World Health Organization
REGIONAL OFFICE FOR Europe

IMPLEMENTING ALCOHOL POLICIES IN THE COMMONWEALTH OF INDEPENDENT STATES

A WORKSHOP OF "FIRST-MOVER" COUNTRIES

ABSTRACT

This report highlights the main outcomes of a first WHO workshop on the implementation of alcohol policies in the countries of the Commonwealth of Independent States (CIS), which took place on the 4-5 December 2019 in Moscow, Russian Federation. CIS countries can be seen as "first movers" in implementing the most cost–effective policies to reduce alcohol consumption and alcohol-attributable harms in the WHO European Region and their contribution is crucial to reaching the noncommunicable disease (NCD) target of a 10% reduction in the harmful use of alcohol by 2025.

KEY WORDS

ALCOHOL – adverse effects
ALCOHOL DRINKING – prevention and control
ALCOHOL POLICY IMPACT
CONSUMER HEALTH INFORMATION
HEALTH POLICY
RISK FACTORS
EUROPE

Document number: WHO/EURO:2020-1202-40948-55497

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FOREWORD

HOW "FIRST MOVER" COUNTRIES BRING CLOSER OUR VISION OF A WORLD FREE OF ALCOHOL-RELATED BURDEN THROUGH IMPLEMENTING ALCOHOL POLICIES

When comparing the WHO European Region with the other five WHO regions in terms of alcohol intake and its harm, the picture seems bleak for our part of the world. We have the highest drinking levels and the lowest abstention rates in the population, as well as the highest proportion of people who engage in heavy episodic drinking and those who have an alcohol use disorder. We are also the region with the largest relative contribution of alcohol to our mortality statistics.

At the same time, we are also the region that has reacted to these challenges early on and in the most active way. As much as alcohol is part of our Region's' history, so are the actions to reduce alcohol consumption and its associated harms. The first European Alcohol Action Plan adopted in 1992, the European Charter on Alcohol adopted in 1995, the Declaration on Young People and Alcohol from 2001 and the Framework for Alcohol Policy in the WHO European Region from 2006 – all of these were important milestones in the Region's long-lasting efforts to combat alcohol-related harms. These documents, which set out the guiding principles and goals for promoting and protecting the health and wellbeing of all people in the Region, were adopted and endorsed long before the Global Strategy to Reduce the Harmful Use of Alcohol, which was adopted by all Member States of the WHO in 2010.

This makes our Region a "first mover" in responding to the harm that stems from alcohol and putting policy measures in place to tackle it, tailoring them to the needs of the vulnerable groups as well as local contexts and resources available, while supporting and bringing the global agenda forward. However, when looking back at the most recent developments, we must acknowledge that although much progress has been made in reducing alcohol use, this progress differs greatly across the Region. While we have clear evidence that drinking levels remained stable in the Member States of the European Union,

we see large declines in the Eastern part of the WHO European Region. Almost all Member States of the Commonwealth of the Independent States have considerably reduced their drinking levels and many of them have introduced important alcohol control measures to do so. Many of these policies have never been introduced anywhere else within such short periods of time or with this intensity or continuity and some of the introduced measures were unique in their design and contribution. This makes the experiences of this part of the Region unique, especially in the light of the enormous alcohol-attributable burden some of the countries had to tackle in the past and continue to address in the present.

The understanding of the implementation of these policies and the impacts they have had provides important lessons for the rest of the Region, contributing to the advancing field of alcohol policy research and offering invaluable insights from real life scenarios and natural experiments. It also brings forward our vision set in the WHO's European Programme of Work, 2020–2025 in protecting the vulnerable, leaving no one behind and enable people to live safer, healthier and better lifestyles.

This report documents an important landmark meeting of representatives of CIS countries as the "first movers" of alcohol control policy in the European Region, giving voice to the policy makers and public health specialists behind the respective policy interventions and highlighting the lessons learned from the field. As the first document of its kind, it also marks the start of a new WHO initiative, which provides a platform for knowledge and best practices exchange for CIS countries and beyond. The envisioned alcohol policy network is aimed to support ministries of health and other authorities in their efforts to mobilise political leaders around public health measures that can reduce the immense economic and health burden caused by alcohol.

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ACKNOWLEDGEMENTS

This report was written by Maria Neufeld, Consultant, WHO European Office for the Prevention and Control of Noncommunicable Diseases, with contributions from Anna Bunova, Junior Researcher, and Boris Gornyi, Leading Researcher, the National Medical Research Centre for Therapy and Preventive Medicine of the Ministry of Health of the Russian Federation. It was revised by Carina Ferreira-Borges, Programme Manager, Alcohol and Illicit Drugs, WHO European Office for the Prevention and Control of Noncommunicable Diseases, Elena Yurasova, Technical Officer, WHO Country Office in the Russian Federation, and Jürgen Rehm, WHO Collaborating Centre and Institute for Mental Health Policy Research, Centre for Addiction and Mental Health, Toronto Canada; Institute of Clinical Psychology and Psychotherapy, Technische Universität Dresden, Germany; Agència de Salut Pública de Catalunya, Barcelona, Spain; and Department of International Health Projects, Institute for Leadership and Health Management, I.M. Sechenov First Moscow State Medical University, Moscow, Russian Federation.

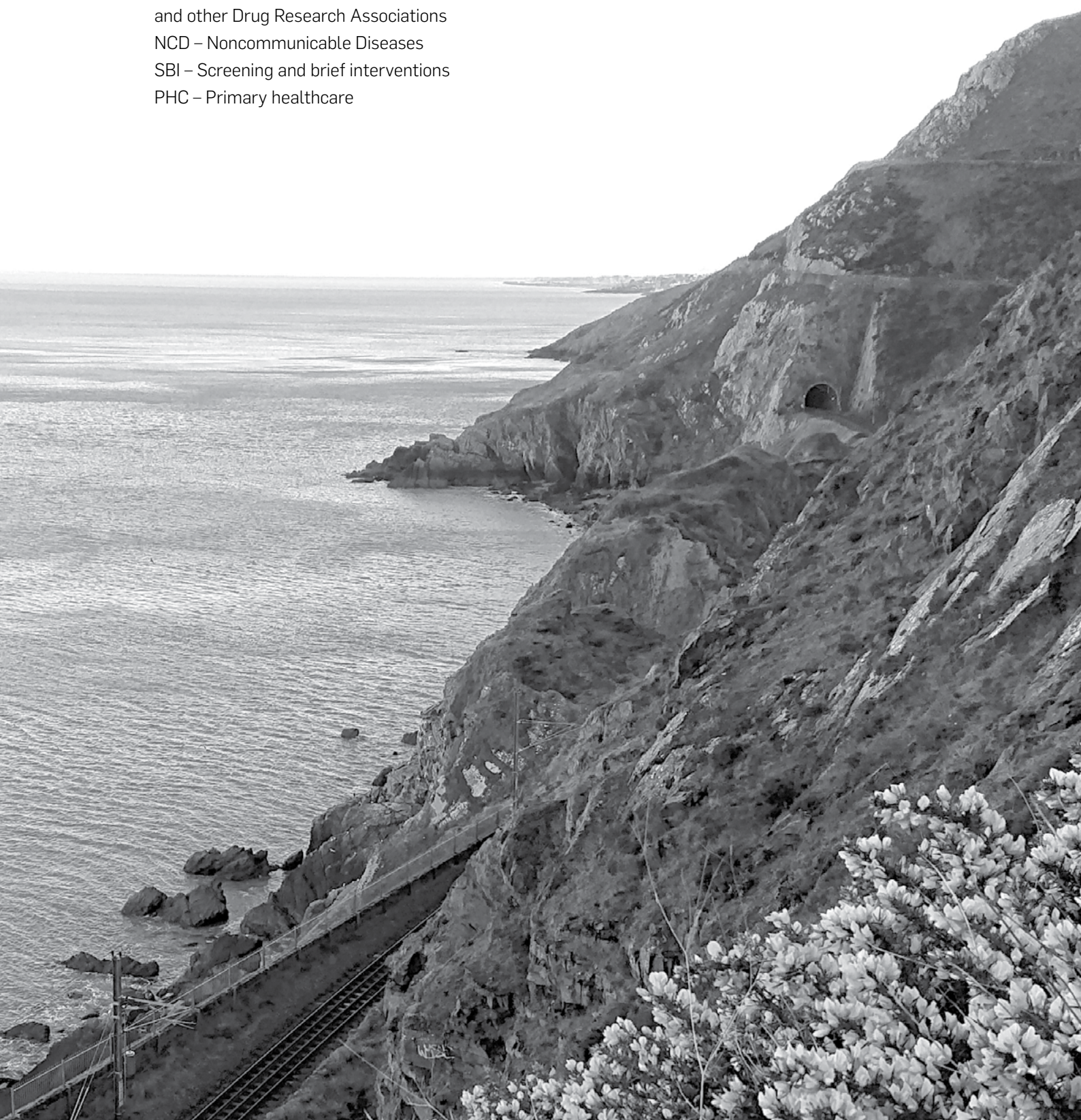
This report is based on materials presented and discussed in the workshop of "first-mover" countries to improve the implementation of evidence-based alcohol-control policies in the WHO European Region. The WHO Regional Office for Europe would like to thank all representatives from Member States, advisers and experts for their active participation during the workshop.

Also, the WHO Regional Office for Europe would like to extend its gratitude to Nino Berdzuli, Director of the Division of Country Health Programmes of the WHO Regional Office for Europe, and João Breda, Head, WHO European Office for the Prevention and Control of Noncommunicable Diseases, for their overall leadership and support for the development of this report.

The publication was made possible by funding from the Government of Turkmenistan with additional support from the Government of Germany, the Government of the Netherlands and the Government of the Russian Federation to the WHO European Office for the Prevention and Control of Noncommunicable Diseases.

ABBREVIATIONS

AUDIT – Alcohol Use Disorders Identification Test
CIS – Commonwealth of Independent States
CSR – Corporate social responsibility
EAEU – Eurasian Economic Union
EGAIS – Unified State Automated Information System
ICARA – The International Confederation of Alcohol, Tobacco and other Drug Research Associations
NCD – Noncommunicable Diseases
SBI – Screening and brief interventions
PHC – Primary healthcare



EXECUTIVE SUMMARY

Countries of the Commonwealth of Independent States (CIS) can be seen as "first movers" in implementing the WHO "best buys" to reduce alcohol consumption and alcohol-attributable harms at individual and population levels, namely 1) increasing alcohol excise taxes, 2) restricting alcohol advertising, and 3) restricting physical availability of retailed alcohol. Overall, substantial declines in alcohol consumption were observed in almost all CIS countries, contributing to the reduction in overall alcohol per capita consumption in the WHO European Region and to the attainment of the noncommunicable disease target of a 10% reduction in the harmful use of alcohol by 2025.

At the same time, experiences and best practices of alcohol control in these countries are not yet well documented, aside from some notable exceptions. Over the past years, various CIS countries have introduced many effective measures to reduce the alcohol-attributable burden, including the three most cost-effective "best buys", and various lessons can be learned from their implementation and consequent challenges.

In response to requests from Member States during the regional consultation in Prague, Czechia, the WHO Regional Office for Europe convened a workshop for exchanging experiences, achievements and setbacks in the field of alcohol-control policies in the eastern part of the Region and brought together 16 representatives from 10 CIS countries. The workshop was held on 4–5 December 2019 in Moscow, Russian Federation.

The experience of these "first-mover" countries that have implemented the WHO-recommended "best buys" could serve to inspire similar action in other countries of the WHO European Region. This report documents the main contributions and discussions of the first WHO-led initiative to improve the implementation of evidence-based alcohol control policies in CIS countries.

BACKGROUND

Across the world in 2016, 3 million people died as a result of harmful use of alcohol. One million of these deaths occurred in the WHO European Region.

Alcohol is responsible for 10.1% of all deaths across the Region and 10.8% of all disability-adjusted life years (DALYs). Of all deaths occurring because of intentional injuries, such as homicides and suicides, 38.8% were attributable to alcohol, while 29.6% of unintentional injury deaths because of road-traffic crashes or falls were caused by alcohol. Almost every third death in the WHO European Region due to digestive diseases is attributable to alcohol, as is every 10th death related to cardiovascular diseases and every 16th cancer death.

Most worryingly, alcohol-related harms to young people are unacceptably high in Europe; about every fourth death in the 20–24 years age group is caused by alcohol. A high proportion of alcohol-attributable harm therefore occurs early in the life-course, making alcohol a leading cause of working years of life lost and consequently of lost economic productivity and development.

Member States discussed the difficulties in implementing alcohol-control policies in the WHO European Region during the regional consultation on implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol and the WHO European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 on 30 September–1 October 2019 in Prague, Czechia. Specifically, they discussed the difficulty of implementing the WHO three best-buy interventions in reducing alcohol-attributable burden:

1. increasing excise taxes on alcoholic beverages;
2. enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising; and
3. enacting and enforcing restrictions on the physical availability of retailed alcohol.

