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Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm

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The views expressed herein are those of the consultants alone and do not necessarily represent the official views of the European Commission.

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Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm

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Foreword

> "National and local efforts can produce better results when they are supported by regional and global action within agreed policy frames" (WHO 2010: 8)

Alcohol is a major contributor to loss of life and to the burden of disease in Europe. Harmful and hazardous alcohol use is associated with a wide range of physical, psychological and social harms and the costs to individuals, communities and society are widely recognised. Smoking, lack of physical exercise, unhealthy diet and alcohol have been identified by WHO as modifiable and preventable risk factors for non-communicable diseases, such as cirrhosis of the liver, cardiovascular disease and cancers. Furthermore, harmful alcohol use is linked with health inequalities, exacerbating problems of poverty in poorer communities, and heavy drinking is a particular concern in some European countries.

The 2006 EU alcohol strategy recognises that a single uniform alcohol policy relevant to all Member States is neither possible nor desirable and that the role of EU policy is to complement national actions. At the same time, concerted action at EU level is crucial to coordinate measures between the individual national policies, to tackle cross-border problems, to increase exchanges of information and to identify and disseminate best practice.

This report presents the findings from a retrospective evaluation of a complex policy strategy. Although constrained by the resources available for the research and by the lack of good cross-national, long-term data, limitations which are common to many evaluations of complex health and social policy strategies, the evaluation provides valuable information, based on the findings from surveys and interviews with a wide range of stakeholders, on the achievements of the EU alcohol strategy and on the challenges it has faced. There have been considerable achievements since 2006. The Committee on National Alcohol Policy and Action (CNAPA), one of the two main instruments set up to support the strategy, has contributed to building consensus across Member States and provided impetus for the development of national policies; the European Alcohol and Health Forum (EAHF) has stimulated concrete stakeholder-driven action to address alcohol-related harms through 'commitments to action'. It is evident that most Member States have updated and strengthened their alcohol strategies over the past six years, building on evidence-based measures and moving in the directions outlined in the EU strategy.

However, Europe's per capita alcohol consumption is still the highest in the world despite a decline in consumption and changes in drinking patterns in some countries over the past thirty years. Issues which inspired the motion for a European Union strategy to support Member States in reducing alcohol-related harm are, therefore, still highly relevant. There is a continuing need for leadership to promote awareness and action to prevent and reduce alcohol related harm by fostering collaboration across and within Member States. There is room to support ongoing policy evolution within Member States towards a broader vision of

alcohol-related action which crosses policy domains but recognises alcohol-related harm as a complex issue which requires a balanced approach if it is to build bridges between diverse interest groups. Collaboration at European level is a key element in achieving WHO objectives of reducing social disparities and health inequalities, balancing different interests and achieving inter-sectoral action to reduce alcohol-related harm. Continuing coordination of action at EU level would maintain and strengthen the common approach supporting further Member State policy developments and the momentum of stakeholder action.

References

Anderson P., Moller L., Galea G. (eds) (2012) *Alcohol in the European Union. Consumption, harm and policy approaches.* WHO Regional Office for Europe.

World Health Organisation 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-Communicable Diseases, WHO, Geneva

World Health Organisation (2010) Global strategy to reduce the harm from alcohol. WHO, Geneva.

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Executive Summary

The European Commission launched in 2006 an *EU strategy to support Member States in reducing alcohol-related harm.* Its priority themes, identified as relevant in all Member States and for which action at EU level adds value, are: (1) protecting young people, children and the unborn child; (2) reducing alcohol-related injuries and death in road traffic; (3) preventing alcohol-related harm among adults and reducing the negative impact on the workplace; (4) informing, educating and raising awareness of the impact of harmful alcohol consumption and of appropriate consumption patterns; (5) developing and maintaining a common evidence base. The strategy calls for further actions at three levels are: measures implemented by Member States at national level; coordination of national policies at EU level; and actions by the European Commission, including through projects, research and stakeholder cooperation.

This assessment looks at the two main instruments set up to support the implementation of the strategy: the Committee on National Alcohol Policy and Action (CNAPA), which coordinates actions and policy development among Member States; and the European Alcohol and Health Forum (EAHF), which stimulates stakeholder-driven actions to reduce alcohol-related harm.

In the absence of specific appropriation or funding instrument for the implementation of the alcohol strategy, its aims and priorities have been shown to guide funding decisions under the EU Health Programme and the EU Research Framework Programme. Member State representatives' views have been solicited on the usefulness of EU projects and research. A further pillar, for implementation of synergies across EU policies, including work done for example in the context of education and youth policies, road safety, or occupational safety and health, is beyond the scope this assessment.

Three information gathering methods have been used in parallel: desk research, including on documents and reports produced or made available in the context of CNAPA and EAHF; surveys addressed to members of CNAPA, members of EAHF, and to further external experts and officials (in all 144 respondents); and follow-up interviews with survey respondents (in all 33 interviews). Advisory Groups of selected CNAPA and EAHF members provided further input. Suggestions for possible ways forward largely arise from the lessons learned with a view to enhance effectiveness in achieving the objectives of the implementation structures and of the strategy.

Committee on National Alcohol Policy and Action (CNAPA)

The objective of the Committee is to coordinate government-driven policies aimed at reducing alcohol-related harm at national and sub-national levels. It could be ascertained that CNAPA has provided a platform for the exchange of information on Member State policies and for the discussion of issues and measures across the priority themes, as well as further issues, such as alcohol taxation or approaches to regulating alcohol advertising Moreover, the Committee has had a role as interface between new knowledge emerging from EU-funded projects and research and Member States' alcohol policy development process.

The results from the enquiries indicate that the Committee has contributed to building consensus among the members on alcohol policy related issues. Coordination and support at EU level through the Committee and through co-financed projects and research has been seen to provide input to the development of national public health policies on alcohol. In addition, across the Member States, a range of policies and measures are considered to be moving in directions outlined in the EU strategy.

Alcohol and Health Forum

The objective of this Forum is to support the implementation of the EU strategy through stimulating and coordinating concrete stakeholder-driven action across the society. The EAHF has mobilised almost 70 stakeholders, from non-governmental organisations to media/advertising bodies to producers/retailers of alcoholic beverages. Members have announced and implemented over 200 'commitments to action' to address alcohol-related harm, some of which are still ongoing. The EAHF appears to have succeeded in mobilising a broad range of stakeholders to address alcohol related harm and in stepping up actions. Actions under the EAHF have also likely contributed to engaging cooperation among stakeholders at national and local levels.

One important strand of work aimed to support further development of industry self-regulatory systems for the marketing of alcoholic beverages. This has been carried out through commitments by EAHF members, through exchange of information in a dedicated Task Force and through reports on the state of play and progress made. Initiatives for further development of self-regulation have built on the effective self-regulation model of the 2006 Advertising Round Table in health and consumer policy areas. The results from the evaluation indicate that the EAHF process has motivated stakeholders to step up action in this area and has thereby contributed to the development and convergence of the alcohol advertising self-regulatory systems across the EU.

The overall strategy process

The main lines of action under the priority themes are summarised below.

Protecting young people, children and the unborn

- Most Member States have strengthened policies on the availability of alcohol since 2006, including age limits, with convergence towards 18 years across beverage categories and with enhanced emphasis on enforcement. Community-based prevention projects are in place in most Member States. Counselling programmes for children in families with alcohol problems and for pregnant women at risk are as well.
- In support of preventing harm from alcohol among young people, EAHF members have undertaken numerous 'commitments to action', and concrete initiatives have been shared in plenary meetings. Activities to reduce exposure to alcohol during pregnancy have included voluntary warning label schemes and awareness-raising targeted to medical professionals.
- Statutory restrictions on alcohol advertising are in place in most Member States, as well as self-regulation and responsible practices in alcohol marketing, in particular in terms of limiting children's and young people's exposure to alcohol advertising.

Reducing injuries and death from alcohol-related road accidents

- It was recorded that in line with EU recommendations, all but two Member States have established a maximum blood alcohol content for driving (BAC) of 0.5 mg/ml or less, and are increasingly introducing lower limits for novice, commercial and public transport drivers and enhancing BAC limit enforcement.
- In this context also, EAHF members have carried out a high number of 'commitments to action', although drink driving was not defined as a priority theme for the EAHF

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

- Evidence shows that advice targeted to harmful drinkers is provided by professionals within health services in three-quarters of Member States. Nevertheless, only half provide on a regular

basis training for health professionals in this area. In two-thirds of Member States prevention or counselling for alcohol use disorders is available in workplaces.
- A key outcome recorded is the EAHF Science Group report on *Alcohol, work and productivity*, highlighting the workplace as a useful access point for health promotion, including for addressing alcohol-related harm.

Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns
- The largest share of initiatives under the EAHF have been awareness-raising and information activities on the impacts of harmful drinking and on appropriate drinking patterns, with young people or adults as target groups, or focussed on the risks of alcohol in specific situations such as during pregnancy or when driving. Through their EAHF commitments, several alcohol producers have taken the initiative to provide information on specific risks though responsibility messages on the packaging labels of alcoholic beverages.

Develop and maintain a common evidence base
- Actions related to this priority theme are primarily foreseen at EU level, with the aim to develop standardised definitions, common indicators, and approaches to obtain comparable information as well as research to fill in information gaps.
- The results of this assessment indicate that the work to develop the common evidence base has supported policy development processes in Member States. While the availability to timely and comparable data remains a priority, challenges remain in this area that would need to be addressed at both EU and Member State level.

Few cross-sectional EU indicators or long-term statistics are currently available on trends related to the ultimate goal of the EU strategy, reductions in alcohol-related harm. The available statistics are not readily suitable for distinguishing between short-term fluctuations and longer-term trends.

It is evident, however, that most Member States have updated and strengthened their alcohol strategies over the past six years, building on evidence-based measures and moving in the directions outlined in the EU strategy. Actions across the society in the strategy's priority themes, whether carried out as part of national public health policies or on a voluntary basis by stakeholders, can be expected, over the longer term, to contribute to reductions in alcohol-related harm.

Added value from EU level action

The results of this assessment show that the EU strategy's five priority themes have been addressed, and remain relevant for Member States and stakeholders. The work carried out so far has had clear results in terms of supporting Member State action.

The EU strategy and its implementation have provided an EU-wide approach to address common issues, including a shared evidence base, and an EU-wide baseline and benchmarks for further action. Continuing coordination and action at EU level would maintain and strengthen the common approach supporting further Member State policy developments and the momentum of stakeholder action and cooperation.

Possible ways forward towards the alcohol harm reduction objectives

Despite the progress described across the five priority themes of the Strategy, the aims of the alcohol strategy have not yet been fully reached and alcohol-related harm remains a concern in all Member States.

Therefore, coordination and support at EU level should be continued and geared towards ways to enhance effectiveness of actions and implementation structures.

Possible ways to enhance coordination and support Member States:

- Enhance the political visibility of the CNAPA, thereby the prominence of the EU strategy, through high-level meetings, links to the EU Presidency agendas and, on cross-policy issues, through greater interaction with other policy areas, including both Commission services and national governments.
- Improve consistency and continuity, for example through a multi-annual work plan and yearly reports, and through synergies from work across health risk factors.
- Explore further channels for dissemination of the outcomes of EU-financed projects and research.

Possible ways to widen and strengthen actions by stakeholders:

- Encourage broader involvement from sectors that are currently under-represented in the EAHF, such as alcohol retailers and social insurers, and explore ways to involve further sectors, such as law enforcement, as well as stakeholders from new Member States.
- Re-focus work under the EAHF on fewer well-defined action areas, identify benchmarks and good practices and formulate guidelines for development and implementation.
- Raise the standards for reporting and evaluation of EAHF members' initiatives in particular to provide firmer basis for demonstrating their added value in reducing alcohol related harm.

A key point recurring throughout this assessment has been the importance of a common evidence base and of common information gathering approaches.

Scientific evidence on the effectiveness of alcohol policy options occupies an important place throughout the implementation of the EU strategy. Research and information systems are considered crucial for the development and implementation of effective actions at EU, national and local level. To further strengthen the scientific underpinnings, a Science Group could be set up to support the entire process to address alcohol related harm, rather than to just provide guidance to the stakeholder forum. The implementation of common EU indicators for monitoring alcohol consumption and related harm, based on a more structured and sustainable approach, would be valuable at EU level and for the work of Member States and stakeholders.

A further point that cuts across the evaluation results concerns the need to clarify linkages and synergies across the priority themes, across the pillars of implementation, and across the multitude of actions and initiatives. Defining concrete targets at EU and Member State level for the aims under the priorities could help position individual initiatives within the wider framework of action and contribute towards a sharper focus on outcomes and impacts.

1 Introduction

1.1 The EU strategy

The European Commission launched in 2006 an *EU strategy to support Member States in reducing alcohol-related harm*[1] focussed on five priority themes which are relevant in all Member States and for which action at EU level has an added value. These are:

1. Protect young people, children and the unborn child;
2. Reduce injuries and death from alcohol-related road accidents;
3. Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
4. Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
5. Develop and maintain a common evidence base at EU level.

Actions under the strategy are carried out at three levels: measures implemented by Member States at national level; coordination of national policies at EU level; and actions by the Commission, including support for projects and research and cooperation with stakeholders. For each theme, the strategy identifies good practices to be taken at these levels.

Under the strategy, the Committee on National Alcohol Policy and Action (CNAPA) was set up to strengthen coordination and policy development. The European Alcohol and Health Forum (EAHF) was set up to stimulate concrete stakeholder-driven action to reduce alcohol related harm.

1.2 Assessment methodology

This report presents the final results of the *Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm*. The overall purpose was to assess the added value of the EU alcohol strategy and its implementation, in terms of enhancing action, cooperation and coordination to reduce alcohol related harm at European and national level.

The assessment was divided into three tasks:

1. Assessment of the Committee on National Alcohol Policy and Action (CNAPA) as an instrument for coordination at EU level, including support to Member States through the development of alcohol data gathering and the knowledge base.
2. Assessment of the European Alcohol and Health Forum (EAHF) as an instrument and process for implementing the EU alcohol strategy, including an assessment of the extent, nature and potential of members' commitments to contribute to the reduction of alcohol-related harm and a case study focussed on further development of responsible practices in the marketing of alcohol beverages.
3. Assessment of the overall EU alcohol strategy process and its added value

The assessment followed the structure laid out in the terms of reference. For each assessment task, a set of evaluation questions were covered. Task 1 addresses CNAPA, the Committee on Data Collection Indicators and Definitions (CDCID) and EU-funded research and projects; Task 2 focuses on EAHF, and Task 3 provides an overview of Member State actions as well as information related to impacts. The overall conclusions (section 5), in turn, review the results in terms of three criteria for policy evaluation:[2]

- Relevance: the extent to which actions relate to objectives; and the extent to which objectives are pertinent to the needs, problems and issues to be addressed
- Effectiveness: the extent to which objectives are achieved

[1] For conciseness, this report often refers to "the EU alcohol strategy" or "the EU strategy".
[2] European Commission (DG Budget – Evaluation unit), EU Activities: A practical guide for the Commission services, July 2004

- Efficiency: the extent the desired effects are achieved at reasonable cost

The process has benefitted from the input and guidance of an Inter-service Steering Group (ISSG) formed by representatives of various Directorates-General of the European Commission.

Information sources

The assessment is based on desk research, on three separate surveys targeted at (1) members of CNAPA, (2) members of EAHF, and (3) a group of external experts and officials[3] and on follow-up interviews with selected members of CNAPA and EAHF. In addition, two advisory groups, made up respectively by CNAPA and EAHF members, provided review and further input.

The *desk research* reviewed work carried out within CNAPA and EAHF and drew on independent, external studies that provided the main evidence base for specific areas of the evaluation. In particular, the joint EC/WHO survey on Member State policies to address alcohol-related harm provided evidence for Task 3; and the mapping reports on the development of industry self-regulatory systems for marketing were used in the case study.[4]

The first *survey* was sent to 54 persons who have at one point or another represented the 27 Member States at CNAPA meetings (representatives of Norway and Switzerland were also contacted). Replies were received from 31 persons (response rate 57%). All surveys were anonymous but respondents were invited to provide coordinates if they agreed to be contacted for a follow-up interview. Respondents from 21 Member States (twelve EU15 and nine EU12 countries) provided such information, plus Norway and Switzerland, indicating that the survey covers more than three-quarters of the total number of Member States and a broad set of CNAPA members. Further details on the CNAPA survey response are found in Annex 1.

The second survey was sent to 123 representatives of 65 EAHF member organisations. Of these, a total of 62 people (50%) replied. This survey too was confidential; respondents who provided contact information represented 34 EAHF member organisations, or more than half of the total. The response rate appears favourable in comparison with recent evaluations in the public health sector.[5] The distribution of respondents' affiliation closely matches EAHF's overall make-up, in terms of categories of membership, suggesting that the responses are representative of EAHF members overall. Further details on the EAHF survey response are found in Annex 2.

The third survey targeted to external experts and officials focussed on an assessment of the contribution of the EU strategy overall, as persons external to the process would not be able to provide feedback on the functioning of CNAPA or EAHF. Responses were received from 51 external persons (a 23% response rate). Further details on the third survey are found in Annex 4.

The results of the surveys showed a greater divergence in views among EAHF respondents than among CNAPA respondents. To ensure that information was gathered from a broad range of stakeholders, priority was given to EAHF members in the follow-up *interviews*.

For the *interviews*, resources were focussed on EAHF members, and a larger number of interviews were carried out for this group. Here interviewees were identified to match the categories of EAHF membership; within these categories, the selection sought to include EU umbrella organisations, as it was felt that these could respond also on behalf of a wider membership. Interviews were carried out with 25 of the 65 EAHF members and 8 CNAPA members out of the 27 Member States.[6] The interviews were focussed on issues

[3] The group of external experts included Member State officials external to CNAPA, current and former members of the EAHF Science Group and external participants at Open Alcohol and Health Forum meetings.
[4] A preliminary, unpublished version of the 2012 mapping report on alcohol was used, due to timing constraints.
[5] For example, the evaluation of the public health programme had a 35% response rate in a survey of beneficiaries who received funding. The evaluation of the ECDC Escaide conference received a 25% response rate in a survey of participants.
[6] Members from Austria, Belgium, Denmark, Estonia, Germany, Hungary, Portugal and the United Kingdom.

considered to benefit from free-format comments and on topics arising from the survey that called for confirmation or further clarification. Comments from the interviews are reported anonymously.

The purpose of the anonymous/confidential approach was to encourage frank and open comments from people involved in the process, as opposed to formal statements from official representatives of Member States or member organisations. The same approach was applied in the two meetings with each of the two Advisory Groups (AG), formed respectively of ten members of CNAPA and ten members of EAHF, which were held under the Chatham House Rule whereby comments made are not attributed to individuals, to member organisations or to Member States.

Limitations of the data gathered

Each of the data sources – desk research, surveys, interviews and advisory group inputs – has specific limitations.

In the *desk research*, the availability of recent, comparable data across the EU27 was found to be limited. for many dimensions of alcohol-related harm. Existing data (summarised in section 4) does not provide sufficient time series and EU-wide indicators to distinguish short-term fluctuations from longer trends that might be linked to the strategy. This has constrained the development of conclusions regarding the impact of the EU strategy thus far on health. It should be noted that there are also methodological issues in this regard: the EU strategy to support Member States in reducing alcohol related harm targets a complex social phenomenon, where a range of social, cultural and economic factors come to play alongside public health policies as well as policies in other sectors and with actions by a broad range of stakeholders. The contribution of the EU alcohol strategy to alcohol policy processes and to the reduction of alcohol related harm is indirect and varies with the particular circumstances in each Member State. Moreover, harm reflects social and individual behaviour, and disease may take years to manifest: as a result, changes in this area are likely to occur over the long term. Nonetheless, timely EU-wide data would provide an overview for considering the impacts of the strategy.

A similar issue concerns data on the impacts of individual EAHF commitments to action (section 3). A methodological concern should be noted in this area as well: EAHF commitments are single actions under a multi-component strategy, and assessments of their individual results may not reflect their contribution to the overall impacts of the EU strategy and of national policies. Nonetheless, the current data limit the formulation of conclusions about the impacts of the commitments.

For the *surveys* of CNAPA and EAHF, as a result of the anonymous/confidential approach, results are presented in terms of the share of respondents, rather than the number of Member States or EAHF members: the results present the opinions of a sample of Member State officials involved in CNAPA and stakeholder officials involved in EAHF. However, it is possible that members that did not respond could have different opinions.

The third survey had a lower response rate then the first two. Moreover, it was sent to a heterogeneous group, including officials and experts with some involvement of the EU strategy (current and former members of the EAHF Science Group and participants in the Open Forum) as well as those from other policy areas who are likely not to have been closely involved. While providing a further data source for selected questions, the third survey does not have sufficient responses to allow comparison across subgroups of respondents.

For the *interviews,* CNAPA members were chosen to provide a range of Member States in terms of geographic distribution as well as the extent of their alcohol policies before the EU Strategy. However, the sample size is small, limiting the conclusions that can be drawn from this source alone.

The perceptions of CNAPA and EAHF members are an important source for the evaluation, and their validity is thus a consideration. Among EAHF members, survey and interview results show differences in the

basic positions of economic operators[7] and those of other members, in particular NGOs and health professionals. These differences in perspectives may have affected their responses concerning the functioning of EAHF as a whole.

Data synthesis and triangulation

At the synthesis stage, the study used two types of 'triangulation' to synthesize results and draw conclusions from across the data gathered: data triangulation from different sources; and methodological triangulation across different approaches (desk research, surveys, interviews, and advisory group meetings). The desk research for Task 3, for example, provided information on an EC/WHO survey on policy measures taken by Member States: this information complements survey and interview results in Task 2 on the role of CNAPA in supporting Member State action. In addition to providing inputs, the Advisory Groups provided a review of the survey data, and in general supported their findings. For CNAPA, the Advisory Group provided further information to supplement the interview responses.

It should be noted as well that data triangulation in most areas was not done on a direct basis: the information gathering stage sought to reduce overlaps between these surveys and interviews in order to make both of manageable size to promote a higher response rate.

Further discussion of the strengths and weaknesses of the data, as well as the triangulation, can be found in the report's annexes.

1.3 Roadmap to the report

The following sections provide the main results of the assessment. Section 2 reviews results from the first task, on CNAPA and related support to Member States. Section 3 presents results from the second task, on EAHF and stakeholder action. Section 4 provides the results of Task 3, describing policy developments in the Member States and an overview of results from EU-wide data on alcohol-related harm. Section 5 presents overall conclusions as well as possible ways to enhance EU action. Further information, including the detailed results for each task, can be found the annexes.

[7] This term is used for members in two categories: advertising, marketing, media and sponsorship organisations; and production and sales organisations.

2 Assessment of the Committee on National Alcohol Policy and Action (CNAPA)

The Committee on National Alcohol Policy and Action CNAPA was established in November 2007, for the coordination and further development of alcohol policies across the EU. CNAPA's work places particular emphasis on the identification and dissemination of good practice to support national policies. The Committee is composed of delegates of Member States governments, together with observers from EFTA countries and the World Health Organization (WHO).

This section presents the results from Task 1, which looked at CNAPA as an instrument for coordination at EU level. The task also considers the support to Member States provided through the development of alcohol data gathering and the knowledge base. The Task 1 assessment addressed six evaluation questions:

1. To what extent has the CNAPA contributed to the coordination of alcohol policies between Member States and with the EU level?
2. To what extent has the CNAPA contributed to further policy development?
3. What additional outputs of the CNAPA contribute to its added value as an instrument at EU level?
4. What are the lessons learned regarding composition, focus and working methods, with a view to enhance effectiveness in achieving the objectives?
5. Has the work at EU level to develop alcohol data gathering and strengthen the knowledge base been useful from the Member States' perspective?
6. Have EU-funded projects and research on alcohol been relevant from the Member States' perspective?

2.1 Contribution to the coordination of alcohol policies

The exchange of information to support the coordination and further development of alcohol policies has been a central role for CNAPA, and data gathering focused on the committee's work for exchange of information on Member State policies and on thematic issues as actions to support Member State coordination.

Main findings

The desk research shows that all but one Member State have provided information on national policies within CNAPA, and 17 have presented national alcohol policies and measures in detail at least once. CNAPA members declared that policies in other Member States were used as examples to present in national policy discussions.

According to desk research, the documents presented at CNAPA meetings have covered all five priority themes of the EU strategy, with the greatest attention given to *the protection of young people, children and the unborn child* and to *the development of a common evidence base*. Further topics addressed include the labelling of alcoholic beverages, pricing and taxation issues, and alcohol and the elderly.

In the survey, CNAPA respondents indicated that *the protection of young people, children and the unborn child* had received the greatest attention, while the *prevention of alcohol related harm among adults and negative impacts at the workplace* have received the least attention.

One conclusion from the Advisory Group was that discussions on thematic issues have been more useful than broad information on Member State policies.

The desk research showed that most documents and presentations at CNAPA have focussed on either the EU or national level. The EU strategy also refers to the role of local multi-stakeholder action in the

implementation of the strategy; this level, however, is less covered in CNAPA's work. In the CNAPA Advisory Group, it was noted that more attention could be paid to work at local level.

For a comprehensive overview of the evaluation's main findings with regard to policy coordination, please refer to section 2 of Annex 1 to this report.

Conclusions

The evidence shows that CNAPA has provided an extensive exchange of information to support the coordination of Member State policies. Its meetings have presented information on national policies across most Member States. Moreover, a range of thematic issues, including but not limited to the priorities of the EU strategy, have been addressed. The survey and interview responses and Advisory Group discussions did not call for a change in focus, though specific topics for greater attention were identified. These results are complemented in Task 3, where a convergence of Member State policy developments is seen for a range of issues under the EU strategy's priority themes.

2.2 Contribution to further policy development

The evidence gathering for this evaluation question investigated the relevance of the topics addressed in CNAPA for Member States, the Committee's contribution to good practices, and overall its role in strengthening consensus among Member States and supporting their policy actions.

Main findings

In addition to addressing all five priority themes (as seen in the previous evaluation question), the desk research has shown that CNAPA meetings in 2010 through 2012 also held cross-policy discussions involving other Commission services beyond DG SANCO. In survey results, over 80% of CNAPA respondents considered the EU-wide thematic topics addressed within CNAPA to have been either very or moderately useful for policy development in their Member State.

Respondents to the interviews indicated that the topics for discussion were appropriate. In the interviews, respondents also cited some topics deserving further attention in the future, such as alcohol and the workplace, protecting children from harm due to adults' drinking (as opposed to the attention given to young people and the unborn child), alcohol and the elderly, pricing and taxation, and issues related to illegal/unregistered alcohol. A stronger focus to the integration of alcohol issues into broader public health topics, such as other major determinants of non-communicable disease (diet, physical inactivity, tobacco and illegal drug use), and cross-policy topics was also called for.

In the alcohol strategy, a range of good practices are identified which have been implemented with positive results in different Member States and which could inspire similar actions and synergies at national level. In its mandate, the CNAPA was foreseen to contribute to building on good practice identified in the EU strategy. According to the survey responses, work within the CNAPA has contributed to the development of policies and good practices to a varying extent across the priority themes identified in the strategy. The survey asked about 16 specific areas of good practice cited in the strategy. Based on the responses, strong contributions have been made in the areas of: development of standardised, EU-wide definitions for data on alcohol use and alcohol-related harm, followed by information and education activities, prevention of drink-driving, and enforcement of restrictions and broad-based community action to reduce alcohol use among young people. The survey respondents indicate that CNAPA's contribution has been more limited in areas including license enforcement and pricing policies.

All the interview responses as well as the Advisory Group workshop indicated that discussions in CNAPA have contributed to a stronger consensus among the members on alcohol policy related issues. Information from both these sources noted, however, that the range of sectors, government bodies and stakeholders

participating in policy discussions in Member States is much broader: at this broader level, consensus has been slower. In the Advisory Group, it was highlighted that the alcohol strategy more generally has contributed to bringing the issue of alcohol-related harm onto the policy agenda across the EU.

Five of the eight interviewed CNAPA members indicated that the Committee's discussions overall had an impact on national policies. CNAPA has been reported as helping to initiate alcohol policies where there had previously been little attention to this area. The three other members interviewed considered the discussions less influential but nevertheless providing an exchange of information that supports national policy discussions.

A comprehensive overview of the findings with regard to policy development can be found in Section 3 of Annex 1. In addition, Task 3 (presented in section 4 of the main report, below) provides related evidence on policy development: it reviews measures taken by Member States, as well as evidence that the EU strategy as a whole has supported these developments.

Conclusions

The survey results indicate that CNAPA has disseminated information on good practices, thus providing guidance to support policy development in the Member States across the priority themes of the EU strategy. The results of Task 3 complement these results, as they show that the EU strategy has been effective in supporting Member State action.

The information gathered in interviews and the advisory group discussions support the conclusion that CNAPA's work has contributed to a stronger consensus among its members, who are public health officials. Moreover it has supported the development of public health policies and measures in Member States, though the extent of its influence has varied across Member States and across policy areas. CNAPA discussions have moreover involved several DGs, and members have identified engagement with other policy areas as a key challenge.

2.3 Additional outputs and working methods, focus and composition

This section combines the results of information gathered from CNAPA members regarding two evaluation questions, on the Committee's additional outputs and on its working methods, focus and composition.

Main findings

While the work of the CNAPA has not led to any specific additional outputs, such as issuing Committee reports or statements, in the Advisory Group discussions, CNAPA's role in fostering an informal network of national officials was highlighted as additional output. In the Advisory Group and in the interviews, CNAPA respondents described the informal network as a source of information in between meetings and as a sounding board for policy issues. (Detailed findings regarding additional outputs can be found in section 4 of Annex 1.)

Regarding the Committee's composition, focus and working methods, in the interviews CNAPA members by and large considered these to be appropriate. The introduction of 'mini-seminars' in recent years to address specific themes was considered a step forward.

The interviews results and the Advisory Group discussions show the first high-level meeting, held in 2011, was considered useful in terms of raising the profile of alcohol issues and supporting national policy developments; continuing such meetings was supported. In both the interviews and the Advisory Group discussions, however, views were divided regarding the appropriate frequency of high-level meetings, i.e. on a yearly basis, or on an ad hoc basis to address key policy issues. (Detailed findings on working methods, focus and composition can be found in section 5 of Annex 1.)

Conclusions

Recent developments in the Committee's working methods have strengthened its focus on key issues for Member State policy development: these include the mini-seminars, the involvement of DGs in other policy areas and the 2011 high-level meeting. As a result, the Committee has had a stronger cross-policy focus, an approach that addresses Member State needs. Holding regular high-level meetings could further support cross-policy work and raise the profile of CNAPA and the EU strategy.

The informal network that has grown among CNAPA members provides a further output that has supported Member States in their policy development.

2.4 Developing alcohol data gathering and strengthening the EU knowledge base

The information gathering for this evaluation question focused first on the development of common indicators at EU level, undertaken by the Committee on Data Collection, Indicators and Definitions (CDCID), established by the European Commission to further the development of common indicators for monitoring and comparative data gathering. Information gathering also considered the collaboration between the EC and WHO on data gathering, and the perception of this work on the part of CNAPA members. CNAPA has followed and discussed these activities.

Main findings

The CDCID agreed on key indicators for monitoring alcohol consumption and alcohol-related harm across the EU. Further work in this area has been carried out including through an EU funded project for Standardizing Measurement of Alcohol Related Troubles (SMART). Another project, ESPAD (European School Survey Project on Alcohol and Other Drugs), has gathered data on youth alcohol consumption.

In the CNAPA survey, about 80% of respondents felt that work for the development of common indicators and of methods for comparative research has been either very or moderately useful. In interviews, CNAPA members explained that in policy discussions, comparisons among Member States helped to explain the severity of national problems.

In the Advisory Group discussions as well as the interviews, however, obstacles for the adoption of common approaches in Member States were noted. While the strategy emphasised work at EU level in this area, implementation of the indicators also depends on Member State data. The obstacles raised in the Advisory Group and in interviews were different in nature in Member States with established data gathering systems, where the introduction of new, common approaches could results in a loss of comparable historical data; and in new Member States, where the capacity and structures for alcohol data gathering are still under development. In the Advisory Group discussion, it was suggested that designating a permanent body, such as Eurostat, to take the lead in the work on common indicators at EU level and establishing national focal points for alcohol data collection could take this work forward (a role for the European Monitoring Centre for Drugs and Drug Addiction, EMCDDA was also proposed).

Starting from 2007, DG Health and Consumers has collaborated with the WHO Regional Office for Europe for joint monitoring of trends in alcohol consumption, alcohol-related harm and alcohol policy development in Member States. Two-thirds of survey respondents felt that the joint work with WHO has been useful. Interview respondents called for further cooperation with WHO.

A comprehensive overview of the findings with regard to data gathering can be found in Section 6 of Annex 1.

Conclusions

The evidence gathered shows that work at EU level has brought forward common indicators, while cooperation with WHO has gathered data to support the common evidence base. The survey and interview results indicate that this work has supported policy development in Member States. Nonetheless, obstacles at both Member State and EU levels have limited the implementation of common indicators and standardised methods across the EU.

2.5 Relevance of EU-funded projects and research

The evidence gathering for this evaluation question prepared an overview of the projects and research funded by the EU; CNAPA members were asked their perception of the role of projects and research for national policy development.

Main findings

Since 2007, the EU Health Programme has supported alcohol related projects with approximately EUR 9 million, and the EU Research Framework Programmes provided approximately EUR 49 million for studies on alcohol and health. These amounts represent, respectively, less than 3% of the total budget of the Health Programme for 2008-2013, and less than 1% of the budget for health under Seventh Research Programme.[8]

The desk research shows that EU-funded projects and research have provided a range of evidence, training materials and good/best practices to address alcohol-related harm. All priority themes of the EU alcohol strategy have been covered by projects and studies, as well as further topics, such as alcohol and the elderly, the affordability of alcoholic beverages, and brief interventions for alcohol use disorders.

Information on 19 of the 27 funded projects has been shared in CNAPA meetings through the end of 2011, as well as 2 of the 7 research studies (the other 5 research studies were still underway in 2011).

About 50% of survey respondents indicated that EU-funded projects and research have contributed substantially to the availability of good practices, evidence or guidance to reduce alcohol-related harm, and a further 44% indicated that their contribution has been moderate. In the interviews, all but one respondent described the use of outputs of EU projects at national level: evidence provided by EU projects and research has fed into national policy discussions, for example in the revision of national alcohol policies. The Advisory Group discussions also underlined the role of project and research results in national policy development and in terms of building the EU-wide evidence base. Members from small Member States in particular underlined the need for work at EU level due to limitations in national research capacities. The Group moreover underlined the importance of the scientific and evidence base for effective policy action and affirmed that its development has been one of the key achievements of the EU strategy.

While a large majority of survey respondents indicated that the dissemination of the results from EU-funded projects and research has been adequate, about 15% found the dissemination less than adequate. So far the CNAPA meetings have been the main channels – and CNAPA members the interface – for disseminating project and research results to national policy makers.

A comprehensive overview of the findings with regard to EU-funded projects and research can be found in Section 7 of Annex 1.

[8] Based on figures taken from:
European Commission (DG SANCO): http://ec.europa.eu/health/programme/policy/2008-2013/index_en.htm
European Commission, Health Research in FP7: The Basics, 2010, available at:
ftp://ftp.cordis.europa.eu/pub/fp7/docs/health-research_leaflet_en.pdf

Conclusions

The survey and interview results, together with the AG discussions, highlighted the importance of the evidence base for policy development in Member States. While the EU strategy has not had a spending programme, resources have been provided for EU projects and research. The evidence gathered indicates that this spending has been useful, as it provided evidence used across the Member States.

3 Assessment of European Alcohol and Health Forum (EAHF)

The objective of the EAHF, created by the European Commission in 2007, is to 'provide a common platform for all interested stakeholders at EU level that pledge to step up their actions to reduce alcohol-related harm, notably in the following areas': [9]

- Strategies aimed at curbing under-age drinking;
- Information and education programmes on the effect of harmful drinking and on responsible patterns of consumption;
- Possible development of efficient common approaches throughout the Community to provide adequate consumer information;
- Actions to better enforce age limits for selling and serving alcohol;
- Interventions promoting effective behavioural change among children and adolescents;
- Cooperation to promote responsibility in and prevent irresponsible commercial communication and sales.

Task 2 assessed EAHF, including the extent, nature and potential of its members' commitments to contribute to the reduction of alcohol-related harm. It also assessed the task forces and the Science Group created under the Forum. The following evaluation questions were addressed:

7. To what extent has the EAHF process been effective in mobilising stakeholders and stepping up action to reduce alcohol related harm?
8. To what extent has the EAHF process been effective as a platform for dialogue, exchange and cooperation?
9. To what extent has the EAHF process contributed to the development of responsible business practices across the EU in the sales and marketing of alcoholic beverages
10. To what extent can the commitments be related to impacts on alcohol related harm reduction?
11. To what extent can the commitments be benchmarked in relation to the best available practices in the area?
12. What are the lessons learned regarding composition, focus and working methods, including the EAHF sub-groups?
13. Has there been cross-fertilization and interactions between the EAHF, the CNAPA and the other structures? What forms of interaction would bring added value?

3.1 Mobilising stakeholders and stepping up action on alcohol-related harm

Membership in the Forum is voluntary, and members include umbrella organisations at EU level, as well as national and sub-national organisations and individual companies. EAHF has four categories of membership:

- Advertising, marketing, media and sponsorship organisations
- Research institutes and others
- Production and sales organisations
- Non-governmental and health organisations

The members commit to take action to address at least one of the Forum's areas of action, focussed on responsible business practices and on protecting children and young people, and to report yearly on the implementation of their actions.

The information gathering included desk research on EAHF membership and on members' commitments to action, together with survey and interview research on members' perceptions of these topics.

[9] Charter establishing the European Alcohol and Health Forum, European Commission, 2007

Main findings on mobilising stakeholders

The total number of members has increased from 53 in 2007 to 68 in August 2012.[10] Production and sales organisations on the one hand, and NGOs and health professionals on the other, are the two largest membership categories. The composition of EAHF membership at both the start and in August 2012 is shown in the table below.

Table 1 Breakdown of Forum members by membership category, 2007 and 2012

Membership category	2007		2012	
	No.	Share	No.	Share
Non-governmental and health organisations	18	34%	26	38%
Advertising, marketing, media and sponsorship organisations	7	13%	7	10%
Production and sales organisations	23	43%	28	41%
Research institutes and others	5	9%	7	10%
Total	**53**	**100%**	**68**	**100%**

Roughly half of the members are organisations operating at EU level. These include EU umbrella organisations for the beer, wine and spirits industries and for public health. National-level members include national associations and individual companies. Only one member is based in the EU12, though the European umbrella organisations include EU12 entities among their own members.

The scope of membership was addressed in the interviews with EAHF members. While economic operators[11] for the most part found that the balance between the different categories was appropriate, half of the non-industry members considered that the private sector was over-represented. As regards possible enlargement of the scope, the following were mentioned: greater participation of retail organisations, as the European umbrella organisation currently participates but few individual companies do; wider participation of the health and social insurance sector, at the moment represented by the European Social Insurance Platform. Wider participation of NGOs from new Member States (only one being based in the EU12 at the moment) was also identified as a key area for attention.

For a comprehensive overview of the evaluation's main findings with regard to stakeholder mobilisation in the context of the EAHF, please refer to section 2.1 in Annex 2.

Main findings on stepping up action

Since the launch of EAHF in 2007 and up until August 2012, the members have submitted altogether 227 commitments to action. Of these, 173 had been completed, and 54 were ongoing by December 2011.

Table 2 Overview of EAHF members' commitments from 2007 to 2012

Commitments completed	173
Commitments ongoing	54
Total	**227**

Note: assessment focused on the 209 commitments completed and ongoing by December 2011.

The desk review showed that commitments had been made in all action areas of the Forum, with a concentration in three areas: (1) cooperation on commercial communication and sales; (2) information and education programmes on the effect of harmful drinking and on responsible patterns of consumption.

[10] EAHF Forum Members: updated list of members. European Commission, DG Health and Consumers. The survey for this assessment was conducted using a 2011 list of 65 member organisations.

[11] This term is used for members in two categories: advertising, marketing, media and sponsorship organisations; and production and sales organisations.

The Forum's areas of action, listed at the start of this chapter, to do not correspond directly with the priorities themes of the EU strategy (listed in section 1.1). Nonetheless, the desk review showed that members' commitments to action have covered the priority themes:[12]

- *Protect young people, children and the unborn child*: 39 commitments to action focussed on youth: compliance with age limits has been a key focus, and 16 addressed exposure to alcohol during pregnancy.
- *Reduce injuries and death from alcohol-related road accidents*: 32 EAHF commitments have been undertaken on drink-driving, although this topic was not included as an action area for EAHF. (At EU level, drink-driving is addressed primarily in the context of road safety policies, including the European Road Safety Charter, another commitment-focussed stakeholder initiative.)
- *Prevent alcohol-related harm among adults and reduce the negative impact on the workplace*: Ten EAHF commitments have addressed issues for adult health, including alcohol-related chronic physical and mental disorders. Four commitments have focussed on workplace issues; nonetheless, this topic was addressed by the EAHF Science Group.
- *Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns*: action dedicated to education and awareness-raising has been a leading area for member commitments. Among these activities, several alcohol producers have made voluntary commitments under EAHF to provide information on risks on alcohol packaging labels.

In terms of the geographical distribution of commitments, the information provided by Forum members in the EAHF database indicates the EU15 as a locus of implementation about twice as often as the EU12.Section 2.2.1 in Annex 2 provides an overview of the evolution of commitments by membership sector since the establishment of the EAHF.

The survey asked respondents whether EAHF membership has inspired new or substantially revised action. The survey results indicate that participation in the Forum led to substantial new action for two-thirds of respondents, who indicated that either *none* of their organisation's commitments would have happened without the Forum (22%) or that *some* of the commitments would not have happened without the Forum (44%). A further 14% indicated that, although the initiatives might have happened irrespective of the Forum, membership in the EAHF influenced the way the commitments were carried out.[13] ()

New activity has been inspired in particular among economic operators, with a majority of respondents stating that some or all of their commitments were due to the Forum: respectively, 38% and 63%, and 11% and 53% for advertising, marketing, media and sponsorship organisations on the one hand and production and sales organisations on the other hand.[14] In contrast, 41% of respondents from the category of NGOs and health professionals indicated that their commitments would have happened in the same way without EAHF participation.

In the interviews, the majority of respondents of the NGO and health professional sector explained that the Forum has not had a substantial impact on their core activities, as their organisations had been working to reduce alcohol related harm already before the advent of the Forum. Nonetheless, one respondent of an umbrella organisation in this sector said that the Forum has prompted greater action at national level by their members; another said that EAHF participation had led to partnerships that now extend outside the Forum; and a third comment cited a stronger approach to monitoring and reporting of their actions due to Forum membership.

Section 2.2.2 in Annex 2 discusses in greater detail survey as well as interview results with regard to the Forum's role in triggering substantially revised action.

[12] Members' commitments have not addressed *a common evidence base at EU level*, as this is not a task for stakeholders; the EAHF Science Group has supported this evidence base, as described below in section (3.6)

[13] As noted in section 1, the survey was carried out on an anonymous basis of persons representing EAHF members: results are provided in terms of shares of responses rather than of EAHF members.

[14] These results are broadly similar to those for the *Evaluation of the European Platform for action on diet, physical activity and health*, another stakeholder structure where for-profit members reported a greater share of new actions than non-profit members.

Conclusions

The desk research shows that EAHF has succeeded in mobilising actors from a broad range of stakeholders, with total membership up by about 30% since the Forum's creation. The interview and survey results also show that the EAHF process has mobilised stakeholders at national and local levels. The survey results indicate that EAHF has stepped up action by stakeholders to address alcohol-related harm, and their commitments to action have addressed the priority themes of the EU strategy, though with a strong emphasis on the theme of information and education. A greater share of new action has come from economic operators, in part as other sectors worked extensively on alcohol-related harm previous to the creation of EAHF.

Moreover, as discussed in section 2.3 of Annex 2, both desk research and interview results note that the EAHF action areas are not directly aligned with the EU strategy's priority themes, which may reduce the effectiveness of EAHF in terms of supporting the strategy's objectives.

3.2 A platform for dialogue, exchange and cooperation

Here, information was gathered on the contribution of the EAHF process to a deeper understanding of the issues on the part of members and to the exchange of good practices. The research also addressed the Open Forum meetings held with non-members: the purpose of Open Alcohol and Health Forum meetings, set in the EAHF Charter, has been *'to give interested non-member bodies and organisations from the EU and beyond an occasion to follow the work of the Forum, and make their opinions known'.*

Main findings

The EAHF plenary meetings have addressed a wide range of thematic issues concerning alcohol-related harm. According to survey responses, participation in work under the EAHF has contributed to deeper understanding of the issues in particular among respondents from production and sales organisations.[15] Survey responses from NGOs and health professionals indicate more limited gains.[16] Please refer to figures 17 and 18 (section 3.1.1) in Annex 2 for a detailed overview of survey results by membership category and field of intervention for this particular question.

In the survey, 70% of respondents reported that participation had led to further cooperation with other Forum members (to a great extent for 29% and to some extent for 43%). The interviews indicated that most partnerships take place among members within the same sector. Nevertheless, economic operators also noted examples of commitments involving cooperation at national and local levels with a broad range of stakeholders, including NGOs, police authorities, healthcare organisations and local authorities.

Over two-thirds of representatives of production and sales organisations reported in the survey that, at least to some extent, participation in the Forum had provided examples of good practice their organisations could use across the EAHF action areas. In contrast, a similar proportion of respondents from the NGO and health professional sector had benefitted less or not at all in terms of good practice (please refer to figures 20 and 21 in Annex 2 for a detailed overview of responses). In interviews, several NGO and health professional members said they turn to other sources of good practice such as research work and other organisations in their field carrying out similar work.

In the survey, 35% of respondents felt the Open Forum meetings had been very successful in showcasing members' activities and in engaging a wider range of stakeholders in discussion; according to 33%, it has

[16] Here again the findings are parallel to those of the *Evaluation of the European Platform for action on diet, physical activity and health* where a high share of industry respondents reported that participation in the Platform increased their understanding of the obesity issue whereas most not-for-profit respondents reported less gains.

been moderately useful. The desk research shows, however, that EAHF members accounted for the majority of participants at the Open Forums, and that the majority of the external participants represented organisations that fit into the categories of EAHF members. It was noted in interviews that Open Forum meetings were a useful mechanism to inform sector organisations not directly involved in the EAHF. Section 3.4 in Annex 2 discusses more in depth evaluation results with respect to perception of the Open Forum and participation in Open Forum sessions.

Conclusions

The information gathered indicates that Forum has provided a platform for dialogue and exchange on issues, among members with different interests and values. This includes the dissemination of good practices. A point to note, however, is that the survey and interviews results show that economic operators perceive greater value and benefit from dialogue and exchange than do other groups.

The interview results and AG discussions suggest that the Forum has succeeded in promoting cooperation but within sectors rather than between, although examples of cross-sector cooperation at national level were also mentioned.

The desk research and interview results indicate that, while the Open Forum meetings have reached non-member organisations, participation has not reached far beyond the scope of the EAHF membership. The Open Forum appears to partially achieve its purpose of informing interested groups and giving them an opportunity to provide input; as only a share of interested organisations has been reached.

3.3 The development of responsible business practices in the sales and marketing of alcohol beverages

For this evaluation question, the desk research reviewed the number of commitments that addressed responsible business practices, as well as the number of EAHF members working in this area. Moreover, a case study provided an in-depth review of the progress on marketing self-regulation carried out via the EAHF process.

Main findings on stakeholders and commitments undertaken

Promoting responsible commercial communication and sales is one of the key areas of action for EAHF.

Over the lifetime of the Forum, almost 40% of economic operators in EAHF have carried out at least one practices in the sales of alcoholic beverages. In total, just over 10% of EAHF commitments focussed on compliance with age limits. In interviews, only one-quarter of respondents felt that the Forum had contributed to a stronger focus on age limits.

During the same period, almost 60% of economic operators in EAHF have carried out at least one commitment on responsible practices in the marketing of alcoholic beverages. In the interviews, a majority of respondents from economic operators highlighted that the Forum process has played a key role in strengthening responsible business practices; in contrast, non-industry members stressed that more could be done on marketing.

As discussed in section 4.1 of Annex 2, in both areas, percentages of members having submitted commitments reflect the distribution of membership in terms of core activities (i.e. relatively fewer members work directly on sales-related areas).

Non-industry organisations have also submitted commitments linked to the development of responsible business practices in marketing and retailing of alcohol. These commitments aim at controlling the enforcement of legal age limits and on alcohol policy laws, monitoring of the alcohol industry's alcohol

advertisements, and provision of information on alcohol marketing regulation and on impacts of marketing and of minimum pricing.

Findings of the case study on marketing

As part of the evaluation, a case study was carried out to form a synthesising picture of the activities and progress towards further development of responsible practices in the marketing of alcoholic beverages and, in particular, to shed light on the added value of EU level coordination and support in this area. The findings case study are presented in detail in Annex 3. Three main information sources were used in the preparation of the case study: desk research, including mapping reports on the self-regulation of alcohol advertising across the EU; and an informal workshop with the EAHF Advisory Group, organised with the specific purpose of obtaining comments and assessments on the added value of the EAHF in this area. The case study shows that, to a large extent, the commitments under the EAHF for further development of responsible marketing practices have used as benchmark and point of reference the model of effective self-regulation outlined in 2006 in the Advertising Round Table relating to policy areas under DG Health and Consumers.

One of the case study's main conclusions is that the EAHF has contributed to the strengthening of self-regulatory systems covering marketing and advertising of alcohol. Representatives from the European Advertising Standards Alliance (EASA) declared that EU action, including through the EAHF, has helped to encourage the setting-up of national-level frameworks for self-regulation through the creation of self-regulation organisations (SROs): Four new self-regulatory systems have started functioning and an additional seven have undergone major overhauls since 2005.[17]

Since the establishment of the EAHF, altogether 50 commitments to action have been submitted (as of April 2012) in the action area of *cooperation to promote responsibility in and prevent irresponsible commercial communication*.[18] Of these commitments, 21 involve EU-level action, 22 relate to the national level, and seven are being or were carried out by individual companies and concern marketing codes and practices in a range of EU countries where these companies operate. In the spirits and beer sectors, the focus of commitments in this area has primarily been on strengthening and implementing self-regulatory codes; in the wine sector, the Forum process has brought about the creation of the Wine Communication Standards (WCS) for responsible advertising of wine products. Commitments from economic operators have also helped expand self-regulation of alcohol advertising to new areas, such as digital marketing. In addition, Forum commitments developed by non-industry member organisations at both EU and national level have been instrumental in monitoring self-regulatory systems for alcohol marketing.

Overall, however, discussions with the Advisory Group in the course of preparing the case study indicated points of divergence in views regarding progress. Whereas NGOs and health professionals pointed to the lack of evidence of a link between self-regulation of alcohol advertising and reductions in alcohol-related harm, for economic operators, strengthening of self-regulatory systems has been an important area of success under the Forum.

Conclusions

The desk review and the case study show that work carried out as part of the EAHF's work or in connection to it has contributed to strengthening and expanding self-regulatory systems, in particular for the marketing of alcoholic beverages. The role of the Forum in the establishment or substantial overhaul of SROs is

[17] Some EAHF members consulted in the context of this evaluation referred to studies criticising the effectiveness of self-regulation. Some of these criticisms are outlined in section 3 of Annex 3. The literature review in section 6 of the same annex also provides some insights in this regard.

[18] The number of commitments indicating 'cooperation to promote responsibility in and prevent irresponsible commercial communication and sales' as a primary area of action is larger: 8 commitments concern enhancing responsible selling or serving alcoholic beverages; despite indicating this area of action, 7 commitments are not directly relevant to self-regulation of alcohol advertising as they mainly involve information and awareness raising on topics such as minimum pricing policies, drink-driving, or responsible drinking.

noteworthy. Moreover, the EAHF process has maintained attention on developments in the field of alcohol marketing, through plenary discussions as well as work by the Task Force on marketing and by the Science Group. In contrast, less action has focused on self-regulation in the area of sales. In part, this may be related to the fact that few retail organisations are represented in the Forum (see section 3.1).

3.4 Relating EAHF commitments to impacts on alcohol-related harm reduction

When joining the Forum, members commit to *'monitor and evaluate the performance of their commitments in a transparent, participative and accountable way'*, as set out in the EAHF Charter. Members of the EAHF submit yearly monitoring reports on the implementation of their active commitments and on the achievements of completed commitments, and independent annual reviews are carried out of the monitoring reports.

It was recognised at the inception phase that data on the impacts of individual commitments to action would likely be quite limited. For this reason, the information gathering for this evaluation question looked at two indirect measures of the impacts of EAHF commitments.

Main findings

First, the assessment looked at the extent to which the commitments under the EAHF can be linked with the aims of the alcohol strategy that concern the reduction of alcohol-related harm directly. In relation to the aims, there has been an uneven distribution among the commitments (see section 5.1.1 in Annex 2).

Furthermore, links between commitments, priorities of the EAHF, and aims of the strategy were sometimes difficult to discern. Nonetheless, a number of commitments concern action in areas where direct links could be expected in the long term and in conjunction with other interventions: this includes drink driving, addressed by almost 15% of commitments, as well as reducing exposure to alcohol during pregnancy, addressed by about 7% of commitments (see also section 2.1).

Another indirect approach considered the ways in which EAHF members evaluate the performance of their commitments (see also section 5.2.1 in Annex 2 for further details on the methodological approach and main results). The first set of annual reviews of monitoring reports, from 2009 to 2011, show a steady improvement in the average quality of these reports across several criteria (including descriptions of the actions, objectives and relevance of the commitments to the aims of the Forum), as well as the inputs used and outputs created. In contrast, the reports on average show no improvement in the quality of the outcome and impact indicators used or the evaluation approaches pursued. It should be noted that impact evaluation was defined as non-obligatory in the EAHF Charter, although strongly recommended. While some members have devoted significant resources to measuring impacts, such approaches are not widespread.

In interviews with EAHF members, major challenges in terms of evaluating impacts were highlighted – these include the complex interactions between interventions (for example voluntary action and policy measures); the fact that results in terms of reduced alcohol-related harm often can only be seen in the long term; the lack of common, comparable evidence base; a need for common indicators; and the resources needed for conducting a robust impact evaluation. Nonetheless, there was in general willingness to improve the measurement of outcomes though doubts remained about the feasibility of measuring impacts.

Conclusions

A steady increase in scores from external evaluations suggests that there has been progress towards better monitoring of the implementation of the commitments to action. Evaluation and reporting of outcomes and impacts, however, has been an under-developed area. Although Forum members generally have an interest in documenting the impacts of their commitments, evaluation tends to remain at the level of outputs or short term intermediate outcomes, due to both methodological and resource-related challenges. As a result, a full picture of the relationship between commitments and impacts cannot be drawn. It should also be noted that

methodological (the role of EAHF commitments as part of a multi-component strategy) as well as resource-related constraints remain in this regard.

It must also be noted that the uneven distribution of commitments across priority themes could affect the Forum's impact on alcohol-related harm reduction.

3.5 Benchmarking commitments to best available practices

This evaluation question looked at use of good and best practice models as benchmarks to strengthen the design of commitments. The information gathering first identified whether good and best practices are available in the areas of EAHF action, and then through interviews asked whether members referred to benchmarks when designing their commitments. Section 6 in Annex 2 provides a detailed discussion of best practice definitions and identifies a number of best practices related to each of the main action areas.

Benchmarking commitments to good practice

Disseminating and building on good practice is at the heart of the EU alcohol strategy. Examples of good practice approaches are listed in the alcohol strategy and have been developed and compiled in EU-funded projects. Further sources include reviews of published evaluations of interventions. Reviews of the research results on the effectiveness of measures and policies to reduce alcohol related harm predominantly look at areas of government action, such as legislation and law enforcement. Such areas are for the most part beyond the scope of stakeholders' activities, although the desk research identified examples of EAHF members having established partnerships with local and national authorities in order to reduce alcohol-related harm.

In interviews, respondents for economic operators reported that the Forum process has been a source of benchmarks and good practice: they cited in particular the large number of commitments flowing from the benchmark model of self-regulation outlined in the Advertising Round Table. The interviewed non-industry respondents made fewer references to the use of benchmarks when developing their commitments, and systematic benchmarking processes seem rare. Both economic operators and non-industry members thought the Forum could play a more prominent role in collecting, setting standards for, disseminating and even developing good/best practice cases.

Conclusions

The interview results as well as the case study show that in the area of self-regulation of commercial communication on alcohol, economic operators benchmark their commitments against a good practice model. This has provided a clear direction of work as well as a structure that can be used to assess initiatives. In other areas, however, the evidence indicates that benchmarking is not widespread and not done systematically. A stronger use of benchmarking could demonstrate that actions follow proven good practice models, which is likely to strengthen their outcomes and impacts.

3.6 Composition, focus and working methods

The evidence gathering under this evaluation question looked at three elements of EAHF work: its plenary sessions, the two Task Forces and the Science Group. Sections 7.1 to 7.4 in Annex 2 provide the context for the main findings presented below. Section 7.5 further elaborates on these findings.

EAHF plenary sessions

Most interviewees found the working methods and administrative processes for the EAHF plenary appropriate. Suggestions for improvement included: shorter presentations to allow more time for discussion; a more participative approach to setting the agenda and identifying speakers; wider use of task forces or

small discussion groups; more detailed summary reports; using the periods between plenary meetings for peer review of commitments.

Task Forces

Two Task Forces were established with the EAHF Charter: a Task Force on Youth-Specific Aspects of Alcohol and a Task Force on Marketing Communication. The role of the Task Forces in advancing the Forum's work was addressed in the interviews. Overall, interviewees found the Youth Task Force brought forward this issue, and its work led to the development of the online Resource on Alcohol and Youth Projects (RAYPRO). This database has provided a step forward, but further work is needed to promote its use. In the EAHF Advisory Group, continuation of the work was, however, suggested with focus on responsible serving of alcoholic beverages.

The Task Force on Marketing Communication supported the overall process towards further development of responsible commercial communication. It functioned as a mechanism for discussion on sensitive topics and started the mapping of self-regulatory systems that was later carried on in more systematic fashion by the Institute of Social Marketing. In the EAHF Advisory Group, continuation of the Marketing Task Force's work was supported, but with a more operational, possibly smaller size and with clear objectives and timelines.

Moreover, the EAHF advisory group discussions highlighted the value of addressing key issues via small groups of Forum members, including task forces, as these can be more efficient at a working level than plenary discussions.

The Science Group

The Science Group, formed of independent scientists following an open call for expressions of interest, was established to provide scientific guidance on issues of relevance to the Forum. Since its creation the Science Group has issued two scientific opinions in response to requests from the EAHF plenary: on the impact of alcohol marketing communication on alcohol consumption by young people in 2009 and on alcohol, work and productivity 2011.

In interviews, about half of EAHF respondents found the report on alcohol and work of good quality and a useful source of information. Views on the report on alcohol marketing and youth drinking were divided. NGOs and health professionals considered the report a useful overview of existing research. Among economic operators, views were mixed: half of the respondents felt that input from broader fields of science would have been beneficial, as well as wider debate in the Forum.

Desk research shows that the Science Group members cover a broad range of areas of expertise in public health. In interviews with EAHF members, however, social science and marketing were noted as areas where the Group's expertise may be thin. Due to resignations, and decisions by DG Health and Consumers not to nominate replacements, the size of the Science Group has shrunk from 20 to 12 members, to the extent of having difficulty in reaching quorum. Due to the Science Group’s semi-official status, its members do not receive remuneration other than reimbursement of expenses, and some EAHF members and Science Group members believed that this has affected participation.

Conclusions

Overall, the interview results indicate that the working methods so far have served the Forum plenary meetings well. While the desk research and interviews indicate that the work of the Task Forces has had mixed results in terms of supporting EAHF action, discussions in the Advisory Group highlighted the value of work in small groups to address complex and controversial issues before bringing them to the EAHF plenary: thus, small groups can strengthen the efficiency of EAHF work.

The Science Group has helped inform EAHF members on two themes. In its scientific opinions it has addressed marketing, a core issue for EAHF work, as well as alcohol and the workplace, an issue that has not yet received great attention in members' commitments. Nonetheless, this group is at a cross-road as it has shrunk from the original size, and its role and objectives may need to be reconsidered.

3.7 Interactions between EAHF and CNAPA

For this evaluation question, desk research looked at interactions between CNAPA and EAHF, while the surveys and interviews information gathered results on the perceptions of members of both groups.

Main findings

The desk research noted that no formal joint activities have been organised between CNAPA and EAHF. CNAPA members are invited to attend the Forum meetings, and a small number do so regularly.

In the survey results, views on interactions and dialogue between EAHF and CNAPA were mixed. In the survey addressed to CNAPA members, 24% of respondents considered interaction to have been very useful, and 28% of little use. In the survey addressed to EAHF members, 41% considered the interaction and dialogue very or moderately useful, whereas 29% said they did not know (see section 8.1.1 in Annex 2 for further details).

In interviews, nearly all Forum respondents across different categories expressed a wish for stronger interaction with CNAPA, calling for greater visibility for CNAPA members in the Forum and more presentations on activities in the two bodies, with room for discussion.

Interviews with CNAPA members indicated a divided opinion, with some appreciating the Forum's work, but only few following it closely, and some questioning the goals of the Forum and being reluctant to further interaction. In addition, few CNAPA members closely follow EAHF commitments in their Member States.

