eurocare EUROPEAN ALCOHOL POLICY ALLIANCE

EUROCARE ANNUAL

REPORT 2006 - 2007

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EUROCARE 17th Annual Report 2006/2007

1. Introduction

This was another busy and eventful year with significant developments occurring both internally and externally. Following the retirement of Derek Rutherford from the post of Honorary Secretary at the Annual Meeting in September 2006, a post he had occupied since the launch of Eurocare in October 1990, a Board of Directors was elected consisting of a chairman (Michel Craplet); two vice chairmen (Rolf Hollinghurst and Tiziana Codenotti), a Treasurer (Sven Olof- Carlsson), a Secretary (Andrew McNeill) and a vice-secretary, Ritva Varamaki.

This new management team oversaw Eurocare's response to the adoption by the European Commission of the long awaited Communication setting out an alcohol harm-reduction strategy. The adoption of this strategy and the developments leading up to it and accompanying it have enhanced Eurocare's position as the foremost non-governmental agency tackling alcohol-related harm at an EU level while also of course placing extra demands on the organisation and, in particular, upon the staff of the Brussels office.

2. Eurocare Organisation and Personnel

a) Changes in Personnel

With the ending of the Bridging the Gap project, Walter Farke ceased to be Eurocare Public Relations Officer in December 2006. Peter Anderson's contract as Policy Consultant to Eurocare also ended at the same time. Emilie Rapley was seconded to the Brussels office by the Institute of Alcohol Studies in March 2007 and has occupied the post of Policy and Public Affairs Officer. Ruth Ruiz continued in her post of Eurocare Policy Officer and Håkon Riegels continued in his post of Head of Office but will leave the organisation at the end of September 2007. Steps are being taken to appoint his replacement.
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b) Finances

As a response to the increasing demand of more transparency, and also as a response to increased attention from Belgium tax authorities', the secretariat together with the treasurer and the office manager of Actis have spent notable time getting the Eurocare accounts and statutes in compliance with Belgium law. This process will, provided that everything goes as planned, be finalised shortly. For the coming years Eurocare has been engaged in the process of creating a more transparent and straightforward system of accounting.

c) Renovation of the building

During the last year, the premises in Rue des Confédérés 96 have been substantially renovated. The renovation started in September 2006 and was finalised in August 2007. Because of disturbances resulting from the renovation work, staff rented office space on EPHA's premises (Rue d'Arlon) during parts of this period. Håkon Riegels has been in charge of the daily contact with the surveyor supervising the work done.

3. Projects

a) Bridging the Gap

The Eurocare project, Alcohol Policy Network in the Context of a Larger Europe: Bridging the Gap (BtG), was co-financed by the European Commission for the years 2004-2006. It was successfully concluded in December 2006. The project included partners in 29 European countries as well as the World Health Organization (European Office), the European Youth Forum, the European Public Health Alliance and the European Cultural Foundation. The main beneficiary was the Alliance House Foundation of the United Kingdom, on behalf of Eurocare. The project received external funding from the Norwegian Policy Network on Alcohol and Drugs (Actis), the Directorate for Social Affairs and Health of Norway, the Ministry of Health of Slovenia, the Polish State Agency for Prevention of Alcohol Problems, IOGT-NTO Sweden, and the Finnish Centre for Health Promotion.

The main aim of the project was to create a vibrant alcohol policy network; to further the development of an integrated Community strategy to reduce alcohol related-harm in the context of a larger Europe as embodied in the Council's conclusions of 5 June 2001; and to support and encourage European countries to implement the Council Recommendation on the drinking of alcohol by young people.

The planned deliverables of the Bridging the Gap 2004-2006 Project were:

- European Alcohol Policy Network, together with collaboration and coordination with other multi-annual projects in the field of alcohol;
- Report of current alcohol policy, identifying barriers and facilitators in all Member States and applicant countries;
- Launch of the Network at a European conference in Poland in 2004, accompanied by the publication of an alcohol policy document;
- Series of theatre sketches contrasting stakeholder views on alcohol policy to convey complex policy issues in an innovative way to and by young people;
- An alcohol policy questionnaire to be produced and distributed for young people by young people.
- An alcohol advocacy policy manual;
- Two advocacy training schools for Policy makers and programme implementers, and;
- Alcohol policy technical visits to new Members States of EU.

The evaluation of the project is attached as Appendix 1

b) Building Capacity (BC)

The Building Capacity project was approved and funded by the Commission as a successor to Bridging the Gap as another three year project which will run until 2010. While circumstances prevented this from being a Eurocare project as such, Eurocare and some of its member organisations have close relationships with the project as partners or work package leaders. Work Package 4 (networking) is being undertaken by DHS (Germany) and will relate particularly closely to Eurocare.

3. Alcohol Policy Youth Network - APYN

As a follow-up to an element of the Bridging the Gap project and the work developed by the European Youth Forum in 2005-2006 in the field of alcohol policy, Joao Silviano Carmo was given a temporary contract by the Alliance House Foundation as Youth Coordinator with the task of assessing the feasibility of setting up an alcohol policy youth network. To facilitate this work Joao Silviano Carmo was appointed Eurocare Consultant on Youth Affairs from 1st May 2007 until 31 December 2007. The specific objectives of the project are to:

- Assess young people’s views on Alcohol Related Harm

- Provide services to empower and enable youth organisations to be active and effective actors in the development, implementation, monitoring and evaluation of Alcohol Policies at the European and national levels
- Involve young people in the field of Alcohol Policy from the local to the European levels by involving networks of youth organisations existing within the membership of the European Youth Forum
- Create a consultative body through the annual political meetings and outcomes of the different activities to both Eurocare and YFJ on alcohol policy
- Enable Youth NGOs to be active players at the definition, implementation and evaluation of alcohol policies and programmes at the local, national, European and international levels

Good progress is being made with this project. Discussions have been held with the European Commission in regard to financial and other support; the European Youth Forum has elected to become a partner of the project, and the Greek Government has also offered support. The project is to be put forward as a commitment in the context of the Alcohol and Health Forum.

4. EU Alcohol Strategy

Eurocare has worked systematically to support the DG SANCO with the aim of obtaining a strategy as strong as possible.

Prior to the release of the Strategy, Eurocare, alerted of the of the possibility that the strategy could be in danger of not being adopted at all, mobilised its members and carried out, with the valuable assistance of the EPHA (European Public Health Alliance) secretariat, a lobby and media campaign in coordination with other Health and Social networks of Organisations. The objective of the campaign was to urge the College of Commissioners to resist the pressure from the Industry and to protect the health and wellbeing of the EU citizens. (See Eurocare's Press Release prior to the adoption of the Strategy – Appendix 2. Letter to the College of Commissioners – Appendix 3).

On 24 October 2006, the European Commission finally adopted the long awaited Communication setting out a strategy to support Member States in reducing alcohol-related harm (Appendix 4). The EU Alcohol strategy has been awaited since in June 2001 the Council invited the Commission to put forward proposals for a comprehensive Community strategy aimed at reducing alcohol-related harm to complement national policies.

The priorities identified in the Communication are to:

- Protect young people and children and the unborn child;
- Reduce injuries and deaths from alcohol-related road accidents;
- Prevent harm among adults and reduce the negative impact on the workplace;
- Raise awareness of the impact on health of harmful alcohol consumption; and on appropriate consumption patterns;
- Develop a common evidence base at EU level.

The strategy identifies areas in which the EU can support the actions of Member States to reduce alcohol related harm, such as financing projects through the Public Health and Research Programmes, exchanging good practice on issues such as curbing under-age drinking, exploring cooperation on information campaigns or tackling drink-driving and other Community initiatives.

The Communication also aims to promote the exchange of good practice between Member States, establishes an Alcohol and Health Forum of interested parties and sets out areas where industry can make a contribution.

Eurocare regarded the introduction of an EU-wide alcohol harm reduction strategy as one of its main objectives and thus strongly welcomed the new initiative while at the same time recognising its' limitations. This is the first-ever European Union Alcohol Strategy and the fact that it exists at all is a victory for public health. It represents the recognition of the extent of the harm caused by alcohol and of the need for coordinated action at EU level. The existence of a Strategy also secures alcohol a place on the EU agenda and means that there will be new opportunities for projects and research on alcohol in the EU, which will be an invaluable boost to an often under-funded area.

The proposal from the Commission was unanimously endorsed by the Council of the EU, who warmly welcomed it. The European Parliament (EP) (See Appendix 6), the Economic and Social Committee (ECOSOC) and the Committee of the Regions (COR) have also delivered their opinion on the EU Strategy. Much of Eurocare's work this year has been directed at ensuring that the organisation's views were taken into account during the preparation of the European Parliament's report on the Strategy.

To that end, the Liaison Office provided the Parliamentarians with position papers, background documents, proposals for amendments and voting lists. The staff also set up and attended meetings with the main MEPs involved in the preparation of the report.

In order to raise awareness among the MEPs of the size and nature of the problems related to alcohol as well as to increase their understanding of effective and cost-effective measures, the Brussels office also organized two major events; a seminar on the Alcohol Strategy and a Lunch meeting on FASD.

a) Eurocare Seminar in the European Parliament: An Alcohol Strategy for Europe?

The EUROCARE Seminar brought together representatives from the Commission, the European Parliament, the WHO and the Public Health Community to analyse the virtues and shortcomings of the EU Alcohol Strategy and to discuss key questions, such as its implementation and follow-up.

The event was co-hosted and chaired by the MEPs Ms Anna Hedh, Mr. Manuel Medina Ortega and Ms Åsa Westlund and was opened by the EU Commissioner for Health, Mr Markos Kyprianou. The presentations were given by Dr. Peter Anderson, Dag Rekve (WHO), Ms Monique Kuunders (STAP), Diane Black and Eurocare's Vice-Chairperson, Ms Tiziana Codenotti.

The Seminar can be regarded as a great success, with approximately one hundred participants, 30 of which were MEPs or MEPs' assistants. In addition, several Health Attachés and NGO representatives attended the Seminar. The seminar also prepared the ground for the staff of the Brussels' office to initiate further contact with MEP's.

The report of the Seminar is attached as Appendix 7

b) Lunch meeting on FASD (Foetal Alcohol Spectrum Disorders) in the European Parliament - Strasbourg

To mark the International FASD Day (9 September) Eurocare organised, together with two MEPs from the Netherlands, Mr Jules Maaten and Ms Dorette Corbey, a lunch meeting at the European Parliament in Strasbourg on the 4th of September (See invitation Appendix 8).

The aim of the meeting was to raise awareness among MEPs of Foetal Alcohol Spectrum Disorders (FASD) as well as measures to curb its incidence. Special attention was given to health warning labels on alcohol beverage containers, as this was one of the most controversial measures proposed in the Foglietta report.

The presentations of the two speakers, Dr. K. O'Malley and Dr. N. van der Lely, were followed by a fruitful debate with the MEPs. The meeting, which was scheduled to last 40 minutes, went on for nearly two hours.

Seven of the MEPs present in the meeting took the floor later on in the day during the debate in plenary on the Alcohol Strategy, and referred to the facts and figures that had been presented to them.

Claude Riviere, Member of Eurocare's Policy Group, presented the recommendations of Eurocare on the Alcohol Strategy.

5. Alcohol and Health Forum

Central for the implementation of the Alcohol Strategy, is the setting up of a European Alcohol and Health Forum. The Forum is chaired by the Directorate General for Health and is intended to provide a common platform for stakeholders from Industry and NGOs at EU level that pledge to take upon themselves commitments, and support actions relevant to reducing alcohol-related harm (Charter of the Forum - Appendix 9).

Moreover, representatives of public institutions at global, European and national level committed to supporting the work of the Forum and actively participating in its meetings take part in the work of the Forum as observers.

The Forum has been regarded as a rather controversial issue among the Brussels NGOs from the beginning, and still is now. Some have argued that the Forum is a distraction from the real issues and should be ignored.

This view is not shared by Eurocare, which considers the Forum to be an integral part of the Commission Alcohol Strategy, and the best option to ensure that alcohol related harm remains high on the political agenda in the EU; it is also an opportunity to challenge the industry on their commitments and in a public forum.

However, Eurocare has been aware of the limitations and dangers of the Forum, and meetings were held with Commission officials and representations made to express its concerns and in an attempt to influence developments. During March 2007, there were three formal meetings where the format of the forum was discussed. In addition, Eurocare attended separate meetings with DG SANCO and also gave its opinion both through letters and less formal channels. Additionally, several members of Eurocare participated on behalf of their respective organisations in the formal meetings.

At the half annual General Meeting, in spring 2007, Eurocare and some of its members (IAS, DHS, Eurocare ITALIA, Alcohol Action Ireland, ANPAA, STAAP) signed up as partners of the Forum together; the forum was launched in Brussels on the 7th of June 2007 (see Eurocare's press release attached as Appendix 10).

6. Television without Frontiers Directive

In 2003, the Commission took the initiative to revise the Television without Frontiers Directive, a directive that Eurocare has followed closely, in an attempt to influence policymakers to take a more health friendly approach with regards to advertising.

The need for modernisation of the directive is due to the fact that the audiovisual industry is undergoing major changes, driven by the convergence of technologies and services: traditional (linear) TV, Internet TV, TV on mobile phones and other mobile devices, etc. In the field of television advertising, the television without frontiers directive is the main Community instrument and article 15

sets up some restrictions concerning alcohol advertising. Alcohol advertisements shall – among other things – not be aimed specifically at minors, shall not link the consumption of alcohol to enhanced physical performance, social or sexual success and shall not claim that it is a stimulant, a sedative or a means of resolving personal conflicts.

A cornerstone in Eurocare's position is that article 15 is not sufficient in the way it protects children and young people from the influence of advertising. While article 15 is all about regulating the content of advertising, Eurocare has argued that there is also a need for regulation regarding the volume of advertising. Evidence shows that the industry is now producing advertisements that do not breach article 15 yet their advertisements remain extremely popular among young people. One of the ways in which they achieve this is, for example, through the use of humour, which is not covered by article 15.

Other issues have been the industry's sponsorship, self-regulation and product placement, all of which have been addressed in Eurocare's position papers (Appendix 11 and Appendix 12).

In spring 2006 the Commission presented their proposal for a revised directive and the European Parliament and the Council started their work processing the dossier. From spring 2006 to December 2006 the Brussels office undertook a broad lobby campaign, targeting the Parliament. The campaign was, in the end, focused on a single issue, namely the "not before 9" watershed.

"Audiovisual commercial communications for alcoholic beverages should not be broadcast between 6 a.m.- 9 p.m." (article 15.2)

The campaign was based on the assumption that 6 a.m.9 p.m. was a key period, during which young people were likely to be watching television.

The message was very simple and easy to communicate, which enabled Eurocare to gain support from several MEPs on this campaign. The initiative was supported by the leading European networks of children and family organisations (EUROCHILD, COFACE, EUROPEAN CHILDREN'S NETWORK, EUROSAFE European Child Safety Alliance) and a common position was prepared for the campaign. In addition to the more traditional campaigning, a new website **'**Not before 9' was set up with support from Tamsin Rose. The intention with the campaign was to encourage MEPs to support Amendment 169, which would prevent alcohol advertising on TV before 9.00 p.m. The website contained examples of print and TV advertising for alcohol which illustrate very clearly the need for a watershed (Appendix 13).

Backed by the Swedish MEP Westlund, our amendment, quite surprisingly, reached the voting in plenary but in the end, was not supported by the majority. 185 MEPs voted to block alcohol adverts before 9.00 pm while 430 MEPs decided that alcohol adverts should be permitted during the early evening programming. Taking into consideration that such an amendment very seldom reaches the plenary session, this somewhat disappointing outcome can nevertheless be considered a success. The campaign received a lot of attention within the parliament; the roll call vote enabled us to easily identify 185 MEPs supportive of a more health friendly directive.

Finally, on the 24th of May 2007, after a legislative process of 18 months, the EU Ministers for Culture and the Media managed, by unanimity, to reach a political agreement on the revision of the Television Without Frontiers Directive.

The text agreed by the Council has been pre-negotiated with the European Parliament, in accordance with the joint inter-institutional declaration on practical arrangements for the co-decision procedure. It is expected that the common position formalizing the Ministers political agreement, will be adopted by the European Parliament with no amendments.

The new Directive should enter into force by the end of 2007.

The new directive reduces the quantitative limits on advertising to a minimum and makes them more flexible. Daily advertising limits are to be removed and hourly advertising rules are to be simplified.

As far as product placement is concerned, Germany was unfortunately unable to fully enforce its' demand for a total ban. The compromise they reached aims to protect consumers, by virtue of clear identification requirements, and to safeguard editorial independence. Product placement will be banned in programmes for children.

With regards to alcohol advertising, a new article, article 3 d, applicable to both linear and non-linear services, has been introduced. The new article establishes that Member States shall ensure that audiovisual commercial communications (i.e. TV advertising, teleshopping, sponsorship and product placement) for alcoholic beverages "must not be aimed specifically at minors and may not encourage immoderate consumption of such beverages".

Article 15, that regulates television advertising and teleshopping for alcoholic beverages on linear services, remains untouched.

7. Minimum Excise Duties

On 8 September 2006, the Commission adopted a proposal to update the existing Directive 92/84/EEC on the approximation of the rates of excise duty on alcohol and alcoholic beverages by increasing the minimum rates in order to take account of inflation and restore their real value agreed by Council in 1992.

In fact, the majority of Member States are unaffected by this proposal as their national rates already exceed the proposed new minimum rates. Although the inflation rate is 31%, the actual impact on prices in the countries affected by the decision will be minimal, for example, for beer, the biggest required increase in national excise duty would be of the order of € 0.01 (one eurocent) on half a litre of beer.

In November last year, the EU Finance Ministers examined the Commission's proposed adjustments but failed to reach an agreement so they decided to delay the decision and invited the Commission to carry out a comprehensive study of the taxation of alcohol and alcoholic beverages, including trends in competitive positions and in levels of taxes and prices.

The results of that study were to be presented to the Council during the second half of 2007, with a view to facilitating further Council decision-making as regards alcohol taxation.

Although the issue of taxation is a matter for the Council to decide, the Parliament is asked to give their opinion. Eurocare has been following this discussions and given its views through letters to the MEPs and press releases (Appendixes 14 and 15).

8. Labelling

On the 18th of June 2007 the European Parliament adopted an amended report on the definition, description, presentation and labelling of spirit drinks by Hors Schnellhardt (EPP-ED, DE).

Although in the introduction, the resolution from the Parliament establishes that the measures applicable to the spirits drinks sector should contribute to the attainment of a high level of consumer protection, the text does not contain any references to health warnings on labels or ingredient listing.

Eurocare gave its view to the white paper through an open consultation in July 2006. The main arguments were that all beverages containing alcohol should carry labelling that includes food improvement agents, as well as sulphites and any other ingredients that might lead to allergies, as consumers have a right to know what is contained in such products. Alcoholic products should also

contain information on the total grams of alcohol in the can/bottle and not just on its alcohol concentration (% by volume) as this is difficult to understand for the average consumer.

9. Eurobarometer Special Report on Attitudes towards alcohol

On 14 March, the European Commission released a Eurobarometer Special Report analysing EU's citizens alcohol drinking habits and their attitudes towards measures taken to combat alcohol-related harm.

The report showed that a remarkably high percentage of EU citizens (75%) had drunk alcoholic beverages during the past 12 months, of which a large majority (87%) have done so within the past 30 days. The survey also showed that the youngest respondents seemed to be more inclined to drink 3 to 4 drinks or more on any given drinking occasion, they also appeared to be the most susceptible to price fluctuations, with nearly half of them claiming that they would buy less alcoholic beverages if the price would increased considerably.

Certain measures aimed at combating alcohol related harm received widespread support. Around three quarters of EU citizens would agree with putting warnings on the containers of alcoholic beverages, introducing lower blood alcohol level for young drivers or banning alcohol advertising which targets young people. Banning the sale and serving of alcohol to people under the age of 18 was regarded as an important measure by 87% of the Europeans surveyed.

Find Eurocare's press release attached as Appendix 16.

10. Eurocare responses to Consultations

a) WHO Consultation: In September 2006, Eurocare sent its' submission to the consultation launched by the WHO Secretariat, seeking the views and opinions of stakeholders on health problems related to alcohol consumption and effective interventions needed at national, regional and global levels to reduce such problems (Appendix 17).

b) Market Access Hearing: In January 2007, Eurocare sent its submission to EU Public Consultation on the EU's market access Strategy in a Changing Global Economy. The aim was to put forward public health concerns linked to trade in alcoholic beverages (Appendix 18).

11. Workshop on Harmful social consequences of alcohol

During EPHA's conference in Bratislava (19th and 20th of April 2007), Eurocare organised a workshop on harmful social consequences of alcohol – addressing poverty, homelessness, social exclusion, health inequalities, child abuse and neglect, and violence. The social harm done by alcohol has a different character, and is in some areas indeed greater than, in economies in transition, due to the fact that health and welfare services are less developed and living conditions and income at a lower standard.

The event was chaired by Anders Ulstein and presentations were made by Emilie Rapley(Eurocare), Adrian Bonner (director of the Addictive Behaviour Group, Division of Psychiatry, University of Kent, England), Hana Sovinova (M.D. National Institute of Public Health, Czech Republic), Professor Jerzy Mellibruda (Institute of Health Psychology, Poland), Derbal Murphy (FEANTSA) and John Mac-en-Leisdeir (chairman of EMNA).

12. Court decisions

a) The ECJ concludes that Sweden's ban on private import restrictions cannot be justified

Luxembourg, 5 June. The European Court of Justice (ECJ) ruled that Sweden's ban on private consumers importing alcoholic beverages is to be considered as an "unjustified quantitative import restriction on the free movement of goods" according to EU law. It also stated that the restriction on private import cannot be justified by claims that it reduces alcohol consumption and that the measure is not proportionate for the objective of protecting young persons from the harmful effects of alcohol. The judgment came as a surprise to many, after the court's advocate general recommended, twice last year, that the European Court uphold Swedish law.

Under Swedish law, alcohol imports are only permitted by the retail monopoly Systembolaget. Private individuals are not allowed to import alcoholic beverages. This means that individuals have to go through the monopoly to import alcoholic beverages.

b) The Commission vs The Netherlands

On 23 November 2006, the European Court of justice ruled that only products acquired by private individuals for their own use, and transported personally by the private individual that purchased them, are exempt from excise duty in the member state of importation. A ruling in a different direction would have meant that private individuals from countries with high excise duties could via internet or telephone buy cheap alcoholic beverages in other EU states and have them delivered to their door while only the duty levied in the country of purchase is paid.