At the same time, Member States from the eastern part of the WHO European Region reported on various successes in implementing these interventions and requested more support from WHO in facilitating networking and knowledge exchange.

In response to the requests made by Member States during the regional consultation, the Alcohol and Illicit Drugs programme of the WHO Regional Office for Europe, in the context of the WHO European Office for the Prevention and Control of Noncommunicable Diseases (NCDs), convened a workshop for exchanging experiences, achievements and setbacks in the field of alcohol-control policies in the eastern part of the Region that brought together 16 representatives from 10 countries of the Commonwealth of Independent States (CIS).

The experience of these "first-mover" countries that have implemented the WHO recommended best buys and various other measures from the broader WHO SAFER framework[1,2] could serve to inspire similar action in other countries of the WHO European Region.

1 The SAFER initiative focuses on five key alcohol policy interventions that are based on accumulated evidence of their impact on population health and their cost–effectiveness and encompasses, besides the three best buys, two additional areas: advancing and enforcing drink–driving counter measures; and facilitating access to screening, brief interventions and treatment for alcohol.

2 World Health Organization (2019). The SAFER technical package: five areas of intervention at national and subnational levels. Geneva: World Health Organization (https://www.who.int/publications-detail/the-safer-technical-package, accessed 8 June 2020).

STRUCTURE OF THE WORKSHOP

All countries of the Commonwealth of Independent States were invited to nominate one or two policy-makers in the field of alcohol control to attend the workshop. Country representatives (health ministry officials, civil servants or national public health directors) from 10 countries were present: Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan and Uzbekistan. Delegates were asked to provide inputs on the current state of alcohol policy implementation in their respective countries and to reflect on current challenges and achievements in alcohol control.

Additionally, the WHO European Office for the Prevention and Control of NCDs invited researchers and technical experts to deliver short presentations on the current research and evidence in alcohol control globally and across the WHO European Region to stimulate discussions.

Over the course of two days and five sessions, workshop participants discussed not only the current state of alcohol control in CIS counties, but also what could be done in the context of CIS countries to further support the evidence base with research and documentation of their respective experiences of alcohol policy implementation. WHO used the workshop as an opportunity to improve its understanding of how the Alcohol and Illicit Drugs programme can best support countries in implementing alcohol-control policies in this part of the Region, and workshop participants explored the possibility of creating a network for exchange of best practices and experiences.

INTRODUCTION TO THE MEETING

The Workshop of "First-mover" Countries to Improve the Implementation of Evidence-based Alcohol-control Policies was held on 4–5 December 2019 in Moscow, Russian Federation.

The meeting was opened by **Sergey Muraviev**, *Director of the Department for International Cooperation and Public Relations of the Ministry of Health of the Russian Federation*. He welcomed the participants (see Fig. 1) and highlighted briefly the importance and success of alcohol policy in the Russian Federation. Mr Muraviev noted that WHO-recommended measures, such as increasing alcohol excise tax, establishing and raising minimum prices and introducing a system for monitoring production and sales of alcoholic beverages, as well as other important key measures have led to a 43% decrease in alcohol per capita consumption in the Russian Federation over the last 15 years[3].

Elena Yurasova, representing *Melita Vujnovic, WHO Representative to the Russian Federation*, noted in her welcoming remarks that the implementation of alcohol policy has tremendous effects on the burden of diseases and that comprehensive policy measures have led to a rise in life expectancy in the Russian Federation – an experience that other countries can replicate if measures are put in place.

Carina Ferreira-Borges, *Programme Manager, Alcohol and Illicit Drugs programme of the WHO European Office for the Prevention and Control of Noncommunicable Diseases*, welcomed participants and expressed gratitude for the opportunity to hold the meeting in the Russian Federation. She noted that such a workshop on exchanging experiences and best practices in alcohol control in CIS countries was being held for the first time. Meetings such as this are crucial to improving the implementation of alcohol control in this part of the Region, which will lead to a reduction in the burden of disease stemming mostly from NCDs, improve population health and lead to rising life expectancy. Addressing alcohol through effective alcohol-control measures will be crucial in closing the current east–west divide in life expectancy that is observed in the WHO European Region.

Fig. 1. Workshop participants. Copyright and credit: ©WHO European Office for the Prevention and Control of Noncommunicable Diseases (NCDs.)

3 WHO Regional Office for Europe (2019). Alcohol policy impact case study: the effects of alcohol control measures on mortality and life expectancy in the Russian Federation. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/en/health-topics/disease- prevention/alcohol-use/publications/2019/alcohol-policy-impact-case-study-the- effects-of-alcohol-control-measures-on-mortality-and-life-expectancy-in-the-russian- federation-2019, accessed 8 June 2020).

SESSION I

THE 10 AREAS OF ACTION OF THE EUROPEAN ACTION PLAN TO REDUCE THE HARMFUL USE OF ALCOHOL 2012–2020 AND THE EVIDENCE BASE BEHIND THE INTERVENTIONS

CIS countries play a crucial role in the observed decline in alcohol consumption in the WHO European Region

The WHO European Region was the first region to approve an alcohol action plan, in 1992 and again in 2000 and 2010. Closely linked to the WHO Global Strategy to Reduce Harmful use of Alcohol and key strategies on the prevention of NCDs in the Region, the European action plan summarizes 10 action areas where interventions can be introduced to reduce alcohol consumption and alcohol-attributable harm at population level. The action plan was adopted by all Member States of the Region and its implementation will help countries to increase public awareness of alcohol and alcohol-related harm, develop effective interventions and improve monitoring and surveillance systems at different levels.

Overall, alcohol per capita consumption has been declining in CIS countries. This has led to the overall decline in alcohol consumption in the WHO European Region, as drinking levels have remained relatively stable or have even increased in other parts of the Region. This decline happened against the background of introducing stricter alcohol-control legislation in many CIS countries, but this relationship has not yet been explored very well. In recent years, various CIS countries have introduced many of the measures that were recommended as part of the European action plan.

Carina Ferreira-Borges, *Programme Manager of the Alcohol and Illicit Drugs programme at the WHO European Office for the Prevention and Control of Noncommunicable Diseases*, gave an overview of trends in alcohol consumption and harm in the WHO European Region. She explained why CIS countries can be considered the first movers in implementing alcohol policy in the Region, and why their contributions have been crucial to implementing the European action plan[4] and achieving the global NCD target of at least 10% relative reduction in the harmful use of alcohol, as appropriate within national contexts[5].

With almost 9.8 litres of pure alcohol per capita (for everyone who is 15 years and older), the level of total alcohol consumption in the WHO European Region is the highest globally, with the highest prevalence of current drinkers and people with alcohol-use disorders in the population. When considering current drinkers only (those who have consumed alcohol within the past 12 months), the numbers are particularly high, with 16.4 litres per capita in drinkers only. There is also a gender gap in drinking levels, as women drink 4.3 litres and men as much as 16 litres per capita. When accounting for drinkers only, men drink as much as 23.1 litres per capita and women drink 8.2 litres per capita. While half (49%) of women in the WHO European Region can be classified as abstainers (those who have not consumed alcohol in the past 12 months or even throughout their life course), this proportion is considerably lower in men, at 31%.

Overall, every 10th death in the WHO European Region occurs because of alcohol. Th proportion is even higher for young people – every sixth death in the age group 15–19 years and almost every fourth among 20–24-year-olds are alcohol-attributable. This means that too many people in the Region are dying too young because of alcohol, and that alcohol mainly is claiming the lives of those who contribute to the economic development of countries.

In CIS countries, however, a general decline in total alcohol per capita consumption has been observed over the past years, while drinking levels were stagnating at European Union (EU) level. This may be related to the fact that many CIS countries are successfully implementing alcohol-control policies, including the WHO best buys (the most cost–effective measures) to reduce alcohol consumption and burden[6]. CIS countries therefore can be considered as "first movers" in introducing key alcohol polices over the past years and accumulating knowledge on their practical implementation. Consequently, it is crucial that CIS countries share these experiences and best practices among each other and with other countries and regions. Overall, the WHO European Region is currently on track to meet the global NCD target of at least 10% relative reduction in the harmful use of alcohol, but this is only because of the CIS countries' contribution[7].

The three best-buy interventions to reduce alcohol-attributable burden are:

- increase excise taxes on alcoholic beverages;
- enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising; and
- enact and enforce restrictions on the physical availability of retailed alcohol.

These three interventions are considered to be cost–effective as they have a cost–effectiveness ratio of ≤ 100 international dollar (I$)/disability-adjusted life-years averted in lower-middle-income countries.

4 WHO Regional Office for Europe (2019). European action plan to reduce the harmful use of alcohol 2012–2020. Copenhagen: WHO Regional Office for Europe (https://apps.who.int/iris/handle/10665/107307, accessed 8 June 2020).

5 World Health Organization (2016). Global NCD target: reducing harmful use of alcohol. Geneva: World Health Organization (https://www.who.int/beat-ncds/take-action/ncd-brief-alcohol.pdf, accessed 8 June 2020).

6 World Health Organization (2017). Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: World Health Organization (https://apps.who.int/iris/bitstream/handle/10665/259232/WHO-NMH-NVI-17.9-eng.pdf?sequence=1&isAllowed=y, accessed 8 June 2020).

7 Probst C, Manthey J, Neufeld M, Rehm J, Breda J, Rakovac I (2020). Meeting the global NCD target of at least 10% relative reduction in the harmful use of alcohol: is the WHO European Region on track? Int J Environ Res Public Health 17(10):E3423. doi:10.3390/ijerph17103423.

Jürgen Rehm, *Senior Scientist, Institute for Mental Health Policy Research & Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health (CAMH), Canada,* presented an overview of key policy measures that have been found to be effective in reducing alcohol consumption and burden from the seminal anthology *Alcohol: no ordinary commodity: research and public policy*[8], a collaborative effort by an international group of scientists to provide cumulative scientific evidence for alcohol policy. The publication provides an overview and rating of 42 policy options across seven areas to reduce alcohol-related harm that were evaluated based on the available evidence of their effectiveness, breadth of research support and comparative testing across regions, countries and subgroups. Of the seven policy areas, the two that received the best ratings are taxation and pricing policies, and restrictions on availability. There is a solid evidence base for both areas and, along with marketing restrictions, they are considered to be the WHO-recommended best-buy interventions to reduce alcohol-attributable burden, as they are cost–effective and easy to implement within national contexts.

There is clear evidence that the increased economic cost of alcohol relative to other commodities reduces demand for alcohol, and that people increase their drinking when prices are lowered and decrease it when prices rise. Increasing alcohol taxes is therefore a very important instrument of alcohol policy as it reduces alcohol-related harms, such as diseases, traffic crashes, violence and crime, and also generates direct revenue for governments. Available studies show that decreasing alcohol taxes contributes to a rise in alcohol-poisoning mortality, specifically in males, and that increasing taxes can reverse this trend. The most important downside effect of raising alcohol taxes is a potential increase in the production and consumption of so-called unrecorded alcohol (alcoholic products that are not taxed as beverage alcohol but are consumed as such; they include home-made, smuggled or illegally produced alcohol). Available evidence suggests, however, that these types of products can never fully substitute for the usual alcoholic beverages; this problem therefore needs to be kept in perspective when calls are made for additional policies aiming to keep alcohol under control through systems for mandatory reporting on production, purchase and implementation of alcoholic products.

Restricting alcohol availability has also been shown to be effective in studies across various countries and populations. Introducing a high minimum drinking age to make alcohol inaccessible to young people, and restricting hours and days of opening and density of alcohol outlets are very effective policy options that are relatively cheap in relation to the costs of health consequences caused by alcohol. The unintended and unwanted consequences of these measures might be an increase in unrecorded purchases, since limited days and hours of sales do not apply to informal and illegal markets.

8 Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K et al. (2010). Alcohol: no ordinary commodity. Research and public policy. Oxford: Oxford University Press.

Introducing a ban on alcohol marketing is the third WHO-recommended best-buy intervention, but evaluation of this measure is more difficult than the others, partly because of the emergence of social media and the Internet, which make evaluation and control harder than for TV or radio.

Other effective measures are drink–driving measures and brief interventions for alcohol in primary care. While being more costly to implement, they are considered to be high-impact strategies that are recommended by WHO together with the three best buys[9] to reduce alcohol use at population level. Drink–driving policies encompass laws on permissible blood alcohol levels and random breath testing that usually have the highest approval ratings at country level, although their effectiveness largely depends on enforcement. Screening and brief interventions for alcohol have been shown to work at individual level, but so far evidence of their effectiveness at aggregate level is lacking. Some implementation studies currently are scaling-up brief interventions at country level and data from their evaluations will provide more insight into this area.