Conclusions

The results of the surveys, interviews and advisory group discussions show that interaction between CNAPA and EAHF has been limited. Some CNAPA members attend Forum meetings and follow its work; however, most do not, and do not follow EAHF members' commitments being carried out in their Member States. The limited interaction between the two main instruments for the EU strategy may mean that some potential synergies are missed – for example, in terms of linking EAHF members' actions more closely to Member State policy priorities.

It can also be noted that national stakeholder platforms have been set up in a few Member States, following the model of the EAHF.[19] While these bodies fall outside the scope of the evaluation study, based on the information reviewed, their interactions with EAHF appear to be very limited. This suggests the existence of an untapped potential in terms of exchange of experiences and lessons learned at both EU and national levels.

[19] Bodies have been created in Portugal and the UK, and in the Netherlands, regular meetings with producers and other stakeholders are being transformed into a formal structure with action plans.

4 The EU alcohol strategy overall

Task 3 considered the EU strategy process overall and added value relating to its potential effects. It is comprised of two evaluation questions:

14. Which developments at national level are moving in the directions outlined in the EU strategy?
15. What evidence is there to show that the existence of the EU alcohol strategy as such has contributed towards progress in reducing alcohol-related harm

4.1 Developments at national level

To address this evaluation question, desk research used information gathered through the joint EC/WHO survey on Member State policies to address alcohol-related harm, which provides an overview of national policy measures on public health policies to reduce alcohol-related harm.[20]

Member State policy developments

The results of the EC/WHO survey show that 16 EU Member States had launched or updated national alcohol strategies between 2006 and 2010, including all but two EU12 Member States. Moreover, the survey provides information on policy measures that have been carried out across the EU strategy's five priority themes and their good practices. Key results include the following actions:

Protect young people, children and the unborn child

- In EC/WHO survey, 15 Member States reported that they had strengthened age limits and other restrictions on the availability of alcohol between 2006 and the end of 2010; as a result, there has been a convergence towards 18 years as the minimum age for purchasing alcohol.[21]
- Based on the EC/WHO survey, at least 20 Member States have established counselling programmes for children in families with alcohol problems, and 21 have counselling programmes for pregnant women at risk.
- Over 20 Member States have statutory restrictions on advertising of alcohol on TV and radio, and at least 16 have restrictions on product placements of alcohol on TV programmes.[22]

Reduce injuries and death from alcohol-related road accidents

- In line with EU recommendations, by 2010 all but two Member States have established a maximum blood alcohol concentration (BAC) of 0.5 mg/ml or less, and at least 15 have lower limits for novice, commercial and professional drivers. Moreover, at least 21 Member States reported in the EC/WHO survey that they have strengthened these measures or their enforcement between 2006 and 2010.

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

- The EC/WHO survey found that in about three-quarters of Member States, health services provide brief advice to harmful drinkers.
- In at least 15 Member States, training programmes are organised regularly for alcohol servers, either by trade organisations or vocational schools.
- A few Member States have introduced pricing policies, such as those directed at 'happy hours' as well as requirements to sell non-alcohol beverages at lower price alcohol ones. At least four Member States changed their excise taxes on alcohol between 2006 and 2010.[23]

[20] WHO/Regional Office for Europe, Alcohol in the European Union: Consumption, harm and policy approaches, 2012. Further information taken from: WHO, European Information System on Alcohol and Health (EISAH), available at: http://apps.who.int/ghodata/?theme=GISAH&region=euro

[21] For some Member States, the minimum age differs for on- and off-premises sales and between beer and wine and spirits. In Member States where 18 is not the limit, it is set at 16 or 17, except for one Member State that did not have a minimum age for off-premises purchases.

[22] Some Member State differ in their regulatory approaches to public vs. private TV and for beer and wine vs. spirits.

- In at least 16 Member States, prevention or counselling programmes are available at workplaces, and about approximately half of these have developed national guidelines in this area; moreover, over 10 Member States reported strengthening their measures to address alcohol in the workplace between 2006 and 2010.

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

- All Member States have carried out regular information campaigns on alcohol issues in recent years, with drink driving and youth as the most common topics.

Develop and maintain a common evidence base at EU level.

Under the EU strategy, actions related to this priority theme are primarily foreseen at EU level (see also section 2.4 and 2.5). At Member State level, it can be noted that at least 15 Member States carry out regular national surveys on alcohol issues and publish regular reports on this topic.

The role of the EU strategy process within national policies

In interviews, 5 of 8 CNAPA members considered that the EU strategy has been an important stimulus for national action; the other 3 respondents felt that national action was strongly developed before the strategy. In the CNAPA Advisory Group, it was highlighted that by identifying common good practices to address alcohol-related harm the strategy has provided a foundation for national action. These results are further supported by the CNAPA survey responses described in section 2.1, which showed the role of the Committee in building on the good practices set out in the strategy. (See also Section 2 of Annex 4 for further details on the information gathered.)

Conclusions

The desk research shows that a broad range of national policy developments has taken place since the launch of the EU strategy. Moreover, the interview results and Advisory Group discussions indicate that the EU strategy has been a stimulus for national action; in addition, survey results on the effect of CNAPA work on Member State policies, presented in section 2, provide further evidence that the EU strategy has had a positive role for Member State policy development.

4.2 Contribution of the EU strategy

The evidence gathering for this evaluation question focused on two areas: the surveys asked whether the EU strategy had addressed issues of concern for the Member States; and desk research reviewed existing data on alcohol-related harm.

Addressing themes of concern to the Member States

In each of the three surveys (CNAPA, EAHF and external experts and officials), over 70% of respondents indicated that the EU alcohol strategy addressed themes of concern to their Member State to a ‘great’ or ‘some’ extent. In each, a majority of respondents indicated that the EU strategy had contributed to the development of policies, actions and strategies in each of the priority themes. (See section 3.1 of Annex 4 for detailed results from the surveys.)

[23] Minimum rates are set in Council Directive 92/84/EEC; in 2006, the European Commission proposed an increase in these minimum rates to account for inflation.

Changes in alcohol-related harm

WHO's 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases highlights the harmful use of alcohol is one of the main risk factors for non-communicable diseases, along with tobacco use, physical inactivity and unhealthy diets.[24] It is estimated that in 2004, alcohol was responsible for 3.8% of deaths worldwide and 4.5% of the global burden of disease.[25] The EU strategy, citing WHO research, states that harmful and hazardous alcohol consumption 'is a net cause of 7.4% of all ill-health and early death in the EU, and has a negative impact on labour and productivity'.

Eurostat data on deaths due to alcohol-abuse shows a slight decrease from 2005 to 2009 across the EU. The national data collected by Eurostat show that these deaths have decreased in 10 Member States, but increased in 6 others[26].

To monitor alcohol-attributable physical disorders, the CDCID selected as indicators hospital discharge rates for alcoholic liver disease and for pancreatitis.[27] For alcohol liver disease, rates decreased in 15 of the reporting Member States in the period of 2007-2009, but increased in 7 Member States. For acute or chronic pancreatitis, hospital discharge rates decreased in two Member States and increased in 18 Member States.

The CDCID has also identified indicators to monitor harm resulting from alcohol during pregnancy and chronic physical and mental disorders due to alcohol use. Here too, the data available do not show clear trends between 2007 and 2009.

The CDCID has identified indicators related to overall consumption of alcohol, as well as to underage and binge drinking. The data available indicate that from 2006 to 2009, the EU12 Member states had a 0.7% decrease in total consumption, while the EU15 saw a 2% decrease. A survey of alcohol consumption among 15 and 16 year-old students in 20 Member States found a decrease in 5 Members States and an increase 3 others, while in most no significant changes were observed.[28]

Section 3.4 to Annex 4, along with the appendix to this annex, provide further and more detailed data results.

Conclusions

In terms of data on alcohol-related harm, it is not possible to establish whether the changes observed represent short-term fluctuation or longer-term trends. It should be recognised, however, that the EU strategy to support Member States in reducing alcohol related harm targets a complex social phenomenon, where a range of social, cultural and economic factors come to play alongside public health policies, and where public health policies interact with policies in other sectors and with actions by a broad range of stakeholders. Moreover, time lags between actions and health impacts play a role.

In looking at the contribution of the EU strategy, the information gathered both for this evaluation question, as well as for the evaluation more generally, nonetheless show that CNAPA and related work at EU level have provided key outputs identified in the intervention logic: they have supported Member State coordination, provided guidance for further policy developments and supported Member States with data, information and good practice. The evidence gathered for the evaluation has also shown the contribution towards the expected effects: convergence of Member State policies, greater consensus in particular among

[24] WHO, 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, 2008.
[25] WHO, Global strategy to reduce the harmful use of alcohol, 2010
[26] It should be noted that definitions differ across Member States. The WHO indicator on alcohol-attributable mortality, using a broad definition, is not available for recent years.
[27] EUROCAT register (European Surveillance of Congenital Anomalies)
[28] The 2011 ESPAD (European School Survey Project on Alcohol and Other Drugs) Report. Substance use among students in 36 European countries. CAN. 2012.

public health bodies on policy approaches; and a strengthened knowledge base. Moreover, the development of Member State policies in the areas of good practice – identified on the basis of evidence gathered both in the preparation of the strategy and in its implementation – can be expected, over the long term, to reduce alcohol-related harm.

5 Overall findings and possible ways to enhance EU action

The previous sections have reviewed results across the three tasks of the assessment. This section draws conclusions regarding the relevance, effectiveness and efficiency of the strategy overall, and then presents possible ways to enhance EU action.

5.1 Overall findings

Relevance

The alcohol strategy addresses an EU-wide problem that has significant social and economic costs. The desk research for Task 3 shows that harmful use of alcohol is one of the main risk factors for non-communicable diseases, as the WHO has highlighted. Alcohol is a factor in accidents, including drink driving, as well as violence and crime; it also reduces work productivity and education attainment, has social and health costs, and thus creates burdens for the EU economy.

The EU strategy has provided a common baseline for action across the EU to address alcohol-related harm. Survey responses, in particular for Task 3, indicate that the EU strategy and its five priority themes have addressed Member State concerns. The desk research and interviews for Task 1 show that EU-funded projects and research have further developed this baseline by gathering evidence on alcohol-related harm and on the effectiveness of policy measures. Discussions in the CNAPA Advisory Group indicate that the strategy and its five themes remain relevant. Some topics like the unborn child, children and the elderly may however deserve further attention, as well as impacts on socially disadvantaged people and the links between alcohol-related harm and social exclusion, recently highlighted by the WHO.

The production and distribution of alcohol are important components of the EU economy. The EU strategy has recognised this by involving stakeholders from these sectors, as well as health care and other stakeholders, through EAHF. Further, issues related to alcohol-related harm often cut across several policy areas. The results of Task 1 on show how CNAPA has addressed policies beyond public health.

In sum, the evaluation has indicated the ongoing relevance of the EU strategy.

Effectiveness

This section reviews evidence regarding the effectiveness of the EU strategy, first, in terms of outputs and effects in the area of support for Member States and second, in the area of mobilising stakeholders and fostering stakeholder action to reduce alcohol-related harm. It concludes with considerations on the overall added value of the EU strategy.

Support for Member States

The information gathered in Task 1 has shown that the EU strategy has produced outputs that support Member State policy development. Notably, CNAPA meetings have supported Member State policy development coordination by providing information on policies within the Member States and on key thematic areas. CNAPA thematic discussions have covered a range of areas relevant for policy development; moreover, CNAPA has provided an interface with new knowledge developed through EU-funded research and projects. Through the participation of other Commission services, CNAPA has covered cross-policy issues.

The review of EU-funded research and projects in Task 1 shows that these support MS with data, information and exchange of good practice. In addition, the CDCID has developed a framework for common indicators and the joint survey with WHO has provided relevant data on alcohol policies. . A broad range of

experts and officials contacted in the course of the assessment underlined that EU-funded projects and research have supported Member State policy developments.

These outputs are in turn linked to effects in three areas.

The information gathered shows that EU-funded research and projects have provided a stronger common evidence base; the survey and interview results as well as AG discussions indicate that Member States have utilised this evidence base in developing national strategies and policy measures. Work under the strategy has developed common indicators, gathered data on alcohol-related harm and monitored national alcohol policies; nonetheless, recent data for populating the common indicators has been limited. The results of Task 1 show that most alcohol projects and research have been discussed in CNAPA, thus providing a direct link to Member State policy makers, though employing further channels could strengthen dissemination.

The EU strategy set out good practices for addressing alcohol-related harm; the results show that these practices provide a foundation for Member State policies, and this base has moreover advanced further through research, projects and policy discussions at EU level. The information gathered indicates that a broad consensus has developed among CNAPA members, who are public health officials, on policies to address alcohol-related harm; consensus within and across EU governments including policy areas beyond public health has moved more slowly.

The overview of EU policy developments in Task 3 shows that Member States have updated their alcohol policies and introduced new measures across the five priority themes of the EU strategy: overall, national policies are moving in the directions outlined in the strategy. In surveys and interviews, Member State officials indicated that the strategy has in many cases supported these policy developments. Member State approaches differ, as some have introduced new alcohol policies while others have focused on strengthening existing policies and measures.

Mobilising stakeholders and fostering stakeholder action

The Forum has mobilised a broad range of stakeholders. The desk research for Task 2 shows that EAHF membership increased from 53 in 2007 to 68 in August 2012. Through members' commitments to action, the EAHF process has also mobilised action by stakeholders at national and local levels.

Between the launch of the EAHF in 2007 and August 2012, Forum members had undertaken 227 commitments to action, of which 173 had been completed and 54 were still ongoing. The survey results for Task 2 indicate that the EAHF process has led to new actions for many stakeholders, in particular economic operators. While some commitments would have taken place without the EAHF, the process has changed the way that actions have been undertaken, including a stronger emphasis on monitoring and evaluation. The development and convergence of self-regulatory systems for alcohol marketing has been one of the key areas where EAHF has stepped up action.

EAHF has created two Task Forces, on youth and marketing, respectively. The results for Task 2 show that both Task Forces have launched follow-up work, notably a database on youth-related projects and mapping reports on marketing. The Task Force on marketing in particular contributed to the EAHF process in this area. Moreover, the EAHF Advisory Group discussions noted that small groups, such as these Task Forces, have been effective in addressing important and controversial issues.

In contrast, the Science Group is at a cross-road. It has produced two reports: one of these, on marketing and youth, addresses a key issue for EAHF members, and it has contributed to awareness-raising. However, members have resigned and not been replaced.

Added value of the EU strategy

The research carried out as part of this evaluation indicates that the strategy has provided an EU-wide foundation for action on alcohol-related harm. Without it, a common approach across the EU would not have developed, and EU work on a common knowledge base would likely have been significantly reduced. National efforts to address cross-policy aspects would have been less strong without an EU-wide exchange

of information. Dialogue and cooperation across a broad range of stakeholders at EU level would have been unlikely to take place to a comparable extent in the absence of an EU strategy.

Recent data on alcohol-related harm are limited and more time is necessary to assess long-term trends since the introduction of the strategy. Moreover, the EU strategy targets a complex social phenomenon, where a range of social, cultural and economic factors come into play. The development of Member State policies in the areas of good practice identified by the EU strategy can be expected, over the long term, to reduce alcohol-related harm. Stakeholder actions addressing some of the strategy's priority themes also follow best practice models and can therefore be expected to influence reductions in harm. Stakeholder action for other priority themes warrant further attention as well as stepped up efforts to identify and adopt good practices and evaluate results.

Efficiency

This section addresses the efficiency of the two main instruments at EU-level under the EU strategy, CNAPA and EAHF, as well as the CDCID and the EAHF sub-groups. It also considers EU-funded projects and research on alcohol-related harm. Efficiency assessments typically look at the way in which inputs are turned into outputs. Outputs resulting from the EU strategy do not lend themselves to straightforward quantification. The approach adopted here is, therefore, fundamentally qualitative: it compares the orders of magnitude of the costs involved in the implementation of the strategy with that of outputs and effects, where known.

The main costs related to CNAPA are those of organising its meetings, as well as staff time to support the Committee. Based on discussions with officials, the costs appear to be within the norm for EU-level consultative groups. The Committee and the network it has supported have provided a mechanism for exchange of information on alcohol policies. The outputs of CNAPA are outlined in the previous section on effectiveness, in particular its support for Member State coordination and policy development.

It does not appear that other existing forums could provide the same results and the same level of efficiency as CNAPA. For example, the WHO also addresses alcohol-related harm, at European and global levels. The WHO European region, however, extends to a far larger area including many countries of the former Soviet Union with a different scale of alcohol-related harm. WHO has little capacity to undertake a cross-policy dialogue, as CNAPA has done through support of different Commission services. At the same time, the EU's close cooperation with the WHO helps to encourage synergies, including joint work, such as the WHO information gathering highlighted in Tasks 1 and 3.

The Committee on Data Collection Indicators and Definitions (CDCID) held two meetings, through which it developed a set of EU-wide indicators for alcohol-related harm. The costs for CDCID have been low according to consulted officials. However, as noted above, progress in the implementation of these indicators has been limited. This is in part due to obstacles at Member State level, though a need for stronger support at EU level may have also affected the process.

The main costs of EAHF are those related to meetings. As described above, its outcomes include the mobilisation of stakeholders, their exchange of information and their engagement in new and improved actions to address alcohol-related harm. The EAHF process has catalysed action at EU, national as well as regional and local levels. Its efficiency is difficult to assess, in part as EAHF is a relatively unique body that does not allow for straightforward comparisons with similar structures.

Among the EAHF, its two Task Forces have mainly had meeting-related costs, and they have addressed important and controversial issues. The main costs of the Science Group are also meeting-related, as its members are not remunerated. Overall, however, a scientific panel under EAHF does not appear to be the most efficient way for scientific experts to support the implementation of the EU strategy, as many projects and research on alcohol-related harm seem to have greater implications for policy measures than stakeholder action.

While no spending programme is linked to the EU alcohol strategy, the EU Health Programme and the Research Framework programmes have provided support to projects and studies on alcohol-related harm. The evidence gathered for Task 1 shows that since 2007 through mid-2012, the EU Health Programme has allocated about 3% of its 2008-2013 budget to alcohol-related projects. Funding for alcohol-related research under the EU's seventh research programme through mid-2012 represents less than 1% of the FP7 Programme's budget for health.[29] Project results have been discussed in both CNAPA and to a lesser extent EAHF, and information gathered for Task 1 shows that the development of the evidence base at EU-level has supported Member State policy development. Moreover, EU-funded projects and research reduce possible overlaps in work carried out at Member State level, encourages synergies and supports small Member States with limited research infrastructure in this field. Overall, a small share of "health" research budget has led to satisfactory outcomes, as expressed by CNAPA officials in Task 1.

Overall, the information gathered indicates that costs of the EU alcohol strategy appear reasonable compared with its value added as a foundation and catalyst for EU-wide action on alcohol-related harm.

5.2 Enhancing EU action

In sum, the assessment has shown that the EU strategy has had a positive added value in terms of addressing alcohol-related harm. Nonetheless, the findings show that alcohol-related harm remains an economic and social burden in the EU, and the aims of the strategy have not been fully reached. Continuing coordination and action at EU level would maintain and strengthen the added value of the common approach, supporting further policy developments in the Member States and maintaining the momentum of stakeholder action and cooperation. If EU action continues, several approaches could be considered to enhance the effectiveness of the current instruments.

CNAPA

The findings show that the work of CNAPA has supported information exchange and convergence of Member State policies, including through cross-policy discussions. This work, and thereby the prominence of the EU strategy, could be enhanced through greater political visibility. The following approaches could be considered:

- Continue high-level meetings and establish links to the EU Presidency agendas
- Enhance current work on cross-policy issues through greater interaction with other policy areas, including both Commission services and national governments.

Moreover, the consistency and continuity of CNAPA's work could be strengthened, for example by the following actions:

- Adopt a multi-annual work plan and monitor its implementation through brief annual reports to improve.
- Draw on synergies with work on other risk factors for chronic non-communicable diseases: the findings highlight the ongoing importance of alcohol as a leading risk factor, and an exchange of information with initiatives on other risk factors could further strengthen EU work and Member States policies to address alcohol.

EAHF

The findings note that several sectors are under-represented in EAHF. Further efforts to bring in members in such areas could strengthen EAHF's effectiveness by providing further avenues for action to address alcohol-related harm:

[29] European Commission, Health Research in FP7: The Basics, 2010, available at: ftp://ftp.cordis.europa.eu/pub/fp7/docs/health-research_leaflet_en.pdf

- Encourage broader involvement from sectors currently under-represented in the EAHF membership, such as alcohol retailers and health and social insurers.
- Expand membership in sectors where the EAHF has provided a major stimulus for action, such as the media sector, including digital media.
- Explore ways to involve further sectors, such as law enforcement and local and regional government.
- Increase participation of stakeholders from new Member States.

To improve the quality of actions carried out by members through the EAHF process and provide further information on results, the following approaches could be considered:

- Re-focus work under the EAHF on fewer well defined action areas that are more clearly aligned with the priorities of the alcohol strategy.
- Identify benchmarks and good practices in these areas and formulate guidelines for development and implementation.
- Building on the guidance provided in the Workshop on monitoring and evaluation in 2008, identify and implement appropriate outcome and impact indicators for efficient and systematic planning, monitoring and evaluation of commitments to action in order to raise standards for reporting.
- Provide further guidance to EAHF members in this area, in particular on methods to evaluate the results of their commitments to action, including the use of outcome and impact indicators.

Strengthening synergies between CNAPA and EAHF, and more generally with Member State policies and actions, could strengthen action by EAHF members. The following approaches could be considered:

- Provide CNAPA members with a yearly overview at national level of EAHF commitments to action, and encourage Member States' active participation in EAHF meetings.
- Encourage more Member States to set up national fora for stakeholders, where this fits national policy approaches, and promote exchange of experience between these national bodies and EAHF.

Considerations for EU action as a whole

The findings show that EU support for the evidence base has been a key element of the EU strategy and its support for Member State action. The following approaches could continue and strengthen the evidence base:

- Consider maintaining support for projects addressing alcohol-related harm under the new EU Health Programme[30] and in the framework of the next EU Research Framework Programme[31], as the findings indicate that these have provided effective and efficient support for Member States. CNAPA could be given a wider role in proposing issues to address, in particular under the new Health Programme, thus enhancing the link between projects and policy goals.
- Explore further channels to further strengthen the dissemination of the outputs of EU-financed projects and research, including effective use of the Heidi tool,[32] in cooperation with CNAPA and relevant DGs, agencies and units of the Commission.
- Undertake further efforts in Member States and at EU level to ensure the implementation of common EU indicators for monitoring alcohol consumption and related harm and ensure for better and timelier EU-wide statistics.
- Consider continuing joint EC/WHO work on alcohol data gathering, as the findings show that this have played an important role in supporting Member State policy work.
- Consider re-creating the Science Group as a body independent of the EAHF, with a mandate to provide support across both instruments and all EU work on alcohol-related harm. The findings highlight that the Science Group has not been efficient in its work, but also highlight the importance of scientific work to support the strategy as a whole. It may be useful, indeed, to consider widening the focus of the group to encompass related topics such as other key risk factors of chronic non-communicable diseases.

[30] The European Commission has made a proposal for a new Health for Growth Programme for the 2014-2020 period, and action in this area will depend on the final programme adopted.
[31] The European Commission has made a proposal for Horizon 2020, the new framework programme for research and innovation, for the 2014-2020 period, and action in this area will depend on the final programme adopted.
[32] See: https://webgate.ec.europa.eu/sanco/heidi/index.php/Main_Page

A further point that cuts across the evaluation results concerns the need to clarify linkages and synergies across the priority themes, across the pillars of implementation, and across the multitude of actions and initiatives.

Defining concrete targets at EU and Member State level for the aims under the priorities could help position individual initiatives within the wider framework of action and contribute towards a sharper focus on outcomes. This could focus attention of EAHF on benchmarks for good practice and on approaches for the evaluation of commitments. Moreover, it could direct CNAPA discussions towards policy areas where significant results can be expected.

Annex 1: Assessment of the Committee on National Alcohol Policy and Action (CNAPA) – Task 1

This annex presents the detailed findings of the desk research, online survey and interviews concerning the Committee on National Alcohol Policy and Action (CNAPA). It opens with a summary of the aims and evaluation framework for Task 1. Results are then presented for each evaluation question.

1 Assessment aims and evaluation framework

1.1 Aims of Task 1

The aim of Task 1 is to evaluate the role of CNAPA within the implementation structure of the EU alcohol strategy, as well as to assess the value added of the development of alcohol data gathering, and of EU-funded projects and research on alcohol as a form of support for Member States through further development of the knowledge base and good practices. The questions set out in the tender specifications represent a broad range of investigation levels; starting from rather general questions, such as assessing CNAPA's role as an instrument for cooperation and coordination between Member States as well as CNAPA's impact on policy development to reduce alcohol-related harm, to more operational issues, most importantly CNAPA's membership and working methods. The question also ask about the relevance and usefulness of the work carried out at the EU level for the Member States.

1.2 Evaluation framework

The terms of reference for the study set out six *evaluation questions* for Task 1; these are elaborated in terms of *assessment criteria*. For each criterion one or more *indicators* were identified, along with specific research techniques. Table 3 below presents the evaluation framework for Task 1.

Table 3 Evaluation framework for the CNAPA assessment

Evaluation question	Assessment criteria	Indicators	Research Techniques
1. To what extent has the CNAPA contributed to the coordination of alcohol policies between MS and with the EU level?	1.1 Work within the CNAPA has been helpful in providing information relating to national policies on alcohol	1.1.1 No. of CNAPA documents and presentations on national policies 1.1.2 Total No. of MS covered by these documents 1.1.3 Perceived value of information exchange	Desk research Desk research Survey
	1.2 Discussions within the CNAPA have contributed towards clarifying Member States' positions vis-à-vis alcohol policy developments and strategies	1.2.1 Perceived role of CNAPA discussions in the development of alcohol policies in Member States	Workshop / Interviews
	1.3 Relevant areas of alcohol policy and action have received adequate attention within the CNAPA	1.3.1 No. of CNAPA documents and presentations by policy and action areas 1.3.2 Extent to which relevant areas of alcohol policy are addressed during CNAPA meetings	Desk research Survey
	1.4 The attention given to alcohol policies at sub-national / national / EU / global level has	1.4.1 No. of documents and presentations presented by policy level	Desk research

Evaluation question	Assessment criteria	Indicators	Research Techniques
	been balanced		
2. To what extent has the CNAPA contributed to further policy development?	2.1 Work within the CNAPA has contributed towards greater consensus on the most promising policies to reduce alcohol-related harm	2.1.1 References to CNAPA work within national reports presented to CNAPA 2.1.2 Extent to which CNAPA members feel that the discussions have led to greater consensus	Desk research Workshop/ Interviews
	2.2 Work within the CNAPA has contributed towards strengthening good practices (as per the alcohol strategy)	2.2.1 Perceptions of impact of work within CNAPA on good practice / alcohol policy within Member States	Survey
	2.3 The specific topics addressed in CNAPA have been the most relevant and useful	2.3.1 Extent to which CNAPA members that the topics addressed in CNAPA have been the most relevant and useful	Survey
3. What additional outputs of the CNAPA contribute to its added value as instrument at EU level?	3.1 The CNAPA has led to further outputs that support the EU alcohol strategy	3.1.1 Additional outputs identified by CNAPA members and other stakeholders	Workshop/ Interviews
4. What are the lessons learned regarding composition, focus and working methods, with a view to enhance effectiveness in achieving the objectives?	4.1 The members of the CNAPA are appropriate for its works	4.1.1 Perception of the appropriateness of representatives at CNAPA	Workshop/ Interviews
	4.2 The CNAPA's working methods are appropriate for its goals	4.2.1 Appraisal of CNAPA's working methods	Workshop / Interviews
5. Has the work at EU level to develop alcohol data gathering and strengthen the knowledge base been useful from the Member States' perspective?	5.1 The development of common indicators and methods for comparative research has been helpful for MS	5.1.1 Extent to which MS representatives feel that the development of common indicators and methods for comparative research has been helpful	Survey Workshop/ Interviews
	5.2 Collaboration between the EC and the WHO to develop joint alcohol data gathering has been helpful for MS	5.2.1 Extent to which MS representatives feel that collaboration between the EC and the WHO to develop joint alcohol data gathering has been helpful	Survey
6. Have EU-funded projects and research on alcohol been relevant from the MS' perspective?	6.1 The topics of EU-funded projects and research on alcohol have provided good practices, evidence and guidance for the development of actions and strategies to reduce alcohol related harm	6.1.1 Review of EU-funded projects and research by topic and no. that have provided good practices, evidence or guidance 6.1.2 Perception that the topics of EU-funded projects have provided good practices, evidence and guidance – by type of respondent (CNAPA members; stakeholders)	Desk research Survey Workshop / Interviews
	6.2 The results of alcohol related EU-funded projects and research have been adequately disseminated to MS experts and policy makers	6.2.1 Perception that that the results have been adequately disseminated to MS experts and policy makers	Survey

1.3 Overview of research techniques for Task 1

The results presented for Task 1 are based on three main sources: desk research of CNAPA documents and project results; responses to an online survey of CNAPA members; and interviews with selected CNAPA members. A fourth source – a workshop held in April 2012 with the CNAPA Advisory Group (AG) for the evaluation – provided further input.

Overview of CNAPA meetings, 2007-2011

Since the start of CNAPA's work in November 2007, there have been nine bi-annual meetings of the Committee, convened and chaired by the European Commission services. The meetings have been held in Luxemburg, with the exception of the second meeting, which took place in Barcelona, and the ninth, high-level meeting, which took place in Brussels.

Meeting	Date	CNAPA members and observers	External presenters	Commission Services	Total
1	5 November 2007	23		5	**28**
2	2 April 2008	29		3	**32**
3	13-14 October 2008	24		4	**28**
4	17-18 February 2009	27		7	**34**
5	24-25 June 2009	18	5	5	**28**
6	27-28 January 2010	26	4	7	**37**
7	14-15 September 2010	24	4	7	**35**
8	1-2 March 2011	35	1	9	**45**
9*	17 November 2011	49	2	8	**59**

*High level meeting with additional participation of senior officials.

The ***desk research*** reviewed two main sets of documents. Firstly, reports and presentations at CNAPA meetings (as indicated in the box above) were assessed in terms of indicators for evaluation questions 1 and 2. The reports and presentations were prepared by a variety of sources, including: services within the European Commission, relevant Member State authorities, WHO representatives as well as various external experts. A total of 94 documents and presentations disseminated at the CNAPA meetings were reviewed.

Secondly, alcohol and health related projects and research funded under the EU health programme or under the EU research framework programmes in the period 2007-2011 were reviewed in order to understand the type of support they provide for the implementation of the EU alcohol strategy at national level. The review of projects was used in the desk research for evaluation question 6.

The ***online survey*** carried out for task 1 addressed evaluation questions 1, 2, 5, and 6. The survey was sent to all CNAPA members[33] on 27 February 2012 and a reminder was sent on 6 March 2012.The survey for CNAPA members consisted of 15 multiple-choice questions and 2 optional free-text questions (specified in the inception report for tasks 1 and 3). In addition, the respondents were encouraged to provide additional feedback via email to the study team. The survey was sent to 54 officials out of which 3 were not delivered (due to inaccurate or outdated contact information), and a total of 31 respondents answered all or some of the questions (a response rate of 57%, counting also the emails not delivered). Respondents could reply anonymously, as this can allow more frank replies. From the respondents who provided their contact details,

[33] Based on a list of persons who have at one point or another attended as Member States representatives as of November 2011, provided by DG Sanco.

together with further contacts with CNAPA members, it is known that replies were received from 21 Member States (twelve EU15 countries and nine EU12 countries), plus Norway and Switzerland.

For technical reasons, respondents were required to fill out the survey in a single attempt (a PDF or Word document was available if the respondents wanted to coordinate their answers internally beforehand). Some respondents did not finish the survey in one attempt and thus failed to answer all the questions. The final mandatory question was answered by 26 respondents, which means that 5 respondents had quit the survey in between. In the following sections, the number of responses is given for each question.

The ***interviews*** were carried out with eight CNAPA members. Interviewees were chosen to provide a mix of Member States, in particular EU12 and EU15; large and small Member States; and to reflect the variation in the structures of Member States' alcohol policies (as per the WHO database on national alcohol policies). Officials of the following eight Member States were interviewed:

- Austria
- Belgium
- Denmark
- Estonia
- Germany
- Hungary
- Portugal
- United Kingdom

The ***workshop*** in April 2012 brought together the members of the CNAPA Advisory Group (AG): see also Annex 9.

Information, opinions and quotes from interviews and workshop discussions are provided in the following sections. These results are intended to illustrate points of view expressed by CNAPA members. Quotations should not be taken as representative of broader opinions.

2 Evaluation Question 1: To what extent has the CNAPA contributed to the coordination of alcohol policies between MS and with the EU level?

This evaluation question is articulated in four assessment criteria. Information was gathered through desk research, the survey, interviews and also in the AG workshop.

2.1 Assessment Criterion 1.1 Work within the CNAPA has been helpful in providing information relating to national policies on alcohol

Indicators	Research Technique
1.1.1 No. of CNAPA documents and presentations on national policies	Desk research
1.1.2 Total No. of MS covered by these documents	Desk research
1.1.3 Perceived value of information exchange	Survey

2.1.1 Indicator 1.1.1: No. of CNAPA documents and presentations on national policies

Table 4 summarises the number of documents and presentations on national policies presented in the CNAPA meetings. This number only considers distinct national presentations and does not include country and policy briefs, or presentations on plans for presidencies (these are covered under indicator 1.1.2).

Table 4 CNAPA documents and presentations on national policies

Meeting	No of documents on national policies	Member State / EFTA Country presenting
1	2	Italy and Germany
2	1	Spain
3	4	Czech Republic, Germany, Latvia, UK (Scotland)
4	6	France, Lithuania, Portugal, UK (3 documents)
5	3	Ireland, UK (Scotland), Poland
6	2	Austria, Bulgaria
7	4	Germany (2 documents), Luxembourg, Malta
8	4	France, Portugal, Sweden and Switzerland
9	2	Estonia and Spain
Total:	**28**	

While some countries have presented on their national policies multiple times, ten MS have never made a presentation on national policy developments: Belgium, Cyprus, Denmark, Greece, Finland, Hungary, Netherlands, Romania, Slovakia and Slovenia.

At the fifth meeting, the country reports were to a major extent replaced by brief accounts on the latest developments in the national policies. Thus, the coverage of national policies was not limited to national reports and presentations as the briefs are accounted for in the summary reports of each CNAPA meeting. This factor is addressed in question 1.1.2.

2.1.2 Indicator 1.1.2: Total No. of Member States covered by the documents

Table 5 summarises the desk research findings on how many Member States have been covered by the documents and presentations at CNAPA meetings. A MS is considered covered when either its representative has given a presentation or a brief on national policy, shared good practice, presented on their country's presidency or discussed a national or regional example (of which there is a record in the summary report of the meeting). A MS is not considered when it is only included in overviews of cross-national reports or statistics.

Table 5 Member States covered in CNAPA documents and presentations

CNAPA Meeting	No of MS covered	MS covered
1	9	DE, FI, FR, IT, IE, NL, SE, UK, SI
2	3	AT, ES, SI
3	8	CZ, DE, FI, FR, LV, PL, SE, UK
4	5	FR, LT, PT, SE, UK
5	13*	BE, DE, DK, EL, FR, IE, NL, MT, PL, PT, SE, SK, UK
6	14*	AT, BG, CZ, DE, IT, LT, MT, NL, PT, RO, SE, SK, SI, UK
7	18*	AT, BE, CZ, DE, DK, EE, IE, IT, LT, LU, LV, MT, NL, PL, PT, SE, SK, SI
8	21*	AT, BE, CZ, CY, DE, DK, EE, ES, FI, FR, IE, LT, LU, LV, PL, PT, RO, UK, SE, SK, SI
9	5	EE, ES, FR, PL, UK

*These MS either presented a document on their national policies or gave a brief on relevant and timely issues in their MS, which was then covered in the meeting Summary Report.

As noted above, for meetings 5 to 8, Member State reports and detailed presentations were to a major extent replaced by country briefs. This accounts for the increase in the number of MSs covered in these meetings. It should be also noted that the 9th meeting was a one-day, high-level meeting; these factors explain the drop in

the number of Member States covered at that meeting. Table 6 below illustrates the coverage of each Member State in CNAPA documents and presentations.

Table 6 Member States covered in CNAPA documents and presentations by type of coverage

Member State	Presentation on National Policies	Briefs	Other (examples, good practice)
Austria	✓	✓	✓
Belgium		✓	✓
Bulgaria	✓	✓	
Cyprus		✓	
Czech Republic	✓	✓	
Denmark		✓	✓
Estonia	✓	✓	✓
Finland		✓	✓
France	✓	✓	✓
Germany	✓	✓	✓
Greece			✓
Hungary			
Ireland	✓	✓	
Italy	✓	✓	✓
Latvia	✓	✓	
Lithuania	✓	✓	
Luxembourg	✓	✓	
Malta	✓	✓	
Netherlands		✓	
Poland	✓	✓	✓
Portugal	✓	✓	
Romania		✓	
Slovakia		✓	
Slovenia		✓	✓
Spain	✓	✓	
Sweden	✓	✓	✓
United Kingdom	✓	✓	✓

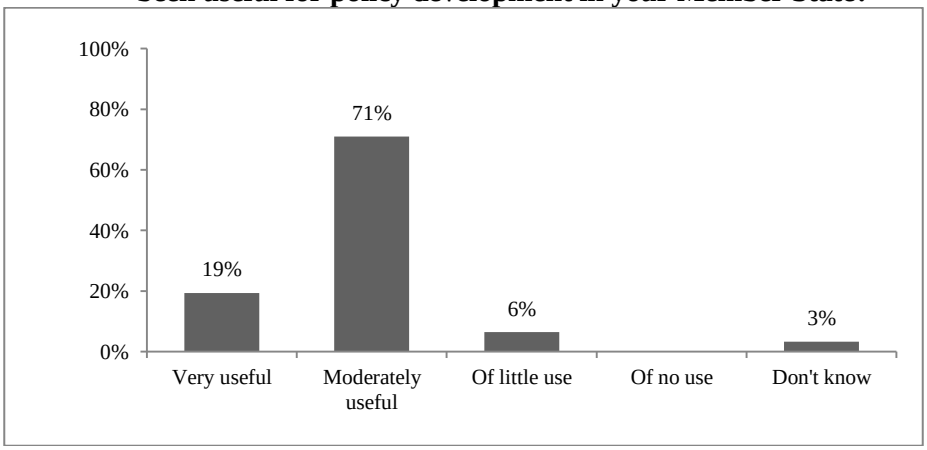
Overall, all Member States except for Hungary have been explicitly covered by the documents presented at CNAPA and in the meeting summary reports; however, the extent of coverage has varied between the MS. Whereas some Member States have presented on multiple occasions, the involvement of others has been less visible. Also, Switzerland and Norway have been covered on several occasions in either national reports or country briefs.

Contrary to expectations, references to CNAPA or to other Member States were not found in national reports, briefs and other documents. At the AG workshop, CNAPA members said that this had not been called for. Moreover, the development of national policies is a slow process, involving a range of inputs and influences that are not directly and immediately visible. (See also below section 3.2.2.)

2.1.3 Indicator 1.1.3: Perceived value of information exchange

The survey findings show that the great majority of the respondents consider that the information provided within CNAPA on alcohol policies in different Member States has been useful, with 22 indicating it was moderately useful (71%), and 6 considering the exchange very useful (19%) (Figure 2).

Figure 1 Has information provided within CNAPA on alcohol policies in different Member States been useful for policy development in your Member State?*



*n=31

In the follow-up interviews, five of the eight respondents cited the value of the exchange of information on policies in other Member States when responding to the question about the role of CNAPA discussions in the development of national alcohol policies (see section 3.2.2 below).

One commented that CNAPA '*is a very good place to learn about other countries' alcohol policies*'; another mentioned as an example information on MS policies for advertising. A third CNAPA representative said WHO monitoring of MS policies had been useful, and it would be valuable to have more detailed reviews as well.

In the Advisory Group workshop, however, it was noted that the Committee's discussions have focused more on thematic issues for alcohol policy in recent years; such a thematic approach was considered a more valuable focus than broad information on national developments.

2.2 Assessment Criterion 1.2: Discussions within the CNAPA have contributed towards clarifying Member States' positions vis-à-vis alcohol policy developments and strategies

Indicator	Research Techniques
1.2.1 Perceived role of CNAPA discussions in the development of alcohol policies in Member States	Interviews/Workshop

2.2.1 Indicator 1.2.1: Perceived role of CNAPA discussions in the development of alcohol policies in Member States

The CNAPA interviewees were asked: '*To what extent have discussions within CNAPA contributed to the development of alcohol policies in your Member State? In what ways?*'

Five of the eight respondents indicated that CNAPA has had an important influence on national policy development.

One respondent said that CNAPA has played '*a major role*' in supporting the development of national policies; another one said that CNAPA discussions contributed '*a great deal*' to the development of policies in their Member State.

Examples cited of specific issues where discussions and information shared in CNAPA have contributed included: raising the minimum age for alcohol purchasing; tightening the blood alcohol level for driving; digital marketing of alcohol beverages; and work on alcohol-related harm, which has been useful in estimating national health losses.

In addition, one CNAPA member provided a written comment in the survey that '*bringing MS together and disseminating information on public health issues and ... tackling issues that arise has proved to be invaluable for*' their Member State, in particular in the preparation of their national alcohol policy.

The other interviewees described a less influential role of CNAPA, but said that the Committee had been '*a very good place to learn about other countries' alcohol policies*' and as a place to engage in discussion with experts in the field.

The interviewees explained that information provided by CNAPA is used in national policy discussions. In the Advisory Group, it was noted that CNAPA's work has been valuable for debate at national level, though it does not always lead immediately to policy action.

2.3 Assessment Criterion 1.3 Relevant areas of alcohol policy and action have received adequate attention within the CNAPA

Indicator	Research Techniques
1.3.1 No. of CNAPA documents and presentations by policy and action areas	Desk research
1.3.2 Extent to which relevant areas of alcohol policy are addressed during CNAPA meetings	Survey

2.3.1 Indicator 1.3.1: No. of CNAPA documents and presentations by policy and action areas

The 94 CNAPA documents and presentations were analysed in terms of the five priority themes of the EU strategy (see Table 7 below). For three themes, the analysis also looked at key topics within the theme.

A CNAPA document or presentation was considered to have covered a theme if it presented detailed attention in terms of a national policy focus, a good practice, exchange of experience, or an example for that theme. Many documents and presentations covered more than one theme; each one addressed is listed in Table 7.

Table 7 CNAPA documents and presentations across the five priority themes of the EU alcohol strategy

Theme:	**1. Protect young people, children and the unborn child**			**2. Reduce injuries and death from alcohol-related road accidents**	**3. Prevent alcohol-related harm among adults and reduce negative impacts on the workplace**		**4. Inform, educate, and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns**		**5. Develop and maintain a common evidence base at EU level**
Meeting	Youth	Children	Unborn child		Among adults	In the workplace	Harmful and hazardous consumption	Appropriate consumption patterns	
1	1			1	1	1	2	1	2
2	2	1	1	2	1	1	2	1	2
3	6	2	2	3	6	1	2	1	1
4	6	2	5	2	6	2	5	4	3
5	9	7	6	7	4	4	5	5	4
6	7	5	6	5	4	3	4	2	6
7	6	2	2	1	1	3	6	4	3
8	7	3	4	3	4	5	3	3	2
9	6	2	2	3	2	3	1	1	2
Total	**50**	**24**	**28**	**27**	**29**	**23**	**30**	**22**	**25**

Out of the priority themes, the protection of *young people, children and the unborn child* received the greatest attention – and in particular the topic of young people. While there are differences among the

number of documents and presentations focusing on the other four priority themes, in general all themes received attention.

In addition to the five priority themes of the EU strategy, the desk research identified other areas that have been extensively covered in CNAPA work, notably the labelling of alcoholic beverages and issues relating to pricing, taxation and affordability, and alcohol and the elderly (Table 8). Some of these documents, as well a number of those under theme four above, also addressed marketing.

Table 8 CNAPA documents and presentations: other themes

Meeting	Labelling of alcoholic beverages	Affordability of alcohol	Alcohol and the elderly	Alcohol and mental health	Issues relating to pricing and taxation
1	2				1
2	1		1		2
3	2	2	3		3
4	4	1		2	4
5	3	4	2	1	2
6	3	1	1	2	3
7	1		8*	1	2
8	2	1	1		3
9	4	1			1
Total	**22**	**10**	**16**	**6**	**21**

* Meeting 7 included a mini-seminar on alcohol and the elderly, which explains the peak in the attention.

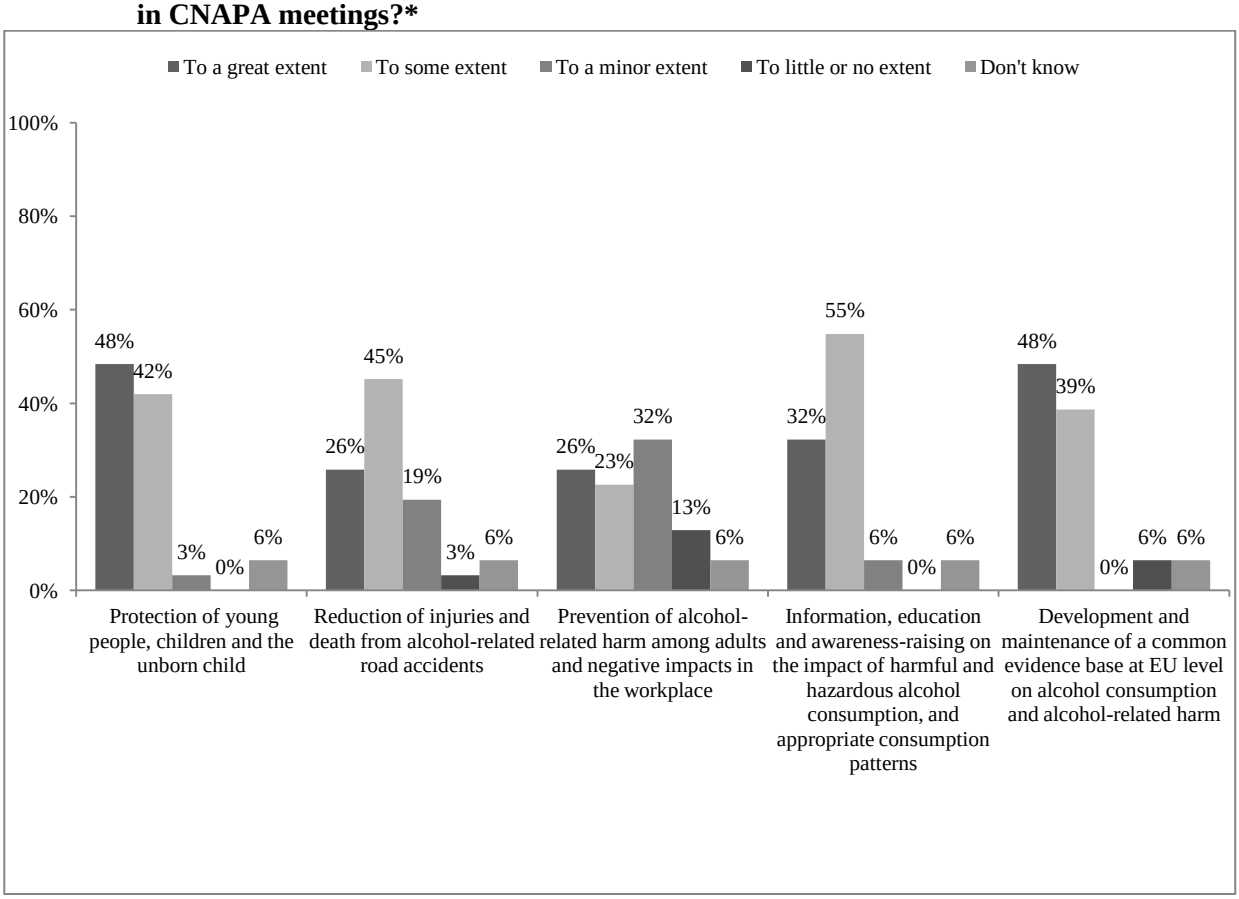
Other areas and issues covered in CNAPA on more than one occasion include: the development of a global alcohol strategy, illicit alcohol markets, cross-border trade, disease burden (infectious diseases and non-communicable diseases) and costs to society (e.g. violence and crime).

2.3.2 Indicator 1.3. 2 Extent to which relevant areas of alcohol policy are addressed during CNAPA meetings

The survey question asked CNAPA members the extent to which each of the five priority themes of the EU strategy were addressed in meetings (see Figure 3 below). Key results include the following:

- For the priority area of *protection of young people, children and the unborn child*, almost 50% of respondents said that it has been covered in CNAPA meetings to a great extent, and over 40% said it had been covered to some extent.
- Respondents indicated that the *development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm*, has also been covered extensively: almost 50% checked 'to a great extent', and almost 40% 'to some extent'.
- For the areas of *information, education and awareness-raising on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns* and *reduction of injuries and death from alcohol-related road accidents*, about half of respondents said that these had been covered to some extent.
- The area that has been covered least in CNAPA meetings, according to the survey respondents, is the *prevention of alcohol-related harm among adults and reduction of negative impacts in the workplace*.

Figure 2 To what extent have the following priority areas of the EU alcohol strategy been addressed in CNAPA meetings?*



*n=31

Many of the respondents also indicated other areas related to the EU alcohol strategy that were addressed in CNAPA meetings. These included: the implementation of national alcohol policies; labelling, taxation, pricing and other regulatory issues; monitoring and surveillance, working with relevant non-state actors; sharing of good practices.

2.3.3 Comments from the CNAPA workshop and interviews

The members of CNAPA participating in the AG workshop took note of the survey results and felt overall that the balance of issues had been appropriate. It was noted that members had played a role in choosing the issues for discussion, which thus reflected the group's priorities. A point made in the workshop was that the three target groups of the first priority theme – children, young people and the unborn child – should be considered separately and in particular greater attention could be paid to children.

2.4 Assessment Criterion 1.4: The attention given to alcohol policies at sub-national/national/EU/global level has been balanced

Indicator	Research Techniques
1.4.1 No. of documents and presentations presented by policy level	Desk research

2.4.1 Indicator 1.4.1: No. of documents and presentations presented per policy level

The Commission's Communication on an EU strategy to support Member States in reducing alcohol related harm highlights that the identified priority themes cut across EU, national and local level. Three levels of action are outlined: the national level, where Member States have the main responsibility for national alcohol

policy; the coordination of national policies at EU level; and complementary and supportive actions by the Commission on the basis of its prerogatives. It is furthermore stated that national strategies could be more effective if supported by local and community based activities. The global level, not mentioned in the Strategy launched in 2006, has increased in importance since 2008 with the process that led to the adoption by the World Health Assembly in 2010 of the *Global strategy to reduce the harmful use of alcohol*.[34]

For this indicator, desk research looked at the administrative or policy level addressed by documents and presentations for CNAPA meetings. A few documents cover more than one level; for example reports by the WHO Regional Office for Europe address both EU specific issues as well as the wider Europe; similarly, the Commission Services' presentations sometimes cover global issues (e.g. when discussing collaboration with the WHO) and EU-level issues in the same presentation. In these cases, the documents have been counted for each relevant level.

Table 9 CNAPA documents and presentations by policy level

	Policy Level				
CNAPA Meeting	**Sub-national**	**National**	**EU**	**Wider Europe***	**Global**
1	-	2	1	-	1
2	-	1	2	-	-
3	1	4	4	-	2
4	-	6	4	1	2
5	1	3	9	-	1
6	-	2	8	2	1
7	1	4	9	1	1
8	-	4	8	4	1
9	1	2	6	3	1
Total	**4**	**28**	**51**	**11**	**10**

*Includes the WHO/Europe region as well as aggregations of the EU and other European countries (Switzerland, Norway and the EU Candidate countries).

In total, 51 out of the 94 documents and presentations at CNAPA meetings have dealt with EU-level issues. National level documents and presentations follow with a count of 28. In contrast, few documents and presentations addressed sub-national levels (e.g. regions or local government). It was noted at the AG workshop that more attention should be paid to work at local government level.

2.5 Key findings for Evaluation Question 1

Regarding information on national policies (assessment criterion 1.1), the results show that CNAPA has provided an exchange of information on national policies to address alcohol-related harm. The desk research findings show that all but one Member State has shared some information regarding national policies within CNAPA either by providing a presentation on national policies, by giving a national policy brief, or by giving examples on good and best practices in their Member State. In the survey, nearly all CNAPA representatives indicated that this information was either very or moderately useful.

In terms of clarifying Member State positions (assessment criterion 1.2), Member State interviews indicate that discussions and information shared in CNAPA feed into national policy discussions, although not necessarily directly: rather, CNAPA discussions provide valuable information that officials at national level can draw on.

In terms of the coverage of relevant areas of alcohol policy (assessment criterion 1.3), an analysis of documents presented at CNAPA meetings shows that these have covered all five priority themes of the EU strategy, with greatest attention given to the protection of young people, children and the unborn child and to the development of a common evidence base. Moreover, a number of other areas were covered, including the labelling of alcoholic beverages, pricing and taxation issues and alcohol and the elderly. A strong majority of CNAPA members perceived that all priority themes identified in the strategy had been covered to a great or

[34] http://www.who.int/substance_abuse/activities/globalstrategy/en/index.html.

to some extent, with one exception: prevention of alcohol related harm among adults and negative impacts at the workplace had received clearly less attention. In the AG workshop, participants by and large felt that the balance among priority themes had been appropriate, although children were mentioned as a target group that should receive more attention.

Regarding the balance of documents by administrative level (assessment criterion 1.4), more than half of documents presented at CNAPA focused on the EU level, and the second-highest share was at national level. Relatively few documents focus on the sub-national level; in the AG workshop, it was noted that more attention should be paid attention to work at local level.

In sum, the desk research and survey results together show that CNAPA meetings have provided extensive information on policies across most Member States; and the Committee has discussed documents and presentations related to the five themes of the EU strategy. The survey responses, interviews and the advisory group workshop all indicate that the information provided in CNAPA has been valuable for policy development in many Member States. CNAPA members identified several topics that deserve greater attention in the future. Moreover, while the EU strategy highlights the importance of local action in its implementation, this level has received relatively little attention in CNAPA.

3 Evaluation Question 2: To what extent has the CNAPA contributed to further policy development?

This evaluation question is articulated in four assessment criteria. Information was gathered through desk research, the survey, interviews and also in the AG workshop.

3.1 Assessment Criterion 2.1: Work within the CNAPA has contributed towards greater consensus on the most promising policies to reduce alcohol-related harm

Indicator	Research Techniques
2.1.1 References to CNAPA work within national reports presented to CNAPA	Desk research (follow-up in the Workshop)
2.1.2 Extent to which CNAPA members feel that the discussions have led to greater consensus	Interviews/Workshop

3.1.1 Indicator 2.1.1: References to CNAPA work within national reports presented to CNAPA

References to the work done within CNAPA in national reports presented at CNAPA meetings were few: only three citations were identified in the document analysis.

As with the lack of references to other Member States' policies (see above section 3.2.1.2) the explanation put forward in the AG workshop was that the focus in Member States' reports is on national developments, not on the inputs that may have contributed.

3.1.2 Indicator 2.1.2: Extent to which CNAPA members feel that the discussions have led to greater consensus

All the interviewees felt that discussions in CNAPA have contributed to a stronger consensus among its members '*on the issues and on what the evidence says*', as expressed by one. Several respondents, however, were quick to point out that consensus among CNAPA members representing the public health sector is not the same as consensus among Member States, as areas other than health also play an important role in alcohol-related policies.

Nonetheless, there is '*more of an understanding*' why certain measures are taken or not taken in different countries, one interviewee explained.

Several respondents cited specific areas they felt had seen greater consensus. These included issues and policies for:

- Early intervention in health services for alcohol-related problems identified in individuals
- Advertising and marketing of alcohol beverages
- Pricing of alcohol
- Alcohol and young people
- Alcohol and the elderly

A couple of interviewees also highlighted the importance of CNAPA in improving understanding of the dimensions of alcohol-related harm, including the links between alcohol and cancer.

While the distinction between consensus respectively within the Committee and among MS policies was also highlighted in the AG workshop, it was noted that CNAPA and the alcohol strategy more generally have brought the issue of alcohol-related harm onto the policy agenda across the EU.

3.2 Assessment Criterion 2.2: Work within CNAPA has contributed towards strengthening good practices (as per the alcohol strategy)

This assessment criterion uses one indicator, based on survey results and concerning the impact of each area of good practice identified in the EU Alcohol Strategy: consequently, the indicator is articulated in 15 sub-questions.

Indicator	Research Technique
2.2.1 Perceptions of impact of work within CNAPA on good practice / alcohol policy within Member States	Survey

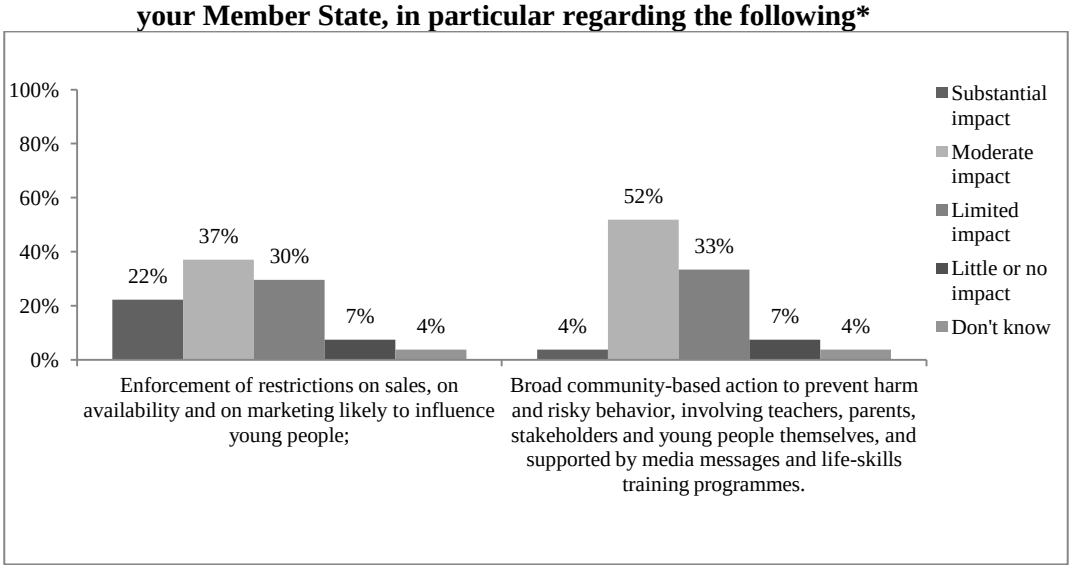
3.2.1 Indicator 2.2.1 Perceptions of impact of work within CNAPA on good practice/ alcohol policy within Member States

Survey questions asked CNAPA members to assess the impacts of the Committee's work across a large number of specific good practices. The responses indicate that CNAPA's work has had an impact, though this varies across the types of good practice.

Protecting young people, children and the unborn

For protecting young people, children and the unborn child, a range of good practices were highlighted in the alcohol strategy, grouped into two main areas: enforcement of restrictions on sales, availability and marketing likely to influence young people; and broad community action supported by media messages and life-skills training. For both areas, a majority of respondents indicated that CNAPA work had either a substantial or a moderate impact on the development of policies and good practices at national level. For broad community-based action, however, few respondents cited a substantial impact. It can also be noted that less than 10% of respondents indicated little or no impact for these two areas.

Figure 3 To what extent has work within CNAPA in the area of *the protection of young people, children and the unborn* had an impact on the development of policies and good practices in your Member State, in particular regarding the following*

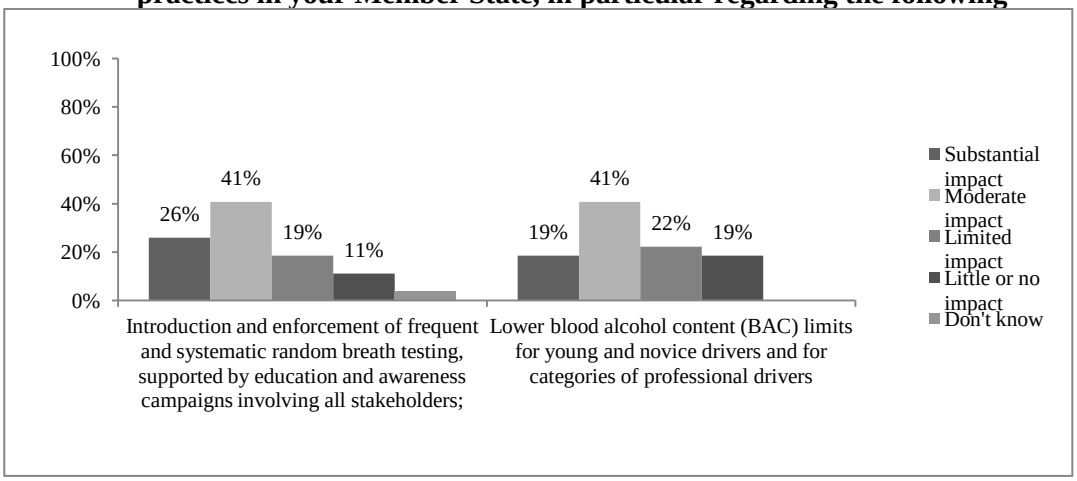


*n=27

Reducing injuries and death from alcohol-related road accidents

For reducing injuries and death from alcohol-related road accidents the alcohol strategy highlighted as good practices: the use of random breath testing for enforcement of blood alcohol limits, supported by awareness-raising; and lowering blood alcohol limits for young and professional drivers. For this priority theme, about 60% of respondents indicated a substantial or moderate impact on their Member State's policies or practices.