APPENDIX 1

EVALUATION REPORT

Bridging the Gap project

Introduction

1. The Bridging the Gap (BtG) project was a three-year project from 2004 to 2006 run by Eurocare[1] and co-financed by the European Commission. The original call for tender from the Commission primarily asked for a project to *"establish a network of expert organisations to support the implementation of the Council Recommendation on the drinking of alcohol by young people and to contribute to further development of a Community strategy to reduce alcohol-related harm."*
2. However, the final project included several other deliverables, such as advocacy training, country visits and the creation of country profiles. This report begins by describing the evaluation methodology, before looking at each of the deliverables in turn. The report concludes by evaluating the project as a whole, and suggesting priorities for future Commission-funded projects on alcohol.

Methodology

3. The evaluation is based upon a case study evaluation methodology (Yin 2003), treating the case as one of intrinsic interest, rather than being generalisable to a larger type. This evaluation can be thought of as a 'process evaluation' rather than an 'outcome' evaluation – that is, it describes the experience and views of the evaluator and project participants, but does not attempt to quantitatively estimate the outcome of the project on pre-specified indicators. Only a process evaluation is possible here given the nature and goals of the project, which were to create specific short-term deliverables as a small part of a long-term and less-defined goal.
4. In practice this means that the project and its surrounding context are investigated using multiple methods, namely:
    - 4.1. ***Network survey*** of all Alcohol Policy Network (APN) members, undertaken in a way to ensure anonymity and maximise response rates. 29 responses have been used in the analysis (including some multiple responses from individual countries), covering 26 of the 29 countries involved in the project.[2]
    - 4.2. ***Advocacy survey*** for all attendees of the advocacy school, undertaken in a way to ensure anonymity and maximise response rates. 36 responses have been used in the analysis, out of the 46 attendees on the course (a response rate of 78%).[3]
    - 4.3. ***Depth interviews***: a series of four depth interviews with the staff who were involved in running the project over the 3 years.
    - 4.4. ***Informal interviews*** with APN members during the Helsinki conference and with European Youth Forum representatives in early 2007.
    - 4.5. ***Workshop*** with the full APN at the final official APN meeting, led by the evaluator with no BtG staff present (see Appendix 3 for the topic guide).
    - 4.6. ***Discussion*** during a session with the APN members who attended the Helsinki conference, led by the BtG coordinator Peter Anderson.

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[1] Eurocare – the European Alcohol Policy Alliance is the leading European NGO network on reducing alcohol-related harm; see www.eurocare.org

[2] All quantitative results in this report are taken from the survey results unless otherwise indicated. Technically 30 countries were involved in the project, but no member could be found for Cyprus at any point in the project. The survey instrument is attached in Appendix 1 to this evaluation. Both this and the network survey were piloted on 1-2 respondents before use.

[3] Note that there were in fact 47 attendees on the course, but one response covered two attendees from the same organisation. The survey instrument is attached in Appendix 3; descriptive statistics from survey are given in Appendix 2 to this evaluation.

4.7. ***Written documentation*** produced in the course of the project, including the original project outline, minutes of four APN meetings, two interim reports, and the project coordinator's own evaluation of the advocacy schools.

4.8. ***Participant observation*** of the evaluator throughout the project, including attendance at the Warsaw and Helsinki conferences and the three official APN meetings, as well as at the first advocacy school in Copenhagen and one of the European Youth Forum working group meetings.

4.9. ***Respondent validation***: Eurocare staff and APN members were invited to comment on a draft version of this report. These comments were then used as a further form of evidence in their own right.

5. These multiple different sources tended to confirm one another; where this was not the case this is discussed in the report.

The Alcohol Policy Network (APN)

6. Building the network involved three different sets of activities. Firstly, potential partners were found for each country and invited to commit to participating in the APN. In most countries this was a simple task, but difficulties were sometimes experienced. In some smaller countries with a lower number of staff working in this area, it was either impossible to find an APN participant (Cyprus) or the APN members found it difficult to spare the time required to participate as fully as other members (Luxembourg, Malta). There were also problems in Poland where three different individuals were members of the network at different points during the project.
7. Secondly, the APN came together for three main meetings (Warsaw, Poland, 15-16th June 2004; Bled, Slovenia, 19th-21st May 2005; Barcelona, Spain, 11th-13th May 2006) and one shorter meeting (at the Helsinki conference, 22nd November 2006) during the project. The APN appeared very happy with the organisation of these meetings, although they were slightly less happy – although still overwhelmingly contented – with the way that decisions were made during the meetings.[4] The only slight problems seem to relate to the compressed agendas within the meetings, which many members felt reduced the time available for discussion. Some BtG staff separately noted that they could have involved APN members to a greater extent in the meetings. While first meeting proceeded on the basis of members being allocated to one of three task forces overseeing different strands of the project, the changing nature of the youth strand (see below) meant that this was not continued at later meetings. Despite this, it is clear that most staff and APN members felt the meetings worked well in building the network.
8. Finally, the network continued to function between meetings, when the BtG staff were frequently in contact with the APN. Network members were happy with the level of contact,[5] although some staff sometimes felt that it was difficult to get many responses for some pressing tasks. The lower level of contact between APN members was the worst aspect of the network from their point of view – although once again, the numbers reporting happiness with this aspect of the project are much more than this reporting unhappiness.[6]
9. Overall, the task of building the network was seen as the main priority for the project by BtG staff and APN members alike, and the consensus view was that this had been done well (indeed, the network is increasingly referred to in the publications of other organisations, such as the WHO's Framework for Alcohol Policy in Europe). There were slight differences however, in that members from Government bodies and BtG staff both saw this as being done 'very well', while those from

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[4] *27 were happy vs. 0 unhappy for the organisation of the meetings; 19 were happy vs. 2 unhappy for the way that decisions were made during the meetings (all results refer to the 29 APN respondents unless otherwise specified). Those not reported as happy or unhappy replied that they were 'neither happy nor unhappy'. Full tables of the responses to each question, together with the exact text of the questions asked, are available in appendices 1 and 2.*

[5] *21 happy vs. 1 unhappy for the happiness with 'communication with the BtG team between meetings'*

[6] *13 happy vs. 2 unhappy for the happiness with 'communication with other APN members between meetings'*

NGOs and 'Other' organisations tended to feel that this had been done only 'fairly well'.[7] The most likely explanation here is that NGOs were already involved in a European network (Eurocare), while the Governmental organisations were involved in a network for the first time and were therefore happier at the very existence of the network.

10. Despite the widespread feeling of accomplishment in building the network, most Eurocare staff and Government APN members felt that widening the coalition to other groups was a priority. Nevertheless, all types of APN members saw maintaining the network as the highest priority for future EU projects,[8] and the strongest feeling from all groups was that this aspect of the project had been successful.

Conferences

11. As well as asking for the creation of a network, the original call for tender asked for projects to *"initiate preparation of a conference on alcohol, health and society to be held in 2005."* In the accepted proposal this was moved to 2004, and took the form of the *Alcohol Policymaking in the Context of a Larger Europe - "Bridging the Gap"* conference in Warsaw on 16-19th June 2004, which was also supported by the Ministry of Health of Poland and the Polish State Agency for Prevention of Alcohol Problems.[9] This immediately followed the 2004 APN meeting, ensuring the active participation of the network in the conference.
12. A further conference connected to the project took place in Helsinki on 20th-22nd November 2006. While the conference was in partnership with Bridging the Gap and worked closely with the APN, it was separately funded by the Ministry of Health of Finland and the Finnish Centre for Health Promotion. For this reason it is not evaluated in any detail in this report, although a separate evaluation has been undertaken by the conference organisers. However, some APN members briefly mentioned the Helsinki conference in their replies, generally suggesting that it had many of the same strengths of the Warsaw conference. Some BtG project funding was used in place of country visits to certain countries, and this is covered under the 'country visits' section below.
13. In organisational terms, both BtG staff and APN members were very satisfied with how the ***Warsaw conference*** went, particularly those from the new Member States. APN members were similarly content with the presentations and workshops at the conference.[10] Nearly 400 participants attended from 32 countries, following a marketing campaign using the APN members to attract country delegations – with the result of what BtG staff suggested was one of the largest ever European conferences on alcohol policy.
14. More broadly, all BtG staff stressed the importance of the conference in terms of the other aspects of the project, particularly the building of the APN and to 'bridge the gap' between the old and new EU Member States. One APN member noted that they had not expected "that common experiences like the two conferences, means that much in giving a common understanding and work platform in the few conference days." Other benefits of the conference were also mentioned, including creating a 'loud noise' to put alcohol higher up the EU agenda, and particularly getting people from within the same country to come together for the first time.
15. While nearly all the feedback on the conference was positive, some BtG staff noted that there could have been a more developed media strategy for the national level, and that the large effort needed to organise the conference may have delayed other activities within the project. Holding major conferences in future was not seen by APN members as a high priority for future projects[11] – possibly because the questionnaire was completed within one month of the Helsinki conference

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[7] This difference between NGOs and Government organisations is further supported by considering that NGOs were only about half as likely (compared to Government organisations) to mention networking in some form as the greatest achievement of the project.

[8] *One of the top 3 priorities for 20 of 28 respondents, and the highest priority of the 9 possible options.*

[9] See http://www.eurocare.org/btg/conf0604/index.html for the programme, participants list, opening speeches, many papers and presentations and the final press release.

[10] *When asked for their happiness with 'the organisation of the Warsaw conference in 2004', 25 were happy vs. 0 unhappy. When asked for their happiness with 'the presentations and workshops at the Warsaw conference', 23 were happy vs. 0 unhappy.*

[11] *'Holding major conferences' was the 6th highest priority of 9 potential priorities, mentioned by 6 members.*

– but many advocacy school attendees felt that regular conferences would help them carry through their intentions to do more advocacy work.

16. In the original proposal, it was planned to endorse a charter at the conference, but for practical reasons it was agreed that this became the document ***A Policy on Alcohol for Europe: Bridging the Gap principles*** ('the principles'). These were agreed at the APN meeting immediately prior to the conference, and summarize a set of alcohol policy issues that the APN believed should be considered throughout Europe. BtG staff were happy with the principles themselves, but felt that the dissemination of these had been done poorly – there was no media strategy, and it was not linked to other deliverables such as the advocacy course. Some staff and APN members suggested that the planned functions of the principles were superseded by the *Alcohol in Europe* report, which had not been anticipated at the beginning of the project. Nevertheless, the principles were translated into Romanian and Spanish, and several APN members noted that they had found these very useful. For example, the Association of the European Regions used the principles in formulating their policy on alcohol, and two APN members cited them as one of the biggest achievements of the project. At the present time the principles are being revised, and will be re-launched during 2007.
17. One aspect of the project added by the BtG team to the original call for tender was the 'horizontal **role of culture**', through theatre sketches, puppets and sketches at the Warsaw conference. The interactive theatre sketches, "Alcoholiens," were prepared by the Polish Association Wybrzezak, in partnership with the European Cultural Foundation, and also aimed to increase young people's participation in and understanding of alcohol issues. The performance (in English) at the conference was widely – although not uniformly – seen to be unsuccessful, possibly due to a lack of communication between the creators and the APN leading to a misunderstanding of the expectations of conference participants. With the very different audiences of young people, however, the sketches were reported to be more successful, being presented at international conferences in Croatia and Estonia, and (in Polish) to 1,100 14-18 year olds (funded by the City of Gdynia). The other cultural activities also had varying degrees of success, reflecting their relatively unpredictable nature. The conference drawings were rarely mentioned, and were not positively discussed when they arose. In contrast, the series of short puppet sketches that satirised the point of view of a drinks company chief executive on each session's topic were very popular, and were retained for the Helsinki conference.

Country profiles

18. The original vision for this strand of work in the accepted proposal was to produce a "report of mapping of current alcohol policy, identifying barriers and facilitators in all Member States and applicant countries." Due to time constraints, this was revised to providing four documents for each country:
    - 18.1. ***An alcohol profile*** – based on profiles from the 2004 WHO Global Status Report on Alcohol.
    - 18.2. ***An alcohol policy summary*** – based on profiles from the 2004 WHO Global Status Report on Alcohol Policies.
    - 18.3. ***A resource of alcohol policy infrastructures*** – a resource of documents, laws and links relating to multiple domains of alcohol policy (e.g. Governmental policy document on drink-driving), in collaboration with the International Union for Health Promotion and Education.
    - 18.4. ***A report on 20th century alcohol policy in the national context*** – based on the profiles from the 2002 European Comparative Alcohol Study (ECAS), and undertaken in collaboration with the National Research and Development Centre for Welfare and Health (STAKES) of Finland. This also included responses to a standardized questionnaire to construct a BtG policy scale.
19. Where the profiles already existed, APN members were asked to spend make sure that these were updated and correct. Where profiles did not already exist – particularly in the new Member States that were not involved in the original ECAS project – the members were asked to complete the profiles according to the agreed template. By the end of 2006, 26 countries had completed the WHO profiles, 23 the ECAS-based profiles, and 17 the infrastructures questionnaires (of 29

countries that have had APN members at some point during the project), and were paid for this work accordingly. However, most APN members also translated the summary of the *Alcohol in Europe* report as an extra, unfunded task.

20. This variation in the size of the task given to each member, combined with different levels of familiarity with country data sources between members, helps to explain the substantial differences in the difficulty experienced and time spent completing this work. Even for the easiest task (the WHO policy profile), as many members found this easy as difficult to complete, while most members found completing the ECAS profile difficult. Several respondents reported that it was not easy to estimate the time involved, but estimation errors are unlikely to explain why 10 members reported spending 15-or-more days on the profiles while 8 members reported less-than-10 days. Surprisingly, though, countries involved in the ECAS project spent longer completing the questionnaires than others – suggesting that it was the amount of information available within a country that made the task harder, rather than a lack of previous reviews.
21. Nearly all APN members reported personally using the country profiles available on the BtG website, and most also reported that their national colleagues knew the information was available.[12] A slightly smaller majority reported using the HP Source website for the information on alcohol policy infrastructures.[13] The country profiles were also used in writing the *Alcohol in Europe* report (see below), while the more detailed profiles together with the other questionnaires will be used by STAKES to produce scientific publications early in 2007.
22. Despite the difficulties in providing the information, BtG staff and APN members alike were happy with the results produced, and APN members were happy with the way their responsibilities were explained. The reports were seen as a valuable tool in enabling comparisons between countries, while the process of compiling the reports also increased the expertise within the network. Regarding future work, APN members estimated that it would take them 9 days per year to update the profiles, compared to the 19 days it took them to complete them within the project, and suggested that bodies such as the Commission and the WHO should work together to minimise duplication in data collection.

Country visits

23. As part of the project's overall aim of 'bridging the gap' between regions of the EU, 'technical policy visits' were planned to each of the 10 new EU member states to help with understanding of the EU's relationship to alcohol issues, to provide technical advice on alcohol policies, and to strengthen the role of NGOs. Only 6 of these visits were ultimately carried out – to Estonia, Latvia, Lithuania, Poland, Slovenia and Turkey – of which the Polish and Slovenian meetings occurred during the preparation for the APN meetings in 2004 and 2005 respectively. The visits that occurred appeared to have been successful in bringing together organisations from multiple different areas of work. At the Lithuanian visit, for example, BtG staff met representatives from 6 NGOs and 6 Government departments covering multiple policy domains, while the Turkish workshop involved staff from 9 departments or Governmental bodies among other participants.[14] APN members from several of the countries involved reported how important the visits had been, in both catalysing national action and in supporting embryonic NGOs.
24. While timetable clashes played a small part in the non-completion of the final two visits,[15] the main reason for the missing visits appears to have been internal difficulties among the BtG staff (discussed in more detail below). Nevertheless, those countries that were not visited were offered the opportunity to use project funds to bring a country delegation to the Helsinki conference, as were the other members from the new Member States and candidate countries. This resulted in 47 people being funded to attend the Helsinki conference, consisting of 2-6 people from each of

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[12] The WHO profiles and the standardized BtG policy questionnaire are available on the project website (and the ECAS questionnaires will also be available in early 2007); the infrastructures document is available from the HP Source website (http://www.hp-source.net/dataoutput.html?module=btg).

[13] *17 members reported using the infrastructures questionnaires, while 25 reported using the BtG country profiles.*

[14] Detailed lists of attendees at these meetings are attached to the yearly BtG reports.

[15] Cyprus and Malta were also not visited, but this primarily results from the absence of an APN member in Cyprus and the severe time constraints on the participation of the Malta member.

Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia and Turkey. Some APN members reported that this had been very useful in developing relationships with people working on alcohol in different areas, and seemed likely to help future national-level collaborations – effects which sound similar to those reported for the visits themselves. Nevertheless, the four countries not receiving a country visit clearly received less support from the BtG team than those countries receiving both a visit and funded places to attend the Helsinki conference.

25. With respect to the more general aim of 'bridging the gap' between different regions of Europe, all BtG staff and a general consensus among the APN suggested that this had been achieved successfully. However, one APN member commented that there was still more work to be done, in that most of the experts involved in the conferences were still from the old Member States.

Young people

26. Aside from the network plan outlined on page 1, the original call for tender also asked proposals to *"promote the involvement of young people in the development of alcohol policies and activities - a priority of the Council Recommendation on alcohol and young people."* In response, the original proposal put forward an "alcohol policy questionnaire to be produced and distributed by young people for young people," with the European Youth Forum (EYF) – a well recognised international body representing the voice of young people across Europe – involved in the APN.
27. This itself changed during the course of the project, for two reasons. Firstly, the original funding partner pulled out from supporting the project, and was replaced by the Norwegian and Swedish Governments who explicitly funded the youth work and gave additional funds to allow the EYF to produce their own report on alcohol. Secondly, the youth involvement was developed during the course of the project so that most of this strand of work was owned by and carried out by the EYF themselves. These reasons combined in making the youth strand separate from most of the rest of the project – and thereby less involved in the network that most APN members – explaining why this strand is evaluated in slightly less detail here.
28. Nevertheless, from interviews with those involved and documentary evidence, a broad picture of the youth work can be outlined. The EYF created a working party (including a BtG staff representative and an expert in research with young people, Ann Hope) to help design the questionnaire and also to go beyond this and write a working group report on alcohol. This working group met three times during 2005-6, and also conducted several teleconferences. Questionnaires were received from EYF member organisations in 16 EU countries and 6 non-EU countries, and a report of the methodology and results was produced by Ann Hope at the end of 2006. An interim report from the group was sent to the European Commission during the run-up to the alcohol strategy in March 2006, and a final report was completed in October 2006 (although it will be published and distributed further in early 2007). A youth advocacy school was also run in Helsinki in November 2006, following which 9-10 EYF members stayed on for the Helsinki conference.
29. APN members and BtG staff were unanimously very happy with the youth involvement in the project in general and the quality of the young people involved, with one staff member seeing this as one of the most important long-term successes of the project. Aside from the interest in the results of the questionnaire themselves, those involved felt that the process of sending out the questionnaire and circulating the report had helped to raise awareness among EYF member organisations. The EYF themselves were also involved in the Commission-instigated European Policy Centre roundtable discussions, as well as their submissions during the process leading to the EU Alcohol Strategy. This may be evidence of the project's effect in increasing young people's involvement, although it is difficult to estimate the extent to which the EYF would have been involved in these debates without this.

Advocacy training

30. While not in the original call for tender, the idea of advocacy training had been around for several years among the BtG staff who had felt that there was a need to improve alcohol advocacy skills within Europe. The original proposal therefore aimed to produce two deliverables – two advocacy training schools, and an alcohol advocacy policy manual. The training manual was being finalised

as this report was being written (although it was originally planned to be available for review by the APN members from January 2005), and it is therefore not possible to evaluate the manual itself here; the rest of this section is therefore concerned with the advocacy training schools.

31. In practice, four rather than two advocacy training schools took place – a 2½ day pilot with primarily APN members in Bled (30 attendees; May 2005); two 3½ day schools in Copenhagen (24 attendees; February 2006) and Barcelona (23 attendees; May 2006); and a 2½ day youth advocacy school with a specialist youth trainer and the help of an alcohol expert in Helsinki (19 attendees; November 2006). However, because the maximum numbers at each school were lowered from the original plan of 66 attendees per school, the total number of people receiving advocacy training was lower than expected.

32. It was decided that it was not appropriate to evaluate the pilot project as this aimed to improve the outcomes for the final advocacy schools, rather than to achieve any specific goals in its own rights. The youth school is also evaluated differently to the other schools, as it was re-designed by a different trainer to be youth-focused, was shorter than the other schools, and was undertaken, funded and evaluated independently of the main project as part of the youth strand (see above). The EYF's own evaluation of the course was positive, as was those of the BtG staff and EYF representatives involved, and this positive effect was enhanced by the opportunity for some of those attending to relate the training to the Helsinki conference which followed. Nevertheless, these positive reports were tempered by the difficulty in meeting the varied expectations of the diverse group who attended, the over-representation of those groups with a long-standing interest in alcohol issues, and many people felt that the duration of the course was too short. While several of those involved expressed a strong desire to repeat this course in future, no final agreement on these has yet been reached.

33. The attendees themselves were from a mixture of NGOs and Governmental bodies, and also split between those working on alcohol only and those working within the wider public health field. All trainees seemed to have been personally motivated to attend the course, explaining their attendance through the expected value of the course in their present work or for general skills in future, rather than because of pressure from their manager.[16] The work experience of the attendees seemed to change between the two courses, however, with Copenhagen attendees having 3 years of experience compared to 7 years for Barcelona attendees – moving further away from the original target group of those 'who are relatively new to the alcohol policy field'. The APN suggested that there was a need to create criteria for future attendees to restrict attendance to only those with low levels of advocacy experience who would be happy to pass the skills gained on to others.

34. Attendees were very happy with nearly all aspects of the organisation of the course.[17] The methods of teaching in the course were also generally welcomed, with the most common opinion of the different methods being that the level was 'about right'. However, there was a slight trend for attendees to have preferred more time learning skills (e.g. planning advocacy campaigns) compared to time spent on quizzes, group exercises and using planning tools. Some BtG staff and APN members also suggested that other advocates and experiences from within the network could have been used within the courses, rather than relying on a single expert trainer.