Kristine Galstyan, *Project Leader of the Public Health Department of the Ministry of Health of Armenia*, presented an overview of the current alcohol legislation in Armenia and spoke of the main challenges. Ms Galstyan outlined a number of reasons that might contribute to a rise in alcohol consumption in Armenia:

- the development of international trade, economic and cultural ties with other countries where alcohol consumption is higher;
- socioeconomic problems that have emerged since Armenia gained independence;
- the presence of various places of recreation, leisure and entertainment, such as discos, nightclubs and cafes, where alcohol use is common;
- the widely spread belief (at least in some regions) that consuming samogon (home-made "moonshine") is less harmful than consuming common alcoholic beverages;
- drinking large quantities of alcohol during social events and ceremonies;
- alcohol use being seen as a cultural marker for masculinity; and
- the popular misconception that drinking about 50–100 g of samogon per day has a health benefit.

Alcohol taxes in Armenia are not adjusted for inflation, and while minimum unit pricing exists across all alcoholic beverages, it is not very well enforced. As a result, alcohol, both the usual alcoholic beverages and home-made alcohol, is highly affordable.

Alcohol-control measures IN ARMENIA

- There is a minimum unit price on all alcoholic beverages, but it is currently not well enforced.
- Alcohol advertising is partially restricted.
- No written national strategy on alcohol is in place.

9 World Health Organization (2018). WHO launches SAFER alcohol control initiative to prevent and reduce alcohol-related death and disability. In: World Health Organization [website]. Geneva: World Health Organization (https://www.who.int/substnce_abuse/safer/en/, accessed 8 June 2020).

Alcohol-control measures IN TURKMENISTAN

- There is a total ban on alcohol advertising.
- The minimum purchasing age of alcohol is 21 years.
- Off-premises sales of alcoholic beverages on holidays and memorial days is prohibited.
- Containers of alcoholic beverages have to feature labels with distinct health warnings of at least 20% size of the label with the message "Alcoholic beverages are harmful to your health!"

There is a ban on alcohol advertising on TV between 18:00 and 22:00, but no restrictions on product placement and sponsorship of sports events. The minimum legal age of purchase for any alcoholic beverage is 18, but it is not well enforced. Retail outlets are regulated via licenses. No regulation of hours and days of sales or density of outlets – neither on- nor off-premises – exists. Special restrictions nevertheless are in place on the sale of alcohol during special events, in government and education institutions, and in children's and health-care organizations.

Labelling of alcoholic beverages is required by law and the label has to feature an ingredient list with caloric value on the front label, and health-related information – a health warning – has to feature on the container.

There are no lower-risk drinking guidelines, and screening and brief interventions for alcohol are not organized and delivered in primary health care or anywhere else. Treatment for alcohol use disorders is provided within specialized (narcology) services.

Ashhabad Nohurov, *Head of the Psychiatric, Narcology and Medical Psychology Department of the Murad Garryev Turkmen State Medical University,* presented on the recently developed and adopted law on the prevention of the harmful effects of alcohol in Turkmenistan.

The law came into force on 1 January 2019 and applies to the following alcoholic products: alcoholic beverages (including all types of spirits), wine products (with the exception of wine materials), low-alcoholic drinks, beer and beverages made on the basis of beer.
Sale of alcoholic beverages is forbidden if there are no duty-paid excise stamps on the container and if the mandatory consumer information is missing. Sales of alcohol on the Internet, through vending machines and establishments without a valid license are not allowed. Retail sales of alcoholic beverages in urban and rural settlements can be carried out only in specialized stationary retail facilities that have a storage room – sale of alcohol in kiosks and in markets therefore is forbidden.

Alcohol consumption in governmental, military, medical, education and cultural institutions is forbidden, as it is in sports, health and recreational facilities, railway stations, airports and all types of public transport, and in any other public space. New provisions on labelling of alcoholic beverages have also been introduced, with health warnings and other health information being mandatory.

During the **panel discussion of the first session**, workshop participants discussed issues of pricing policy and arising issues of illegal alcohol. Jürgen Rehm noted that one disadvantage of raising alcohol taxes might be an increase in the production and sales of illegal alcoholic products, so immediate action in two directions is needed: raising alcohol taxes and monitoring illegal and informal sales; and developing and enforcing specific policies in relation to unrecorded alcohol.

Workshop participants also discussed the contribution of alcohol policies to road safety. It was noted that after a number of drink–driving measures were introduced, total alcohol consumption in Australia declined at population level. The question of whether preventing people from obtaining a driver's license if they are registered with the diagnosis of alcohol dependence in the narcology system was an effective road-safety measure was considered. This regulation is in place in some of the countries and it was felt that overall, such practice can contribute to stigmatization, might be a significant barrier to help-seeking behaviours and may additionally aggravate the course of treatment and treatment outcomes.

Various questions were addressed to the two representatives who presented country highlights from Armenia and Turkmenistan. Kristina Galstyan spoke about issues of diagnosing alcoholic psychoses in Armenia and the related stigmatization in society. She also explained that at the moment, there is no written national strategy on alcohol, although the Ministry is very interested in developing one and is welcoming ideas on how to approach this task. Ashkhabat Nokhurov noted that the adoption of the national law on the prevention of the harmful effects of alcohol helps to ensure a comprehensive approach to combatting harmful use of alcohol and reducing the high prevalence of heavy episodic drinking in current drinkers. Overall, it was noted that it is important to have a separate legislative document setting the vison and objectives for reducing alcohol consumption and regulating alcoholic beverages and their sale and consumption, rather than having fragmented regulations across different documents and legislative acts.

SESSION II

PRICING POLICIES: MINIMUM PRICING ACROSS THE REGION

Pricing policies

Pricing policy and, specifically, alcohol taxation feature on the WHO-recommended best buys to reduce alcohol-attributable burden. Raising taxes, however, is a challenging task: usually it is not popular with decision-makers, who fear that it might negatively impact future elections, and it can cause concerns that raising taxes may mean increases in unrecorded alcohol consumption.

Implementing a minimum price on alcoholic beverages – that is, a price below which alcoholic beverages cannot be sold by law – is another type of pricing policy leading to price increases, although in this case the revenue goes to the alcohol industry and not to the state, at least in countries where the state is not the main producer.

Jürgen Rehm, *Senior Scientist, Institute for Mental Health Policy Research & Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health, Canada*, presented on the effectiveness of different pricing policies.

Increasing alcohol taxes is one of the most cost–effective methods of reducing alcohol consumption and reducing its harms, and is one of the three WHO-recommended best buy interventions. There is a strong evidence base behind this approach, which has been shown to be effective across different countries and regions.

Raising taxes is an effective but unpopular measure that policy-makers often hesitate to implement because of industry arguments that it might negatively affect the economy and result in unemployment, or increase consumption of unrecorded alcohol, or because they fear that it might negatively influence future elections. Another fear is that taxation is an omnibus measure that is not focused on heavy drinkers – the people risking the most harm. Unsurprisingly, pricing policy is the area with the lowest implementation score (on a scale from 0 to 100) out of all 10 areas of action in the WHO European Region[10]. An important reason for this low score is the fact that most countries do not adjust their alcohol tax for inflation, which leads to lower alcohol prices over time relative to other prices and population income.

Implementing minimum unit prices on alcoholic beverages is an additional pricing mechanism that can regulate economic affordability of alcohol and thereby influence levels of consumption and harm. Minimum prices on alcoholic beverages, at least vodka or spirits, are in place in many countries of the eastern part of the WHO European Region, but there are almost no studies on its effects. Available evidence comes from higher-income countries like Canada and the United Kingdom and is mostly based on modelling studies. Overall, the results suggest that introducing minimum unit prices has immediate impact and is successful in reducing the amounts of alcohol purchased. The effects seem to be stronger in heavy drinkers and people with lower socioeconomic status – the people experiencing most of the harms caused by alcohol and who are the main consumers of cheap alcohol. The effects of minimum unit prices have not been validated over longer time intervals, however, and broader evaluation studies are required.

Another issue in implementing minimum unit pricing is that the revenue of the increased prices of alcoholic beverages go to the alcohol industry in countries where the state is not the main producer of alcohol, while the same effects of reducing alcohol-attributable burden can be achieved with taxation systems by, for instance, over-proportionally taxing cheaper alcohol.

Pricing policy should be seen as the main policy instrument to decrease

10 WHO Regional Office for Europe (2017). Policy in action. A tool for measuring alcohol policy implementation. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/__data/assets/pdf_file/0006/339837/WHO_Policy-in-Action_indh_VII-2.pdf?ua=1, accessed 8 June 2020).

Minimum pricing and minimum unit pricing

- A **minimum price** on alcoholic beverages sets a level below which a bottle or container of this beverages cannot be sold
- A **minimum unit price** on alcoholic beverages sets a level below which a unit of alcohol cannot be sold. Therefore, minimum unit prices are levied in proportion to the volume of *pure alcohol* a drink contains
- Minimum pricing and minimum unit pricing can be an additional pricing policy, along with taxation, to reduce alcohol-related harms,
- CIS countries are “first movers” in implementing such policies, and more research is needed to evaluate their effects in real-life settings over time.

Alcohol-control measures IN KAZAKHSTAN

- Alcohol taxes have constantly been raised over the past years and a minimum retail price for spirits has been introduced.
- Alcohol production is monitored online and alcohol advertising is prohibited.
- The minimum purchasing age of alcohol is 21 years. and there is a night-sale ban in place, depending on the alcohol content. Beverages with an alcohol content below 30% cannot be sold between 23:00 and 08:00, while those with an alcohol content of 30% and above cannot be sold between 21:00 and 12:00 of the following day.

alcohol-attributable harm and to increase state revenue. More studies should be done on how minimum pricing can be used to achieve these goals. Various CIS countries introduced minimum pricing a long time ago, raising it over time to adjust for inflation, sometimes in tandem with increases in alcohol taxes. CIS countries can therefore be considered as "first movers" in implementing minimum pricing on alcohol and more evaluation studies from this part of the Region are needed to improve the evidence base.

Gulnara Kuspekova, *Head of the Public Health Department of the Department of Public Health Policy, Ministry of Health of Kazakhstan,* gave a short overview of implementation of alcohol policy in Kazakhstan.

While there is not yet a monitoring system in place for retail sales of alcoholic beverages, Kazakhstan has invested in developing a tracking system to record volumes of produced alcohol in real time, using modern technologies on every production site. The devices provide automated transmission of information on production volumes and wholesale operations in real time. Currently, 48 manufacturers of alcoholic beverages are connected to the system.

Sale of alcoholic beverages is permitted only for licensed enterprises, with licenses obtained from the state corporation Government for Citizens or via the website of the Government of Kazakhstan. Only alcoholic beverages that meet the requirements of the relevant technical regulations and which have a duty-paid excise stamp can be sold. Every retail sale outlet has to be equipped with a cash register with a special scanner that recognizes information on the excise stamps.

A minimum retail price has been set for vodka and other spirits and alcohol taxes on vodka have been raised by 400% since 2013. Alcohol advertising has been prohibited since 2004 and the minimum purchasing age for alcohol is 21 years, with fines for violations relatively high. Sales of alcoholic beverages with an alcohol content of 30% and higher (such as vodka, cognac and other spirits) are prohibited between 21:00 and 12:00 of the following day, while sales of all other alcoholic beverages are prohibited between 23:00 and 08:00 of the following day.

Consumption of alcoholic beverages on the streets and public places (with the exception of on-premises serving locations) is prohibited, as is appearing in public places in a state of intoxication that causes public alarm. Overall, about 14% of offenses in Kazakhstan are committed by people who are in a state of alcohol intoxication.

Kazakhstan has developed a new government programme for 2020–2025 that aims to prevent alcohol dependence, promote a healthy lifestyle, reduce offences committed by people in an intoxicated state and increase health literacy among the population.

Nodira Adilova, *Narcologist from the Narcological Dispensary of the city of Tashkent*, highlighted briefly the situation with alcohol use and state alcohol policy in Uzbekistan.

Currently, there is a need to review the legislative base of alcohol control policy in Uzbekistan, as a rise in alcohol consumption levels is feared. Retail sales of alcohol increased by 60% between 2003 and 2018, from 1.6 litres to 2.6 litres of pure alcohol per person of 18 years and older. At the same time, the relative share of spirits in the total sales of alcohol increased from 74% to 89% between 2005 and 2018, while the share of low-alcohol beverages decreased during the same time period from 15% to 3% for wine and from 11% to 8% for beer. This contrasts with overall development in the European Region, where the opposite trend of declining spirits consumption is observed.

The current trend observed in Uzbekistan therefore raises cause for concern, as consumption of spirits is more associated with riskier drinking patterns, causing more harm at population level.