Figure 4 To what extent has work within CNAPA in the area of *the reduction of injuries and death from alcohol-related road accidents* had an impact on the development of policies and good practices in your Member State, in particular regarding the following*



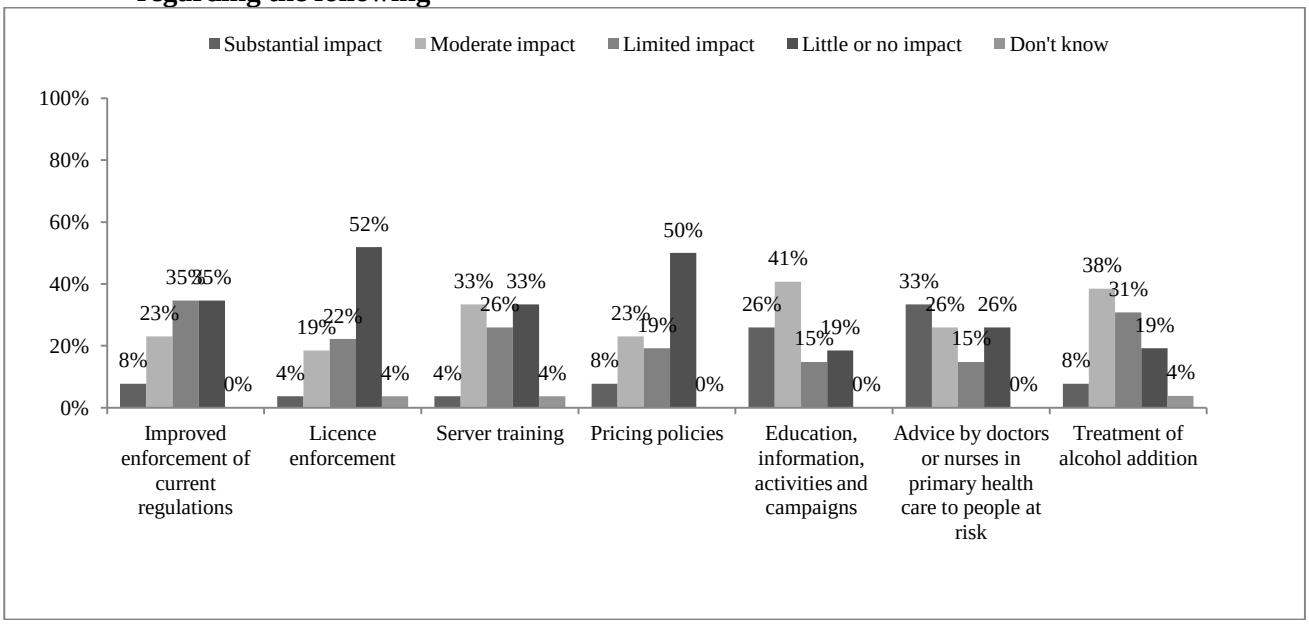
*n=27

Preventing alcohol-related harm among adults and reducing negative impacts in the workplace

For preventing alcohol-related harm among adults and reducing negative impacts in the workplace, a range of good practices were identified in the alcohol strategy, such as: better enforcement of current regulations; license enforcement and server training; pricing policies; provision of advice to people at risk and of treatment for alcohol addiction; and education and information activities to mobilise public support for interventions. Respondents' perceptions of impact vary between the good practice areas:

- A majority of CNAPA members indicated that the Committee's work had a substantial or a moderate impact on national policies and practices in the areas of *advice by doctors and nurses* and *education and information activities and campaigns*; for both areas, over 25% of respondents indicated a substantial impact.
- Nearly 40% of respondents said that work on *treatment of alcohol addiction* had a moderate impact; however, fewer than 10% referred to a substantial impact.
- In the other areas – *pricing policies, server training, license enforcement* and *improved enforcement* – fewer than 10% of respondents indicated a substantial impact and fewer than 35% indicated a moderate impact. In these areas, one-third to one-half of respondents reported little or no impact on policies or practices in their Member State.

Figure 5 To what extent has work within CNAPA in the area of *the prevention of alcohol-related harm among adults and the reduction of negative impacts in the workplace* had an impact on the development of policies and good practice in your Member State, in particular regarding the following*

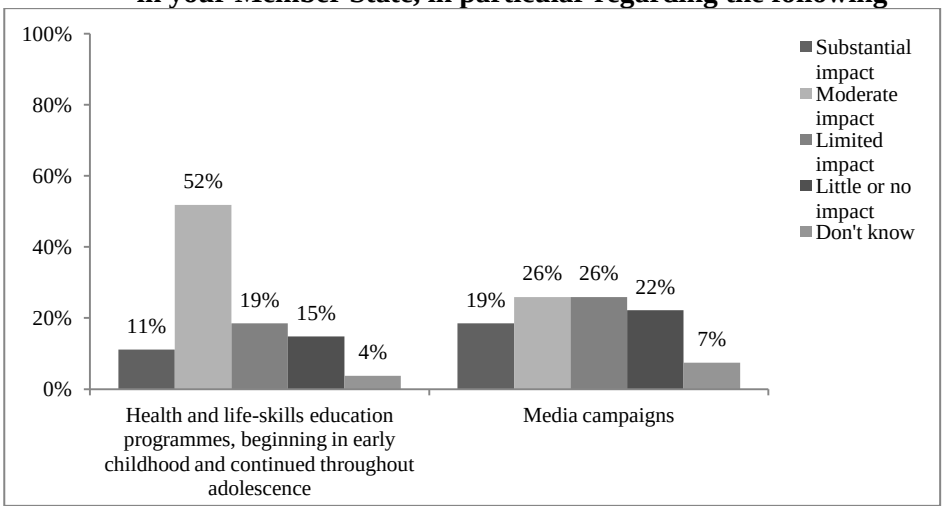


*n=27

Information, education and awareness-raising

For informing, education and raising awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns, the alcohol strategy identified as good practices health and life-skills education programmes for children and adolescents, and media campaigns to inform and raise awareness among citizens and to support policy interventions. For this priority theme, over half of respondents reported that CNAPA work on *health and life-skills education programmes* had a moderate impact on national policies and practices; however, only about 10% referred to substantial. On the other hand, 19% of respondents cited a substantial impact for *media campaigns*.

Figure 6 To what extent has work within CNAPA in the area of information, education and awareness-raising on the impacts of harmful and hazardous alcohol consumption, and on appropriate consumption had an impact on the development of policies and good practices in your Member State, in particular regarding the following*

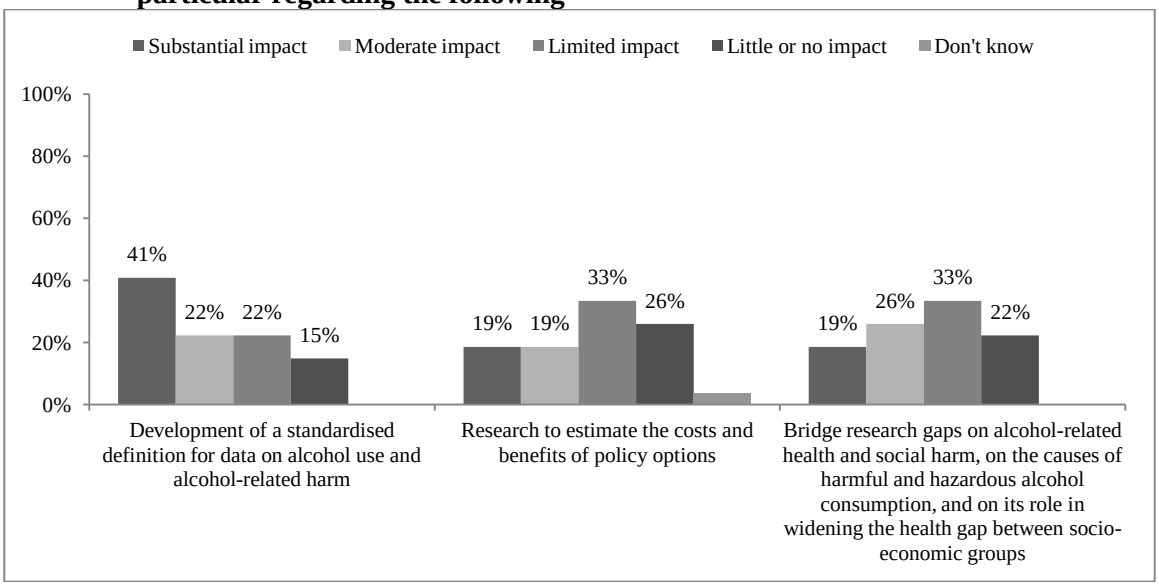


*n=27

Development of a common evidence base

For the development of a common evidence base the alcohol strategy identified as important areas of action: the development of standardised definitions; research to estimate the costs and benefits of policy options; and bridging research gaps relating to alcohol related hard, to the causes of harmful and hazardous drinking, and to the role of alcohol in health gaps between socio-economic groups.

Figure 7 To what extent has work within CNAPA in the area of the development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm had an impact on the development of policies and good practices in your Member State, in particular regarding the following*



*n=27

For this priority theme, 40% of respondents reported that work in CNAPA on a *standardised definition for data* had a substantial impact on policies and practices in their Member State. Responses were lower for the two other areas of good practice – *bridging research gaps* and *research to estimate costs and benefits of policies options*. In addition, over 20% of respondents indicated that work in these two areas had little or no impact.

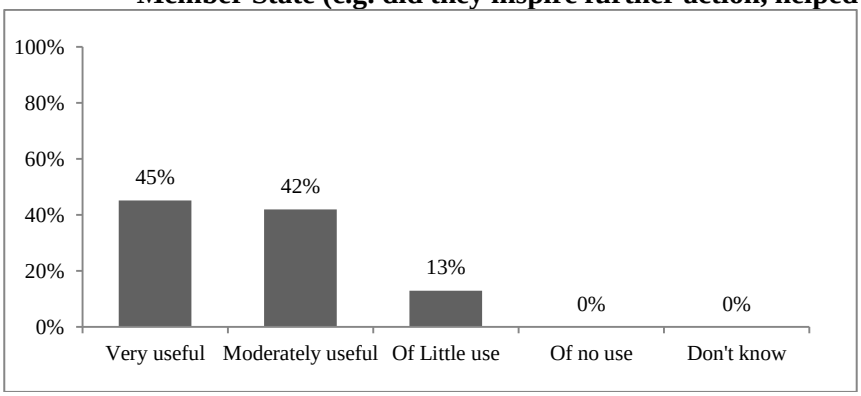
3.3 Assessment Criterion 2.3: Specific topics addressed in CNAPA have been the most relevant and useful

Indicator	Research Technique
2.3.1 Extent to which CNAPA members perceive that the topics addressed in CNAPA have been the most relevant and useful	Survey

3.3.1 Indicator 2.3.1 Extent to which CNAPA members perceive that the topics addressed in CNAPA have been most relevant and useful

A high number of survey respondents indicated that the topics addressed in CNAPA have been useful: 45% indicated that the topics have been very useful for their Member State; a further 42% indicated that they were moderately useful. No respondents stated that the topics were of no use or 'don't know'.

Figure 8 Have the topics addressed within CNAPA been useful for policy development in your Member State (e.g. did they inspire further action, helped you improve your work, etc.)?*



*n=29

3.3.2 Comments from the interviews

In the interviews, in general CNAPA members considered the topics that were the focus of work to be well chosen (see also indicator 2.12). The 'mini-seminars', focussed on topics of interest identified by Committee members, were in particular appreciated.

In the Advisory Group, the value of bringing experts and Commission officials from other policy areas was noted. This includes: related health areas, such as drugs and tobacco, where there can be cumulative impacts on health and for this reason and more generally an exchange of policy measures may be valuable; as well as areas beyond the health field.

One written comment from an EU15 member to the survey highlighted this point:

> '*Particular[ly] helpful I found presentations from other departments in DG SANCO or other DGs, to give information on ... the process ... on various topics directly linked to alcohol, but not necessarily happening in DG SANCO (like taxes etc.)*'

The box below provides an overview of the presentations from other DGs at CNAPA.

The interview respondents identified a few issues that they felt deserved greater attention. The following topics were mentioned:

- Alcohol and the workplace
- Protecting children from harm due to adults' drinking (considered to have received less attention than the other aspects of the strategy's first them, i.e. young people and the unborn child)
- Illegal/unregistered alcohol.

Presentations by other Commission services (i.e. other than DG Health and Consumers) to CNAPA meetings

According to CNAPA agendas, the following presentations have been made:

- Meeting no. 6 (Jan. 2010): DG Taxation and Customs Union, on the two EU Directives on alcohol excise duties adopted in 1992
- Meeting no. 7 (Sept. 2010): DG Justice, overview of the EU policy on illicit drugs; combined use of alcohol and illicit drugs
- Meeting no. 8 (Mar. 2011): Eurostat, on alcohol data collection activities
- Meeting no. 9 (Nov. 2011): DG Mobility and Transport, drink-driving in the context of the EU road safety policy, 'Policy orientations on road safety 2011-2020'
- Meeting no. 10 (April 2012):
    - DG Taxation and Customs Union, update on policy development regarding excise duties on alcohol, including the Commission proposals
    - Eurostat, coverage of alcohol in EU consumer price monitoring
    - DG Information Society and Media, 'State of play of the 1st report on the application of the Audiovisual Media Services Directive (AVMSD)'.

In total, five other DGs have made presentations to CNAPA.

3.4 Key findings for Evaluation Question 2

In their interview responses and also at the AG workshop, many CNAPA members stated that the Committee's work has led to a greater consensus among its members on a range of issues for alcohol-related harm (assessment criterion 2.1); however, they also emphasised that consensus among public health officials is not the same as a consensus among Member States, where policies are developed together with other sectors and government bodies and influenced by a range of stakeholders.

Regarding assessment criterion 2.2 on CNAPA's contribution to strengthening good practices, in survey responses, CNAPA members indicated that the Committee's work has contributed to Member State action across most of the good practices identified in the EU strategy, including standardised definitions for data on alcohol use and alcohol-related harm, followed by information and education activities, prevention of drink-driving and enforcement of restrictions and broad-based community action to reduce alcohol use among young people. (Several of these topics, including young people and drinking driving, are also highlighted above under Evaluation Question 1 as key areas where CNAPA has supported Member State polices.) However, CNAPA's role was seen as less strong for several good practice topics, in particular: enforcement, pricing policies, server training, media campaigns and the costs and benefits of policy options.

Moreover, more than 80% of CNAPA members considered the topics addressed within CNAPA to have been either very or moderately useful for policy development in their Member States (assessment criterion 3.3). The interview results confirmed that the topics in focus have been well chosen, although some were identified for greater attention. These included: alcohol and the workplace, protecting children from harm due to adult drinking, alcohol and the elderly, pricing and taxation and issues related to illegal/unregistered alcohol. Greater attention to cross-policy areas was called for.

In sum, the survey responses, interviews and comments in the AG workshop indicate that the Committee has played an important role in contributing to the development of Member State's alcohol policies, though its influence has varied across Member States. Nonetheless, only one interviewee considered national policies to be ahead of discussions at EU level. Several areas for greater attention were identified. Moreover, a stronger cross-policy approach to work on alcohol and health will be valuable.

4 Evaluation Question 3: What additional outputs of the CNAPA contribute to its added value as instrument at EU level?

4.1 Assessment Criterion 3.1: CNAPA has led to further outputs that contribute to coordination and further development of alcohol policies

Indicator	Research Technique
3.1.1 Additional outputs identified by CNAPA members and other stakeholders	Interviews/Workshop

4.1.1 Indicator 3.1.1 Additional outputs identified by CNAPA members

The work of the CNAPA has not led to concrete outputs, such as issuing Committee reports or statements. In the AG workshop, however, it was suggested that CNAPA go further and provide formal advice for policy making; it was also noted that the High-level Group on Nutrition and Physical Activity has done so. A concern was raised, however, that this could result in discussions over wording, taking time away from exchanges on thematic issues.

The AG workshop highlighted the role of CNAPA in fostering networking was highlighted as an additional output. The example was given of a topic discussed in CNAPA, brief healthcare interventions to address alcohol-related problems. After the meeting, one member wished to learn more and asked CNAPA colleagues for details on the approaches in their Member States.

The role of the informal network was then pursued in interviews. Nearly all interviewees (7 of 8) considered the network of CNAPA members an important source of information also between Committee meetings. CNAPA has lowered the threshold for contacting one or more members for specific information. As many information requests and replies are circulated to the full mailing list, it was noted that even without asking particular questions, CNAPA members may learn from the email exchanges.

The value of the network was recognised even by an interviewee who otherwise did not consider CNAPA to have had a strong impact on the development of national policies in their Member State: '*I quite often contact other CNAPA members individually*', the interviewee said, considering these contacts a valuable sounding board for policy issues.

4.2 Key findings for Evaluation Question 3

The responses highlighted CNAPA's role in creating an informal network of national officials involved in the development of public health policies on alcohol: this has been useful as a source of information and as a sounding board for policy issues. It could be useful to support this informal function of CNAPA.

5. Evaluation Question 4: What are the lessons learned regarding composition, focus and working methods, with a view to enhance effectiveness in achieving the objectives?

5.1 Assessment Criterion 4.1: The composition of the CNAPA are appropriate for its methods

Indicator	Research Technique
4.1.1 Perception of the appropriateness of representation in CNAPA	Interviews/Workshop

5.1.1 Indicator 4.1.1 Perception of the appropriateness of representation in CNAPA

CNAPA members' views of the composition of the Committee were explored in the interviews, including regarding the continuation of high-level meetings. A first high-level meeting was held in 2011, and a second will be held in autumn 2012.

Most (6) interviewees considered CNAPA's composition to have been largely appropriate.

One interviewee, however, regretted that some Member States do not have a stronger continuity in their CNAPA representation (in part due to several authorities having a direct role on alcohol policy). Another point made was that CNAPA includes a mix of policy makers, experts and scientists; while this is the choice of each Member State, stronger involvement of policy makers could strengthen CNAPA's overall policy influence.

Interviewees were asked about the value of high-level meetings: a first one was held in 2011, and a second will be held in autumn 2012. The idea of continuing meetings of higher-ranking officials was in general supported.

One respondent said that the first high-level meeting was considered '*useful inside our country*', and to have contributed to raise the profile for alcohol policy at national level. Half (4) of the interviewees supported the continuation of high-level meetings regularly, for example on a yearly basis, and interspersed with meetings in the ordinary composition.

While supportive of high-level meetings, other members also expressed some reservations. A point made was that higher-ranking representation by Member States should be matched with higher-level representation on the side of DG SANCO. Another interviewee said that a number of European meetings (organised by EU and WHO) are intended to be at high level; ensuring high-level participation in all of them may present a challenge for Member States. High-level CNAPA meetings should therefore be organised to address specific topics, such as discussion on a new strategy, rather than on a regular basis, this official concluded.

5.2 Assessment Criterion 4.2: CNAPA's working methods are appropriate for its goals

Indicator	Research Technique
4.2.1 Appraisal of CNAPA's working methods	Interviews/Workshop

5.2.1 Indicator 4.2.1 Appraisal of CNAPA's working methods

CNAPA's working methods were, by and large, found appropriate and the meetings well prepared. The recently introduced mini-seminars, focussed on specific themes of interest, as well as the circulation of information accompanying meeting summaries were considered very useful.

Ideas for further development were also put forward. Some form of regular overview of CNAPA's activities, such as a document to provide the '*whole picture*' on the Committee's work, was suggested. Greater confidentiality of meeting agendas was called for, so as to invite less lobbying attention.

5.3 Key findings for Evaluation Question 4

The CNAPA members interviewed were, by and large, content with the Committee's composition and working methods, which appear to have been appropriate. The mini-seminars should be continued as a mechanism to focus on thematic issues. Yearly overviews of CNAPA work will be useful.

The first high-level meeting was considered useful, and continuing such meetings was supported. Views were divided, however, regarding frequency. Holding yearly high-level meetings would appear appropriate if CNAPA is to take a stronger role, including in addressing cross-policy issues.

6 Evaluation Question 5: Has the work at EU level to develop alcohol data gathering and strengthen the knowledge base been useful from the MS perspective?

This evaluation question focusses on EU actions for the development of common indicators, data gathering and research to support the implementation of the alcohol strategy. EU-funded projects and research have also supported the development of the knowledge base: these are addressed under Evaluation Question 6.

6.1 Assessment Criterion 5.1: The development of common indicators and methods for comparative research has been helpful for MS

A Committee on Data Collection, Indicators and Definitions (CDCID) was established by the Commission for furthering the development of common indicators for monitoring and comparative data gathering. The Committee has two main objectives: first, to contribute to more reliable, comparable and regularly updated data on alcohol consumption, including both volume and drinking patterns, as well as on alcohol-related health harm; second, to develop common indicators enabling the monitoring of status and trends in alcohol consumption and alcohol-related harm to health.

In December 2008, the CDCID agreed on three key indicators for monitoring alcohol consumption and alcohol-related harm:

- Volume of consumption: Total yearly per capita (15 years+) consumption of pure alcohol.
- Pattern of consumption: harmful drinking measured by intake of 60+ grams of pure alcohol on one occasion, monthly or more often, during the past 12 months.
- Alcohol-attributable health harm: Alcohol-attributable years of life lost, with chronic and acute conditions as sub-indicators.

The committee identified, from among existing sources of comparative data, further indicators relating to the priority themes of the alcohol strategy. Data gaps and the need for work to develop further indicators were noted. The Committee's remit was limited to identifying indicators.[35]

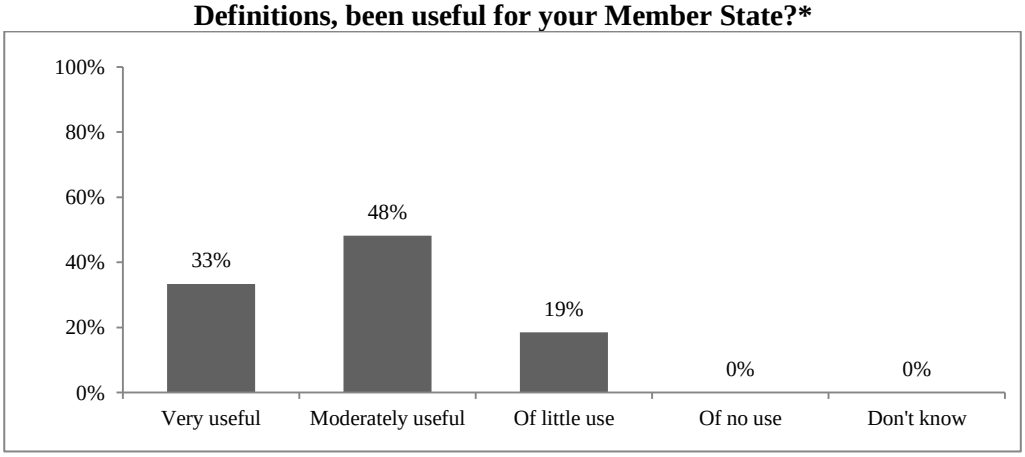
The work of the CDCID was presented and discussed CNAPA meetings, including in a mini-seminar which brought together different strands of work to advance comparative data gathering and monitoring.

Further work in this area has been carried out including through an EU funded project for Standardizing Measurement of Alcohol Related Troubles (SMART).[36] A collaborative project between Member States, ESPAD (European School Survey Project on Alcohol and Other Drugs), has gathered data on youth alcohol consumption.[37]

Indicator	Research Technique
5.1.1 Extent to which MS representatives feel that the development of common indicators and methods for comparative research has been helpful	Survey Interviews/Workshop

[35] European Commission (DG SANCO), Report on the work of the Committee on Alcohol Data, Indicators and Definitions, February 2010. http://ec.europa.eu/health/indicators/committees/alcohol_subindicators_draft_6_2010-02-22.pdf.
[36] http://www.alcsmart.ipin.edu.pl/index.html
[37] http://www.espad.org/

Figure 9 Has joint work on the development of common indicators and methods for comparative research, including the work of the Committee on Alcohol Data, Indicators and Definitions, been useful for your Member State?*



*n=27

6.1.1 Indicator 5.1.1: Extent to which MS representatives feel that the development of common indicators and methods for comparative research has been helpful

One-third of the responses to the online questionnaire indicate that work for the development of common indicators and methods for comparative research has been very useful for their Member State; in addition, almost one-half reported that this work has been moderately useful (48.15%). However, almost 20% responded the work done has been of little or no use.

6.1.2 Workshop and interview results on common indicators

The discussion in the AG workshop noted difficulties in the adoption of common indicators. Notably, for Member States that previously gathered data on alcohol-related harm, a switch to the indicators proposed by the CDCID could result in a break in historical data. Nevertheless, an example of the implementation of recommended common indicators at national level was highlighted.

In the interviews, the development of common indicators was considered useful by EU12 respondents, even '*one of the most valuable areas*' of EU work to implement the strategy, even though some national capacity problems have arisen in adopting the common indicators related to the establishment of a new type of data collection.

In contrast, existing national data sets and the loss of their time series was mentioned by several EU15 respondents as a challenge in the adoption of common indicators, although an example of collecting data for both national and EU indicators was also mentioned.

In the CNAPA Advisory Group, there was call for a permanent body, for example Eurostat, to take the lead in the work on common indicators; a role for the European Monitoring Centre for Drugs and Drug Addiction, EMCDDA, was also proposed. Interviewees made further suggestions to address these problems: continuing work towards common definitions (e.g. the definition of a standard drink); establishing national focal points for alcohol data, as is done for data on illicit drugs; further cooperation with WHO to put in place common indicators.

6.2 Assessment Criterion 5.2: Collaboration between the EC and the WHO to develop joint data gathering has been helpful for Member States

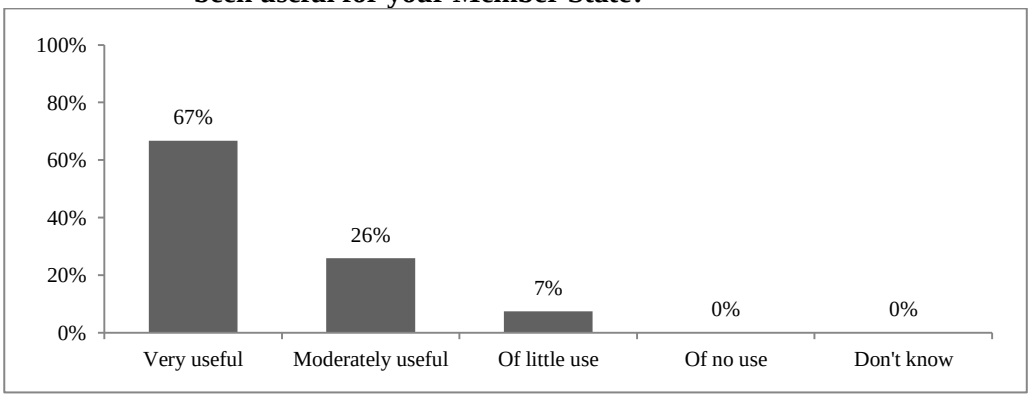
Indicator	Research Technique
5.2.1 Extent to which MS representatives feel that collaboration between the EC and the WHO to develop joint alcohol data gathering has been helpful	Survey

6.2.1 Indicator 5.2.1: Extent to which MS representatives feel that collaboration between the EC and the WHO to develop joint alcohol data gathering has been helpful

Starting from 2007, DG SANCO has collaborated closely with the WHO Regional Office for Europe to develop a common alcohol information system, including joint surveys (2008, 2011, 2012) to monitor trends in alcohol consumption, alcohol-related harm and alcohol policy development in the EU and in the wider Europe.

The CNAPA members' survey responses show that two-thirds of respondents feel that collaboration between the EC and the WHO to develop joint alcohol data gathering has been very useful, while 25% deem the collaboration moderately useful.

Figure 10 Has joint work on data gathering between the European Commission and the WHO been useful for your Member State?*



*n=27

6.3 Key findings for Evaluation Question 5

About 80% of the CNAPA survey respondents felt that work for the development of common indicators, including through the CDCID, has been useful (assessment criterion 5.1). Nonetheless, implementation in the Member States has been slow. The AG workshop and the interviews identified capacity issues as well as a reluctance to give up existing data gathering schemes in EU15 among the challenges. Identifying a permanent body at EU level such as Eurostat to take the lead in this work, as well as the designation of national focal points were among the proposals made to address this issue.

Two-thirds of survey respondents felt that the joint work on data gathering between the European Commission and WHO had been useful for their Member State (assessment criterion 5.1): this cooperation should continue, and could support efforts to improve data gathering.

In sum, work in this area, identified as a priority under the EU alcohol strategy, remains incomplete and calls for a more structured approach.

7 Evaluation Question 6: Have EU-funded projects and research on alcohol been relevant from the MS' perspective?

Projects and research relevant to the development of policies and measures to prevent alcohol related harm have been financed primarily via the EU health programme (Public Health Programme 2003-2008 and

Health Programme 2008-2013) and via the EU research framework programmes under DG Research and Development (FP6 2002-2006 and FP7 2007-2013).[38]

The EU health programme deploys various funding instruments including project grants, grants for organising conferences, operating grants, tenders for commissioned studies, and joint actions. Since 2007, the EU health programme has supported alcohol related projects with approximately EUR 9 million. This represents less than 3% of the total budget of the programme for 2008-2013, EUR 321 million.[39]

Since 2007, approximately EUR 49 million has been granted under the EU research framework programme for research on alcohol and health; major projects funded earlier include DRUID with EUR 19 million. The EUR support provided since 2007 through mid-2012, 49 million, represents less than 1% of the FP7 Programme's budget for health.[40]

The CNAPA meetings have included regular updates on funding decisions and progress of alcohol related projects.[41] Several projects and studies have been presented in detail in CNAPA meetings with the aim of promoting further policy development, and providing good practices, evidence or guidance.

7.1 Assessment Criterion 6.1: The topics of EU-funded projects and research on alcohol have provided good practices, evidence and guidance for the development of actions and strategies to reduce alcohol-related harm

Indicator	Research Technique
6.1.1 Review of EU-funded projects and research by topic and no. that have provided good practices, evidence or guidance	Desk research
6.1.2 Perception that the topics of EU-funded projects have provided good practices, evidence and guidance	Survey Workshop / Interviews

7.1.1 Indicator 6.1.1 Review of EU-funded projects and research that have provided good practices, evidence or guidance

This section is separated into two parts. The first part looks at alcohol related projects and studies that have received funding under the EU health programme during 2007-2011. The second part looks at alcohol and health related research projects financed through the EU research framework programmes in the same period.

Projects and research under the EU health programme

Table 10 below follows an overview of relevant projects, commissioned studies and conferences that have received funding in 2007-2011. Operating grants are excluded; no joint actions were funded in that period. Projects started before the launch of the EU alcohol strategy are included if they have continued to receive funding in the strategy's period of implementation. Where there is continuity of action from projects financed before the launch of the strategy, the previous project is also mentioned along with its follow-up. Some projects are not alcohol specific but address alcohol, at least to some extent, in the context of broader health topics, including the use of illicit substances.

[38] Projects related to alcohol as a public health issue have to some extent been carried out under further EU funding programmes (for example the Daphne III programme to prevent violence). The examination here is limited to the Health Programme and the research framework programmes.
[39] Total budget based on DG SANCO: http://ec.europa.eu/health/programme/policy/2008-2013/index_en.htm The calculation does not include alcohol-related projects that may be funded in the last year of the programme.
[40] European Commission, Health Research in FP7: The Basics, 2010, available at: ftp://ftp.cordis.europa.eu/pub/fp7/docs/health-research_leaflet_en.pdf
[41] Summary Report, CNAPA Meeting 3, European Commission, October 2008.

Table 10 Alcohol related projects, studies and conferences that have received funding under the EU health programme in 2007-2011

Project/study title and period	Identifying Best/good practice	Training and manuals	Evidence (esp. results of practices)	No. of CNAPA meetings where discussed/cited
Protection of young people, children and the unborn child				
APYN: Alcohol Policy Youth Network (2008-2010)		✓	✓	3
ChAPAPs: Children affected by Parental Alcohol Problems (2006-2009)				1
CLUB HEALTH (2009-2012)		✓	✓	1
EUDAP I and II—European Drug Addiction prevention trial (2003-2005 & 2009-2011)		✓	✓	2
Healthy Nightlife Toolbox (2006-2010)		✓	✓	1
Kinship Carers (2007-2010)	✓		✓	1
PROTECT (2009-2012)			✓	5
TAKE CARE: Strategies towards responsible alcohol consumption for adolescents in Europe (2009-2012)	✓		✓	2
Ten D by Night (2007-2009)				1
Reduction of injuries and death from alcohol-related road accidents				
HEROES (2007-2010)		✓	✓	
PEER Drive Clean (2006-2008)				
PHP, Pathways for Health Project (2005-2007)	✓			
Prevention of alcohol-related harm among adults and reduction of the negative impacts on the workplace				
EWA European Workplace and Alcohol (2009-2012)				2
FASE Focus on Alcohol Safe Environment (2007-2010)	✓	✓		4
PHEPA and PHEPA II: Primary Health Case European Project on Alcohol (2003-2005 & 2006-2009)		✓	✓	
Information, education and awareness-raising on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns				
ENHR II: Report on nutrition and health status (2006-2009)			✓	1
Development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm				
DYNAMO-HIA (2006-2010)		✓	✓	1
SMART—Standardizing Measurement of Alcohol Related Troubles (2007-2010)			✓	4
EISAH: European Information System on Alcohol and Health WHO EURO: development of alcohol information system (2008-2012)	✓	✓	✓	2
Other areas				
Policy development and implementation				
4th European Alcohol Policy Conference 2009			✓	2
Building Capacity (2006-2010) and Bridging the Gap (2004-2006)		✓		
Alcohol and the elderly				
VINTAGE (2008-2010)	✓		✓	5
Treatment of people with alcohol- and drug-related problems				
IATPAD: Improvement of Access to Treatment for People with Alcohol and Drug Related Problems (2006-2009)		✓		3
Marketing of alcoholic beverages				
AMMIE: Alcohol Marketing Monitoring in Europe (2009-2011)		✓	✓	5
ELSA: Enforcement of national Laws and Self-regulation on advertising and marketing of Alcohol (2005-2007)		✓	✓	

Project/study title and period	Identifying Best/good practice	Training and manuals	Evidence (esp. results of practices)	No. of CNAPA meetings where discussed/cited
HAPI: EU-wide overview of the market and regulation regarding types of alcoholic beverages with potentially particular appeal to minors (2012)			✓	1
Affordability of alcoholic beverages				
RAND Europe: The affordability of alcoholic beverages in the European Union (2009) & Further study on the affordability of alcoholic beverages in the EU (2012)			✓	2

The table indicates whether projects have identified good or best practices, provided training and manuals or presented evidence on the results of measures and practices. The number of CNAPA meetings in which a project has been presented or cited is also indicated. The actions are grouped according to the priorities identified in the EU alcohol strategy (several projects cover more than one priority; however, each is only counted in its area of primary focus).

Based on this analysis, out of the 27 projects reviewed in the section:

- 6 have provided good/best practices for reducing alcohol-related harm;
- 13 have prepared training and manuals; and
- 19 have provided evidence concerning best/good practices.

Projects under the EU research framework programmes

Table 11 below summarises the results of desk research carried out to understand the types of support for the implementation of the EU alcohol strategy provided by projects financed under the EU research framework programmes. The examination is focussed on projects that address alcohol related harm from a public health perspective.[42] The relevant projects have been carried out under the 7th framework programme (FP7) with one exception: project DRUID (2006-2010), which focussed on driving under the influence of alcohol, illicit drugs and medicines, was granted funding under the 6th framework programme (FP6).

Table 11 Projects related to alcohol and health (as a public health issue) that have received funding under the EU framework programmes in 2007-2011:

Project/study title and period	Identifying good/best practice	Training and manuals	Evidence (esp. results of practices)	No. of CNAPA meetings where discussed/cited
Protection of young people, children and the unborn child				
AAA-PREVENT (2010-2012)		✓	✓	
RICHE research project on child health (2010-2013)		✓	✓	
Reduction of injuries and death from alcohol-related road accidents				
DRUID: Driving under the Influence of Drugs, Alcohol and Medicines (2006-2010)		✓		1
Other areas				
Alcohol and the elderly				
CHANCES (2010-2015)				
Brief interventions for alcohol use disorders				
ODHIN: Optimising delivery of healthcare interventions (2011-2014)				
Cross-cutting				
ALICE RAP: Addictions and Lifestyles in Contemporary Europe, Reframing Addictions Project (2011-2016)				
AMPHORA: Alcohol Measures for Public Health Care European Project on Alcohol (2009-2012)	✓	✓	✓	1

[42] Biological and biomedical research focussed for example on alcohol and cancer or alcohol and liver disease are excluded.

The projects are grouped according to the priorities identified in the EU alcohol strategy (projects are only identified for the primary area of focus). Here as for the previous table, their provision of best/good practice, training and manuals and evidence is highlighted. The number of CNAPA meetings in which a project has been presented or cited is also indicated.

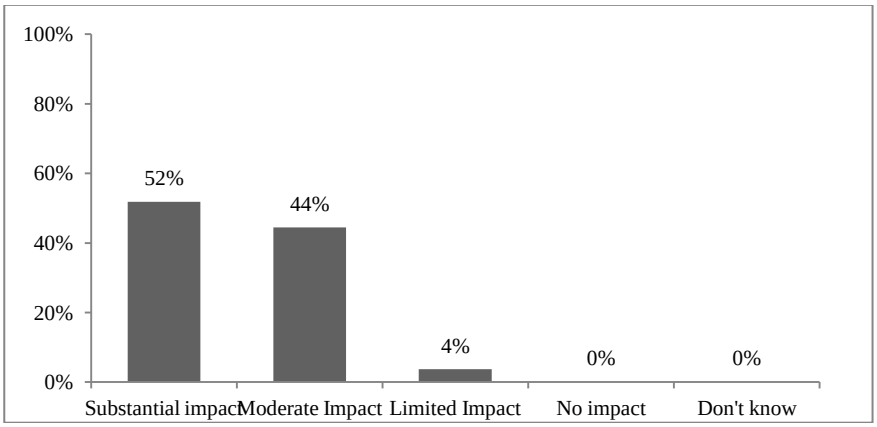
Based on this analysis, out of the 7 FP6 and FP7 projects:

- One has provided good/best practices for reducing alcohol-related harm;
- Four prepared training and manuals and a fifth plans to do so; and
- Three have provided evidence concerning best/good practices.

7.1.2 Indicator 6.1.2: Perception that the topics of EU-funded projects have provided good practices, evidence and guidance

Over 50% of survey respondents indicated that EU-funded projects and research had contributed substantially to the availability of good practices, evidence or guidance to help reduce alcohol-related harm; a further 44% indicated that their contribution has been moderate.

Figure 11 How would you assess the contribution of EU funded projects and research on alcohol to the availability of good practices, evidence or guidance on how to reduce alcohol-related harm?*



*n=27

In the interviews, all but one respondent mentioned having made use of outputs of EU projects at national level. Evidence provided by EU projects feeds into national policy discussions: for example, one CNAPA member explained that all EU project results were assessed in the revision of the national alcohol policy.

The interview respondents mentioned several specific topics where input from EU-funded projects or research was valuable. These included: labelling of alcoholic beverages; brief interventions in health services; alcohol and the workplace; advertising; and alcohol and young people.

It was, however, noted in the AG workshop that in some areas there is a lack of continuity and follow-up for studies, with alcohol and the elderly and alcohol-related harm in the workplace mentioned as examples, although it was recognised that researchers' choices of topics also play a role. Greater cross-fertilisation between research projects on alcohol-related harm was also called for. In addition, in written comments to the survey, one respondent suggested that CNAPA should have a stronger role in identifying areas for research.

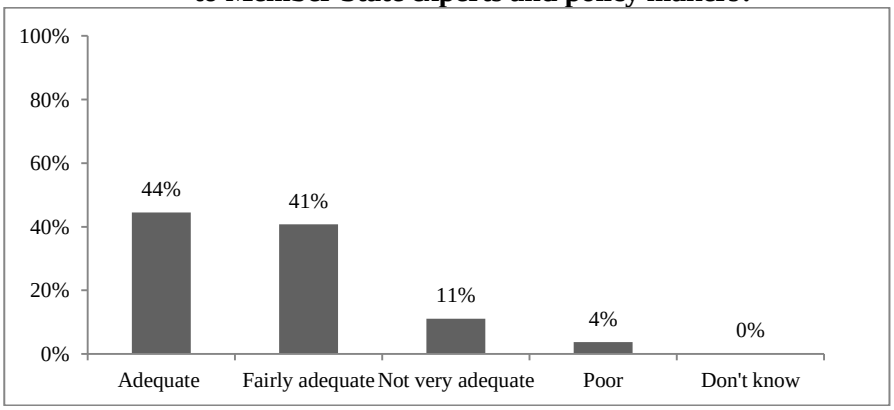
7.2 Assessment Criterion 6.2: The results of alcohol related EU-funded projects and research have been adequately disseminated to MS experts and policy makers

Indicators	Research Technique
6.2.1 Perception that that the results have been adequately disseminated to MS experts and policy makers	Survey

7.2.1 Indicator 6.2.1: Perception that the results have been adequately disseminated to MS experts and policy makers

The survey responses indicated that the dissemination of results from EU-funded projects and research to MS experts and policy makers has been adequate (44%) or fairly adequate (41%). Nevertheless, gaps in the dissemination seem to exist, as 15% found the dissemination not very adequate or poor.

Figure 12 How would you assess the dissemination of EU-funded projects and research on alcohol to Member State experts and policy makers?*



*n=27

The AG workshop brought further light to this issue. CNAPA meetings were considered a good channel for disseminating results from EU-funded projects. It was highlighted that national officials do not otherwise receive detailed information on projects, unless their Member State is directly involved via national institutions. Suggestions for improving dissemination were put forward, such as the creation of a database of research findings, and a requirement for research projects to consider the science/policy interface and disseminate results to policy makers.

7.3 Key findings for Evaluation Question 6

The desk research shows that EU-funded projects and research have provided a range of evidence, training materials and good/best practices for addressing alcohol-related harm. All priority themes of the EU alcohol strategy have been covered, as well as topics not explicitly mentioned in the strategy, such as alcohol and the elderly and the affordability of alcoholic beverages. Both the survey and interviews indicate that evidence provided by EU projects has been valuable for national alcohol policy discussions (Assessment Criterion 6.1).

In sum, the results from the different sources of evidence show that EU-funded projects and research have been an important element of the implementation of the EU alcohol strategy, and valuable for policy development in many Member States.

Information on EU-funded projects and research has been provided in CNAPA meetings, although to a lesser extent regarding projects under the research framework programme. While CNAPA members are largely satisfied with this approach, so far, CNAPA meetings have been the main channels, and CNAPA members the main interface, for disseminating information to national officials. Further approaches for dissemination would be valuable.

8 Overview and discussion

This section draws together and discusses the results for the individual evaluation questions, also taking into account input from workshop meetings with the Advisory Group. In doing so, it first reviews the strengths and weaknesses of the evidence base. The discussion also considers key links with results from the other two tasks of the assessment, on EAHF and on the EU strategy overall.

Strengths and weaknesses of the evidence base

The evidence gathered for Task 1 has both strengths and weaknesses (see also section 2.2 and Annex 12). First, the survey had a good response rate, with replies from at least 21 Member States. However, it is possible that the minority of non-responding members had different opinions than those presented here. Second, resources for interviews were focused on EAHF: as a result, the number of interviewed CNAPA members is small, though the CNAPA advisory group meetings brought in further perspectives. Together the interviews and AG discussions (which between them involved experts from 14 Member States) elaborate on the most part of key topics covered by the survey.

A further issue is whether the main source of information, CNAPA members, has an inherent bias. For example, participants might exaggerate their own role and that of the Committee. While this is hard to judge, it should be noted that in interviews, CNAPA members explained that links between Committee's work and Member State policies are indirect. Here and more generally for Task 1 results, it is valuable to compare the results to those of the EC/WHO survey on Member State policies, presented in Task 3: the EC/WHO work shows that Member States introduced a range of policy measures to address alcohol-related harm in the past five years. These results support the responses of CNAPA members that the Committee and the EU strategy more generally have supported Member State policy development.

The different sources of evidence complement and validate each other. The survey results were presented to the CNAPA Advisory Group, which found them credible and overall in line with members' experiences and observations. The desk research is consistent with survey results in overlapping or linked areas.

Overview of key results

The evidence shows that CNAPA has *contributed to further coordination of alcohol policy development*, including through exchange of information. Extensive information has been provided on policies and policy processes and most Member States have been covered. Thematic discussions have moved forward policy understandings.

Several specific themes and topics would deserve greater attention, such as alcohol-related harm experienced by children. Relatively little attention has been devoted in CNAPA discussions to work at local or regional levels. This is a gap, as the EU strategy notes that national strategies could be more effective if supported by local and community based activities. Moreover, the local and regional levels of government do not participate in either of the two main instruments for implementing the EU strategy, CNAPA and EAHF (EAHF members nonetheless carry out many commitments at local level). One mechanism for engagement could be via the EU Committee of the Regions (included among the observers of the EAHF but not participating actively): this body discussed the Commission's proposal for the EU alcohol strategy, but has not been engaged in CNAPA's work. Other approaches could also be considered, including in the context of EAHF (this topic is discussed further in Task 2).

CNAPA has also *contributed to further policy development* in Member States. Here in particular, the survey and interview conclusions are supported by the results of the EC/WHO survey (see Task 3), which maps out policy developments across Member States and in Norway and Switzerland.

CNAPA discussions have contributed to a stronger consensus among its members on alcohol policy. While CNAPA members all represent the health sector, at Member State level a broader range of government sectors and stakeholders participate in policy discussions: here, the development of consensus has been slower. These results highlight a key issue: the importance of engaging with other policy areas, such as

taxation, in moving forward on alcohol-related policies. CNAPA has started to do so, with presentations from other Commission services but clearly more remains to be done to engage with other policy areas both at national level and at EU level. Inviting representatives of other Ministries to discuss cross-sector issues in thematic CNAPA meetings was suggested and supported as one approach.

Seeking links and synergies with policies addressing other health risk factors will also be valuable. Chronic non-communicable diseases are responsible for the overwhelming majority of ill health and early deaths in the EU. The WHO's 2008-2013 *Action plan for the global strategy for the prevention and control of noncommunicable diseases*[43] identifies alcohol as one of the four main risk factors for non-communicable diseases, along with tobacco, diet and physical inactivity. In several Member States, alcohol policies are part of broader public health policies that cover broader risk factors or address a wider range of substances, such as tobacco and illegal drugs. There may be synergies and lessons learned that can be shared across these areas; moreover, for some population groups risk factors and health problems tend to cluster. A further area highlighted in particular in the CNAPA Advisory Group concerns addictions in the context of the prevention and treatment of wider psychiatric disorders.

In general, CNAPA members felt that the Committee's *working methods* were appropriate for its role. It should be noted that the Committee's working methods have undergone an evolution. Indeed, in interviews, members praised the introduction of 'mini-seminars' focused on specific themes as well as the involvement of other DGs in discussions on cross-sector topics. A further step suggested and supported would involve outlining a clearer roadmap of directions and working methods.

An unplanned but positive output of the Committee's work has been the emergence of *an informal network* among CNAPA members, which has provided an additional channel for sharing information and has functioned as sounding-board in policy development.

As regards the *composition* of the Committee, which includes a mix of policy makers, experts and scientists, policy-maker participation from a yet larger number of Member States could raise the Committee's profile.

A related issue concerns *high-level meetings* of CNAPA, which started with a first high level meeting, in 2011. While there is broad support from members for the continuation of high-level meetings, balancing regularity and feasibility is necessary, as it was pointed out that gathering high-level officials to regular yearly meetings might not be possible. An alternative that received wide support is to organise high level meetings only when high level involvement would help move forward on strategic issues.

High-level meetings would, however, raise the profile of the Committee, and thereby the political weight of the EU alcohol strategy, and would help engage other policy areas. It can be noted that the EU body addressing diet issues has evolved from a network of experts into a High Level Group on Nutrition and Physical Activity, which convenes with technical participation, and this could provide a model for CNAPA.

While CNAPA thus far has not issued reports or statements, high-level meetings could provide a framework for that. The Advisory Group highlighted, however, that aiming at political statements would profoundly change the nature of the meetings and of the Committee. Instead, other approaches for fostering consensus on priority issues were suggested, such as supporting consensus conferences or addressing key issues one at the time in the context of Presidency agendas.

CNAPA members strongly feel that the work to *develop the evidence base, common indicators and alcohol data gathering* has been useful. Common approaches in monitoring and comparative data is seen of crucial importance but at the same time complexities and challenges are involved that hamper progress. Even though incomplete, current data is valuable and existing cross-country statistics help put national data into perspective and provide arguments for national action.

At EU level, however, the lack of timely, cross-country data for common indicators hinders assessment of the impacts of the EU strategy: this is seen in Task 3, the assessment of the EU strategy overall.

[43] Available at: http://www.who.int/nmh/publications/9789241597418/en/index.html

Consequently, bringing forward work in this area is an important objective for the EU and one that will support Member State policies as well.

Among the obstacles have been, in the EU12, a lack of capacity to put in place new methods and indicators has been a problem; in the EU15, concern that the adoption of common indicators will entail loss of historical data for national indicators.

One factor is that CNAPA members are usually not the ones responsible within their Member States for health statistics: thus, a broader set of actors needs to be engaged to bring this work further. At EU level, Eurostat could play an important role; indeed, Eurostat currently collects certain data on alcohol-related deaths (presented in Task 3). Recently, the EMCDDA has taken responsibility for the regular Europe-wide survey of substance use among teenagers, and this organisation could also play a role. The designation of national focal points for alcohol data, to take forward work on common approaches, would also be an important step forward.

EU-funded *projects and research* have been an important component of the EU strategy overall. They have covered all five priority themes as well as several topics that go beyond the priorities identified at the launch of the strategy in 2006, such as alcohol and the elderly. There was broad agreement among CNAPA members about the value of the evidence and good practices provided by these projects for their Member States.

While most CNAPA members felt that the dissemination of the results of EU-funded projects has been adequate, there was also a degree of dissatisfaction. CNAPA members themselves are one of the main interfaces providing project results to national policy discussions. Further channels for disseminating results could be considered, such as use of the DG SANCO's web-based Heidi-wiki tool.[44] A strong message in the advisory group was that EU-funded projects and research are an investment and their outputs should feed in policy processes.

Improving the interface between science and alcohol policy more generally could help to strengthen implementation of the EU strategy. Here, a broader role for the Science Group, currently under EAHF, may provide a mechanism. This topic is discussed further in Task 2.

In light of these results, the next section puts forward a number of suggestions to enhance the work of CNAPA.

9 Enhancing the work of CNAPA

Despite policy developments in recent years, alcohol-related harm continues to an important health and economic burden in the EU. Therefore, a range of policy measures could be strengthened. Moreover, CNAPA, and thereby the implementation of the EU strategy, could benefit from enhanced *political visibility*. CNAPA's work could also be strengthened through improvements to its approach and working methods, to support better *consistency and continuity.*

Possible ways to enhance political visibility

- Involve and foster interaction with relevant policy areas beyond public health through greater participation, as appropriate, of other Directorates-General and other Ministries in mini-seminars and Committee meetings, including high-level meetings.
- Organise regular high-level CNAPA meetings to address strategic issues.
- Link CNAPA's work to the EU Presidency agendas by inviting as co-chair the Member State holding the Presidency in the Council.
- Support work toward greater consensus on priority issues, for example, in the context of consensus conferences of the formulation of Presidency agendas.

[44] See: https://webgate.ec.europa.eu/sanco/heidi/index.php/Main_Page

- Seek greater interaction with other policy areas was strongly supported in the CNAPA advisory group's discussions, and members saw this as an important way forward for the Committee.

Possible ways to enhance consistency and continuity

- Outline a multi annual work plan for CNAPA, identifying priority topics and ways to move forward.
- Produce a brief, yearly report from CNAPA to highlight key developments, to summarise activities and to present the next work plan.
- Continue to focus on key topics and themes through mini-seminars and, as appropriate, *ad hoc* reports.
- Encourage members to nurture and make use of the informal network of experts formed by the national officials involved in CNAPA's work.
- Strengthen links and seek synergies with other relevant policy areas, including the prevention of chronic non-communicable diseases where hazardous alcohol consumption is among the main risk factors as well as the prevention and treatment of addictions and psychiatric disorders.

Annex 2: Assessment of European Alcohol and Health Forum (EAHF) – Task 2

This Annex presents detailed findings for Task 2, the assessment of the contribution of the EAHF to promoting dialogue and mobilising action for implementing the EU alcohol strategy.

1 Assessment aims and evaluation framework

1.1 Aims of Task 2

The aim of Task 2 is to assess EAHF as an instrument and process for implementing the EU alcohol strategy, including the extent, nature and potential of members' commitments.

The evaluation questions guiding this assessment look at the extent to which the EAHF process has mobilised relevant stakeholders to action and promoted dialogue and cooperation among them. Moreover, concrete actions resulting from Forum members' commitments as well as cross-fertilisation of other instruments of the EU alcohol strategy are a key focus in this task.

1.2 Evaluation framework

The terms of reference set out seven *evaluation questions* for Task 2; these are elaborated in terms of *assessment criteria.* The inception report, agreed with DG SANCO, identified one or more *indicators* for each criterion, along with the research techniques to be used. The table below presents this approach. As can be seen, the assessment is based on:

- Desk research;
- Responses to an online survey of EAHF members; and
- Interviews with EAHF members.

Moreover, it draws on inputs provided in the workshop with the EAHF Advisory Group (25th April 2012). The research techniques are described further in section 4.1.3. Table 12 below sets out the evaluation framework for Task 2.

Table 12 Evaluation framework for the EAHF assessment

Evaluation question	Assessment criteria	Indicators	Research Techniques
1. To what extent has the EAHF process been effective in mobilising stakeholders and stepping up action to reduce alcohol related harm?	1.1 The scope of the EAHF membership is optimal for generating and stepping up action in relevant sectors	1.1.1 No./share of Forum membership by sector and Member State (2009-2011) 1.1.2 Perception that membership is appropriate	Desk research Workshop / Interviews
	1.2 The membership in the EAHF has inspired new or substantially revised action	1.2.1 No. of commitments by year and membership sector 1.2.2 Perception that the membership has led to new or substantially revised action	Desk research Interviews
	1.3 Commitments are consistent with the aims of the alcohol strategy	1.3.1 No./share of commitment by Forum action area (taking into account qualitative aspects such as geographic coverage)	Desk research
	1.4 There has been progress towards a transparent, participative and	1.4.1 Progress in monitoring scores 1.4.2 Perception that monitoring has	Desk research Survey

Evaluation question	Assessment criteria	Indicators	Research Techniques
	accountable approach to monitoring	seen progress	
2. To what extent has the EAHF process been effective as a platform for dialogue, exchange and cooperation?	2.1 Participation in the EAHF process has contributed to deeper understanding of the issues addressed and of views and positions involved	2.1.1 Perceived understanding of the issues by Forum members	Survey
	2.2 The EAHF process has helped develop further cooperation between stakeholders	2.2.1 Perceptions of EAHF process	Interviews
	2.3 The EAHF process has contributed to the exchange and promotion of good practices	2.3.1 Perception by Forum members that the process has brought to light useful elements that can be applied in their own field	Survey
	2.4 The Open Forum has been successful in showcasing members' activities and engaging a wider range of stakeholders in discussion	2.4.1 Perception of Open Forum	Survey
		2.4.2 External participation at the Open Forum: no. and type of external participants	Desk research
3. To what extent has the EAHF process contributed to the development of responsible business practices across the EU in the sales and marketing of alcohol beverages?	3.1 Economic operators have carried out, in relation to their membership in the Forum, actions (commitments) focused on responsible practices in the sales of alcoholic beverages	3.1.1 No./share of economic operator participants whose commitments have focused on responsible practices in the sales of alcoholic beverages	Desk research
	3.2 Economic operators have carried out, in relation to their membership in the Forum, actions (commitments) focused on responsible business practices related to marketing of alcoholic beverages	3.2.1 No./share of economic operator participants whose commitments have focused on responsible business practices related to marketing of alcoholic beverages	Desk research
	3.3 Non-industry members have carried out actions (commitments) aimed at contributing to the development of responsible business practices	3.3.1 No./share of non-industry participants whose commitments have focused on the development of responsible business practices (breakdown between owners and co-owners) 3.3.2 No. of commitments related to responsible business practices (overall and broken down by a) sales, b) marketing) and level of ambition	Desk research
	3.4 The EAHF process has contributed to progress across the EU towards enhanced compliance with age limits for selling and serving alcoholic beverages	3.4.1 No. of commitments focusing on age limits 3.4.2 Perceptions that the EAHF process has contributed to progress towards enhanced compliance with age limits	Desk research Interviews
	3.5 The EAHF process has contributed to progress across the EU towards	3.5.1 Perception that the process has contributed towards progress in the development of responsible business	Interviews

Evaluation question	Assessment criteria	Indicators	Research Techniques
	further development of responsible business practices in the marketing of alcoholic beverages	practices for marketing	
4. To what extent can the commitments be related to impacts on alcohol-related harm reduction?	4.1 Alcohol-related harm in Europe has fallen over the period of EAHF's work	*No indicator identified*	Desk research
	4.2 The EAHF commitments have addressed key areas of alcohol-related harm	4.2.1 No. of EAHF commitments that cite each key area of alcohol-related harm (as per the aims of EU alcohol strategy) as a target 4.2.2 The Forum's commitments and the aims of the alcohol strategy are appropriately aligned with each other	Desk research
	4.3 The EAHF commitments and actions contributed to improve the process seeking a reduction of alcohol-related harm	4.3.1 Perceptions of the contribution of EAHF commitments	Workshop / Interviews
5. To what extent can the commitments be benchmarked in relation to the best available practices in the area?	5.1 Best available practices exist for each of the action areas and the commitments collectively meet such benchmarks	5.1.1 List of best available practices for main action areas 5.1.2 Cross-checking of commitments and their distribution against list from 5.1.1	Desk research Desk research
6. What are the lessons learned regarding composition, focus and working methods including the EAHF sub-groups?	6.1 The membership of the sub-groups is appropriate for their activities	6.1.1 Share of sub-group members by type 6.1.2 Perception that membership is appropriate	Desk research Interviews
	6.2 The working methods of the EAHF including sub-groups has been appropriate for their activities	6.2.1 Perception that working methods are appropriate	Workshop / Interviews
7. Has there been cross-fertilisation and interactions between the EAHF, the CNAPA and the other structures? What forms of interaction would bring added value?	7.1 There is adequate interaction among EAHF, CNAPA and other structures	7.1.1 Perception that dialogue has been adequate, by members of each organisation 7.1.2 Examples of, and potential for, cross-fertilisation	Survey Interviews
	7.2 Stronger interaction among the bodies would be valuable	7.2.1 Perception that stronger interaction would be valuable, by members of each body; proposals for new forms of interaction	Interviews

1.3 Overview of the research techniques for Task 2

The questions for both desk research and field research were agreed in the inception report. The desk research used relevant reports and literature as agreed with DG SANCO. Sources are indicated in the text where applicable. The main sources include: the EAHF Database; commitment descriptions; Monitoring Progress Reports (2009 to 2011) and the list of EAHF members. The main desk research was conducted in January and February 2012, and updated according to changes in member composition.

The online survey was pilot tested before being administered to the full range of respondents and modified accordingly (see Annex 5 for details). On 27 February 2012, all EAHF members were

invited to complete the survey. A reminder was sent out on 6 March and the survey was closed on 19 March.

The survey was sent to all 67 member organisations of the EAHF. In total, 123 representatives of these organisations (many being represented by more than one person) received an email invitation to complete the online survey; of these, five emails failed to be delivered. The survey was completed by 62 persons representing 37 member organisations. Replies to the questionnaire were thus received from 55% of EAHF members. The response rates for individual questions, however, varied from 50% to 36%.

Overall, the response rate appears favourable in comparison with recent evaluations in the public health sector. The evaluation of the Public Health programme had a 35% response rate in a survey of beneficiaries who received funding.[45] The evaluation of the ECDC Escaide conference received a 25% response rate in a survey of participants.[46]

The table below presents the distribution of EAHF representatives responding to the survey, by type of Forum member. The division in four types of Forum members is similar to the classification used in the yearly Monitoring Progress Report focussed on the quality of members' reports on the implementation of commitments to action under the EAHF.[47] The distribution of survey respondents is quite similar to the composition of the Forum (see table 13 below), an indication that the sample is representative of EAHF members.

Table 13 Number and share of respondents answering the EAHF survey, by type of Forum member, compared with the distribution of Forum members

Type of Forum member	Distribution of survey respondents % (n)	Distribution of EAHF members, 2011[48]
Non-governmental and health organisations	35% (22)	37%
Advertising, marketing, media and sponsorship organisations	13% (8)	11%
Production and sales organisations	39% (24)	42%
Research institutes and others	13% (8)	11%
Total	**100% (62)**	**100%**

Respondents were asked to indicate the level at which their activities take place (respondents were encouraged to indicate all levels that applied to their activities): 76% indicated EU level, 45% Member State level and 23% local level. In addition, 13% specified in which Member States their activities take place.

