

(e) working with other United Nations agencies to share best practices, technical knowledge and expertise in developing, evaluating and safeguarding evidence-based alcohol control policies;

(f) providing technical guidance to Member States, including on:

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

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

(h) supporting Member States in building their capacity to continue providing essential alcohol-related health and care services alongside emergency response measures in the case of future health emergencies; and

(i) expanding platforms for NGOs, civil society organizations, people with lived experience, and academics to:

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

MONITORING AND EVALUATION

35. A robust monitoring and evaluation framework will be set up and described in detail in the background document and this will be further refined in consultation with Member States.

36. A final report on the implementation of the framework will be submitted to the Regional Committee for Europe in 2025 with recommendations for the way forward for the period 2026–2030, in line with the global Action Plan (2022–2030) to effectively implement the Global strategy to reduce the harmful use of alcohol as a public health priority.

= = =