In the **moderated panel discussion** following the presentations, workshop participants concluded that minimum unit pricing strategies for alcohol need to be different across different countries. While countries with a high per capita income and a relative low share of unrecorded alcohol in the total consumption of alcohol can benefit from having minimum pricing in place, those with lower incomes and a higher share of unrecorded alcohol might not see the same positive impact, as consumers may shift to drinking cheap unrecorded products. Alexandr Nemtsov, Head of the Informatics Department of the Moscow Research Institute of Psychiatry of the Federal Medical Research Centre of Psychiatry and Narcology, noted the implementation of a higher minimum price on vodka in 2010 had led to a substantial decline in cheap alcoholic beverages in smaller retail outlets in the Russian Federation, which overall has contributed to a decline in alcohol consumption at population level.

Participants noted that dialogue involving different ministries is necessary before the implementation of alcohol policy measures, specifically pricing policies. Ms Kuspekova and Ms Adilova answered a number of questions raised by the workshop participants. For instance, it was clarified that time restrictions on the sale of alcoholic beverages apply across all regions in Kazakhstan uniformly, depending on alcohol content. Moreover, centres for temporary adaptation and detoxification are available throughout the country, designed to provide specialized assistance to people who are intoxicated. Ms Nodilova clarified that currently, various ministries are involved in the process of discussing a new alcohol strategy and that relevant steps will be implemented in the near future.

Alcohol-control measures IN UZBEKISTAN

- The minimum purchasing age of alcohol is 20 years
- There is a total ban on alcohol advertising
- Alcohol containers have to feature labels with distinct health warnings
- There is need to revise the legislative framework of alcohol control policy in Uzbekistan, as there are some worrying trends observed in relation to increasing spirits consumption.

SESSION III

COMMERCIAL COMMUNICATIONS: MARKETING AND LABELLING OF ALCOHOLIC BEVERAGES

Commercial communications

Underestimating the impact of commercial communication can lead to increased alcohol consumption, especially among children and young people. Marketing of alcohol products should be subject to strict regulation by countries, using governmental control but also with the support of the population. Labelling of alcohol products is needed to increase consumer awareness of the harmful effects of alcohol and gain their support.

Carina Ferreira-Borges, *Programme Manager of the Alcohol and Illicit Drugs programme at the WHO European Office for the Prevention and Control of Noncommunicable Diseases*, presented on the state of implementation of labelling of alcoholic products in the WHO European Region.

Labelling of alcoholic beverages is a WHO-recommended practice and is in line with principles of consumer protection. Any foodstuff product has to have a label with a list of ingredients, nutritional values and information on potential harms, such as potential allergic reactions. Alcohol should not be an exception and consumers have the right to know what they are drinking.

Alcohol is a psychoactive substance, the consumption of which causes overall negative consequences for the individual and society. Alcohol has carcinogenic and mutagenic effects that so far have received little public awareness. Alcohol labels on containers present a unique opportunity to change this, since consumers repeatedly are exposed to messages at key points of contact – the point of purchase and consumption.

Labels are appealing because of their relatively low cost to regulators, their broad and unparalleled reach among users and higher exposure among the heaviest drinkers, who are at risk of greatest harms.

Labelling of alcoholic products provides the consumer with information about the ingredients, nutritional value and the dangers of the product. So far, there is a consensus from evidence reviews that suggests the following[11]:

- Tobacco warning labels contribute to changing attitudes, beliefs and behaviours.
- Alcohol warning labels may influence perception of risk, intentions to cut down and support for public policies on alcohol.
- Introduction of the warning label in the United States of America in 1989 had limited impact on drinking behaviour but led to an increase in awareness of the messages.
- Pictorial warnings can raise awareness and understanding of the risks.
- General messages ("Alcohol increases your risk of cancer") are perceived as more believable and convincing compared to specific message. The same applies to qualitative ("Alcohol increases your risk of breast cancer") as opposed to quantitative messages.

Some lessons can be learned from the field of tobacco control. The introduction of tobacco labelling in Canada as part of its commitment to the WHO Framework Convention on Tobacco Control has reduced smoking by more than 30% in 40 years. A significant proportion of Canadian smokers began to report that

Labelling

- **Alcohol labelling** provides consumer information on the ingredients, nutritional values and harms of a product.
- Evidence suggests that alcohol health warnings might have the same effects as tobacco health warnings in raising public awareness of risks and harms.
- The WHO Framework Convention on Tobacco Control is a treaty adopted by countries in response to the tobacco epidemic. It requires parties to implement large, rotating health warnings on all tobacco product packaging and labelling.

11 WHO Regional Office for Europe (2017). Alcohol labelling - A discussion document on policy options (2017). Copenhagen: WHO Regional Office for Europe (https://www.euro.who.int/__data/assets/pdf_file/0006/343806/WH07_Alcohol_Labelling_full_v3.pdf, accessed 8 June 2020)

they thought about the risks of smoking and gave up cigarettes because of warning labels. There is no framework convention on alcohol that would, as an internationally binding instrument, require alcohol labelling, and research on the impact of alcohol labelling is still scarce.

Evidence from the latest quasi-experimental study in Yukon, Canada, however, shows that the introduction of health warnings and further information on alcoholic beverages have resulted in a decline in per capita consumption[12,13], with the biggest impact being observed in heavy drinkers (the people who see the health warnings most frequently). The labels feature a health warning on increased risk of developing cancer due to alcohol use and information on standard drinks and lower-risk drinking guidelines. Representatives of the alcohol industry intervened in the process of the study, but this only led to an increase in media coverage and public awareness, which might have contributed to the decrease in alcohol sales.

The study also suggests rotating, colourful and highly visible labels with impactful messages and media coverage of the study had a cascade impact on alcohol consumption.

Labelling of alcoholic beverages is in place in most CIS countries but similar regulations are lacking for most EU countries and the rest of the WHO European Region, as documented by the most recent WHO Health Evidence Network report on alcohol labelling[14]. It is important to document the experiences and best practices of CIS countries in this area and evaluate the effectiveness and impact of alcohol labels at national level, as the data of the Canadian study were collected in Yukon only, which has the smallest population of any province or territory in Canada.

Maria Neufeld, *Consultant of the Alcohol and Illicit Drugs programme at the WHO European Office for the Prevention and Control of Noncommunicable Diseases*, presented on the technical regulations of the Eurasian Economic Union (EAEU) on the safety of alcoholic beverages and, specifically, which regulations apply to alcohol labelling.

The Technical Regulation of the Eurasian Economic Union on the Safety of Alcoholic Beverages (TR EAEU 047/2018) that will come into force in 2021 applies to all types of alcoholic beverages intended for use in the territory of the EAEU Member States (Armenia, Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation). The regulation document reflects the minimal requirements for production, storage, transportation, circulation, sale and utilization of alcoholic beverages and ensures uniform terminology and harmonized requirements for various types of alcoholic beverages across

Eurasian Economic Union (EAEU)

- The EAEU is an economic union between Armenia, Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation and has an integrated single market of 180 million people.
- The EAEU has various technical regulations in place, including safety regulations for alcoholic beverages that mandate alcohol labelling.
- EAEU regulations require a health warning of at least 10% size of the label on alcoholic beverages.

12 Zhao J, Stockwell T, Vallance K, Hobin E (2020). The effects of alcohol warning labels on population alcohol consumption: an interrupted time series analysis of alcohol sales in Yukon, Canada. J Stud Alcohol Drugs 81(2): 225–37.

13 Hobin E, Schoueri-Mychasiw N, Weerasinghe A, Vallance K, Hammond D, Greenfield TK et al. (2020). Effects of strengthening alcohol labels on attention, message processing, and perceived effectiveness: a quasi-experimental study in Yukon, Canada. Int J Drug Policy 77:102666.

14 Jané-Llopis E, Kokole D, Neufeld M, Hasan OSM, Rehm J (2020). What is the current alcohol labelling practice in the WHO European Region and what are barriers and facilitators to development and implementation of alcohol labelling policy? Copenhagen: WHO Regional Office for Europe (Health Evidence Network (HEN) synthesis report 68; https://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/frequently-asked-questions-faq-about-alcohol-and-covid-19/what-is-the-current-alcohol-labelling-practice-in-the-who-european-region-and-what-are-barriers-and-facilitators-to-development-and-implementation-of-alcohol-labelling-policy-2020, accessed 8 June 2020).

the Member States. It also contains specific and detailed requirements for packaging and labelling of alcoholic products.

Labels of alcoholic beverages produced in the EAEU must feature the following information: name of the alcoholic product, location of the manufacturer and organization, alcohol content, container volumes, ingredients list, sugar concentration, use of any food additives, production and expiration date and storage conditions. The label also has to feature a contrasting health warning of at least 10% of the size of the label, applied in upper-case letters with an easily readable font of the largest possible size. The message "Excessive use of alcohol is harmful to your health" has to be featured in the national language and/or in Russian. For low-alcohol drinks, information on volume of pure alcohol per container needs to be featured. The container has to have the following message:

Not recommended for persons under eighteen years of age, pregnant and breastfeeding women, persons with diseases of the central nervous system and inner organs.

The following health warning needs to feature on the label of alcoholic products sold on the territory of Kazakhstan:

The use of alcoholic beverages is contraindicated by people under twenty-one years of age, pregnant and breastfeeding women, people with disorders of the central nervous system, kidneys, liver and digestive tract.

Information is applied on the labels in any way that ensures it can be read clearly. The inscriptions, signs and symbols should be contrasted against the background. Labels may also contain additional information about the manufacturer, including in the form of pictograms, drawings, symbols, other signs and (or) their combinations.

Maria Neufeld noted that this technical regulation is quite unique, as it is an international binding document that provides the legal basis for the labelling of alcoholic beverages across different countries. Currently it is the only international document obliging manufacturers of alcoholic beverages to provide comprehensive information to consumers on the container. No such document exists for the EU, where most countries do not feature any information on labels and where foodstuff products are better regulated in this regard.

It therefore is important to document and evaluate the experiences of CIS countries as "first movers" in labelling practices because so far, no formal assessments of alcohol labelling exist in this part of the Region.

Nurmakhmad Gulzoda, *Specialist from the Primary Health Care Reform and International Relations Department of the Ministry of Health and Social Protection of the Population*, gave a short overview of alcohol control policy in Tajikistan.

The Health Code of 15 March 2017, which covers the provision of treatment for people with alcohol dependence, is the main legal document on health issues in Tajikistan.

Alcohol-control measures IN TAJIKISTAN

- Excise taxes on alcohol have been increased over the past years, and a total ban on alcohol marketing has been introduced.
- Alcohol can be sold only in larger retail outlets, not in kiosks or markets.

No studies or research projects on lower-risk drinking guidelines for the population of Tajikistan have been conducted. Drunk–driving is prohibited and there is a blood alcohol concentration limit in place, but there are no official standards for determining intoxication for drivers.

Sale of alcoholic beverages in small retail facilities and markets is prohibited, with the exception of specialized markets. Alcoholic beverages therefore can only be purchased in large retail outlets. Excise taxes on alcoholic beverages (including beer and even alcohol-free beer) and ethyl alcohol have been raising since 2018. The rates increased more for ethyl alcohol than low-alcoholic drinks. Manufacturers of alcoholic beverages cannot act as sponsors of any event and promote their products there. A total advertising ban on all alcoholic beverages was introduced in 2017.

In the **following panel discussion**, Tatyana Korotkevich, Deputy Director for Organizational and Methodological Work of the Republican Scientific and Practical Centre for Mental Health in Minsk, Belarus, noted that the health warning "Excessive use of alcohol is harmful to your health" is misleading. Clearly, the available evidence shows that any consumption of alcohol overall is harmful to health, so the message should be amended accordingly, preferably with more concrete health warnings. Carina Ferreira-Borges raised the question of potentially conducting a study similar to the Canadian one in the CIS countries to assess the impact of alcohol labelling on consumers. Kristina Galstyan, in turn, noted that currently there is no way to provide data on the effectiveness of implementation of these measures in Armenia.

Workshop participants discussed the possibility of having visual health warnings highlighting the dangers of alcohol use and the number of standard drinks that the specific container contains. However, it was also noted that the practice of displaying standard drinks might not be useful at this point as the majority of the population in the respective countries are not familiar with this concept. Also, unlike Canada, where the Yukon labelling experiment was carried out, CIS countries do not have any national lower-risk drinking guidelines that would operate with the concept of standard drinks, so having standard drinks on labels of alcohol containers cannot be linked to these guidelines. Nurmakhmad Gulzoda, as the representative of Tajikistan, answered questions about the current state of alcohol control in his country. He noted that religion has an impact on alcohol consumption in Tajikistan and that the slight increase in total per capita consumption observed over the past years is possibly related to the overall political and socioeconomic situation.

Ashhabad Nohurov mentioned that containers of alcoholic beverages produced in Turkmenistan have to feature an ingredients list on their labels or other parts of the container in Turkmen and in English (see Fig. 2 for an example of a label from Turkmenistan). A health warning of at least 20% of the label has to feature on the container, appearing in black upper-case letters on a contrasting white background. The health warning has the following message: "Alcoholic beverages are harmful to your health!" Additionally, domestic

alcoholic beverages need to have the following health information on the label:

Alcohol products are not recommended for consumption by people under twenty-one years of age, pregnant and breastfeeding women, people with disorders of the central nervous system, kidneys, liver and digestive tract.