Telephone interviews were conducted with 25 EAHF members in June 2012. The selection of the 25 members drew first on all the members who indicated in survey responses their availability to be interviewed. In consultation with DG SANCO, further members were added to ensure that the list of interviews was balanced across the membership categories. The distribution of the interviewees is shown below.

- Advertising, marketing, media and sponsorship organisations: 2
- Research institutes and others: 1
- Production and sales organisations: 12
- Non-governmental and health organisations: 10

[45] COWI, 1st interim evaluation of the Public Health Executive Agency (Executive Agency) (EAHC since July 2008): Final report, December 2010

[46] COWI and Milieu Ltd, Evaluation of the European Scientific Conference on Applied Infectious Disease Epidemiology (ESCAIDE), March 2012

[47] http://ec.europa.eu/health/alcohol/forum/forum_details/index_en.htm#fragment2.

[48] See also indicator 1.1.1.

All interviewees selected accepted the invitation, including those that had not volunteered in the survey responses. An overview of the interview topics were sent to the interviewees beforehand. The duration of the interviews was between 30-70 minutes. The summary form of each interview was sent to the interviewee for review and approval. As agreed, interviewees are identified by their category but not by their name or the name of their organisation.

Information, opinions and quotes from the interviews and workshop discussions are provided where relevant in the following sections. These results are intended to illustrate points of view expressed by EAHF members. Quotations should not be taken as representative of broader opinions.

2 Evaluation Question 1: To what extent has the EAHF process been effective in mobilising stakeholders and stepping up action to reduce alcohol-related harm?

The objective of the EAHF is to '*provide a common platform for all interested stakeholders at EU level that pledge to step up their actions to reduce alcohol-related harm*'. [49] The evaluation question addresses two key elements of the EAHF objective: mobilising stakeholders and stepping up their actions towards reducing alcohol-related harm. To answer this question, the EAHF process is defined as the framework set up for the EAHF by the Charter, including the establishment of the EAHF and its subgroups; the principles for designing, presenting, monitoring and evaluating commitments; and the rules for membership. Effectiveness is assessed by looking at the composition of the Forum, the number and distribution of commitments submitted and the quality of monitoring.

This will be assessed by examining whether:

- Distribution of EAHF members by sector and Member State is appropriate;
- Membership has led to new or substantially revised action;
- Distribution of commitments across the action areas is appropriate when considering the overall priority themes of the EU alcohol strategy;
- Progress towards a transparent, participatory and accountable approach in the monitoring of the commitments.

2.1 Assessment criterion 1.1: The scope of the EAHF membership is optimal for generating and stepping up action in relevant sectors

Indicators	Research Techniques
1.1.1 No./share of Forum membership by sector and Member State (2009-2011)	Desk research
1.1.2 Perception that membership is appropriate	Interviews

The assessment criterion includes an overview, based on desk research, of the number/share of Forum members by nationality, by type and by sector. It also addresses the balance between different sectors, the balance between umbrella and national/local organisations, and members' suggestions for additional actors or sectors that it could be valuable to include in the EAHF process.

2.1.1 Indicator 1.1.1(a): Number and share of Forum members by geographic scope (2007-2011)

Desk research

[49] European Commission, Charter establishing the European Alcohol and Health Forum, 2007.

In terms of the geographic scope, three categories of Forum members have been defined. First, the Europe-wide members, including umbrella organisations operating at the European level. The international members include umbrella organisations working at the international level. Finally the Member State level includes companies as well as organisations working at the national or sub-national level.

Almost all member organisations are based in the EU15: only one, from Estonia, comes from a new Member State. Organisations based in the UK are well represented with seven members. Only one member organisation is based in Southern Europe (Italy).

Table 14 Breakdown of European EAHF members by geographic scope, early 2012

Geographic area	**No**
Europe-wide	31
International[50]	4
Member State level, including economic operators	32
Total	**67**
Breakdown by Member State	
Austria	1
Belgium	2
Estonia	1
Finland	1
France	4
Germany	3
The Netherlands	4
Ireland	3
Italy	1
Sweden	4
UK	7
Nordic Countries[51]	1

As summarised in the table below (Table 15), 35 EAHF members are umbrella organisations. Most operate at the European level (31), but some also work at the international level (4). Among the remaining members, 19 are national organisations and 13 are individual companies. This shows the considerable diversity of the members of the Forum.

The Forum's Charter states that members include:

- Umbrella organisations operating at European level
- Organisations operating at national or sub-national level
- Individual companies

Table 15 Members, distributed by type: umbrella, national organisation or individual company

Type of member	**Number (% share of total)**
Umbrella organisations (Europe-wide and international)	35 (52%)
National organisations	19 (28%)
Individual companies	13 (19%)
Total	**67 (100%)**

[50] Alcohol Policy Youth Network (APYN), International Centre for Alcohol Policies (ICAP, based in the USA), International Federation of Medical Students Associations, World Federation of Advertisers (WFA).
[51] Nordic Alcohol and Drug Policy Network, which is also a member of EUROCARE.

This overview shows that EAHF members are quite heterogeneous: they range from European industry associations, such as those for beer and wine producers, to European public health groups, including groups those for cancer and liver disease, to individual national companies and associations. Several companies and national public health groups are both individual members and also members of European umbrella organisations.

Interview results

According to interview results, there does not seem to be a clear consensus concerning adequacy of the current composition of the Forum in terms of type. Some Forum members indicated that individual companies and national organisations may still be insufficiently represented. Others emphasised the importance of having umbrella organisations in the Forum in order to encourage more EU-level activities. Finally, a few members said that involving more participants in the Forum could diminish effectiveness of the dialogue and exchange between members.

2.1.2 Indicator 1.1.1(b): Number and share of Forum members by Sector (2007-2011)

Four major member categories were defined that correspond to those in previous Forum Monitoring Progress Reports[52]:

- Non-governmental organisations (NGOs) and health professionals
- Advertising, marketing, media and sponsorship organisations
- Production and sales organisations
- Research institutes and others (including the social insurance sector)

Production and sales organisations and NGOs and health professionals are the two largest membership categories. They currently encompass, respectively, 37% and 42% of members. Advertising, marketing, media sponsorship organisations and research institutes and others account for 10% of membership each.

It should be noted that in this report, the production and sales organisations and the advertising, marketing, media sponsorship organisations are together referred to as 'economic operators', and the research and others and the NGOs and health professionals are referred to as 'non-industry members'.

Table 16 Breakdown of Forum members by sector and year

Type of Forum member	2007		2008		2009		2010		2011		2012	
	No.	Share	No.	Share	No.	Share	No.	Share	No.	Share	No.	Share
Non-governmental and health organisations	18	34%	20	34%	24	38%	24	38%	24	37%	25	37%
Advertising, marketing, media and sponsorship organisations	7	13%	7	12%	7	11%	7	11%	7	11%	7	10%
Production and sales organisations	23	43%	27	46%	27	42%	26	41%	27	42%	28	42%
Research institutes and others	5	9%	5	8%	6	9%	7	11%	7	11%	7	10%
Total	**53**	**100%**	**59**	**100%**	**64**	**100%**	**64**	**100%**	**65**	**100%**	**67**	**100%**

From 2007 to 2012, the total number of members rose by fourteen (see Table 16 above). In the first three years of the Forum's existence (2007-2010), the number of new members rose from 53 to 64. After this, growth in number of members has slowed.

[52] http://ec.europa.eu/health/alcohol/docs/monitoring_progress3_en.pdf

Although there have been fluctuations in the percentages over the years, the overall composition of the Forum members have remained quite constant. This is furthermore reflected when assessing members accepted since the founding. In total, 19 new members have been accepted[53]; of those, eight are production and sales organisations, eight are NGOs and health professionals and three members represent the research and others sector, showing a generally balanced uptake of new members.

The distribution of membership provided in the table above is only one indicator of the balance between different sectors in the Forum. It does not account for the level of involvement and actual contribution of the members to the Forum process. To complement this information, interview results regarding the balance between the four sectors are summarised below.

2.1.3 Indicator 1.1.2: Perception that membership is appropriate.

In the interviews with Forum members, views on the appropriateness of membership were polarised. Overall, non-industry members considered that there is overrepresentation of the private sector (particularly of the alcohol industry), while economic operators tended to find the balance appropriate.

Non-industry members and some producer organisations' representatives pointed out that there are substantial differences in the resources available between the commercial and non-commercial members. According to them, economic operators possess comparatively more human and financial resources to allocate for the activities associated with the Forum process: for the development and implementation of commitments, for preparing and participating in Forum meetings, and for research, evaluation and monitoring of commitments.

Some representatives of NGOs and health professionals said it is difficult (sometimes impossible) to find the human resources for participating and preparing the meetings, and that they in general have fewer resources for activities related to the Forum membership. It was pointed out that the Forum is open for everyone to join, but organisations that have more resources are more likely to join.

On the production and sales side it was generally agreed that retail organisations, both the on- and off-trade, could be better represented. These organisations play an important role in linking producers with consumers. Retailers are instrumental in some of the key issues the Forum is aiming to address, for example compliance and enforcement of age limits for selling alcoholic beverages.

Some members pointed out that the social insurance sector should be better represented in the Forum as they bear significant part of the economic costs associated with alcohol misuse. It was also suggested that social groups that are directly exposed to alcohol-related harm, such as children and other relatives of alcohol abusers, should be represented in the Forum.

Interviewees pointed out that NGOs and health professionals based in new Member States are represented to a limited degree, allegedly due to resource constraints, although the Commission on a routine basis offer payment of NGOs travel expenses (one person) connected to the participation in EAHF meetings.

It was pointed out that the "average" target groups are currently not well represented in the Forum. For example, the youth organisations involved represent specific policy orientations, rather than the views of average young consumers.

Finally, some interviewees suggested that Member State authorities (ministries) and agencies should also take part in the Forum's activities. This issue is further discussed under evaluation question 7.

[53] Three members have quit the Forum.

2.2 Assessment criterion 1.2: EAHF membership has inspired new or substantially revised action

Indicators	Research Techniques
1.2.1 No. of commitments by year and membership sector	Desk research
1.2.2 Perception that the membership has led to new or substantially revised action	Interviews

The assessment criterion regards the evolution in the number of active commitments and the number of commitments by membership sector since the establishment of the EAHF. The online survey included a question to ascertain the extent to which members' actions resulted from their participation in the Forum. This assessment is supplemented with input from the interviews.

2.2.1 Indicator 1.2.1: Number of commitments by year and membership sector

Table 17 below presents an overview of active commitments by year and type of Forum member. Since commitments can stretch over more than one year, the total number of commitments active in any given year may be higher than the annual number of commitments submitted. Moreover, it should be noted here and also in subsequent sections that commitments vary also in terms of their geographic scope and extent of work: commitments can act at local level, at regional or national scale, and some cover EU-wide actions, including activities in a range of Member States.

Table 17 Number of active commitments by sector and year, 2007 through end 2011

Type of Forum member	**2007**		**2008**		**2009**		**2010**		**2011**	
	No.	Share	No.	Share	No.	Share	No.	Share	No.	Share
Non-governmental and health organisations	7	19%	17	17%	23	22%	30	29%	35	33%
Advertising, marketing, media and sponsorship organisations	0	-	7	7%	5	5%	5	5%	3	3%
Production and sales organisations	25	69%	70	68%	68	64%	60	58%	57	54%
Research institutes and others	4	11%	9	9%	10	9%	8	8%	10	10%
Total	**36**	**100%**	**103**	**100%**	**105**	**100%**	**103**	**100%**	**105**	**100%**

The total number of active commitments increased in the first year of the Forum but has since been fairly stable at around 100 commitments in operation per year. Indeed, during interviews, members referred to intense activity in the start-up period regarding not only the number of submitted commitments, but also, for instance, in the number of external participants that attended the Open Forum sessions.

The number of submissions in 2007 was 72, with many commitments not becoming operational until 2008. In 2008, the number of new commitments was only 25, most members already having an active commitment in place. In the following years, the number of new commitments per year has increased slowly, from 31 in 2009 to 43 in 2011 (see indicator 1.3.1). It should also be noted that commitments differ greatly in scope.

The production and sales organisations started out with the largest share of the commitments with 69% of the total in 2007, but by the end of 2011 the share had decreased to 54%. A similar trend is observed in the advertising, marketing, media and sponsorship sector, where the share of active commitments has decreased between 2008 and 2011.

On the other hand, commitments submitted by NGO and health professional organisations increased as a share of active commitments from 19% at the establishment of the Forum to 33% by the end of 2011. The share of commitments by research institutes' and other types of members has remained more or less stable.

2.2.2 Indicator 1.2.2: Perception that the membership has led to new or substantially revised action

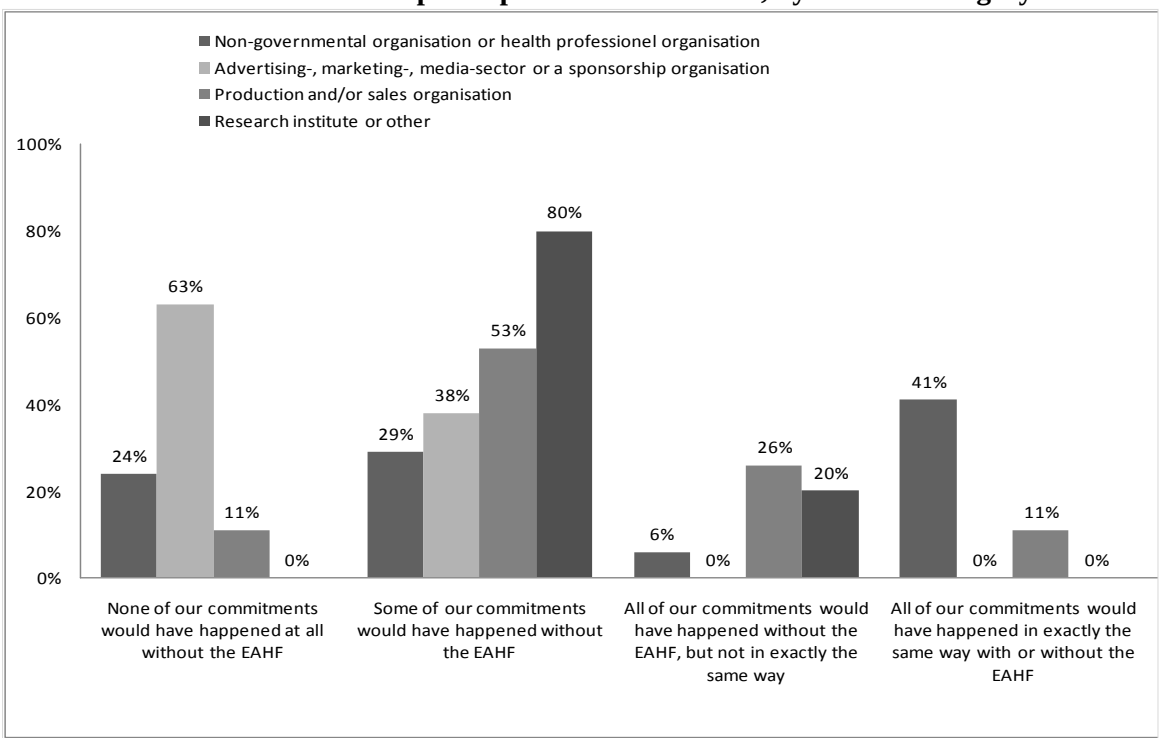
Survey results

In the online survey, a question about the influence of EAHF membership on the submission of commitments was included. Members were asked: Looking at your own organisation's commitments, to what extent were these a direct result of its participation in the EAHF?

A total of 66% of responses indicated that either *none* of the commitments would have happened without the Forum (22%) or that *some* of the commitments would have happened without the Forum (44%); a further 14% indicated that membership in the EAHF influenced the way that the commitments were carried out. Only 18% of respondents answered that commitments would have happened in exactly the same way regardless of the EAHF process. These results suggest that the Forum has had decisive influence on new action in the alcohol field.

A closer look at the respondent categories answering to the question (see figure 14 below) reveals that a high share of respondents from the advertising category indicated that their commitment would not have happened without the EAHF (63%) or that some of their commitments would have happened without the EAHF (38%).

Figure 14 Looking at your own organisation's commitments, to what extent were these a direct result of its participation in the EAHF?, by member category*



*n=49

53% of respondents from production and sales organisations indicated that some of their commitments would have happened without the EAHF. 80% respondents from the research category also chose this option in the online survey.

While an important share of respondents from the NGOs and health professionals category stated that none of their commitments would have happened without the EAHF (24%), or that only some of their commitments would have happened without the EAHF (29%), a large share indicated that the commitments would have happened anyway (41%).

It can be noted that a similar question was asked in the 2010 *Evaluation of the European Platform for action on diet, physical activity and health* (the phrasing of the question here was based on that evaluation, to allow comparability). The Platform is also a stakeholder structure, though working in a different field related to health. The results are quite similar. In the survey for that evaluation, a majority of the for-profit (industry) sector indicate their commitments would not have occurred without the Platform, or not in the same way; in contrast, 60% of not-for-profit members of the Platform responded that they would have carried out their commitments in the same way without the Platform.

Interview results

The survey results were elaborated upon in the interviews. Forum members were asked the following questions:

- Has there been any change over time in your organisation's commitments under the Forum? Have they evolved in terms of breadth, depth or duration?
- Do new commitments build on previous ones or are they separate actions?
- For your organisation, has membership in the Forum led to new or substantially revised actions to reduce alcohol-related harm?

Most members describe the first commitment(s) as building on already established activities. Representatives from production and sales organisations indicated that subsequent commitments are largely based on inspiration acquired through the Forum: *'Our first commitment already existed, but the Forum brought focus and perspective to it'; 'We had existing activities, but the Forum made it more solid and fixed'.*

On the other hand, most interviewees from the NGOs and health professionals sector explained that the Forum has not had a substantial impact on their activities – the same actions would be carried out regardless of the Forum. It was also pointed out that commitments under the EAHF may represent only a small part of NGO and health professional activities around alcohol.

> *Our commitments tend to be separate actions. From all the activities we carry out, it is relatively easy to compartmentalise certain activities and present them as commitments to the Forum. For the Forum, we submit (as commitments) a very small portion of what we actually do.*

Examples of the Forum's influence concern, on the one hand, new activities such as the introduction of pictogram labelling on alcoholic beverages, or the training of staff. On the other hand, examples related to improved management of actions through increased focus on monitoring, including outcomes and outputs, and setting quantifiable goals.

Representatives from production and sales organisations pointed out that the commitments have contributed to an increased awareness of the importance of reducing alcohol-related harm. In several economic operators, the management are involved in formulating commitments. Moreover, they declared that corporate strategies and procedures are revised in light of Forum outcomes.

Several interviewees affirmed that the content of commitments has developed through their membership of the Forum. For instance, commitments have become broader in scope by expanding from the local level to the EU level, or from one to several target groups.

Some interviewees from production and sales organisations perceived EAHF membership as providing credibility; 'a quality stamp', that enables the implementation of commitments and other activities in cooperation with relevant stakeholders: for example when industry members wish to set up cooperation with NGOs and other partners at the local level.

Several members have furthermore enhanced the communication of commitment-related activities by redesigning websites, translating commitments to other languages and by adding new topics to existing communication platforms.

Concerning intra-sector cooperation, representatives of NGOs and health professionals affirmed that they routinely interact with and develop commitments with other organisations in their sector, and there have been no fundamental changes in this approach due to the Forum. However, they recognised that the Forum functions as a catalyst for 'new constellations of activities', scale and speed, and strengthening monitoring and reporting.

2.3 Assessment criterion 1.3: The distribution of the commitments across the action areas is consistent with the aims of the alcohol strategy

Indicator	Research Techniques
1.3.1 No./share of commitment by Forum action area	Desk research

2.3.1 Indicator 1.3.1: Number/share of commitments by Forum action area

As a condition for their participation, members each take actions to address at least one of the six action areas identified in the Charter establishing the European Alcohol and Health Forum. These action areas are the following:

- Strategies aimed at curbing under-age drinking;
- Information and education programmes on the effect of harmful drinking and on responsible patterns of consumption;
- Possible development of efficient common approaches throughout the Community to provide adequate consumer information;
- Actions to better enforce age limits for selling and serving alcohol;
- Interventions promoting effective behavioural change among children and adolescents;
- Cooperation to promote responsibility in and prevent irresponsible commercial communication and sales.

Table 18 below shows the distribution of submitted commitments within the action areas; data is collected from the EAHF database. Please note that the action area on information and education programmes in the database has been divided into two categories: 'the effect of harmful drinking' and 'responsible patterns of consumption',[54] and that the database wording of the action areas is slightly different to the wording in the Charter. Finally, when categorising a commitment, it is possible to select several action areas, and several commitments cover more than one action area. In the table, each area is accounted for.

Table 18 Number of commitments submitted, by action area

Action area	2007	2008	2009	2010	2011	Total
Develop a strategy aimed at curbing under-age drinking	7	3	1	5	3	**19**
Develop information and education programmes on the effect of harmful drinking	26	3	15	13	19	**76**
Develop information and education programmes on responsible patterns of consumption	19	11	12	11	14	**67**
Develop efficient common approaches to provide adequate consumer information	8	2	2	6	8	**26**

[54] This division was presented in the 1st Progress Monitoring Report, chapter 2, p. 9.

Action area	2007	2008	2009	2010	2011	Total
Enforce age limits for selling and serving of alcoholic beverages	7	5	1	8	4	**25**
Promote effective behavioural change among children and adolescents	7	3	2	5	3	**20**
Better cooperation/actions on commercial communication and sales	26	7	8	7	13	**61**
Total	**72**	**25**	**31**	**38**	**43**	**209**

Note: Commitments can cover more than one action area; each area is accounted for.

The table illustrates the development in the number of commitments submitted from 2007-2011. The numbers indicate high activity in 2007 with 72 submitted commitments, followed by a decrease in 2008. From 2008 onwards, there was a slight increase in commitments submitted annually.

Most commitments have been submitted under the following action areas: 'Better cooperation/actions on commercial communication and sales'; 'Develop information and education programmes on the effect of harmful drinking'; and 'Develop information and education programmes on responsible patterns of consumption'. The action area that has received the lowest number of commitments is 'Develop a strategy aimed at curbing under-age drinking' (under-age drinking is also directly addressed under the action area 'Enforce age limits for selling and serving of alcoholic beverages').

It was mentioned in the Advisory Group that the classification of the commitments was somewhat arbitrary. However, the distribution provides an initial indication of the overall focus of members' commitments.

2.4 Assessment criterion 1.4: There has been progress towards a transparent, participative and accountable approach to monitoring

Monitoring of members' commitments is an essential part of the Forum's Charter, requiring that '*there is sufficient outside involvement in reviewing progress and outcomes to create trust in the processes*'.[55] Forum members are expected to monitor the performance of their individual commitments in a '*transparent, participatory and accountable way*', and to '*report on the inputs, outputs and outcomes of the commitments*' by presenting them on a website.[56]

In practice, for each commitment, a yearly monitoring report is prepared, presenting the implementation process: a description on how interventions or activities are realised. The overall purpose of the exercise is to enhance trustworthiness and transparency as well as to develop good practice on monitoring. In this context, systematic monitoring is crucial to ensure that Forum members are able to assess the progress of ongoing initiatives and adapt them in a timely manner in the face of unforeseen challenges or constraints.

The main goal of the monitoring exercise is to ensure that the commitments, as presented in the monitoring reports, are clearly written and thus understandable to the general public. Overall, the general reader should get a clear understanding of what the commitment is about and what the respective Forum member has done in the reported period to implement the commitment, and with what result.

In order to follow the implementation of the EAHF commitments and to assess to which extent there is a transparent, participatory and accountable approach to monitoring, Monitoring Progress Reports were prepared in 2009,[57] 2010,[58] and 2011[59].

[55] Charter establishing the European Alcohol and Health Forum, European Commission, 2007.

[56] Charter establishing the European Alcohol and Health Forum, European Commission, 2007. Annex 2.

[57] EAHF. First Progress Report on the Implementation of the EU Alcohol Strategy http://ec.europa.eu/health/alcohol/docs/monitoring_progress_en.pdf.

In the monitoring process, Members submit their monitoring reports in a standardised format comprising 12 sections that relate to the main requirements stated in annex 2 ("Monitoring Commitment") of the Forum's Charter, including summary; implementation description; objectives; relevance to the aims of the Forum; input; output; outcome and impact indicators, etc.. Where the implementation of a commitment has been completed, the annual report is also a final report: in this case, Forum members are in addition requested to present information regarding their evaluation and dissemination activities (sections that are not mandatory for intermediate monitoring reports). Each section receives a maximum score of five if all applicable criteria are fulfilled. Information provided in each section of the reports[60] is assessed on the basis of criteria on specificity, clarity, focus and measurement.

The assessment criterion involves an examination of the progress in monitoring scores in the three Monitoring Progress Reports made in 2009, 2010 and 2011. To provide this information, the web survey asked respondents to indicate how many monitoring reports they have read, and to provide their views on the usefulness of those reports.

Indicators	Research Techniques
1.4.1 Progress in monitoring scores	Desk research
1.4.2 Perception that monitoring has seen progress	Survey Interviews

It was a shared view among interviewees that monitoring commitments helps ensure transparency and credibility, not only among Forum members but also vis-à-vis external audiences. This mechanism also seems to be instrumental in developing and sharing good practice; systematic monitoring is crucial to ensure that Forum members are able to assess ongoing initiatives and timely adapt them in the face of unexpected challenges or constraints.

2.4.1 Indicator 1.4.1: Progress in monitoring scores

These three Monitoring Progress Reports were based on an assessment of the quality in individual members' monitoring activities.[61] These assessments provide an opportunity to compare the quality of the information provided in the monitoring reports.

It is specified in the Forum Charter that '*Outcome and impact indicators go above the minimum agreed requirements to monitor a commitment*', why it should be noted that the Monitoring Progress Reports focuses on the quality of reporting, not the effectiveness of the underlying commitments. However, members are recommended to execute a basic evaluation if possible: '*Depending on the nature of the commitment some basic evaluations are possible and should be done*'.[62]

Looking at the development of the scores, there has been a significant, steady improvement in monitoring scores between 2009 and 2011. This applies namely to the reporting fields 'Relevance', 'Implementation', 'Input indicators' and 'Output indicators', 'Evaluation details' and 'Dissemination of commitment results'.

[58] EAHF. Second Monitoring Progress Report. http://ec.europa.eu/health/alcohol/docs/monitoring_progress2_en.pdf.
[59] EAHF. Third Monitoring Progress Report. http://ec.europa.eu/health/alcohol/docs/monitoring_progress3_en.pdf.
[60] Section 10, "other comments" is not assessed. The rationale for this exception is provided in the methodological section of this report.
[61] The overall framework for evaluating the quality of members' monitoring reports is based on the use of "SMART" procedure. Each report field was assessed on a scale from 0 to 5; 0 being no (sufficient response, 5 being excellent. See for instance EAHF, Third Monitoring Progress Report.
[62] Charter establishing the European Alcohol and Health Forum, European Commission, 2007. Annex 2.

Table 19 Progress in median score per report field 2009-2011, 0 meaning no (sufficient) response, 5 meaning excellent[63]

Section	Report field	Median scores		
		2009	2010	2011
1	Commitment summary*	Not scored	Not scored	Not scored
2	Link to the websites relating to the commitment*	Not scored	Not scored	Not scored
3	Description of the implementation of the commitment	3	3.5	4
4	Objective of the commitment	3	3	3.5
5	Relevance to the aims of the Forum	2	3.5	4.5
6	Input indicators	3	3.5	4.5
7	Output indicators	3	3.5	4
8	Outcome and impact indicators	3	2.5	3
9	Evaluation details	3	2.5	2.5
10	Other comments related to monitoring the commitments	4	Not scored	Removed
11	Dissemination of commitment results	3	3	3
12	References to further information relating to the monitoring of the commitment*	Not scored	Not scored	Not scored

Source: EAHF, Third Monitoring Progress Report.
*The assessment has been focussed on crucial/minimum reporting fields. The summary, links and references have therefore not been scored.

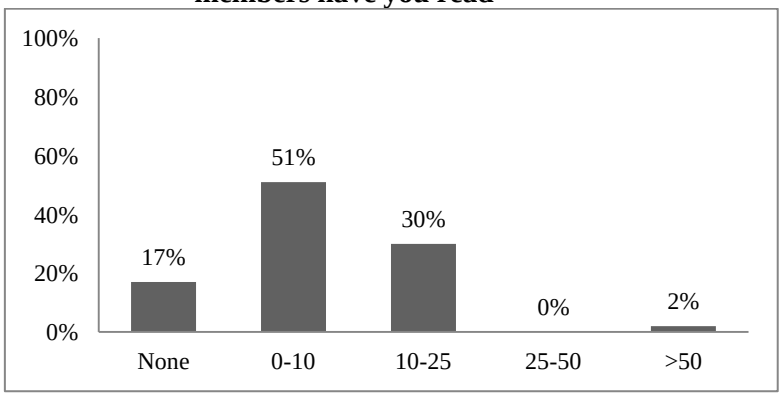
Despite this general improvement over time, in one report field median scores decreased and then stabilised from 2009 to 2011. This concerns the 'Evaluation details' (requiring a description of the tools and methods used, including references to both internal and external evaluators), where monitoring reports often provide little information. Moreover, the score for outcome and impact indicators has not improved from 2009 to 2011, and even declined in 2010 (it should be noted that these indicators are recommended but not required elements of reporting). [64]

In the EAHF Advisory Group, it was noted that some members devote significant resources to monitoring, including through the use of third party input and independent assurance in evaluation.

2.4.2 Indicator 1.4.2: Perception that monitoring has seen progress

Many EAHF members show active interest in the implementation and progress of other members' commitments. 51% of respondents to the online survey declared to have read between 0 and 10 monitoring reports, 30% between 10 and 25 reports and 2% more than 50 reports.

Figure 15 Approximately how many of the 2011 monitoring reports from other EAHF members have you read*[65]



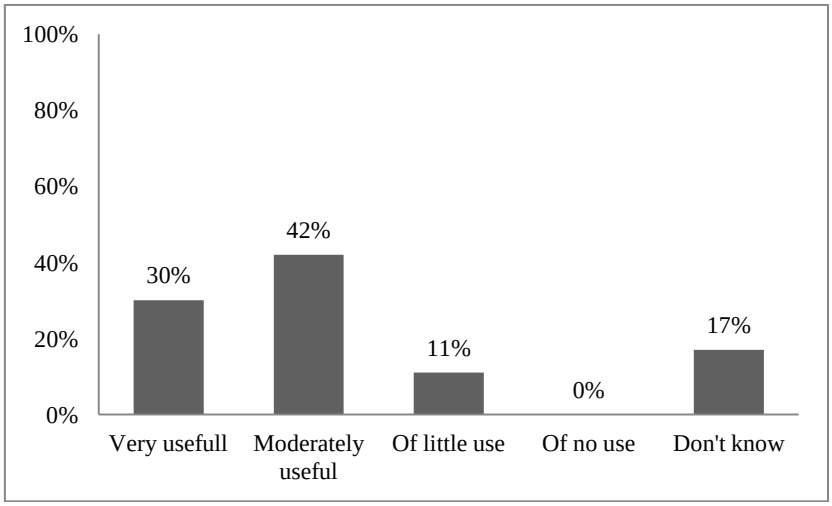
*n=53
Note: The four categories overlap

[63] EAHF. Third Monitoring Progress Report
[64] EAHF. Third Monitoring Progress Report
[65] The questionnaire contained an error: Since there was a category 'none', the category '0-10' should have been '1-10'; the subsequent categories should have been '11-25'; '26-50' and '>50'.

There seem to be no substantial differences across sectors, although production/sales organisations read on average more reports than the other members, and research institute/other members read relatively few reports.

Moreover, survey results suggest that members find the monitoring reports informative. Respondents assessed to what extent the monitoring reports had been useful in improving their knowledge and awareness of other members' commitment-related activities. Almost one third, 30%, stated they found them very useful; 42% moderately useful; and 11% of little use while 17% did not know (this share corresponds to the share of respondents who had not read any reports).

Figure 16 How useful have these monitoring reports been in improving your knowledge and awareness of other members' commitment-related activities*



*n=53

According to the survey, an important share of members do read monitoring reports, and more than 70% of the member representatives find them very or moderately useful in improving their knowledge and awareness of other members' commitment-related activities. In the interviews, a Forum member added that monitoring reports could serve as a form of internal quality assurance in order to ensure that '*their own reporting was right*'. The median scores given to individual monitoring reports has increased in almost all reporting areas from 2009 to 2011. This indicates a positive development in the quality of the monitoring and reporting on the implementation of commitments.

The topic of reporting and monitoring outcomes, and particularly impacts from commitments, is discussed under evaluation question 4.

2.5 Key findings for Evaluation Question 1

The desk research showed that the Forum has mobilised a large number of actors on the public health side as well as among economic operators related to alcohol production, sales and marketing.

For the economic operators, participation in the Forum has led to a substantial level of new or revised action to address alcohol-related harm, according to the survey results as well as the interviews. However, for non-industry members, it appears that the Forum has had a more limited impact on activities.

The desk research showed progress in monitoring and reporting across all members. However, the assessment of outcome and impact indicators has not improved. While this information is not

obligatory, Forum members broadly agree that more emphasis could be put on the assessment of commitments' impacts.

Forum members indicated several areas where membership could be increased, including the retail sector, the social insurance sector and NGOs and health professionals from new Member States. It would be useful to explore further ways of broadening membership and perspectives. For example, the EU strategy highlights the role of local action in its implementation. However, this level of government is not currently involved directly in either of the strategy's two main bodies. In the area of media, the role of digital media was a topic at the April 2011 EAHF plenary, and here too membership might be increased.

3 Evaluation Question 2: To what extent has the EAHF process been effective as a platform for dialogue, exchange and cooperation?

This evaluation question assesses the extent to which the Forum members feel they have gained a deeper understanding of issues addressed and the extent to which the Forum has helped develop cooperation between stakeholders in the EAHF process. It also looks at the Open Forum meetings, which offer external actors and EAHF members an opportunity to exchange views and information on alcohol-related topics. This evaluation question reviews the external participation at the Open Forum as well as the perception of the Open Forum by Forum members.[66]

For this evaluation question, desk research and field research results are presented.

3.1 Assessment criterion 2.1: Participation in the EAHF process has contributed to deeper understanding of the issues addressed and of views and positions involved

Indicators	Research Techniques
2.1.1 Perceived deeper understanding of the issues by Forum members	Survey

The EAHF process covers six different action areas. To assess whether the process has contributed to a deeper understanding of the issues addressed and of the views and positions involved, one of the survey questions addressed this issue.

Below are presented the topics of the EAHF plenary meetings. The topics have addressed all key areas of alcohol-related harm lined up in the EU alcohol strategy (pregnancy and protection of the unborn child has not been treated as a separate topic, but as a part of labelling). Moreover, topics concerning marketing, pricing, and retail have been presented and discussed in the Forum.

Table 20 Topics addressed in the EAHF plenary meetings

Meeting	Topics addressed in the meeting
2 (16 April 2008)	Pricing and retailing
3 (13 November 2008)	Affordability
4 (11 March 2009)	Affordability Marketing communication
5 (12 November 2009)	Marketing communication Youth Labelling
6 (11 March 2010)	Digital media and responsible marketing
7 (18 November 2010)	Alcohol-related harm and the workplace Guidance to retailers Alcohol sponsorship

[66] Open Forum members were among the 'outsiders' contacted for the third survey, which focused on Task 3.

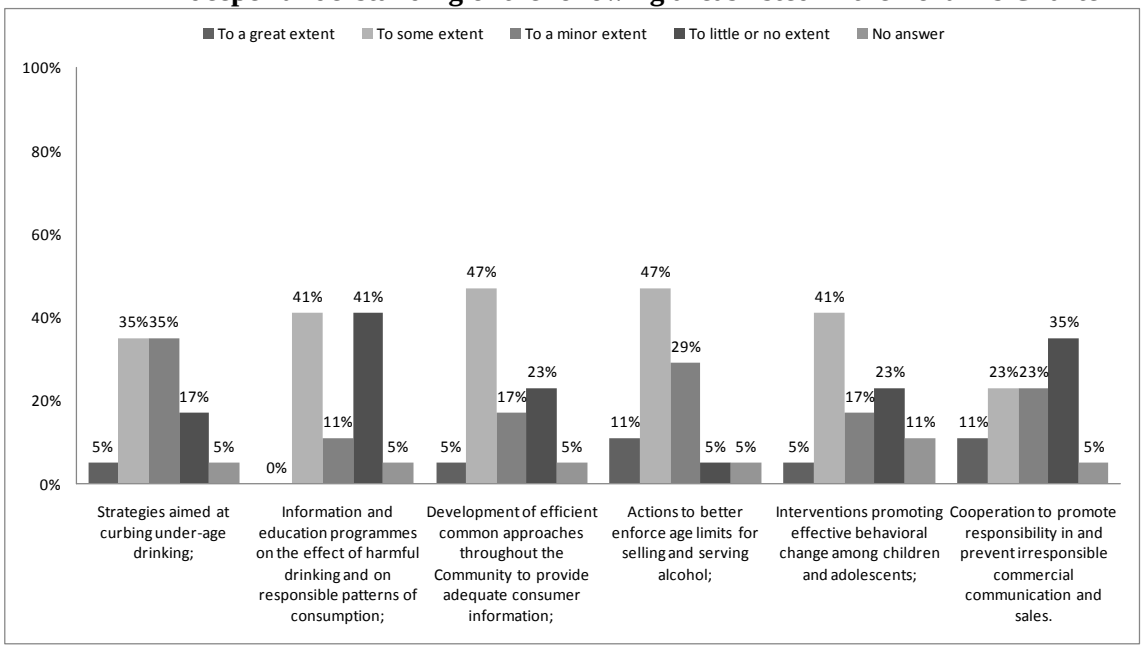
Meeting	Topics addressed in the meeting
	RAYPRO (Resource on Alcohol and Youth Projects) Drinking and driving
8 (08 April 2011)	Alcohol and the workplace Service training Non-communicable diseases Labelling
9 (19 October 2011)	The young: involvement, alcohol and violence, age limits, culture Alcohol and the family Alcohol and the workplace
10 (26 April 2012)	Responsible marketing

3.1.1 Indicator 2.1.1: Perceived deeper understanding of the issues by Forum members

As all key areas of alcohol-related harm had been addressed in the Forum plenary meetings, it was relevant to ask survey respondents for each action area to what extent the participation in the EAHF had helped them gain deeper understanding. The question asked about their 'personal' understanding, as this provides a question that can be answered more simply and directly than one about 'organisational' knowledge; moreover, as participants in the Forum, respondents would be the ones to participate in information exchanges. The interviews indicated that the information gained at the Forum meetings actually is disseminated in the organisations: In the interviews with the economic operators, it was mentioned that the membership of the Forum had '*led to a higher awareness of the importance to reduce alcohol related harm internally*'.

Figures 17 and 18 below present, respectively, survey results for NGOs and health professionals as well as production and sales organisations. These two groups are identified as having the most divergent opinions and representing the largest share of members. For each action area,[67] the distribution of answers on the categories 'To a great extent', 'To some extent', 'To a minor extent', 'To little or no extent' and 'No answer' is given.

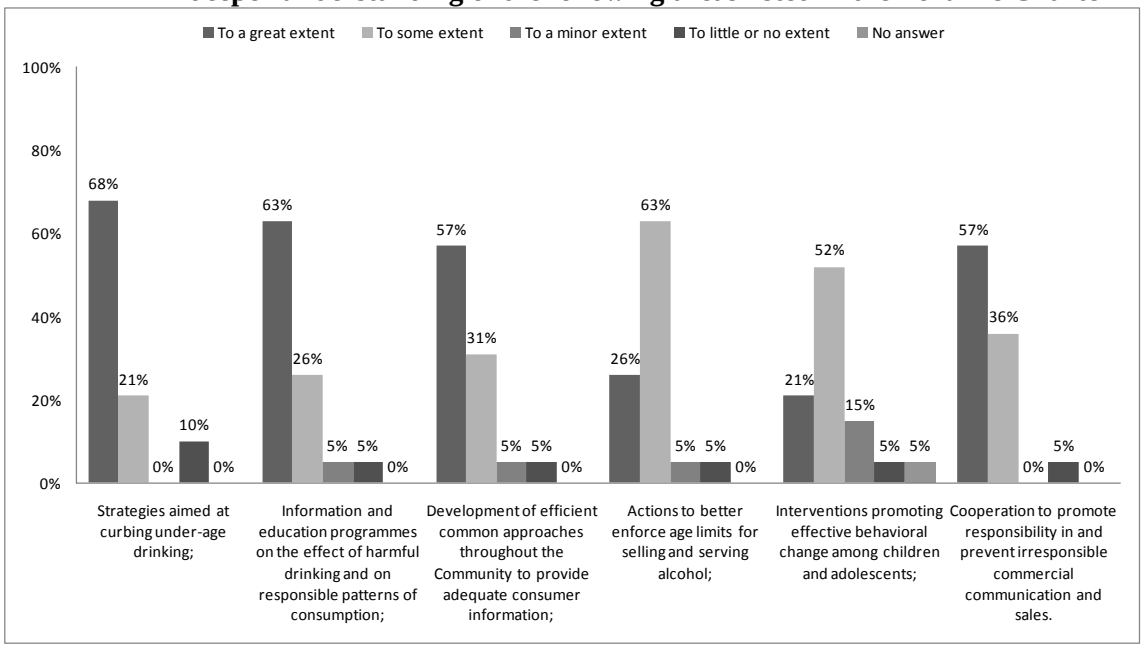
Figure 17 To what extent has participation in the EAHF helped you personally gain a deeper understanding of the following areas listed in the Forum's Charter*



*n=17

[67] The action areas 'Information and education programmes on the effect of harmful drinking' and 'Information and education programmes on responsible patterns of consumption' have been merged.

Figure 18 To what extent has participation in the EAHF helped you personally gain a deeper understanding of the following areas listed in the Forum's Charter*



*n=19

The two figures suggest important differences in the extent to which the production and sales organisations and the NGOs and health professionals perceive that they have gained deeper understanding of the action areas. For all action areas, the production and sales organisations have a higher share of respondents indicating that they have gained a deeper understanding 'to a great extent'. Conversely, a higher share of respondents within the NGO and health professional category answered that they have gained deeper understanding 'to little or no extent'. This applies to all action areas, except 'Actions to better enforce age limits for selling and serving alcohol', where in both categories 5% of respondents indicated that they have gained deeper understanding 'to little or no extent'.

The differences arguably have to do with previous background and knowledge of the professionals surveyed. In the EAHF Advisory Group, participants from the NGO and health professional sector commented that this is because they already had a strong understanding of the issues.

3.2 Assessment criterion 2.2: The EAHF process has helped develop further cooperation between stakeholders

Indicator	Research Techniques
2.2.1 Perceptions that EAHF process the EAHF process has helped develop further cooperation between stakeholders	Survey Interviews

3.2.1 Indicator 2.2.1: Perceptions the EAHF process has helped develop further cooperation between stakeholders

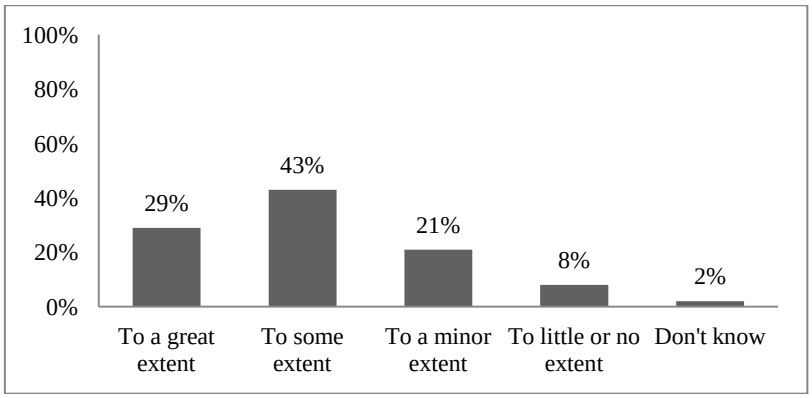
A question specifically addressing cooperation was included in the survey: 'To what extent has participation in the EAHF helped your organisation or its national networks pursue further cooperation with other members of the Forum on actions to reduce alcohol-related harm?' [68] A majority of 70%

[68] The question is modelled on the evaluation of the European Platform for action on diet, physical activity and health: http://ec.europa.eu/health/nutrition_physical_activity/docs/evaluation_frep_en.pdf.

responded that participation has been helpful 'to a great extent' (28%) or 'to some extent' (42%). A minority of 21% replied that participation had helped them 'to a minor extent'. Finally, 8% replied that it has helped them 'to little or no extent' and 2% did not know.

These results suggest that the EAHF has been an important driver for cooperation among members.

Figure 19 To what extent has participation in the EAHF helped your organisation or its national networks pursue further cooperation with other members of the Forum on actions to reduce alcohol-related harm*



*n=50

Interviewees were asked the following questions: 'To what extent has your organisation cooperated with Forum members from other sectors on commitments?' and, 'to what extent has your organisation - due to the Forum - cooperated on commitments with other sectors at national or local level?'

The interviews confirmed survey results: for the majority of members, participation in the Forum has helped to pursue further cooperation with other members, for instance through joint commitments.

Interviewees indicated that partnerships are typically formed within their own sector and only rarely involve partners from other sectors represented in the Forum.

According to some interviewees, mainly the economic operators, at EU level, the main barrier to cooperation across sectors is the lack of willingness to cooperate on the part of EU-level NGOs and health professionals, stemming from fundamental disagreements regarding Forum membership as well as the acceptable remit of commitments. Conflicts of interest on the part of economic operators were mentioned by NGOs and health professionals as the main reason for such disagreements. Some economic operators expressed in turn their frustration at the attitude maintained by some non-industry members:

> *We could use a better cooperation among the different stakeholders about the commitments. When we try to cooperate with NGOs; for instance in the evaluation of our commitments, they refuse.*

Another explanation presented in this context was that there are limits to what can be achieved in terms of cooperation on the EU level, because the implementation of commitments is mainly local. Therefore, it was argued, it would be even more important to identify venues for cooperation between different sectors at the local and Member State level than at the EU level.

Whereas cooperation across sectors at the EU level is limited, the EAHF was often identified during interviews with economic operators as a catalyst for cross-sector cooperation at the local and national levels. Here, alcohol industry representatives mentioned several examples of local NGOs; healthcare organisations; road safety groups; alcohol dependency treatment providers as well as government and local authorities, including police, being engaged in partnerships with the industry. According to

interviewees, these partnerships result in part from a guarantee of seriousness and quality conveyed by the EAHF process.

Many members, both from the non-industry sector and the economic operators sector, acknowledged a link between national or local alcohol-related policies and their commitments; examples included integrating national health authorities' recommendations in their information or education materials, or engaging in binding commitments vis-à-vis public authorities. For example this is widely seen in commitments concerning prevention of drink-driving. In several countries, commitments have been submitted in cooperation with road/traffic authorities.

Interviewees were also asked what could be done to enhance dialogue within the Forum. The responses revealed differing opinions in this regard. Some interviewees described the Forum dialogue as politicised and polarised with a need to enhance dialogue. This concerned mainly the economic operators.

A recurrent suggestion for improving dialogue was forming smaller discussion groups to address specific topics, while keeping in mind the need for a balanced representation of members. Smaller groups could contribute to enhanced knowledge between members and encourage some members to participate more actively in the Forum. In contrast, it was also argued that smaller groups would exclude from the dialogue members who for one reason or another are not included.

It was also suggested that the dialogue could be enhanced by increasing the number of Forum meetings from two per year to three or four. Further suggestions were that there should be a better monitoring of the timing of the meetings, because frequently there is no time left to discuss issues that are towards the end of the meeting agenda, and that more time should be allocated for discussions and less for presentations. It was also suggested that the dialogue would be enhanced if Forum members had more say in the selection of Forum plenary topics and speakers.

In conclusion, the EAHF process has contributed to closer cooperation and to new partnerships among members. At EU level, this has happened mainly within sectors. At the national and local levels, the EAHF has contributed to cross-sector cooperation in part by conferring a label of seriousness or quality to alcohol industry initiatives. Examples were mentioned of commitments involving local and national collaboration between sectors whose differing views on some particular aspects of alcohol policy have proven difficult to reconcile at a higher level of interaction.

3.3 Assessment criterion 2.3: The EAHF process has contributed to the exchange and promotion of good practices

Indicators	Research Techniques
2.3.1 Perception by Forum members that the process has brought to light useful elements that can be applied in their own field	Survey

In its founding Charter, the EAHF is seen as a channel for disseminating successful initiatives to potential partners and emulators across the EU. This assessment criterion assesses the extent to which participation in the EAHF has provided examples of good practices that have been applied in the members' respective fields of activity.

The Forum's Charter foresees an Open Forum,[69] which provides an opportunity for EAHF Members and external parties from the EU and beyond to exchange views on and knowledge of ways to reduce alcohol-related harm. The Open Forum could also contribute to the establishment of new cooperation and networks. Thus far three Open Forum meetings have been held: in 2008, 2009 and 2010.

[69] Charter establishing the European Alcohol and Health Forum, European Commission, 2007.

An overview of external participation in the Open Forum meetings is provided in the section, as well as EAHF members' perceptions of the Open Forum's success in showcasing members' activities and engaging a wider range of stakeholders in discussion.

3.3.1 Indicator 2.3.1: Perception by Forum members that the process has brought to light useful elements that can be applied in their own field

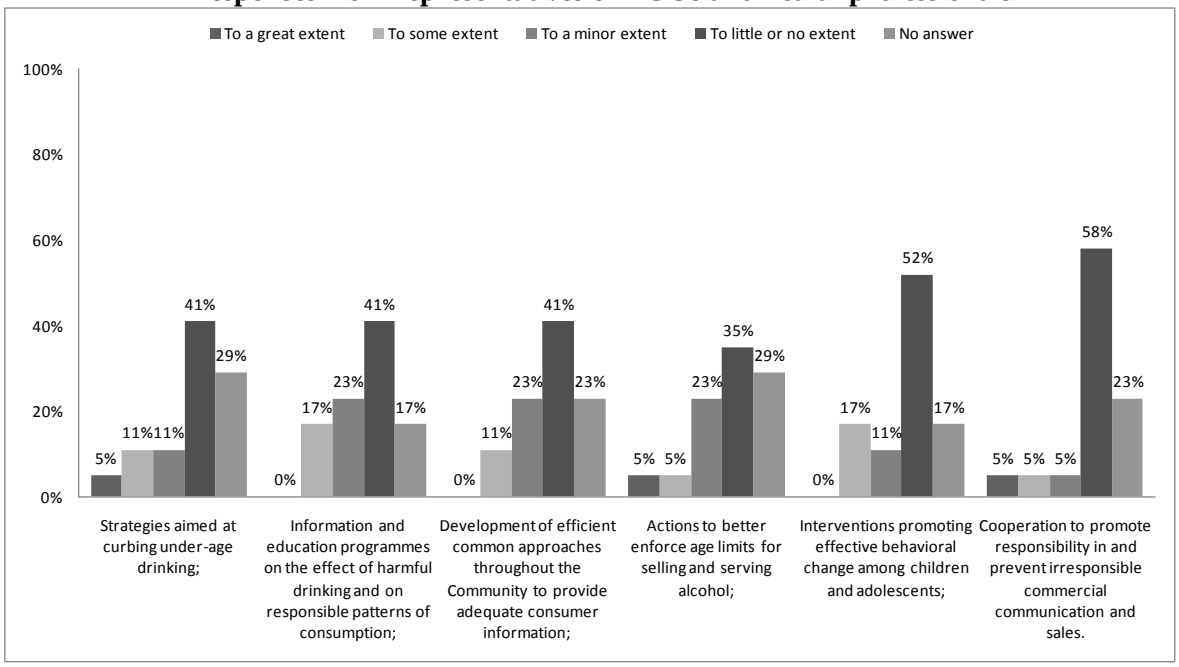
Figures 20 and 21 below present the responses of the two major member categories: 'NGOs and health professionals' and 'Production and sales organisations' to the survey question corresponding to this indicator. The question was presented separately for each of the Forum's action areas. The figures show that the sectors differ in the extent to which they perceive that participation in the EAHF has provided examples of good practice that their organisation has in turn incorporated in its policies, actions and strategies.

The graphs suggest that in particular the production and sales organisations have benefitted from participating in the EAHF. In five out of six action areas a large majority or at least almost half of survey respondents indicated that participation has to a 'great' extent provided examples of good practice that have been applied in their organisation's policies, actions and strategies. The exception concerned interventions to promote effective behavioural change among children and adolescents, where the typical answer was to 'some' (47%) rather than 'great' (26%) extent.

In contrast, the NGOs and health professionals seem to have benefitted less from the participation. In five out of six action areas, only a quarter or a third of respondents indicated that good practice examples have been provided to 'great', 'some' or 'minor' extent. The share of responses indicating gain was largest (40%) for information and education activities on the effects of harmful drinking and on appropriate consumption patterns. The area where only minimal gains were reported concerned cooperation to promote responsibility and prevent irresponsible commercial communications and sales. For both categories of members, the gains have been smallest in the area which seems the furthest removed from the respective core activities.

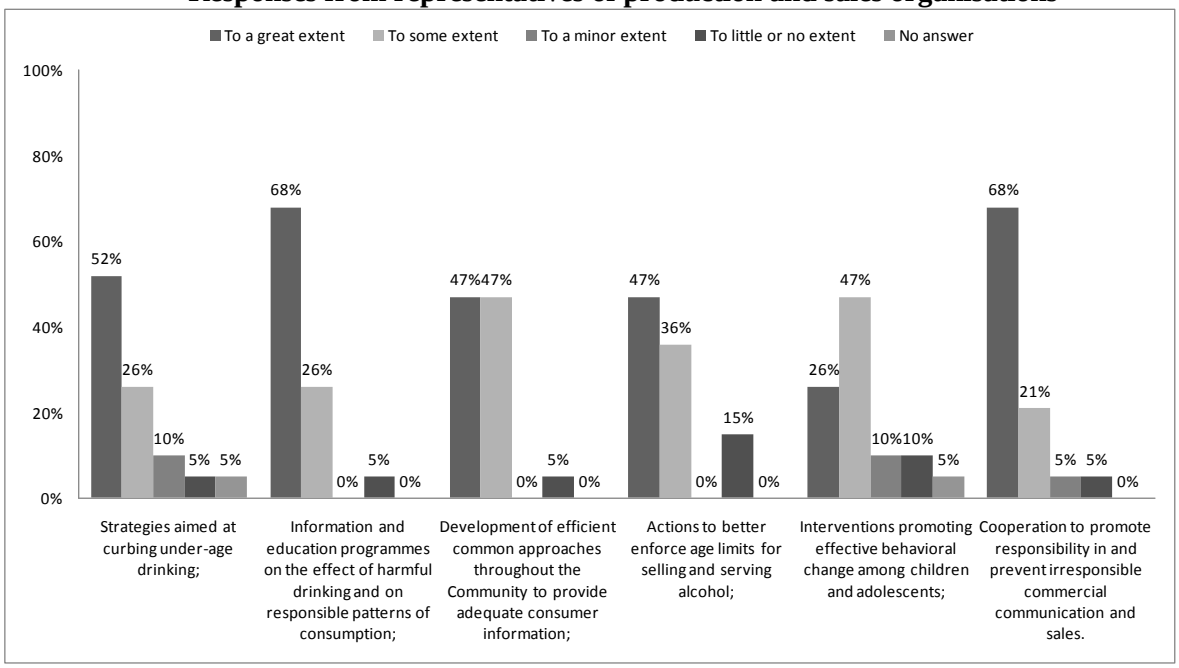
In the interviews and in the Advisory Group, representatives of the production and sales sector provided several examples of toolkits, standards and guidelines that they have shared through the participation in the EAHF, however, no such examples were provided by the NGO and health professional sector. The explanation could partly be due to differences in work practices and organisation types. NGO and health professional organisations are often specialised and their commitments may be disease-specific or focussed on narrow target groups. The scope for exchange of good practices is therefore more limited than in the production and sales organisations where for example the framework for developing responsible business practices is to a large extent shared.

Figure 20 **'To what extent has participation in the EAHF provided examples of good practice that your organisation has applied in its policies, actions and strategies? Responses from representatives of NGOs and health professionals***



*n=17

Figure 21 **To what extent has participation in the EAHF provided examples of good practice that your organisation has applied in its policies, actions and strategies? Responses from representatives of production and sales organisations***



*n=19

3.4 Assessment criterion 2.4: The Open Forum has been successful in showcasing members' activities and engaging a wider range of stakeholders in discussion

Indicators	Research Techniques
2.4.1 Perception of the Open Forum	Survey
2.4.2 External participation at the Open Forum: no. and type of external participants	Desk research

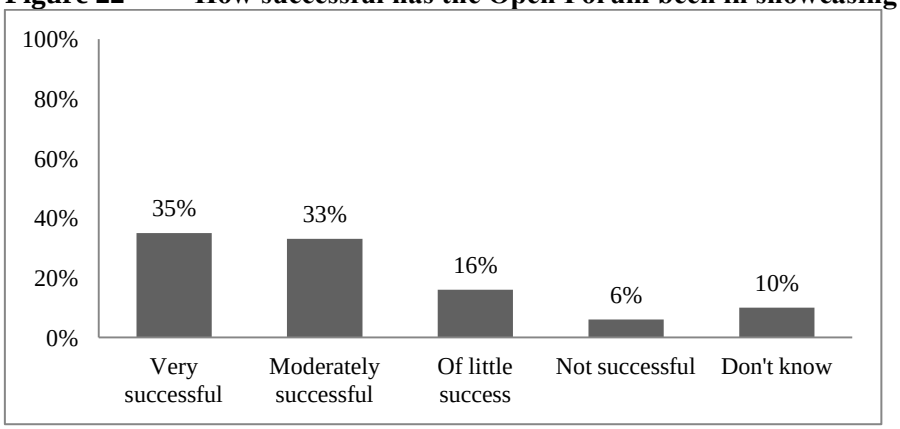
The Open Forum is convened in order '*to give interested non-member bodies and organisations from the EU and beyond an occasion to follow the work of the Forum, and make their opinions known*'.[70]

With the purpose of assessing whether the Open Forum has been successful in meeting its objectives, thus contributing to the effectiveness of the EAHF process, two questions were included in the survey: one concerned success in showcasing members' activities, the other concerned the engagement of a wider range of stakeholders in discussion.

3.4.1 Indicator 2.4.1: Perception of the Open Forum

Respondents to the online survey were asked to assess the Open Forum's success in showcasing member activities. As shown below, two thirds of respondents considered the Open Forum 'very' (35%) or 'moderately' (33%) successful in this respect. Whereas 16% considered the Open Forum 'of little success', 6% found it unsuccessful in showcasing members' activities and 10% did not know.

Figure 22 How successful has the Open Forum been in showcasing members' activities*

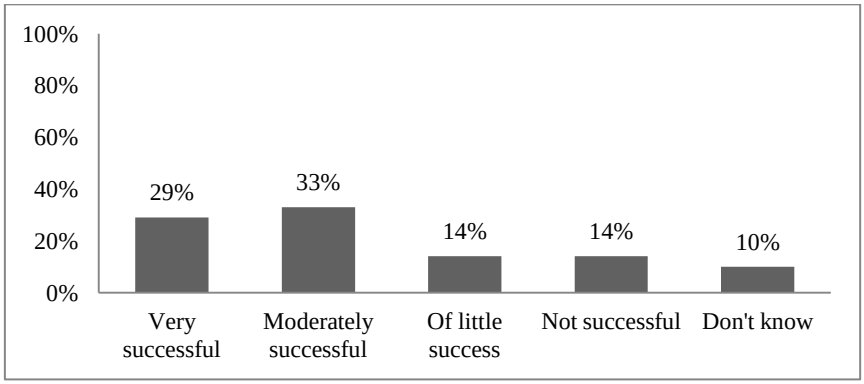


*n=49

As can be seen in the figure below, the distribution of responses was quite similar to the question concerning the Open Forum's success in engaging a wider range of stakeholders in discussion. Two thirds considered the Open Forum 'very' (29%) or 'moderately' (33%) successful in this respect, 14% though it has 'little success', another 14% found it unsuccessful and 10% replied they did not know.

[70] Charter establishing the European Alcohol and Health Forum, European Commission, 2007.

Figure 23 How successful have the Open Forum meetings been in engaging a wider range of stakeholders in discussion*



*n=49

Table 21 How successful have the Open Forum meetings been in engaging a wider range of stakeholders in discussion*

Member type	Very successful Share (No.)	Moderately successful Share (No.)	Of little use Share (No.)	Of no use Share (No.)	Don't know Share (No.)
Non-governmental and health organisations	18% (3)	36% (6)	29% (5)	6% (1)	12% (2)
Advertising, marketing, media and sponsorship organisations	75% (6)	-	-	13% (1)	13% (1)
Production and sales organisations	11% (2)	47% (9)	5% (1)	26% (5)	11% (2)
Research institutes and others	60% (3)	20% (1)	20% (1)	-	-

A large majority of respondents in the advertisement and research categories considered the Open Forum to have been very successful, whereas respondents from the NGOs and health professionals and from the production and sales organisations appeared less enthusiastic in this regard. It is also worth noting that 26% of respondents from production and sales organisations found the Open Forum of no use.