35. A variety of aims were seen as important by the advocacy school attendees, including both knowledge (effective policies, other countries' experiences) and skills (working more effectively, developing a strategy, building coalitions) as well as meeting new people. Learning how to give effective interviews to the media was seen as slightly less important, mainly because this was not as relevant to those working within Government.[18] Most of these were seen as being achieved

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[16] *3 respondents replied that the fact that 'My manager wanted me to attend' was a reason behind their attendance – but in all cases they also replied that they thought the course would be useful for their work.*

[17] *An average of 1.2 to 1.5 on a 5-point scale for each of the general organisation, the social activities, and the financial arrangements. Happiness was slightly less but still high for the number of people (1.7) and the amount of work to do before attending the course (1.9).*

[18] *'Know how to give effective interviews to the media' received the lowest importance score of all the aims (an average of 2.4 on a 5-point scale where 1 = Very important and 5 = Not important, compared to 1.7 to 2.0 for the others), although there were still many more individuals saying it was important (<3; 20 people) compared to saying it was unimportant (>3; 5 people).*

well, and two of them were seen as being done particularly well – learning about harm/policies, and understanding alcohol industry views.[19]

36. At the end of the course, most attendees reported intending to share the knowledge and skills gained with colleagues, and also to exchange information with the people they met on the course. These were commonly achieved by the end of 2006, with over half of the attendees saying they shared knowledge/skills with others, and about one-quarter saying they had kept in contact with people from the course (although sometimes only those within their country).[20] Many attendees also said they were likely become more active in media advocacy, with around half of those managing it by the end of 2006.[21] APN members also suggested that many attendees had used the skills learnt on the course, although they were less aware that the skills had been shared with colleagues.
37. The weakest intentions were for planning an advocacy strategy around the release of the *Alcohol in Europe* report – although most of those saying they would do this had achieved it during 2006 – and for building a coalition or developing a media plan, neither of which was reported as achieved by any attendees. The majority of attendees also said that an email list for people on the course, a BtG alcohol advocacy newsletter, and regular European alcohol advocacy conferences would all have helped them carried out more of their intentions following the course.[22]
38. Overall, the attendees were very happy with the course, with over three-quarters saying they would 'definitely' recommend it to a colleague, and nearly all saying that they had found that there were 'much more benefits than costs' in attending.[23] APN members similarly noted that both they and the people who attended were very happy with the course. The course organiser noted that there was a potential to use the courses as a catalyst to promote more advocacy work within a country, and that the courses would be modified in future to 'training the trainers' who could cascade the courses to a greater number of individuals (including those who do not speak English).

General advocacy

39. As well as 'bridging the gap' between different regions of Europe, the project also aimed to bridge the gap between evidence and policy. 'Advocating for evidence-based policy' and 'Influencing EU activities on alcohol' were some of the more important project aims according to the APN members (particularly those from the old Member States), and were also mentioned by BtG staff. Similarly, representatives of the WHO and European Commission noted the importance of broad coalitions building the pressure on Member States to act in reducing alcohol-related harm.
40. While more APN members felt that this had been done 'well' than those saying it had been done 'not well', these were the lowest average success scores out of the 7 aims members could choose from.[24] Similarly, advocacy – either in general, or referring particular to the EU – was the most

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[19] *These two areas had an average of 1.8 on the 5-point scale (1=Very well, 5=Not well), compared to 2.2 to 2.4 among the other areas.*

[20] *29-30 attendees (of 36 respondents) said they would probably or definitely share skills/knowledge, and 26 said they would probably/definitely keep in contact with people from the course. By the end of 2006, 17 (of 31 replying to this question) had shared skills/knowledge, and 8 had kept in contact with other people from the course.*

[21] *17-18 attendees (of 36) said they would probably/definitely develop a strategy and become more active in media advocacy. By the end of 2006, 10 had become more active in media advocacy and 7 had made steps towards creating a strategy in their organisation, although this had not always been completed yet.*

[22] *All three suggestions were approved by 20-22 respondents (see Appendix for exact frequencies). Substantial minorities of respondents also said that reminders of key learnings points from the course and the support of a country-based coalition*

[23] *29 of 36 attendees said they would definitely recommend the course to a colleague, with 6 saying they probably would and only 1 saying 'Maybe' (none said they were unlikely to). Similarly, 29 of 36 attendees said there were 'much more benefits than costs' in attending, with 3 saying there was 'a little more' and 3 saying that the costs and benefits of attending were 'about the same'.*

[24] *14 saying this had been done well vs. 3 done not well for advocacy; 9 well vs. 4 not well for influencing the EU. These had averages of 2.4 and 2.7 respectively on a 5-point scale (1=Very well, 5=Not well), compared to 1.9 to 2.2 for the other five areas.*

commonly mentioned failing or missed opportunity of the project,[25] and was the 3rd highest of the 9 possible priorities for future work.

41. In one sense this perception of failure – or *relative* failure, given that most APN members still felt this was done well – is unsurprising, given that the EU strategy on alcohol had been released only just before the evaluation questionnaire was completed, and that many APN members were disappointed with the content of the strategy. Yet even before the strategy had been released, some APN members had mentioned that too few political experts and politicians had been involved in the project. In contrast, all BtG staff felt that the gap between evidence and policy had been narrowed, particularly through the APN members press work for the release of the *Alcohol in Europe* report, but also in the sense that alcohol was much higher on the EU agenda – and with a better understanding of effective policies – at the end of the project than at the start. Several APN members also mentioned how the project had helped them with advocacy work within their own countries, or that it had increased the pressure for domestic action.

Capacity, knowledge and motivation

42. An implicit goal of the network was to increase the capacity of members to act on alcohol *within* their own countries. APN members themselves saw increasing knowledge (of other countries' experiences, of evidence-based policies, and of EU activities on alcohol), and to a lesser extent increasing motivation/capacity, as important aims of the project.[26] This was particularly true for the new Member States, where increased knowledge (of both what works, and of EU activities) were the most important aims for the project behind building the network. In practice, only 1 member suggested that most of these were done less than 'quite well' (with the rest spread from 'quite well' to 'very well'), although 3 members felt this for 'increasing knowledge of other countries' experiences'.

43. While it was generally agreed that some of the effects of the project will not be seen for a further 1-2 years, most members reported that the project had already helped them in their day-to-day work, in a wide variety of ways.[27] Most members felt that it had helped them build networks within their own countries,[28] which many members and BtG staff felt would strengthen the BtG as a whole. Several countries reported holding BtG-related national conferences, while probably the strongest development was in Denmark – here a national BtG network was formed containing multiple tiers of government officials, NGOs, researchers and prevention workers working together over a sustained period.

44. Some members also felt that the project had helped with their own organisation's credibility, either with other organisations or with the media. The knowledge gained from being part of the network was also used by many members, either personally or by using the many documents provided (e.g. the principles, the *Alcohol in Europe* report), and several members reported that the project had spread an understanding of evidence-based alcohol policy more widely in their country.[29] The provision of knowledge was a high priority for future work according to APN members – 16 of 28 members mentioned this in some form, either in terms of providing more knowledge on evidence-based policies, or in providing information on alcohol in the EU.[30]

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[25] *Noted by 7 APN members of the 21 who provided responses to the open question.*

[26] *23-25 important vs. 1-2 not important for the various knowledge responses; 22 important vs. 3 not important for motivation/capacity.*

[27] *23 respondents replied positively when asked "Has being part of the BtG project helped in any way in your day-to-day work within your country."*

[28] *22 of 28 respondents in the closed question; 20 of 22 respondents in the open question.*

[29] *In response to the open question on how the project was used, 9 of 22 respondents mentioned using the knowledge personally, and 5 mentioned using documents obtained through the project.*

[30] *10 respondents replied that 'providing knowledge on 'what works' was one of their top 3 priorities for future projects, and 10 also felt this for 'Providing information on alcohol in the EU'. 4 respondents mentioned both of these as priorities, and 16 respondents mentioned one or the other.*

Other areas

45. APN members were generally quite happy with the **BtG website**.[31] While BtG staff agreed that this achieved the minimum requirements and the website officer had worked effectively, they also felt that it was far short of their vision for the website, and suggested that it should have been strategically managed more effectively.

46. As outlined in the original proposal, the project liaised well with **other Commission-funded projects** on alcohol. Representatives from the Primary Health Care European Project on Alcohol (PHEPA), Enforcement of National Laws and Self-Regulation on Advertising and Marketing of Alcohol (ELSA) and Pathways for Health Project (PHP) gave information to APN members during the network meetings. The PHP project itself used the APN to collect information as part of the project, both saving the expense of building a new network and adding to the expertise of the existing network.

47. A further Commission-funded piece of work that was integrated into the project was the ***Alcohol in Europe* report**, written by Peter Anderson (the BtG coordinator) and the present author. The authors received the network's help in ensuring up-to-date information for the report, translating the summary of the report into each of the EU languages, and also used one of the APN meetings as one of the consultations on the draft report. In return, the network received several presentations on the contents of the report, and the Eurocare office in Brussels coordinated press releases across the EU as the report was released. Several APN members mentioned the report as an unexpected bonus or as helping with work within their country, while some of the BtG staff noted how this advocacy showed the strength of the network.

48. From the perspective of **Eurocare** itself, the project was seen as a success in terms of developing the relationship with the European Commission and increasing the strength of the NGO network in the new Member States. Nevertheless, some NGOs who were members of both Eurocare and the APN expressed concerns as to the extent to which the APN catered for the special needs of NGOs, and they and some BtG staff noted that NGOs appeared inhibited in expressing their concerns within the project. This may be a further factor in explaining why NGOs thought the building of the network had been done 'well' (rather than 'very well' according to the other APN members). It was suggested that there needed to be greater clarity about the symbiotic relationship between the APN and Eurocare network, particularly given the partial overlap in membership, and that future projects should be more sensitive to the different needs of NGOs rather than Governmental or other organisations. Despite this, the BtG staff all felt that the unusual combination of NGOs, experts and Government officials had been a particular strength of the project.

Internal difficulties

49. As mentioned when discussing the country visits, all BtG staff noted that there were internal difficulties among the staff during the project. While most of the staff and well-informed APN members felt that "it would not have been noticed by the outside world" (as one of them put it), this does not appear completely true in three senses:

    49.1. Firstly, these difficulties meant that a greater burden was put on key BtG staff during the project, which meant that there was insufficient time for certain planning to take place. This can be seen most strongly for the website, but can also be seen for e.g. the media strategy for the BtG principles.

    49.2. Secondly, these difficulties seem to have been primarily responsible for the non-completion of the country visits. While the funded country delegations from these countries at the Helsinki conference seemed to be successful in meeting some of the same objectives, it is clear that two countries received less support from the project by virtue of not experiencing the planned visit from the BtG staff.

    49.3. Finally, these difficulties meant that it was more difficult to have critical discussions within the BtG structure. The main outcome of this was that the participation of APN members in

[31] *When asked to rate their happiness with the 'the website of the BtG project', 20 reported that they were happy while only 1 reported that they were unhappy.*

some of the work strands was reduced – for example, the members' participation in the country visits, advocacy schools and APN working groups was less than may have otherwise occurred.

50. Nevertheless, nearly all aspects of the project were achieved successfully irrespective of these difficulties, particularly in terms of the key aims – that is, the creation of a network and the involvement of youth within the project. It is therefore fair to say that these difficulties did not materially affect the overall success of the project, and that those outside the staff would barely have been affected by it at all in most situations.

Conclusions

51. The different aspects of work outlined in this report add up to a very successful project as a whole. The key aims – the building of a network, and the involvement of young people – were both achieved very successfully. The advocacy schools were much appreciated by those participating in them, the conferences were widely seen to be impressive, and the country profiles were felt to have provided valuable information for researchers and APN members alike. Aside from some relatively unimportant tasks that could have been carried out slightly more effectively, the only real failing of the project relates to two country visits that did not take place.

52. This overwhelmingly positive picture is confirmed by the APN members, who mostly reported that the project had brought much more benefits than costs – including all of the members from the new Member States.[32] Nevertheless, there remain lessons to learn for future projects such as the Building Capacity project – in particular in terms of further improving advocacy and the link to policymakers, as well as broadening the coalition to a wider set of organisations. If future projects manage to learn these lessons while retaining the success of the BtG project, then they are likely to be even more successful in building an infrastructure for reducing alcohol-related harm in Europe.

BY BEN BAUMBERG, FEBRUARY 2007

Bridging the Gap project evaluator
Policy & Research Officer, Institute of Alcohol Studies

[32] *In response to the question 'Overall, do you feel that the benefits of taking part in the BtG project have outweighed its costs?', 17 respondents said 'much more benefits than costs', 9 said 'a little more benefits than costs' and 1 said 'about the same'. No respondents said that the costs outweighed the benefits.*

APPENDIX 2

eurocare
EUROPEAN ALCOHOL POLICY ALLIANCE

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People or profits

Who's being served?

On 25 October what will the Commission decide?

Leading public health agencies and non-governmental organizations in Europe are calling on the European Commission to resist alcohol industry pressure to abandon its alcohol harm reduction strategy.

Even before it has been officially published, the alcohol industry has stepped up its attempts to block the adoption of the strategy due to be discussed by the College of Commissioners on Wednesday 11 October. The strategy was drawn up following lengthy discussion with the health ministries of all the member states.

Dr. Michel Craplet, the Chairman of the European Alcohol Policy Alliance says that "It is now time for the Commission to take a lead and show that it really means to serve the well-being of European citizens rather than the commercial interests of the alcohol industry".

Dr. Peter Anderson, the author of an influential report for the Commission on alcohol harm calls on the European Commission "to have the courage to actually come up with measures that will make a difference".

Europeans drink more than anyone else in the world and European society is suffering because of it. Alcohol drains the European economy by 125 billion euros every year.

Alcohol inflicts an enormous toll on European ill-health from birth to the grave. Over 60,000 underweight births are due to alcohol each year, and drinking during pregnancy is a major cause of birth defects with life long consequences. More than a quarter of young adult deaths in men are due to alcohol, and 10,000 suicides are caused by alcohol each year. In older age, 50,000 Europeans die each year of an alcohol caused cancer, including 11,000 female deaths from breast cancer.

Children bear the brunt of alcohol related harm. One in six of child abuse is due to alcohol and more than 7 million children live in families wrecked by alcohol.

Two fifths of all domestic violence inflicted on women is due to alcohol and alcohol is a cause of two fifths of all murders.

Failure to adopt the strategy now will set back for years the cause of tackling one of major causes of ill-health and premature death and a wide range of social problems affecting young people disproportionately.

APPENDIX 3

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B-1049 BRUSSELS
Belgium

Brussels, 19 October 2006

Dear Mr. Barroso,

Ahead of the meeting of the College of Commissioners where the Communication for a Strategy to reduce the health and social harm done by alcohol in Europe is to be discussed, we call on the European Commission to resist the pressure from the Alcohol Industry and to give preference to the health and well-being of the European citizens over the commercial interests of the Industry.

EUROCARE (The European Alcohol Policy Alliance) is an alliance of 46 voluntary and non-governmental organizations working on the prevention and reduction of alcohol related harm in Europe. Member organisations are involved in research and advocacy, as well as in the provision of counselling services and residential support for problem drinkers, the provision of workplace and school based programmes and the provision of information to the public.
Eurocare advocates the prevention of alcohol related harm in Europe through effective evidence based alcohol policy. http://www.eurocare.org/

Notwithstanding the positive contribution made by the production and sale of alcoholic beverages to the economy of the EU, in terms of revenues and employment, alcohol-attributable disease, injury and violence also drain the health, welfare, employment and criminal justice sectors across the EU some €125bn a year (equivalent to 1.3% GDP)33. This is only the tangible cost of alcohol to the EU society and does not include alcohol –related pain, suffering and lost life.

[33] Actual spending on alcohol related problems accounts for €66bn:

- Healthcare and treatment: The cost of treating alcohol-attributable ill health is estimated to be €17bn, together with €5bn spent on treatment and prevention of harmful alcohol use and alcohol dependence.
- Crime: Alcohol-attributable crime is estimated to cost European police, courts and prisons €15bn per year, as well €12bn in crime prevention expenditure & insurance administration and €6bn of criminal damage.
- Traffic accident damage (€10bn)

Potential production not realised due to absenteeism, unemployment and premature mortality accounts for a further €59bn.

In addition, alcohol is one of the major causes of ill-health and premature death in Europe and causes a wide range of social problems affecting young people disproportionately.

More than a quarter of young adult deaths in men are due to alcohol, and 10,000 suicides (1 in 6 of all suicides) are caused by alcohol. In older age, 50,000 Europeans die each year of an alcohol

caused cancer, including 11,000 female deaths from breast cancer.

Alcohol is also a major contributory factor in accidents with a fatal outcome (1 in 3 of all road traffic fatalities are caused by alcohol). 17,000 people die from drink driving accidents in a year in Europe (10,000 of these pedestrians and passengers).

Children bear the brunt of alcohol related harm. One in six of child abuse is due to alcohol and more than 7 million children live in families wrecked by alcohol. Over 60,000 underweight births are due to alcohol each year, and drinking during pregnancy is a major cause of birth defects with life long consequences.

Two fifths of all domestic violence inflicted on women is due to alcohol and alcohol is a cause of two fifths of all murders.

Given the globalisation of trade and communications across Europe and the fact that the EU has shared or exclusive competence over certain areas that are relevant for alcohol policy (internal market, CAP, trade law….), it is no longer possible for individual countries to act alone in tacking the growing problems associated with alcohol. Urgent action is needed on European level to support the Member States reducing the health and social harm due to alcohol consumption.

We call on the European Commission to respond to the request made to this Institution by the Heads of State of the EU in 2001, and reiterated in 2004, and to put forward its proposals for a comprehensive strategy to reduce health and social alcohol related harm.

Yours sincerely,

Michel Craplet
Chairman of Eurocare

Cc College of Commissioners

Encl: Key facts from the Report Alcohol in Europe

APPENDIX 5

eurocare
EUROPEAN ALCOHOL POLICY ALLIANCE

EUROCARE press release on the EU Alcohol Strategy

Eurocare welcomes the strategy and announces that it will continue to support DG SANCO in its efforts to reduce the harm done by alcohol in Europe. We would also like to congratulate DG SANCO on its first draft which would have had an impact in reducing the harm done by alcohol.

We are sad to see that despite the efforts of the European Health Community and DG SANCO to protect the health and wellbeing of European citizens, in the end, the alcohol industry and other parts of the commission have ensured that the strategy reflects the undue influence of the alcohol industry, which has been responsible for one of the most intensive lobbying campaigns ever known in regard to public health policy.

Public health specialist Dr. Peter Anderson, the author of the report "Alcohol in Europe", stated "The alcohol industry has lobbied to put their own profits above the needs of the European people, with commission officials other than those directly involved with health issues surrendering to its pressure".

He said the proposed EU alcohol policy is "much weaker than the first draft and has a much greater focus on education as the answer to solving the problems of alcohol, when the evidence shows that it does not work ". He regretted that measures that could have made a real difference such as a "better regulation of the product and its marketing", were no longer in the text of the Communication.

About the way the industry has lobbied and misrepresented the strategy, Andrew McNeill, Honorary Secretary of Eurocare said "We regret to see the industry's paw prints are all over the Communication", and added "Given that the industry has made it abundantly clear that it is opposed to the whole idea of a public health strategy on alcohol, how can it possibly be seen as a main collaborator in implementing it".

APPENDIX 6

EUROPEAN PARLIAMENT

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30.7.2007

REPORT

on an European Union strategy to support Member States in reducing alcohol-related harm
(2007/2005(INI))

Committee on the Environment, Public Health and Food Safety

Rapporteur: Alessandro Foglietta

MOTION FOR A EUROPEAN PARLIAMENT RESOLUTION

on an European Union strategy to support Member States in reducing alcohol-related harm
(2007/2005(INI))

The European Parliament,

– having regard to Article 152 of the EC Treaty,

– having regard to the Commission Communication on an EU strategy to support Member States in reducing alcohol related harm (COM(2006)0625),

– having regard to Council Recommendation 2001/458/EC of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents[1],

– having regard to the Council Conclusions of 5 June 2001 on a Community Strategy to reduce alcohol-related harm[2],

– having regard to Commission Recommendation 2004/345/EC of 6 April 2004 on enforcement in the field of road safety[3],

– having regard to the World Health Organisation (WHO) Stockholm Declaration on Young People and Alcohol 2001,

– having regard to various judgments of the Court of Justice of the European Communities (Franzen case (C-189/95), Heinonen case (C-394/97), Gourmet case (C-405/98), Catalonia (C-190 and C-179/90), Loi Evin (C-262/02 and C-429/02),

– having regard to the WHO resolution of 25 May 2005 on Public-health problems caused by harmful use of alcohol (WHA 58.26),

– having regard to target 12 of Health 21 of 1999 and the Action Plan on Alcohol 2000-2005 of WHO European Region,

– having regard to Rule 45 of its Rules of Procedure,

– having regard to the report of the Committee on the Environment, Public Health and Food Safety (A6-0303/2007),

A. whereas the terminology to be used when discussing alcohol-related harm should be based on official terminology as established by the WHO so as to avoid ambiguous wording and meaning,

B. whereas the problem of hazardous and harmful alcohol consumption, especially among young people, is evident at European level, whereas such consumption damages the human organism, in particular in children and young people, and causes deaths through related diseases and accidents as well as social problems and crime, while also doing great damage to the European economy, and whereas the need to implement evidence-based alcohol policies is nowadays a priority for all Member States,

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[1] OJ L 161, 16.6.2001, p. 38.
[2] OJ C 175, 20.6.2001, p. 1.
[3] OJ L 111, 17.4.2004, p. 75.