Labels of low-alcohol drinks have to feature the recommendation of consuming not more than one container per day.

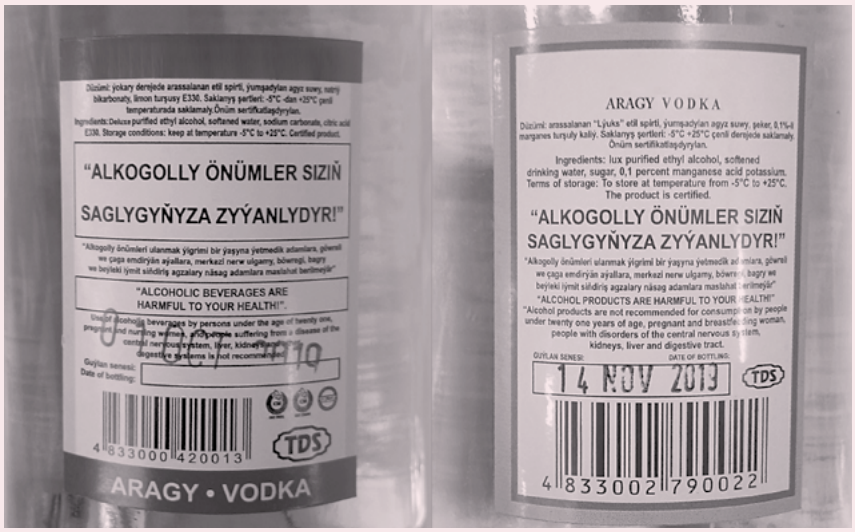


Fig. 2. Labels on vodka bottles in Turkmenistan that feature a health warning of at least 20% of the label

SESSION IV

PROTECTING HEALTH – MANAGING INTERFERENCE FROM THE ALCOHOL INDUSTRY AND OTHER ECONOMIC ACTORS

Corporate social responsibility (CSR)

CSR is a type of industry and business self-regulation that is committed to managing the social, environmental and economic effects of the business's operations responsibly and in line with public expectations and environmental concerns. It is a broad term that recently has more commonly been used in relation to alcohol manufacturers, as the alcohol industry increasingly positions itself as a responsible and interested "citizen" who is aware of the harm stemming from alcohol consumption and who takes part in various intersectoral partnerships to improve public health issues related to alcohol.

For manufacturers of any product, however, one simple rule applies: the more you sell, the more profit you will make. For addictive products like alcohol it is clear that most of the overall product sales are generated by a minority of heavy-using consumers, who are also the ones who experience the most harm. Addressing these harms effectively will affect product sales and conflicts with the interests of corporations. CSR is one of, and underpins, several routine activities of commercial entities in the interests of their shareholders.

Management of conflict of interest therefore is essential when it comes to interaction with commercial entities, especially in the field of research. Investigating and fully understanding the conflicts and risks involved, developing and implementing general guiding principles and procedures for open decision-making and transparently declaring all interactions with organizations with vested interests at all times should be the guiding principles of these interactions.

Niamh Fitzgerald, *Associate Professor at the Institute for Social Marketing & Health Research, University of Stirling, United Kingdom (Scotland)*, presented on alcohol-industry initiatives in the field of corporate social responsibility (CSR) in relation to public health and spoke about arising issues in the management of conflict of interest.

Alcohol-industry CSR schemes became an integral element of how the alcohol industry frames and promotes itself in the public's eye. CSR is a type of industry self-regulation code that is committed to managing the social, environmental and economic effects of its operations responsibly and in line with public expectations. Independent studies document, however, that CSR can be seen as a new promotion strategy and a new measure by which companies and corporations are judged, as CSR can positively affect the opinion of consumers about the manufacturer and their products.

CSR campaigns have been shown to have no or almost no impact on public health, but promote certain brands and their products. CSR programmes in the field of tobacco have been used to expand the number of access points to governments and decision-makers, thereby providing the industry with more opportunities to meet and talk to officials. Fooks et al.[15] analysed 764 internal tobacco-industry documents and concluded that the emergence of CSR is not just about making a profit, but is a new measure against which companies and multinational corporations are judged. Through engaging in CRS, companies now endeavour to make, or at least appear to make, a positive impact on the environment, consumers, employees and society in addition to making money for their shareholders.

Analyses of CSR in the alcohol industry reveals its misleading nature, as CSR practices allow alcohol companies to strengthen their own commercial interests while failing to reduce alcohol use and its harm at population level.[16]

For addictive products like alcohol, it is clear that most overall product sales are generated by a minority of heavy-using consumers. These consumers are also those who experience the most harms of alcohol in the population.[17,18] Addressing these harms effectively will affect product sales and conflicts with the interests of corporations. This conflict is illustrated starkly in the study by Bhattacharya et al. in United Kingdom (England), which found that alcohol-sales revenue to the industry would decline by two fifths, or £13 billion, if all drinkers were to comply with the United Kingdom Government's recommended consumption limits.[19]

Ms Fitzgerald used the example of a CSR campaign conducted in Ireland to

15 Fooks GJ, Gilmore AB, Smith KE, Collin J, Holden C, Lee K (2011). Corporate social responsibility and access to policy élites: an analysis of tobacco industry documents. PLoS Med. 8(8):e1001076.

16 Babor TF, Robaina K, Brown K, Noel J, Cremonte M, Pantani D et al. (2018). Is the alcohol industry doing well by "doing good"? Findings from a content analysis of the alcohol industry's actions to reduce harmful drinking. BMJ Open 8(10):e024325.

17 Gmel G, Rehm, J. (2003). Harmful alcohol use. Alcohol Res Health 27(1):52.

18 Lewer D, Meier P, Beard E, Boniface S, Kaner E (2016). Unravelling the alcohol harm paradox: a population-based study of social gradients across very heavy drinking thresholds. BMC Public Health 16(1):599.

19 Bhattacharya A, Angus C, Pryce R, Holmes J, Brennan A, Meier PS (2018). How dependent is the alcohol industry on heavy drinking in England? Addiction 113(12):2225–32.

highlight the attempts of the alcohol industry to influence alcohol policy in a country. Ireland has one of the highest levels of alcohol consumption in the EU, especially among young people, and there has been considerable progress in recent years in moving forward with public health legislation to reduce harms. On 3 February 2015, a new draft of the Public Health (Alcohol) Bill was published in Ireland and included WHO recommendations such as multiple new regulations on alcohol advertising and sponsorship, and cancer warning labels on products and minimum unit pricing. In response to this, a responsible-drinking campaign called "Stop out-of-control drinking" was launched, funded by Diageo, the world's largest spirits producer. The stated aim of the campaign was "changing Ireland's culture of drinking for the better" and making "out-of-control drinking" socially unacceptable by 2021.

The campaign was initiated with a series of advertisements and social media activity and claimed to be independent. It was overseen by a board made up of prominent psychologists, children's charity executives and doctors and a representative of Diageo. Independent analyses, however, revealed that the campaign was more likely to undermine, rather than promote, public health because it sought to define alcohol problems in Ireland as relating to behaviour, not consumption. The campaign and its spokespeople often refused in media interviews to define moderate drinking except in behavioural terms. The campaign presented the problem in Ireland as one of peers, parents, culture and psychology, focused more on specific groups such as young women, and made no mention of price, availability or marketing of alcohol as the main contributory factors. The campaign also tried to delay Ireland's Public Health Bill through the development of its own action plan, which ultimately failed. It is concerning, however, how easily public health advocates could be co-opted to be the voice of the industry.

Niamh Fitzgerald continued to speak of the management of conflict of interest, which is central when interacting with the alcohol industry, as her example of the Irish campaign shows.

CSR is just one of several routine activities of commercial entities delivered in the interests of their shareholders. Other tactics used by the alcohol industry to protect their own interests are:

- using the media – making claims of negative consequences of alcohol-control policy and funding advertising in the media;
- building relationships with stakeholders by spending time together to build reputation, influence and access (this is effective lobbying, not loud campaigning!);
- threatening, and taking, legal action to overturn, delay and "chill" policies seen as posing risks to the business model;
- funding research (or counter-research) and researchers; and

- attacking the reputation of opponents, including scientists, professionals and policy-makers.

Using effective alcohol policy measures to curb sales and consumption reduces on the one hand alcohol-related health and social problems, and on the other compromises the economic interests involved in the production and sale of alcoholic beverages. This is an inherent conflict of interest between public health and the alcohol industry.

For now, there is little literature available on practical strategies on how to manage conflicts of interest; the main focus is on transparency rather than how to make decisions about whether and when to interact with industry representatives.

The International Confederation of Alcohol, Tobacco and other Drug Research Associations (ICARA), which is an international umbrella organization for research societies across the globe concerned about alcohol, tobacco, other drugs and behavioural addictions, has recently published guidelines on the management of relationships with organizations with vested interests.[20] A vested interest can be defined as "a strong reason for supporting a particular action which will give a personal or financial advantage", for instance when an individual or an organization is interested in promoting a specific view or opinion about alcohol research or policy for commercial reasons.

Several groups of organizations have vested interests in the field of alcohol and the risks and benefits of interaction with, and accepting support or sponsorship from, each of these organizations will vary. When such an organization funds, meets or works with a reputable organization, the arrangement can serve to enhance the sponsor's reputation and promote one kind of research or policy response over others, which is often used to sow confusion. It can also create a reciprocal relationship that can lead to bias. This is true of all funders, but the greater the conflict in missions/beliefs/viewpoints, the more problematic is the funding arrangement.

The ICARA guidelines offer three main principles and practical steps when engaging and managing relationships with organizations with vested interests.

1) **Due diligence**: the risks of the proposed arrangement need to be fully understood by establishing clear information on the proposed sponsor or funder, their aim, function and political activities, the original source of funding, and proposed conditions (informal or contractual) governing the arrangement. This relates not only to the organization offering support, but also the broader grouping or industry of which they may be part.

20 International Confederation for Alcohol, Tobacco & Other Drug Research Associations (2019). Guidelines on the management of relationships with organizations with vested interests. Mansfield (CT): University of Connecticut (https://icara.uconn.edu/wp-content/uploads/sites/1106/2020/02/ICARA-Guidelines-Relnships-w-Vested-Interests-Final-2019-1.pdf, accessed 8 June 2020).

Alcohol-control measures IN THE REPUBLIC OF MOLDOVA

- Implementation of the national programme to reduce alcohol-related harms has been influenced by the alcohol industry. Awareness campaigns are actively conducted and screening and brief interventions for alcohol are being introduced.
- Regulations on alcohol marketing are still pending – although they are developed and agreed on, they are not yet adopted and enforced.

2) **Open decision-making:** a thorough and open discussion on the ethical and practical implications related to this type of funding should be promoted. General guiding principles and procedures should be developed, considering advantages and disadvantages of funding from various sources, the degree of influence by the sponsoring organization which is acceptable and the risks to the credibility and focus. The agreed policy and principles should guide future decision-making.

3) **Transparency in all relationships**: agreed policies and procedures, all types of funding or other arrangements with external organizations, and any related conditions and limitations should be declared in a transparent manner to the society members and to the general public.

Conflicts of interest can arise in any interactions with the alcohol industry. The risk is highest when aims clash (for example, for health bodies). Active management of such risks and active management of conflict are necessary for public sector bodies to maintain credibility and objectivity.

Tudor Vasiliev, *Head of the Monitoring, Evaluation and Integration of Medical Assistance Division of the Republican Narcology Dispensary from Chisinau*, provided examples of involvement of the alcohol industry in alcohol-control policy in the Republic of Moldova and how this has led to changes in legislation.

Several examples were described, with the most recent one being linked to the wine industry and how its increased importance to the country's economy translated into important changes in alcohol-control measures.

In the 1990s, the importation of strong alcoholic beverages was strongly supported, which explains why spirts dominated and accounted for 60% of total alcohol consumption. Until 2002, beer manufacturers strongly advocated for their interests and were successful in removing beer from laws regulating alcohol. This, in combination with advertising and sponsorship, contributed to an increase in beer consumption by 35%.

A national holiday, Wine Day, celebrated at the beginning of October, was introduced in the country in 2002 by government decree. Its aims are to support the quality of wine products, strengthen the country's wine-making traditions, foster a culture of wine consumption and attract tourists. The decree was followed by a new law on wine and vines that classified wine as a food product and not as an alcoholic beverage (Article 2 of Law No. 57 of 03/10/2006). Moreover, after amendments to this law in 2017, wine is no longer taxed.

The Parliament of the Republic of Moldova approved at second reading amendments prohibiting the advertising and promotion of alcohol in December 2017, but the law did not enter into force as it was not submitted for approval by the President of the Republic of Moldova.