During interviews, Forum members emphasised that a wider range of external participants in Open Forum meetings, especially from Member States, would be beneficial to the EAHF process. '*More emphasis could be put on relevant stakeholders - and not only 'the usual suspects' attending the Open Forum*'. This issue is further discussed in the following indicator on participation in the Open Forum.

3.4.2 Indicator 2.4.2: External participation at the Open Forum

Overall, participation in the Open Forum decreased from 2009 to 2010, especially due to a decline in external participants. This, however, was partially due to practical circumstances for the 2010 Open Forum (see below) and no general conclusions should be drawn from this. Concerning the composition it can be seen that the majority of the external participants consisted of the same categories as Forum members.

Table 22 below displays an overview of the participants, divided into three groups: Forum members; observers of the Forum;[71] and external participants. The table shows that the majority of participants

[71] The observers mentioned are: the European Parliament, EU Member States, The Economic and Social Committee, The Committee of the Regions, The World Health Organization, represented by Headquarters and the Regional Office for Europe (contributes to the Forum in relevant technical areas), The International

have been EAHF members and about one tenth regular observers to the Forum. The share of external participants has been in the range 26-35%.

Table 22 Breakdown of participants at the Open Forum in Forum members, observers of the Forum and external participants[72]

Type of participant at the Open Forum	1st Open Forum, 17 April 2008		2nd Open Forum, 30 April 2009		3rd Open Forum, 19 November 2010	
	No.	Share	No.	Share	No.	Share
Forum member	97	68%	97	52%	78	60%
Observer at the Forum	9	6%	24	13%	13	10%
External participant	38	26%	67	35%	40	30%
Total	144	100%	188	100%	131	100%

In order to shed further light on the external interest for the Open Forum, a breakdown of the external participants is presented in Table 23 below, according to their sector/category. The external participants are grouped according to the four categories used for indicator 1.1.1 and two additional categories: CNAPA members and government representatives. The largest group of the external participants consists of the advertising, marketing, media and sponsorship organisations, although government representatives also make up a large share of the participants. The latter come from non-EU countries, including the Russian Federation, Korea and Switzerland as well as from regional authorities. The two categories NGO and health professional organisations, and research institutes and others have had relatively few representatives.

To some extent, the steep decline in participants from 2009 to 2010 can be explained by air transportation problems due to the Eyjafjallajökull volcanic eruption that disrupted European air travel: the Open Forum meeting planned for April was cancelled and re-scheduled for November; at that time the number of participants was limited by a smaller conference venue. The reduction in the number of participants should therefore not necessarily be interpreted as lack of interest.

Table 23 Breakdown of external participants at the Open Forum by category[73]

Type of external participants at the Open Forum	1st Open Forum 17 April 2008		2nd Open Forum 30 April 2009		3rd Open Forum 19 November 2010	
	No	Share	No	Share	No	Share
Non-governmental organisations and health professional organisations	8	21%	7	10%	3	7%
Advertising, marketing, media and sponsorship organisations	12	32%	26	39%	19	48%
Production and sales	3	8%	11	17%	4	10%
Research institutes and others	4	10%	9	14%	2	5%
Government representatives	8	21%	7	10%	11	28%
CNAPA	3	8%	7	10%	1	2%
Total	**38**	**100%**	**67**	**100%**	**40**	**100%**

In the interviews, a number of respondents indicated that a wider range of participants in Open Forum sessions might enable a more effective sharing of good practice. There is room for Member States to be better represented, either via CNAPA or otherwise. More active promotion of the Open Forum meetings and a higher profile for the meetings were called for. One suggestion was to create 'road-

Organization of Vine and Wine contributes to the Forum in relevant technical areas. The participation of some observer bodies in the EAHF plenary meetings has been minimal.

[72] Participation in the Open Forum is registered by DG SANCO.

[73] Participation in the Open Forum is registered by DG SANCO. Categorisation is made by COWI/Milieu as part of the evaluation.

shows' at national level to disseminate the good/best practices identified in the EAHF and to promote the idea of a multi-stakeholder action. It was highlighted that multi-stakeholder Forums resembling the EAHF have been set up at the national level in Austria, Portugal and the United Kingdom. Several EAHF members considered these initiatives highly beneficial for local cooperation between actors.

3.5 Key findings for Evaluation Question 2

The EAHF plenary meetings have addressed a wide range of thematic issues concerning alcohol-related harm. In general, the Forum has helped participating economic operators to gain a deeper understanding of issues addressed in the Forum as well as of positions and activities of Forum members from other sectors. Members of other sectors declared they have benefitted to a lesser extent in this regard. Economic operators reported that the EAHF has contributed to the exchange of good practices; this has been much less the case for non-industry members. These findings are similar to those of the *Evaluation of the European Platform for action on diet, physical activity and health* where a high share of industry respondents reported that participation in the Platform increased their understanding of the obesity issue whereas most not-for-profit respondents reported fewer gains.

A large number of EAHF respondents reported that participation has led to further cooperation with other members – however, this has taken place mainly within membership categories rather than across them.

Although the survey responses indicated a general satisfaction with the Open Forum, Forum members accounted for the majority of participants at Open Forum meetings, and many external participants represented organisations in the same categories as Forum members. In interviews, many Forum members said that the Open Forum process could benefit from engaging a broader range of actors.

4 Evaluation Question 3: To what extent has the EAHF process contributed to the development of responsible business practices across the EU in the sales and marketing of alcohol beverages?

This evaluation question concerns the action area 'Better cooperation/actions on responsible commercial communication and sales'. This section presents findings of desk research on commitments regarding sales and marketing.

Responsible practices with regard to sales are in this evaluation question defined as activities related to the retail sector, including for instance training of sales staff to enhance compliance with age limits. Responsible practices related to marketing are defined as activities in commercial communication, such as self-regulation and codes of conduct for responsible marketing of alcoholic beverages. Commitments sometimes apply to both areas.

Responsible business practices in the marketing of alcoholic beverages relevant to the work of the Forum are also discussed in the Case Study presented in the appendix to Task 2.

4.1 Assessment criteria 3.1 and 3.2: Economic operators have carried out, in relation to their membership in the Forum, actions (commitments) focused on responsible practices in the sales and marketing of alcoholic beverages

Indicators	Research Techniques
3.1.1 No./share of economic operator participants whose commitments have focused on responsible practices in the sales alcoholic beverages	Desk research
3.2.1 No./share of economic operator participants whose commitments have focused on responsible business practices related to marketing of alcoholic beverages	Desk research

These two assessment criteria concern solely economic operators and those of their commitments related to responsible practices in sales and marketing.

4.1.1 Indicators 3.1.1 and 3.2.1: Number/share of economic operators whose commitments have focused on responsible practices in the sales and marketing of alcoholic beverages

In order to identify the members that have submitted commitments related to responsible practices in the sales and marketing of alcoholic beverages, commitments were analysed in the EAHF action areas 'Better cooperation/actions on commercial communication and sales' (61 commitments) and 'Enforce age limits for selling and serving of alcoholic beverages' (25 commitments).

Over the lifetime of the Forum, 38% of economic operators have submitted at least one commitment addressing responsible practices in *sales.* About 40% (5) of the members working on sales are EU or international umbrella groups, the other economic operators are individual economic operators or national associations. Table 24 below lists these EAHF members. Commitments in this category typically include training of staff, encouragement of ID-checking, etc.

Table 24 Economic operators whose commitments focus on responsible practices in the sales and marketing of alcoholic beverages

Responsible practices in the *sales* of alcohol beverages		**Responsible practices in the *marketing* of alcohol beverages**	
No.	Share of total economic operators	No.	Share of total economic operators
1. Ahold N.V 2. Anheuser-Busch InBev 3. Association of small and independent breweries in Europe 4. Brown-Forman 5. Delhaize Group 6. Diageo 7. EuroCommerce 8. European Forum for Responsible Drinking 9. Finnish Hospitality Association 10. HOTREC 11. SABMiller 12. Swedish Hotel & Restaurant Association (SHR) 13. The Brewers of Europe	38%	1. Advertising Information Group 2. Association of small and independent breweries in Europe (SIB) 3. Association of Television and Radio Sales Houses (Egta) 4. Brewers of Europe 5. Anheuser-Busch InBev (ABI) 6. Heineken (International) 7. SAB Miller 8. Comité Européen des Entreprises Vin (CEEV) 9. European Association of Communication Agencies (EACA) 10. European Forum for Responsible Drinking (EFRD) 11. European Publishers Council (EPC) 12. European Spirits Organisation (CEPS) 13. Bacardi Martini 14. Brown-Forman 15. Diageo 16. Pernod-Ricard S.A. 17. The Scotch Whisky Association 18. European Sponsorship Association (ESA) 19. British Beer and Pub Association 20. WFA	59%

Members that submitted commitments addressing responsible practices in the sales of alcoholic beverages have the retail and hospitality sector as their core business area, i.e. the EU retail umbrella organisations, a supermarket, and national industry associations. Relatively few economic operators in

the Forum have retailing and hospitality as their core business (eight),[74] and five of these have submitted at least one commitment. In addition, about 60% (eight) of the total number of alcohol producers or their organisations in the Forum have submitted commitments in the field of responsible sales of alcohol.

Over the lifetime of the Forum, 59% of economic operators have focussed on responsible practices related to *marketing* of alcoholic beverages. Commitments concern the development of self-regulation of commercial communication, or the implementation at national level of umbrella organisations' code of conduct for self-regulation in marketing. About 60% (11) of those working on marketing are EU or international umbrella groups.

The 59% of economic operators who submitted marketing-oriented commitments represents organisations traditionally engaged in marketing: producers and advertising/media organisations. Economic operators that did not submit commitments related to responsible practices are mostly represented by retail and hospitality organisations, which may not have a major role in marketing of alcohol.

In sum, commitments under the EAHF have given rise to important activity towards further development of responsible business practices. This concerns especially marketing of alcoholic beverages, and to a somewhat lesser extent responsible retailing. It is worth noting that the topic of responsible business practices has been extensively addressed also in Forum meetings.

During interviews, it was also pointed out that marketing has been covered rather extensively in the Forum over the past years. Whereas a number of non-industry Forum members would like to see continued focus on marketing, some economic operators suggested that there has been too much focus on the issue, especially because progress in discussions has been slow due to underlying (even irreconcilable) differences in opinion. A point made by an NGO/health professional organisation representative was that there should be a requirement that commitments be in the core area of competence of the organisation carrying out the commitment.

Based on the desk research and inputs from members, more active involvement by actors in the retail sector might contribute to more comprehensive and potentially more effective action, both in on-trade and off-trade trade. This said, two major hospitality/retail umbrella organisations have submitted commitments in order to raise awareness of these aspects among their members.

4.2 Assessment criterion 3.3: Non-industry members have carried out actions (commitments) aimed at contributing to the development of responsible business practices

Indicator	Research Technique
3.3.1 No./share of non-industry participants whose commitments have focused on the development of responsible business practices (breakdown between owners and co-owners)	Desk research
3.3.2 No. of non-industry commitments related to responsible business practices (overall and broken down by a) sales, b) marketing) and content of commitments[75]	Desk research

This assessment criterion provides an overview of non-industry members' actions focusing on the development of responsible business practices. These members' commitments are broken down

[74] EuroCommerce, British Retail Consortium, Delhaize Group, Royal Ahold, British Beer and Pub Association, Finnish Hospitality Organisation, Swedish Hotel and Restaurant Association, HOTREC.
[75] Incorporates considerations relative to the commitments' content/level of ambition.

according to whether non-industry members are owners or co-owners of the commitment. Indications regarding the content and scope of the commitments are likewise provided as appropriate.

4.2.1 Indicators 3.3.1 and 3.3.2: Number/share of non-industry members whose commitments have focussed on the development of responsible business practices and number of commitments submitted by non-industry participants related to responsible business practices.

Out of 31 non-industry members in the Forum, four have submitted six commitments under action area 'Better cooperation/actions on commercial communication and sales' and 'Enforce age limits for selling and serving of alcoholic beverages' focussing on responsible business practices. Two non-industry members have submitted commitments concerning responsible practices in the *sales* of alcohol beverages, and two have submitted commitments concerning *marketing.*

Table 25 below provides details on the non-industry members, of co-owners of commitments (committed to contributing to putting the commitment into action); and a short summary describing the aims of each commitment. The table displays two examples of cooperation between members - here NGOs and health professionals. Likewise, coalitions between economic operators occur in the submission of commitments. In general, cooperation within sectors was pointed out in the interviews with Forum members to be catalysed by the EAHF.

The content of the commitments ranges widely. The economic operators' commitments regarding responsible business practices include 'active' components such as self-regulation of commercial communication (marketing), training of staff and encouragement of ID-checking (sales). The commitments of the non-industry organisations address controls of the enforcement of legal age limits and on alcohol policy laws, monitoring of the alcohol industry's alcohol advertisements, and provision of information on alcohol marketing regulation and on impacts of marketing and of minimum pricing.

Table 25 Non-industry members having submitted commitments focusing on the development of responsible practices*

Member	Co-owner	Commitment title	Summary	Focus: sales or marketing
Active - sobriety, friendship and peace	UNF - The Swedish Youth Temperance Union	Mystery shopping	The aim is to carry out random tests in shops and bars/pubs in order to check how they respect existing age limits. Test results will be systematically compared to see possible trends in the enforcement of legal age limits for purchasing alcohol.	Sales
Alcohol Action Ireland		Publication on the case for minimum pricing	The report provides key information on minimum pricing, and dispels myths and misinformation currently circulating in the media.	Sales
Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA)		Enforcement of the LOI EVIN (Code of Public Health)	The aim of the commitment is to monitor existing advertisements in magazines in order to control the enforcement of the alcohol policy law (Loi Evin) and bring illegal ads and commercial communication to court.	Marketing
		Enforcement of the LOI EVIN (Code of Public Health) Continuation	Continuation of the first commitment on Enforcement of the LOI EVIN.	Marketing
National Foundation for Alcohol Prevention (STAP)	IOGT-NTO and EUROCARE Italia	Overview European Alcohol Marketing Regulations & Overview Research on Effects Alcohol	The aim of the commitment is to provide an overview of marketing regulations in Europe and an overview of research findings related to the impact of alcohol advertisement and alcohol sponsorship. These actions build on the ELSA	Marketing

Member	Co-owner	Commitment title	Summary	Focus: sales or marketing
		Marketing	project[76] and are in part carried out as the AMMIE project, both co-funded under the EU health programme.	
		Alcohol Marketing in Health Perspective	The output of this commitment is: 1. An updated overview of the alcohol marketing regulations in Europe 2. A trend report on alcohol marketing in 5 countries. As part of the AMMIE project EUCAM will deliver a report about alcohol marketing trends in the Netherlands, Bulgaria, Denmark, Germany and Italy. The AMMIE project is co-financed by the European Commission. 3. Information about the impact of alcohol marketing 4. A training program for NGOs	Marketing

* Commitments identified in the action areas 'Better cooperation/actions on commercial communication and sales' and 'Enforce age limits for selling and serving of alcoholic beverages' with some adjustments due to inappropriate selection of areas in the commitments submission form.

4.3 Assessment criterion 3.4: The EAHF process has contributed to progress across the EU towards enhanced compliance with age limits for selling and serving alcoholic beverages

Indicators	Research Techniques
3.4.1 No. of commitments focusing on age limits	Desk research
3.4.2 Perceptions that the EAHF process has contributed to progress towards enhanced compliance with age limits	Interviews

To assess contribution of the EAHF process to enhanced compliance with age limits, the criterion takes into account commitments focusing on age limits within the sales of alcoholic beverages. The findings are supplemented by input from the interviews with members of the Forum and assessment of the evaluation details from commitments' monitoring reports.

4.3.1 Indicator 3.4.1: Number of commitments focusing on compliance with age limits

The total number of commitments under the action area 'Enforce age limits for selling and serving alcoholic beverages' is 25, or 12% of all commitments submitted since the creation of the Forum. An additional commitment was identified as targeting the action area, but had been categorised under another action area. Out of the 26 commitments submitted, 14 were submitted by eight production companies, eleven were submitted by four hospitality/retail organisations, and one was submitted by a non-industry member.

The majority of the commitments - submitted by economic operators - include training of sales and bar staff. One commitment is focussed on assessing compliance with age limits (through mystery shopping).

76 The ELSA project (Enforcement of national Laws and Self-regulation on advertising and marketing of Alcohol) co-financed by the European Commission, was coordinated by STAP and included 23 Member States and Norway.

Table 26 Commitments focusing on age limits

Commitment name	Member	Evaluation details
Mystery Shopping	Active - sobriety, friendship and peace	No interim/final reporting
Onder de 16 is fris de boodschap (Under 16 a soft drink is the message)	Ahold N.V.	No interim/final reporting
Training responsible 'Perfect Servers'	Anheuser-Busch InBev	Recent submission: no reporting
Ensuring responsible sales	Anheuser-Busch InBev (ABI)	Recent submission: no reporting
Beer - Beverage of moderation	Association of small and independent breweries in Europe	No formal evaluation component
Enforcement of age limits for selling and serving alcoholic drinks	British Beer & Pub Association	Some form of compliance evaluation
Best Bar None	Brown-Forman	Some form of compliance evaluation
Server Training Module	Brown-Forman	Some form of compliance evaluation
Education of cashiers to sell only alcohol products to people above 18 years	Delhaize Group	No formal evaluation component
Sales Force Awareness Program for New Alcohol Sales Legislation	Delhaize Group	No formal evaluation component
A Safer Nightlife Partnership - Server Training	Diageo plc	Evaluation of level of success of campaign, satisfaction/usefulness of training
Initiative 18+	Diageo plc	Evaluation of level of success of campaign, satisfaction/usefulness of training
Raising awareness of retailers to carry out actions against abuse of alcohol	EuroCommerce	No formal evaluation component
Training Guides for Responsible Service of Alcohol	European Forum for Responsible Drinking	Evaluation at level of success of campaign, satisfaction/usefulness of training
Enforce age limits for serving and selling alcoholic beverages	Finnish Hospitality Association	Some form of compliance evaluation
Raising awareness of National Associations / Call for actions	HOTREC	No formal evaluation component
Bartenders Training on Responsible Consumption Program	SABMiller	Evaluation at level of success of campaign, satisfaction/usefulness of training
Actions for responsible service of alcohol	Swedish Hotel & Restaurant Association, SHR	No formal evaluation component
Actions for responsible service of alcohol - continuation	Swedish Hotel & Restaurant Association, SHR	No formal evaluation component
Polish Brewers - Underage drinking	The Brewers of Europe	Evaluation at level of success of campaign, satisfaction/usefulness of training
The Belgian Brewers - Curbing underage drinking: ‘Respect 16’	The Brewers of Europe	No formal evaluation component
The German Brewers Association (DBB) – ‘Bier? Sorry. Erst ab 16’	The Brewers of Europe	Evaluation at level of success of campaign, satisfaction/usefulness of training

4.3.2 Indicator 3.4.2: Perceptions of the contribution of EAHF process contributed to enhanced compliance with age limits for selling and serving alcohol.

The direct contribution of the EAHF process to enhanced compliance with age limits for selling and serving alcohol is difficult to assess, firstly because of differences in regulations and enforcement practices across Member States and lack of comparable data on compliance across the EU, secondly because only a minority of the relevant commitments under the EAHF involve an assessment of levels of compliance.

This indicator reviews the level of evaluation of the commitments focusing on age limits. It then draws on interview results on this topic.

Where monitoring reports describe the evaluation details of the commitments, this information is summarised in the table above. For some commitments, a monitoring report has not yet been submitted, and information on evaluation is therefore not available. For others, no formal evaluation component was given in the monitoring report, however, some members indicated that they perform an internal evaluation.

In only five commitments is some kind of compliance evaluation conducted. This includes for example monitoring to ensure compliance with regulations on alcohol serving. For six commitments, an evaluation at level of success of campaign, satisfaction/usefulness of training is conducted. Overall, this provides only few indications of enhanced compliance.

In the interviews, Forum members were asked to what extent the Forum process has contributed to enhanced compliance with age limits. Whereas some members found the Forum processes to have contributed to a high extent, others found them to have contributed only to a limited extent. The answers did not to differ substantially according to sector. Several members mentioned that they found it difficult to assess the Forums' contribution. Overall it seems that, to a certain degree, the EAHF has contributed to increasing focus on age limits. A number of members representing both the economic operators and the non-industry organisations, however, also pointed out that the topic could receive more attention in the Forum as it seems to have been rather neglected recently.

To help improve compliance with age limits, economic operators suggested that further involvement from actors in the retail and hospitality sector may be useful, as these actors are currently under-represented in the Forum. Member States representatives' presence was furthermore called for by a number of interviewees, since Member State-level regulation, control and enforcement play a key role in this area. The Challenge 21 and Challenge 25 schemes in the UK were suggested as a possible starting point to improve compliance with age limits, as the Forum could encourage the adoption of comparable practices.[77]

4.4 Assessment criterion 3.5: The EAHF process has contributed to progress across the EU towards further development of responsible business practices in the marketing of alcoholic beverages

Indicators	Research Techniques
3.5.1 Perception that the process has contributed towards progress in the development of responsible business practices for marketing	Interviews

[77] Challenge 25 is a scheme whereby anyone who appears to be under the age of 25, seven years above the age required to buy alcohol in the UK, could be asked to provide a form of ID to prove their age.

4.4.1 Indicator 3.5.1: Perception that the process has contributed towards progress in the development of responsible business practices for marketing

During interviews, Forum members were asked about their assessment of the Forum's contribution to the development of responsible business practices in the marketing of alcohol beverages. (It should be noted that the issue of responsible business practices regarding marketing is addressed in depth in the case study.)

Perceptions of progress varied considerably across sectors. Whereas economic operators were generally very positive, non-industry members found that the Forum process has contributed only slightly or not at all towards the development of responsible business practices.

According to a number of economic operators, the process has been an important catalyst for the development of responsible marketing practices for alcohol. Progress has been made with respect to both the self-regulatory codes and the systems put in place to enforce these codes. Moreover, economic operators highlighted that the European Commission and the NGO sector have challenged the industry in the context of the Forum, thereby contributing to the development of these systems. It was also pointed out that some industry commitments in this area have been evaluated and verified by independent third parties. A further point noted was that while for the alcohol industry there has been significant progress in the field of responsible marketing, there is substantial room for improvement regarding the development of responsible business practices regarding sales. To this end, greater involvement by retailers was called for.

Several responsible marketing practice codes were cited as examples during interviews. These notably include the WFA-led Responsible Marketing Pact, the 7 operational standards and the Beer Pledge initiative of The Brewers of Europe, the CEPS Charter and the CEPS Road Map 2015, and CEEV's Wine communication standards.

> *The process has been a driving force in the development of responsible business practices for the marketing of alcoholic beverages. In general, while some things already existed, the Forum has helped step up the professionalism of the initiatives.*

On the other hand, non-industry members appear to be less optimistic regarding responsible business practices development in the context of the Forum. Most of interviewees from this group considered that there has been little progress in this area: '*We do not believe they would engage in any action that [would] reduce their sales and influence their bottom line'*.

Some representatives from non-industry members did however find that improvements have taken place notably relating to the labelling of alcoholic beverages. One interviewee stated:

> *In both areas [sales and marketing], industry groups could really step up their actions. There is disappointment among public health organisations that they haven't done so. There are, however, promising examples: the beer industry has started to use '18+ recommended age of drinking' labels, even in countries where the minimum drinking age for beer is 16.*

4.5 Key findings for Evaluation Question 3

The Forum has contributed to strengthening and expanding self-regulatory systems in the sales and especially the marketing of alcoholic beverages. Almost 40% of economic operator members have carried out commitments on responsible practices for sales, while almost 60% have had commitments on responsible practices for marketing. For marketing, economic operators have a benchmark, the model outlined in the 2006 Advertising Round Table. The Forum process has been important in maintaining attention on this area of work.

Although a substantial number of commitments focusing on age limits have been submitted (26), members of the EAHF reported difficulties in assessing the Forum's direct contribution to enhanced compliance with age limits for selling and serving alcohol. This is complicated by different legislation and enforcement practices across the EU. Moreover, an evaluation on compliance is only conducted for a few commitments focusing on age limits.

The development of responsible business practices for marketing is addressed in detail in the separate case study on this topic.

5 Evaluation Question 4: To what extent can the commitments be related to impacts on alcohol-related harm reduction?

As will be discussed with respect to Task 3, assessing the direct impacts of the EU alcohol strategy, let alone of only one of its components, on alcohol-related harm is extremely difficult. This kind of assessment requires a long-term approach and must take account of complex interactions at different levels of intervention. Moreover, as noted in section 2.4.1, the use of outcome and impact indicators in the monitoring reports for commitments is recommended but not required; moreover, the quality of these indicators and of evaluation details in the reports has not been strong.

In the face of these issues and limitations, two main approaches were used to address the issue of impacts. The first assessed by desk research the commitments of EAHF members in terms of the aims of the EU alcohol strategy. This is arguably an imperfect proxy for impacts on harm but it is also a useful indication of the strategic orientation of members' actions in the context of the Forum and their potential contribution to the strategy's aims. This analysis will furthermore contribute to an assessment of the degree to which the Forum's commitments and the aims of the alcohol strategy are appropriately aligned with each other.

In the second approach, the interviews asked if and how Forum members had attempted to assess the impacts of commitments. A solid amount of research has proven which measures are effective in reducing alcohol-related harm.[78] The assessment of a practice's effectiveness, however, has proven complicated for several reasons. Firstly, other sources of evidence, including professional expertise and knowledge on the ground, may be valuable, and these may not always be considered in scientific research. Secondly, a single practice in itself may only be effective – or may be significantly more effective – when it is a component of a broad-based approach or strategy.[79] In this context, the contribution of an action may be positive, but attribution of specific reduction in harm presents complex challenges. For example, a drink-driving campaign can be a contributing factor to a decrease in road accidents, but it would be very difficult to identify how many of the reduced number of accidents are attributable to the campaign when it acts together with greater activity of the police, stronger penalties and other factors.

5.1 Assessment criterion 4.2: The EAHF commitments have addressed key areas of alcohol-related harm

Indicators	Research Techniques
4.2.1 No. of EAHF commitments that cite each key area of alcohol-related harm (as per the aims of EU alcohol strategy) as a target	Desk research

[78] Babor, T., et al., Alcohol- No ordinary commodity. Research and public policy. Second edition, Oxford, 2010; Saunders, J., and Rey, J., Young people & alcohol. Impact, policy, prevention, treatment. Wiley-Blackwell, 2011; Thom, B., and Bayley, M., Multi-component programmes: A new approach to prevent and reduce alcohol-related harms. York: Joseph Rowntree Foundation, 2007.

[79] Thom, B., and Bayley, M., Multi-component programmes: A new approach to prevent and reduce alcohol-related harms. York: Joseph Rowntree Foundation, 2007.

4.2.2: The Forum's commitments and the aims of the alcohol strategy are appropriately aligned with each other	Desk research

The aims for reducing alcohol-related harm (defining the key areas of alcohol-related harm) are presented under each of the five priority themes of the EU Alcohol Strategy.[80] Desk research has focused on those aims that were considered to *directly* address the reduction of alcohol-related harm.[81]

- Aim 1: To curb under-age drinking, reduce hazardous and harmful drinking among young people;
- Aim 2: To reduce the harm suffered by children in families with alcohol problems;
- Aim 3: To reduce exposure to alcohol during pregnancy, thereby reducing the number of children born with foetal alcohol disorders;
- Aim 4: To contribute to reducing alcohol-related road fatalities and injuries;
- Aim 5: To decrease alcohol-related chronic physical and mental disorders;
- Aim 6: To decrease the number of alcohol-related deaths;
- Aim 8: To contribute to the reduction of alcohol-related harm at the workplace.

The following aims were not included:

- Aim 7: To provide information to consumers to make informed choices
- Aim 9: To increase EU citizens' awareness of the impact of harmful and hazardous alcohol consumption on health, especially the impact of alcohol on the foetus, on under-age drinkers, on working and on driving performance

These aims are excluded, as information and education are means that can support one or more of the aims above. In additions, aims 10 and 11 on monitoring and evaluation were not included, as these are instruments for assessing progress towards the other aims.

5.1.1 Indicator 4.2.1: Number of EAHF commitments that cite each key area of alcohol-related harm as a target;

Indicator 4.2.2: The Forum's commitments and the aims of the alcohol strategy are appropriately aligned with each other[82]

This question is assessed by providing an overview of the EAHF commitments that relate to the key aims listed above. This table was compiled by combining search in the EAHF database with a content analysis.

Table 27 EAHF commitments by key area of intervention

Priority theme, EU Alcohol Strategy	Key aims under the priority themes		No. of EAHF commitments
Protect young people, children and the unborn child	Aim 1	To curb under-age drinking, reduce hazardous and harmful drinking among young people.	39[83]
	Aim 2	To reduce the harm suffered by children in families with alcohol problems	1
	Aim 3	To reduce exposure to alcohol during	16

[80] Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions. An EU strategy to support Member States in reducing alcohol related harm. 24.10.2006.

[81] Aims 7, 9, 10 and 11 concern information, awareness raising and evaluation. These aims are excluded here because information and education are means that can be used for working towards one or more of the aims above. Monitoring and evaluation activities are considered instruments for assessing progress towards the EU alcohol strategy's aims.

[82] The indicator is placed under assessment criterion 4 to provide a greater coherence.

[83] Commitments in the action area 'Develop a strategy aimed at curbing under-age drinking and enforce age limits for selling and serving of alcohol beverages.' Five commitments are categorised in both action areas.

Priority theme, EU Alcohol Strategy	Key aims under the priority themes		No. of EAHF commitments
		pregnancy, thereby reducing the number of children born with foetal alcohol disorders	
Reduce injuries and deaths from alcohol-related road traffic accidents	Aim 4	To contribute to reducing alcohol-related road fatalities and injuries	32
Prevent alcohol-related harm among adults and reduce the negative impact on the workplace	Aim 5	To decrease alcohol-related chronic physical and mental disorders	10
	Aim 6	To decrease the number of alcohol related deaths	0
	Aim 8	To contribute to the reduction of alcohol-related harm at the workplace	4

Aim 1, *'to curb under-age drinking, reduce hazardous and harmful drinking among young people'* is addressed under Forum action areas 'Develop a strategy aimed at curbing under-age drinking' and 'Enforce age limits for selling and serving of alcohol beverages.' The number of commitments targeting aim 1 was therefore identified by searching the EAHF database on this action area.

For the remaining aims (2 to 6 and 8), the action areas do not correspond directly to the aims of the EU alcohol strategy and searching the EAHF database was therefore not an option. Instead, a content analysis was carried out. All commitment summaries were read and categorised according to the following target groups or areas of intervention (which draw on the table above):

- Children in families with alcohol problems
- Alcohol during pregnancy
- Alcohol-related road fatalities and injuries
- Physical and mental disorders
- Reduction of alcohol related deaths
- Reduction of alcohol-related harm at the workplace and promotion of workplace interventions

A full list of the relevant commitments is provided in Appendix I to Annex 2. Some commitments targeted several of the aims; these were included in all relevant categories.

Under priority theme 'Protection of young people, children and the unborn child', 39 commitments target the key area aiming at curbing under-age drinking and enforcing age limits. This is the largest number of commitments that have been submitted for a single key area. When asked which priority theme should receive continued attention, most members agreed that this priority, which has been widely discussed in the Forum, should receive continued attention. Furthermore, members identified enforcement of minimum age limits and education of school children as areas requiring greater attention.

Sixteen commitments concern the exposure to alcohol during pregnancy. Most of these are related to the labelling of alcoholic beverages.

Only one commitment addresses the reduction of harm suffered by children in families with alcohol-abuse problems (it concerns the legal rights of children growing up in families with alcohol-abuse problems). A number of Forum members have identified children suffering from parental alcohol abuse as a vulnerable group needing more attention in the context of Forum activities.

Thirty-two commitments target the reduction of alcohol-related road fatalities and injuries, i.e. aim 4 of the EU alcohol strategy. As the prevention of drink-driving was not identified as an area of action in the Charter establishing the EAHF, it was not available in the closed list available for indicating the priorities for a commitment. Many of the drink-driving related commitments are therefore related to campaigns to prevent drink-driving. Such commitments have mainly been submitted by economic operators, often in cooperation with local or national authorities.

Some Forum members stated in the interviews that the work on alcohol-related road fatalities has already yielded important results, but some also noted that a lot more could be done in the area, especially with regard to involving the competent Commission services (i.e. DG MOVE). One of the interviewees also pointed out that progress in this area could be faster because, unlike other areas, widespread agreement exists on the goal of tackling drink-driving.

Fourteen commitments target the reduction of alcohol-related harm at the workplace and promotion of workplace interventions. Ten commitments aim at reducing alcohol-related physical and mental disorders, and 4 commitments aim to contribute to the reduction of alcohol-related harm at the workplace and to promote workplace-related actions. Prevention of alcohol-related harm among adults and prevention of alcohol-related harm at the workplace have also been identified by some Forum members as areas requiring greater attention in the Forum.

No commitments explicitly targeting reduction in the number of alcohol-related deaths were identified. Arguably, however, most of the other aims indirectly contribute to the reduction of alcohol-related deaths as a distal outcome.[84]

The analysis indicates an uneven emphasis on the topics of the commitments. A substantial part of the commitments concern curbing under-age drinking, activities to curb underage drinking and to reduce alcohol-related road fatalities and injuries. Activities towards other target groups identified in the alcohol strategy (children, the unborn child, alcohol-related diseases) or arenas (reduction of alcohol-related harm at the workplace) are relatively much fewer. This suggests that the commitments under the Forum may not have contributed equally to the achievement of the EU alcohol strategy's aims.

An explanation of this could be that that the links between the priority themes of the EU alcohol strategy and the action areas of the Forum are not straightforward. Some of the aims addressed by very few commitments are categorised by not having an action area directly connected to them. For instance this concerns the aim '*to decrease alcohol-related chronic physical and mental disorders*' or '*to reduce the harm suffered by children in families with alcohol problems*'.

In the interviews and in the written comments to the survey, some members of the Forum mentioned that the logic of intervention of the implementation structure would be stronger if the action areas in the Forum Charter and the priorities in the strategy were more explicitly and directly related.

> *Overall, the Charter has stepped away from the EU alcohol strategy. The alcohol strategy priorities and the Charter's action areas are at this point unrelated. They should have been directly related.*

> *A key issue is that the commitments of the EAHF members do not directly flow from the EU Alcohol Strategy. If the Forum is to be effective as an implementation structure then the aims of the Forum and the commitments of its members need to be directly linked to implementing the strategy, using the Strategy wording as opposed to having separate Forum aims.*

5.2 Assessment criterion 4.3: The EAHF commitments and actions contributed to improve the process seeking a reduction in alcohol-related harm

Indicators	Research Techniques
4.3.1 Perceptions of the contribution of EAHF commitments	Interviews

[84] The Committee on alcohol data, indicators and definitions selected as the key indicator for alcohol-attributable health harm alcohol-attributable years of life lost, calculated based on mortality statistics.

The assessment criterion builds on qualitative data collection during interviews with EAHF members. The respondents were asked to what extent commitments submitted by EAHF members have contributed to the process towards alcohol-related harm reduction.

5.2.1 Indicator 4.3.1: Perceptions of the contribution of EAHF commitments

During interviews, Forum members were asked: '*In your organisation's commitments, have you evaluated and measured the results of the actions? If so, can you provide examples of impacts?*'

When assessing this indicator, it is important to bear in mind that outcome and impact evaluation is not obligatory under the EAHF Charter, although strongly recommended; however, the assessment of outputs is required.

All of the Forum members interviewed for this evaluation stated that they evaluate and measure their actions in some way. Most members assess indicators of outputs that have been achieved, for instance: number of workshop attendees; number of visitors to the initiative website; number of online accounts opened; and feedback from a satisfaction survey. In general, Forum members are interested in further evaluating the impacts of their commitments. For instance, it was mentioned by the representative of a production organisation that they plan to include questions on behaviour change in consumer surveys.

For some of the production organisations, ambitious evaluations have been or are to be performed. Some have included research institutions for their evaluations. These few cases attempted to measure not only the output of their commitments but also the outcome and impacts on behaviour and attitudes.

For instance, the preliminary results of an evaluation of a commitment in the form of a school education project led by a production organisation was reported to have led to a change in attitudes and build-up of self-esteem, confidence, and the ability to resist peer pressure among young people.

Another example is the evaluation of a recent commitment. The evaluation will assess the change of behaviour among teenagers in intervention and control groups each of more than 1000 persons before and after the activities.

Most Forum members interviewed concluded that the results observed to date appear promising as regards behavioural change. However, none of the interviewees was able to suggest a direct connection between a commitment and impacts on alcohol-related harm, since no impact assessment was conducted.

Although there was a wish to document impacts of commitments, it was widely agreed among the interviewed Forum members that the impact of commitments on alcohol-related harm is very complicated to measure. Three predominant reasons were identified.

Firstly, interviewed Forum members thought that it was very difficult to measure the impact of one separate action. For example:

> *It is difficult to assess the impacts of commitments because it is a complex issue which requires a multi-component approach. There are fundamental differences between contribution and attribution. What we can say is that commitments are making a contribution to tackling alcohol-related harm, but the impact is difficult to measure.*

Secondly, some Forum members stressed the need to continue work on developing, supporting and maintaining a common evidence base. Moreover, members pointed to the absence of a common and compatible evidence base and the absence of reliable indicators across the EU: '*we need common indicators for pregnancy, workplace and adults in general in order to measure impacts.*'

Finally, resource constraints were also identified as a key barrier for carrying out impact assessments. '*It is a question for us if we can devote the necessary resources to these activities [impact assessment]*'.

5.3 Key findings for Evaluation Question 4

Directly relating EAHF commitments impacts on alcohol-related harm is difficult at this stage, as information is limited and a number of commitments concern action in areas where results could be expected in the long term, and in conjunction with other actions, such as policy developments.

A review of EAHF commitments in terms of the priorities of the EU alcohol strategy shows that the Forum's actions have not been equally distributed, with a concentration of action on some topics and scant attention to others. Members point out that more emphasis could be put on several topics, including the negative impact of alcohol on adults, the elderly and the workplace, on children suffering from parental alcohol abuse and on enforcement of age limits in sales of alcoholic beverages. However, no clear consensus is found on the priorities. (The comparison also shows, however, room for greater alignment between the EU alcohol strategy priorities and the EAHF Charter's action.)

Evaluation has tended to remain at the level of outputs or short-term outcomes, rather than on impacts. Nonetheless, some members have conducted impact assessments of their commitment activities; however, many for many EAHF members, this exercise is methodically challenging and resource-demanding.

Members were interested in further evaluation of the results of their commitments, but called for more tools and information for conducting impact and outcome assessments.

6 Evaluation Question 5: To what extent can commitments be benchmarked in relation to the best available practices in the area?

This evaluation question covers two assessment criteria: the availability of sources of good/best practice relevant to the action areas of the EAHF; and an assessment of the extent to which EAHF members draw on these practices when developing their commitments to action.

The first part of the evaluation question is based on desk research, focussed in particular on sources of good/best practice that have been made available with some form of support from the Commission, through the EU Health Programme or in the context of the EAHF.

The second part of the evaluation question draws on desk research and interviews. Respondents were asked to assess the extent to which they had applied good or best practices when developing commitments to action under the EAHF, and indicate sources of good/best practice used by them.

6.1 Assessment Criterion 5.1: Best available practices exist for each of the action areas

Indicators	Research Techniques
5.1.1 List of best available practices for main action areas	Desk research
5.1.2 Cross-checking of commitments and their distribution	Interviews Desk research

A key issue at the start is that there is no unequivocal definition of what constitutes 'best practice'. The EU strategy identifies 'good practices' for each of its priority themes, and also refers to the exchange of 'best practice' with Member States and stakeholders, as well as to research to provide evidence for 'best practice'. The Forum's charter also refers to both 'good' and 'best' practices,

including in terms of monitoring commitments. Other documents also refer to both, and the two terms are sometimes used interchangeably.

Common characteristics for good and best practices include:

- Concrete results that support policy goals (in this case, reducing alcohol-related harm);
- Capacity to be reproduced or adapted by other actors
- Endorsement, including through partnership, of a wide range of stakeholders including government

It seems, however, that a general agreement on 'best practices' has so far been elusive.[85] 'Best' practices imply a choice of the most promising 'good' practices in a specific area, or the most promising elements from them. This implies either that they are identified through an assessment of research evidence, or through a broad process that evaluates different practices.

For example, the methodology employed by Babor et al. (2010) to define whether a public health policy or intervention to reduce alcohol related harm is a 'best practice' is to rate it on a scale from 0-3, according to three criteria: effectiveness, amount of scientific evidence and cross-national testing. Only practices with a score of 2-3 in each category are nominated as 'best practices'. This means that the practice is effective, that there is sufficient evidence of the effects, and that the result of the practice can be repeated in different countries. In general, there is a considerable amount of literature concerning the effectiveness of public health policies and interventions in reducing alcohol-related harm. Over the years, numerous academic works have been published that assess what works and what does not.[86] That said, it may be complex to prove the effectiveness of any single action or practice, due to other sources of evidence which may not always be considered in research. Furthermore, a single practice might only be effective, or might increase its effectiveness, when it is a component in a broad-based approach or strategy.[87] See also evaluation question four for further discussion.

Furthermore, many sources focus on government policy measures, including legislation and enforcement. This means that their results are only to some extent applicable for members of the Forum. Nonetheless, one area where EAHF members could play a role is in carrying out actions that are part of a multi-component strategy to implement policy.

6.1.1 Indicator 5.1.1: List of best available practices for main action areas

The table below lists a range of sources of best practice – or good practice – made available since 2006 with some form of support from the Commission. The first category embraces the academic research, for example, the report *Alcohol in Europe* (Anderson & Baumberg 2006),[88] which was produced in the preparatory phase leading to the launch of the EU strategy to support Member States in reducing alcohol related harm. The report *Alcohol in the European Union* published by the WHO Regional Office for Europe in 2012, addresses many of the same areas of action as the previous report, and summarises main research findings since 2006.[89]

[85] The report of an EU project on policy related to alcohol and the elderly included the following comment: 'It is always difficult in practice to define what a best practice is. Worldwide, different views and perspectives, different elements and variables can influence the definition of best practice. The definition should be also influenced by the context, by different economic situation, different resources that could have a role in orienting the policy making process towards practice that, even if not best, should have a relevant impact on the ability to deal with a public health problem.' L. Segura et al., Best practices on preventing the harmful use of alcohol amongst older people, including the transition from work to retirement, VINTAGE Project WP5 Report, 2010.

[86] Babor, T., et al., Alcohol- No ordinary commodity. Research and public policy. Second edition, Oxford, 2010; Saunders, J., and Rey, J., Young people & alcohol. Impact, policy, prevention, treatment. Wiley-Blackwell, 2011; Thom, B., and Bayley, M., Multi-component programmes: A new approach to prevent and reduce alcohol-related harms. York: Joseph Rowntree Foundation, 2007.

[87] Thom, B., and Bayley, M., Multi-component programmes: A new approach to prevent and reduce alcohol-related harms. York: Joseph Rowntree Foundation, 2007.

[88] Anderson, P., and Baumberg, B., Alcohol in Europe. London: Institute of Alcohol Studies, 2006.

[89] Alcohol in the European Union. Consumption, harm and policy approaches. WHO, 2012.

In the context of the EAHF, sources of good/best practice were identified and made available as part of the online Resource on Alcohol and Youth Projects (RAYPRO),[90] developed along a concept outlined by the EAHF Task Force on youth-related aspects of alcohol. Two reports were drawn up by the Institute of Social Marketing of Stirling University: a scoping study on alcohol and youth health, drawing on peer reviewed literature and case studies of evaluated interventions published 2000-2010;[91] and a report on school-based alcohol education in the EU in which examples of good/best practice and case studies published after 2005 were identified.[92] In the 'Further resources' section of the RAYPRO, a list of links to existing compilations of good practice available online was provided, directing to national and thematic project databases and to sources of guidance on methodologies for evaluating projects and interventions.[93]

Finally, several projects funded under the EU health programme have identified good/best practices. For example, the main purpose of the project Healthy Nightlife Toolbox[94] was to identify best practice tools for creating safer nightlife settings. Descriptions of evaluated interventions, references to literature and contact information for experts were made available through an online database. A handbook providing guidance on creating a healthy and safe nightlife was also produced.

The list of good/best practice sources is presented in the table below, with relevance for the action areas of the EAHF indicated. Since the list is focussed on sources made available with some form of support from the Commission it is of necessity illustrative rather than comprehensive. It should also be noted that the list has been drawn up with the action areas and target groups under the EAHF in mind. Examples of good practice in other areas, for example good practice and guidance on brief interventions for alcohol use disorders among adults, produced in the PHEPA projects,[95] or interventions to reduce alcohol related harm among the elderly identified in the Vintage project[96] are excluded.

The core area of action for the EAHF 'further development of the self-regulation of commercial communication on alcohol' is excluded from the good/best practice examination presented in this section. The reasons are twofold. Firstly, the academic literature relating to alcohol advertising is focussed on assessing the effectiveness of legislation based controls.

Secondly, the largest part of EAHF commitments to action in this area refer to a single source of good/best practice, the model of effective self-regulation outlined in 2006 as a result of the Advertising Round Table on policy areas under DG Health and Consumers.[97] Moreover, some of the commitments to action constitute themselves a 'best practice model': the standards for responsible commercial communication formulated by the EFRD, the CEEV and The Brewers of Europe are meant to be transposed and implemented through national self-regulatory schemes. Discussion on best practice in this area is therefore presented in the Case Study on progress in further development of responsible practices in the marketing of alcoholic beverages.

The table below indicates that best practices are to be found in all of the relevant action areas. Most of the identified best practices concern information and education, within both EU projects as well as academic research.

[90] https://webgate.ec.europa.eu/sanco_eahf/raypro/.
[91] Angus, K. et al., Evaluated interventions to reduce alcohol-related harm among young people. Institute for Social Marketing, Open University & University of Stirling, 2010, available at https://webgate.ec.europa.eu/sanco_eahf/raypro/public/externalReportForm.html.
[92] Cairns, G. et al., Synthesis report on the effectiveness of alcohol education in schools in the European Union. Institute for Social marketing, Open University & University of Stirling, 2009, available at http://ec.europa.eu/health/alcohol/docs/ev_20091112_co11_en.pdf.
[93] https://webgate.ec.europa.eu/sanco_eahf/raypro/public/furtherResourceForm.html.
[94] http://www.hnt-info.eu/.
[95] http://www.phepa.net/units/phepa/html/en/Du9/index.html..
[96] http://www.epicentro.iss.it/vintage/project.asp..
[97] Self-regulation in the EU advertising sector. A report of some discussion among interested parties. DG Health and Consumer Protection, 2006.

Table 28 Examples of good/best practice sources relevant for action areas under the EAHF[98]

	Source	Curb under-age drinking	Alcohol information and education	Enforcement of age limits	Behavioural change among children and adolescents	Prevention of drink-driving
Academic research	Anderson, P., and Baumberg, B., Alcohol in Europe. London: Institute of Alcohol Studies, 2006.		✓	✓		✓
	Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. WHO, 2009.		✓	✓		✓
	Handbook for action to reduce alcohol-related harm. WHO, 2009.		✓			✓
	Alcohol in the European Union. Consumption, harm and policy approaches. WHO, 2012.	✓	✓	✓		✓
RAYPRO resources	Cairns, G., et al., Synthesis report on the effectiveness of alcohol education in schools in the EU. Inst. for Social Marketing, Open Univ. & Univ. of Stirling, 2009.		✓			
	Angus, K., et al., Evaluated interventions to reduce alcohol-related harm among young people. Institute for Social Marketing, Open Univ. & Univ. of Stirling, 2010.	✓	✓	✓	✓	✓
	RAYPRO: Further resources[99]	✓	✓	✓	✓	✓
Projects	Pathways for Health 2006-2007[100]		✓			✓
	EUDAP 2005-2009[101]	✓	✓		✓	
	HEROES 2007-2010[102]					✓
	Healthy Nightlife Toolbox 2007-2010[103]		✓	✓		✓
	FASE 2008-2010[104]	✓		✓		
	PROTECT 2009-2010[105]		✓			
	TAKE CARE 2009-2012[106]	✓		✓	✓	
	Club Health 2009-2012[107]			✓		

[98] Action area 3 - development of efficient common approaches to provide adequate consumer information – is subsumed under 'alcohol information and education', which encompasses information on the effects of harmful drinking and information on responsible consumption patterns. Discussion on good practice in self-regulation of commercial communication on alcohol is presented in the Case Study focussed on this topic. Prevention of drink-driving is not among the original focus areas of the EAHF but is included here as a large number of commitments address this topic under the broader area of information and education.

[99] https://webgate.ec.europa.eu/sanco_eahf/raypro/public/furtherResourceForm.html.

[100] http://www.dhs.de/dhs-international/english/pathways-for-health-project.html.

[101] http://www.eudap.net/.

[102] http://www.ryd.eu/heroes/project.php.

[103] http://www.hnt-info.eu/.

[104] http://www.faseproject.eu/wwwfaseprojecteu/fase-elements/case-study-environments.html.

[105] http://protect-project.eu/.

[106] http://www.lwl.org/LWL/Jugend/lwl_ks/Praxis-Projekte/Take_Care_Start/?lang=en.

[107] http://club-health.eu/.

6.1.2 Indicator 5.1.2: Extent to which EAHF members draw on best practice.

In order to assess to what extent the commitments refer to good practice, Forum members were in interviews asked whether they look at good/best practices elsewhere when developing commitments.

Overall, the answers showed differences in what areas members refer to good/best practices. Moreover, members found difficulties in the application of good and best practices. Finally, the interviews showed that no systematic comparison to best practices results were conducted.

According to the survey, production and sales organisations have to a high extent applied good practices that were provided by the membership of the EAHF. This applies in particular to best practices within the action areas information and education, as well as commercial communication and sales where two thirds of the production/sales organisations indicated that 'to great extent' they apply best practices provided by the EAHF.

During interviews, this was confirmed. Many production and sales organisations refer to some set of standards, guidelines, good or best practice in the design of their commitments, although some of them are internal good practices within an organisation. External best practice examples referred to by production and sales organisation members primarily regard self-regulation standards. The work of The Brewers of Europe and European Advertising Standard Alliance, the STIVA standards, and the report of the Advertising Round Table of 2006 were mentioned as inspiration or benchmarks for commitments. A representative of a large production organisation pointed out that standards initiated and accepted by the leading producers can start a 'snowball' effect where smaller economic operators start applying the standards. Best practices in the area of marketing communication are further discussed in the Case Study contained in the present report.

On the other hand, the survey and the interviews revealed that non-industry members applied examples of good practices encountered through their membership of the EAHF only to a very limited extent. In the survey, only 17% of NGOs and health professionals said that they to great or to some extent apply best practices provided by the EAHF.

An umbrella NGO stated in the interview that '*best practices are not applicable to our organisation*'. Nonetheless, non-industry members emphasised that they base their commitments on research-based evidence, including EU-funded research such as the AMPHORA and ALICE RAP projects. Interviewees from this sector reported that other organisations' practices and web pages are sources for inspiration to new commitments or other activities.

To some extent, this can be explained by more specific commitments in the NGO/health professional sector. Whereas best practices for industry organisations concerning self-regulation constitutes a relevant topic for most production companies in the EAHF, the NGO/health professional sector is more fragmented, some working on developing best practices on their own. Some representatives from this sector indicate that due to the different nature of the commitments, the Forum has not yet succeeded in presenting best practices that are relevant to their work:

> *The Forum has been quite a good platform to present good/best practice, but so far what has been presented has not been closely linked to what we do. There are usually one or two priority themes for each Forum meeting and most have not been relevant as the nature of commitments can be very different.*

In the interviews, members also identified the problems of defining best practice not relating to self-regulative measures. One respondent explained: '*Commitments could be benchmarked if you would know the best practice. There are issues legitimately defining what best practice is. Who decides that?*' As well as being difficult to identify, best practice could be difficult to apply. Some best practices are to high extent dependent on contextual factors such as legislation and alcohol culture. Interventions that are effective in one Member State might not be effective in another.

Among members basing their commitments on good/best practices, only a few reported a systematic benchmark of commitments to the practices, for instance with the purpose of verifying the degree of fulfilment. This cross-checking tends to take place on an ad hoc basis.

Both economic operators and non-industry members stated that the Forum could play a more prominent role in collecting, setting standards for, disseminating and even developing best practices. Given the broad spectrum of members, the EAHF provides a good forum for further development and identification of good practices. One member stated, '*the true added value of the Forum lies in identifying good practices*'.

In particular, best practices within general topics such as information, education, behaviour change and early intervention could be relevant for both non-industry and economic operators. These topics could receive strengthened attention when presenting best practices in the Forum.

Finally, EAHF members did not refer to supporting government policies as possible examples of best practice. As noted in the previous section, academic literature has identified areas of proven good/best practice in particular for policy measures. EAHF commitments can play a role in supporting such measures, for example when they are part of a multi-component approach to support policy goals. Babor et al. note that multi-component activities, including authorities, can have an effect on reduction of alcohol-related harm.

There are several examples in the EAHF database on cooperation between members and authorities. This applies in particular to production organisations establishing cooperation with local or governmental authorities concerning drink-driving activities. The box below provides three examples.

Examples of multi-component activities in cooperation with authorities

Swedish Hotel and Restaurant Association: Actions for responsible service of alcohol: Working with local authorities, including in Stockholm and Gothenburg on actions against members in SHR due to service to under-age or intoxicated people.

SABMiller: The Establishment of Cooperation between the Company, the Government and an NGO to Prevent Together Drinking and Driving: Responsibility message in commercial communication and on packaging on drink driving. A Memorandum on cooperation with the Ministry of Transport (Czech Republic) on information campaigns

Alcohol Beverage Federation of Ireland (ABFI): Being drinkaware.ie - further promotion of positive drinking behaviours. With the government and social partners in Ireland

6.2 Key findings for evaluation question 5

Examples of good practice approaches are listed in the EU alcohol strategy and have been further developed and compiled in EU-funded projects, as well as in the academic literature. While many such examples focus on government policies, good/best practices can be identified for the five EAHF action areas not related to commercial communication. In addition, examples

can be found of EAHF commitments that support government policies as part of a multi-component approach, in particular in the area of drink-driving.

A significant number of economic operators draw on available best practices when designing commitments. For this purpose, the EAHF has been beneficial for exchanging best practices.

In other areas, however, and also for non-industry respondents, the use of benchmarks when developing commitments, and of a systematic benchmarking process, seems rare. Both economic operators and non-industry members called on the Forum to play a more prominent role in collecting, setting standards for, disseminating and even developing best practices.

This is a key area for action, as it can help to strengthen the 'intervention logic' linking commitments to reductions in alcohol-related harm.

7 Evaluation Question 6: What are the lessons learned regarding composition, focus and working methods including of the EAHF sub-groups?

The Charter establishing the European Alcohol and Health Forum sets out the composition, focus and working methods of the Forum. As organisational forms for the work, the Charter foresees plenary meetings, Open Forum meetings, a Science Group and Task Forces, no more than two at a time, to work based on specified mandates. With the Charter, the Task Force on Youth-Specific Aspects of Alcohol and the Task Force on Marketing Communication were established at the start, and no further Task Forces have been established since.

The evaluation question reviews lessons learned about the processes of the working methods of the EAHF and its sub-groups with specific attention on their composition and focus. For the Science Group, the information gathering found that issues about working methods are closely linked to the Group's interaction with EAHF, and as a result this topic also treated here, rather than under Evaluation Question 7.

The evaluation question is based on two assessment criteria:

- Assessment criterion 6.1: The membership of the sub-groups is appropriate for their activities

Indicators	Research Techniques
6.1.1 Share of sub-group members by type	Desk research
6.1.2 Perception that membership is appropriate	Interviews

- Assessment criterion 6.2: The working methods of the sub-groups have been appropriate for their activities

Indicators	Research Techniques
6.2.1 Perception that working methods are appropriate	Workshop / Interviews

For clarity, this section reviews each of the subgroups in turn: the Science Group, the Task Force on Youth-Specific Aspects of Alcohol and the Task Force on Marketing Communication.

The Forum members interviewed as part of this evaluation were asked three questions relating to the sub-groups' work and its usefulness.[108] The questions were:

- To what extent were the Science Group's opinions—one on the impact of marketing on drinking by young people, one focused on alcohol and work—useful in any way?
- To what extent was the Task Force on Youth-Specific Aspects of Alcohol useful in advancing work related to the Forum?
- To what extent was the Task Force on Marketing Communication useful in advancing work related to the Forum?

7.1 Science Group

The Science Group was established by the EAHF Charter. The main tasks of the Science Group are to stimulate cross-EU networking of scientific activities for the issues relevant to the European Alcohol and Health Forum and, on request, to:

- Provide scientific guidance to the members of the European Alcohol and Health Forum;
- Offer guidance on monitoring/evaluation and, on the basis of output from monitoring, on areas where action by Forum members could help reduce alcohol-related harm, and the forms of action;
- Provide in-depth analyses of key issues identified by the European Alcohol and Health Forum.[109]

Table 29 Members of the Science Group, March 2012 [110]

Name	Member State	Affiliation	Active as of March 2012
Prof. Peter ANDERSON	UK	Maastricht University, Faculty of Health, Medicine and Life Sciences, United Kingdom	
Prof. Roumen BALANSKY	BG	National Centre of Oncology, Sofia	
Dr Alberto BERTELLI	IT	University of Milan, Department of Human Morphology, Italy	✓
Prof Patrice COUZIGOU	FR	University Victor Segalen, Bordeaux 2, France	✓
Prof. Ludovic DROUET	FR	Groupe hospitalier LARIBOISIERE – FERNANDWIDAL,Groupement hospitalier universitaire Nord, Paris	
Prof. Irmgard EISENBACH-STANGL	AT	European Centre for Social Welfare Policy and Research, Vienna	
Prof. Bohumil FIŠER	CZ	Masarykova Universita (Masaryk University), Brno	
Prof. Ian GILMORE	UK/IE	Royal College of Physicians, London, United Kingdom	✓
Prof. Morten GRØNBÆK	DK	University of Southern Denmark, National Institute of Public Health, Denmark	✓
Prof. Eileen KANER	UK	Newcastle University, Institute of Health and Society	
Ulrich KEIL	DE	University of Münster - Institute of Epidemiology and Social Medicine	
Prof. Michael KLEIN	DE	Catholic University of Applied Sciences North Rhine-Westphalia, Centre of Excellence on Applied Addictions Research, Germany	✓

[108] As it would be complex for outsiders to judge the appropriateness of the groups' working methods, the questions presented in the interviews focussed on perceptions of the usefulness of the groups' respective outputs.

[109] Charter establishing the European Alcohol and Health Forum, Annex 3.

[110] An analysis of members' coverage could be performed on basis of CVs from DG SANCO.

Name	Member State	Affiliation	Active as of March 2012
Prof. Ronald KNIBBE	NL	Maastricht University, Department of Health Promotion and Health Education, the Netherlands	✓
Dr Katrin LANG	EE	Tartu University, Department of Public Health Estonia	✓
Dr Marjana MARTINIC	DE	International Center for Alcohol Policies (ICAP), Washington DC	✓
Dr Jacek MOSKALEWICZ	PL	Institute of Psychiatry & Neurology, Warsaw Poland	✓
Dr. Alojz NOCIAR	SK	Research Institute of Child Psychology and Pathopsychology	
Dr Dusan NOLIMAL	SI	National Institute of Public Health, Ljubljana Slovenia	✓
Dr. Alicia RODRIGUEZ-MARTOS	ES	Agència de Salut Pública (Public Health Agency), Barcelona	
Prof. Anders ROMELSJÖ	SE	Stockholm University, Center for Social Research Karolinska Institutet, Department of Public Health Sciences, Sweden	✓

Members were appointed by the Chair of the Forum, following an open call for expressions of interest. A maximum of 20 permanent members are appointed, seeking the broadest possible representation of scientific expertise and geographical coverage. All members must have a university degree in a relevant scientific area, preferably at postgraduate level, and more than 10 years' experience at a level to which these qualifications give admission.[111] Members' areas of expertise should be related to the Forum's area of action, and should therefore cover a broad spectrum of topics.[112]

Currently, the Science Group (March 2012) has 12 members: of the 20 initial members, eight have resigned, citing in particular professional and health reasons.[113] The original and current members of the Science Group are listed in Table 29 above.

The European Commission identified the expertise covered by the original members of the Science Group (see Table 30 below), across 14 topic areas. With the current, reduced membership some areas are covered less strongly. (It should be noted, however, that two original and current members are not included in this analysis.)

Table 30 Expertise covered by the original members of the Science Group

Area of Expertise	No. of original SG members*	No. of current SG members*
Addictology	11	6
Anthropology	1	1
Behavioural Science	5	3
Consumer Safety and Consumer Information	7	5
Criminology	5	2
Disease Prevention	10	5

[111] Call for expression of interest in membership of the Science Group of the European Alcohol and Health Forum http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/alcohol_call_en.pdf.

[112] The topics are: public health, health promotion, health education, disease prevention, occupational health, epidemiology, consumer safety and consumer information, psychology, psychiatry, behavioural science, mental health, addictology, criminology, sociology, anthropology, health economics, health outcomes research, marketing research, social marketing, pharmacology, injury and accident prevention. Call for expression of interest in membership of the Science Group of the European Alcohol and Health Forum http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/alcohol_call_en.pdf.