C. whereas hazardous and harmful alcohol consumption is an important health determinant and a threat to public health, which is responsible for a wide range of health and social harm,

D. whereas Article 152 of the Treaty states the competence and the responsibility of the European Union to address public health problems by complementing national actions in this field, whereas work at EU level to identify and disseminate best practices, which has produced positive results in this field, is an important complement to national policy measures, whereas consideration of effective national action plans should be used as a basis for similar measures in other Member States and create synergies at national level,

E. whereas economic and social factors (workplace stress, excessive workloads, unemployment, job insecurity, etc) can play a key role in hazardous and harmful alcohol consumption and in precipitating alcohol dependence,

F. whereas the Member States are employing a variety of strategies to prevent hazardous and harmful alcohol consumption and/or reduce alcohol-related health problems,

G. whereas it is desirable that the European Union formulates general objectives for curbing the harmful effects of hazardous and harmful alcohol consumption in the Member States and is able to undertake measures in close cooperation with Member States in order to prevent alcohol-related harm affecting both drinkers and third parties, which includes harmful effects on health, such as foetal alcohol syndrome (FAS) and foetal alcohol spectrum disorders (FASD), hepatic diseases, cancer, increased blood pressure and heart attacks, and traffic accidents and accidents in the workplace, but also social harm, such as domestic and family violence, child neglect, unemployment, poverty, social stigma and social exclusion,

H. whereas the Court of Justice of the European Communities has repeatedly confirmed that combating alcohol-related harm is an important and valid public health goal,

I. whereas, although the same worrying drinking patterns are being seen among young people in the different Member States, drinking patterns and traditions vary between different parts of the European Union, a fact which should be taken into account when formulating a European approach to alcohol-related problems, to enable each Member State to tailor its response to the problems and the nature of the alcohol-related harm involved; whereas a single, uniform alcohol policy for all EU countries would not be possible, whereas there are still a number of alcohol policy issues which cross borders and make the implementation of national alcohol policy increasingly difficult for individual Member States; whereas there is therefore a need for concerted action at EU level; whereas the Commission should urge Member States to pursue an effective and ambitious policy of combating hazardous and harmful alcohol consumption, and should give the Member States as much support as possible in doing so,

J. whereas political measures at national or EU level can never be a substitute for the responsibility for moderate and limited alcohol consumption, which ultimately lies with the individual and the family,

K. whereas guidelines for low-risk consumption may be indicated through campaigns across Europe addressed to the public and adapted to the specific circumstances of the Member States; whereas strong, targeted measures should be undertaken to prevent hazardous and harmful alcohol consumption among drivers and workers, whereas measures should also be taken to prevent the consumption of alcohol by minors and pregnant women,

L. whereas society pays a major part of the costs of hazardous and harmful alcohol consumption; whereas, as a consequence, everybody would benefit from an efficient reduction of alcohol-related harm, whereas it is therefore reasonable to adopt certain limitations to the access to alcoholic beverages,

M. whereas health claims may not be made at all on alcoholic beverages and nutrition claims only in exceptional cases, as laid down in Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods[1],

N. whereas alcohol consumption influences considerably the metabolism of various nutrients; whereas alcohol consumption exerts an influence on the action of various medicines because of the existing interaction between them,

O. whereas the damaging effects of alcohol consumption on the liver have been well established, as well as the detrimental effects on the central and peripheral nervous systems, and increasingly so in today's ageing society,

1. Welcomes the Commission approach taken in the Communication on the hazardous and harmful consumption of alcohol and its harmful health consequences; calls, however, on the Commission*,* while not undermining the subsidiarity principle, to formulate ambitious general objectives for the Member States with a view to curbing hazardous and harmful alcohol consumption; calls on the Member States to pay particular attention to vulnerable social groups, such as children, young people and pregnant women, and to address the problems of hazardous and harmful alcohol consumption by young people, workers and drivers by means of information and awareness-raising campaigns and, where appropriate, a review of compliance with existing national laws;

2. Acknowledges that alcohol consumption can be considered as a part of the European cultural heritage and life style; acknowledges that low alcohol consumption, i.e. 10 grams per day according to the WHO-Regional Office for Europe Action Plan on Alcohol 2000-2005 (PAEA), helps to prevent cardiovascular diseases and ischemia in some middle-aged individuals; recognises that while moderate consumers represent the majority of alcohol consumers, hazardous and harmful alcohol consumption is a significant minor behavioural pattern;

3. Points out that hazardous and harmful alcohol consumption occurs in all social groups and is caused by a wide variety of factors, making a comprehensive approach to combating this problem essential;

4. Acknowledges that interventions based on proper scientific evaluation are necessary if hazardous and harmful alcohol consumption is to be effectively reduced; considers that, since alcohol is one of the most significant health determinants, it is very important to collect data across the European Union and especially data on the correlation between levels of alcohol and road accidents, alcohol and liver diseases, and alcohol and neuropsychological disturbances, syndromes and diseases*;* therefore invites Member States and all stakeholders to increase resources dedicated to collection of data and improving the efficiency of information, and to prevention campaigns and programmes;

5. Points out that the most urgent problems of hazardous and harmful alcohol consumption are related to the effects of alcohol on young people, who are more vulnerable to physical

[1] ***OJ L 404, 30.12.2006, p. 9; corrigendum in OJ L 12, 18.1.2007, p. 3.***

and emotional suffering as well as to social harm from their own or other people's drinking;

6. Is worried about the increase in alcohol consumption among minors and young people and notes a worrying trend on their part to start drinking at an ever-earlier age and, given their greater willingness to take risks, to engage in dangerous forms of behaviour such as binge drinking, other forms of hazardous alcohol consumption which aim at drunkenness, mixed consumption of alcohol and drugs, and driving whilst under the influence of alcohol and drugs;

7. Stresses that young adolescents tend to increase their alcohol consumption when entering university life; considers that increased efforts at universities may contribute to lowering the number of heavy consumers of alcohol in the future; therefore calls on the Member States to intensify their prevention programmes in this area;

8. (i) Calls on the Commission to list and quantify the concrete harmful effects of alcohol consumption among young people in the Member States with a view to subsequently formulating European objectives for Member States aimed at curbing hazardous and harmful alcohol consumption by young people with Member States committing themselves to reducing these harmful effects at European level, taking into account the efforts already undertaken,

   (ii) Without prejudice to any obligations imposed by Community legislation, stresses that the Member States are free to determine the form of measures to be taken at national level, but that they should report to the Commission on the progress made in combating hazardous and harmful alcohol consumption among young people,

   (iii) Notes that the Commission has a supporting role to play in the achievement of the European objectives by helping the Member States to exchange knowledge and best practices and to carry out European research on combating the harmful effects of alcohol consumption by young people;

9. Calls on the Commission and Member States, with the involvement of relevant non-governmental organisations and economic associations in the context of the Health and Alcohol Forum proposed by the Commission, to encourage the exchange of proven practices, in particular with a view to preventing hazardous and harmful alcohol consumption among children and young people, and to adopt the following measures:

   (i) to launch education campaigns to be conducted by Member States and interest groups on the risks of hazardous and harmful alcohol consumption, especially through school-based educational programmes directed towards children and adolescents, in particular by encouraging them to engage in regular sports activities, but also towards parents in order to prepare them to speak about alcohol-related problems within a family setting, and towards teachers; the idea of responsible and moderate consumption by adults should also be put across at an early stage,

   (ii) to limit the access to and availability of alcoholic drinks for young people, for instance by strictly implementing the existing legislation which prohibits selling alcohol to young people, by intensifying controls on sellers and distributors, such as restaurants and bars, supermarkets and retailers,

(iii) to involve retailers and the catering industry in identifying and implementing concrete measures to prevent the selling and serving of alcohol and alcohol pops to minors,

(iv) to particularly focus on such beverages as "alcopops", which are specifically targeted at young people, in order to ensure that their alcoholic nature can be clearly identified by consumers through measures such as stricter labelling requirements for such drinks, and requirements for clearer separation of alcopops from soft drinks in shops, and the selling to minors prohibited; also to promote higher taxes on such beverages,

(v) to draw up guidelines, to be implemented at national level, setting an age limit for purchasing, selling and serving alcoholic drinks,

(vi) to promote at European level blood alcohol content (BAC) limits as close as is workable to 0.00 % for new drivers, as already proposed by Parliament in its resolution of 18 January 2007 on the European Road Safety Action Programme - mid-term review[1], bearing in mind that some prepared foods may contain traces of alcohol,

(vii) to provide more possibilities to know and verify the blood alcohol content also through the use of auto-calculation on the Internet and the widespread availability of breathanalysers, especially in discos, pubs and stadiums, and on motorways and roads in general, in particular during night hours, and to ensure that the message conveyed to the consumer is that drinking and driving are not compatible,

(viii) to take any necessary measures to increase controls on drink-driving to the maximum,

(ix) to strengthen the sanctions for drink-driving imposed by Member States, such as prolonged withdrawal of the driving licence and periods of confiscation of the vehicle,

(x) to encourage Member States to ensure the availability of alternative public means of transportation for drivers who have consumed alcohol,

(xi) to encourage the extension of "designated-driver programmes" ("who drives doesn't drink") through educational means in view of their beneficial impact on road safety, while reminding passengers of the effects of hazardous and harmful alcohol consumption,

(xii) to set up a European prize for the best campaign against hazardous and harmful alcohol consumption directed at schools and young people,

(xiii) to intensify the exchange of best practice between Member States on how to work against hazardous and harmful alcohol consumption, and between national police forces on controls on drink-driving by young people ,

(xiv) to promote initiatives designed to guarantee psychological follow-up for individuals taken to hospital with acute alcohol intoxication;

10. (i) Calls on the Commission to quantify the incidence of FAS (Foetal Alcohol Syndrome) and FASD (Foetal Alcohol Spectrum Disorders) in the Member States with a view to subsequently formulating European objectives for the Member States aimed at curbing FAS and FASD, with Member States committing themselves to reducing their incidence at European level, taking into account the efforts already undertaken,

[1] Texts Adopted, P6_TA(2007)0009.

(ii) without prejudice to any obligations imposed by Community legislation, stresses that the Member States are free to determine the substance of the measures to be taken at national level, but that they should report to the Commission on the progress made in combating FAS and FASD,

(iii) notes that the Commission has a supporting role to play in the achievement of the European objectives by helping the Member States to exchange knowledge and best practices and to carry out European research on combating FAS and FASD;

11. Takes the view that both women and men should be better informed about the risks of alcohol use during pregnancy and about FASD in particular, in order to avoid new-born babies and adolescents being affected by diseases and developmental delays caused by alcohol use during pregnancy; emphasises that appropriate warning on the package of alcoholic beverages may prevent women from drinking alcohol before and during pregnancy; notes that, for problem drinkers, further support during pregnancy and follow-up after birth may be necessary; further suggests that gynaecologists and antenatal clinics should be trained to identify potential cases of hazardous and harmful alcohol consumption as early as possible and to support these women to give up alcohol completely during their pregnancy;

12. Takes the view that men should be better informed about the link between alcohol consumption and impotence;

13. Stresses that alcohol advertising and marketing practices should not be directed at minors;

14. Asks the Commission and the Member States to draw up guidelines for the advertising of alcoholic beverages on television and to ensure the implementation of the new Television Without Frontiers Directive once it is adopted; asks the Commission to encourage audiovisual media service providers to include in their codes of practice rules on the scheduling of alcoholic beverage commercials;

15. Welcomes and supports the undertakings regarding self-regulation given, for example, by the advertising industry and alcoholic beverage producers; in that connection, calls on the Commission and the Member States to check that these undertakings are honoured and, if they are not, to impose penalties;

16. Points out that Member States are currently able to introduce obligatory health warnings for alcoholic beverages; recalls that front of pack labels may include the warnings that alcohol can cause serious health and mental health problems, that alcohol is addictive and that alcohol consumption during pregnancy may be harmful to the foetus; notes also that health warnings on alcohol may require European harmonisation similar to health warnings on tobacco and ask the Commission therefore to publish before 1 January 2010 either a legislative proposal to introduce health warnings on alcoholic beverages, or a communication to explain why in contrast to health warnings on tobacco, the introduction or harmonisation of health warnings on alcohol is not necessary; suggests that health warnings could in particular warn against the dangers related to alcohol consumption during pregnancy;

17. Calls on the Commission to promote initiatives aimed at exchanging best medical practices in a variety of healthcare settings as well as promoting independent and impartial information campaigns designed to raise awareness about the risks of hazardous and harmful alcohol consumption; campaigns should also be directed towards people vulnerable to neuropsychological disturbances, syndromes and diseases and to people who

are old, lonely, separated or isolated, as they are more exposed to seeking relief in alcohol consumption, thereby further damaging their condition and increasing their risk of suffering neuropsychological disturbances, syndromes and diseases;

18. At the same time, asks the Commission to promote the spread of instruments such as the AUDIT (Alcohol Use Disorders Identification test) developed by the World Health Organisation, which allow the quick identification of people who are at risk even before they acknowledge having a problem with alcohol; points out that timely informal discussion between general practitioners and patients is one of the most efficient tools to inform patients about the risks linked to hazardous and harmful consumption of alcohol and to promote the necessary behavioural changes in problem drinkers; calls on Member States to support the qualification of doctors (GPs) on alcohol problems and disorders and adequate interventions;

19. Considers that the Commission and Member States should undertake the necessary measures to tackle harmful social impacts of alcohol, such as bullying and domestic violence; asks for more social and psychological support for families which suffer from hazardous and harmful alcohol consumption; calls for special social assistance for children that live in a family with alcohol-related problems; proposes the institution of an emergency number to denounce alcohol-related abuse in the family;

20. Is concerned at the heavy alcohol consumption of many elderly people, which is often prompted by physical pain or feelings of loneliness and hopelessness; points out that alcohol problems in old age represent an important issue which is becoming more pressing as a result of demographic ageing;

21. Takes the view that increased knowledge about alcohol consumption and its relation to sick leave, long-term sick leave and early retirement is necessary; considers it important, in respect of EU and Member States' employment law, to address drinking problems at the workplace by encouraging persons concerned to seek help, but recalls that this should always be done with due regard for the privacy and the rights of the individual; urges employers to pay particular attention to hazardous and harmful alcohol consumption within the workplace by running preventive educational programmes and providing assistance to workers with alcohol problems;

22. Is convinced that reducing the number of road accidents and related harm caused by alcohol (17 000 deaths per year) is a priority for the European Union; therefore

    (i) calls on the Commission to list and quantify the concrete harmful effects of driving under the influence of alcohol in the Member States with a view to subsequently formulating European objectives for the Member States aimed at curbing drink-driving, with the Member States committing themselves to reducing the harmful effects of drinking, taking into account the efforts already undertaken,

    (ii) without prejudice to any obligations imposed by Community legislation, stresses that the Member States are free to determine the form of the measures to be taken at national level, but that they should report to the Commission on the progress made in combating drink-driving,

    (iii) notes that the Commission has a supporting role to play in the achievement of the European objectives by helping Member States to exchange knowledge and best practices and to carry out European research on combating the harmful consequences of drink-driving;

23. In order to better address the risks related to hazardous and harmful use of alcohol on the road, the following measures should be adopted:

    (i) to promote a considerable increase in controls on blood alcohol content and to address the highly varied enforcement rate between Member States aiming at convergence of the frequency of controls as well as exchanging good practices as regards the places where the controls should be carried out,

    (ii) to promote heavier sanctions for drink-driving, such as prolonged withdrawal of driving licences,

    (iii) to promote at European level blood alcohol content limits as close as is workable to 0,00% for drivers of transportation means requiring a category A and B driving licence and for drivers of transportation means requiring a higher category of driving licence and for all professional drivers, bearing in mind that some prepared foods may contain traces of alcohol;

24. Stresses that all effective measures to avoid drink-driving should be promoted; urges the further development of alcohol lock systems and other instruments which mechanically prevent drink-driving, notably for professional drivers;

25. Invites the Commission to launch impartial and independent information campaigns, or to support such campaigns conducted by Member States, in collaboration with interest groups, promoting responsibility and moderation in consumption and highlighting the negative impacts of hazardous and harmful alcohol consumption on physical and mental health as well as on social well-being;

26. Invites the Commission and the Member States to step up and coordinate their respective activities aimed at combating various forms of addiction and to submit, by 2010, an exhaustive general survey of hazardous and harmful alcohol consumption patterns and addictive behaviour and the causes thereof;

27. Urges Member States to tackle the problem of illegal and black market sales of alcohol, to control the quality of the alcohol sold and to intensify controls on home-made alcohol products (such as distilled products) which can be lethal for human life;

28. Invites all stakeholders to promote, within the Health and Alcohol Forum proposed by the Commission, the implementation of concrete actions and programmes to tackle alcohol-related harm, given that the main objective of the Forum would be to exchange best practice, collect commitment to engage in actions, secure proper evaluation of the actions and monitor their effective implementation; looks to the Commission also to involve representatives of Parliament in the Health and Alcohol Forum and to submit annual reports to it on the progress made by the Forum;

29. Instructs its President to forward this resolution to the Council and Commission and to the governments and parliaments of the Member States.

EXPLANATORY STATEMENT

The problem of hazardous and harmful alcohol consumption is now taking on considerable and worrying proportions in all EU Member States although the value traditionally attributed to alcohol has varied from tradition to tradition, region to region, and country to country.

One fundamental distinction that can be made is between southern and northern Europe, i.e. between areas forming part of the so-called 'wet culture' - in which, according to an age-old tradition passed on through the generations from each person's earliest childhood, wine is served with food, is something to be drunk with pleasure and to be taken in moderation, and forms part of the local cultural and traditional heritage - and the 'dry' culture - in which, as a result of the mood-changing properties attributed to alcohol and the fact that it is not consumed as a part of normal day-to-day patterns, alcohol is drunk outside meal times, generally at weekends and in huge quantities for the purpose of losing one's social inhibitions and escaping the conformism and rigidity imposed by social mores.

However, patterns have been changing over the last few decades throughout Europe towards more uniform behaviour and drinking patterns, especially among the younger generations, including a significant increase in the use of alcohol for social purposes and as a mood changer.

Studies conducted by many institutions, governments, associations and operators in the sector have therefore highlighted a worrying tendency - albeit among a minority of the population in Europe - towards inappropriate consumption of alcohol, which sometimes leads to genuine abuse.

Thus, the moderate use of alcohol can be considered as something that is not negative in itself, representing a feature of the culture and tradition of certain countries, whereas hazardous and harmful alcohol consumption can only be seen as dangerous to the wellbeing of European citizens because, as is known, it causes huge damage to people's health in addition to its various indirect effects such as road accidents, domestic violence, in particular against children, an increase in aggressive behaviour and child abuse.

The figures regarding the impact of hazardous and harmful alcohol consumption on European society give us food for thought. The studies carried out by the European Commission, in particular, refer to thousands of deaths in Europe each year owing to hazardous and harmful alcohol consumption. More than half of these are caused by alcohol-related road accidents. Alcohol abuse is responsible for 16% of cases of ill-treatment of children in the family. More than 60 000 people in the European Union are affected by the foetal alcohol syndrome.

Such problems cannot be left without an adequate response at European level. Member States have already undertaken to prevent and reduce problems related to hazardous and harmful alcohol consumption within the WHO. However, the action they take at national level is based on different policies, the result being that their approaches differ considerably, thus reducing the effectiveness of measures, especially in border areas.

A European dividend is therefore essential in the fight against hazardous and harmful alcohol consumption even though it must be borne in mind that the competence conferred on the European Union by Article 152 of the Treaty only provides for complementary action and, owing to the aforementioned cultural diversity between Member States, it is difficult, if not impossible, to put forward a single model for the 27 Member States.

It is possible, however, to adopt a number of basic measures and, above all, to endeavour to educate the public to drink responsibly, to publicise the harmful effects of hazardous and harmful alcohol consumption, to remind producers and distributors of their responsibilities, to ask operators in the sector to provide the necessary support, to involve schools and families, to send out a message providing young people with positive examples and to increase awareness of risks among the more vulnerable sections of society.

This can take place, in particular, through a comprehensive strategy involving, in addition to coordination measures between the individual national laws and campaigns, increased exchanges of information and of good practice. Your rapporteur is convinced of the need for determined action through measures that have been proved to be effective.

First of all, accurate information should be provided through an awareness-raising campaign at all levels - family, school and media. The latest research conducted by the WHO shows that information campaigns aimed at these objectives and seeking to make people aware or more aware of the issues have proved particularly effective and it would therefore be appropriate to promote greater use of this type of initiative.

Secondly, by approving the Commission's communication, which focuses on the five priorities in combating the harmful effects of hazardous and harmful alcohol consumption, the rapporteur suggests that one of the main objectives of EU action should be to focus on protecting young people.

There is clear evidence of increased hazardous and harmful alcohol consumption among young people, linked to a lowering of the age at which they start to drink alcohols. Dangerous and socially accepted consumption patterns are spreading in a fairly consistent manner throughout the European Union, including binge drinking, i.e. drinking more than five units of alcohol together with the aim of losing control and lowering one's inhibitions, the simultaneous consumption of alcohol and drugs, and more frequent excessive consumption.

Member States and the European Union should take a more stringent and effective approach especially in this area. It is the duty of the institutions to ensure that the weakest members of society are protected against social trends that are dangerous to their health. Young people are amongst the most vulnerable in that they are generally more exposed than adults to the risk of conformity and the influence of fashion and trends. It should also be remembered that young people represent future consumers and that, if properly educated, they will therefore contribute to reducing the harmful effects of hazardous and harmful alcohol consumption in tomorrow's society. It is nevertheless difficult to draw the line between the stage in life when a person should be considered 'young' and therefore 'at risk' and the stage when society and institutions can pay less attention to them and allow freedom of choice to take over from legal constraints. Here again, individual Member States have taken different stances on the issue. However, in general, the protection threshold under which it is prohibited to sell or serve alcohol to minors is between the ages of 16 and 18. A common threshold should be established for the whole of the European Union, which in my view should at the very least be the age of legal majority. The European Union does not have the power to impose such a minimum age, but could at least provide strong advice on the subject, and that is what we wish to advocate with this strategy.

There should also be increased checks on and penalties for the sale of alcohol to people under the legal age.

As regards the category of young people who have reached their majority but are still vulnerable, it would seem possible and appropriate to establish measures to be taken to restrict their access to consumption.

The rapporteur would propose, in particular, restricting the availability and possibility of supply of alcohol to young people by introducing higher prices, through specific taxation on alcopops, which are specifically aimed at young consumers.

In any case, appropriate measures should be taken, in particular, to promote greater awareness of the risks and physical and mental harm caused by hazardous and harmful alcohol consumption. It should be reiterated that action must be taken through education and information because hazardous and harmful alcohol consumption is essentially, like so many other behavioural problems, a question of attitude. To improve society, we need to change general attitudes.

As regards the aim of reducing alcohol-related road accidents, which, sadly, primarily affect young people, a larger number of checks on drivers is required to ensure that it is considered not merely possible but extremely probable that such checks occur. This is the only way to ensure that such action provides the necessary deterrent effect to avoid hazardous and harmful alcohol consumption by drivers.

To this end, and with a view to sending out a strong signal in combating the major problem of youth hazardous and harmful alcohol consumption, your rapporteur would propose establishing extremely stringent limits, on the blood alcohol level for new drivers. This measure would also be useful for persons learning to drive as adults, who would not have the necessary experience to be in full control of their vehicle even at the authorised alcohol rates. Here again, the European Union does not have the power to impose a limit but can, through this strategy, send out a clear message as to what Europe feels should be done and call on Member States to place special emphasis on the matter.

Similarly, BAC limits should be lowered for drivers of larger vehicles and professional drivers, given the dangerousness of such vehicles and the need to ensure that the speed of their reactions during working time is not diminished by alcohol consumption.

As regards public health, steps should be taken to promote widespread basic health measures. Screening of alcohol-related disorders should be stepped up under the responsibility of local doctors. This concerns the ‘brief intervention’, consisting in giving all patients consulting a doctor for whatever medical reason a simple questionnaire, through which susceptibility to or the presence of problems relating to hazardous and harmful alcohol consumption may be identified. Early experiments are proving successful: normally, people at risk are not aware of their dangerous behaviour which can lead to alcoholism and, through this screening exercise, can be provided with advice in order to tackle the problem in good time.

More information is also needed on the risks of alcohol consumption for pregnant women. The figures on the extent of the foetal alcohol syndrome, which affects 60 000 people in Europe, to which should be added the figures on underweight births in Europe owing to alcohol consumption, around 60 000 per year, show clearly that there is not enough information on the subject. It is obvious that large-scale campaigns are needed to encourage a responsible attitude on the part of couples wishing to have children, and in particular future mothers.

Alcohol abuse is also often responsible for violent behaviour, in particular domestic violence.