Information and awareness campaigns are carried out. Recently, a campaign called "Sober Mind" was conducted. It was aimed at the general population and pregnant women and was also meant to prevent drink–driving. Currently, screening and brief interventions are actively being introduced, with 615 medical workers, including more than 200 doctors, being trained in providing brief interventions regarding alcohol consumption.

Another change in alcohol legislation and regulation is the introduction of pictograms on alcohol labels warning about the dangers of alcohol consumption by pregnant women and stating that alcohol use by people under the age of 18 years is prohibited.

Overall, Mr Vasiliev noted that the proportion of people who understand that drinking alcohol is harmful has increased in the Republic of Moldova over the past years.

Tofig Musayev, *Head of Population Health Department, Public Health and Reforms Centre, Ministry of Health of Azerbaijan*, reported on the overall implementation of alcohol policy in Azerbaijan.

Azerbaijan has a rather low level of alcohol consumption due to the country's traditions, religion and family values. Starting in January 2020, the "Temporary Sanitary Norms and Rules for Energy Drinks" forbid the use of any ethyl alcohol in the production of energy drinks, thereby effectively banning alcohol-based energy drinks in Azerbaijan. According to these sanitary norms and rules, labels of energy drinks need to feature the following message: "Do not mix and do not drink with alcohol".

A new Law on the Protection of Children from Harmful Information restricts from January 2020 the promotion of alcoholic beverages and puts in place changes in tax legislation to raise substantially alcohol excise rates on domestically produced alcoholic beverages (by 150% on beer, 100% on wine, 60% on spirits and up to 5% on all other alcoholic beverages).

Current legislation prohibits minors being targeted in alcohol advertisements. Advertising of alcoholic beverages in print media, audio and video materials intended for minors, and the free distribution of alcoholic beverages to minors during promotions, are prohibited.

Retail sale of alcoholic beverages occurs only through stationary trading networks equipped with cash registers. Alcohol sale is forbidden in mobile kiosks, trucks, cars and other non-stationary objects. Licenses are required for the production, import and sale of ethyl alcohol and alcoholic beverages.

Two per cent of road-traffic crashes are related to alcohol consumption and penalties for drink–driving have been tightened in recent years.

Alcoholic beverages produced for sale in Azerbaijan feature the following information on the label – "Drivers, pregnant women, persons under 18 years of age are not recommended to drink alcohol" – but this is not found on every

Implementation of alcohol policy
IN AZERBAIJAN

- Drink–driving measures have been tightened as part of a nationwide drink–driving campaign.
- Alcoholic beverages feature health warnings and the sale of alcohol-based energy drinks has been prohibited

container. Domestically produced alcoholic beverages intended for export to the Russian Federation feature the following sentence: "Excessive use of alcohol is harmful to your health."

Workshop participants discussed various examples of lobbying and promotion of the interests of the alcohol industry. The alcohol industry often sponsors the construction of sports facilities in various CIS countries while advocating, for example, for loosening alcohol policies to allow for promotion and advertising of alcohol during sports events. Boris Gornyi, leading researcher at the National Medical Research Centre for Preventive Medicine of the Ministry of Health of the Russian Federation, asked if such campaigns might also have positive effects. Various participants noted that while they may have benefits for individuals or specific population groups, they do not bring health benefits at the broader population level and might be even harmful.

Through such campaigns, seen as CSR measures, the alcohol industry builds a reputation for itself and gains necessary access to decision-makers. Daria Khalturina, Head of the Health Risk Prevention Department of the Federal Research Institute for Health Organization and Informatics of the Ministry of Health, Russian Federation, added that the alcohol industry was repeatedly trying to undermine alcohol policy in the Russian Federation, specifically

the development of the national strategy to reduce alcohol-related harms. When the national strategy was developed in 2009, for instance, the alcohol industry attempted to develop a parallel strategy with measures that are known to be ineffective, but this was exposed by the media. Ms Khalturina also emphasized the need for a WHO guiding document on the dangers of cooperation with the alcohol industry and asked if such a document could be developed in the future.

The issue of misinformation and so-called fake news on social networks and misleading research sponsored by the alcohol industry was discussed. Various questions were asked of country representatives. Tudor Vasiliev answered queries about changing proportions of alcoholic beverages in total per capita consumption in the Republic of Moldova and the social and health consequences this might create. Against the backdrop of a general decline in total consumption, an increase in wine consumption and a decline in spirits-drinking is being seen. Parallel to this development, mortality from alcoholic psychoses has decreased and life expectancy in men has increased. Tofig Musaev added to his presentation that it is very necessary to develop a WHO document that would define the international binding framework for alcohol policy, following the example of the WHO Framework Convention on Tobacco Control.

SESSION V

UNRECORDED ALCOHOL CONSUMPTION AND PUBLIC HEALTH

Unrecorded alcohol

Unrecorded alcohol is alcohol that is not accounted for in official statistics on alcohol taxation or sales because it is usually produced, distributed and sold outside the formal channels under governmental control. There are different types of unrecorded alcohol and different sources of data and various approaches to estimating unrecorded alcohol exist.

Globally, unrecorded alcohol is more frequently consumed in low- and lower-middle-income countries. In some countries where alcohol consumption is illegal or strongly restricted, unrecorded is the most common type of alcohol.

Available evidence shows that in the WHO European Region, the main public health concern posed by unrecorded alcohol is not its quality, but its cheap price and high availability, especially in some CIS countries. Effective measures have been developed and implemented to reduce unrecorded alcohol consumption, such as tracking systems for the production and sale of alcoholic beverages in combination with specific anti-counterfeit excise stamps.

Artyom Gil, *Associate Professor, Higher School of Health Administration, I.M. Sechenov First Moscow State Medical University, the Russian Federation,* gave an overview of the different methods of monitoring unrecorded alcohol consumption at country level and explained why unrecorded alcohol poses a special challenge for public health.

Unrecorded alcohol is a broad WHO term for alcohol that is not accounted for in official statistics on alcohol taxation or sales because it is usually produced, distributed and sold outside the formal channels under governmental control. Unrecorded alcohol includes the following types and subcategories:

- home-made alcohol (can be illegal depending on local legislation);
- smuggled alcohol;
- alcohol obtained through cross-border shopping (recorded in a different jurisdiction);
- illegally produced and/or undeclared alcohol and counterfeit alcoholic beverages; and
- surrogate alcohol – alcohol that was not produced as beverage alcohol (such as medicinal tinctures, cosmetic products and colognes, and technical fluids) but is used as such.

Total adult (aged 15+) per capita consumption as estimated by WHO is the sum of recorded and unrecorded consumption, corrected for tourist consumption. While recorded consumption is covered in routine statistics such as retail sales and taxation, unrecorded alcohol consumption needs to be estimated through various measures.

The main methods of estimates are: population-based surveys that assess unrecorded consumption as part of the study, such as the WHO STEPwise Approach to Surveillance survey;[21] expert assessment through various techniques; availability surveys of unrecorded alcoholic products; the use of state statistics on production of sugar, raw ethanol, non-beverage products or 100% alcohol-attributable conditions or other indicators that can be used for indirect assessment; and synthesis of available data and statistical modelling .

Globally, about 25% of alcohol consumed is unrecorded, with one of the lowest proportions observed in the European Region (18% of total consumption). Unrecorded alcohol is usually the cheapest form of alcohol and the usual time and place restrictions of sale do not apply to it. It often contains highly concentrated alcohol (up to 95% alcohol content) and is associated with heavy episodic drinking. Because of its cheap price and unregulated availability,

21 WHO Regional Office for Europe (2020). WHO STEPwise approach to surveillance. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/en/health-topics/noncommunicable-diseases/pages/monitoring-and-surveillance/tools-and-initiatives/who-stepwise-approach-to-surveillance, accessed 8 June 2020).

Unrecorded alcohol and public health

- **Unrecorded alcohol** poses a special challenge to public health, especially in CIS countries because it is usually cheaper and usual restrictions do not apply.
- Its main harm stems from ethanol itself and not from other admixtures and substances.
- Unrecorded alcohol is usually consumed by vulnerable population groups who already are at higher risk of alcohol-related harm.

Alcohol-control measures IN KYRGYZSTAN

- A minimum price for spirits is in place and alcohol excise taxes have been raised over the past years.
- A unified automated information system for state monitoring of produced and sold volumes of ethyl alcohol and alcoholic beverages is in preparation.

it is also usually consumed by vulnerable populations, such as people of low socioeconomic status, people from rural areas with less infrastructure, people with alcohol-use disorders and people from low-income and lower-middle-income countries. With some notable exceptions, unrecorded alcohol is often of the same quality as recorded alcohol, and the most harm from its consumption stems from ethanol alone.

The population-based case-control study from Izhevsk, the Russian Federation, documented the negative impact of the consumption of surrogate alcohol on public health, especially men's health.[22,23]

Cases of deaths in men aged 25–54 years that occurred during a defined time window were matched to living controls and various indicators of the two groups were compared, including alcohol consumption and, specifically, consumption of surrogate alcohol. Prevalence of surrogate alcohol consumption in the deceased men was significantly higher at 42%, while 8% of the matched controls consumed surrogate alcohol. The study highlighted that surrogate alcohol consumption is one of the main contributing factors to premature mortality in Russian men and is highly associated with problem drinking behaviours such as frequent episodes of hangovers, very heavy drinking and withdrawal from normal social life because of heavy use of alcohol (the so-called *zapoi*).

Rakhatbek Mamytkozhoev, specialist from the Kyrgyzstan Association of Village Health Committees, spoke about the difference between production and sale numbers of alcoholic beverages in Kyrgyzstan and how this can be seen as a sign of large proportions of alcohol being consumed unrecorded, which is in line with WHO estimates.

Both alcohol consumption and prevalence of alcohol-attributable morbidity and mortality, such as alcohol poisoning, alcohol dependence and alcoholic psychoses, have declined in Kyrgyzstan. Most of the population are abstainers and abstention rates are particularly high among females.

More attention needs to be paid to alcohol monitoring, however. Currently, there are five alcohol production plants, six vodka and spirits distilleries, 15 breweries and 19 wineries operating in the country. At the same time, a big difference is observed between production, sale and import numbers of alcoholic beverages: for vodka, for instance, 517 1000 decalitres were produced in 2018 but overall only 3773 thousand decalitres were consumed, according to recorded sale statistics. The gaps were smaller for beer, wine and cognacs and brandies, but the differences were still substantial. Both domestic production and imports of alcoholic beverages have been declining substantially over the past six years according to state statistics, but sales of

22 Leon DA, Saburova L, Tomkins S, Andreev E, Kiryanov N, McKee M et al. (2007). Hazardous alcohol drinking and premature mortality in Russia: a population based case-control study. Lancet 369(9578):2001–9.

23 Tomkins, S., Saburova, L., Kiryanov, N., Andreev, E., McKee, M., Shkolnikov, V., & Leon, D. A. (2007). Prevalence and socioeconomic distribution of hazardous patterns of alcohol drinking: study of alcohol consumption in men aged 25–54 years in Izhevsk, Russia. Addiction, 102(4), 544-553.

alcoholic beverages have not declined at the same pace and it is not possible to assess the volume of stored alcoholic beverages through state statistics.

Alcohol excise taxes started to be raised in 2013 and official production numbers of alcoholic beverages have declined in parallel, although generated state revenue from alcohol has overall declined over the past years. Minimum prices for vodka are in place for wholesale and retail sale, but they are not very well enforced as products below the set price are still available in some stores and shops. Excise stamps are used to prevent counterfeiting and ensure correct payment of excise taxes. It nevertheless is common that larger containers of 0.5 litres volume are sold with excise stamps for 0.25 litres containers and below, thereby effectively evading tax payments.

Alcohol producers of Kyrgyzstan follow production quotas. For the period January–March 2019, the established quota was 633 240 decalitres, but state statistics show the industry has produced 877 400 decalitres. The fact that Kyrgyzstan is currently developing a system for monitoring and tracking produced and sold volumes of alcohol, similar to the systems used in Kazakhstan and the Russian Federation, is influencing the situation; it remains to be seen how production and sale indicators will change over time.

Daria Khalturina, *Head of the Health Risk Prevention Department, Federal Research Institute for Health Organization and Informatics of the Ministry of Health of the Russian Federation*, presented on the Unified State Automated Information System (EGAIS), which collects data on production, distribution and sales of alcoholic beverages and beverage alcohol.

Ms Khalturina explained that EGAIS initially was developed as early as 2005 and that its implementation occurred in a stepwise manner. Up to 2016, the system only collected data and monitored produced volumes of beverage alcohol, spirits and wine, but thereafter EGAIS was introduced first for wholesale and then for retail sales in urban settings, although at the moment it does not comprehensively cover beer, cider and mead. From 2017 the system has covered retail sales in rural settings. Sales of beer, cider and mead are recorded through a web application, but not the main system. Having EGAIS equipment is mandatory for every producer and seller of alcohol and is part of the licensing procedure in the Russian Federation.