[113] DG SANCO, Communication, 20 December 2011.

Epidemiology	17	10
Health Economics	3	1
Health Education	14	8
Health Outcomes Research	11	7
Health Promotion	15	9
Injury and Accident Prevention	9	6
Marketing Research	1	0
Mental Health	7	4

Source: DG SANCO, based on information provided by Science group members
* Two members not included

As seen in the table above, the group's original 20 scientists came from 17 Member States, of which 6 from the EU12. The current membership comes from 11 Member States, of which only 3 EU12 members.

Since its creation, the Science Group has met biannually. The number of participants in the Science Group meetings has varied due to resignations as well as absenteeism. At the latest three meetings, the quorum was not reached (see table 31 below).

Table 31 Overview of quorum reached at Science Group meetings based on number of members

Meeting	Date	Members present/total	Quorum reached
9th*	2011-09-15	6/13	No
8th	2011-03-11	6/13	No
7th	2010-10-25	6/15	No
6th	2010-05-18	10/20	Yes
5th	2009-10-19	13/20	Yes
4th	2009-06-19	15/20	Yes
3rd	2009-02-23	12/20	Yes
2nd	2008-10-29	13/20	Yes
1st	2008-06-30	18/20	Yes

* Audio conference

The current and former members of the Science Group were invited to participate in the third survey, and were also asked questions regarding the group itself. Nine of twenty current and former members of the Science Group responded to the short survey submitted, making this a very small sample. Nonetheless, eight of nine respondents felt that the membership of the group was appropriate to 'a great' or to 'some' extent.

A few Science Group members also made written comments on issues concerning the composition of the group. One member wrote that the Science Group consisted of a large number of biomedical experts – however, there was little role for this expertise. Another former member felt that the Science Group members did not have expertise for the requests received.

In an interview, however, one member of the Science Group stated that the members had '*a remarkable spectrum*' of expertise across areas related to alcohol and health. This member also noted that the Science Group can bring in further expertise for its work, and did so for the two reports it prepared.

In interviews with EAHF members, some also mentioned this topic. In particular, several representatives of economic operators of the Forum indicated that not all relevant professional areas were fully covered. Marketing, taxation and behavioural economics were identified as additional disciplines from which the Science Group work could benefit.

Science Group working methods

In an interview, one member of the Science Group commented that it took some time to build working relationships within the group. This member noted that the group has worked both in plenary sessions and in smaller teams to prepare the reports requested by EAHF, and said that the resignations and difficulty in bringing together members is not unusual for a group made up of busy professionals.

In the survey of Science Group members, eight of nine respondents felt that the membership and working methods were appropriate to 'a great' or to 'some' extent. In written comments, however, current and former members of the Science Group member raised a couple of concerns about working methods. One is that the start of the work was difficult. Another comment was that there was a '*significant requirement in time and personal resources in order to undertake the tasks that were set before the group*' – however, members' involvement is not compensated.

A third member commented that the Science Group:

> *'had difficulties to find its role, and it seemed sometimes as if the mandate was not clear. I think that this contributed to reduced participation. It was also unclear how its work was seen by EAHF and EU. I think that a Science Group nevertheless is important'.*

A few Forum members in interviews also raised concerns about the lack of remuneration for Science Group members, suggesting that members already attached to EU-funded research could have a greater incentive to work in the Science Group than others.

Interactions between EAHF and the Science Group

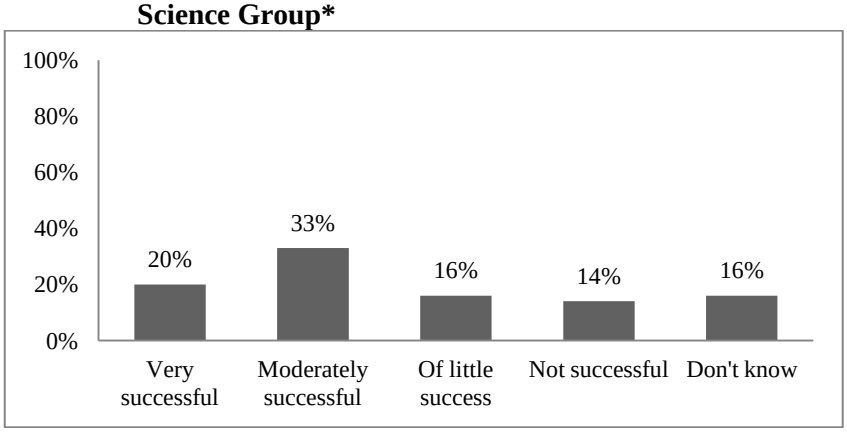
With the exception of the 10th meeting in April 2012, the Science Group has been on the agenda of all EAHF plenary meetings: in the 1st and 2nd meetings to discuss the call for interest and nominations; in the 3rd and 4th to discuss progress on and results of the first request for scientific opinion; in the 5th and 6th to discuss possible topics for a second request; in the 7th, 8th and 9th to discuss progress on and results of the second request for scientific opinion. The Science Group has been represented in the EAHF meetings by its chair or vice chair, on two occasions accompanied by another member of the group.

Since the creation of the Forum, two scientific opinions have been requested of and delivered by the Science Group: 'Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people?' in 2009,[114] and 'Alcohol, work and productivity' in 2011.[115] These opinions have been a central focus of the interaction between the Science Group and EAHF a whole. For both scientific opinions, members of the EAHF were invited to contribute with potentially relevant data or materials, and in both cases a range of documents were forwarded to the Science Group by the Secretariat.

In survey results, more than half Forum respondents, 53%, indicated in the survey that the interaction has been successful, either 'very successful' (20%) or 'moderately successful' (33%). Nevertheless 30% found the interaction less than successful, 'of little success' (16%) or 'not successful' (14%). Again, 16% of respondents did not voice an opinion.

[114] http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf.
[115] http://ec.europa.eu/health/alcohol/docs/science_02_en.pdf.

Figure 24 How would you assess the EAHF's dialogue and interaction with the Science Group*



*n=49

Moreover, the survey results show that opinions on the dialogue and interaction with the Science Group differ across the categories of Forum members. Whereas 76% of the respondents from NGOs and health professionals and half of the advertising, marketing, media and sponsorship organisations find it very or moderately successful, 47% of the respondents from sales and production companies find it of little or no use. The answers of the research institutes and others are more fragmented; 40% find it successful, 20% find it of little or no use and 40% replied 'Don't know'.

Table 32 How would you assess the EAHF's dialogue and interaction with the Science Group? Answers by category*

	Very /moderately successful Share	**Of little/no use Share**	**Don't know Share**	**Total (No.)**
Non-governmental organisations and health professionals	76 %	12 %	12 %	(17)
Advertising, marketing, media and sponsorship organisations	50 %	38 %	13 %	(8)
Production and sales	37 %	47 %	16 %	(19)
Research institutes and others	40 %	20 %	40 %	(5)

In interviews, further interaction with the Science Group is also welcomed by Forum members, although as noted above many economic operators have reservations concerning its composition. Concretely, interaction could consist of better updates on the Science Group's work in order for Forum members to prepare for meetings. Better updates would also prepare members to contribute with qualified input for the work, bearing in mind that the Science Group should work independently.

Most Forum members interviewed deemed the report 'Alcohol, work and productivity' to be useful and of good quality, and to consider different approaches on reducing alcohol related harm at the workplace. The report is mentioned as a source of information in the preparation of commitments. Some members, however, were less enthusiastic, one explanation given being that there is limited scope for involvement at the EU level in this area.

The report 'Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people?' treats an important and delicate subject in the EAHF context. Assessments of the opinion's relevance and usefulness diverge between economic operators and non-industry actors.

From a NGO/healthcare sector point of view, the report has been widely useful. It has provided NGOs and health professionals with an important overview of existing research activities.

> *We could debate on the results of the opinions, but regardless they have provided very useful information that we are considering when preparing commitments. We don't know where else we would have gotten the information, if not provided by the Science Group.*

Representatives of non-industry members also pointed out, however, that further discussion about the actual implementation of the results of the Science Group opinion is necessary.

> *A key lesson is that the Science Group has been excellent to address gaps in evidence. More discussion though, could be needed in order to find out how to employ this valuable data.*

Among representatives of economic operators in the Forum, assessments of the Science Group's report were mixed. Most of these representatives felt that that a broader perspective, notably by getting input from commercial and behavioural fields of science, would have been beneficial. Members also mentioned that the work of the Science Group could to a greater extent have been debated in the Forum in order for Forum members to provide input. The rigour in the underlying research work was questioned by some, and it was suggested that the conclusions of the report were 'unnecessarily politicised'. On a more general level, some Forum members found that the Science Group primarily focused on policy rather than on scientific issues that could contribute to the development of actions in the context of the Forum's work.

In the interviews, a number of Forum members suggested that there is significant scope for the Science Group to 'serve the Forum' better, by sticking more closely to alcohol-relevant, action-oriented scientific issues.

It was acknowledged in the Advisory Group that the Forum could be more active in requesting the Science Group's opinion or assessment, and to a greater extent benefit from the Group's scientific expertise.[116]

One member of the Science Group remarked that EAHF itself is an experiment, and having a Science Group within it was 'ingenious', as it allowed a dispassionate look at evidence. He felt that the differences in members' views concerning science were 'predictable', and actually less strong than expected. This member also suggested that, while the Science Group's original form was appropriate, it could have a wider and more useful role now if its work extended beyond EAHF to supporting other elements of the EU strategy.

In sum, the Science Group's objectives have been partly fulfilled by providing scientific guidance and by providing in-depth analysis of key issues identified by the Forum. Although with some reservations about the composition and the focus of the Science Group, members acknowledged the usefulness of the Science Group's work. However, the Science Group has in total only received two tasks. A stronger focus on assigning the Science Group to specific tasks,

[116]The Science Group's Rules of Procedure specify two procedures for designating a task to the Group: '1) Requests [from the EAHF] for scientific opinions shall be submitted by the Secretariat to the Science Group through its Chair 2)The Science Group may draw the European Alcohol and Health Forum's attention to any issue falling within its remit. The European Alcohol and Health Forum shall decide on the action to be taken including, if appropriate, a request for a scientific opinion or a report on the matter and inform the Science Group accordingly.'

for instance guidance on evaluation and monitoring, could be applied in the Forum. Moreover, a broader composition of members could be considered. From a more structural point of view, it could be considered to assign the Science Group to serve the Commission in more general matters.

7.2 Task Force on Youth-Specific Aspects of Alcohol

The Task Force on Youth-Specific Aspects of Alcohol was established by the EAHF Charter. The objectives of the Task Force are:[117]

- To examine trends and drivers in drinking habits of young people and of the alcohol-related harm they suffer;
- To examine approaches that have a potential to reduce alcohol-related harm suffered by young people, and in particular strategies aimed at curbing under-age drinking and drink-driving by young people, actions aimed at promoting responsible selling and serving, and interventions aimed at educating and empowering young people;
- To make recommendations to the Forum.

In order to ensure the effective functioning of the Task Force, the EAHF Charter provided that a maximum of 20 members were to be appointed, with no more than one member from each of the organisations represented in the Forum. Particular emphasis was to be given to youth and family organisations to ensure a balanced representation of the different stakeholders.[118]

As shown below, 20 members represented NGOs or health professional organisations, of which two represented youth organisations and one a family organisation. Seven members represented production or sales organisations. A full list of members of this Task Force is provided in Appendix II to Annex 2.

Table 33 Members of the Task Force Youth-Specific Aspects of Alcohol[119]

Member		**No**
NGO or health professional organisations		**13**
	Youth organisations	2
	Family organisation	1
Production and sales organisations		**7**
Total		**20**

The Task Force on Youth-Specific Aspects of Alcohol met four times since the creation of the Forum. The first meeting, on 22 November 2007, served to adopt the rules of procedure, to identify the priority working areas and to agree on a work plan for the Task Force.[120] The last meeting was in January 2009. As indicated in its last report to the EAHF plenary meeting, with the development of a concept for a clearinghouse for projects focused on youth and alcohol, to be taken forward independently of the Task Force, the Task Force as such reached a natural conclusion.[121]

[117] Charter establishing the European Alcohol and Health Forum, Annex 4.

[118] European Alcohol and Health Forum Task Force on Youth-Specific aspects of Alcohol Mandate, Rules of Procedure and Work Plan.

http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/alcohol_taskfmandate_en.pdf.

[119] http://ec.europa.eu/health/alcohol/docs/science_list_2010_en.pdf.

[120] http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/alcohol_taskf20071122_en.pdf.

[121] http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/alcohol_forum_taskfreport_en.pdf.

In interviews, members of the Forum found that the Task Force Youth-Specific Aspects of Alcohol was useful only to a limited extent in advancing work related to the Forum. Indeed, many respondents did not recall the conclusions reached by the Task Force. To some extent, this was recognised by a member of the Task Force Youth-Specific Aspects of Alcohol in an interview, expressing that the Task Force '*has been useful in some regards, but not coming through strong enough*'.

The interview respondents who did discuss the Task Force felt its work should be continued with further discussion and guidance. Some interviewees suggested, for example, that a toolkit on responsible serving (e.g. to prevent serving to minors) could be developed in the context of the Task Force. The RAYPRO database project,[122] based on the concept outline by the Task Force Youth-Specific Aspects of Alcohol, was considered to have been a valuable initiative, but many of the interviewees suggested that further work would be required to make it more accessible and promote its use.

7.3 Task Force on Marketing Communication

Due to the developments in the field of advertising and self-regulation, as well as debate concerning the issues, DG SANCO decided to pursue the work begun in the 2006 Advertising Round Table, and to consider other related issues of common interest. The EAHF Task Force on Marketing Communication was set up for that purpose.[123]

The tasks of the Task Force, as defined in the EAHF Charter, are:

- To examine best practice actions aimed at promoting responsibility in marketing, and preventing irresponsible marketing;
- To examine and build upon the report of the Directorate General for Health and Consumer Protection on the Advertising Round Table;[124]
- To examine trends in product development, product placement, sales promotions and other forms of marketing, and trends in alcohol advertising and sponsorship;
- To make any appropriate recommendations to the Forum.

The members of the Task Force were appointed by the Chair of the Forum, following a call for expressions of interest among the Forum members and after consultation of the EAHF at its first plenary meeting on 17 October 2007.[125] In total, 21 members were selected (see table 34 below; the specific members are listed in Appendix II to Annex 2).

Table 34 Members of the Task Force on Marketing Communication[126]

Category	No
Non-governmental and health professionals	**9**
Production and sales organisations	**6**
Advertising, marketing, media and sponsorship organisations	**6**
Total	**21**

[122] The on-line database RAYPRO, a Resource on Alcohol and Youth Projects, supports sharing information on projects and activities to reduce alcohol-related harm among children and young people, and promotes good practice based on sound evaluation of effectiveness. https://webgate.ec.europa.eu/sanco_eahf/raypro/public/introductionForm.html.

[123] Charter establishing the European Alcohol and Health Forum, Annex 4.

[124] The Advertising Round Table identified some key elements for effective self-regulation of advertising in policy areas under the DG for Health and Consumer Protection. http://ec.europa.eu/consumers/overview/report_advertising_en.pdf.

[125] Charter establishing the European Alcohol and Health Forum, Annex 4.

[126] http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/alcohol_forum_taskf2_en.pdf February 2012.

The working methods of the Task Force have evolved over time. Six meetings were held on a biannual basis, starting on 11 December 2007 and concluding with the meeting on 9 June 2009.[127] Reports consisting of a mapping exercise were prepared in three related areas: self-regulation, social marketing and targeting/not targeting youth. The reports were based on information supplied by economic operators as well as on selected academic studies.[128]

The work of the Task Force on Marketing Communication concerns issues that have proven sensitive in the context of the Forum. The working process of the Task Force included debates at the plenary level, a process that several Forum members supported in interviews: *'[the Task Force] really did engage everybody, it has been useful and it has enabled fair discussion and open debate*'.

However, members of the Task Force indicated in the interviews that the work could be improved by establishing a '*clear consensus of what it is there for and what it is trying to achieve*', since some Task Force Members seem to have rather antagonistic views regarding objectives.

Interviewed Forum members also pointed out the need to build on the work that has been conducted so far in the context of this Task Force, otherwise motivation and commitment by members could be negatively affected and thus so would expected outcomes.

A number of interviewed Forum members agreed that it would be valuable to continue the work of both Task Forces. However, their management and composition would need to be revised. A more operational, possibly smaller structure with clear objectives and timelines was considered a possibly more beneficial option.

7.4 General EAHF working methods

In the interviews, Forum members were asked about the EAHF working methods and administrative processes.

Many respondents appreciated that there is a topical focus for each plenary session. Also, the Flash Reports, published since the 9th plenary meeting, are considered helpful and an improvement from previous reporting practices. Some respondents said they would like the actual Summary Reports to be more detailed; one member found the current Summary Reports did not always reflect agreed actions or what actually happened and was discussed at meetings.

Numerous suggestions for further development of the Forum's working methods were put forward by interviewees. Many expressed a desire for more time for discussion during the plenary meetings, since meetings often run over the allotted time and very seldom is there sufficient time to discuss the last items on the agenda. In a trade-off between more time for discussions and presentations, the majority of Forum members interviewed supported the former.

Several Forum members remarked that they would like more clarity on how the agenda is set; one member expressed the need for more transparency and involvement of members when selecting the topics and inviting speakers for sessions. It was also remarked that the agenda should be sent out earlier.

[127] http://ec.europa.eu/health/alcohol/events/index_en.htm#anchor5_more.
[128] http://ec.europa.eu/health/alcohol/forum/forum_details/index_en.htm#fragment3.

Many Forum members proposed smaller discussion groups during the plenary meetings. It was felt that smaller discussion groups could provide more time and room for dialogue and enhance personal relations across sectors. A further suggestion was that the time between sessions could be used for peer review of commitments submitted to the Forum.

The information relating to the EAHF provided on the Commission's website was considered satisfactory by the respondents who mentioned the website. One respondent suggested that the website might be developed in order for members to interact and to see what other members are doing in between sessions; another respondent would like the website to be easier to navigate.

To improve the communication among Forum members and with third parties, a session similar to those of the *High Level Group on nutrition and physical activity's* joint meetings with the *EU Platform for Action on Diet, Physical Activity and Health*[129] was suggested by one Forum member in an interview. The experience was that this kind of session was beneficial in order to communicate to government representatives the useful work being done within the Forum.

Some interviewees suggested having more than two plenary sessions per year for numerous reasons: to keep the momentum; to allow for more discussions; to enable a joint session with CNAPA and to allow more members to present on their actions. Others, however, were concerned about the resource implications for their organisations of more sessions.

7.5 Key findings for Evaluation question 6

Overall, the interviewed Forum members find the working methods of the Forum to be appropriate; a few suggestions for improvement were made.

The Science Group has helped inform EAHF members about scientific evidence, in particular on the topics of its two opinions. Overall, Forum members find the two opinions of the Science Group useful, although views on the report 'Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people?' diverge between the economic operators and the non-industry members. Research on science and policy interactions has shown that scientists can help inform discussions – but will not resolve controversies at the level of interests or values.[130] This is seen in the reactions of EAHF members to Science Group outputs, in particular the report on marketing.

The Science Group is, however, at a crossroads, as it has lost 8 of 20 initial members due to resignation, and it has had not reached a quorum in recent meetings.

While a large share of Forum members wish to continue working with the Science Group, many indicate a desire for support on practical issues related to commitments. This may not be the best use of the Science Group itself. A range of scientific issues nonetheless are at the heart of any strategy to address alcohol-related harm, and a broader role for the Science Group, assisting not only EAHF, may be valuable.

Forum members have found the Youth Task Force of Alcohol useful to a limited extent. Continuation of the work was, however, suggested with a focus on responsible serving of alcoholic beverages. The development of the online Resource on Alcohol and Youth Projects (RAYPRO), along a concept outlined by the Youth Task Force, was considered to have been a valuable initiative but requiring further work to promote the use of the online resource.

[129] http://ec.europa.eu/health/nutrition_physical_activity/policy/index_en.htm.
[130] See e.g. Pielke, R.A. Jr, The Honest Broker, 2007.

The Task Force on Marketing Communication was an important element in the overall process towards further development of responsible commercial communication. It functioned as a mechanism for discussion of sensitive topics and started the mapping of self-regulatory systems that was later carried on in more systematic fashion by the Institute of Social Marketing. It could be valuable to continue to use this Task Force to address sensitive but core issues for the Forum. Its membership and size may bear review, however.

8 Evaluation Question 7: Has there been cross-fertilisation and interactions between the EAHF, the CNAPA and the other structures? What forms of interaction would bring added value?

This evaluation question examines the level of interaction and the possible benefits that could be derived from further interaction between the EAHF, the Committee on National Alcohol Policy and Action (CNAPA) and the Committee on Alcohol Data, Indicators and Definitions (CDCID). More precisely, this section assesses if there has been adequate interaction among EAHF and these structures, *adequate* being understood as a fruitful dialog and interaction. Members of the EAHF and the CNAPA were asked their perception of the dialogue between the structures in the surveys.

Furthermore, the evaluation question also addresses the potential for stronger interaction. Data for this section was collected through interviews with members of the EAHF and CNAPA.

8.1 Assessment criterion 7.1: There is adequate interaction among EAHF, CNAPA and other structures

Indicators	Research Techniques
7.1.1 Perception that dialogue has been adequate, by members of each organisation	Survey
7.1.2 Examples of, and potential for, cross-fertilisation	Interviews
7.2.1 Perception that stronger interaction would be valuable, by members of each body; proposals for new forms of interaction	Interviews

8.1.1 Indicator 7.1.1: Perception that dialogue has been adequate, by members of each organisation;

The EAHF members who responded to the online survey were asked about the EAHF dialogue and interaction with other structures: the CNAPA, the Science Group, the Committee on Alcohol Data, Indicators and Definitions.

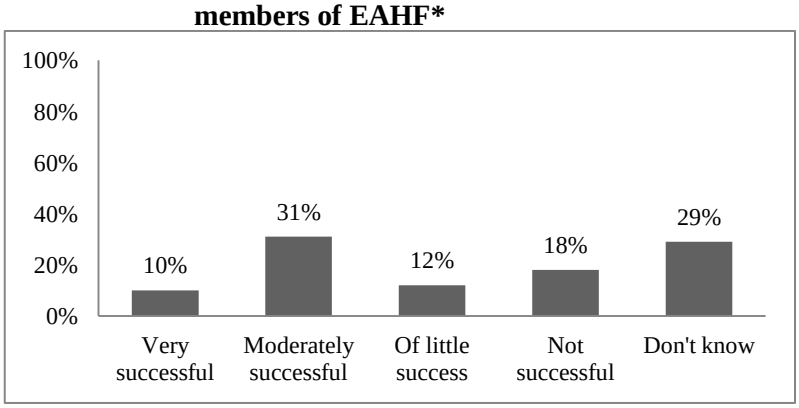
Interaction with CNAPA

Interaction between the EAHF and CNAPA has taken place indirectly through brief reports on current activities relayed by Commission staff in both directions, through occasional 'guest' presentations, and through Member States' representatives attending EAHF plenary meetings as observers. The number of Member States attending has varied from 12 in the 1st EAHF meeting to one in the 10th meeting. After the first three meetings, attendance declined to the level of 1-4 Member States present per meeting. In all, 18 Member States have attended at least once, and three have been represented in more than half of the EAHF plenary meetings.

When asked in the survey about interaction between the EAHF and the CNAPA, 41% of EAHF members indicated that the interaction has been 'very successful' (10%) or 'moderately successful' (31%). While a smaller share, 30% considered the interaction to have been 'of little success' (12%) or not successful (18%), an almost equal share (29%) did not voice an opinion on this.

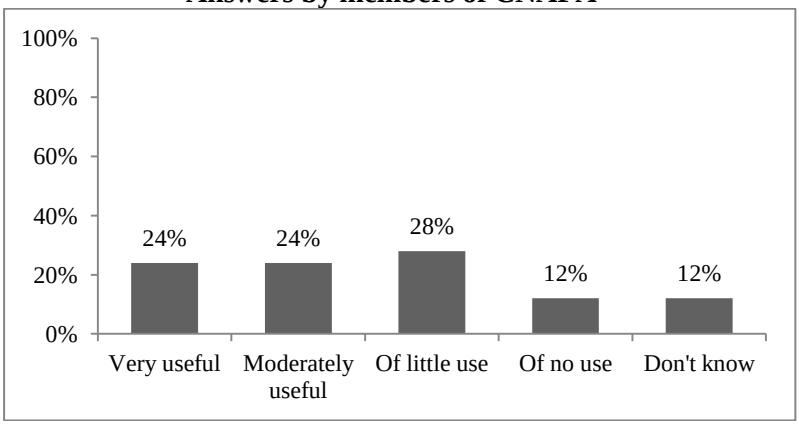
When a similar question was presented to members of the CNAPA, the responses were divided: on the one hand more positive, in the sense that 48% of CNAPA respondents considered the interaction 'very' (24%) or 'moderately' (24%) useful, and on the other hand more sceptical as 40% thought it had been of 'little use' (28%) or of 'no use' (12%). In the case of CNAPA members, only 12% responded 'don't know'.

Figure 25 How would you assess the EAHF's dialogue and interaction with the Committee on National Alcohol Policy Action (CNAPA), Answers by members of EAHF*



*n=49

Figure 26 How would you assess the CNAPA dialogue and interaction with the EAHF Answers by members of CNAPA*



*n=25

During interviews, most Forum members stated that there had been only very limited interaction with CNAPA. Several members acknowledged a reasonable limit for action since the CNAPA is a policy body and the EAHF is about action.

The interviews with CNAPA members confirmed the sharp division in opinion about the Forum. One respondent said that the Forum is 'very important' as the commitments 'have the potential for wide population coverage'; this respondent called, however, for greater attention to the delivery of the commitments. Another CNAPA interviewee, however, said that the Forum is

a ‘strange construction’. This respondent, and in total half of the eight CNAPA interviewees, was concerned about the strong role of the alcohol industry in the Forum.

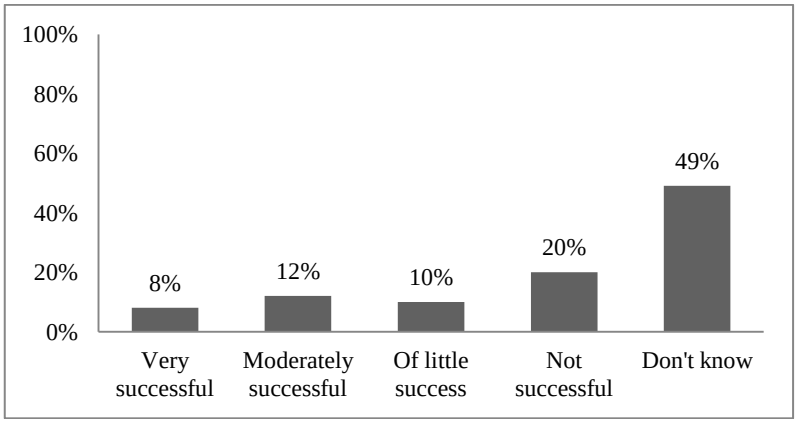
The CNAPA respondents were also divided in terms of the attention they paid to the Forum’s work. A few said they had attended Forum meetings, and one replied that they read Forum reports regularly. These respondents said that they had some information on commitments carried out in their Member States, but none had a complete overview.

Interaction with the Committee on Alcohol Data, Indicators and Definitions

Interaction between the Forum and the CDCID has been limited to two brief reports, in the 4th EAHF meeting on the establishment of the Committee and in the 5th meeting on the selection of key indicators on alcohol-related harm, recommended to Member States as common indicators for monitoring progress towards the aims of the EU alcohol strategy.

When asked about the dialogue and interaction with the Committee on Alcohol Data, Indicators and Definitions, almost half the Forum respondents replied ‘Don't know’ (49%). 8% of respondents indicated that the interaction has been ‘very successful’, 12% that it has been ‘moderately successful’, 10% replied that it has been ‘of little success’, and 20% replied that it has not been successful. Some members stated that they indicated ‘Don't know’ because they recalled no dialogue or interaction with the CDCID.

Figure 27 How would you assess the EAHF's dialogue and interaction with the Committee on Data Collection Indicators and Definitions (CDCID)*



*n=49

8.1.2 Indicator 7.1.2: Examples of, and potential for, cross-fertilisation[131]

This section assesses examples and suggestions provided by Forum and CNAPA members concerning the cross-fertilisation between the Forum and CNAPA, and the CDCID. For examples on the Science Group, see evaluation question 6. This section builds on data gathered in the interviews.

CNAPA

The interviews indicated that from all sectors in the Forum, there is a strong wish to develop interaction with the CNAPA.

[131] This section also captures the main parameters to be covered under assessment criterion 7.2, Stronger interaction among the bodies would be valuable, indicator 7.2.1: Perception that stronger interaction would be valuable, by members of each body; proposals for new forms of interaction.

Many EAHF members said they review the minutes of CNAPA meetings when available.

A number of interviewees said that closer cooperation would be valuable as much action to reduce alcohol-related harm takes place at the national level: it could contribute to the exchange of practices and experiences at the Member State level and to provide inspiration for new commitments and actions.

Some members also noted that alcohol policy is a national prerogative, and stated an interest in receiving greater information on national practices and policies in areas such as minimum pricing and marketing, as such information could provide opportunities for members to work further at the national level.[132] Moreover, a member suggested that involvement of other ministries beyond those for health could be relevant to some topics, notably transport ministries as an example for drink-driving campaigns.

Forum members suggested that more interaction could be ensured by establishing a formal framework for the CNAPA - EAHF cooperation. This should be established by opening a part of the CNAPA agenda for Forum members.

Further suggestions were: more active participation by CNAPA members in the Forum; more presentations from both bodies concerning activities; and more room for dialogue and discussion. Some members suggested a joint meeting – if only once – to enhance knowledge. In addition, although some Forum members indicated that they already have a good connection to their national representative, some expressed a desire for greater contacts with CNAPA members.

In the CNAPA interviews, responses concerning stronger links with EAHF divided respondents. One CNAPA member who expressed concern about the strong role of industry in the Forum said '*it would be useful to have at least one CNAPA meeting [a year] next to a Forum meeting*' to allow more CNAPA members to attend, and that greater participation and intervention by CNAPA members would be valuable. However, two other CNAPA respondents did not want stronger links to the Forum.

CDCID

Concerning the CDCID, Forum members also called for more interaction. Until now it has been very limited, and some Forum members are not aware of an open dialogue at all, according to the survey and the interviews. Several Forum members expressed that more work could be done in order to identify common indicators for monitoring by Member States, but also for the commitment outcome. Concretely, the need for common indicators for pregnancy, workplace and adults in general in order to measure impacts were mentioned.

8.2 Key findings for Evaluation question 7

Interaction between CNAPA and EAHF has been limited. While some CNAPA members attend Forum meetings as observers, their number decreased after the first years of EAHF activity. Most CNAPA members have little knowledge of EAHF commitments being carried out in their Member States.

[132] Attention was drawn to the good example of the Swedish presidency, presenting national alcohol policies for Sweden.

Members across different categories indicated more interaction between EAHF and CNAPA would be valuable in order to exchange practices and to better enable members set up commitments and other activities at the national level.

National platforms resembling the EAHF have been set up in three Member States: Austria, Portugal and the UK. While these bodies fell outside the scope of the evaluation study, based on the information reviewed, their interactions with EAHF appear to be very limited. Exchange of experiences and lessons learned could be valuable.

There has been very limited interaction between the EAHF and CDCID. Nonetheless, many Forum members expressed a wish to strengthen these links. The CDCID has worked on developing indicators for alcohol-related harm. Its work, however, appears most valuable at EU and Member State levels, while EAHF members would instead need greater support for indicators related to their commitments.

9 Overview and discussion

This section draws together the results for the individual evaluation questions. In doing so, it reviews the strengths and weaknesses of the evidence base, and also draws on results from the other tasks and on workshop meetings with the Advisory Group.

Strengths and weaknesses of the evidence base

The strengths and weaknesses of the evidence for the evaluation are briefly summarised next (for further details, please refer to the overview table in Annex 12).

Both surveys and interviews covered member categories in similar shares to those of overall membership. While non-replying members may have differing views, umbrella groups that represent a wider range of stakeholders are well covered by surveys and interviews. Based on this, the responses can be considered to be representative.

Response rates to the online survey were generally high, supporting the validity of survey results. For a number of questions, however, response rates were lower.

A methodological concern that emerged during the evaluation has to do with the fact that EAHF members include umbrella groups as well as individual companies and NGOs. Using a member organisation as the unit of analysis does not take into account variation in their size. Possible bias due to the heterogeneous nature of EAHF membership can however be considered to be minimal, as main variations in responses appear across categories, not between umbrella organisations and smaller, individual members.

Other methodological issues relate to potential biases in responses to specific evaluation questions. For example, EAHF members could be expected to highlight their own commitments as good practice examples. However, few outside the marketing self-regulation field appeared to do so. A related methodological weakness has to do with the fact that responses may be biased due to the high stakes held by part of the members. Moreover, survey and interview responses to questions on the Science Group appeared to be conditioned by members' prior reactions to the Group's reports, particularly relating to the impact of marketing on drinking by young people.

It can also be noted that EAHF members in different categories have quite different interests and values. It is possible that these differences reflect on their opinions and perceptions of the EAHF overall. At the same time, these dynamics are integral part of the Forum, which was created for dialogue and cooperation across stakeholder categories.

Overall, the different streams of evidence for Task 2 complement each other and the key results were found convincing by the EAHF Advisory Group. Survey results are consistent with information gathered through interviews in areas such as the Forum's added value in terms of mobilising stakeholders and stepping up action to reduce alcohol-related harm, or interaction between CNAPA and EAHF. Interviews are in turn generally consistent with desk research findings, for example in identifying impact assessment of commitment as an under-developed area. One exception concerns discrepancies between members' appreciation of the Open Forum as a mechanism for showcasing activities and engaging a wider range of stakeholders and desk research findings showing that outside participation in Open Forum meetings has been rather limited.

Overview of key results

1. Mobilising stakeholders and stepping up action

The Forum process has played an important role in *mobilising stakeholders* with a view to reducing alcohol related harm, and its membership has grown over time. A geographical imbalance however persists, as virtually all member organisations are based in the EU15. During interviews, non-industry members considered that the private sector was over-represented whereas most economic operators considered the balance between the different member categories to be appropriate. There is, however, broad agreement that the Forum process would benefit from greater participation of retail organisations and from the health and social insurance sector.

The EAHF has succeeded in *stepping up stakeholder action to address alcohol-related harm*; more so in sectors not previously engaged in work in this area. Economic operators, particularly advertising, marketing, media and sponsorship organisations identified the Forum as a source of inspiration to initiate or step up action to reduce alcohol-related harm. In the survey, two thirds of respondents indicated that either none or some of their organisation's commitments would have happened without the Forum; this was most evident among economic operators. These findings parallel the results of the *Evaluation of the European Platform for action on diet, physical activity and health* in 2010.

Members' initiatives have however concentrated in just a few action areas. Revisiting the action areas may be considered, including for more direct alignment with the priorities of the overall strategy.

There has been progress towards *transparent, participative and accountable monitoring* of the implementation of the commitments to action. However, evaluation and reporting of outcomes and impacts is an under-developed area and should receive more attention in order to demonstrate the contribution of the activities to the reduction of alcohol related harm.

2. A Platform for dialogue, exchange and cooperation

The Forum has provided a *platform for dialogue* on a wide range of thematic issues related to alcohol-related harm. It has also served to promote exchanges among members with different interests and opinions, as well as to disseminate good practices. A point to note, however, is that economic operators perceive greater value and benefit from dialogue and exchange than do other groups. Here, again, the findings are parallel to those of the *Evaluation of the European Platform for action on diet, physical activity and health* where a high share of industry respondents reported increased understanding of the obesity issue whereas most not-for-profit respondents reported fewer gains.

The Forum has succeeded in promoting cooperation but within sectors rather than between, although there are also examples of cross-sector cooperation at national level.

According to the survey and interviews, the Open Forum meetings have been successful in showcasing members' activities and in reaching non-member bodies and organisations. Nevertheless, desk research suggests that Open Forum sessions have not reached too far beyond the scope of the EAHF membership. Measures to enhance the interest of these sessions to wider audiences could be considered, as well as other mechanisms to disseminate EAHF work.

3. The development of responsible business practices

The EAHF has to some extent contributed to *developing responsible business practices in the sales of alcohol beverages*, although the attention given to this area seems to have decreased over time. The EAHF has likewise been instrumental in strengthening and expanding *self-regulatory systems in* the *marketing of alcoholic beverages*, where economic operators have had a benchmark to follow, the best practice model outlined in the Advertising Round Table in 2006. The Forum process has helped maintain high attention on this field of work and has led to creating or updating common standards and broadening the scope of self-regulation to new areas, such as digital marketing.

Nevertheless, self-regulation of the marketing of alcoholic beverages is an area where opinions remain divided among the different categories of Forum members. NGOs and health professionals generally pointed out the lack of evidence of a link between self-regulation of alcohol advertising and reductions in alcohol-related harm and that self-regulatory codes tend to focus on the content rather than the volume of alcohol advertising, a key factor addressed in research on the effects of alcohol advertising (for example in the Science Group's work in this area). For many economic operators, strengthening of self-regulatory systems has been an important area of success under the Forum. This divergence across member categories in their assessment of progress applies to most areas covered by the case study.

4. Impacts on alcohol-related harm

Assessing direct impacts in a context of multiple-causality phenomena is extremely challenging. There is indeed limited information to link commitments to action under the EAHF and *impacts on alcohol-related harm reduction* and, at this point, the assessment of these linkages can only be done indirectly. A number of commitments concern action in areas where direct links could be expected in the long term and in conjunction with other interventions. Nevertheless, the commitments tend to focus on a limited range of topics.

Despite the challenges, assessing the effectiveness of commitments in contributing to alcohol-related harm reduction is crucial for the overall EAHF process. Although Forum members generally have an interest in documenting the impacts of their commitments, evaluation tends to remain at the level of outputs or short term intermediate outcomes, due to both methodological and resource-related challenges.

Further work on the evaluation and impact of commitments would therefore be a valuable step forward, and one where Forum members across different categories appear willing to work. In addition, to ensure and demonstrate positive results, the commitments to action should be more clearly linked to the aims of the overall strategy, with the intervention logic explicated.

5. Benchmarking to best available practices

Work under the alcohol strategy has brought forward *knowledge on good practices*. For economic operators in particular, the Forum process has been an important source of *benchmarks and good practice examples*, the large number of commitments flowing from the

benchmark model of self-regulation outlined in the Advertising Round Table being a case in point. However, in other areas explicit benchmarking of commitments is not widespread and not done systematically.

Strengthening the use of good and best practices in the development of commitments is a key area for the Forum to address. Bridging the gap between the availability of good or best practices that have proven to contribute to the reduction of alcohol-related harm and the design of commitments would strengthen the 'intervention logic' linking commitments to reductions in alcohol-related harm.

6. Composition, focus and working methods

Current *working methods* have served the Forum well, although improvements in the organisation of the plenary meetings, e.g. in order to allow more time for discussion, could be considered. The usefulness of the *Task Forces* has been mixed and their future work would benefit from smaller group size and clear objectives and timelines.

The *Science Group* has helped inform EAHF members about scientific evidence on the few topics addressed by the Group. Nonetheless, this group is at a cross-road as it has shrunk from the original size, and as the scientific opinions, while addressing key issues for alcohol policy, have not been directly applicable in the Forum's work.

7. Cross-fertilisation and interactions with CNAPA

Interaction between CNAPA and EAHF has been limited. No formal joint activities have been organised between CNAPA and EAHF, apart from some CNAPA members attending Forum meetings as observers. Only few CNAPA members seem to follow the Forum's work or be aware of Forum members' commitments being carried out in their Member States.

Views expressed by interviewees on interactions and *dialogue* between EAHF and CNAPA were mixed, in that some CNAPA members were in favour of more interaction whereas others were content with the current situation. Conversely, Forum respondents across different categories expressed a wish for stronger interaction with CNAPA.

It can be noted that in the area of diet and nutrition, the two structures similar to EAHF and CNAPA – the Platform for action on diet, physical activity and health and the High-level group on nutrition and physical activity – do meet regularly.

It can also be noted that national platforms resembling the EAHF have been set up in three Member States: Austria, Portugal and the UK. While these bodies fell outside the scope of the evaluation study, based on the information reviewed, their interactions with EAHF appear to be very limited. Exchange of experiences and lessons learned could be valuable.

10 Based on the results discussed in this section, possible ways forward to enhance EAHF action are presented next. Enhancing EAHF action

The suggestions put forward here to enhance EAHF action relate to the following areas: expanding the Forum's membership; strengthening action in key areas; adopt systematic benchmarking and evaluation practices for commitments; improve the Forum's working methods; and strengthening interaction between CNAPA and EAHF.

Expanding membership

- Encourage broader involvement from sectors currently under-represented in the EAHF membership, such as alcohol retailers and health and social insurers, particularly in countries where these play a major role in health promotion (e.g. Belgium).
- Increase the participation of civil society and other stakeholders from new Member States.
- Consider involving further sectors, such as bodies representing local governments. Identifying appropriate organisations would be essential given that the Committee of Regions already has an observer role in the EAHF. Licensing authorities were identified as one group of key actors.
- Expand membership in sectors where the EAHF has provided a major stimulus for action, such as the media sector (including digital media).

Strengthening action

- Align the action areas of the EAHF more consistently with the priorities of the alcohol strategy.
- Consider providing support through the EU Health Programme for joint initiatives where different categories of EAHF members work together.[133]

Benchmarking and evaluation of commitments

- Building on the guidance provided in the Workshop on monitoring and evaluation in 2008:
    - Identify appropriate outcome and impact indicators for the planning, monitoring and evaluation of commitments to action,
    - Identify good practices for cost-effective approaches to evaluate the outcomes and impacts of EAHF commitments, looking also at methods in similar bodies, such as the EU Platform on Diet, Physical Activity and Health
    - Include outcome and impact indicators in the obligatory information to be provided at the submission of a commitment to action.
- Step up joint efforts to identify good practice and lessons learned to inform future work. This could include a review of selected completed commitments as well as of plans for new commitments in order to propose ways for strengthening the initiative. In addition other relevant outputs should be drawn upon, such as best practice criteria emanating from the Youth Task Force and used in the RAYPRO online resource.
- Continue the work of the Task Force on marketing communication to track progress through commitments for further development of self-regulation. It may be useful to focus the mandate and review the composition of the Task Force to ensure it is seen as representative of EAHF membership as a whole.
- Improve the commitments database and reporting tool to enhance user-friendliness, widen search functions and create more meaningful categories for action areas and target groups.

Most of the ways forward listed here will to some extent require that specific instruments be put in place. Discussions with the EAHF Advisory Group suggest that it would be preferable to first agree on the key objectives and focal areas and then determine the resources required as well as the optimal organisational setting; e.g. task forces, working groups, peer review panels, etc.

[133] The European Commission has made a proposal for a new Health for Growth Programme for the 2014-2020 period, and action in this area will depend on the final programme adopted in co-decision.

Working methods

- Continue making use of the EAHF advisory group to assist in planning plenary meetings, in particular to identify topics and contributors.
- In plenary meetings:
    - Build more discussion time into agendas.
    - To enhance dialogue, split into smaller groups for discussion on specific topics.
- Continue the Task Force approach to discuss and identify options for progress on specific issues.
- To reach groups beyond the EAHF membership, identify key target groups for Open Forum meetings and design timing, venue, contents and promotion activities accordingly. For example, one possible topic would be to engage local and regional governments and other actors to discuss EAHF existing commitments and new opportunities at these levels.
- Consider contacts with related organisations, such as the Road Safety Charter, to encourage potential synergies among a broad range of stakeholders.
- Consider further mechanisms to disseminate information on EAHF and its work.
- Prepare and publish yearly overviews of the implementation at national level of EAHF commitments to action, for stakeholders as well as CNAPA members.

Strengthening links between CNAPA and EAHF

- Step up efforts to ensure that the actions at national and local levels through EAHF commitments fit into national policy priorities
- Provide CNAPA members with a yearly overview at national level of EAHF commitments to action.
- Encourage Member States' active participation in EAHF meetings.
- Encourage Member States to explore the merits and challenges of national multi-stakeholder platforms such as those set up in Austria, Portugal and the UK, in part informed and inspired by the EAHF (setting up such structures would of course be the decision of the Member States, based on national priorities and approaches).

11 Appendix I: background information for assessment criterion 4.2

List of EAHF members whose commitments relate to EAHF aims 1-6 and 8

Umbrella organizations
Active - sobriety, friendship and peace
Alcohol Policy Youth Network (APYN) 2
Association of European Cancer Leagues (ECL)
Association of European Professional Football Leagues (EPFL) 5
Association of small and independent breweries in Europe (SIB)
Association of Television and Radio Sales Houses (Egta)
Brewers of Europe
Comité Européen des Entreprises Vin (CEEV)
Committee of Professional Agricultural Organisations in the EU – General Confederation of Agricultural Cooperatives in the EU (COPA-COGECA)
EUROCARE
EUROCOMMERCE
European Association of Communication Agencies (EACA)
European Association for the Study of the Liver
European Cider and Fruit Wine Association (AICV) 4
European Federation of Associations of Beer and Beverages Wholesalers (CEGROBB)
European Federation of Magazine Publishers (FAEP)
European Forum for Responsible Drinking (EFRD)
European Midwives Association (EMA)
European Mutual Help Network for individuals and families with Alcohol-Related Problems (EMNA)
European Public Health Alliance
European Publishers Council (EPC)
European Social Insurance Platform (ESIP) 1
European Spirits Organisation (CEPS)
European Sponsorship Association (ESA)
European Trade Union Confederation (ETUC) 5
European Transport Safety Council (ETSC)
European Youth Forum
HOTREC
International Center for Alcohol Policies (ICAP)
International Federation of Medical Students Associations
ReLeaf (European Young Persons' Network for Drug and Alcohol Health Promotion)
Standing Committee of European Doctors (CPME)
World Federation of Advertisers (WFA)
Individual companies
Anheuser-Busch InBev (ABI) 1
Heineken (International)
SAB Miller
British Retail Consortium
Delhaize Group
Royal Ahold
Bacardi Martini
Brown-Forman
Diageo
Moët Hennessy
Pernod-Ricard S.A.
The Absolut Company (also known as V&S Group)
National Organizations
The Swedish Youth Temperance Association (UNF)
Advertising Information Group (Zentralverband der deutschen Werbewirtschaft and Fachverband

Werbung und Marktkommunikation Österreich)
Alcohol Beverage Federation of Ireland (ABFI) 3
German Football League (DFL) 5
Alcohol Action Ireland
Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA)
EUROCARE Italia
Estonian Temperance Union
German Centre for Addiction Issues (DHS)
Institute of Alcohol Studies (IAS)
Institut de Recherches Scientifiques sur les boissons alcoolisées (IREB)
IOGT-NTO
National Foundation for Alcohol Prevention (STAP)
Nordic Alcohol and Dug Policy Network (NordAN) 2
Royal College of Physicians, London
National Youth Council of Ireland
British Beer and Pub Association 1
Finnish Hospitality Organisation (MaRa) 2
Swedish Hotel and Restaurant Association (SHR) 2
The Scotch Whisky Association

Commitments Classified by EU Strategy aim

Aim 2: To reduce the harm suffered by children in families with alcohol problems.

ALL RIGHTS Campaign

Aim 3: To reduce exposure to alcohol during pregnancy, thereby reducing the number of children born with Fetal Alcohol Disorders

Commitments
AssoBirra (Italian Brewers and Malsters Trade Association) - "If you're expecting a child, alcohol can wait"
Pictoral labelling commitment
Communication platform about responsible alcohol consumption
Raising awareness of drinking alcohol while pregnant
Awareness raising of Foetal Alcohol Spectrum Disorders (FASD)
ALCOHOL AND PREGNANCY DON´T MIX
FAS SEMINARS AND WEBSITE IN ESTONIA
Reinforcing responsible drinking messages
Programme to provide information to consumers in Europe
To ascertain the education and practices of midwives in member states on reducing alcohol related harm preconception and during pregnancy
To ascertain the education and practices of midwives in member states on reducing alcohol related harm preconception and during pregnancy
Fight against alcohol-related harm: the role of social insurers
Fight against alcohol-related harm : the role of social insurers. An example : prevention regarding consumption of alcohol by pregnant women
Marketing Self-Regulation
The placement of the French pregnancy logo on the back label of all of Pernod Ricard's wine and spirit brands in the EU-27 countries.

Aim 4: To contribute to reducing alcohol-related road fatalities and injuries

Being drinkaware.ie - further promotion of positive drinking behaviours
Dutch Brewers Association (CBK) - Assurance on Self-regulation report.
AssoBirra (Italian Brewers and Malsters Trade Association) - "O bevi o guidi" (Either You Drink or You Drive)
Austrian Brewers Association - Trockenfahrer.at
La Carretera te pide SIN
Polish Brewers - Drink Driving in Poland Beer Industry Program
The Danish Brewers' Association - "Do you see the problem?"
The Danish Brewers' Association - Er du klar til at køre? (Are you ready to drive?)
Increasing awareness: designated drivers

Drink Drive Forum
Pictoral labelling commitment
Partnerships to encourage responsible consumption and address alcohol related harm
Communication platform about responsible alcohol consumption
Multilateral cooperation on prevention the issue of Drinking & Driving embedded
Responsible drinking - Check Your BAC-upgraded application
Responsible drinking - SMS Program
The Establishment of Cooperation between the Company, the Government and an NGO to Prevent Together Drinking and Driving
Upgrade of responsible drinking service Promile INFO
Upgrade of responsible drinking web site napivosrozumem.cz
contribute to consumer awareness of information service on blood alcohol content (BAC)
Social dialogue on responsible consumption empowered by self-awareness toolkit
New Eurocare website
Reinforcing responsible drinking messages
Programme to provide information to consumers in Europe
Marketing Self-Regulation
Consumer Awareness
Independent Evaluation
"Responsible Student Parties" implementation in Europe - updated March 2011
"The Drink Driving Policy Network" Programme
Safe and Sober
Safe and Sober and the Alcolock
Mobilising the medical profession

Aim 5: To decrease alcohol-related physical and mental disorders

Commitments
Collaborative Recommendations on Alcohol Consumption and Cancer Control
Manchester Resettlement Project
Awareness raising of the link between drinking alcohol and risk of developing certain types of cancer
service finder and information leaflets
Promote the education and training of healthcare professionals in the field of alcoholic liver disease
European Clinical Practice Guidelines (CPGs) for detection/treatment of alcoholic liver disease (ALD)
Fight against alcohol-related harm: the role of social insurers
Mobilising the medical profession
Resource tool on alcohol addiction and homelessness

Aim 8: To contribute to the reduction of alcohol related harm at the workplace, and promote workplace related actions.

Commitments
New Eurocare website
Prevention, education and management of alcohol problems in the workplace
Marketing Self-Regulation
Mobilising the Medical Profession

12 Appendix II: members of the EAHF Task Forces

Members of the Task Force Youth-Specific Aspects of Alcohol[134]

ORGANISATION	MEMBER	CATEGORY
Association of European Cancer Leagues (ECL)		
- Ulster Cancer Foundation	Mr Gerry MC ELWEE	NGO
Comité Européen des Entreprises Vins (CEEV)	Ms Aurora ABAD	Production/Sales
EUROCARE	Ms Nathalie Rodriguez MC CULLOUGH	NGO
	Mr João SALVIANO CARMO	NGO
- Alcohol Action Ireland	Ms. Mary CUNNINGHAM	NGO
- Estonian Temperance Union	Ms Lauri BEEKMANN	NGO
- IOGT-NTO	Mr Robert DAMBERG	NGO
EUROCOMMERCE		
- British Retail Consortium	Mr Nick GRANT	Production/Sales
European Forum for Responsible Drinking (EFRD)	Mrs Gaye PEDLOW	NGO
European Mutual Help Network for individuals and families with Alcohol Related Problems (EMNA)	Mr Adri HULSHOFF	NGO, Family
European Public Health Alliance	Prof. Mark BELLIS	NGO
European Transport Safety Council (ETSC)	Mr Timmo JANITZEK	NGO
European Youth Forum	Ms Ines PRAINSACK	NGO, Youth
Institut de Recherches Scientifiques sur les boissons alcoolisées (IREB)	Mrs Nicole LEYMARIE	Research
ReLeaf (European Young Person's Network for Drug and Alcohol Health promotion)	Ms Mia MYLLYMAKI	NGO, Youth
Standing Committee of European Doctors (CPME)	Ms Swanehilde KOOIJ	NGO
The Brewers of Europe	Mr Simon SPILLANE	Production/Sales
The European Spirits Organisation (CEPS)	Mr Jamie FORTESCUE	Productions/Sales
- Bacardi Martin	Mr Chris SEARLE	Productions/Sales
- Brown-Forman	Ms Elizabeth CROSSICK	Productions/Sales
OBSERVERS	**MEMBER**	
Austria - Bundesministerium für Gesundheit, Familie und Jugend	Dr Doris KOHL	
Austria - Bundesministerium für Gesundheit, Familie und Jugend	Prof. Dr. Michael MUSALEK	
Bulgaria - Ministry of Health	Mrs Vilia VELIKOVA	
Czech Republic - Ministry of Health	Ms Hana SOVINOVA	
The International Organisation of Vine and Wine (OIV)	Dr Jean Claude RUF	
The World Health Organization (Headquarters and the Regional Office for Europe)	Ms Maria RENSTROM	

[134] http://ec.europa.eu/health/alcohol/docs/science_list_2010_en.pdf , February 2012.

Members of the Task Force on Marketing Communication[135]

ORGANISATION	MEMBER	Category
Advertising Information Group (Zentralverband der deutschen Werbewirtschaft and Fachverband Werbung und Marktkommunikation Österreich)	Ms Julia BUSSE	Advertising, marketing, media and sponsorship organisations
Association of European Cancer Leagues (ECL)		
National Association for cancer prevention and combat Galati - Romani	Mr Cristea CONSTANTIN	NGO
Association of Television and Radio Sales Houses (Egta)	Mr Bertrand CAZES	Advertising, marketing, media and sponsorship organisations
Comité Européen des Entreprises Vins (CEEV)	Mr José Ramon FERNANDEZ	Production and sales
EUROCARE	Mr Anders ULSTEIN Dr Daniela ALEXIEVA	NGO
German Centre for Addiction Issues (DHS)	Mr Walter FARKE	NGO
National Foundation for Alcohol Prevention (STAP)	Mr Wim VAN DALEN	NGO
European Association of Communications Agencies	Mr Dominic LYLE	Advertising, marketing, media and sponsorship organisations
European Federation of Magazine Publishers (FAEP)	Mr MAHON David	Advertising, marketing, media and sponsorship organisations
European Forum for Responsible Drinking (EFRD)	Mr Peeter LUKSEP	NGO
European Public Health Alliance	Prof. Gerard HASTINGS	NGO
Royal College of Physicians, London	Dr Nick SHERON	NGO
European Publishers Council (EPC)	Ms Angela MILLS WADE	Advertising, marketing, media and sponsorship organisations
European Sponsorship Association (ESA)	Ms Helen DAY	Advertising, marketing, media and sponsorship organisations
European Youth Forum	Ms Ines PRAINSACK	NGO
Standing Committee of European Doctors (CPME)	Mr Jukka SIUKOSAARI	NGO
The Brewers of Europe	Ms Catherine VAN REETH	Production and sales
The European Spirits Organisation (CEPS)	Mr Eelco van RAVENSWAAIJ	Production and sales
Diageo	Mr Clayton FORD	Production and sales
Moët Hennessy	Mr Pierre-Yves QUERTON	Production and sales
Pernod Ricard S.A.	Mr Rick CONNOR	Production and sales
ORGANISATION	**MEMBER**	
World Federation of Advertisers (WFA)	Mr Malte LOHAN	
OBSERVERS	**MEMBER**	
Austria - Bundesministerium für Gesundheit, Familie und Jugend	Dr Doris KOHL	
Austria - Bundesministerium für Gesundheit, Familie und Jugend	Prof. Dr. Michael MUSALEK	
Bulgaria - Ministry of Health	Mrs Masha GAVRAILOVA	
The International Organisation of Vine and Wine (OIV)	Dr Jean Claude RUF	
The World Health Organization (Headquarters and the Regional Office for Europe)	Ms Maria RENSTROM	

[135] http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/alcohol_forum_taskf2_en.pdf February 2012

Annex 3: Case study on marketing

1 Introduction and methodology

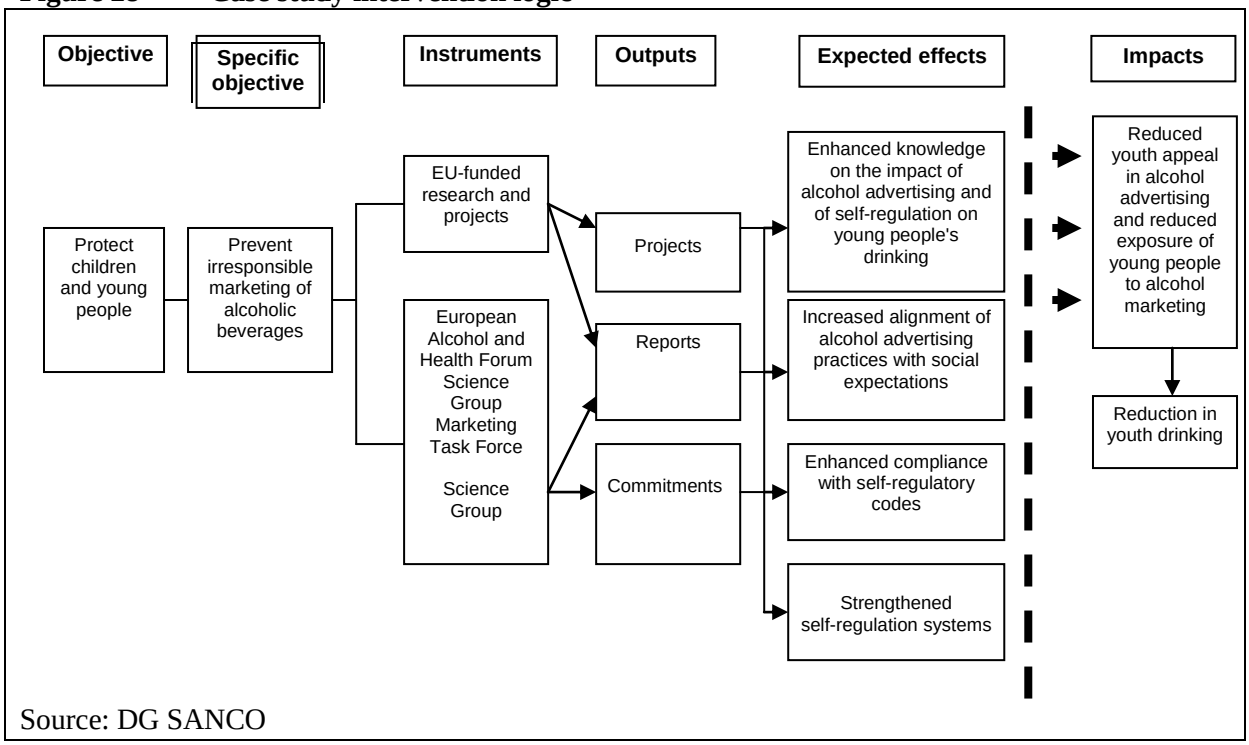
The aim of this case study is to provide a synthesising picture of the activities and progress towards further development of responsible practices in the marketing of alcoholic beverages and, in particular, to shed light on the added value of EU-level coordination and support in this area. Particular attention is paid to work carried out as part of the European Alcohol and Health Forum (EAHF) process as well as to EU-funded projects.

Desk research for this report is based on EU-funded projects and studies as well as on outputs from the Forum process, such as work carried out under the Marketing Task Force and Forum members' commitments under the action area of *cooperation to promote responsibility in and prevent irresponsible commercial communication and sales*. Relevant documents published by the European Advertising Standards Alliance (EASA) have likewise been consulted.

In addition to desk research, the case study draws on interviews conducted with Forum members in the context of Task 2 of this evaluation. Another particularly valuable source of information for the preparation of the present study has been the meeting held between EAHF Advisory Group members and the evaluation team on 11 July 2012 (see Annex 10 for a summary of this meeting).

The assessment carried out as part of the present case study follows the intervention logic recommended by DG SANCO and presented in the diagram below.

Figure 28 Case study intervention logic



Source: DG SANCO

The main instruments outlined in the diagram as well as their relevance for this case study are briefly presented in the next section. By reviewing projects, reports and commitments (i.e. the outputs in the diagram), this case study discusses the contribution of the EU alcohol strategy, particularly of the Forum process, to the following key areas corresponding to the expected effects in the intervention logic:

- Strengthened self-regulatory systems[136] and development of self-regulatory codes[137]
- Enhanced compliance with self-regulatory codes
- Increased alignment of alcohol advertising practices with social expectations
- Enhancement of knowledge on the impact of alcohol advertising and of self-regulation on young people's drinking.

The first three areas are closely interlinked. Meaningfully assessing Forum-driven progress in each of these areas requires a good understanding of their mutual interactions as well as of the framework to which they relate. In this sense, it is important to bear in mind that self-regulation is framed by legal provisions at both national and EU level. The scope of national legislation has a direct impact on the self-regulatory system as it determines the role that self-regulation can play.[138] Tradition in the use of soft law instruments is also identified as an influential factor.