It is proposed, in this connection, that an emergency number be established at European level which people can call to report incidents of domestic violence, in particular to protect children.

One effective approach, as highlighted by the Commission, is to tackle the problem of ***hazardous and harmful alcohol consumption*** at work, especially when one considers that the working environment is where information can be distributed widely. Employers can also be encouraged to act responsibly by establishing a dialogue and providing support for employees with alcohol problems. However, there is no denying that the problem concerns people's private life and that a worker’s privacy must be respected in this field.

The rapporteur agrees on the need to set up the forum on alcohol and health, as proposed by the Commission, to promote exchanges of information and look into new measures to combat hazardous and harmful alcohol consumption. Effective conclusions should be drawn by sharing the data collected at national level.

Any such measures should, however, be taken in such a way as to ensure that they are feasible and will be effective, and it should be noted that European Union action must provide a dividend and be complementary to national and local policies.

APPENDIX 7

eurocare

Seminar in the European Parliament (Brussels)
An Alcohol Strategy for Europe?

Wednesday 31 January 2007

Programme

12:45 – 12:50 ***Welcome by the Chairs, Ms Anna Hedh, Mr. Manuel Medina Ortega and Ms Åsa Westlund***

12:50 – 13:00 **Key aspects of the EU strategy to support Member States in reducing alcohol related harm**

Keynote speaker: Commissioner Markos Kyprianou, DG Health

13:00 – 13:30 **The impact of Alcohol in Europe**

Dr Peter Anderson - International Public Health Consultant. Co-author of the Report for the Commission "Alcohol in Europe: A Public Health Perspective"

13:30 – 13:45 **WHO initiatives to reduce alcohol related harm**

Dag Rekve – World Health Organization, Geneva

13:45 – 14:00 **Eurocare recommendations for effective action to reduce the burden of alcohol problems**

Ms. Tiziana Codenotti, Vice Chairman, Eurocare

14:00 – 14:15 **Is the industry really willing to cooperate to curb underage drinking? - Marketing of alcohol to young people**

Ms. Monique Kuunders. Policy Adviser. National Foundation for Alcohol Prevention. STAP. The Netherlands.

14:15 – 14:30 **Personal Testimony: The lives behind the statistics**

Ms. Diane Black, adoptive mother of three children with fetal alcohol syndrome, mother of a child killed by a drunk driver, sister to an alcoholic man.

14:30 – 15:00 **Debate –** Michel Craplet – chairman of Eurocare- will open the debate

Seminar Report

Key aspects of the EU strategy to support Member States in reducing alcohol related harm

Keynote speaker: Commissioner Markos Kyprianou, DG Health

Please note that the official recording of the seminar did not start until the next point.
The seminar was opened by the socialist MEP, Anna Hedh, who highlighted the importance of having a strategy.
Mr Kyprainou took up that point and started by speaking about the numerous difficulties encountered during the process of approval of the Strategy and how there were some elements of the Industry…

(Here starts the official recording) …. Trying to discredit the initiative just by commenting on something that we were not planning to do. For the first time in my political life, and I have been in politics for sometime, I had to defend myself against something I was not planning to do anyway and then having to explain why didn't I do something that I was not planning to do in the first place. It was kind of a surreal situation, but at the end of the day, we all learned from these experiences, I believe in the motto "what does not kill you makes you stronger", in this sense, I believe this experience all made us stronger.

I know that some would have liked this proposal to go further, whilst some say it has gone a bit too far, but the fact is that this is the first strategy, the first initiative at European level seeking to deal with alcohol related harm; it should be viewed as a first step in the right direction. This strategy follows a pragmatic approach, which can be revised, and rectified, should the situation not improve. Something we have to make clear from the beginning is that we are not dealing with alcohol as a product; rather, our central concern is that of alcohol related harm. This can be understood as abuse of the product, both in terms of excessive consumption, or consumption in inappropriate circumstances (during pregnancy, before driving, or in any other situation where alcohol consumption can lead to harm). More details and statistics can be found in the strategy.

We know that alcohol is a serious health determinant in the EU and that we have serious problems of alcohol abuse in the EU; but since other speakers will discuss these issues in more detail, I would like to focus on the politics of this. In my mind one of the greatest achievements of having the strategy adopted is the acknowledgement, in effect, of the existence of alcohol related harm, the acknowledgement that there is a problem. In order to find solutions to a problem you first have to acknowledge the existence of it. I believe that, through this strategy, this has been officially and formally accepted by everyone and so it has the fact that it is in the EU's interest to deal with this harm.

One of the criticisms made to us was that the European Commission and the EU should not get involved, in the sense that responsibility to deal with this issue lies with Member States rather than there being an overarching European interest. This argument was rejected both by the Commission and the Council, who last December, endorsed the strategy proposed by the Commission. The approval by these two Institutions was a recognition of the fact that this is not just an issue of internal market (although it is true that many of the issues that touch upon alcohol affect internal market issues as well) and of the fact that DG SANCO has the clear remit, dealing with health in the EU, to promote strategies in this area. In my view, this strategy represents a milestone. Maybe some of you here would have wanted the strategy to be more ambitious, and include more concrete proposals; but we should not ignore the significance of this strategy, the first to deal with alcohol related harm at Community level, which, among other things, creates political pressure on those Member States that were not willing to take action in this area to do so.

I can assure you that if you look at the detail of the strategy, you will see that everything that matters, all the issues of concern, are included in the proposal. There was a consensus from the beginning that

there was no intention at this point to proceed with binding legislation (in the areas where the EU is competent).
All the issues that are important, and have to be discussed and reflected upon by Member States and that can become action or strategies of Member States, are included in the strategy. There may have been amendments in the wording of these, or alterations in the presentation, but more importantly, the 'substance' is there. All the important issues, even the more controversial ones, are included within this strategy, which testifies of the overarching European interest in this area.

This is a first strategy, a first step to form a common approach at European level. But this is also a pragmatic strategy; given the difficulties of legislating at EU level, this is a tentative approach to attempt to deal with the pressing problem of alcohol related harm. This approach consists of, in effect, the implementation of guidelines and voluntary commitments on the part of the Member States; an exchange of best practices (the importance of such an initiative should not be underestimated) and the collection of data and information on which we can base further actions; and finally, voluntary codes of conduct and self-regulation for the alcohol industry. The exchange of best practices among Member States is very important as it seems that throughout the EU, Member States individually are taking action to combat certain aspects of alcohol related harm. It is important to make sure that Member States communicate among themselves, and coordinate actions, learning from each other experiences, both in terms of positive and effective measures and actions, as well as less successful ones.

As mentioned before, this is the first step, and if this approach does not deliver certain results, we may have to review our initial approach, and make more binding proposals. As you may have realised, I have not been reading the speech I had prepared; you have experts speaking to you today about the harm done by alcohol, and you are all familiar with the debates surrounding these issues, so I thought it would be more interesting to present the politics behind the strategy as well as outline our views and visions.

The Communication singles out five priority areas.

- **The protection of young people, children and the unborn child**

The main priority of the strategy are young people, by which I mean not only young people as consumers but also children; we want to protect the unborn child from the mother's alcohol consumption during pregnancy as well as protect children living in families with alcohol problems.

- **Reduce injuries and death from alcohol-related road accidents**

The toll of road accidents and deaths from alcohol related road accidents have taken dramatic dimensions all over Europe.

- **Prevent alcohol-related harm among adults and reduce the negative impact on the workplace**

- **Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns**

We will be targeting the sales of alcohol to underage people and want to promote responsible retailing; establishments have a social responsibility not to serve alcohol to intoxicated customers. But all of these measures will only become effective if we manage to raise the level of awareness and educate consumers, which is why this strand of the strategy is so important.

- **Develop and maintain a common evidence base at EU level**

Evidently, we cannot achieve this alone, and in terms of the implementation of the strategy, we are very much relying on continued support from the NGOs. But of course, we also need the commitment of other stakeholders: the alcohol industry, the retailers, the advertising industry, the media and many more stakeholders; all need to be part of the solution – since they are part of the problem, after all, and have already expressed their willingness to work with us.

In an attempt to bring everybody together we are setting up the Alcohol and Health forum, which is modeled on the Obesity Platform. We are working hard to make it possible for the first meeting of the Forum to take place in June. The forum will be provide a platform for all stakeholders, and we will make sure that all express commitments to contribute to solving the growing problem of alcohol related harm.

We will also be relying on the work done by Member States in the implementation of the strategy, as well as the support from other European Institutions in this process.

The Council has already unanimously welcomed the Strategy and the European Parliament, the Committee of the Regions and the Economic and Social Committee are presently preparing their reports on the Communication.

The rest of the stakeholders as well as the NGOs form a very important element, not only in order to balance the presence and participation of the industry in this forum, but also because they work more closely with citizens and consumers; this means that many of the actions will be better implemented with the help and the assistance of the NGOs.

A very important issue is that of alcohol marketing and advertising; we are still considering whether there will be a separate working group that will deal with this issue or if it is to be tackled within the framework of the Forum. This issue is very tricky and in fact, more complicated than that of the targeting of advertising of "junk food" to children. In the case of "junk food", adverts clearly directed at children can be controlled. But in the case of alcohol advertising the problem is that young people drink to mimic the behaviour of adults, and therefore there exist no cartoons advertising whisky or vodka. In this sense, the issue of the increasing sophistication of the marketing of alcohol products may require a separate, dedicated working group

It is very important that excessive alcohol consumption and drunkenness are not "glorified" in the advertisements or in films, as we know that this is one of the factors influencing the behaviour of young people. There is an increasing trend towards binge drinking among young people all over Europe. This is not only a problem occurring in northern European countries though; Spain for example has a serious problem of youth binge drinking and this is spreading to other countries as well. For once, we should take timely preventative action in the EU, rather than simply adopting a reactive approach to the problem. In my opinion, the film industry also has a role to play at the heart of this debate, and we will try and work with various organizations within this field.

I am looking forward to receiving the report of the Parliament on this issue, which is a very important one for us. It is vital that we have the three Institutions on board: The Commission adopted the proposal, the Council endorsed it and I hope the Parliament will take a similar approach, following which, we will able to fully proceed with its implementation.

I am quite optimistic that now that the work has started, we will be able to deliver results; if this does not work, we will come back with more binding proposals.

But I hope that everyone has received the message, everyone has accepted the message and everybody will be committed to deliver and achieve the expected results and outcomes.

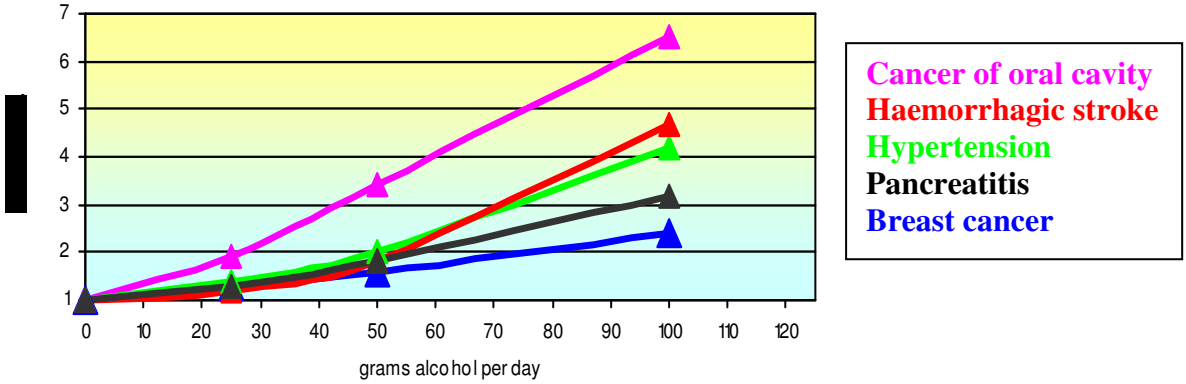
The Impact of Alcohol In Europe

Peter Anderson MD, PhD, MPH

Five facts about alcohol:

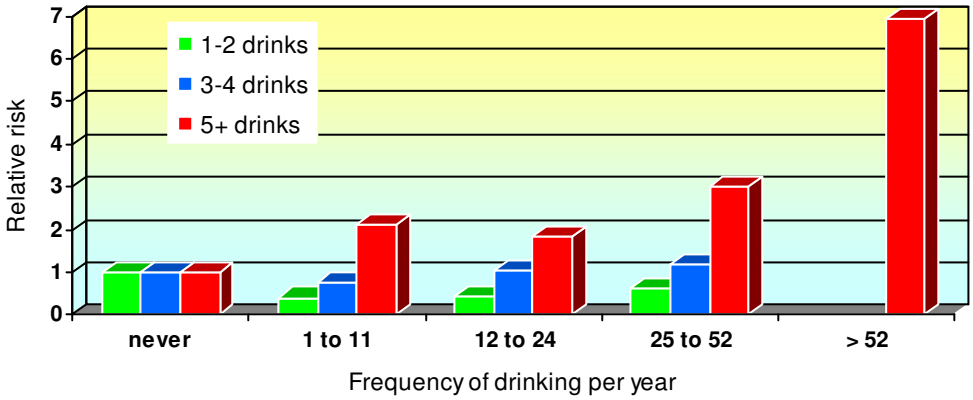
1.- Alcohol is a toxic substance. Alcohol is a toxin that can harm almost any system or organ of the body. There is clear scientific evidence that at least 60 different acute and chronic medical disorders are related or caused by alcohol consumption. There is wide individual variation in the toxic effects of

consuming a given amount of alcohol so it is difficult to predict how anyone individually may react to a given amount of alcohol but in general, there is no threshold below which consumption can be regarded as entirely risk free.
This is illustrated by the graphic below that looks at the relative risk of a number of conditions in relation to grams of alcohol consumed a day on average (where 10 grams is a glass of wine). For all of these conditions and in fact for all conditions related to alcohol the risk increases with increasing alcohol consumption.



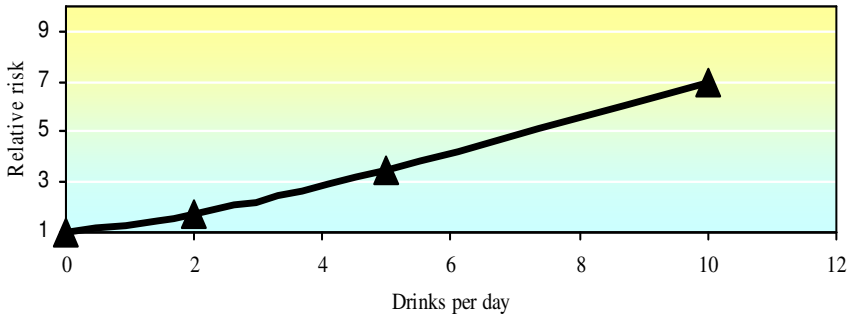
Alcohol also increases the risk of accidents and injuries. The graphic below is taken from a Finnish study that looks at the relative risk of dying from an accident or injury in relation to both, the frequency of drinking per year (which is along the horizontal axis) and within each frequency, how often someone drinks beer, the amount they usually drink on a single occasion.

Both, how frequently people drink and the amount they drink on any one of their drinking occasions, the more they drink, the greater is the risk of dying of a fatal accident or injury.



2.- Alcohol produces dependence. Alcohol produces a state of dependence, depression of the Central Nervous System and stimulation, ill effects, and the liability for abuse. This for alcohol is similar to all other drugs of dependence, including heroin, cocaine, amphetamines and so on. And again with no means of identifying whether or not an individual is at risk, or not at risk, of becoming dependent, although the evidence shows that in general the more a person drinks the more that person is at risk of becoming dependent.

The data below has been taken from a very large American study that shows the risk of being dependent in relation to the number of drinks per day. And some people, even at low levels of alcohol consumption, are at great risk of still getting dependent on alcohol.



3.- Alcohol is an important health determinant in Europe. Each year, alcohol causes in Europe 17,000 deaths from road traffic accidents (1 in 3 of all road traffic fatalities); 27,000 deaths from other accidents; 10,000 suicides (1 in 6 of all suicides); 45,000 deaths from liver cirrhosis; 50,000 cancer deaths, of which 11,000 are female breast cancer deaths; 17,000 deaths due to neuropsychiatric conditions, and some 200,000 episodes of depression. In fact is the young who pay the brunt of this alcohol related harm; **28% of all male deaths at age 15-29 years are due to alcohol and some 11% of all deaths occurring to women between the ages of 15 and 29 years are due to alcohol.**

4.- Alcohol harms people other than the drinker. Each year, alcohol causes: Some 50% of all violent crime that occurs to people; Some 40% of all domestic violence; 4 in 10 of all murders; 10,000 deaths in drink-driving accidents for people other than the drink-driver (so another passenger or a pedestrian); 60,000 underweight births; it is estimated that alcohol is responsible in Europe for some 16% of all child abuse and neglect; and somewhere in a range of between 5 and 9 million children living in families adversely affected by alcohol. One interesting fact about harm to others than the drinker, is that in northern Europe homicide's rate is some 18 million per year, in central Europe is 10 million and in southern Europe is 14 million. The proportion of the homicides that are due to alcohol is: one half northern Europe, 55% in central Europe and over 61% in southern Europe.

5.- In economic terms, alcohol does not pay its way. The estimate for the overall social cost of alcohol in Europe is some 125 billion euros each year (about the same as the social cost of tobacco). This is at least 3 times what is estimated to be the value of the alcohol industry in Europe, 5 times what is the tax revenue intake for governments and some 14 times the trade balance (= exports of alcohol outside the EU minus the imports). If we look at wine, we see an even greater distortion in the figures: the social cost of wine is estimated to be some 42 billion euros, that is 5 times the value of the wine industry, 20 times the trade balance for wine in europe and we have to remember that the Common market organisation subsidises the wine industry with about 1.5 billion euros each year. Taking into account this subsidies the social cost of wine is about 80 times what could be the trade balance of wine in Europe.

<u>Five actions to reduce the harm done by alcohol 5 (this is not an exhaustive list)</u>

1.- Maintain the relative price of alcohol. Between 1990 and 2006 alcohol in England l has become relatively 40 % cheaper. And when we look at alcohol consumption , we can see that this has gone in parallel with the affordability of alcohol. This is clear in every country, as the price of alcohol goes up, people tend to drink less and when the price comes down people tend to drink more. So the price is very important. Price makes a difference to people's consumption. It is also interesting to see that in England as consumption has changed, admissions to hospitals for mental and behavioural disorders due to alcohol has nearly doubled over the same time period and so have alcohol related deaths. Increases in alcohol taxes have shown to reduce a very wide range of harms. Increased tax rates have a greater impact on; Younger drinkers, heavier drinkers and poorer drinkers. Another way of affecting young people consumption is to have a very targeted tax, for example on drinks that are most popular among young people (see the case of Germany and taxes on alcopops).

2.- Manage the availability of alcohol. If you make alcohol more available consumption goes up and harm goes up.

3.- Lower blood alcohol levels for driving, with high visibility testing. Evidence shows that when the number of roadside breath tests carried out per year go up the number of casualties from road accidents involving illegal blood alcohol levels go down. Very sound scientific evidence shows that in order to have a real impact in terms of reducing drink driving, people need to be stopped regularly and tested with a breath meter whether or not they have alcohol in them. Drivers have to have the feeling that they are going to be stopped. Another important measure is to lower the Blood Alcohol Concentration (BAC) levels for driving.

There are some measures that **DO NOT** work:

-Designated Driver Campaigns (Bob Campaign)- someone is designated not to drink and to drive the rest home- . There has been quite a lot of scientific research on the impact of these designated driver schemes and there is no evidence or so ever that they reduce drink driving accidents and fatalities. Until there is evidence available that they do have an impact it would not be appropriate to go on invest large sums of money in these campaigns.

4.- Restructure advertising regulation to manage both content and volume of advertisements. There is considerable evidence that the content of advertisements alters beliefs, attitudes, and expectancies about alcohol amongst young people. Young people are drawn particularly to elements of music, popular characters and humor in advertisement. Young people who like advertisements believe that:

- positive consequences of drinking are more likely;
- their peers drink more frequently;
- their peers approve more of drinking

These beliefs interact to produce greater likelihood of drinking, or of intention to drink in the near future.

There is good evidence that the volume of advertisements increases:

- The likelihood of young people starting to drink
- The amount that they drink

A study carried out in Belgium with secondary school children showed that, more exposure to television viewing and to music videos, were both independently associated with more alcohol consumed whilst going out in the following year.

Another American study shows that amongst non-drinkers, exposure to in-store beer displays predicted drinking onset in the next two years. And amongst drinkers, exposure to alcohol ads in magazines or beer stands at sports or music events predicted greater frequency of drinking two years later.

A study in Los Angeles showed that those 11-12 year old who watched 60% more alcohol advertisements on TV than the average, one year later, were more likely to have used beer, spirits or wine and more likely to have 3 or more drinks on one occasion.

These results for alcohol are rather unsurprising, since, there is accepted scientific evidence that advertising increases the likelihood of starting to smoke and influences food choices amongst young children. Why alcohol should be any different from this?.

Self-regulation and Co-regulation: There is no scientific evidence whatsoever that tests the effectiveness of self-regulation or shows that it works, but there is considerable documentation and experience that shows that it does not work. The alcohol and adverting industries argue powerfully that they should be responsible for self-regulating themselves, but from the scientific point of view, there has been no documented evidence that this is a system that actually works in terms of protecting

young people. There is considerable experience and documentation that there are many advertisements that break codes, and certainly are not within the spirit of what should be an acceptable advertisement for young people.

Example: the Martini advertisement, shows the importance of humor and is an example of what young people like (it was quoted as their favorite by the majority of young people intrerviewd in the Netherlands).

In the new Member States, a lot of work needs to be done to bring the standard of advertisements to what is an acceptable level.

The European case law supports statutory and effective regulation of both, the content and volume of alcohol advertisements. The Loi Evin (in France) establishes that no sponsorship by the alcohol industry is permitted. This law was taken to the European Court because it was held to be illegal by prohibiting the retransmission of sporting events from one country to another because in France you can not have advertising around the field of sports events and then show that on TV. The ruling from the Court said that it is in fact undeniable that advertising acts as an encouragement to consumption and the French rules on TV advertising are appropriate to ensure their aim of protecting public health and they do not go beyond what is necessary to achieve such an objective.

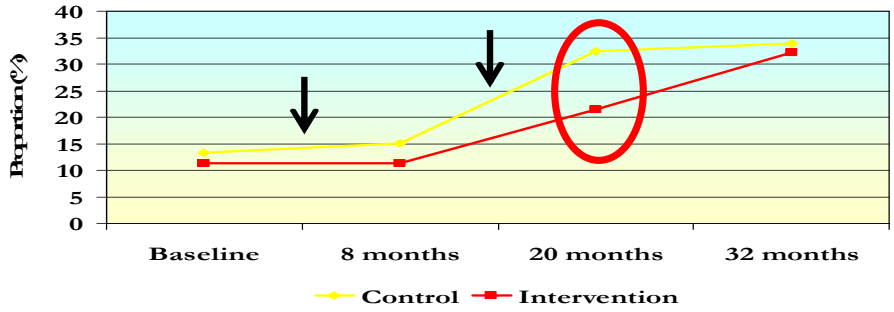
5.- Re-invest money on educational campaigns that make a difference. There have been may studies that have looked at the impact of prevention programmes involving school education.