The EGAIS system allows tracing and tracking of each bottle produced, not only at the level of the distillery, but also through the whole production and sale process right through to the final consumer. The system is overseen by the Federal Service for Alcohol Market Regulation, a government agency under the Ministry of Finance. The system also allows for correct payments of alcohol excise tax and is an effective measure to reduce unrecorded alcohol production through, for instance, non-declaration of produced volumes by production plants.

Producers of alcoholic beverages apply bar codes to their containers that are registered with the EGAIS system and later scanned through special

The Unified State Automated Information System (EGAIS) IN THE RUSSIAN FEDERATION

- EGAIS is a monitoring system for alcohol products that was developed in the Russian Federation.
- EGAIS has undergone significant upgrades and expansion since its introduction and now covers production, distribution, and wholesale and retail sale.
- Consumers can track the bottle from the production plant to the cashier register using a QR code on their purchase receipt via a mobile application.
- Production and sale of counterfeit and illegal alcohol could be reduced significantly because of EGAIS.

equipment whenever the alcoholic beverages are transported, stored or sold. Cash registers at points of sales are equipped with special scanners. The cash-register programme uses the EGAIS transport module, which transfers information to the server of the Federal Service for Alcohol Market Regulation in real time. There, the information is processed, and it is checked if the specific bottle is registered with the system and has already been sold somewhere else. The server sends the response to the local cash register and the product is released. The consumer is issued a receipt with a specially generated QR code that contains data on the sold product from the production plant up to the point of sale. The QR code can be scanned through a special Anti-counterfeit ALCO mobile application, which provides consumers with essential information on the origin and authenticity of the purchased product.

Ms Khalturina noted that after the introduction of the EGAIS system, state revenues from alcohol taxes almost doubled while sales and consumption of alcoholic beverages decreased. Implementing the EGAIS system cost about 700 000 Russian roubles, and this relatively high cost needs to be covered by alcohol producers and sellers. This has led to a decline in small producers on the Russian alcohol market but also, most importantly, to a substantial decrease in small retail outlets.[24]

One of the current issues with the EGAIS system is the fact that established fines are quite low, especially for producers who do not have EGAIS equipment. This means that producers of alcohol can still produce large volumes of alcohol that might go undeclared and untaxed. There are also various enforcement issues on points of sales that need to be resolved over time. The introduction of the EGAIS system into retail sale nevertheless is a very important measure to reduce overall unrecorded alcohol production and consumption in the Russian Federation. Incidence of alcoholic psychoses and mortality from alcohol poisoning and other alcohol-attributable conditions has decreased substantially since the introduction of the system, but many other measures have also been taken to decrease the share of unrecorded alcohol in total consumption.[25]

Workshop participants discussed the need for monitoring strategies for unrecorded alcohol in CIS countries and exchanged practical experiences. Unrecorded alcohol is a multifaceted problem that needs to be taken into account when developing and implementing alcohol policy. With any measure introduced to regulate recorded consumption, specific measures need to be taken to mitigate unwanted consequences in relation to unrecorded alcohol to avoid shifts in consumption. Tudor Vasiliev shared the experience of the Republic of Moldova, where the introduction of licensing of home-made wines has helped to decrease its overall share, but the production of counterfeit alcohol has now become a bigger issue as there are no specific regulations in place to counter this development.

24 Khaltourina D, Korotayev A (2015). Effects of specific alcohol control policy measures on alcohol-related mortality in Russia from 1998 to 2013. Alcohol Alcohol. 50(5):588–601.

25 Neufeld M, Rehm J (2018). Effectiveness of policy changes to reduce harm from unrecorded alcohol in Russia between 2005 and now. Int J Drug Policy 51:1–9.

Carina Ferreira-Borges noted that from a public health perspective, individual producers of home-made alcohol are not the main issue that needs to be taken in consideration, but rather the alcohol industry that produces undeclared and untaxed products at industrial scale. Governments nevertheless need to make sure they bring unrecorded production under national regulations; specific policy options are available for each subcategory of unrecorded alcoholic products.[26]

Maria Neufeld and Artyom Gil also noted that various industries that produce different types of unrecorded products exist in many CIS countries. In the Russian Federation, for instance, there are manufacturers of cheap cosmetic alcohols that are known to be misused as surrogates by heavy drinkers with lower socioeconomic status. Their share, however, could be reduced following specific regulations that were put in place after a mass methanol poisoning occurred in Irkutsk, caused by the consumption of cosmetic lotions.[27]

Workshop participants also discussed the EGAIS system and made recommendations on its implementation in Kyrgyzstan, which were commented on by Daria Khalturina. The representative of Kyrgyzstan, Rakhatbek Mamytkozhoev, answered questions about the public's attitude towards unrecorded alcohol in his country and explained how inspections of retail outlets are carried out, yet again emphasizing the need for a more comprehensive monitoring approach.

26 Lachenmeier DW, Taylor BJ, Rehm J (2011). Alcohol under the radar: do we have policy options regarding unrecorded alcohol? Int J Drug Policy 22(2):153–60.

27 Neufeld M, Rehm J (2018). Newest policy developments regarding surrogate alcohol consumption in Russia. Int J Drug Policy 54:58–9.

SESSION VI

SCREENING AND BRIEF INTERVENTIONS FOR ALCOHOL USE AS A MEASURE TO STRENGTHEN THE HEALTH SYSTEM'S RESPONSE

Screening and brief interventions (SBI) for alcohol

WHO recommends SBI for alcohol at primary health-care level as one of the most effective measures to address and reduce alcohol-attributable harms. Screening is necessary to identify people with hazardous and harmful patterns of alcohol consumption that puts them at risk. On the basis of screening, brief interventions can be delivered to those at risk to motivate them to reduce their alcohol intake before health and social consequences become pronounced.

WHO has developed the **Alcohol Use Disorders Identification Test (AUDIT)** to deliver quick and standardized screening. This is a simple 10-question test that helps to assess individual risk levels and also to identify alcohol dependence and some specific consequences of harmful drinking.

Frederico Rosario, *Manager of the Alcohol-related Problems Project Health Centre Grouping (ACeS) of Dão-Lafões, Portugal*, presented on barriers to. and facilitators of. the implementation of alcohol screening at primary health-care level, highlighting the experience of Portugal.

Screening and brief interventions (SBI) for alcohol at primary health- care level is an evidence-based practice used to identify, reduce and prevent problematic use of, and dependence on, alcohol. Its aim is to reduce the overall health and social consequences of alcohol use through motivating the individual to reduce or quit drinking. SBI is recommended by many national guidelines and is also a WHO-recommended strategy and one of the five action areas of the WHO SAFER framework.

Screening for alcohol currently is not being implemented in many primary health-care settings as there are various barriers to its implementation, all of which have been thoroughly described in the literature.[28] A study with medical workers from primary health care in Portugal revealed that 60–70% of staff reported that they were lacking: knowledge and training; the time and the needed organization for preventive counselling; and the materials needed for screening and counselling.

These barriers need to be addressed to increase SBI for alcohol in primary health-care settings. Based on a cluster randomized controlled trial[29] in which primary health-care staff were given tailored training on overcoming barriers and facilitators for implementing SBI, a series of conclusions for practical implementation were drawn. It was found that the following factors can increase screening in primary health care:

- providing training and support tailored to local barriers, with more focus on motivational determinants;
- addressing barriers to both screening and brief interventions;
- involving all primary health-care staff (doctors, nurses, receptionists and others) and working as a team; and
- providing support through SBI materials, feedback on performance and a referral network.

Anna Bunova, *Junior Researcher, Department of Primary Prevention of Chronic Noncommunicable Diseases in the Health-care System, National Medical Research Centre for Therapy and Preventive Medicine of the Ministry of Health of the Russian Federation*, presented on a large multicentre study of adapting and validating the Alcohol used Disorders Identification Test (AUDIT) tool in the Russian Federation.

Barriers to delivering SBI for alcohol

- Various barriers exist to delivering SBI for alcohol at primary health-care level.
- For implementation of SBI, it is crucial to tailor training and resources to these local barriers.
- Motivational determinants, teamwork and availability of good training materials and screening instruments is important for successful implementation.

28 Johnson M, Jackson R, Guillaume L, Meier P, Goyder E (2011). Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence. J Public Health 33(3):412–21.

29 Rosário F, Vasiljevic M, Pas L, Fitzgerald N, Ribeiro C (2019). Implementing alcohol screening and brief interventions in primary health care: study protocol for a pilot cluster randomized controlled trial. Fam Pract. 36(2):199–205.

The Alcohol Use Disorders Identification Test (AUDIT)

- AUDIT was developed by WHO in the 1980s as a simple way to screen and identify people who are at risk of developing alcohol problems. It is a simple 10-question test with good psychometric qualities.
- AUDIT has been translated into several languages and several country-specific adaptations exist.
- AUDIT is currently being adapted and validated in the Russian Federation, accounting for local drinking patterns and behaviours.

AUDIT is a simple 10-question test developed by WHO that has been widely translated into different languages and is used as the standard screening instrument for alcohol use and as part of the SBI approach in various countries.

Following the development of the WHO training manual on alcohol brief interventions for primary care[30] and its translation into Russian, the expert group involved in tailoring the resources to the context of primary health care in the Russian Federation was confronted with inconsistent versions of AUDIT in the country. Concerns were voiced about whether the test adequately captures drinking volumes and patterns typically found in the Russian Federation. It was found that a Russian version of AUDIT had never been validated for the general population to be used in primary health-care facilities. As a result of this discussion, a validation procedure for AUDIT in the Russian Federation was initiated and a project advisory board was formed, involving experts from various disciplines. Representatives from the following institutions constituted the board:

- Ministry of Health of the Russian Federation;
- WHO European Office for Prevention and Control of Noncommunicable Diseases and WHO Country Office in the Russian Federation;
- Federal Research Institute for Health Organization and Informatics of the Ministry of Health of the Russian Federation;
- National Research Centre for Therapy and Preventive Medicine of the Ministry of Health of the Russian Federation;
- I.M. Sechenov First Moscow State Medical University;
- National Research Centre on Addictions, V. Serbsky National Medical Research Centre for Psychiatry and Narcology of the Ministry of Health of the Russian Federation; and
- Moscow Research and Practical Centre for Narcology of the Department of Public Health, Moscow.

Adaptation and validation involves a multi-step process that currently is ongoing. Several qualitative and quantitative pre-studies were carried out as part of the initial problem analysis. In the course of systematic reviews of available validation studies of AUDIT in the Russian Federation and existing translations of the test into Russian, it was found that many different translations existed and that the test was never validated in the Russian Federation. On the basis of the reviews and qualitative interviews with experts, an adapted version of the test was constructed, following established WHO translation procedures.

30 WHO Regional Office for Europe (2017). WHO alcohol brief intervention training manual for primary care. Copenhagen: WHO Regional Office for Europe (https://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/2017/who-alcohol-brief-intervention-training-manual-for-primary-care-2017, accessed 8 June 2020).

It was then piloted in several institutions and settings and the process was overseen by the advisory board, who also acted as an expert panel during the adaptation process. The final version of the translated and adapted test was then used in a large-scale validation study in which several primary health-care facilities from various regions of the Russian Federation were involved and where a total sample of about 2000 participants was recruited.[31]

Based on the results of the study, Russian-specific thresholds for hazardous and harmful alcohol use and possible alcohol-use disorders will be determined and the Russian AUDIT will be made available for the implementation of SBI in the context of the Russian Federation.

Tatyana Korotkevich, *Deputy Director for Organizational and Methodological Work in the Republican Scientific and Practical Centre for Mental Health in Minsk*, reported on the ongoing implementation of SBI for alcohol in Belarus.

Alcohol-attributable mortality is declining in Belarus, but indicators have stagnated in the last three years.[32]

Starting in 2018, per capita consumption has been calculated for adults only (those aged 15 years and older). Consumption of domestic fruit wines makes up the largest proportion of all alcoholic beverages consumed, but when converted into litres of pure alcohol, spirits account for about half of all alcohol consumed. The Government programme "People's health and demographic security of the Republic of Belarus" for the period 2016–2020 is now in place as well as the national subprogramme "Prevention and overcoming of drunkenness and alcoholism". The letter programme has two specific tasks: reducing the level of negative social and economic consequences of drunkenness and alcoholism; and reducing the volume of consumption by the population of alcoholic and low-alcohol drinks and beer.