Progress in self-regulation activities is discussed by taking into account the multiple levels at which they unfold: EU-level initiatives (applying either to the alcohol industry as a whole or just to one or several sub-sectors); development of national self-regulatory frameworks as well as national-level commitments; and corporate marketing and communication codes and practices.

Discussion regarding the enhancement of knowledge on the impact of alcohol advertising and of self-regulation on young people's drinking draws primarily on desk research and is essentially descriptive, although it incorporates some elements gathered from discussions with EAHF Advisory Group members.

The remainder of this case study is structured as follows. Section 2 presents an overview of the main Forum-related instruments and outputs relevant to marketing and advertising of alcoholic beverages. Sections 3 to 6 discuss progress with regard to the expected effects outlined in the case study intervention logic and that can be related to the EU alcohol strategy. Section 7 concludes.

2 Responsible marketing of alcoholic beverages and the European Alcohol and Health Forum (EAHF): an overview

In the EU alcohol strategy, an important strand of action at EU level consists in work with stakeholders to create sustained momentum for cooperation on responsible commercial communication. This has been a core area of action in the framework of the European Alcohol and Health Forum (EAHF). Action has been channelled by means of the following instruments: the Task Force on Marketing Communication, Forum members' commitments and interaction, and the Science Group of the EAHF. Research projects funded under the Health Programme of the EU have also been instrumental in this area.

2.1 Advertising Roundtable

A starting point for the work was provided by Round Table discussions in 2005-2006 among interested stakeholders on self-regulation of advertising in the policy areas under DG Health and Consumers.[139] The Advertising Round Table resulted in an outline of a best practice model for a self-regulatory system, with basic components (best practice criteria) defined for four aspects:

[136] According to EASA, self-regulatory systems are 'devised by an industry, profession or sector for its own regulation. EASA (2010): 'Advertising self-regulation in Europe and beyond', the Blue Book, 6th edition, p. 9.
[137] Progress in terms of the development of self-regulatory codes is discussed along with the strengthening of the self-regulatory systems, as these two areas are closely related.
[138] 'Self-Regulation in the EU Advertising Sector: A report of some discussion among interested parties', 2006, p. 15.
[139] ibid.

Effectiveness; Independence; Coverage; and Funding. The basic components of the best practice model are outlined in the box below.

Table 35 The basics components for a Best Practice SR model on advertising[140]

1. Effectiveness

1.1 Provision of copy advice

- The self-regulation organisations (SROs)[141] should offer the provision of copy advice particularly for media where advertising copy may have so short a shelf-life to negative adjudications.
- Copy advice should ideally be provided free of charge.

1.2 Complaint handling

- All SROs, from establishment onwards, should establish and publish both performance objectives year by year and records of their performance against those benchmarks.
- Each SRO should have an explicit objective, to the effect that it should be easy to find through which channel to complain.
- There should be a benchmark for the ease with which any form for the submission of complaints is completed. This objective should be endorsed by its governing board and verified year by year in its customer satisfaction surveys.
- There should be a standard for the speed with which complaints are handled.
- There should be a systematic duty to publish decisions. This is a tool for increasing transparency of the system and increased public confidence.
- SROs could recommend to the advertising industry for its agreement and action, minimum standards for training of newly recruited young advertising staff and for the design of internal compliance processes.

1.3 Sanctions

- Sanctions for non-compliance with codes, for repeat offences and for consistently ignoring codes or adjudications, should be clear and effective.
- The minimum sanction should be timely withdrawal of advertising copy.
- Withdrawal should apply, in the absence of explicit local SR decisions to the contrary, not only in the jurisdiction of the adjudication but throughout the business concerned; differences in codes and cultural expectations may today mean that different decisions are reached in different markets.
- The collaboration of the media as a whole in backing the decisions of the SRO is an important element to enforcing the sanctions. The adoption more generally of 'compliance clauses' in advertising contracts should help to make sanctions more effective.

1.4 Consumer awareness

- Complainants should be involved systematically in follow-up satisfaction surveys, which should be conducted in accord with survey best practice and may be outsourced in order to increase trust in the results.
- It is important that self-regulatory processes demonstrate a high level of transparency in order to establish and maintain a high level of public confidence that will increase also consumer awareness.

2. Independence

2.1 Involvement of interested parties in code drafting

- SROs should ensure that in the development of codes the relevant views of all stakeholders are taken into account; e.g. relevant government ministries and agencies; academia; relevant business sectors; ethical authorities; consumer, family, youth and other relevant citizen organisations.
- Over time, monitoring should include indicators designed to verify that the stakeholders' involvement meets the expectations of the society within which the SRO operates.
- Each SRO should have an explicit view as to who are its stakeholders. Such a list could be expanded to meet local needs. Over time, customer surveys should include questions designed to verify that the current definition of the stakeholders meets the expectations of the society within which the SRO operates.

2.2 Involvement of independent persons in the complaints adjudication process

[140] 'Self-Regulation in the EU Advertising Sector: A report of some discussion among interested parties', 2006, p. 17-32.

[141] In the present context, an SRO is a 'body set up and funded by the advertising industry to apply a code or rules regulating advertising content'. EASA (2010): 'Advertising self-regulation in Europe and beyond', the Blue Book, 6th edition, p. 9.

- Adjudication bodies should be composed of a substantial proportion of independent persons. Those persons could be selected on the basis of calls for expressions of interest, and appointed by the SRO board.
- It could also include possible cooperation with statutory authorities for the appointment of the independent persons of the adjudication bodies. All adjudication body members should be subject to rules on the avoidance of conflict of interests and on the declaration of interests.
- A jury is fundamental in guaranteeing the independence of the process. Composition, nomination process, independence and integrity of its members are the key determinants for the credibility of the system.
- The business and self-regulation community should remain open to the benefits, as well as the costs of the development of some more clearly 'independent' presence at all levels.

3. Coverage of all forms of commercial communication

- Advertising SROs today in Europe aim to cover not only pure advertising but all other forms of 'commercial' or 'marketing' communication.
- It is important to find a generic definition, encompassing all advertising techniques using any medium or distribution channel based on new technology.
- Another issue of concern is the new emerging trend for 'buzz marketing' and 'word of mouth'.
- SROs should keep under review any trend to significantly increase the proportion of 'adspend' that escapes self-regulation.
- On both the European and national level considerable effort has been put into providing basic legal requirements, specifically for direct and interactive marketing. Legislation therefore underpins self-regulation of the individual marketing sector.
- SROs must commit to keeping abreast of emerging techniques, to discussing with all stakeholders any concerns raised by these techniques, and to deciding promptly either to deal with these concerns or to alert the public authorities that they would need to develop an alternative approach. Public authorities cannot assume that self-regulation would be the fall-back for such issues, where legal approaches seem inadequate.

4. Voluntary industry funding

- There are currently two general funding models for self-regulation in place across Europe a) based on membership contributions/subscriptions and b) based on a levy on advertising or media spend.
- Introducing a funding system relying on a levy on advertising or media spend seems to be the most effective. Levies should be designed to meet essential SRO costs. Current experience suggests that a small fraction (0.1 – 0.2 per cent) of advertising turnover would be more than adequate.
- Public money (from local as much as EU sources) could be used to supplement industry efforts in, for example, Cohesion Fund recipient Member States. This would be desirable in the start-up phase of self-regulation.

2.2 Task Force on Marketing Communication

In the framework of the Alcohol and Health Forum, the Task Force on Marketing Communication was established to pursue the work initiated in the Advertising Round Table, and to consider other issues of common interest around advertising, marketing and self-regulation. As defined in the EAHF Charter, the Task Force is in charge of examining best practice in the field of responsible marketing communication of alcohol as well as of monitoring relevant developments and making recommendations to the Forum. The composition and tasks of the Marketing Communication Task Force are also discussed in Appendix to Annex 4 of this report, under the section on Task 2 (sub-section 7.3).

The Task Force on Marketing Communication convened six times between December 2007 and June 2009. In addition, a Special Workshop on 'Developing self-regulation for marketing communication' was organised as part of the Swedish EU Presidency's Expert Conference on Alcohol in Stockholm in September 2009. In the Task Force meetings and workshops, a range of topics were addressed through presentations and discussions, ranging from the relationship between legislation-based regulation and self-regulation to the potential of social marketing in promoting responsible drinking. A table outlining

the main topics addressed in each of the Task Force's six meetings as well as the conclusions reached in those meetings is presented as a reference table at the end of this case study.

A work programme for the Task Force was outlined in the chair's conclusions based on a workshop in March 2008. Recommendations to EAHF members included:

- Cooperation to ensure that the principles of self-regulatory codes extend all along the value chain (retail/on-trade)
- EU-wide independent monitoring as to youth aspects of self-regulation, in a manner complementary to self-monitoring by self-regulatory organisations (SROs)
- Involving young people in adjudicating what is 'attractive' to them
- Development/adjustment of self-regulatory codes to new media

The best practice model outlined in the Advertising Round Table was confirmed as the benchmark for self-regulatory processes, and a mapping of the state of play and progress towards best practice was started. In 2009, this resulted in a 'Mapping exercise report' drawn up by the Institute of Social Marketing (ISM) of the University of Stirling based on information provided by EAHF members.[142] In 2012, the mapping exercise[143] was updated by the ISM in a slightly more systematic fashion and also expanded to address stakeholder perspectives on further development of self-regulation along the lines identified in the 2009 Special Workshop.[144] The results of this mapping exercise are further discussed in section 3.1 of this case study.

In the 2008 Task Force workshop it was noted that self-regulatory behaviour should target audiences that are on average older than the overall population, not younger, as public opinion expects less exposure towards young people. This led to another mapping exercise report, 'Targeting / Not targeting youth', put together by the ISM drawing on information provided by EAHF members.[145] The report describes measures taken by economic operators to ensure that underage youth are not targeted with alcohol advertising.

2.3 Science Group

Another point arising from the Task Force workshop was that the relationship between marketing exposure and volume demand (i.e. alcohol consumption) is complex, as advertising is only one part of a multifactorial environment and as it is unclear how trends in advertising correlate with harmful drinking. It was highlighted that the working hypothesis of DG Health and Consumers was that the balance of evidence shows cumulative effect of marketing on young people's knowledge, attitudes and behaviour. To clarify this issue, a task was formulated in subsequent meetings of the EAHF for the Science Group to examine available scientific evidence. The Science Group concluded that there is a positive correlation between alcohol marketing exposure and the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol.[146]

In the 4th meeting of the EAHF, in which the Science Group's opinion was presented and discussed, the Chair noted that the Science Group's opinion confirmed DG Health and Consumers' working hypothesis that alcohol advertising has an effect on young people and concluded that the Science Group's opinion would provide one building block for conclusions in the 5th meeting.

[142] Institute of Social Marketing (2009): 'Self-Regulation. Mapping exercise report'.
[143] Progress towards best practice in self-regulation of alcohol marketing communication in the EU. Institute of Social Marketing, August 2012.
[144] Some EAHF Advisory Group members indicated that their inputs to the preparation of the 2012 update of the mapping exercise do not seem to have been duly taken into account.
[145] Targeting / Not targeting Youth. Mapping exercise report. Institute of Social Marketing, 2009.
[146] Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? A review of longitudinal studies. Scientific Opinion of the Science Group of the European Alcohol and Health Forum, 2009.

The steps identified in the 5th meeting were: a) to update the mapping report on self-regulatory structures; and b) to build on the points for further development identified in the Special Workshop to bridge the gap between the past activities of the Task Force and the next stage of the Forum's response to the need to better protect children and young people from alcohol marketing. During the discussion, two ideas for projects were raised, relating to the value of an EU-wide collection of data on young people's exposure to alcohol and marketing; and the drivers of underage drinking.

2.4 EAHF members' commitments to action

In the same vein, under the Alcohol and Health Forum, *cooperation to promote responsibility in and prevent irresponsible commercial communication and sales* was identified as one of the core areas of action in which the organisations joining the Forum were invited to submit a commitment to action and report on its implementation and achievements in adherence with the 'Monitoring Commitment' annexed to the EAHF Charter. Section 3.2 in this case study discusses relevant commitments submitted by Forum members since the establishment of the EAHF.

2.5 Research projects

The above-mentioned activities have built on, and overlapped with, a series of projects carried out under the EU Health Programme, with the Dutch Institute for Alcohol Policy (STAP) as the lead partner: Enforcement of national Laws and Self-regulation on Advertising and marketing of Alcohol (ELSA, 2005-2007); Focus on Alcohol Safe Environment (FASE, 2008-2010); Monitoring Alcohol Commercial Communications in Europe (AMMIE, 2009-2010).[147] The AMMIE project notably comprised testing the functioning of self-regulatory systems by identifying and filing complaints on alcohol marketing practices that appeared to be in violation of national self-regulatory rules, and comparing the SRO rulings against the views of rating panels composed of young people, in particular as regards potential appeal to young people.[148] The structure for carrying out these activities and disseminating their outputs is the European Centre for Monitoring Alcohol Marketing (EUCAM), started as a project in 2007 and established as a European Foundation in 2009. The main outcomes of these projects are discussed in section 6 of this case study.

3 Strengthening of self-regulatory systems and development of self-regulatory codes

As stated in the introduction, self-regulatory systems are multi-tiered. Therefore, assessing the extent to which these systems have been strengthened since the adoption of the alcohol strategy as far as alcohol marketing and advertising is concerned requires taking into account this articulated landscape. It is also worth bearing in mind that the very self-regulation model to which the developments outlined in this section correspond does not go uncontested. During interviews as well as at the informal meeting with EAHF Advisory Group members, a number of criticisms were formulated. These include the limited capacity of self-regulatory systems to protect vulnerable groups; the fact that complaint handling systems are often ill-adapted to the increasingly fragmented media market landscape; the little attention attached to advertising volume restrictions; and the failure of self-regulatory codes to sufficiently address alcohol promotion in the form of images and associations (e.g. sponsorship of sport events or teams).

[147] The total EU funding for these projects has amounted to € 922,000. The project activities have extended across various Member States: 23 MS in ELSA, 5 MS in FASE and 7 MS in AMMIE.
[148] http://www.eucam.info/eucam/home/ammie.html.

3.1 Summary of findings from ISM mapping exercises

As stated in the previous section, an initial attempt to provide a synthesising picture of self-regulation in the area of alcohol marketing and advertising was the mapping exercise on self-regulation performed in 2009 by the ISM under the auspices of the Marketing Task Force, based on information provided by the concerned economic operators. It aimed at gathering information on self-regulation in Member States as well as at EU level, and at identifying best practices. This exercise found that the development of self-regulation structures and systems varied to a considerable extent in Europe; and that relevant information was dispersed across alcohol sectors (beer, wine, spirits); and along the value chain of each sector. The 2012 update of this mapping exercise[149] does not include findings regarding progress compared to the 2009 situation given that data are not directly comparable. The reason for this lack of comparability is that, unlike in 2012, standardised data collection was not used in 2009.

The 2012 update does however provide some interesting insights. It draws on data from monitoring and validation reports by economic operators as well as SRO web sites. It is also based on contacts with key informants from all Member States, for each country one from a pool of economic operators and one from the non-commercial sector (civil society or national government).[150]

For three best practice dimensions – effectiveness, independence and comprehensiveness[151] – progress was assessed in terms of the number of countries in which the relevant elements are in place: progress was considered 'extensive' when at least 85% of the countries met the criterion, 'moderate' when 60-84% met the criterion, and 'limited' when fewer than 60% met the criterion. The results are summarised in the table below.

Table 36 Summary of findings from ISM 2012 mapping exercise

Category	Degree of progress	No. of MSs
Effectiveness		
Provision of copy advice	Extensive progress	24
Recommendations on training for staff and compliance processes	Limited progress	14
Publishing of performance objectives and evaluation results	Limited progress	16
Ease of complaints procedure	Moderate progress	18
Commitment to publishing of SR decisions	Extensive progress	25
Sanction procedures for non-compliance	Extensive progress	27
Broad sanctions application to achieve a comprehensive impact	Moderate progress	21
Verifiable Independence		
Involvement of non-commercial stakeholders in code development	Limited progress	15
Substantial non-commercial representation on adjudication bodies	Moderate progress	18
A demonstrably 'open' attitude to the involvement of independent stakeholders at all levels of SR	Limited progress	5
Comprehensiveness of SR across the multiplicity of promotional channels and activities		
14 countries (52%) reported extensive coverage (13 or more channels and activities)		
8 countries (30%) reported moderate coverage (10 or more channels and activities)		
3 countries (11%) reported limited coverage (less than 10 channels and activities)		
Data was not available for two countries (7%)		

Source: ISM, 2012.[152]

Within the effectiveness component, extensive progress has been achieved in the areas of sanction procedures for non-compliance; provision of copy advice; and commitment to publishing decisions.

[149] Progress towards best practice in self-regulation of alcohol marketing communication in the EU. Institute of Social Marketing, August 2012.

[150] With 41 responses received from a total of 54 informants the response rate was 76%. Some members of the EAHF Advisory Group stated that not all information provided was used in the version of the report consulted for this evaluation.

[151] The 'Funding' dimension is not assessed.

[152] As noted above, some members of the EAHF Advisory Group stated that not all information provided was used in the version of the report consulted for this evaluation.

Conversely, only limited progress was reported for training for staff (on compliance procedures) and compliance processes and publishing of performance objectives and evaluation results.

Data collected as part of the study suggest that a number of Member States have achieved particularly significant progress towards best practice. In Austria, Denmark, the Netherlands, Spain and the UK, less than 'extensive' progress was reported in only one or two categories, with no more than one category for which limited progress was reported.

When applying identical assessment criteria to self-regulation across promotional channels and activities, data show that only 'limited' progress has been achieved in the areas of *price promotion*, *product placement*, *labelling/packaging*, and *free samples and prizes*. Moderate progress has been achieved in the areas of *sponsorship*, *leafleting* and *promo merchandise*. Progress in all other promotional channels and activities investigated can in turn be considered to have been 'extensive'. Relevant results presented in the ISM report are summarised in table 37 below.

Table 37 Level of progress across promotional channels and activities

Level of progress	Range	Channel/Activity
Comprehensive	86% and more (22-25*) of MSs have SR measures in place	TV
		Radio
		Cinema
		Newspapers
		Magazine
		Outdoor advertising
		Direct mail
		Interactive digital media
Moderate	61-85% (16-21) of MSs have SR measures in place	Sponsorship
		Leafleting
		Promotional merchandise
Limited	60% and less (15 and less) of MSs have SR measures in place	Price promotions
		Product placement
		Labelling/Packaging
		Free samples and prizes

*For 2 MS, no data was available; the thresholds are calculated assuming 25 as the maximum.
Source: ISM 2012

3.2 The role of Forum members' commitments

Since the establishment of the EAHF, altogether 50 commitments to action have been submitted (as of April 2012) in the action area of *cooperation to promote responsibility in and prevent irresponsible commercial communication*.[153] Of these commitments, 21 involve EU-level action, 22 relate to the national level, and seven are being or were carried out by individual companies and concern marketing codes and practices in a range of EU countries where these companies operate. Progress in terms of commitment development at each of these three levels is discussed next.

EU level

EU-level initiatives have been carried out on the one hand by the advertising/media sector and, on the other hand, by alcohol producers. The advertising/media sector initiatives typically involve gathering information on regulatory or self-regulatory practices and disseminating such information to the

[153] The number of commitments indicating 'cooperation to promote responsibility in and prevent irresponsible commercial communication and sales' as a primary area of action is larger: 8 commitments concern enhancing responsible selling or serving alcoholic beverages; despite indicating this area of action, 7 commitments are not directly relevant to self-regulation of alcohol advertising as they mainly involve information and awareness raising on topics such as minimum pricing policies, drink-driving, or responsible drinking.

sector. Initiatives by alcohol producers, in turn, tend to involve activities aimed at enhancing the implementation of existing self-regulatory codes or further development of self-regulatory schemes (e.g. training).

Initiatives for further development of self-regulatory schemes have been carried out in all sub-sectors of alcohol production: beer, wine, and spirits. As the baseline situation in the sectors was different, also the initiatives for further development have been different in nature.

In the spirits sector, common guidelines for marketing communications were first formulated by the Amsterdam Group in the 1990s. The Common Standards for Commercial Communications were issued by the European Forum for Responsible Drinking (EFRD) in 2005. The emphasis of the initiatives submitted as commitments under the EAHF has been on revising and expanding these standards and transposing them into national self-regulatory codes. Members from the European Spirits Organisation (CEPS) and EFRD, which represent the spirits industry in the EAHF, identified the Forum as having enabled the adoption of a systematic, long-term comprehensive approach to the development of responsible practices in their commercial communication activities. This has translated into the 2015 Roadmap, which is an umbrella commitment spanning a five year period and setting forth new commitments to be undertaken by spirits producers across the EU by the end of 2015.

The 2015 Roadmap encompasses five objectives. Objective 1 directly relates to marketing communication. It concerns the conclusion of national agreements to include a responsible drinking message on marketing communications (preferably in the form of a consumer information website).[154] In the wine sector, no common standards for commercial communication existed until launched in 2009 as part of the Wine in Moderation Programme, the wine sector's commitment to action under the EAHF.[155] The CEEV Wine Communication Standards (WCS) aim at 'strengthening and intensifying the promotion of responsible advertising of Wines and by shaping commercial communication for their products in such a way that it does not promote harmful consumption.'[156] The objective is to expand the endorsement of the WCS by wine producers and other stakeholders along the wider wine value chain. According to CEEV's 2011 WIM implementation report, nine countries (of which eight EU Member States: Cyprus, France, Germany, Greece, Italy, Portugal, Spain, and United Kingdom) had started participating in the WIM programme and codes of commercial communication had been developed and transposed in three countries during the period 2008-2010.[157]

In this sense, wine industry representatives consulted in the context of this evaluation declared that the Forum has helped develop on-the-ground action. More precisely, being able to present resource-consuming measures as an externally imposed imperative (i.e. 'coming from Brussels') had enabled progress that would have been difficult otherwise. In particular, by changing local actors' perception of the need for self-regulation of their commercial communication activities, as many professionals in the wine sector initially perceived this as unnecessary.

In the brewing sector, where Responsible Communications Guidelines were issued in 2003 by The Brewers of Europe, emphasis has been on putting into practice seven operational standards formulated by The Brewers of Europe to ensure codes are operating within appropriate self-regulatory systems and aligned with the best practice model outlined in the Advertising Round Table in 2006.

Table 38 below summarises EU-level commitments carried out by economic operators and relating to alcohol marketing communication.

Table 38 EU-level commitments in the area of responsible marketing communication

[154] CEPS Roadmap 2015, commitment monitoring report.
[155] The wine sector is represented in the EAHF by the *Comité Européen des Entreprises Vins* (CEEV).
[156] http://www.wineinmoderation.eu/images/stories/documents/EN/WIM-WCS_EN.pdf.
[157] 'Wine in Moderation' (WIM) Programme, Implementation report 2008-2011, p. 7 ff.

EAHF member/s	Period of operation[a)]	Main contents of the initiative	Level of monitoring
EGTA, association of television and radio sales houses	2008-2009	Compendium of statutory and voluntary regulations concerning alcohol advertising on TV across the EU.	Not applicable
	2010	Dedicated web site to facilitate access to the compendium.	Not applicable
European Association of Communication Agencies (EACA)	2008-2009	Training seminars for advertising agencies on responsible commercial communications codes of alcohol producers and EASA best practices for self-regulation.	Attendance figures
	2011	Guidance (web site) for communication agencies on EU regulations and self-regulatory codes concerning alcohol marketing.	Not applicable
European Publisher's Council (EPC)	2008	Study on the role of self-regulatory practices and commercial influences (marketing of alcoholic drinks) within the new media landscape.	Not applicable
	2008-2010	Development by EASA of digital marketing communication best practice and implementation by national self-regulatory organisations. Training workshop on digital marketing communications.	Not applicable
European Sponsorship Association (ESA)	2008	Survey of self-regulatory practices relating to alcohol among sports and cultural events sponsorship rights holders.	Not applicable
	2009-2011	Development of guidance documents for rights holders.	Not applicable
Comité Européen des Enteprises Vins (CEEV) With: COPA-COGECA	2008-2011	Development of European Wine Communication Standards building on existing national self-regulation codes of the wine sector. *1 Basic principles; 2 Inclusion of moderation message; 3 Contents of advertisements*	Number of countries having transposed common standards in national codes.
	2011-2014	Continuation of the 2008-2011 commitment: Promoting specific WCS for commercial communications, building on existing national self-regulation codes.	
European Forum for Responsible Drinking (EFRD) With: CEPS, EACA, WFA, EASA	2007-2010	On-line training on responsible alcohol marketing.	Number of persons registered on web site. User evaluation of web site.
	2011-2014	Training roadshows on EFRD Common Standards.	
	2010-2011	Monitoring report on EFRD members' adherence to the 30/70 audience composition rule for spirits advertising.	Monitoring print and TV advertisements for 2 months in 2009 in selected countries.
European Spirits Organisation (CEPS)	2007-2011	Incorporating the EFRD Common Standards in national self-regulatory codes of the spirits sector. The Common Standards are based on Guidelines for Commercial Communications on Alcoholic Beverages launched in 1994 by The Amsterdam Group. Last revision of the Standards was in 2010 and a Guidance Note on Digital Media was added in 2011.	Number of countries having a code in place, number of codes aligned with Common

EAHF member/s	Period of operation[a)]	Main contents of the initiative	Level of monitoring
		1 Basic principles; 2 Responsible placement (30/70 rule); 3 Responsible content; 4 Compliance with laws, regulations and other industry codes.	Standards.
	2011-2016	Adopting European Guidelines on Responsible Marketing Communications, building on the EFRD Common Standards and also covering digital media.	
Scotch Whisky Association (SWA)	2008-2009	The Code of Practice for Responsible Marketing and Promotion of Scotch Whisky was adopted in 2005 by all SWA member companies. Drawing on an audit of implementation the Code was updated in 2008. Geographical coverage of the code was extended to the EU.	2nd audit in implementation in 2010
Brewers of Europe (BoE)	2007-2010	Recommending 7 operational standards (adopted in 2007, aligned with the best practice model outlined in the 2006 Advertising Round Table) for national action plans for self-regulation of commercial communications in the brewing sector. Guidance, monitoring and reporting on implementation. *1 Full code coverage; 2 Increased code compliance; 3 Impartial judgments; 4 Fast procedure; 5 Effective sanctions; 6 Consumer awareness; 7 Own-initiative compliance monitoring.*	For each standard: number of countries in which implemented.
	2012 - 2014	Updating the Guidelines Implementation Manual to ensure that national guidelines contain provisions specific to social media.	
World Federation of Advertisers (WFA) Co-owners: ABinBev, Bacardi-Martini, Brown-Forman, Carlsberg, Diageo, Heineken, Pernod-Ricard, SABMiller Associated: BoE, CEEV, CEPS, EFRD & EASA, ESA	2012-2015	Developing common standards for alcohol advertising in social media.	
	2012-2015	Implementing the 30/70 audience composition rule across the spirits, beer and wine sectors to ensure not targeting minors.	
	2012-2015	Reinforcing standards to ensure that marketing communications are not designed to target or appeal primarily to minors.	
a) Ongoing actions highlighted			

Some EAHF members referred to monitoring tools developed in the context of the Forum (e.g. the so-called traffic light systems, which use a colour key to visually represent the implementation status of commitments to action) as an effective means to steer action among their constituencies, and to overcome initial reluctance to the adoption of monitoring mechanisms following a name-and-shame logic. An example of this role of the Forum as catalyst for mobilisation at the local level is the Beer Pledge launched early 2012 by The Brewers of Europe. It is a voluntary initiative encompassing 3,500 European brewers. It is based on three pillars, one of which is ensuring responsible advertising through the implementation of social media guidelines addressing the exposure of minors to beer advertising. It also foresees the use of a 'toolkit on consumer awareness' of the ability and process to complain about potentially irresponsible advertising, covering the background to the issue and

highlighting best practice approaches, with a view to increasing consumer awareness of complaints mechanisms.[158]

A new phase in the development of self-regulation of alcohol marketing communication started with the Responsible Marketing Pact led by the World Federation of Advertisers (WFA), submitted in May 2012 as three separate commitments to action under the EAHF. This initiative brings together the wine, beer and spirits sectors to: develop common standards for alcohol advertising in social media; implement the 30/70 audience composition rule (not placing advertisements in media where the share of under-18s in the audience is larger than 30%); and reinforce standards to ensure that marketing communications are not designed to target or appeal primarily to minors. The three WFA-led commitments to action are expected to lead to an agreement on common standards across the national SROs in 2013, and to a first report on compliance in 2014.

At the time of writing, guidelines for digital media are included in the EFRD Common Standards for alcohol marketing communications for the spirits sector as a result of a 2010 update. Digital media (pop-ups, banners and brand websites) were included in EFRD's 2009 compliance monitoring report. Guidelines in this area are also part of some major brewers' company codes. The 30/70 audience composition rule, in turn, is implemented in the spirits sector as well as by some major brewers. In the UK, Ireland and the Netherlands, all sectors adhere to a 25/75 audience composition threshold.

In addition to commitments developed by EU-level organisations of economic operators, civil society organisations and public health and research institutions have carried out actions that are relevant to the assessment of progress towards stronger self-regulatory systems of alcohol marketing communication. The Dutch National Foundation for Alcohol Prevention (STAP), together with IOGT-NTO and EUROCARE Italia, has carried out as a commitment to action[159] under the EAHF activities that have encompassed: gathering information on the volume and content of alcohol advertising across EU countries; gathering information on the regulation and self-regulation of alcohol advertising across the EU; assessing the functioning of self-regulatory schemes; gathering and disseminating research results on the effects of alcohol advertising; training NGOs on how to promote effective controls on alcohol advertising.

3.3 National level

National self-regulatory frameworks shape the rules that inform self-regulation of alcohol-related commercial communication practices in each Member State. Discussions with EAHF Advisory Group members suggest that EU action, including through the EAHF, has helped to encourage the setting-up of national-level frameworks for self-regulation through the creation of self-regulation organisations (SROs). Representatives from the European Advertising Standards Alliance (EASA) agreed that the EAHF process has been instrumental in this regard and indicated that four new self-regulatory systems have started functioning[160] and an additional seven have undergone major overhauls since 2005.[161] These cover 97.9% of the EU population and 98% of 'adspend'.[162] Stakeholders also indicated that there has been a convergence in the functioning of SROs across the EU, although difficulties continued to exist in some Member States.

The findings in the 2012 ISM mapping exercise by Stirling University are consistent with the idea that the Forum has provided 'a forum within which to discuss tackling the issue of alcohol related harm

[158] European Beer Pledge, online leaflet, http://www.brewersofeurope.org/docs/publications/2012/pledge_leaflet_final_4_web.pdf .
[159] The activities have been divided on two consecutive commitments, 2008-2009 and 2010-2011, with 'better cooperation/actions on responsible commercial communication and sales' vindicated as the primary area of action for the first one, and 'developing a strategy aimed at curbing under-age drinking' in the second one.
[160] Bulgaria, Lithuania, Luxembourg and Poland.
[161] Austria, Belgium, France, Germany, Greece, Portugal and Sweden.
[162] EASA (2011): EASA Charter Validation progress report 2005-2011. Updated report 2011, p. 3.

(particularly in young people) and help the different SROs connect and exchange ideas'.[163] It also highlights examples of progress achieved in this area in Member States such as Portugal (alcohol-related work by the Instituto Civil da Autodisciplina da Comunicação Comercial, ICAP) and Cyprus (self-regulation system governing commercial communications for beer). However, the mapping exercise report underscores that results in this area are rather inconclusive. Informants contacted by the ISM in Member States were requested to assess the extent to which the EAHF has contributed to the development of the self-regulatory system regarding alcohol marketing communications. Two thirds of the respondents were unsure of the contribution of the EAHF (replying 'don't know') and the rest were divided between considering the Forum to have contributed either 'moderately'/'a lot' or 'a little'/'not at all'. Although few respondents provided further comments, a small number commented that discussions were insufficiently focused on public health objectives to make a positive contribution to self-regulatory good practice.

The majority of the national-level initiatives developed as EAHF commitments concern the implementation of one or several of the operational standards by national member organisations of The Brewers of Europe. These commitments are presented in Table 39 below.

Table 39 National-level commitments by member organisations of The Brewers of Europe, 2007-2012

Operational standard	BG	CZ	CY	DK	ES	HU	IE	NL	PL[a]	PT	RO	SE	SK
1 Full coverage		√							√				√
2 Increased code compliance	√				√	√			√				
3 impartial judgments			√			√			√		√		
4 Fast procedure		√			√	√			√				
5 Effective sanctions	√					√							
6 Consumer awareness		√	√	√	√				√	√		√	
7 Own-initiative compliance monitoring	√				√	√	√	√	√				√
All standards					√					√	√		
Other					√[b]		√[c]						√[d]

a) 5 separate commitments
b) Addressing digital marketing communications
c) Implementation of 25/75 audience composition rule agreed with the Department of Health and Children.
d) Implementation of 30/70 audience composition rule

Source: Brewers of Europe

The brewing sector's national-level initiatives for implementing the operational standards are not identical but reflect differences in the baseline situation. In some countries, the self-regulatory scheme may already have largely met the standards and a fairly low level of additional activity has been called for; for example raising public awareness of the existence of the self-regulatory scheme. In others, an advertising self-regulatory system may have been close to non-existent and therefore the initiative has started with putting the basics in place; for example by establishing an advertising self-regulatory body.

[163] ISM 2012, p. 38.

It is important to note that comparable implementation at national level has likewise taken place in the wine and beer sectors. It is however subsumed into the European umbrella's commitments and therefore not visible as a large number of separate national-level initiatives as with the brewing sector. As can be seen in table 40, in two cases national-level initiatives already carried out under the EAHF involve monitoring by NGOs of the compliance of alcohol advertising with national legislation (e.g. Loi Evin in France) or with self-regulatory regimes (in Austria and Germany).

Table 40 National-level EAHF commitments in the area of responsible marketing communication[a]

EAHF member	Period of operation	Main contents of the initiative	Countries
Advertising Information Group (AIG)	2008	Training for the advertising industry on self-regulatory codes for alcohol advertising.	Germany, Austria
	2010-2102	Setting up copy-advice service relating to alcohol advertising. Roadshow, leaflet and web site to promote the service.	Germany, Austria
Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA)	2007-2012[b]	Enforcement of the Loi Evin (Code of Public Health 1991) through monitoring alcohol advertising and bringing to court advertisements in breach of the code.	France
a) Excluding commitments by Brewers of Europe member organisations b) 2 consecutive commitments			

3.4 Corporate level

The company-level initiatives have in most cases built on an existing company code or policy for responsible commercial communication, and have sought to enhance compliance through staff training and in some cases to revise or expand the code. These commitments correspond to initiatives that are often part of these companies' own codes of commercial communications (e.g. AB InBev, Heineken, SAB Miller) or global corporate social responsibility (CSR) codes (e.g. Brown-Forman). There is one example of a new company code having been developed as a commitment under the EAHF.[164]

Table 41 Corporate level commitments in the area of responsible marketing communication

EAHF member	Period of operation*	Main contents of the initiative and countries concerned
ABInBev	2007-2010	Raising the implementation level of InBev's Code of Commercial Communications launched in 2005, including through training. New version of code created upon merger of InBev and Anheuser-Busch in 2008. Belgium, Czech Republic, Germany, France, Hungary, Italy, United Kingdom, Netherlands, Bulgaria, Romania, Luxembourg [The code also applies in Russia, China, Canada, US, Brazil, Argentina, Ukraine, South Korea.]
	2012-2015	Continued training to ensure compliance with the Anheuser-Busch InBev Commercial Communications Code. Austria, Belgium, France, Germany, Ireland, Italy, Luxembourg, Netherlands, United Kingdom

[164] However, while the work carried out in the context of this case study has benefitted from extensive interaction with EU-level organisations, fewer direct contacts with representatives from individual companies have taken place. The evaluation team has therefore fewer elements to assess the extent to which these initiatives result from the EAHF process other than the 'baseline' description in the EAHF commitments database.

EAHF member	Period of operation*	Main contents of the initiative and countries concerned
Bacardi Limited	2008-2010	Developing training on Bacardi Marketing Principles launched in 2004 and re-launched via Social Responsibility Policy in 2006. Social responsibility e-learning module launched in 2010. Creating database for storing all advertising and marketing materials. EU-wide
Brown-Forman	2008-2010	Developing a Corporate Social responsibility Code also covering marketing. Development of training tool. 10+ EU member States
	2011-2013	Developing training plan on responsible digital marketing communications, based on own code and EFRD/DiSCUS guidance.
Heineken	2008-2009	Developing online training tool for own marketing staff on Heineken's Rules for Responsible Commercial Communication. EU-wide [The rules apply also in export markets.]
SABMiller	2007-2009	Enhanced staff training on SABMiller Policy on Commercial Communication launched in 2004 (revised in 2008 & 2011). New training materials, including e-learning tool. One-day training for marketing staff, short training for various other groups. Czech Republic, Germany, Hungary, Italy, Netherlands, Poland, Romania, Slovak Republic, Spain, United Kingdom

*Ongoing actions are shaded.
Source: DG SANCO, EAHF commitment database

4 Monitoring and compliance

Strengthening compliance monitoring mechanisms and making available relevant information in this regard are crucial to ensure high levels of adherence to self-regulatory codes. Representatives of industry EAHF members interviewed for the present evaluation identified the Forum process as a turning point with regard to their efforts to monitor compliance. Industry members indicated that, to a significant extent, this results from the way in which they have been challenged by both the European Commission and civil society organisations in the context of the Forum.

The Forum process was also underscored by some participants in the informal meeting organised with EAHF Advisory Group members as having contributed to mutual surveillance and cooperation in terms of observance of self-regulatory codes.

The results of efforts to promote and monitor compliance with self-regulatory codes are somewhat difficult to assess, as there have been changes in the assessment parameters, the time and geographic coverage and the level of disaggregation of the different compliance monitoring exercises that have been carried out in connection to the EAHF process.

This section briefly summarises progress regarding the development of monitoring and compliance support mechanisms associated with self-regulatory codes in the field of marketing of alcohol beverages. Information on compliance rates is provided wherever available.

It is important to underline that this section focuses on compliance mechanisms as such. Efforts to ensure the independence of such systems are accounted for in section 5 of this case study, as part of a broader discussion around the alignment between self-regulatory systems and social expectations. Section 6 of this case study discusses, in turn, research work regarding the role of these systems in ensuring the protection of vulnerable groups from exposure to alcohol marketing and advertising.

This following summary refers to the alcohol industry as a whole as well as to each of the three main sub-sectors within the alcohol industry: beer, spirits and wine.

4.1 Compliance in the alcohol sector as a whole

To date, the most recent comprehensive compliance monitoring report available that is relevant for the subject matter of this case study is EASA's 2008 'Alcohol Advertising Monitoring Compliance Report'. It monitors compliance of self-regulatory organisations across Europe on advertisements that appeared in 2007 in TV and print media in 19 EU Member States, covering all three main sub-sectors within the alcohol industry: beer, spirits and wine.

The monitoring exercise encompassed 19 EU Member States. Instead of covering the entire year of 2007, the three peak months in advertising were selected for the sub-sectors of beer (April, May and June), wine and spirits (October, November and December for both). 2582 advertisements were reviewed from the Xtreme Information database; 2011 of them were print media, and 481 were TV advertisements.[165]

The 2008 report monitored compliance with the following codes:

- The ERDF Common Standards;
- The Brewers of Europe Guidelines for Responsible Commercial Communication;
- Relevant national advertising standards, codes, and national sectorial codes;
- Relevant national advertising laws.

The average compliance rate for television and print ads was 94%. 6% (137 ads) of the ads were found to be in breach of content rules and 3% (75 ads) did not respect the requirements for responsible drinking messages (RDM). No breakdown of compliance rates per sub-sector (beer, wine and spirits) was provided in the report.

Directly comparing these results with those in previous years' compliance monitoring reports is not straightforward due to the methodological caveats outlined earlier in this section. An overview table is presented below for illustrative purposes.

s can be seen in table 42, compliance rates have remained high over the life of the Forum. However, there seems to have been a relative decline over time. This is acknowledged in EASA's 2008 report, but to some extent attributed to statistical effects.[166]

An industry-wide review of compliance with self-regulatory codes in marketing communication of alcohol has not taken place since 2008 and no updates are expected before 2013. An industry-wide compliance monitoring has never been performed in the following EU Member States: Bulgaria, Cyprus, Denmark, Estonia, Latvia, Lithuania, Luxembourg, Malta and Poland.

All other relevant compliance monitoring reports available at the time of writing offer a partial coverage of the alcohol sector. The strongest efforts in this regard seem to have taken place within the spirits industry. Compliance in each of the alcohol industry's main sub-sectors in discussed next.

[165] 114 out of the 2582 were excluded from further calculation because they either were out of the remit of the exercise (111 ads) or could not be reviewed for technical reasons (3 ads).

[166] According to the report, the slight decrease in compliance rates from 96.4% in 2005 to 94% in 2008 can be explained by the differences in methodology of the evaluation exercises. The 2008 exercise measured the compliance rated in 19 participating countries, compared to 13 countries in 2005, 13 in 2006 and 15 in 2007. It is also stated that in some of the newly assessed countries, the SROs were less mature, thus accounting for the slight decrease in compliance rates. The report noted that 'comparing the specific country responses for the last year [2007 when the compliance rate was 95.6% and 14 countries were assessed] to the current, the levels have not decreased'. Some EAHF Advisory Group members also noted that codes have been strengthened over this period.

Table 42 Compliance rates with self-regulatory codes in the alcohol industry, 2005-2008

Country	Compliance rate % 2005	Compliance rate % 2006*	Compliance rate % 2007**	Compliance rate % 2008***
AT	96.3	96.1	100.0	
BE	88.9	95.8	95.7	
CZ	92.0			
DK			100.0	
FI				
FR			85.7	
DE	99.0	98.5	98.0	
EL	100.0	99.2	99.0	
HU	95.4	94.9	100.0	
IE	97.2	99.5	98.1	
IT	93.4	97.3	98.5	
NL	95.5	99.3	96.4	
PL	99.2	89.3	92.3	
PT	99.0	99.5	99.4	
RO				
SK		88.1	97.7	
SI				
ES	89.2	96.6	97.2	
SE				
UK	98.6	92.6	94.5	
Total	**96.4**	**96.0**	**95.6**	**94.0**

*The monitoring exercise was, as in 2005, performed in 13 countries; in 2005 the Czech Republic was included, and in 2006 Slovakia was included instead.
**The monitoring exercise was performed in two additional countries: Denmark (excluding the beer sector) and France.
***The monitoring exercise was performed on 19 participating countries. In comparison to 2008, the exercise again included the Czech Republic (as in 2005); was further extended to cover Finland, Romania, Slovenia, and Sweden; and excluded Denmark. In comparison to previous exercises (2005-2007) where advertisements were monitored for the full calendar year of the previous period, the 2008 compliance exercise monitored advertisements for the three consecutive months with the highest volume in alcohol ad creation: April-June for beer, and October-December for Spirits and Wine. No breakdown of compliance rate per country was provided in the 2008 report.
Sources: EFRD, EASA.

4.2 Compliance monitoring in the spirits industry

In 2009, EASA released its report 'Compliance Monitoring for Spirits Advertising Run by Digital Media'.[167]

This report constituted the first attempt to monitor compliance of digital marketing communications. It covered 13 EU Member States. The review covered ads in the Xtreme database for the months of May, June and July 2009 (i.e. outside of the peak advertising season for spirits, which runs through October, November and December). The two complementary phases of the review were: Phase 1, a review of spirits pop-ups and banners captured by the Xtreme Information Database; and Phase 2, a review of spirits advertiser-owned websites. The report monitored the compliance with the following codes:

- The EFRD Common Standards
- The EFRD internet guidelines issued in January 2009
- Relevant national advertising standards, codes, and national sectorial codes
- Relevant national advertising laws

[167] Sponsored by the European Forum for Responsible Drinking (EFRD).

During Phase 1, 75 pop-ups and banners were captured by the Xtreme information database. The number was low because these tools are not most commonly used by alcohol marketers. Of these, 31% (23 ads) responded to all necessary requirements, while 28% (21 ads) did not respect the requirements for responsible drinking messages (RDM), and 37% (28 ads) did not mention the RDM in a country where it was not compulsory. During Phase 2, 368 websites were reviewed by the participating SROs. Of these, 93% (343 websites) were not subject to further remarks, and 7% (25 websites) had one or more problematic items flagged. The table below presents the number of items flagged, by issue, during Phase 2 of the monitoring assessment. The report provided no breakdown of websites reviewed by country, nor does it include disaggregated data on issues flagged per country.

Table 43 Issues flagged as part of Phase 2 of the assessment of 'Compliance Monitoring for Spirits Advertising Run by Digital Media'

Issue	No of items
Attractiveness to minors	8
Irresponsible consumption	6
Sexual success	4
Social success	3
Hazardous activities	3
High alcohol strength	1
Privacy	1
Misleading	1
Legality	1
Total	**28**

Source: EASA, 2009

Another useful reference for the discussion in this section is the report commissioned by EFRD in 2011 on the application of audience profiling in EU Member States.[168] This report sought to monitor compliance with the 70/30 rule (Art. 2.2 of the ERDF Common Standards) among the members of EFRD and CEPS and does therefore not apply beyond the spirits sector. It covered all spirits advertising on TV and print media between 1 October 2009 and 31 December 2009 in, respectively, six and seven EU Member States (both sets of Member States differing in turn from each other). This period was chosen for allegedly being the time of the year with most spirits advertising.

For TV, the report concluded that 96.4% out of a total 47,593 ads by CEPS and EFRD members in the seven Member States covered, Denmark, Germany, Greece, Hungary, Italy, the Netherlands and Spain, complied with the 70/30 rule.

Table 44 Audience profiling monitoring report, results summary for spirits advertising on TV

Country	Cases reviewed	Non-compliant cases	Compliance rate
DK	2,903	258	91%
HU	12,679	696	95%
DE	2,860	69	98%
EL	8,128	23	99%
IT	6,283	17	99%
NL	2,431	226	91%
ES	12,309	427	97%
Total	**47,593**	**1,716**	**96%**

Source: Landmark Europe, 2011.

As for print media, none of the publications considered to target the under 18 year-olds was found to contain spirits advertising during the monitoring period in the six countries covered by the assessment: France, Germany, Italy, Portugal, Spain and the United Kingdom.

[168] Report prepared by Landmark Europe on the basis of the results of a monitoring programme carried out by Accenture Media Management.

4.3 Compliance monitoring in the beer industry

Attempts to monitor compliance have taken place in the beer sector as well, although information on compliance rates is scarce. Available reports tend to focus rather on measures undertaken to promote compliance.

EASA's 2008 Beer Advertising Monitoring report, which covered TV and print ads from 2007, concluded that '95% of the ads were found in compliance with the content requirements of the codes and laws they were monitored against, and that 2 % of the ads monitored did not respect the requirements for responsible drinking messages in countries where displaying such a message was compulsory.'[169]

According to a 2010 implementation report,[170] 18 out of Brewers of Europe's 27 members had revised the content or the remits of their code between the launch of the organisation's seven Operational Standards in September 2007 and March 2010. Over the same period, the same amount of members had organised trainings on self-regulation or revised the provision of copy advice services for beer advertising. In addition, according to the report, between September 2007 and March 2010, members in ten EU Member States either 'created complaint-handling systems and corresponding enforcement sanctions; or improved the array of tools to discourage brewers found in breach of the code from violating the rules in the future'.[171] Likewise, over the same period, members in 19 EU Member States 'had run a national compliance monitoring exercise on alcohol advertising' or 'introduced a procedure to log complaints before the relevant SRO or national brewers association secretariat'.[172] The 2010 implementation report does not provide an account of the results of the above-mentioned monitoring exercises.

4.4 Compliance monitoring in the wine industry

As with the beer sector, information on compliance with self-regulatory codes is scarce apart from EASA's 2008 Alcohol Advertising Monitoring Compliance Report, which as previously stated covered the alcohol industry as a whole. Monitoring efforts within the wine industry have focussed primarily on implementation. Relevant information in this regard was published in 2011 as part of European Committee of Wine Enterprises - CEEV's **'**Wine in Moderation Programme, Implementation report 2008-2010'.

Objective 3 of the Wine in Moderation programme is 'Promoting responsible commercial communication, through the adoption of a common code of conduct for commercial communication, building on national self-regulatory codes'.

The 2011 implementation report states, as discussed earlier in this case study, that three codes of commercial communication were developed and transposed in as many countries. It also highlights that 100% of the CEEV and the European Confederation of Independent Winegrowers (CEVI) communication material included the WIM logo and tagline; and that over 20 million people have been exposed to the logo and the message in commercial communication by wine companies. No further information on compliance is provided in the implementation report.

[169] EASA (2008): Beer Advertising Monitoring report 2008, p. 12.
[170] Brewers of Europe (2010), 'Responsible beer advertising through self-regulation'. Evidence underpinning this information was reviewed by auditor KPMG Sustainability.
[171] ibid., p. 31.
[172] ibid., p. 33.

5 Increased alignment of alcohol advertising practices with social expectations

The increased alignment of alcohol advertising practices with social expectations is one of the expected effects of progress in self-regulatory practices in marketing. Determining such social expectations is however not straightforward given the notion's subjective connotations. A relatively narrow approach is adopted here in these regard: for the purposes of this case study, social expectations are interpreted in terms of the three main focal areas identified during discussions with Forum members. All three areas relate to the components outlined in the 2006 Advertising Roundtable best practice model and are, in turn, closely interrelated. Progress in relevant areas outlined in the best practice model but not discussed at length with Forum members (mainly relating to transparency and consumer awareness) is summarised at the end of this section.

5.1 Involvement of independent professionals in the process of drafting and reviewing self-regulatory codes

The first of these areas has to do with the involvement of independent professionals in the process of drafting and reviewing self-regulatory codes. Although, according to economic operators, the Forum has triggered stakeholder consultation initiatives (in particular, in 2008 and 2010 by the spirits industry) in the context of reviewing self-regulatory codes, these consultations have had only limited success in engaging Forum members that are not economic actors. Some non-industry EAHF Advisory Group members noted that the Advertising Roundtable best practice model explicitly mentions the need for interested parties to be involved not only in code review but also in code drafting.

According to EASA, five EU SROs added stakeholder involvement features to their standard procedures between 2005 and 2007. Two SROs added the possibility of involving non-industry stakeholders in drafting or updating codes to their standard procedures between 2007 and 2009. EASA also states that 87% of all advertising SROs are currently consulting with external stakeholders when drafting or updating their codes.[173] In absolute terms, 19 SROs had these consultations among their standard procedures in 2011, compared to 9 in 2005. Non-industry EAHF members contended that the involvement of non-industry actors in self-regulatory code drafting has been limited thus far.

Another important element highlighted as part of the Advertising Roundtable model in this regard is the possibility of devising indicators and administering surveys to verify that the expectations of the society within which a given SRO operates are met regarding stakeholder involvement. Economic operators and non-industry EAHF members disagreed as to the extent to which there has been progress in this area.

5.2 Involvement of independent persons in the complaints adjudication process

The second area relates to the involvement of independent persons in the complaints adjudication process and, more precisely, the composition of juries in SROs. Although EAHF Advisory Group members generally agreed that some progress has been achieved in this area, they diverged significantly in their assessment of such progress. A difficult balance seems indeed to be required here between the expertise provided by each member of the jury and the stakeholder group that they directly or indirectly represent.

The 2005-2011 EASA Charter Validation progress report claims that 91% of advertising SROs currently have 'a number of jury members that are academics, consumer representatives, etc.'[174] Compared to the 2005 situation, ten new SROs had an independent element in their jury in 2011

[173] EASA (2011): EASA Charter Validation progress report 2005-2011. Update report 2011.
[174] ibid., p. 3.

according to EASA. These are: Austria, Belgium, Bulgaria, Lithuania, Luxembourg, Poland and Slovakia.

While economic operators viewed this figures as a sign of good progress in this area, non-industry actors underscored that adjudication processes continue to have a representativeness deficit.

5.3 Involvement of independent reviewers in the monitoring of compliance

The third area concerns the involvement of independent reviewers in the monitoring of compliance with self-regulatory codes. Table 45 below summarises instances where this involvement has taken place.

Table 45 External reviewers in compliance monitoring processes

Monitoring exercise	Reviewer	Reviewer's affiliation
'Advertising Compliance Monitoring, Report 2006'(EFRD)	Lucien Bouis	European Economic and Social Committee (EESC)
	Jack Law	Alcohol Focus Scotland
'Advertising Compliance Monitoring, Report 2007' (EFRD)	Lucien Bouis	European Economic and Social Committee (EESC)
	Jack Law	Alcohol Focus Scotland
	Pat Cox	Former President of the European Parliament
'Alcohol Advertising Monitoring Compliance Report 2008' (EASA)	Lucien Bouis	European Economic and Social Committee (EESC)
	Jack Law	Alcohol Focus Scotland
	Marie-Hèlene Cussac	Generation Europe
'Monitoring process of spirits advertising run by digital media' (2009, EASA)	Albert Recasens	Confianza Online
	Jack Law	Alcohol Focus Scotland
	Arnaud Houdmont	Generation Europe

Source: EFRD, EASA.

With regard to the first three elements discussed in this section, it is important to note that the ISM 2012 update concluded that only limited progress has been achieved with regard to the involvement of non-commercial stakeholders in self-regulatory code development, and recommended greater involvement of young people at all stages of self-regulation (consulting, developing codes, monitoring, etc.) as well as a better understanding of what appeals to young people. It also highlighted the need for greater involvement by NGOs in the daily operation of self-regulation (developing guidelines, participating in decisions).

5.4 Transparency and consumer awareness

Additional elements included in the Advertising Roundtable best practice model that explicitly address the alignment between self-regulatory systems and social expectations relative to fundamental issues such as transparency, public confidence and consumer awareness. More precisely, the best practice model highlights the need to publish complaint-related decisions and to conduct follow-up satisfaction surveys among complainants.

These issues were not addressed in depth in the course evaluation and EASA reports are therefore the main source of information in this regard. EASA claims that 83% of SROs in the EU are actively involved in raising awareness of their organisation's work and informing the general public of the possibility to complain free of charge about advertising content. In absolute terms, this means 19 SROs in 2011 compared to 7 in 2005.

Regarding the publication of jury adjudications, EASA reports that 21 SROs had incorporated this feature to their procedures as of 2011, compared to 16 in 2005.

6 Enhancement of knowledge on the impact of alcohol advertising and of self-regulation on young people's drinking

The issue of a causal link between the marketing and advertising of alcohol products and drinking behaviour, in particular of youth, is contentious. A key point arising from the 2008 workshop was that the relationship between marketing exposure and volume demand (i.e. alcohol consumption) is complex, as advertising is only one part of a multifactorial environment and as it is unclear how trends in advertising correlate with harmful drinking. It was highlighted that the working hypothesis of DG Health and Consumers was that the balance of evidence shows cumulative effect of marketing on young people's knowledge, attitudes and behaviour. To clarify this issue, a task was formulated in subsequent meetings of the EAHF for the Science Group to examine the available scientific evidence (see 6.1).

A number of studies on the matter have been carried out in connection with the work of the Forum or, more broadly, with the alcohol strategy. This section presents an overview of these studies' main findings, either in their final or draft version.[175]

6.1 Work under the EAHF Science Group

Following on from the EAHF's second plenary meeting in April 2008, the EAHF Science Group was entrusted with investigating the relationship between the alcohol marketing and alcohol consumption. To that end, the Science Group convened a special working group to preside over the subject. Findings were published in February 2009, as part of a Science Group opinion.[176] The Science Group opinion explored the links between the marketing of alcohol and the volume of alcohol consumption, with particular emphasis on young people. It reviewed several different methodological approaches as to how the relationship between advertising and drinking patterns could be analysed.

Overall, the Science Group found that longitudinal studies represent the best methodological approach for undertaking research in the future. Based on the review of 13 longitudinal studies, the Science Group concluded that alcohol marketing has a bearing on some aspects of adolescents' drinking behaviour. The opinion report's main conclusion was that 'the overall description of the studies found consistent evidence to demonstrate an impact of alcohol advertising on the uptake of drinking among non-drinking young people, and increased consumption among their drinking peers'.[177] These findings were upheld also when confounding variables were controlled for.[178]

The opinion indicated, however, that, although statistically significant, the impact of marketing communication on drinking behaviour is, on average, not large.[179]

[175] It is noted, however, that a number of the Forum members interviewed in the context of this evaluation expressed their concern about the methodological approaches adopted for these studies.

[176] EAHF Science Group (2009): 'Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? A review of longitudinal studies'. Scientific Opinion of the Science Group of the European Alcohol and Health Forum, 2009.

[178] Some EAHF Advisory Group members contended that not all confounding variables were considered in the study. They quoted page 16 of the Science Group's opinion: '[…] a potential limitation of the findings is the relationship between the variables of interest and other confounding factors" and "it is impossible to know if all relevant variables were measured and adjusted for, and thus not possible to know if residual confounders could have influenced the analysis'.

[179] EAHF Science Group (2009), p. 15.

In line with the conclusions from the 2008 Task Force workshop, the Science Group also noted that marketing communications are just one aspect of determinants of alcohol consumption and alcohol-related harm, and that it can be difficult to isolate the impact of one aspect from the others.

6.2 Enforcement of national Laws and Self-regulation on advertising and marketing of Alcohol (ELSA) project

Research findings in the context of the ELSA project are broadly consistent with those in the Science Group opinion. Indeed, one of the ELSA project reports highlighted that the volume of advertisements and media exposure affect the likelihood of young people to start to consume alcohol, to increase the amount of consumption overall, and to increase the amount of consumption per occasion. Another key finding of work carried out under ELSA was that alcohol marketing may be effective in appealing to underage young people even without violating self-regulatory codes, and that no scientific evidence was available that tests the effectiveness of self-regulation or demonstrated its effectiveness in regulating the content of advertisements.[180]

6.3 Focus on Alcohol and Safe Environment (FASE) project

The conclusions from the 2007 FASE[181] report on alcohol and advertising suggest that self-regulation is often insufficient. According to this report, self-regulatory codes tend to focus on content restrictions rather than volume restrictions. However, content restrictions do not account for the cumulative effects of marketing campaigns that often reach consumers through several channels. The report also called into question the criteria used by the industry to assess the effectiveness of self-regulation.

Based on literature review, the study outlines a set of criteria for an effective alcohol marketing policy. Special focus was given to the protection of young people. By means of comparison with these criteria, the report concluded that volume and content restrictions are stronger when embedded in law than when self-regulated by economic operators.

The relatively early date of release of this report warrants for it to be considered indicatively, as any potential evolution of self-regulation of alcohol marketing and advertising in connection with the EAHF may not be captured.

6.4 Alcohol Marketing Monitoring in Europe (AMMIE) project

A report recently published as part of the Alcohol Marketing Monitoring in Europe (AMMIE) project explores a number of topics that are common to the FASE report.[182] Some of its findings also point in the same direction. It states, for example, that marketing-related restrictions affecting alcoholic beverages tend to be easily circumvented, as 'content restrictions that are in place in self-regulatory codes are ambiguous and open to interpretation'.[183] The study therefore concludes that volume restrictions are more effective than content restrictions, and that the former are 'essential' to protect vulnerable groups from being exposed to 'harmful alcohol marketing practices'. The AMMIE report adds that existing self-administered sanctions within the alcohol industry tend to be ineffective, and that legal recourse is often required instead.

[180] Anderson, P. (2007), The Impact of Alcohol Advertising: ELSA project report on the evidence to strengthen regulation to protect young people. Utrecht: National Foundation for Alcohol Prevention, p.51.
[181] http://www.faseproject.eu/wwwfaseprojecteu/about-fase/.
[182] STAP (2012): Commercial Promotion of Drinking in Europe. Key findings of independent monitoring of alcohol marketing in five European countries.
[183] ibid., p. 38.

6.5 HAPI consortium study on trends and drivers of young people's drinking habits and beverage preferences

A study looking at young people's beverage preferences and wider drivers of youth drinking has been carried out in 2012 by the HAPI Consortium on behalf of DG Health and Consumers.[184] The study uses sales data and data derived from the ESPAD survey to examine young people's beverage preferences and in particular whether certain beverage categories, such as ready-to-drink mixtures, play a special role in young people's drinking and whether there are any specific determinants for the use of such drinks. It concludes that no specific category of alcoholic beverages stands out: alcoholic products appeal to young people but how they are packaged and marketed does not seem to depend much on the characteristics of the product, and the drivers of drinking among young people appear to be the same across beverage categories.

6.6 AMPHORA

The AMPHORA project is co-financed by the Seventh Framework Programme (FP7) of research of the European Commission. It is therefore not directly linked to the EAHF process. A number of results of desk research being currently carried out in the context of this project are summarised here given their relevance for the subject matter of this case study as well as references to some of the studies discussed earlier in this section (and the resulting triangulation possibilities).[185]

Some of the project research findings refer to the methodological difficulties involved in assessing the impact of alcohol advertising on young people's drinking behaviour. It is underscored, for example, that while longitudinal studies consistently suggest that exposure to media and commercial communications on alcohol is associated with the likelihood that adolescents will start to drink alcohol, and with increased drinking amongst baseline drinkers (i.e. in line with the conclusions of the Science Group), expectancy and econometric studies have so far proven rather inconclusive in this regard.