Below are the results of one of the best accepted reviews of the impact of educational programmes in the short, medium and long term in changing young's people behaviour with regards to alcohol. The authors of this review were unable to find one study that was effective across all of the outcome indicators that they looked at in terms of young's people drinking. They did find quite a lot of studies that were effective in one area but not the other. They also found lot of studies that have no effect at all in terms of changing young's people behavior and even a small number of studies that had a negative impact and made things worse. School based education aimed to reduce alcohol related harm is not an effective intervention to reduce alcohol related harm; although there is evidence of positive effects on increased knowledge about alcohol and in improved attitudes, there is no evidence for a sustained effect on behaviour. *Whilst the provision of information and persuasion to reduce alcohol related harm might seem appealing, particularly in relation to younger people, it is unlikely to achieve sustained behavioural change in an environment in which many competing messages are received in the form of marketing and social norms supporting drinking, and in which alcohol is readily available.*

Follow-up:	Partially effective	In-effective	"Negative" effect
Short-term (≤ 1 year)	14	23	3
Medium-term (1-3 years)	13	19	2
Long-term (over 3 years)	3	6	0

A good example of a well-designed study is the School Health and Alcohol Harm Reduction Project (SHAHRP study) from Australia, which aimed to reduce alcohol-related harm in secondary school students. The study found that the intervention group (which received eight to ten 40 to 60 minute lessons on skill-based activities to minimize harm at age 13 years, and twelve further skills based activities delivered over 5-7 weeks at age 14 years) consumed significantly less alcohol at 8-month

follow-up (31% difference), and were less likely to consume to risky levels (26% difference), by 17 months after the intervention, the total amount of alcohol consumed by intervention and comparison groups had lessened to a 9% difference and the difference in risky drinking to 4%.



The impact of 2 education sessions [↓] on binge drinking in 13-15 year olds

In conclusion: Educational programmes should not be implemented in isolation as an alcohol policy measure or with the sole purpose of reducing the harm done by alcohol, but rather as a measure to reinforce awareness of the problems created by alcohol and to prepare the ground for specific interventions and policy changes. So if a country wants to introduce a new drink driving legislation on warning labels on bottles for pregnant women, this is the time when education can make a difference by sensitising the population to these laws.

WHO[39] initiatives to reduce alcohol related harm

Dag Rekve – World Health Organization (Geneva)

From 1990, the WHO together with the World Bank and the Harvard School of Medicine, conducted The Global Burden of Disease Study, which measured the weight of the different diseases in the global disease burden and the different risk factors contribution to the global level of disease, disability and death.

When in 2002, the World Health Report came out presenting the global and regional estimates of the burden of disease caused by 25 risk factors, it came as a shock for many people to see that alcohol was responsible for 4% of disease burden and 3.2% of all deaths globally, and that alcohol was the foremost risk to health in low-mortality developing countries and the third in developed countries.

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[39] The World Health Organization is the United Nations specialized agency for health.

The **World Health Assembly** (WHA) is its supreme decision-making body. It meets in Geneva in May each year, and is attended by delegations from all 193 Member States to approve the WHO programme and to decide major policy questions.

The **Executive Board** is composed of 34 representatives from the WHO Member States that are technically qualified in the field of health. The main Board meeting, at which the agenda for the forthcoming Health Assembly is agreed upon and resolutions for forwarding to the Health Assembly are adopted, is held in January, with a second shorter meeting in May, immediately after the Health Assembly, for more administrative matters. The main functions of the Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work.
Most of the decisions taken in the framework of the WHO are taken by consensus and are not binding.

WHO Member States are grouped into **six region**s. Each region has a regional office with their respective directors and their own political life.

Note: The possible positive effects of alcohol on coronary diseases are subtracted in the mentioned figures. If they had not, most probably alcohol would have surpassed tobacco at the global level.

Alarmed by the extent of public health problems associated with harmful consumption of alcohol, the World Health Assembly issued in 2005 a resolution on health problems caused by harmful use of alcohol stating the need to address this issue in a much more thorough way on the global level.

Activities following the WHA resolution:

- Progress report on public-health problems caused by harmful use of alcohol [pdf 76kb]
- WHO Consultative Meeting on Alcohol and Public Health (7-9 June 2005)
- Open consultations with representatives of alcohol industry, agricultural and trade sectors (8-3-06)
- Meeting with representatives of NGOs and professional associations (24-4-06)
- WHO sought views of stakeholders on health problems related to alcohol consumption (15-09-06)
- Meeting with stakeholders on health problems related to alcohol consumption (9-10- 06)
- 1st WHO Expert Committee[40] on Problems Related to Alcohol Consumption (10-10-06) – this is the highest scientific body of the WHO. They will produce a report this year on the range of public health problems attributable to alcohol consumption as well as scientific and empirical evidence of effectiveness of different policies and interventions to reduce alcohol-related harm.

On Monday this week the Executive Board (see footnote 1) has decided that Alcohol will be discussed again this year in the WHA in May this year.

Also the Regions of the WHO are starting to place a higher emphasis on alcohol:
- The western pacific, South East Asia and Eastern Mediterranean have placed the alcohol issue high on the agenda, and have a resolution and a technical paper, strategies etc.

- The **European Region**: long standing focus on alcohol, came up with a new framework on alcohol policy in 2005 (http://www.euro.who.int/document/e88335.pdf) which has already been agreed on by the Ministers of Health.

Challenges the WHO faces when dealing with alcohol-related problems:

- How can we protect abstention as a possible choice?: The three main determinants behind the burden of disease attributable to alcohol consumption are: the overall consumption, the drinking patterns and the levels of abstention. At present, 50% of the world population are abstainers. However, these rates of abstention are likely to decline with increasing affluence (there is a strong link between wealth and alcohol consumption). How to protect abstinence as a possible choice is one of the biggest challenges at global level. This is not that much of a problem for the European Region, where levels of consumption could not increase any more (except in some southern and eastern countries where the levels of abstention among women are quite high).

- Cultural sensitivities: Of course there are cultural connotations attached to alcohol consumption but there are also some things that are universal and should not be culturally sensitive ; for example the victim of a drunk driver does not really care whether he got drunk by drinking a very good Bordeaux or if he drunk unrecorded alcohol. Some things are universal and should not be culturally sensitive; other things are cultural sensitive, and we need to look at how we can reduce alcohol related problems

[40] An expert committee is an international group of experts that provides WHO with the latest scientific and technical advice on a broad range of medical and public health subjects. Members of such expert groups are all drawn from the expert advisory panels and serve in their personal capacities rather than as representatives of governments or other bodies. Their views do not necessarily reflect the decisions or the stated policy of WHO. Membership of an expert committee lasts only for the duration of the meeting.

in a culturally feasible way. Besides, cultural sensitivity is a two way approach: How can we protect countries that want to keep restrictive alcohol policies because of these cultural sensitivities? This is a very difficult issue in a world where the tendency is to free trade and liberalization.

- Positive health and social effects of alcohol consumption sometimes blur the picture and make it difficult for us to look at how we can reduce the harmful effects of alcohol. We know alcohol is a means to satisfy certain human needs and what we should ask ourselves is whether these needs have to be satisfied with alcohol. We need to have a frank and open discussion about this.

Equity is an extremely important issue in that equation: who gets the benefits and who gets the harm?

- The role of the industry: Given that alcohol is a legal commodity and at the same time a psychoactive and dependence-producing substance, what should be the role of the industry in the formulation and implementation of alcohol policies, given that they have a commercial interest.
This is still under discussion. There are some guidelines in the Framework for the European Region.

- Try to find a way in which the local, regional, national and global levels can reinforce each other in a positive way, so we can reduce alcohol-related harm globally, which will affect us in our daily life.

Eurocare recommendations for effective action to reduce the burden of alcohol problems

Ms. Tiziana Codenotti, Vice Chairman, Eurocare

Eurocare welcomes the Strategy and will continue to support the Commission in its implementation. To have a European Strategy on Alcohol was one of Eurocare's main goals since its foundation. The Strategy puts alcohol high in the EU political agenda and constitutes an explicit recognition of the fact that alcohol-related harm is very widespread and pervasive, and significantly affects people other than the drinker himself.

Since this is a Commission's strategy, we believe that there is a need for an impact assessment of other DG's policies and decisions on alcohol policy and health.

Although we are very pleased that the Strategy has finally seen the light, we regret to see that the Strategy makes a few concessions to the industry which reflects the fact that the EU is still more of a common market than a political union. The industry, should of course be heard, but we should not forget that there are some fundamental differences between the industry's objectives and the objectives of a health policy on alcohol.

We are also concerned about the lack of plans for harmonized legislation. Trade agreements and the Internal Market rules have increased the difficulty of maintaining effective alcohol policies at the national level for example when it comes to advertising and marketing practices, drink driving or cross border trade. Here there is thus a need for concerted action at EU level.

As regards the Alcohol and Health Forum, we think it would be important to involve other DGs such as agriculture, internal market and taxation in order to raise awareness among the Commission officials about the harm done by alcohol so that they realise why alcohol cannot be treated as an ordinary commodity. There should also be a group of independent experts, appointed by the Commission, who can provide assistance and guidance throughout the process as well as figures and facts. We are also concerned about the number of meetings per year and the administrative burden of the 'commitment' system, which will drain the already quite scarce human and financial resources of the NGO members. We therefore believe that the number of meetings should be strictly limited to avoid draining Commission and NGO resources and time. Experience from the EU Diet Platform has also shown that industry plays a very active role in relation to the Platform – using it to promote their initiatives, gain access to senior policy-makers and gather legitimacy for their activities. They have extensively used the logo of the Platform for their own events, in their marketing information and in the media.

Eurocare welcomes the five priority themes and the 11 aims set out in the strategy.

1st priority theme: Protect young people, children and the unborn child

We are pleased to see that one of the aims is to reduce the harm suffered by children in families with alcohol problems. In 1998, Eurocare together with COFACE[41] prepared a report "Alcohol Problems in the Family", that showed that, at least, 7 million children in the EU15 live in families wrecked by alcohol.

I would also like to add that youth binge drinking is exacerbated not only by the continued availability but also by the increased spending power of young people, which makes alcohol relatively cheaper. We support the use of increased taxes on products particularly attractive to young people and the restrictions on sale, availability and marketing. Both measures are mentioned in the strategy as examples of good practice.

With regards to the implementation of life-skills teaching programmes in reducing binge drinking, we would like to point out that there is no evidence to support the widespread implementation of these programmes - as their effectiveness has yet to be proven. A variety of educational approaches have been used in an attempt to reduce the harm done by alcohol, and the evidence shows that whilst the provision of information and persuasion to reduce alcohol related harm might seem appealing, particularly in relation to younger people, it is unlikely to achieve sustained behavioural change

2nd Priority theme: Reduce Injuries and deaths form alcohol-related road traffic accidents

We would like to emphasise the importance of frequent random breath testing; the establishment of a maximum blood-alcohol level and the introduction of zero or 0.2g/l BAC for young and novice drivers as effective measures to reduce alcohol-related injuries and fatalities

Measures such as the BOB campaigns (designated driver campaigns) have shown to be not effective.[42]

Eurocare's recommendation: Strict enforcement combined with active awareness raising.

4th Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption and on appropriate consumption patters

We regret to see the strong emphasis on education, information activities and campaigns as effective policies in reducing the harm done by alcohol throughout all the text of the strategy as the result of the undue influence of the Industry.
The evidence is much stronger on regulation including taxes, restrictions on availability and restrictions on the marketing of alcohol. With this we don't mean that that education and information should not be delivered, everybody has the right to be informed of the harms cause by alcohol. Education should not be seen as the only and simple answer to reduce alcohol-related harm. Education programmes should not be implemented in isolation as an alcohol policy measure or with the sole purpose of reducing the harm done by alcohol but rather, as a measure to reinforce awareness of the problems created by alcohol and to prepare the ground for specific interventions

Also very important is that the information to the public has to be complete and impartial. So we believe the Industry should not be involved in providing education and information.

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[41] **Confederation of Family Organisations in the EU http://www.coface-eu.org/**

[42] See Eurocare's report on Drinking and Driving in Europe (2003)
http://www.eurocare.org/pdf/papers/drinkdriving.pdf

The right of all people to valid impartial information and education on the consequences of alcohol consumption on health, the family and society was recognized in the European Charter on Alcohol, signed more than 10 years ago in Paris by the Member States of the European Region of the WHO. And we still experiencing incomplete and partial (biased) information. There is still a lot of work to do in this area. Still there is a lot a false information about the health benefits of alcohol consumption.

5th Priority Theme: Develop, support and maintain a common evidence base

We fully support the need for a European monitoring system on alcohol, similar in function and funding to the European drugs monitoring system (EMCDDA) and the need for further studies to evaluate the effectiveness of actions and interventions, as proposed in this Communication.

Eurocare can support the implementation of the European Alcohol Strategy by bringing in the NGO/civil society element without which no public health strategy on alcohol is likely to succeed Also through its network and projects, Eurocare helps in raising public and political awareness; provides good practice and know how, and; takes part in the policy process at EU level to develop the dossier further.

We are very pleased to hear the Commissioner saying that the strategy is just a first step and I am sure that Eurocare members will work hard towards the implementation of the Strategy.

Is the industry really willing to cooperate to curb underage drinking? - Marketing of alcohol to young people

Ms. Monique Kuunders. Policy Adviser. National Foundation for Alcohol Prevention (Netherlands)

The alcohol Industry is primarily a marketing industry.

The fact is a lot of alcohol marketing is appealing to young people; in order to limit the impact of alcohol marketing on young people we need to cut down the increasingly large volume of it that is appealing to young people.

A quote from the 2005 annual report of Heineken reads “in 2005 we increased our spending in innovation and marketing in order to reinforce our brand portfolio and to address declining beer consumption in western countries”. Ultimately, the alcohol industry goal is to increase their profits by selling their product and designing appealing and effective alcohol marketing strategies is a means to do this.

Analyzing alcohol advertisements and the messages they contain, it is evident that these ads are quite simply funny and nice. They do not say anything but suggest and build an image around drinking and the alcoholic drinks. The advertisements are more about portrayals of lifestyles, motivations, aspirations and coolness, and less about the product.

Some examples of alcohol advertising that are appealing to young people: Heineken commercial. Most of the 200 15-year-old we interviewed in the Netherlands, mentioned this advert as their favourite, and yet, it does not show anyone drinking.

However, our concern should not simply be the very explicit, extreme and sexually arousing messages, but the ever increasing volume of commercial communications.

Here are some examples of **products** targeted to young adults; the problem is that young teenagers want to be adults and they look up at adults and at the products used by young adults.

Examples of **events sponsored** by alcohol brands include sport events, concerts, parties, etc. Sponsorship and advertising have in fact become indistinguishable. The prime purpose of sponsorship, like advertising, is to promote the all important brand images that are used to appeal to young drinkers. Events and programmes are chosen first and foremost for their potential in this area. Careful consumer research is carried out to examine the image of particular programmes or sports and the most appropriate and influential ones are then selected.

Sponsorship is particularly well suited to the communication of brand imagery, in the sense that it is more hidden, enabling covert or "subliminal" messages to be conveyed. This is easily used to sidestep controls on advertising, as well as being cheaper method, which is potentially less exposed to criticism.

Here are some examples of **merchandising products** that show the extent to which alcohol brands have become more than a just product. What about having your own Martini pool, Heineken key-ring, Bacardi-belly button ring or Bacardi mobile phone cover and accessories ….

An example of a website which promotes the beer tender for all-time beer access from your kitchen and you can practice online pouring a beer.

Here are some examples of websites of brands that are very popular among young people and that contain many playful elements.

www.bacardi.nl
- Cocktail recipes
- Learn salsa (footsteps on screen)

www.grolsch.nl
- collect 'music miles'
- bar game; bar empire game; big beer quiz …..

www.malibu.nl
- Jam session

www.heineken.nl
- Clone a girl (and if you have a webcam and a can of beer you can also clone it)

On these websites there aren't many references to the alcoholic beverage itself.

If the impact of alcohol marketing can be so worrying, to what ends are these appealing promotions designed ?

Most of the marketing practices are targeted to young adults (18 to 25 years old) because they are the biggest drinkers. Research shows how brand allegiance rises strongly during teenage years, that is why creating brand allegiance among young people and children is an investment that the industry is sure to cash in on later. Advertising to teenagers is, in effect an investment in future customers.

Alcohol advertisers often promote their products to young adults and not to teenagers, which is forbidden. The problem however is that teenagers look up to young adults and they are attracted to products for young adults. So even if they advertise to young adults, teenagers are likely to be attracted to these products as well.
And that is why even if alcohol advertisers do not target young people, their products and advertising will be very appealing to young people.

There is regulation, like the Television Without Frontiers, to protect consumers, specifically minors. The TV Without Frontiers Directive as well as many of the codes and regulations establishes that alcohol advertising should not suggest that consumption of alcohol contributes to social or sexual success.

However, regulation does not prevent the huge amount of very appealing alcohol promotion that associates alcohol with coolness, party, fun….

This is partly because the existing regulation prohibits explicit messages about alcohol consumption; however, as you have just seen, most promotions of alcoholic beverages do not send out explicit messages about alcohol, but rather, convey a message about 'lifestyle' or use the means of humour promote the product.

On the other hand, these regulations do not prevent alcohol marketing from being everywhere and broadcast around the clock. There are many countries that do not have time bans on advertising. And the result is that, for example, in the Netherlands, almost half of alcohol television commercials are broadcast before 9 p.m. and therefore reach a young audience.

So in order to limit the impact of alcohol advertising to young people you need to reduce the exposure of young people to alcohol advertising by introducing time limitations.

Content restrictions are not proven to be effective. But if content is restricted it should be very clear how. A good example is the Loi Evin in France, where alcohol advertising is restricted to product information only.

Personal Testimony: The lives behind the statistics

Ms. Diane Black, adoptive mother of three children with fetal alcohol syndrome, mother of a child killed by a drunk driver, sister to an alcoholic man.

I am invited here today to tell you about my family and how we have been affected by alcohol. I am going to tell you three stories, really. Parts of my stories happened in the US, as I grew up there, and parts here in Europe, where I have lived for over eighteen years.

First I want to tell you about my brother. When I was a little girl, I really looked up to him. He was big and strong and knew everything. He could read hard books and he could open jars when the lids were on tight and he knew how to spell the hard words and explained to me that "ren-dez-vus" was really pronounced "ron-day-voo." He wasn't afraid of anything: he would kill spiders in my room and when we went fishing, he put the worms on the fishhooks for me.

Somewhere during high school, he started doing drugs. Those were the hippie years, and all the kids in the honors club, the smart kids, were taking LSD and smoking marijuana. Well, it didn't take them very long to figure out that alcohol was cheap, more-or-less legal, and easy-to-come-by. Over the years, my brother drank more and more. He dropped out of college, was in a mental hospital for a while, then got a job at the post office. He basically worked for 8 hours, then came home and drank till he passed out, and then usually got up in time for work again. Over the years, he was in and out of trouble, apparently with some alcohol treatment, sometimes in prison, and sometimes living on the street or in a Salvation Army center. He didn't have much contact with anybody in the family. Sometimes he would call, drunk, at 3 o'clock in the morning and talk endlessly around in circles.

Finally, he lost his job while he was lying in intensive care for gastric bleeding. When he got out of the hospital, the union helped him sue successfully to get his job back, which he, of course, lost again within a few months. He withdrew his retirement fund of about 30 thousand dollars and went across the country to move in with a drunk friend who lived with his mother, and this friend said his mother wouldn't mind. Well, she did mind. So my brother ended up living in cheap hotels and living it up with prostitutes until his money ran out. He went to a shooting range, rented a rifle, put the end of the

barrel into his mouth, and pulled the trigger. We had his body cremated and spread his ashes on the banks of the Potomac River in a place he used to love.

My next story is about my son. When I was about 19. I enjoyed being pregnant. The birth naturally wasn't so much fun, but I had the most beautiful baby boy in the world.

He grew up happy and healthy. Naturally there were a few bumps along the way, like the day when he was five years old when he played gas station with the garden hose and my car. Or when I remember how angry he was at me when he found out that Santa Claus wasn't real: he was furious that I had 'lied' to him. That took a lot of explaining on my part! My son was brilliantly intelligent, and won numerous awards and honors as he went through school. He was so annoyed because he got 'only' a 790 out of 800 on his SAT, the American college entrance exam, and he planned to do it over to get a perfect score.

The day after his 19th birthday, while on a bicycle tour in the countryside, on a beautiful sunny afternoon, he was hit by a drunk driver, a young man who had sat the whole morning in the bar drinking strong beer. The driver was racing at 100 km/hour in the village, over a hill where he could not see ahead of him. My son was just laughing at a joke with his friend, when the car hit him, he was thrown onto the hood of the car, and then slid into the ditch by the road. His friend screamed, a neighbor ran to get the doctor, but his heart stopped beating within minutes.

My son was dead, my future was dead. I wanted to run out into the street and throw myself under a car so I could go to join him. This was 14 years ago. I have found other purposes in life, but I still look forward to dying, so that I can be with my son again.

My last story comes up to the present. Almost 11 years ago, my husband and I adopted 3 children. The oldest was three years old, the twins were 16 months. We knew their mother was an alcohol addict, but had no idea that alcohol can have such severe effects on the unborn.

The oldest child was hyperactive, unpredictable, and dangerous. He spent the days zooming back and forth in the living room screaming or climbing the curtains or throwing all his legos out the window by handfuls. He might be standing nicely on the sidewalk next to me, and when a truck came down the road, suddenly run out right in front of it. When he was about five, the twins used to have little round blue marks on their throats. I would ask the twins, "How did that happen? Did you fall on a stick?" but they couldn't tell me. Then one day I saw how it happened. The oldest dragged his little brother out of my sight and, telling him, "I am going to teach you a lesson!" he strangled him with his thumbs in his brother's throat.

As a baby, my daughter used to wake up screaming in the night up to seven times, and she could not be comforted. I found out years later that she had hallucinations. She remembered as a baby seeing monsters in her bed, and seeing her room change into a gymnasium. Her twin brother was off in his own little world, either crying or giggling with his eyes rolled up to the ceiling.