Legislative changes were discussed and partially implemented to allow for the introduction of SBI into the health-care system. Amendments were made to the national law on the provision of psychiatric care. In accordance with these changes, patients with identified signs of a mental disorder who do not pose a direct danger to life or health of the patient or other people and do not require referral to a specialist service can be treated by a general practitioner if they wish. The appropriate medical care is provided to the degree established by the Ministry of Health and on the basis of clinical protocols for the provision of medical care for mental and behavioural disorders in general medical practice, approved by the Ministry of Health. The conclusion of the general practitioner on the state of the patient's mental health is preliminary and will not form the basis for any procedures restricting their rights and freedoms. These changes prevent any involuntary addiction treatment, which can be imposed in the case of an established addiction diagnosis by a narcology

Alcohol-control measures
IN BELARUS

- Alcohol consumption and alcohol-attributable harms have been declining, but indicators have stagnated over the last three years.
- Legislative changes were introduced to allow general practitioners to provide medical help to people with signs of mental disorders without the necessity to refer them to specialists, which is the legal base for delivering SBI at primary health-care level.
- Clinical protocols for the provision of SBI are under development and primary health-care staff training has already been carried out in some pilot regions

31 Rehm J (in press). Adaptation of and protocol for the validation of the Alcohol Use Disorders Identification Test (AUDIT) in the Russian Federation for use in primary healthcare. Alcohol Alcohol.

32 Grigoriev P, Bobrova A (2020). Alcohol control policies and mortality trends in Belarus. Drug Alcohol Rev. 10.1111/dar.13032. doi:10.1111/dar.13032

specialist, and avoid any stigmatization associated with narcology settings. The changes allow general practitioners to provide SBI in primary health care.

The next step towards implementing SBI in Belarus was to develop a clinical protocol for its provision. Different screening instruments were proposed to detect problem drinking and potential alcohol problems, including alcohol-use disorders – the CAGE screening test, the Fast Alcohol Screening Test (FAST) and AUDIT. Currently, no decision has been made on a screening tool that will be implemented as part of the protocol.

Training is being carried out with primary health-care staff as part of the routine training and qualification programme, in which health workers learn how to screen and identify patients at risk. Ms Korotkevich summarized the main barriers to providing SBI in Belarus as documented during this training:

- reluctance of general practitioners to deal with the patient's alcohol problems;
- lack of knowledge and related skills and experience;
- a common paternalistic approach to health care;
- limited time during which the primary-care doctor communicates with the patient (12–15 minutes);
- lack of qualified trainers for training and support; and
- inability to use financial incentives for delivered SBI due to limited resources of the health system. Some pilot projects are underway in regions where SBI is carried out, but the overall impact has not yet been evaluated.

In conclusion, Ms Korotkevich outlined the following actions that are needed to facilitate implementation of SBI in Belarus:

- provide an evidence synthesis of the effectiveness of SBI in primary care at national and regional levels;
- align forces and find synergies with other healthy lifestyle initiatives;
- provide information support;
- develop registration and monitoring systems;
- validate the screening test validation at national level; and
- allocation targeted financing for the implementation of SBI.

In the **following panel discussion**, workshop participants discussed the difficulties that arose in implementation of screening and brief counselling in their respective countries and reported on their overall experiences. Tudor Vasiliev noted that motivation of primary health-care staff is one of the main barriers. He indicated that in the Republic of Moldova, screening with AUDIT is a mandatory routine procedure that is paid from health insurance budgets and is at the same time a performance indicator for medical staff.

Workshop participants also discussed the advantages and disadvantages of AUDIT as the most commonly used type of screening instrument. Overall, AUDIT was found to be useful as different versions of it exist for self-completion and for screening with a medical professional, where it can serve as an entry point to providing brief interventions. Shorter versions of AUDIT can be used to save time.

Boris Gornyi asked at which exact point in the primary health-care system AUDIT could be implemented and where exactly patients could be screened upon contact. Various scenarios were proposed and discussed, such as at the reception desk when registering, when making an appointment online or over the phone, while waiting at the primary health-care facility to receive medical attention, upon admission to the hospital or as part of the population-wide dispanserization process.[33]

Maria Neufeld asked about experiences of translating the English-language term "screening and brief intervention" into Russian and other national and local languages, as sometimes primary health-care experts do not appreciate how the term "intervention" can be interpreted in their local language as it implies a rather invasive procedure, which might pose another barrier to SBI implementation. Most participants mentioned that they see no problem in using the term "brief interventions" in their respective context, but some mentioned there they might be a problem with "screening" as this term is not used for detecting risk factors.

33 Dispanserization denotes preventive activities undertaken at population level that are organized within primary health-care facilities, mostly polyclinics, in various CIS countries. Dispanserization measures typically include preventive and specialized medical examinations for early detection and prevention of diseases and risk factors, including alcohol and tobacco use. They are carried out regularly, sometimes with specific requirements attached to their implementation, including the frequency of testing that is determined by sex, age and professional activity.

CLOSING SESSION

Closing session and conclusions of the workshop

Carina Ferreira-Borges, *Programme Manager of the Alcohol and Illicit Drugs programme at the WHO European Office for the Prevention and Control of Noncommunicable Diseases*, invited all participants to make final remarks, suggesting future collaboration as part of a CIS country network on exchanging experiences and best practices in alcohol-control policy. All participants welcomed this suggestion and some provided suggestions for future topics to be discussed and covered as part of such an initiative.

Tatyana Korotkevich, Deputy Director for Organizational and Methodological Work at the Republican Scientific and Practical Centre for Mental Health in Minsk, Belarus, mentioned that CIS countries are similar to each other in the way the health-care systems are set up, so it is important and necessary to maintain working relations. She emphasized that for Belarus it would be very important to develop a dialogue with the economic sector on developing alcohol policy and to convince alcohol producers and their supporting state structures that measures should be taken to reduce the harmful effects of alcohol consumption. Belarus is interested in introducing SBI at primary health-care level, so being part of such an initiative and having the possibility to exchange with other CIS countries would be crucial.

Tudor Vasiliev, Head of the Monitoring, Evaluation and Integration of Medical Assistance Division of the Republican Narcology Dispensary in Chisinau, Republic of Moldova, noted that each country has its own specificities, in general but also in the way alcohol policies are developed. It would therefore be important to have an international guiding framework that could unite the course of action of various countries, similar to the WHO Framework Convention on Tobacco Control. He noted that this is something that might be discussed in the future as part of the emerging network, and mentioned that it might be useful to revisit the now 25-year-old European Charter on Alcohol,[34] as a lot of new evidence on alcohol has accumulated.

Tofig Musayev, Head of Population Health Department, Public Health and Reforms Centre of the Ministry of Health of Azerbaijan, suggested the creation of special WHO training on how to create dialogue with decision-makers and how to manage any conflict of interests.

Daria Khaltourina, Head of the Health Risk Prevention Department of the Federal Research Institute for Health Organization and Informatics of the Ministry of Health of the Russian Federation, supported the idea of having regular meetings to exchange experiences among CIS countries. She emphasized that such a network will help develop alcohol policies, adopt best practices and reduce alcohol mortality in various countries.

Gulnara Kuspekova, Head of the Directorate of the Public Health Protection Department for Public Health Policy, Ministry of Health of Kazakhstan,

34 WHO Regional Office for Europe (1995). European Charter on Alcohol. Copenhagen: WHO Regional Office for Europe (https://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/pre-2009/european-charter-on-alcohol,-1995, accessed 8 June 2020).

suggested inviting specialists from ministries of finance or other ministries to such meetings to develop dialogue and discuss possible solutions to arising issues in relation to alcohol-control policy.

Rakhatbek Mamytkozhoev, specialist from the Kyrgyzstan Association of Village Health Committees, emphasized that a CIS country network could be the starting point for developing a regional framework for alcohol control, which can lay the ground for the development of a framework convention for alcohol similar to the WHO Framework Convention on Tobacco Control.

Ashhabad Nohurov, Head of the Psychiatric, Narcology and Medical Psychology Department of the Murad Garryev Turkmen State Medical University supported the idea of a CIS countries network to exchange experiences. He suggested discussing and implementing best practices in the prevention of the harmful effects of alcohol within health systems. This suggestion was echoed by Boris Gornyi, leading researcher from the National Medical Research Centre for Preventive Medicine of the Ministry of Health of the Russian Federation, who emphasized the need to focus on medical issues related to monitoring and prevention as well as provision of medical care to people who have problems with alcohol.

Carina Ferreira-Borges summarized the main discussion points of the meeting and thanked all the participants. She noted that the creation of such an initiative would require continuity of meetings and official nomination of network focal points. It would also be important that such an initiative was included in national plans to facilitate planning and budget allocation for network activities to cover items such as travelling expenses. The experiences of CIS countries as “first movers” are not yet very well documented and the present meeting and initiative will hopefully change this in the future.

APPENDIX NO. 1.
Scope and purpose of the meeting

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Workshop of "first mover" countries to improve the implementation of evidence-based alcohol control policies	/2
4-5 December 2019 Moscow, Russian Federation	29 October 2019
	Original: English

Scope and purpose

The WHO European Region continues to have the highest levels of per capita alcohol consumption (9.8 litres of pure alcohol per year), and, globally, the highest proportions of burden of disease attributable to alcohol, with 10.1% of all deaths and 10.8% of all disability-adjusted life years attributable to alcohol consumption. Most worryingly, alcohol-related harms done to young people are unacceptably high in Europe; about every fourth death in the 20-24-year age group is caused by alcohol. Therefore, a high proportion of alcohol-attributable harm occurs early in the life-course, making alcohol a leading cause of working years of life lost and hence of lost economic productivity and development.

During the Regional Consultation on the implementation of the WHO Global strategy to reduce the harmful use of alcohol and the WHO European Action Plan to reduce the harmful use of alcohol (2012-2020) on 30 September - 1 October 2019 in Prague, Czech Republic, Member States discussed the difficulties in implementing policies linked to reducing availability and marketing and increasing prices of alcoholic beverages and also discussed the need for more action in the area of strengthening the health system's response.

Countries in the Eastern WHO European region like Belarus, the Republic of Moldova, the Russian Federation and Ukraine have the highest proportion of alcohol-attributable mortality in all-cause mortality with the largest alcohol-
On the other hand, countries from the Caucasus and central Asia such as Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan have the largest absolute increases in alcohol-attributable

mortality as compared to other sub-regions of the WHO European Region over the past two decades, although trends have been decreasing lately.

At the same time, these regions are the ones, where alcohol control policies were actively implemented in the course of the last years as a response to the enormous burden, although there is big variance across as well as within countries. These alcohol control measures are in line with the WHO "SAFER" framework on the five areas of intervention at national and subnational levels towards a world free from alcohol related harms, namely 1) restricting alcohol availability, 2) enforcing drink driving countermeasures, 3) providing screening, brief interventions, and treatment for risky alcohol consumption, 4) ban alcohol advertising and 5) increasing alcohol prices. The experience of these "first mover" countries who have implemented the WHO recommended "best buys" and the "SAFER" framework could serve to inspire similar action in other countries of the WHO European Region.

However, the "first movers" themselves also face significant challenges in evaluating and communicating the impact of their policies, defending their approach and advocating for further action. In response to the requests made by the Member States during the Regional Consultation in Prague, WHO Regional Office for Europe convenes a workshop for exchanging experiences, achievements and set-backs in the field of alcohol control policies in the above-mentioned countries of the WHO European Region.

The workshop aims to:

- discuss drinking trends and effectiveness of the existing alcohol control policies;
- provide a forum to exchange experiences and lessons learned;
- identify common experiences and approaches that might be transferable to other contexts;
- discuss strategies to address ongoing challenges and anticipate potential policy barriers, including resistance from industry; and
- explore opportunities to work together through concerted action based on common principles,

Discussions will feed directly into a WHO report that will provide an overview of the implementation of evidence-based alcohol control policies in the countries attending the workshop. It is expected that the report will support national policy-makers and inform the technical support that WHO provides to countries in this area.

The meeting structure will involve group discussions and sharing of experiences among the participants. The working language of the meeting will be English and Russian, and simultaneous interpretation will be provided. Documents for the meeting will be made available at the meeting room.

APPENDIX NO. 2. Provisional Agenda

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
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Provisional agenda

1. Opening session.
2. Reflection from the 2019 regional consultation on the implementation of the European Action Plan to Reduce the Harmful Use of Alcohol (EAPA).
3. The evidence base of the 10 areas of action of the EAPA.
4. Successes and challenges in pricing policies – the case of minimum unit prices.
5. Alcohol marketing and labelling – implementation examples.
6. Protecting alcohol control policies from industry interference and management of conflicts of interest.
7. Monitoring systems of alcoholic beverages and reduction of unrecorded alcohol consumption– exchange of best practices.
8. Successes and challenges in implementing alcohol screening in preventive services – identifying best models from local experience.
9. Closing.

APPENDIX NO. 3. List of participants

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List of participants

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Ministry of Health of the Republic of Azerbaijan

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Belarus

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WHO regional Office for Europe

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Luxembourg
Malta
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Montenegro
Netherlands
North Macedonia
Norway
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WHO/EURO:2020-1202-40948-55497

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