I did not know then that prenatal alcohol exposure damages the body and brain so heavily. In particular the prefrontal cortex is often heavily damaged, destroying executive control, that is the ability to exercise self-control, to foresee the consequences of actions, and conscience. Researchers now estimate that 1-3 children per thousand in the western world are born with full Fetal Alcohol Syndrome, and that probably 1 in a hundred have some learning or behavioral disorders without having all the characteristics of the full syndrome. For most of these children, the role of prenatal alcohol exposure is never recognized. They receive diagnoses of ADHD, autism or PDD-NOS, or are just labelled as unmanageable, violent, without a conscience. They face a future with high risk of alcoholism, broken relationships, unemployment, mental illness, and criminality, and nobody will ever realize that the underlying cause was brain damage due to prenatal alcohol exposure.

My kids are now 14, 12, and 12. With much work and constant support and supervision, the twins are doing well. My daughter is a champion rider in her small village riding school, and her twin brother is a valued player in a village soccer team. They are two years behind their age level in school, which is

alright, because in any case they are very small for their age. My oldest has just started middle school. This means he has to travel by bike and bus, and is away from home all day long. This is also an age when Dutch young people are already regularly getting drunk, very worrisome, because due to his prenatal alcohol exposure, my son is at high risk of alcohol addiction. I am not sure, I think he has started experimenting with alcohol. In any case, he is becoming uncontrollable and angry. On New Year's Eve, we watched a movie together, as is our custom. Then we had fondue for a late supper, and shot off fireworks at midnight. About quarter to one, we sent the kids to bed, watched a National Geographic show about the beavers, then we locked up all the doors and went to bed ourselves. At 3:30, the doorbell rang insistently. My husband went down in his pajamas to answer the door while I paused to grab my robe. Just as I came down the stairs I heard an angry voice saying, "Your son.....!" I said, "But he is lying in his bed!" but as I came a step further down, whom did I see standing there with his arm tightly gripped by an angry neighbor lady! It turns out that he had waited till we were asleep, unlocked the doors and slipped out to meet a "friend," and together they had thrown firecrackers through the mail slot into the lady's house. Apparently the reason for doing so was that some kids said "she was weird." She had awoken to the noise and her hall full of smoke. This was one day after we had read in the newspaper how some boys burned a house down by doing just that, and my son had angelically said how awful that was and that he would never do such a thing.

I was invited to tell these stories to remind us that all the statistics and reports are about real people, about real tragedies. You all know about alcohol addiction and drunk driving, I hope I have been able to give you an insight into the spectrum of harm caused by prenatal alcohol exposure.

APPENDIX 8

eurocare EUROPEAN ALCOHOL POLICY ALLIANCE

INVITATION

Lunch meeting on FASD (Foetal Alcohol Spectrum Disorders)

Place: European Parliament – Room "ZONE CANAL C.00.1"- Strasbourg
Date: Tuesday, 4 September 2007
Time: 13h00

Hosted by MEPs Mr **Jules Maaten** (ALDE) and Ms **Dorette Corbey** (PSE)

You are cordially invited to the lunch meeting that Eurocare is organising together with MEPs Mr Jules Maaten and Ms Dorette Corbey to mark the International FASD Day.

Drinking alcohol during pregnancy is the leading known cause of mental retardation and birth defects in the EU. It affects about 1% of people in the EU27 (i.e. nearly 5 million people) and is the only one that is 100% preventable. The umbrella term, **Foetal Alcohol Spectrum Disorders (FASD),** describes the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These can include physical, mental, behavioural and or learning disabilities with possible lifelong implications.

Although many pregnant women abstain from alcohol, there is still a substantial number of women in all the EU Member States who continue to drink during pregnancy– ranging from 25% in Spain to 35%-50% in the Netherlands and even higher rates in the UK or Ireland.

This meeting will be a unique opportunity to learn more about this condition and to discuss with specialist working in the field the different policy options to curb its incidence.

Speakers:

Dr Kieran O'Malley. He has worked with FASD patients for 17 years. For the last 9 years, until he moved back to Belfast last February, he was working at the Fetal Alcohol & Drug Unit, in the University of Washington (Seattle), where much work has been done on FASD and its prevention. Kieran is both doctor and a psychiatrist, and has researched and published extensively on FASD.

Dr Nicolaas van der Lely is a paediatrician from the Netherlands. He works as Chief Resident in the Pediatrics Departmenat the Reinier de Graaf Hospital. He is well known and highly respected in the Netherlands for his extensive research on alcohol and youth. In December 2006, he launched a multidisciplinary alcohol outpatient clinic for children with problems related to alcohol use.

If you wish to attend, please send the attached form to jules.maaten-assistant@europarl.europa.eu

For any additional information please contact Mr Maaten's office. **Tel.** : +32 (0)2 28 45606

APPENDIX 10

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Eurocare and Members to join the EC's Alcohol and Health Forum

Today marks the launch of the European Commission's 'Alcohol and Health Forum', a multistakeholder platform bringing together civil society and businesses pledging to take action to reduce alcohol related harm in Europe. Eurocare welcomes the action oriented remit of the Forum and is committed to fully supporting DG Sanco, whose work has been pivotal in firmly establishing alcohol on the EU political agenda. We hope that all European alcohol producers and retailers will participate in the Forum, and commit to evidence based actions, thus explicitly recognising their responsibilities towards curbing alcohol related harm in Europe, in particular among young people.

The Alcohol and Health Forum represents the backbone of the European Commission's 'EU Strategy to Support Member States in Reducing Alcohol Related Harm'. The Strategy, released last October, addresses the adverse health effects related to harmful and hazardous alcohol consumption as well as the related economic and social consequences. The Council of Ministers first voiced the need for a comprehensive EU level strategy in 2001; despite the efforts and mobilisation of both DG Sanco and Europe's public health community to protect the health and well being of European citizens, the final strategy reflected the alcohol industry's intensive and unprecedented lobbying campaign. Health Commissioner Markos Kyprianou shared this concern at the time and admitted that he had been "surprised at the aggressiveness of the lobbying campaign by certain parts of the alcohol industry (which) created doubts as to their willingness to cooperate". Participation in the Forum and voluntary commitment to concrete action, is crucial for these sections of the alcohol industry, in order to regain credibility, promote corporate social responsibility, and above all, avoid the implementation of EU level legislation.

The Forum, hosted by DG Sanco, is modelled on the EU Platform on Diet, Physical Activity and Health, launched in March 2005. It focuses on concrete 'commitments' for action, which will be assessed, monitored and evaluated with the assistance of a Science Group. The 'Committee on National Policy and Action', a structure separate to the Forum composed of Member States representatives, will coordinate national alcohol policies and ensure translational exchange of good practice.

Andrew McNeill, Honorary Secretary of Eurocare said: " We welcome the presence of a Science Group, to ensure that industry commitments are evidence based and relevant. Most importantly, we are pleased to see a clear separation between the Forum as a platform for action, and the Committee on National Policy and Action as one for policy discussion among member states:we believe public health policies on alcohol should be formulated without the interference of commercial interests."

APPENDIX 11

Eurocare's position paper on the revision of the "Television Without Frontiers" Directive

eurocare
EUROPEAN ALCOHOL POLICY ALLIANCE

EUROCARE is an alliance of 45 voluntary and non-governmental organisations from all over Europe dedicated to the prevention and reduction of harm done by alcohol. http://www.eurocare.org

Our comments and concerns are strictly motivated by reasons of public health, in particular the protection of minors.

ALCOHOL IS NOT AN ORDINARY COMMODITY

Apart from being a drug that can lead to both physical and psychological dependence, alcohol is a toxic substance and a cause of some 60 diseases and conditions (including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including an increased risk of premature birth and low birth weight. (See annex 1 "The harm done by alcohol to the individual drinker").

Alcohol is a key health determinant, responsible for 7.4% of all ill-health and premature death in the European Union, which makes it the 3rd leading risk factor, after high blood pressure and tobacco.

Alcohol is also a cause of harm to others than the drinker, including some 60,000 underweight births, up to 9 million children living in families adversely affected by alcohol and 10,000 traffic deaths to people other than the drunk driver in the EU each year.

It can be estimated that alcohol causes nearly 195,000 deaths in the EU each year[43] (over 25% of male deaths in the age group 15-29 years are caused by alcohol). Further, alcohol-attributable disease, injury and violence cost the health, welfare, employment and criminal justice sectors across the EU some €125bn a year. Equivalent to 1.3% GDP (i.e. €650 for each household)[44].

PROTECTING YOUNG PEOPLE AND CHILDREN FROM THE IMPACT OF ALCOHOL ADVERTISING

Statistical evidence shows a trend towards increased risky use of alcohol among young people[45].

This is all the more cause for concern as youths who begin drinking early in life are significantly more likely to become dependent on alcohol later[46]. Starting to drink at an early age has also been linked to unintentional injuries, motor vehicle crashes, physical fights, unplanned and unprotected sexual behaviour, antisocial personality, conduct disorder, and academic underachievement.

References:

[43] WHO's Global Burden of Disease study (Rehm et al. 2004)
[44] Anderson, P. and Baumberg, B. (2006). Alcohol in Europe. A public health perspective. http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm.
[45] Hibell B, Andersson B, Bjarnason T, Ahlström S, Balakireva O, Kokkevi A, Morgan M (2004): The ESPAD Report 2003. Alcohol and Other Drug Use Among Students in 35 European Countries
[46] Hingson R. W. et al. Age at Drinking Onset and Alcohol Dependence. *Arch Pediatr Adolesc Med.* 2006;160:739-746

Children and young people constitute an important target group for the alcohol industry because they represent the market of tomorrow, the drinkers of the future. Creating brand allegiance among children and young people is an investment the industry is sure to cash in on.

Content analyses of the appeals used in alcohol advertisements suggest that drinking is portrayed as being an important part of sociability, physical attractiveness, masculinity, romance, relaxation and adventure. Many alcohol advertisements use humour, rock music, animation, image appeals, celebrity endorsement and animal characters, which increase their popularity with underage television viewers[47]. Not surprisingly, alcohol commercials are among the most likely to be remembered by teenagers and the most frequently mentioned as their favourites. [48]

Also, children are aware of alcohol advertising and find many such commercials attractive. For example, according to a survey carried out by the Center on Alcohol Advertising, elementary school children are more familiar with the Budweiser frogs that they are with cartoon cereal characters such as Tony the Tiger[49].

By definition, alcohol advertising is one-sided and presents alcohol consumption as a safe and problem-free practice, de- emphasizing the potential health risks and negative consequences. Through its messages, alcohol advertising maintains the social desirability of drinking, overshadows the risk of alcohol to individual and public health, and contradicts prevention objectives.

Both, article 15 and 3 g (e) of the proposed Directive, seek to protect minors by prohibiting the specific targeting of minors. However the ubiquity of alcohol advertising ensures that it can hardly be missed by them. Indeed, the reality is that regardless of whether these advertisements are specifically targeting minors, even young children are aware of alcohol advertisements and tend to remember them.

A growing body of research shows that exposure to and enjoyment of alcohol commercials cause minors to develop more positive expectancies and attitudes towards alcohol, which in turn influences the onset of drinking age, as well as patterns and levels of alcohol consumption[50]. Thus, Eurocare believes that restricting the volume of commercial communications of alcohol products is likely to reduce harm.

Eurocare calls for the inclusion of measures in the Directive that restrict the volume of audiovisual commercial communications for alcoholic beverages such as a 9 p.m. watershed ban on alcohol advertising.

ARTICLE 15

The subtlety and complexity of much marketing and advertising simply defies regulation.

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[47] M. J. Chen et al. Alcohol advertising: What makes it attractive to youth? Journal Health Communications 10 (2005)

[48] Aitken, P.P. et al.. (1988): Television advertisements for alcohol drinks do reinforce under-age drinking. British Journal of Addiction 83: 1399-1419.
-Aitken, P.P. et al. (1988): Ten to sixteen-year-olds' perceptions of advertisements for alcoholic drinks. Alcohol and Alcoholism 23: 491-500.
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-Grube, J. W. (1993). Alcohol portrayals and alcohol advertising on television. Alcohol Health and Research World, 17, 6166.

[49] Centre on Alcohol Advertising, USA

[50] Martin, S.E. and Snyder, L.B. and Hamilton, M. and Fleming-Milici, F. and Slater, M.D. and Stacy, A. and Meng-Jinn, C. and Grube, J.W. (2002): Alcohol advertising and youth. Alcoholism: Clinical and Experimental Research 26: 900-906.
-Hill, L. and Caswell, S. (2001) Alcohol advertising and sponsorship: commercial freedom or control in the public interest. In Eds. Heather, N., Peters, T.J. and Stockwell, T. International Handbook of alcohol dependence and problems. Chichester: John Wiley and Sons Ltd. pp 823-846, 2001.
-Chen M-J, Grube JW. (2002). TV beer and soft drink advertising: what young people like and what effects? Alcohol Clin Exp Res 26(6):900– 6.

Since advertising uses association, suggestion and symbolism, rules as the ones in article 15, intended to restrict the contents of advertising, will therefore never be infallible.

Eurocare believes that Article 15 should be strengthened by adding time limits (e.g. 9 p.m.), programme limits (e.g. youth and sports) and limits on concentration of alcohol advertising (e.g. no more than one alcohol advertisement per programme) which are more easily enforceable.

In particular a new rule should be added to article 15 specifying:

"Audiovisual commercial communications for alcoholic beverages should not be broadcast before 9 p.m." (article 15.2)

Monitoring mechanisms and clear dissuasive sanctions should be put in place. It is a fact that where a company can make greater profit by ignoring the rules contained in article 15, it is likely to do so. Therefore, heavy sanctions capable of acting as deterrents need to be put in place.

SELF-REGULATION AND CO-REGULATION

Self-regulation is most commonly adopted by the industries under threat of governmental regulation. This is particularly the case with regard to commercial sectors that involve products harmful to health, such as tobacco or alcohol.

To date, self-regulation of commercial communications by the alcohol industry does not have a good track record for being effective. The industry is too strongly motivated to bend or circumvent the rules.

- **Self-regulatory Codes or Codes of practice:**

Most self-regulatory codes are largely irrelevant to the way alcohol advertising actually works as they deal with the content and the style of advertising rather with the volume.

Although it is a well-established fact that the attitudes and behaviour of the public are affected by the sheer number and repetition of advertisements, and not only by their content[51], none of the existing self-regulatory codes contains any provision on the quantity / volume of advertising such as time-limits, programme limits (e.g. youth or sports programmes) and limits on concentration of alcohol advertising.

Typically, self-regulatory codes include provisions similar to those in article 15 of the Directive that establish a number of criteria advertisements shall comply with (e.g. not to be aimed at minors, not to couple alcohol with social or sexual success, not to show intoxication or minors drinking, or not to link alcohol with driving). Research has consistently shown that the interpretation of this kind of provisions varies depending on whether the review is being carried out by an industry appointed body, representatives of the public or the specific target audience involved[52].

As noted above, the content of contemporary marketing is increasingly sophisticated and subtle. This presents an increased challenge for monitoring and control of content. The fact that viewers are ''active recipients'' of advertising creates another major difficulty for the application of rules of content. Advertising messages are received and understood in the context of the recipients' lived experience. For example, advertisements that contain cues to indicate intoxication, without expressly showing it, can reinforce the norms supportive of heavy drinking. Research has documented that young people interpret advertisements as indicating drinking to intoxication even though these advertisements would not necessarily be perceived as such by all viewers[53]. Similarly, while many

[51] Grube, J.W. (1993). Alcohol portrayals and alcohol advertising on television. *Alcohol Health and Research World, 17* (1), 61-66.
[52] Saunders B, Yap E. (1991). Do our guardians need guarding? An examination of the Australian system of self regulation of alcohol advertising. Drug Alcohol Rev. 10:15–7.
[53] Wyllie A, *et al.* (1997). A qualitative investigation of responses to televised alcohol advertisements. Contemporary Drug Problems. 24: 103–32.

codes restrict the use of young people in advertisements, having them present is not necessary for an advertisement to be appealing to under-age drinkers – it is enough to show the lifestyles to which young adults aspire[54]. Thus, much alcohol marketing is likely to be effective in appealing to underage young people without violating the codes.

Eurocare strongly believes that the objective should be not only to control the content and the style of the advertising, which is important but not enough, but also to reduce the volume of advertising in order to reduce exposure of young people and children to alcohol advertising.

More objective and less open to interpretation criteria aimed at reducing the volume of advertising such as time-limits, programmes limits and limits on concentration of alcohol advertising are easily implemented and monitored and more difficult to circumvent.

- Involvement of the industry at the **adjudication stage:** deciding whether a violation has taken place and imposing an appropriate sanction.

On average, it takes a few months for the self-regulatory bodies to rule on a complaint. The result is that by the time these bodies give a verdict, even if the complaint is upheld and the advertisement has to be withdrawn, it is already too late and the advertisement has already done its harm / job.

Further, most of these self-regulatory bodies only hand down recommendations rather than fines. This is so in spite of the fact that where a company can make a greater profit by ignoring self-regulation than complying, it is likely to do so, especially where no-compliance in not easily detected by the consumer or likely to harm the particular company's reputation.

Eurocare believes that only fines that are heavy enough can act as effective deterrents.

PRODUCT PLACEMENT

EUROCARE does not support a relaxation of the rules relating to product placement. We support the principle of separation between advertising and programme content as necessary to prevent consumers from being misled.

We fear that the review of the Directive's provisions on product placement will lead to an increase in exposure to alcohol communications by minors and therefore we urge that a paragraph be added to Article 3h specifying:

"Audiovisual media services must not contain placement of alcoholic beverages or product placement from undertakings in furtherance of the manufacture or sale of alcoholic beverages".

SPONSORSHIP

Sponsorship and advertising have in fact become indistinguishable. The prime purpose of sponsorship, like advertising, is to promote the all important brand images that are used to appeal to young drinkers. Events and programmes are chosen first and foremost for their potential in this area. Careful consumer

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Wyllie A, Zhang JF, Casswell S. (1998a). Responses to televised alcohol advertisements associated with drinking behaviour of 10-17-year-olds. Addiction. 93(3):361–71.
-Wyllie, A.; Zhang, J.F.; and Casswell, S. (1998b) Positive responses to televised beer advertisements associated with drinking and problems reported by 18- to 29-year-olds. *Addiction* 93(5):749–760.

[54] Hill, L. and Caswell, S. (2001) Alcohol advertising and sponsorship: commercial freedom or control in the public interest. In Eds. Heather, N., Peters, T.J. and Stockwell, T. International Handbook of alcohol dependence and problems. Chichester: John Wiley and Sons Ltd. pp 823- 846, 2001.

research is carried out to examine the image of particular programmes or sports and the most appropriate and influential ones are then selected.

Both are trying to get across the same image based messages. In addition, the two mediums are deliberately used to support each other.

Of the two, sponsorship is perhaps of greater concern, since it is particularly well suited to the communication of brand imagery; is more hidden, enabling covert or "subliminal" messages that can get round the defences of their "wary" and media literate young targets; it is easily used to sidestep controls on advertising; and finally it is cheaper and less exposed to criticism.

Therefore Eurocare urges that a paragraph should be added to Article 3h specifying:

"Audiovisual media services may not be sponsored by undertakings whose principal activity is the manufacture or sale of alcoholic beverages"

ADDITIONAL COMMENTS

We are aware that audiovisual commercial communications of alcoholic beverages are only one of the mediums the industry uses to reach minors along with Internet, radio, printed press, SMS on mobiles and others. Thus, restrictions on audiovisual commercial communications will not be enough in isolation but are, in any case, in line with the recommendations of the Council of the EU[55] and the WHO Declaration on Young People and Alcohol[56]

[55] Council Recommendation 2001/458/EC of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents [Official Journal L 161 of 16.06.2001].
[56] WHO Declaration on Young People and Alcohol, 2001 http://www.euro.who.int/AboutWHO/Policy/20030204_1/

APPENDIX 13

Request to support the Westlund Amendment (n 169) to article 15 of the Audiovisual Services Directive: no alcohol adverts on TV before 9.00 p.m.

eurocare
EUROPEAN ALCOHOL POLICY ALLIANCE

EUROCARE is an alliance of 46 voluntary and non-governmental organisations from all over Europe dedicated to the prevention and reduction of harm done by alcohol. http://www.eurocare.org

The leading Children, Family and Health Organisations are united in calling upon MEPs to vote to Ban all alcohol advertising on TV before 9.00 pm

Dear MEP,

On 12 December 2006, MEPs at the Plenary session of the European Parliament will vote on the draft of the Audiovisual Directive that has been forwarded by the Education and Culture Committee.

A cross-party group of 65 MEPs, led by Mrs Åsa Westlund, has put forward an amendment (num AM 169) for the plenary vote which would ensure that before 9.00 p.m. no alcohol adverts would be shown on television.

The amendment adds a new paragraph to article 15:

"Television advertising for alcoholic beverages should not be broadcast between 6.00 a.m. and 9.00 p.m."

This amendment builds on the views of the ITRE and FEMM Committee. Both Committees have in their opinion on the draft Directive adopted amendments to ban all alcohol advertising between 06.00 am and 09.00. Unfortunately, none of these amendments were taken up by the lead Committee - CULT- in its list of recommended amendments for the Plenary session.

The arguments for the Amendment are as follows:

- the majority of the TV audience before 9.00 is families and children. The programming schedules (e.g light entertainment, soap operas) reflect this and so should the advertising.
- alcohol is an addictive substance that contributes towards 60 physical and mental diseases and conditions
- children and families pay a heavy price in terms of domestic violence, child abuse and neglect caused by adult drinking
- there is an increasing trend across Europe of starting to drink younger (average 1st drink is 12.5 years old) and young people drinking heavily
- alcohol advertising - despite the existing restrictions - is very attractive for young people and uses strong sexual and social images to sell products
- alcohol advertising is inappropriate on TV before 9.00 in the evening.

Eurocare has together with a group of people working in the alcohol and health NGO community created a website (http://www.notbefore9.eu) which sets out the background of the Amendment and

shows examples of TV and print adverts for alcohol products. These adverts - despite the existing restrictions in Article 15 of TV without Frontiers - clearly break the guidelines of not targeting minors or linking alcohol with driving, sexual or social success. They demonstrate the need for establishing a time framework for alcohol advertising on television.

This initiative is being supported by the leading NGO networks working on children's rights and wellbeing:

- **EURONET** - The European Children's Network- a coalition of networks and organisations campaigning for the interests and rights of children.

- **EUROCHILD** - a network of 34 organisations and individuals working in and across Europe to improve the quality of life of children and young people.

- **European Child Safety Alliance** - a programme of EuroSafe. Its mission is to advance child injury prevention throughout Europe by enhancing the quality of children's lives

- **COFACE** - The Confederation of Family Organizations in the EU - an organization which links together 60 family organizations across the Member States of the EU and as such, it gives a voice to many millions of parents and children.

And by the leading NGO network working on public health, the European Public Health Alliance **(EPHA)** that represents over 100 non-governmental and other not-for-profit organisations working on public health in Europe.

We would be very pleased to provide more information or answer any questions that you may have on this topic.

Yours faithfully,

APPENDIX 14

eurocare
EUROPEAN ALCOHOL POLICY ALLIANCE

European Public Health Alliance

Brussels, Tuesday 08 May 2007

Dear Member of the European Parliament,

In the upcoming plenary session of the 09 May 2007, the Lulling report on the Alcohol minimum excise duties Directive will be voted on.[57]

EPHA -the largest European network of health NGOs, representing more than 100 not-for-profit organizations- and Eurocare -the European Alcohol Policy Alliance representing 46 organizations working on the prevention and reduction of alcohol related harm- call upon health champions in the European Parliament to **vote against this report** that serves the interests of the alcohol industry at the expense of the health and well-being of European citizens and to support the proposal from the European Commission to increase the minimum rates of excise duties in line with inflation in order to maintain their real value as agreed by the Council in 1992[58].

More precisely, health NGOs are very concerned by two major proposals in the report, namely:

- The elimination of the minimum excise duties on alcohol
- A Code of Conduct establishing that those Member States levying excise duty rates above the EU average should freeze and reduce them gradually

The report prepared by Ms Astrid Lulling, vice-chairman of the Beer Group in the Parliament, treats alcohol merely as a product that is traded and ignores the fact that alcohol is responsible for 7,4% of all ill-health and premature death, is the cause of some 60 diseases and conditions; and it is also a key cause of harm to people other than the drinker, including crime, violence and injuries, and therefore should not be regarded simply as an ordinary commodity.

Several studies[59] have demonstrated that price and tax measures are an effective policy option in reducing the harm done by alcohol and that young people are particularly sensitive to price. Policies that increase alcohol taxes and prices have been shown to reduce the proportion of young people who are heavy drinkers, to reduce underage drinking, to reduce per occasion binge drinking. They also

[57] Report on the Proposal for a Council Directive 92/84/EEC on the approximation of the rates of excise duty on alcohol and alcoholic beverages ((COM 2006) 0486- C6 03/9/2006-2006/0165 (CNS)), Committee on Economic and Monetary Affairs, Rapporteur: Astrid Lullig.
[58] Council Directive 92/84/EEC on the approximation of the rates of excise duty on alcohol and alcoholic beverages
[59] See for example Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, Grube JW, Gruenewald PJ, Hill L, Holder HD, Homel R, Österberg E, Rehm J, Room R & Rossow I (2003). Alcohol: No Ordinary Commodity. Research and Public Policy. Oxford, Oxford Medical Publication, Oxford University Press.

delay intentions among younger teenagers to start drinking and slow progression towards drinking larger amounts. Heavy drinkers are also very sensitive to increases in prices.

Research[60] also shows that such measures lead to reductions in deaths from liver cirrhosis, fatality rates from traffic crashes, and reduced rates of crime, including assault, violence related injury, homicide, family violence, and child abuse and other violence towards children.

Further, imposing taxes on alcohol also helps governments to meet the fiscal costs of alcohol related harm, it is a way of 'internalising' these costs to the sellers and drinkers in proportion to the alcohol consumed, rather than being met by all taxpayers.

It is important to note that Member States who have adopted high excise duties, have done so in the interest of public health rather than economic benefit. The measures proposed in the Lulling report would only penalize and increase the pressure on those Member States that have chosen to regulate alcohol taxes as a means of protecting citizen welfare[61].

By treating alcohol as an ordinary economic commodity the proposal fails incorporate health concerns and therefore breaches the Treaty's obligation to ensure a high level of human health protection in the definition and implementation of all Community policies and activities.

We call upon the Members of the EP to oppose this proposal that serves the interests of the alcohol industry at the expense of the interests of the health and social wellbeing of European citizens, by voting **against** the report and supporting the proposal from the Commission to re-valorise the minimum rates of excise duties on alcohol in line with inflation.

Yours faithfully,

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[60] Ornstein, S. I. (1980) Control of alcohol consumption through price increases. Journal of Studies on Alcohol, 41, 807–818.

Ornstein, S. I. and Levy, D. (1983) Price and income elasticities and the demand for alcoholic beverages. In: Galanter, M., ed. Recent Developments in Alcoholism. New York: Plenum.

Ornstein, S.I. (1980) Control of alcohol consumption through price increases. Journal of Studies on Alcohol, 41, 807-818.

Österberg, E. (2001) Effects of price and taxation. In: Heather, N., Peters, T. J. and Stockwell, T., eds. International Handbook of Alcohol Dependence and Problems: Part VI: Prevention of Alcohol Problems, pp. 685–698. Chichester: John Wiley and Sons, Ltd.

US Department of Health and Human Services (USDHHS) (1997) Ninth Special Report to the US Congress on Alcohol and Health from the Secretary of Health and Human Services, no. 97– 4017. Rockville, MD: US Department of Health and Human Services, Public Heath Service, National Institute of Health (NIH), National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Godfrey, C. (1988) Licensing and the demand for alcohol. Applied Economics, 20, 1541–1558.

Leung, S. and Phelps, C. (1991) My kingdom for drink. A review of estimates of the price sensitivity of demand for alcoholic beverages. In: Hilton, M. E. and Bloss, G., eds. Economics and the Prevention of Alcohol-Related Problems, pp. 1–32. Rockville, MD: US Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism (NIAAA).

[61] Although alcohol policies have converged in Europe over the last 50 years, substantial differences in alcohol taxes persist, which results in cross-border shopping, thus impeding the ability of many Member States to implement effective policies. The consequences of differential taxes between countries are compounded by the high and increasingly liberal limits of the amount of alcohol that individuals can transfer between countries.

Background information:

In 1992, the then 12 EU Member States unanimously agreed to set minimum levels for excise duties on beer, spirits and other alcoholic drinks apart from wine. The aim was to reduce the market distortions caused by widely differing excise levels.

On 8 September 2006, the Commission adopted a proposal to update the existing Directive 92/84/EEC on the approximation of the rates of excise duty on alcohol and alcoholic beverages by increasing the minimum rates in order to take account of inflation and restore their real value agreed by Council in 1992. Based on Eurostat data the total inflation rate for the period between 1993 and 2006 has been estimated by the Commission at around 31%.

In fact, the majority of Member States are unaffected by this proposal as their national rates already exceed the proposed new minimum rates. Although the inflation rate is 31%, the actual impact on prices in the countries affected by the decision will be minimal, for example, for beer, the biggest required increase in national excise duty would be of the order of € 0.01 (one eurocent) on half a litre of beer.

Commission press release:
http://europa.eu/rapid/pressReleasesAction.do?reference=IP/06/1165&format=HTML&aged=0&language=EN&guiLanguage=en

On November last year, the EU Finance Ministers examined the Commission's proposed adjustments but failed to reach an agreement so they decided to delay the decision and invited the Commission to carry out a comprehensive study of the taxation of alcohol and alcoholic beverages, including trends in competitive positions and in levels of taxes and prices.
The results of that study were to be presented to the Coulcil during the first half of 2007, with a view to facilitating further Council decision-making as regards alcohol taxation.

EU Council press release:
http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/ecofin/91899.pdf

APPENDIX 15

eurocare EUROPEAN ALCOHOL POLICY ALLIANCE

Eurocare Press Release , 23 May 2007

European Parliament votes against Lulling report on minimum excise duties on alcohol

Eurocare welcomes the results of the voting in the European Parliament on the minimum excise duties The Members of the European Parliament have today voted against the adoption of the report prepared by the vice-chairman of the Beer group in the European Parliament, the MEP from Luxembourg, Ms Astrid Lulling, on minimum excise duties on alcohol.

Eurocare welcomes the results of this voting against this proposal that serves the interests of the alcohol industry at the expense of the interests of the health and social wellbeing of European citizens. The report prepared by Ms Astrid Lulling, contained two major proposals that where of great concern to the health NGOs, namely:

- The elimination of the minimum excise duties on alcohol
- A Code of Conduct establishing that those Member States levying excise duty rates above the EU average should freeze and reduce them gradually.

By treating alcohol merely as a product that is traded the report ignored the fact that alcohol is responsible for 7,4% of all ill-health and premature death, is the cause of some 60 diseases and conditions; and it is also a key cause of harm to people other than the drinker, including crime, violence and injuries, and therefore should not be regarded simply as an ordinary commodity.

Andrew McNeil, Honorary Secretary of Eurocare, the European Alcohol Policy Alliance, welcomed the results of the voting and said that "by treating alcohol as an ordinary economic commodity the proposal from Ms Lulling failed to incorporate health concerns and therefore breached the Treaty's obligation to ensure a high level of human health protection in the definition and implementation of all Community policies and activities". McNeil added that "evidence shows that price and tax measures are an effective policy option in reducing the harm done by alcohol and young people are particularly sensitive to price. Member States who have adopted high excise duties, have done so in the interest of public health rather than economic benefit. The measures proposed in the Lulling report would only penalize and increase the pressure on those Member States that have chosen to regulate alcohol taxes as a means of protecting citizen welfare."

Socialist spokeswoman on the report, Donata Gottardi: "alcohol consumption can be affected by the rate of excise duties and for many governments in Europe, the fact that they are mandatory is a key element of health policy".

APPENDIX 16

eurocare EUROPEAN ALCOHOL POLICY ALLIANCE

European Commission releases Eurobarometer Special Report on attitudes towards alcohol

Eurocare welcomes public support for Alcohol Strategy

Eurocare welcomes the Eurobarometer Special Report on attitudes towards alcohol, released today by the European Commission, and hopes the survey will be repeated at regular intervals in order to, amongst other things, measure the success of the EU Alcohol Strategy in reducing the harm done by alcohol in Europe. The low awareness among EU citizens of the permitted blood alcohol levels or the trend among the youngest respondents to drink 3- 4 drinks or more on any given drinking occasion, show that the EU has still a long way to go in this field.

Andrew McNeil, Honorary Secretary of Eurocare, the European Alcohol Policy Alliance, welcomed the findings in the report and said that "although the results of the survey show that there is still much work that needs to be done, there is also a considerable public support for tackling drink driving and underage drinking, which bodes well for the Commission Strategy". Around three quarters of EU citizens would agree with putting warnings on the containers of alcoholic beverages, introducing lower blood alcohol level for young drivers or banning alcohol advertising which targets young people. Banning the sale and serving of alcohol to people under the age of 18 was regarded as an important measure by 87% of the Europeans surveyed.

Notes to the editors:

1. The special Eurobarometer on Alcohol is available at:
http://europa.eu.int/comm/health/ph_publication/eurobarometers_en.htm

APPENDIX 17

eurocare EUROPEAN ALCOHOL POLICY ALLIANCE

RESPONSE FROM EUROCARE TO THE WHO CONSULTATIVE DOCUMENT ON HEALTH PROBLEMS RELATED TO ALCOHOL CONSUMPTION

PLEASE ENTER THE ORGANIZATIONS VIEWS ON THE MAGNITUDE OF HEALTH PROBLEMS RELATED TO ALCOHOL CONSUMPTION BELOW. MAX 300 WORDS

Apart from being a drug that can lead to both physical and psychological dependence, alcohol is a toxic substance and a cause of some 60 diseases and conditions, including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including an increased risk of premature birth and low birth weight.

Alcohol is a key health determinant, responsible for 7.4% of all ill-health and premature death in the European Union, which makes it the 3rd leading risk factor, after high blood pressure and tobacco.

Alcohol is also a cause of harm to others than the drinker, including some 60,000 underweight births, as well as 16% of child abuse and neglect and up to 9 million children in the EU living with problem drinking parents. Alcohol also affects other adults, including an estimated 10,000 deaths in drink-driving accidents for people other than the drink-driver, with a substantial share of alcohol-attributable crime also likely to occur to others.

It can be estimated that alcohol causes nearly 195,000 deaths in the EU each year. including 17,000 deaths per year due to road traffic accidents (1 in 3 of all road traffic fatalities), 27,000 accidental deaths, 2,000 homicides (4 in 10 of all murders and manslaughters), 10,000 suicides (1 in 6 of all suicides), 45,000 deaths from liver cirrhosis, 50,000 cancer deaths, of which 11,000 are female breast cancer deaths, and 17,000 deaths due to neuropsychiatric conditions as well as 200,000 episodes of depression (which also account for 2.5 million DALYs).

Young people shoulder a disproportionate amount of this burden, with over 10% of youth female mortality and around 25% of youth male mortality being due to alcohol. Little information exists on the extent of social harm in young people, although 6% of 15-16 year old students in the EU report fights and 4% report unprotected sex due to their own drinking.

Alcohol is a cause of health inequalities both between and within Member States, causing an estimated 90 extra deaths per 100,000 men and 60 extra deaths per 100,000 women in the newer EU10 countries, compared to the older EU15 countries. Within countries, many of the conditions underlying health inequalities are associated with alcohol, although the exact condition may vary (e.g. cirrhosis in France, violent deaths in Finland). Worse health in deprived areas also appears to be linked to alcohol, with research suggesting that directly alcohol-attributable mortality is higher in deprived areas beyond that which can be explained by individual-level inequalities.

PLEASE ENTER THE ORGANIZATIONS OPINIONS ON EFFECTIVE INTERVENTIONS TO REDUCE HEALTH PROBLEMS RELATED TO ALCOHOL CONSUMPTION. MAX 300 WORDS

Based on existing evidence Eurocare believes the following policies and programmes to be the most effective in reducing the harm done by alcohol:

Regulate the alcohol market:

- Increasing the price of alcohol
- Excise Duties (particularly important in targeting young people): Taxing beverages proportionately to the amount of alcohol content. The level of tax should at least be sufficient to cover the cost of dealing with alcohol problems. Excise duties should not be seen solely as a means of raising revenue but also as a "social welfare" tax, a proportion of alcohol taxes should be earmarked to fund programmes to reduce the harm done by alcohol or use a proportion of alcohol taxes to fund programmes.
- Managing the availability of alcohol: restrictions on the availability of alcohol; reducing the number and density of outlets, including availability in supermarkets and general retail stories; changing the location of outlets; reducing the days and hours of opening; establishing a minimum system of licensing for the sale of alcoholic products.
- Restricting alcohol promotion: Prohibiting the use of direct or indirect incentives that encourage the purchase of alcohol products (sales promotions).
- Alter the drinking context[62]: Establishing a minimum drinking age law backed up with a range of severe penalties against sellers and distributors , such as withdrawal of licence or temporary and permanent closures. Such strategies are also more effective when backed up by community based prevention programmes.

- Reduce Drinking Driving: Key elements of successful countermeasures against drinking and driving:

- Unrestricted (random) breath testing, to increase the perceived risk of being caught.
- Lowered blood alcohol concentration (BAC) levels (0,5 g/L and 0,2 g/L for young drivers and drivers of public service and heavy goods vehicles).
- License suspension for a minimum period of 12 months for drivers above 50 mg%. Penalties graded depending on the BAC level and proportionate to the seriousness of the offence, particularly in cases resulting in death or injury to others.
-Alcohol locks can be effective as a preventive measure, but as a measure with drink driving offenders, only work as long as they are fitted to a vehicle.
-Comprehensive community-based educational and mobilization programmes, including urban planning and public transport initiatives.
-Special treatment programmes for problem drinkers convicted of drink driving offences.

- Alcohol Advertising:

-Restricting the volume and content of commercial communications of alcohol products: Imposing a ban on alcohol advertising, promotion and sponsorship of events, TV radio / programmes, sports.

[62] There is growing evidence for the impact of these strategies, however, they are primarily applicable to drinking in bars and restaurants, and their effectiveness relies on adequate enforcement.

-Treatment of Alcohol Problems:

-Brief physician advice (i.e. early intervention programmes) in primary health care settings: Integrated evidence-based guidelines for brief advice, training and support programmes to deliver brief advice; ensuring widespread availability and accessibility of these programmes; common minimum standards for health and social care workers in relation to the knowledge and skills required for the identification and management of alcohol problems.

The impact of policies that support education, communication, training and public awareness is low. Educational programmes are only effective as a measure to reinforce awareness of the problems created by alcohol and to prepare the ground for specific interventions and policy changes.

PLEASE ENTER ANY OTHER COMMENTS. MAX 300 WORDS

While the Alcohol Industry has a responsibility to market their products according to laws and agreements of the Member States, we do not accept that they have a role in deciding public health policies. The setting and implementing of public health policies with respect to alcohol policy should be protected from commercial and other vested interests of the alcohol industry.

The industry shall focus on server training, compliance with laws, employee assistance and (possibly) a limited role in countering drink-driving, but they should not be involved in youth education given conflicts of interest.

APPEDIX 18

eurocare
EUROPEAN ALCOHOL POLICY ALLIANCE

Eurocare response to market access hearing
http://ec.europa.eu/trade/issues/sectoral/mk_access/index_en.htm

An EU strategy on market access must take a wider perspective than trade alone in order to promote a sustainable global economic development. This is a long term profitable strategy for EU exporters and good for third country societies.

1. Reason for concern: Alcohol is today the fifth largest risk factor contributing to the global burden of disease (premature death and morbidity), which accounts for about as much disability and death globally as tobacco. Worldwide, about 76.3 million have alcohol use disorders. Alcohol, globally, contributes to 1.8 million deaths and widespread social, mental and emotional consequences (source: WHO)

2. Importantly, when considering the importance of emerging markets, in low mortality developing countries alcohol is the leading risk factor, while it is 'only' at 11th place in high mortality developing countries (source WHO). Economic development in major Asian markets, for example, may therefore contribute to a relative increase in the burden caused by alcohol consumption worldwide. Studies by the World Bank and the WHO point out that consumption of tobacco and alcohol increase significantly in countries in transition.

3. Eurocare notes that health determinants like the harmful use of alcohol need to be countered by comprehensive public policies as called for by the Council already in 2001.[63] The Council has recently in its support for the Commission Alcohol Strategy called upon the Member States to:

    - "foster a multi-sectoral approach in the prevention of alcohol-related harm to ensure the contribution of all areas of public government at all national levels", and
    - "to give specific emphasis to the enforcement of national legislation that can contribute to reducing alcohol-related harm, such as […] and on selling and serving alcoholic beverages".

4. The EU should make sure that its trade policies are not limiting third countries ability to establish the comprehensive and public health based policies the EU itself recommends for its Member States.

5. A comprehensive public health response to tackling health determinants like alcohol will seek to reduce the health and social consequences by *inter alia* reducing access, limiting promotion, and increasing prices. These measures are in principle contrary to liberalisation of trade with regard to certain particular commodities like alcohol.

6. Eurocare acknowledges the many benefits trade may bring to society and call for an integrated approach where public health not only is protected from negative impacts of trade, but one where health and economic development may be mutually supportive.

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[63] Council Conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm (OJ C 175, 20.6.2001, p. 1);

7. Eurocare also acknowledges the rationale for negotiating the regulatory environment for foreign investment and trade in regions and countries other than the EU. However, progress can be made without reducing States ability to respond to public health risks.

8. The objective of moving towards a level playing field may be desirable but must not be confused with the lowest common denominator or a race towards the bottom.

9. The objective of reaching a level playing field must not take precedence over a public health aims since health regulators need a flexible capacity regarding changing health treats that may require seemingly disproportionate responses (ref alcopops).

10. The discrepancies in treatment of domestic and foreign products and services may be regrettable from a trade point of view, for example the more severe taxation of foreign alcoholic beverages than domestic, but may in some instances be seen as a pragmatic compromise between the increasingly globalised trade and the still domestic responsibility for finances, business and health etc. A further harmonisation of the regulatory environment may or may not be desirable, but should not be seen as a trade issue only.

11. A predictable business environment where the rule of law prevails may be achieved without lowering public health provisions; on the contrary it should be seen as an opportunity towards securing both global health and global trade by for instance using trade as a lever to move towards advances in other policy areas too.

12. Such approach, which is a strategic political approach, may not be in the interest of all EU business interests but acknowledges its responsibility to act on behalf of the European Union and its wider interests.

13. The strategic discussion on market access should take as point of departure the imperative that EU business respect national laws and regulations when operating in foreign markets and national or local policy developments with the aim to improve them. Equal attention should therefore be given to this concern as to the need for governments and regulators to respect the rules of international trade agreements. In short, an asymmetric relationship between international trade agreements and national and local health policies must be avoided. One remedy of many is to introduce adequate references to health protection in trade agreements or outright exclusions where appropriate.

14. The need to consider the wider implications of market access to society. The market place where goods are traded cannot be seen in isolation from the society it is a part of and the consumers that purchase the goods and services.

15. There is a need to acknowledge the diversity of challenges to health world wide and the need for a diverse response according to country specific circumstances. Similar regulations may in different countries and regions serve different purposes or have varying effect and importance.

16. States must have the freedom to establish necessary public policies in response to public health problems if and when they appear or change and improve existing ones. Since foreign trade and investment may contribute to economic growth and thus contribute to increase in life style related diseases, trade policies must not be of any hindrance to future public policy responses, in particular since such response will provide sustainability to the economic development and social cohesion and thus contributing to the global economy and stability.

17. There is a need to acknowledge the particular situation of societies in development and in transition: In many instances where market access becomes a question of great interest, the target country is an economy in transition. In that respect the EU should acknowledge that in the case of economies in transition the EUs perspective should rather be one of looking at *societies in transition* rather than economies in transition.

18. In particular we point at the need for the EU when negotiating international agreements on trade to seek input from public health experts.

19. There is an obligation on behalf of the EU to include public health and consumer safety considerations in all EU policy areas, and where appropriate use its influence to raising standards globally with regard to consumer safety and public health.

20. The EU when advancing its goals of market access should make sure that the EU trade polices are in accordance with the EUs wider policy objectives, in particular being in accordance with its development policy, "ensuring that non aid policies can assist developing countries in achieving the Millennium Development Goals"[64] to mention one.

21. There is a need for greater policy coherence internationally as recognised by the WHO between "trade and health policy so that international trade and trade rules maximize health benefits and minimize health risks, especially for poor and vulnerable populations" (World Health Assembly 27 May 2005). "To create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in their trade and health policies" (ibid).

22. Eurocare believes the initiatives to improve market access globally must be paralleled by, and should refer to, initiatives at UN and WHO level to reach adequate agreements on protecting and improving health in societies where economic premises are affected by trade with the EU and thus pursuing a balanced approach in global development through relevant agencies and negotiations.

23. Eurocare, besides the need for taking health into consideration in all EU policies, also trade, proposes to introduce Health Impact Assessments in its foreign trade policies, recognising that 'all policies, programmes and projects receive an adequate impact assessment that includes human health' (WHO), in particular with regard to sustainable development.

[64] Joint statement by the Council and the representatives of the Governments of the Member States meeting within the Council, the European Parliament and the Commission "The European Consensus on Development", 20.12.2005.