Work in the context of the AMPHORA project acknowledges the existence of studies suggesting that self-regulation is not effective.[186] In addition, the report points to evidence and experience that the self-regulation of commercial marketing of alcohol does not prevent the kind of marketing that has an impact on younger people, particularly when it is not backed up by a legal framework and effective sanctions.[187] It is noted that statutory regulation of commercial communications seems to be more effective than self-regulation in limiting inappropriate exposure of commercial communications to young people. This is consistent with findings from both AMMIE and FASE. Furthermore, the need for third-party review of complaints concerning breaches is underscored.

NB: at the time of writing, RAND Europe is carrying out for DG Health and Consumers a study in which data on the placement of advertisements and audience demographics are used to assess young

[184] Anderson, P., et al., An overview of the market for alcohol beverages of potentially particular appeal to minors. HAPI Consortium, 2012.

[185] No findings for this project have been published at the time of writing. This section draws on information from the project's Database of Scientific Information: http://www.amphoraproject.net/bbdd.php?b=3.

[186] For example, van der Zeijden, P., van der Horst, R., Self-regulation practices in SANCO policy areas. Brussels, EIM Business & Policy Research, and British Medical Association, 2008; Under the Influence: the damaging effect of alcohol marketing on young people. London: British Medical Association, 2009; Hawkes, C., Regulating and litigating in the public interest: regulating food marketing to young people worldwide: trends and policy drivers. Public Health, 97:1962–1973, 2007; Jones, S.C., et al., How effective is the revised regulatory code for alcohol advertising in Australia? Drug and Alcohol Review, 27:29–38, 2008.

[187] Davis, R.M., et al. (eds), The Role of the Media in Promoting and Reducing Tobacco Use. NCI Tobacco Control Monograph Series No. 19. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 07-6242, 2008.

people's exposure to alcohol marketing in audio-visual and online media. The findings are presently unavailable.

7 Conclusions

The findings outlined in previous sections of this report have enabled the evaluation team to formulate a number of conclusions. These conclusions are presented here in terms of the main expected effects in the intervention logic of this case study.

7.1 Strengthened self-regulatory systems and development of self-regulatory codes

Since its creation, the EAHF has contributed to the strengthening of self-regulatory systems covering marketing and advertising of alcohol. The EAHF has helped trigger action to expand the coverage of these self-regulatory systems for the marketing and advertising of alcohol, both thematically and geographically.

Among economic operators that are party to the EAHF, umbrella organisations in the advertising and alcohol sectors are responsible for most of the action at EU level in this regard. In the spirits and beer sectors the focus has primarily been on strengthening and implementing self-regulatory codes. In the wine sector, the Forum process has brought about the creation of the Wine Communication Standards (WCS), which seek to ensure responsible advertising of wine products. At national level, action to strengthen self-regulatory systems for alcohol marketing and advertising has been most visible in the beer sector, as national members of The Brewers of Europe have carried out 17 commitments between 2007 and 2012. Most commitments by individual companies build upon existing codes or initiatives; a new company code has been developed as a commitment under the EAHF. Training plays a prominent role in many EAHF corporate-level commitments.

Moreover, the Forum has been instrumental in the creation, or overhaul, of self-regulation SROs, although five EU Member States do not have an advertising SRO yet. The Forum has likewise contributed to the exchange of knowledge and best practices among these SROs. Commitments developed by civil society organisations and public health and research institutions at both EU and national level have also contributed to strengthening self-regulatory systems for alcohol marketing communication. They have done so by gathering information and assessing these systems' functioning as well as their performance in ensuring compliance.

In terms of the self-regulatory system's effectiveness, according to ISM's 2012 mapping exercise update, extensive progress has been achieved in the areas of sanction procedures for non-compliance; provision of copy advice; and commitment to publishing decisions. Conversely, only limited progress was reported for training for staff and compliance processes and publishing of performance objectives and evaluation results.

7.2 Enhanced compliance with self-regulatory codes

According to representatives from economic operators interviewed in the context of this evaluation, the Forum process has resulted in substantial efforts by industry actors to put in place compliance monitoring and enforcement systems, and has helped trigger on-the-ground action. Indeed, economic operators generally acknowledged that challenges from both the European Commission and non-industry actors have encouraged them to step up action in this area. It must be noted that the effectiveness of self-regulatory systems in protecting vulnerable groups against irresponsible marketing practices for alcohol beverages has been called into question by non-industry members as well as by some scientific studies.

The results of efforts to promote and monitor compliance with self-regulatory codes are somewhat difficult to assess, as there have been changes in the assessment parameters, the time and geographic coverage and the level of disaggregation of the different compliance monitoring exercises that have been carried out in connection to the EAHF process. In addition, no industry-wide compliance monitoring has yet been performed in the following EU Member States: Bulgaria, Cyprus, Denmark, Estonia, Latvia, Lithuania, Luxembourg, Malta and Poland.

On the basis of available data, compliance rates have remained high over the life of the Forum. However, there seems to have been a relative decline over time.

7.3 Increased alignment of alcohol advertising practices with social expectations

Assessing the role of the Forum in bringing commercial communication practices of economic operators in the alcohol business closer to social expectations is singularly difficult, as interpretations of these expectations vary across stakeholder groups. The following conclusions refer to a rather narrow definition of social expectations that is based on the Advertising Roundtable model as well as discussions with EAHF members.

Independent reviewers have been involved in four EU-level compliance monitoring exercises since 2006. However, there seems to be room for improvement as far as ensuring the independency of self-regulatory processes is concerned, particularly in terms of the involvement of independent persons in the complaints adjudication process. The corresponding commitment in EASA's Charter stipulates that the SRO should include 'an independent element in the adjudication jury'. Although a large number of SROs now comply with this requirement, it is the view of non-industry EAHF members that a single element per jury board may not be enough to ensure that the composition of juries is representative.

Furthermore, the Forum process has had little success in engaging non-industry stakeholders in the review of self-regulatory codes. Discussions with stakeholders also suggest very limited involvement of non-industry stakeholders in self-regulatory code drafting. In the same vein, the ISM 2012 update concluded that only limited progress has been achieved with regard to the involvement of non-commercial stakeholders in self-regulatory code development, and recommended greater involvement of young people at all stages of self-regulation (consulting, developing codes, monitoring, etc.) as well as a better understanding of what appeals to young people. It also highlighted the need for greater involvement by NGOs in the daily operation of self-regulation (developing guidelines, participating in decisions, etc.).

Progress has been achieved with regard to transparency and consumer awareness of self-regulatory systems; particularly in terms of the number of SROs currently informing the general public of the possibility to complain free of charge about advertising content as well as of those publishing of jury adjudications.

7.4 Enhancement of knowledge on the impact of alcohol advertising and of self-regulation on young people's drinking

Finally, scientific evidence has been produced in connection with the Forum's activities (EAHF's Task Force and Science Group) as well as under the EU Health Programme. This evidence has shed light on the impact of alcohol advertising and of self-regulation on young people's drinking and tends to comfort the working hypothesis of DG Health and Consumers regarding the effect of marketing on young people's knowledge, attitudes and behaviour. Research results in this area tend however to be more robust in the case of longitudinal studies than of expectancy and econometric studies.

The enhancement of the knowledge base in this area has nevertheless been constrained by methodological difficulties linked to data availability and comparability as well as to the multi-faceted nature of behavioural drinking patterns. Furthermore, the impact of alcohol advertising and of self-

regulation on drinking behaviour is a relatively recent scientific research field, at least in the EU (for example, only two out of the 13 longitudinal studies reviewed by the Science Group focused on Europe). In this sense, there is substantial room for improvement in terms of reporting and data gathering, as a number of the studies available to date draw on data from outside the EU. In addition, the role of cultural and societal factors in determining drinking behaviour seems to have been rather absent from research work to date and appears as an area where further research may be beneficial. The importance of these factors is notably highlighted in the 2009 opinion of the Science Group.

List of references for the case study

Anderson P, Bruijn A, Angus K, Gordon R and Hastings G. 'Impact of Alcohol Advertising and

Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies. Alcohol & Alcoholism' (2009)

Anderson P, Suhrcke M, and Brookes C. HAPI Consortium 'An overview of the market for alcohol beverages of potentially particular appeal to minors' (2012)

Anderson, P., 'The Impact of Alcohol Advertising: ELSA project report on the evidence to strengthen regulation to protect young people' (2007) Utrecht: National Foundation for Alcohol Prevention

CEEV 'Wine Communication Standards (WCS)' http://www.wineinmoderation.eu/images/stories/documents/EN/WIM-WCS_EN.pdf (4 September 2012)

CEEV 'Wine in Moderation Programme, Implementation Report 2008-2010' (2011)

CEEV 'Wine in Moderation Programme' http://www.wineinmoderation.eu/ (4 September 2012)

European Advertising Standards Alliance (EASA) 'Alcohol Advertising Monitoring, Compliance Report' (2008)

European Advertising Standards Alliance (EASA), 'Beer Advertising Monitoring report' (2008)

European Advertising Standards Alliance (EASA) 'Compliance Monitoring for spirits advertising run by digital media, 2009 Report' (2009)

European Commission, DG SANCO '3rd meeting of the Task Force on Marketing Communication, Summary Report' (2008)

European Commission, DG SANCO '4th meeting of the Task Force on Marketing Communication— Social Marketing Workshop, Summary Report' (2008)

European Commission, DG SANCO '5th meeting of the Task Force on Marketing, Summary Report' (2009)

European Commission, DG SANCO '6th meeting of the Task Force on Marketing Communications, Summary Report' (2009)

European Commission, DG SANCO 'Draft summary report on the 1st meeting of the Task Force on Marketing Communication' (2007)

European Commission, DG SANCO 'Self-Regulation in the EU Advertising Sector: A report of some discussion among interested parties' (2006)

European Commission, DG SANCO 'Task Force on Marketing Communication, Workshop Programme' (2008)

European Commission, DG SANCO 'Task Force on Marketing Communication, Social Marketing Workshop, Chair's Conclusions'(2008)

European Forum for Responsible Drinking (EFRD) 'Common Standards for Commercial Communications' (2008)

European Forum for Responsible Drinking (EFRD) 'EFRD Common Standards on Responsible Marketing, Revised version' (2010)

European Forum for Responsible Drinking (EFRD) 'Monitoring Report on he application of audience profiling across the EU' (2011)

European Forum for Responsible Drinking EFRD 'Common Standards for Commercial Communications' (2006)

European Spirits Organisation CEPS 'CEPS Road Map 2015 Implementation Report 2011' (2012)

European Spirits Organisation CEPS 'CEPS Road Map 2015' (2010)

Generation Europe 'Workshop Report, The Amsterdam Group's Common Standards for Commercial Communications' (2004)

Hospital Clínic de Barcelona (FCRB) 'The AMPHORA Project' http://www.amphoraproject.net/index.php (4 September 2012)

Institute of Social Marketing, University of Stirling 'Progress towards best practice in self-regulation of alcohol marketing communication in the EU' (2012)

Institute of Social Marketing, University of Stirling 'Self-Regulation. Mapping exercise report' (2009)

Institute of Social Marketing, University of Stirling 'Social Marketing Mapping Exercise Report' (2009)

Institute of Social Marketing, University of Stirling 'Targeting/Not Targeting Youth Mapping Exercise Report' (2009)

Landmark Europe 'Alcoholic Beverage Advertising and Marketing in Europe' (2007)

Science Group of the European Alcohol and Health Forum 'Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? A review of longitudinal studies' (2009)

STAP Consortium 'Commercial Promotion of Drinking in Europe, Key Findings of Independent Monitoring of Alcohol Marketing in Five European Countried' (2012)

STAP Consortium 'Commercial Promotion of Drinking in Europe. Key findings of independent monitoring of alcohol marketing in five European countries' (2012)

STAP Consortium 'Enforcement of national Laws and Self-regulation on Advertising and marketing of Alcohol ELSA 2005-2007' http://www.stap.nl/elsa/ (4 September 2012)

STAP Consortium 'Focus on Alcohol Safe Environment FASE 2008-2010' http://www.faseproject.eu/wwwfaseprojecteu/home/home.html (4 September 2012)

STAP Consortium, European Centre for Monitoring Alcohol Marketing (EUCAM) http://www.eucam.info/eucam/home/about_eucam.html (4 September 2012)

STAP Consortium: 'Monitoring Alcohol Commercial Communications in Europe AMMIE 2009-2010' http://www.eurocare.org/eu_projects/ammie (4 September 2012)

The Brewers of Europe 'Responsible Communications Guidelines' (2003)

The Brewers of Europe "European Beer Pledge' http://www.brewersofeurope.org/docs/publications/2012/pledge_leaflet_final_4_web.pdf (4 September 2012)

The Brewers of Europe, EASA 'Leading by example-Responsible beer advertising through self-regulation' (2010)

WHO Regional Office of Europe, Denmark 'Evidence for the Effectiveness and Cost–Effectiveness of Interventions to Reduce Alcohol-Related Harm' (2009)

World Federation of Advertisers 'The Responsible Marketing Pact' http://ec.europa.eu/health/alcohol/docs/ev_20120418_co14_en.pdf (4 September 2012)

Case Study reference table: Summary of meetings of the Task Force on Marketing Communication

Meeting	Main topics addressed	Main findings, outputs and conclusions
1 (11 December 2007)	- The mandate, work plan and working methods of the Task Force; - Initial exchange of ideas on actions that could be examined regarding marketing communication; - Discussion of and a draft outline on a workshop to help focalising and prioritising the work of the Task Force.	Outputs: - Draft outline of a workshop to help focalising and organising the work of the Task Force including the following: State of play, facts and figures; youth; new media; other aspects. - Established date and venue for the workshop.
2 (4-5 March 2008)*	- State of play in the frills of alcohol marketing and communication; - Spread and volume of marketing communication; - EU legal framework; - Self-regulation mechanisms and functioning; - Patterns of 'irresponsible commercial communication and sales'; - Youth aspects of alcohol marketing; - New media: definition, challenges, self-regulation, way forward; - Other aspects	Conclusions: - DG SANCO's working hypothesis is that the balance of evidence shows cumulative effect of marketing on young people's knowledge, attitudes and behaviour; - The codes and principles in SR may not reach all parts of alcohol value chain and are unable to deal with prove or volume of alcohol; - Social marketing can have a positive impact on attitudes and behaviour; media can play a role in social norming around alcohol in society; - The Science Group wouled prepare an opinion on the linkage between marketing and youth attitudes/behaviour; - EASA would report back to the Forum on marketing code for new media; - Social marketing would be further discussed; - A paper on Self-Regulation along the value chain would be prepared for the April Plenary.
3 (16 July 2008)	- EASA's Work in Digital Marketing Communication; - SR situation in the Member States; - Work of the Science Group; - On marketing communication and the targeting of youth; - Applying SR codes to the hospitality industry and the retail sector; - Social marketing; the role of industry; - Self-regulation in the Netherlands; - Involvement of all stakeholders in SR practices.	Conclusions: - The procedure for meeting summary reports would remain the same; - A library would be launched on the alcohol page of the Commission's public health website. - A more differentiated and precise picture of the SR situation in MS would be ready by the end of 2008; - The Chair recognized fundamental disagreements between Task Force members on 'the importance of marketing communication for alcohol-related harm (compared to other drivers) and the impact of marketing communication, the Chair does not expect to achieve consensus on this issue in the Task Force and the Forum'; - No consensus was reached on the 20%/30% issue; there is a need to provide more information; - According to the latest Eurobarometer, the majority of the EU population would support banning alcohol advertising targeting young people; - In the UK, the marketing code of the alcohol industry has been adopted by the hospitality industry. As the Task Force did not clearly agree that this could be done in all MS (and show a coherent value chain approach), the Chair concluded that, as a starting point, the part of the value chain covered by codes should be mapped; - A separate meeting would be organized to further discuss social marketing; - To make SR monitoring process more inclusive, all stakeholders need to be involved in SROs.
4 (12 November 2008)	- Overall focus of the meeting on Social Marketing; - Discussion of two papers on Social Marketing drafted by Professor Hastings; topics included an appropriate	Conclusions: - Task Force members still demonstrate opposing views on the involvement of economic operators in Social Marketing, related in particular to effectiveness and 'source-credibility'. - No consensus was reached on whether positive or negative messages are more effective; - Also, no consensus was reached on whether the large volume of marketing does or does not have a neutralizing effect

Meeting	Main topics addressed	Main findings, outputs and conclusions
	message (positive vs negative); the environment of Social Marketing activities; - Discussion of presentation by Dr. Gallopel-Morvan; - Private initiatives in Social Marketing in the area of reducing alcohol-related harm; - Governmental initiatives in Social Marketing in the area of reducing alcohol-related harm. - Way forward regarding reports on Self-Regulation, Social Marketing and 'targeting/not targeting youth'.	on social marketing; and on whether effectiveness could be increased by statutory measures and taxation. - By the chair: there are several obstacles to social marketing and its evaluation, but campaigns can also be effective; outstanding issues have to be resolved regarding cooperation, sharing of practices and information, and the involvement of economic operators. Findings: - By Dr. Gallopel: negative images attract more attention than positive ones; social marketing can change social norms, but it takes at least 5-10 years; Social Marketing is expensive (on cost-effectiveness); industry initiated and sponsored Social Marketing is not credible or effective. - Dr. Salasuo on the 'Drunk you're a fool campaign' of the Finnish Brewers: the impact of the campaign on behaviour is hardly demonstrable; and the campaign can probably not be replicated in other countries with a different (drinking) culture. - Mr. Tancock from the UK Department of Health: people tend to underestimate the risks of alcohol consumption; the NHS is still a 'strong brand' in the UK and its messages could be more credible and trusted than the ones from the Department of Health; - Tiziana Codenotti on the 'Alcohol Prevention Day in Italy': the impact of the event on drinking behaviour is not clear; in some cases 'moderation' is not the right advice (e.g. pregnancy or driving).
5 (10 March 2009)	- Presentation of the 'Choices' campaign by Diageo on excessive drinking in the age group between Legal Purchase Age and the age of 25; - The effects of alcohol marketing during the European Championship Football 2008 on young persons; - Discussion on the three mapping-exercise reports: Self-regulation across Member States, Targeting/not targeting youth; - The way forward on Self-Regulation	Conclusions: - By the chair: alcohol sponsorship needs a more structured debate in a future meeting. The role of branded social marketing might be added to the list of public health initiatives to be studied. Future studies could be made more robust by increasing the transparency (e.g. through early sharing of methodologies). - By STAP: there is a need to address the role of promotional items in alcohol marketing; to monitor exposure of young people, and to restrict sport-related alcohol marketing and sponsorship. - On the three mapping exercises: the reports would be completed with additional information to give a more complete map on the situation country by country. - On SR in marketing: the cinema sector was raised as a relatively unexplored environment to review the practice of alcohol advertising; although the under-aged are not being targeted with campaigns, there is a need to monitor who is actually being reached more effectively. - Progress had been made on mapping self-regulation and targeting but further work is still needed. This applies a fortiori to the report on Social Marketing. - The Open Forum would take place at the time of political change (election of EP and a new College of Commissioners) and is the right moment to convey the achievements and objectives. - Accountability is necessary to highlight achievements; the stance of businesses needs to be understood to secure the continuity of cooperation. Findings: - By Diageo: youth 'leaders' have to be targeted; no impact was found when targeting the 'indifferent'; some Task Force members suggested the campaign could be seen as empowering people to drink right up to their limits. - Research presented by STAP on alcohol marketing during the European Championship Football 2008: 'higher exposure to alcohol marketing during the Championship increased knowledge of alcohol brands, increased a positive attitude to beer and increased the intention to drink alcohol. Owning a promotional item, such as the Heineken hat-horns was found to increase alcohol consumption'. - By Peeter Luksep on SR: marketing channels which do not reach the under-aged at all do not exist; there is no regular monitoring for the Common Standards of 70:30;

Meeting	Main topics addressed	Main findings, outputs and conclusions
6 (9 June 2009)	- Alcohol advertising in cinemas; - Alcohol sponsorship; - Commitments by the Brewers of Europe (BoE) on the implementation and extension of the seven operational standards; - European Advertising Standards Alliance (EASA)commitments; - Reports on mapping exercises in the three areas of Social Marketing, targeting/not targeting youth and Self-Regulation.	Conclusions: - From discussion on alcohol advertising in cinemas: many cinemas would go out of business without the revenue generated by advertising; a dialogue between MS and wider stakeholder involvement might be useful and should be encouraged; - From discussion on alcohol sponsorship: there should be a greater standardization of rules, in particular on responsible drinking messages. The European Sponsorship Association (ESA) on alcohol sponsorship could provide the leadership role on best practices on all aspects of sponsorship and public health. - On BoE commitments by the chair: some of the obstacles could be addressed by benchmarking against the 2006 Report quality standards; sustainability could be determined by the independence of reviewers. - On the three mapping exercises: Task Force members should submit suggestions and comments to the Commission for the reports to be finalised afterwards; - Discussions of the further work of the Task Force should take place in the subsequent EAHF plenary meeting. Findings: - On advertising in cinemas: there are relatively few complaints about alcohol advertising. - The European Sponsorship Association (ESA) on alcohol sponsorship: A survey of sponsor recipients found that self-regulation is commonplace, and that the most common position was a total ban or ban on some alcohol categories. 90% of people surveyed would support responsible marketing of alcohol as conditional term. There are no exact figures on size of the marketplace, but 22 % of organisations accept sponsorship from beer and wine sponsors, with no figures available for spirits.

Annex 4: Assessment of the overall EU alcohol strategy process and added value – Task 3

The Specifications for the evaluation explain that:

"Overall EU alcohol strategy process" refers to the existence of the EU alcohol strategy as such and to the implementation, instruments and results which collectively have the potential to contribute to the reduction of alcohol related harm across the EU.

This section presents detailed information specifically on the two evaluation questions for this task. (Separately, the main report synthesises results across the three evaluation tasks and provides an overview of results concerning the EU strategy.)

1. Assessment aims and evaluation framework

1.1 Aims of Task 3

Task 3 considers the implementation process of the EU alcohol strategy as a whole, with a view to determining the extent to which the strategy is contributing toward the reduction of alcohol-related harm. The assessment uses desk research, and in particular looks at the development of Member State policies on alcohol-related harm, based on information gathered jointly by the Commission and the WHO. In addition, a limited number of task 3 questions were included in the surveys and interviews for tasks 1 and 2. Moreover, some of the questions addressed under those tasks also have a bearing on the strategy as a whole.

The table below in section 6.1.2 contains an overview of the main evaluation questions applying to task 3, along with the associated assessment criteria and indicators.

1.2 Evaluation framework

The framework for Task 3 is based on two evaluation questions (see table 46 below).

Table 46 Evaluation framework for the assessment of the overall EU alcohol strategy

Evaluation question	Assessment criteria	Indicators	Research Techniques
1. Which developments at national level are moving in the directions outlined in the EU alcohol strategy?	1.1 The EU alcohol strategy process has served as inspiration in the development of actions and strategies at national level	1.1.1 Perceptions of the role of EU Alcohol strategy process within national health policies	Interviews
	1.2 There is wide use of proven good practices especially to tackle the priority themes of the EU alcohol strategy	1.2.1 Examples of good practice in Member States' policies	Desk research
	1.3 There is convergence in MS' approaches to reducing alcohol related harm	1.3.1 Identification of similar practices across Member States' policies 1.3.2 Perceptions that there is a convergence in Member States' approaches	Desk research Workshop / Interviews
2. What evidence is there to show that the existence of the EU alcohol strategy as such has contributed towards	2.1 The priority themes for action identified in the EU alcohol strategy have adequately taken up, addressed	2.1.1 Perception that Member States' concerns have been addressed by the Alcohol Strategy	Survey/ interviews

Evaluation question	Assessment criteria	Indicators	Research Techniques
progress in reducing alcohol related harm?	and supported the priorities at national level		
	2.2 The EU alcohol strategy has adequately addressed the priority areas	2.2.1 Perceptions that the Alcohol Strategy has adequately addressed the identified common priority areas	Survey/ interviews
	2.3 The views expressed by stakeholders, MS representatives, observers or other experts contacted in the context of the assignment reflect an acknowledgement of a positive contribution from the EU alcohol strategy, at national level or beyond, to the process towards reducing alcohol-related harm	2.3.1 Index of responses to questionnaire and interviews 2.3.2 Perceptions of EAHF representatives and external experts and officials on the role of the EU alcohol strategy	All surveys Surveys and interviews
	2.4 Alcohol-related harm has fallen in the EU over the period of the alcohol strategy	2.4.1 Harm resulting from alcohol during pregnancy 2.4.2 Alcohol-attributable deaths 2.4.3 Prevalence of alcohol-attributable chronic physical/mental disorders	Desk research

1.3 Overview of research techniques for Task 3

The desk research for Task 3 draws in particular on information gathered jointly by the European Commission and WHO on the development of national policies to address alcohol-related harm.[188] In addition, the desk research has referred to several sources for statistics on alcohol-related harm, including Eurostat and WHO.

The surveys of CNAPA and EAHF members included two questions related to Task 3. The short, third survey was sent to external experts and officials included the same questions. This third survey was sent to the following groups:

- Current and former members of the Science Group (19 in total)
- Participants at Open Forum meetings that are not EAHF (or CNAPA) members (143 names)
- Selected academic experts proposed by the study team's senior advisor (14 persons)
- Member State officials working in other policy sectors, proposed by members of the ISSG. In practice, this involved contacts provided by DG Agriculture and DG EAC (44 in total).

In total, 220 persons were contacted in this third survey, and 51 responses were received, for a total response rate of 23%.

The interviews with CNAPA officials, EAHF representatives and external officials and experts also addressed aspects of Task 3. Information, opinions and quotes from the interviews and workshop discussions are provided where relevant in the following sections. These results are intended to illustrate points of view, and individual quotations should not be taken as representative of broader opinions.

[188] The main results are published in: WHO/Regional office for Europe, Alcohol in the European Union: Consumption, harm and policy approaches, 2012

2 Evaluation Question 1: Which developments at national level are moving in the directions outlined in the EU Alcohol Strategy?

2.1 Assessment Criterion 1.1 The EU Alcohol Strategy process has served as inspiration in the development of actions and strategies at national level

Indicators	Research Techniques
1.1.1 Perceptions of the role of EU Alcohol Strategy process within national health policies	Interviews

2.1.1 Indicator 2.1.1: Perceptions of the role of EU Alcohol Strategy process within national health policies

In the interviews, CNAPA members were asked: 'To what extent has the EU Alcohol Strategy process inspired new action or helped to step up action to reduce alcohol-related harm in your country?'

In their answers, six of the eight CNAPA interviewees indicated that the Strategy had inspired action at Member State level. Interviewees referred to the existence of an EU strategy as such as 'a stimulus' for national policy action, and to the value of the EU Strategy for policy discussions, in particular within the national government.

WHO's policy documents on alcohol, such as the 2010 *Global strategy to reduce the harmful use of alcohol*, were also mentioned. It was also highlighted that both the Global strategy and the EU Strategy were important, and the WHO global strategy had been more present in national debate in the past two years. In another case it was pointed out that the WHO strategy has some important elements not found in the EU alcohol strategy, and also that the two documents created some confusion at national level: *'it would be better to have one common framework'*.

Of the two interviewees who did not consider the EU strategy as a stimulus, one preferred not to reply having only recently joined CNAPA, and the other said that national alcohol policies had already been quite developed before the EU strategy.

In addition, in the CNAPA Advisory Group, it was highlighted that the strategy has provided a baseline for action by identifying common good practices to address alcohol-related harm.

2.2 Assessment Criterion 1.2 There is wide use of proven good practices especially to tackle the priority themes of the EU alcohol strategy
Assessment Criterion 1.3: There is convergence in MS approaches to reducing alcohol-related harm

Indicators	Research Techniques
1.2.1 Examples of good practice in Member States' policies	Desk research

Indicators	Research Techniques
1.3.1 Identification of similar practices across Member States' policies	Desk research
1.3.2 Perceptions that there is a convergence in Member States' approaches	Interviews

2.2.1 Indicator 1.2.1: Examples of good practice in Member States' policies

Indicator 1.3.1: Identification of similar practices across Member States' policies

These two indicators are addressed together, using drawing on the EC/WHO survey results, which provide information on the development of alcohol policies. This section presents an overview of key policies in place, together with developments from 2006. In most cases, information is available on policies in place at the end of 2010; details on policy developments vary. It should be noted that the EC/WHO survey results are reported for 29 countries: the EU27, plus Norway and Switzerland, which are also participating in the EU strategy.

National strategies and coordination bodies

According to the Joint EC/WHO survey, 21 of the 29 countries reported the existence of a written national alcohol policy at the end of 2010. A separate source of information, the WHO Alcohol Policy Timeline, indicates that at least 16 of the 27 Member States have either introduced a first national strategy (as in Belgium) or revised their existing strategy, as in Finland (see Table 47 below). In addition, WHO reports that in 2011 at least one Member State was in the process of drafting a national alcohol strategy.

In addition, most reporting countries have created a national coordination body to address alcohol-related harm, and 13 Member States established or revised their national coordination body between 2006 and 2010.

Table 47 National policy developments on alcohol-related harm 2006-2010

	Total no. of MS that reported developments*		
Policy Development	EU27***	EU12	EU15***
National Strategy**	16	10	6
Coordination Body	13	6	7

* Each MS is only counted once for each area of policy development, even if it has taken action more than once over the period
**Draft strategies as well as strategies in a part/region of a country are not counted.
***Data not available for the Netherlands and UK.
Source: WHO, Alcohol Policy Timeline, 2012

Actions to protect young people, children and the unborn child

The Alcohol Strategy lists the following good practices in this area:

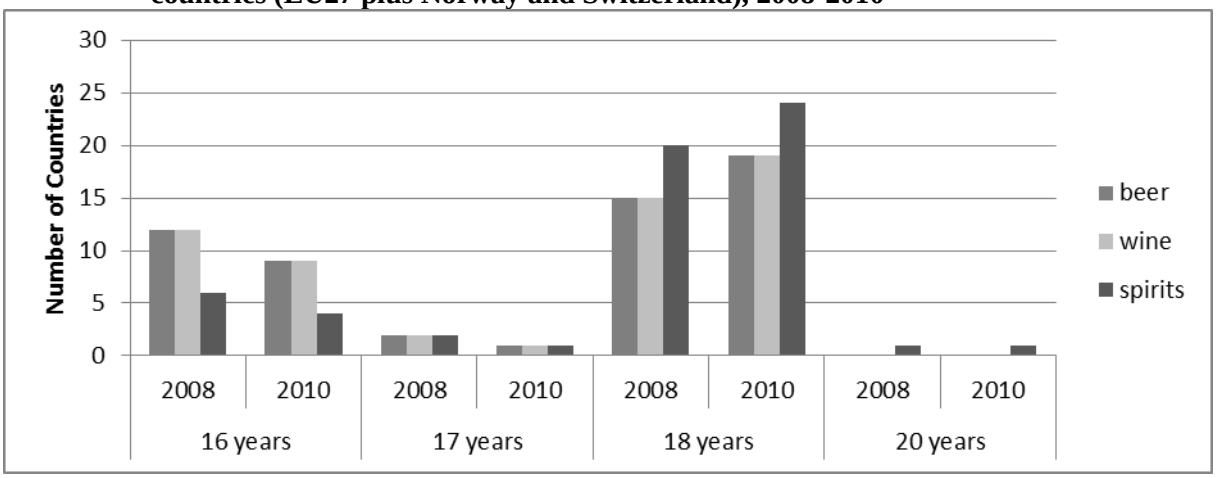
- Enforcement of restrictions on sales, on availability and on marketing likely to influence young people
- Broad community-based action to prevent harm and risky behaviour, involving teachers, parents and young people themselves and supported by media messages and life-skills training programmes

The joint European Commission/WHO survey provides information on Member State measures in both areas.

Regarding ***restrictions on sales***, and in particular age limits, all 29 countries have set a legal minimum age limit for the on-premise sale of alcohol, and the vast majority (23) has a minimum age limit for off-premise sales as well (see figures 29 and 30 below). The most common minimum age is 18 years, applied to on-premise sales of spirits in 23 countries and to on-premise sales of beer and wine in 18

countries. For off-premise sales, the 18-year minimum age (or higher) is used for spirits in 20 countries, and for beer and wine in 17 countries.

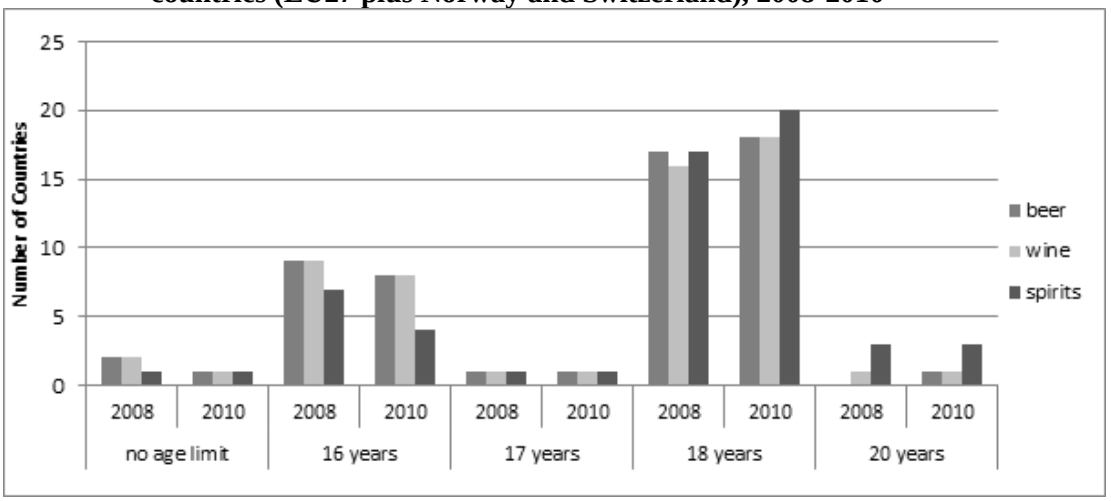
Figure 29 Minimum age limits for on-premises sale of beer, wine, and spirits, by number of countries (EU27 plus Norway and Switzerland), 2008-2010



Source: EC/WHO joint Survey, WHO Regional Office for Europe (2012a), European Information System on Alcohol and Health (EISAH)

As regards measures for the enforcement of age limits, in the responses given in the EC/WHO survey in May 2011, enforcement by the police or other authorities was rated as by far the most important measure, followed by awareness campaigns directed at sellers and servers or at young people. In addition, there is a growing use of test purchasing to check the application of age limits: in Member States including Sweden and the United Kingdom, local governments check this directly and also work with NGOs to case out 'mystery shopping' (test purchases by minors).

Figure 30 Minimum age limits for off-premise sale of beer, wine and spirits, by number of countries (EU27 plus Norway and Switzerland), 2008-2010



Source: EC/WHO joint Survey, WHO Regional Office for Europe (2012a), European Information System on Alcohol and Health (EISAH)

Around two-thirds of the countries require a licence for on- or off-premise sales of alcohol products. In Finland and Sweden, alcoholic beverages above a given strength are sold through government-controlled retail monopolies.

According to the EC/WHO survey, 17 of the 29 countries reported the development of stronger measures regarding the availability of alcoholic beverages covering sales restrictions as well as licensing and other measures.[189]

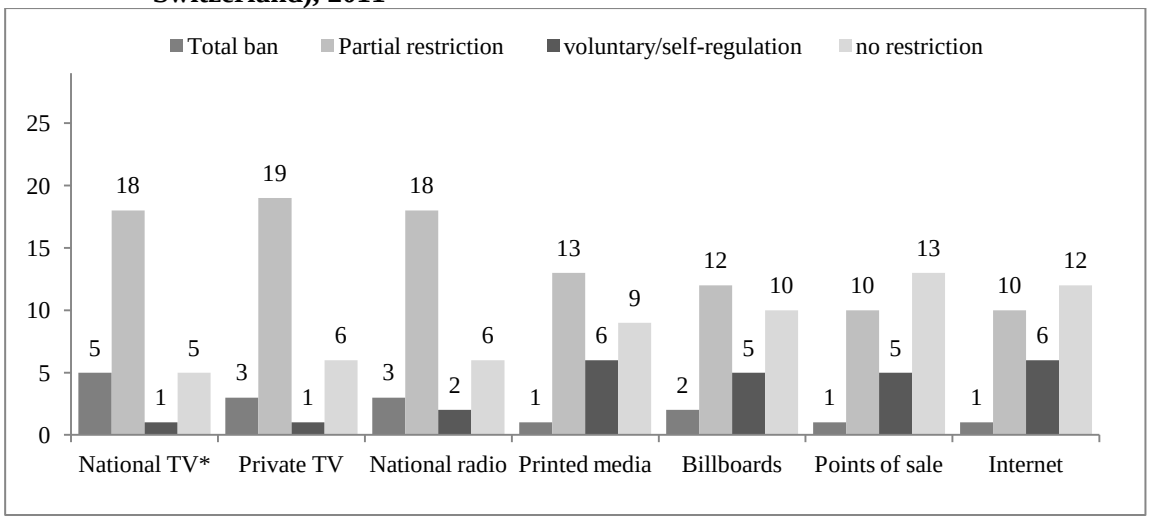
In terms of ***marketing restrictions***, legally binding regulations on alcohol advertising are in place in the majority of countries at national level (figures 31 and 32 below provide data for beer sales). The number of countries with regulations on the advertising of alcoholic beverages and product placement in different media are shown below for beer. Wine and spirits show similar figures, though there are differences: notably, total bans on alcohol advertising are applied more often on spirits advertising than on the advertising of beer or wine, in particular for broadcast media.

Most of the 29 countries have partial restrictions on marketing, product placement and sponsorship. However, 10 or more countries have no restrictions advertising and marketing on billboards, at point of sale, or on the Internet. The latter area is identified as a concern, due to the popularity of online media among young people and the importance of social media in influencing behaviour.

Fewer countries regulate product placements on television: total bans are in place in 5 of the 29 countries (though in one, not for private TV), and partial restriction in 12 others.

Nonetheless, regulation of marketing is the exception to the trend towards stronger alcohol policies according to the EC/WHO survey: 17 countries did not report any changes in this area, whereas marketing regulation was reported to have weakened in 3 countries.

Figure 31 Member States with restrictions on advertising for beer, (EU27 plus Norway and Switzerland), 2011

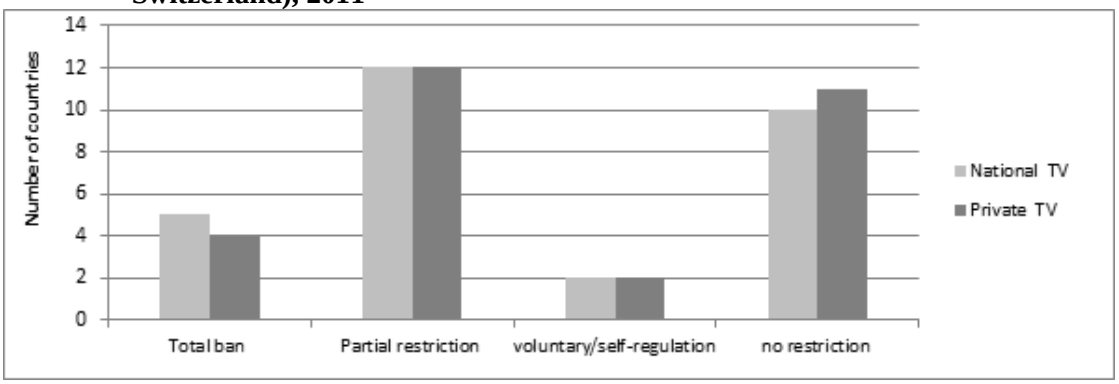


Source: European Information System on Alcohol and Health (EISAH)

Almost all countries (27 of 29) reported in the EC/WHO survey the presence of ***community-based intervention projects*** involving young people and/or civil society, with non-governmental organizations and local government bodies as the most commonly involved stakeholders[190]. Moreover, community action is also one of the main areas where countries reported the greatest movement towards stronger policies (21 countries).[191]

[189] EC/WHO joint Survey, WHO Regional Office for Europe (2012a), Fig.22 p. 119
[190] EC/WHO joint Survey, WHO Regional Office for Europe (2012a), European Information System on Alcohol and Health (EISAH)
[191] EC/WHO joint Survey, WHO Regional Office for Europe (2012a), Fig.22 p. 119

Figure 32 Countries with restrictions on product placement for beer (EU27 plus Norway and Switzerland), 2011



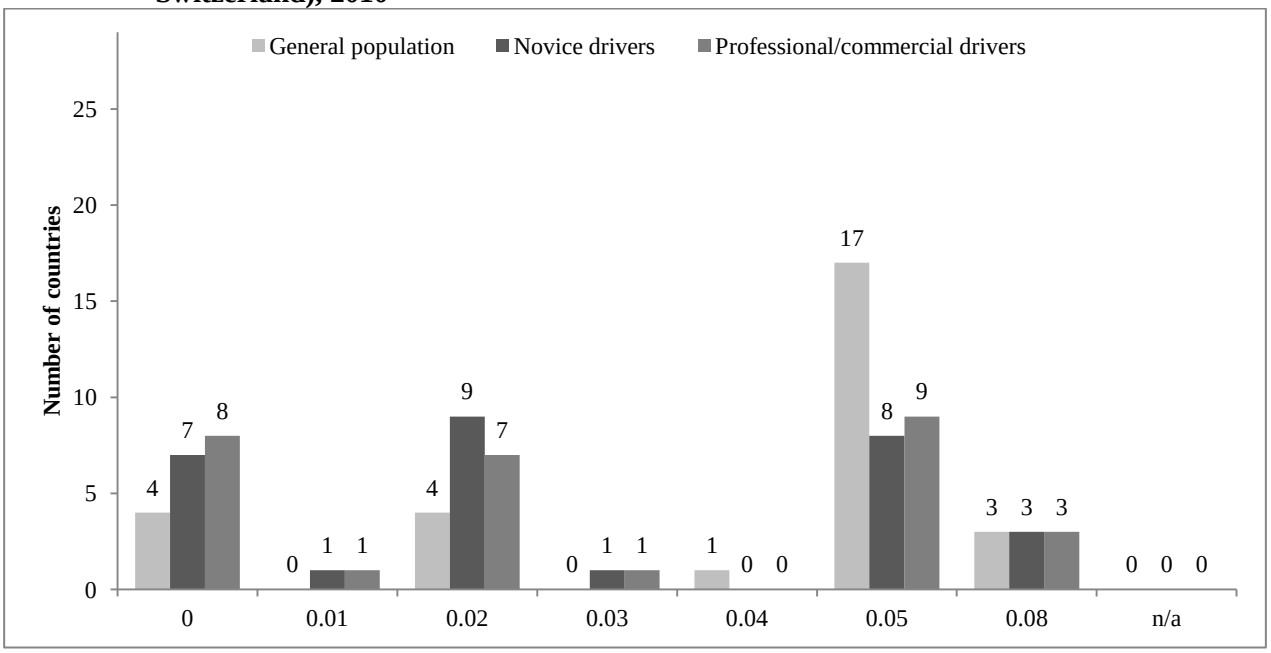
Source: European Information System on Alcohol and Health (EISAH)

Reduce injuries and death from alcohol related road accidents

The following good practices are identified in the EU Strategy:

- Introduction and enforcement of frequent and systematic random breath testing, supported by education and awareness campaigns involving all stakeholders
- Lower blood alcohol content (BAC) limits for young and novice drivers and for categories of professional drivers

Figure 33 Maximum legal BAC level by number of countries (EU27 plus Norway and Switzerland), 2010



Source: European Information System on Alcohol and Health (EISAH), EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

At the end of 2010, almost all EU countries had established a ***maximum legal BAC*** level of 0.5 g/litre (sometimes stated as 0.5 mg/ml) or below for general population drivers, with four countries adopting a zero tolerance level. Towards the end of 2011, Ireland reduced its maximum permitted BAC level from 0.8 g/litre to 0.5 g/litre for general population drivers. This has left only Malta and the United Kingdom with a level of 0.8 g/litre.

Breath-testing was widely used to enforce BAC limits: by 2010, over 20 Member States implemented random breath-testing either by mobile police patrol units or in stationary roadside checkpoints. In addition, 15 had mandatory driver education programmes for habitual offenders.

In addition, drink-driving has been the most common topic in nationwide ***awareness-raising campaigns*** carried out during the three years to 2010.

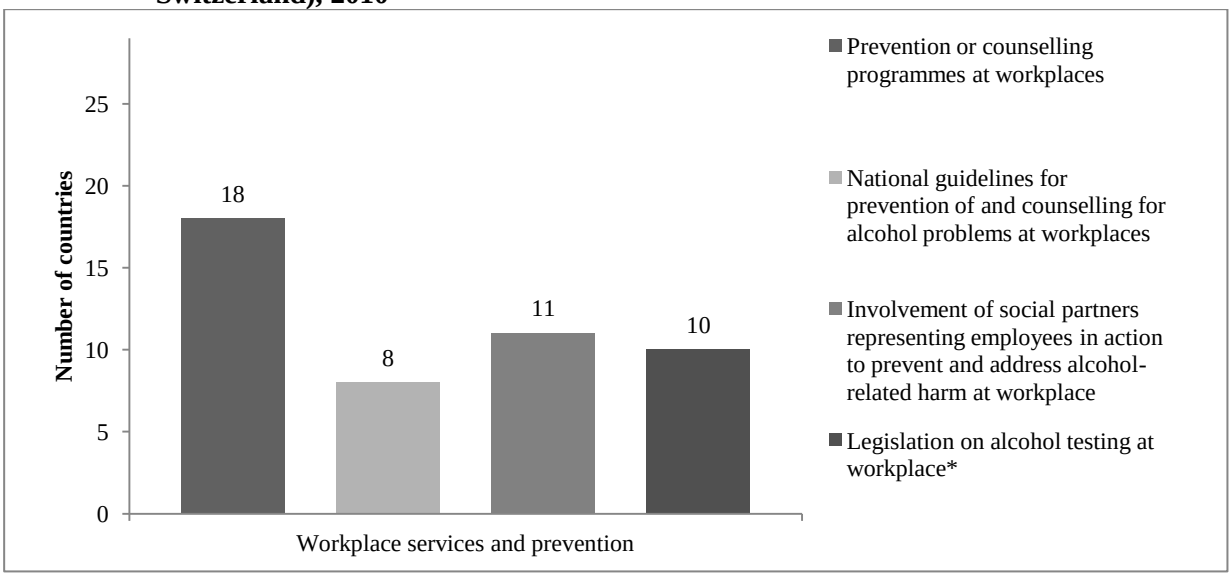
Overall, according to the EC/WHO survey, a high number of countries (23 of the 29) reported strengthened measures to address drink-driving over the period from 2006 to 2010.

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

The following good practices are identified in the EU Strategy:

- Improved enforcement of current regulations
- Licence enforcement
- Server training
- Pricing policies
- Community and workplace-based interventions
- Education, information activities and campaigns
- Advice by doctors or nurses in primary care to people at risk
- Treatment of alcohol addiction

Figure 34 Countries with workplace services and prevention, (EU27 plus Norway and Switzerland), 2010



*Data missing for one country
Source: European Information System on Alcohol and Health (EISAH), EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

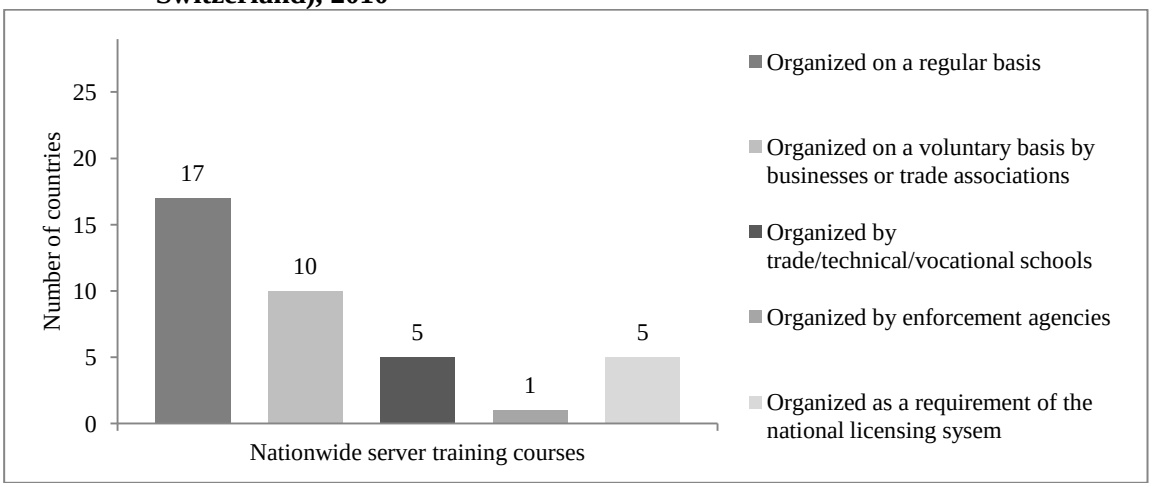
Work-based programmes may include prevention or counselling programmes, national guidelines for prevention of and counselling for alcohol problems at workplaces, involvement of social partners representing employers and employees in action to prevent and address alcohol-related harm at workplaces and legislation on alcohol testing at workplaces. While prevention and counselling programmes seem to be common practice in the majority of Member States[192], other services and legislation are still underdeveloped.

In 13 of the 29 countries, measures to address alcohol in the workplace strengthened between 2006 and 2010; they remained more or less unchanged in 14 countries and weakened in one country.

192 EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

Server training courses were reported in available nationwide in 17 of the 29 countries. In most of the 17 countries, such courses are organised on a voluntary basis by businesses or trade associations (see Figure 35 below).

Figure 35 Server training on a regular base by number of countries (EU27 plus Norway and Switzerland), 2010



Source: European Information System on Alcohol and Health (EISAH), EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

Regarding ***pricing policies***, all 29 countries levy excise duty on beer and spirits, but in eight countries wine is still not subject to this duty. Value added tax (VAT) is levied on all alcoholic beverages including wine in all countries. As in the case of excise duty rates, VAT rates vary across beverage categories. In addition, 5 of the 29 countries have set an additional levy on specific products ('alcopops' and other ready-to-drink mixtures); the same number have a requirement to offer non-alcoholic beverages at a lower price than alcoholic beverages, and bans on volume discounts or below cost selling.

Moreover, 13 of the 29 countries report that their policies related to alcohol pricing and affordability grew stronger from 2006 to 2010; 13 reported no change and 3 reported weaker policies. Regarding excise duties, the WHO timeline shows that at least four Member States changed their excise duties on alcohol between 2006 and 2010.

The EC/WHO survey shows an increase in the average nominal price alcoholic beverages over the five years to 2010 in 17 of the 29 countries. , These results do not, however, consider affordability (i.e. changes in income along with changes in alcohol prices).

Regarding ***advice by doctors and nurses***, the majority of Member States had by 2010 a national treatment policy involving the referral and treatment of people with alcohol use disorders.

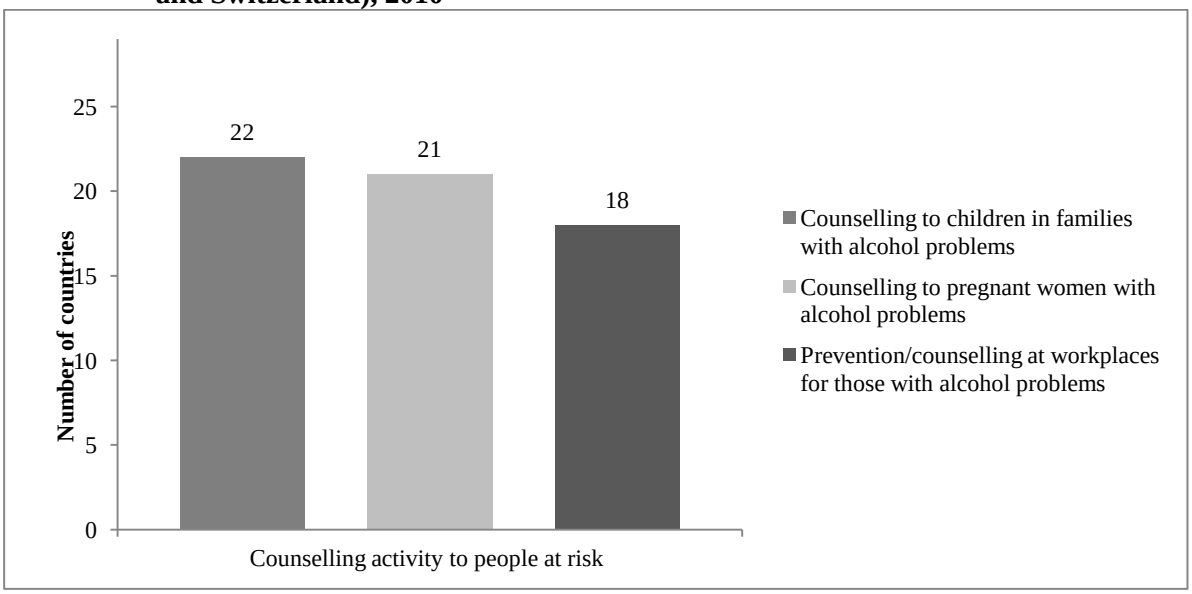
Table 48 Countries offering services and interventions by the health services, (EU27 plus Norway and Switzerland), 2010

Health services response	No. of countries
Brief interventions for health promotion and disease prevention	21
Training modules in screening and brief interventions for alcohol problems	14
Clinical guidelines for brief interventions endorsed by at least one health care professional body	18

Source: EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

Counselling for children in families with alcohol problems is provided in 22 of the 29 countries; in 21 countries for pregnant women; and in 18 countries at workplaces (see Figure 36 below). One important concern, however, is that only a small share of people in need appear to receive counselling and advice when programmes exist: WHO estimates that this can be as low as 5% to 10%.

Figure 36 Counselling activity to people at risk by number of countries (EU27 plus Norway and Switzerland), 2010



Source: European Information System on Alcohol and Health (EISAH), EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

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

The following good practice is identified at EU level:

- Health and life skills education programmes, beginning in early childhood and continued through adolescence
- Media campaigns

As regards activities to reduce alcohol-related harm through awareness-raising, information and education, the EC/WHO survey covered policies relating to school-based education on alcohol, nationwide awareness-raising activities carried out during the previous three years, and the use of alcoholic beverage packages or alcohol advertisements as a vehicle for raising awareness about risks related to alcohol consumption.

Almost three quarter of the countries reported that ***education programmes*** relating to alcohol (or broader substance use) are carried out nationwide as part of the school curriculum, in most cases as a legal requirement.

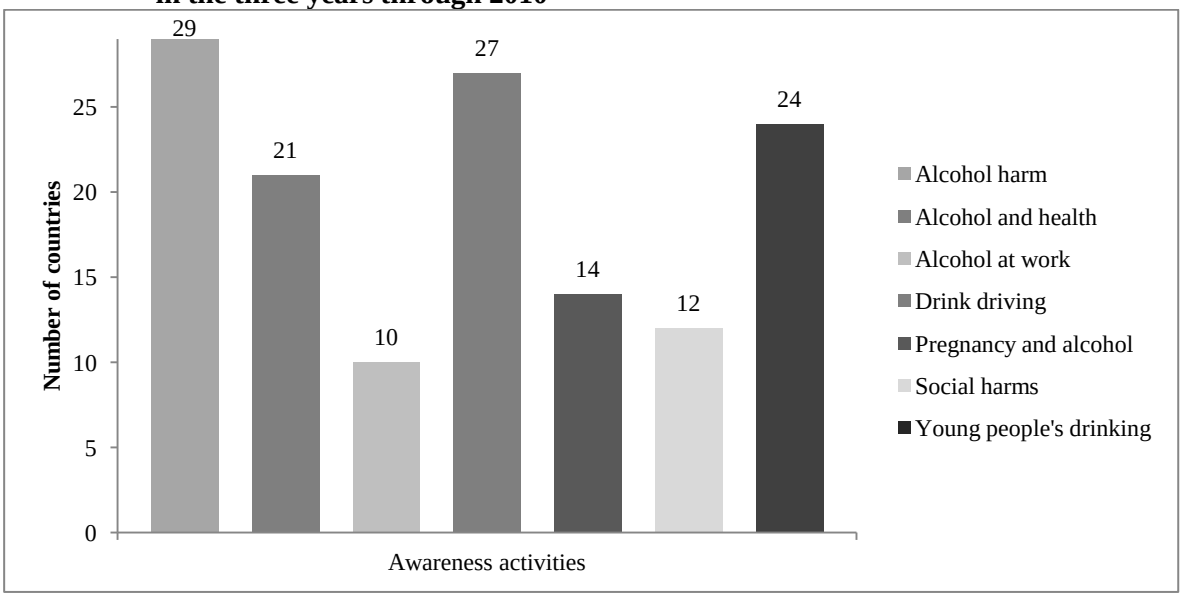
Table 49 Number of countries with school-based education and policies, (EU27 plus Norway and Switzerland), 2010

Education and policies	No. of countries
Nationwide educational programmes involving teachers, schoolchildren and/or parents as part of the school curriculum	20
Legal obligation for schools to carry out alcohol prevention as part of school curriculum/health policies	18
National guidelines for the prevention and reduction of alcohol-related harm in school settings	15

Source: EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

Some form of national awareness-raising on alcohol-related harm has been carried out in all 29 countries in the three years through 2010. In 27 countries, such activities covered drink driving; and in 24, drinking by young people.

Figure 37 Awareness activities, by number of countries (EU27 plus Norway and Switzerland), in the three years through 2010



Source: European Information System on Alcohol and Health (EISAH), EC/WHO joint Survey, WHO Regional Office for Europe (2012a)

Few of the countries reported the existence of requirements to provide information on alcohol-related harm on packages and in advertisements. Nine countries have a legal requirement at national level for health warning labels to be placed on alcohol advertisements. Two countries reported a legal requirement at national level to place health warning labels on alcoholic beverage containers.

Develop and maintain a common evidence base at EU level

The development of work in this are at EU level has been addressed in particular under Task 1. It can be also noted that at national level, 17 of the 29 countries publish a regular report on the alcohol situation in the country, while 18 carry out regular national surveys. The topics covered vary considerably: Alcohol-related traffic accidents, harm to health and policy responses are among the most commonly monitored. As regards drinking habits, under-age drinking appears to be monitored more closely than drinking by adults.

2.2.2 Indicator 1.3.1: Perceptions that there is a convergence in Member States' approaches

The information gathered by WHO on policy developments in Member States, summarised above, highlights a range of areas where there has been convergence in Member States' approaches to reducing alcohol related harm (indicators 1.2.1 and 1.3.1).

In the AG workshop as well as interviews, CNAPA members cited a number of areas of convergence, including age limits for alcohol sales and BAC limits for drink driving. It was also noted that, at a more general level, there has been convergence between EU15 Member States, several of which already had strong alcohol policies, and EU12 Member States, where alcohol policies have been less well-developed.

2.3 Key findings for Evaluation Question 1

Most Member States have put in place many policies to address alcohol-related harm, and many have updated their strategies since 2005. Member States have taken a range of policy actions across the five

priority themes of the EU strategy. Moreover, a number of have strengthened their policies since 2005, in the directions set out in the Strategy.

Notably, all Member States have set a legal minimum age for the on-premise sale of alcohol, and there is convergence towards setting the minimum at 18. Nationwide school-based programmes addressing alcohol are in place in 20 countries (out of the 27 Member States, plus Norway and Switzerland). All but two Member States have implemented the 2001 Recommendation to reduce BAC levels for driving to 0.5 mg/ml, and a majority have introduced stricter limits for novice and commercial drivers. The majority use random breath testing to enforce BAC limits. Drink driving is the most common topic for awareness-raising campaigns.

In interviews, CNAPA members considered that the EU Strategy has been a stimulus for national action (except where national action was felt to be already strongly developed). In the CNAPA Advisory Group, it was highlighted that by identifying common good practices to address alcohol-related harm the strategy has provided a baseline for action.

3 Evaluation Question 2: What evidence is there to show that the existence of the EU alcohol policy as such has contributed towards progress in reducing alcohol-related harm?

3.1 Assessment Criterion 2.1 The priority themes for action in the EU Alcohol Strategy have adequately taken up, addressed and supported the priorities at national level

Indicators	Research Techniques
2.1.1 Perception that Member States' concerns have been addressed by the Alcohol Strategy	All surveys

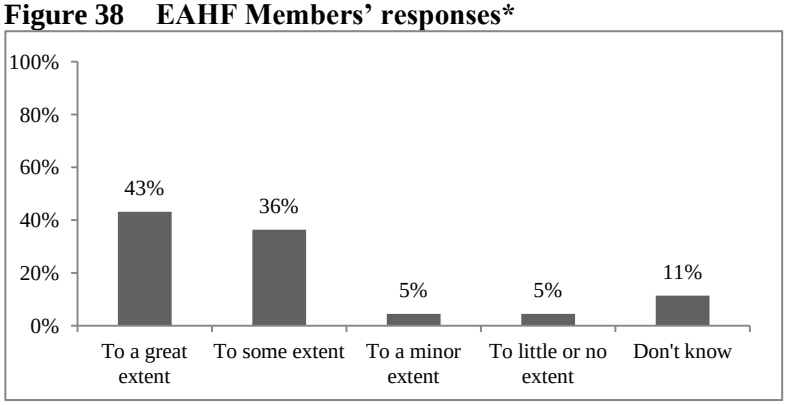
3.1.1 Indicator 2.1.1: Perception that Member States' concerns have been addressed by the EU Alcohol Strategy

Survey results

Each survey asked the following question: 'To what extent does EU Alcohol Strategy address themes of concern for your Member State?'

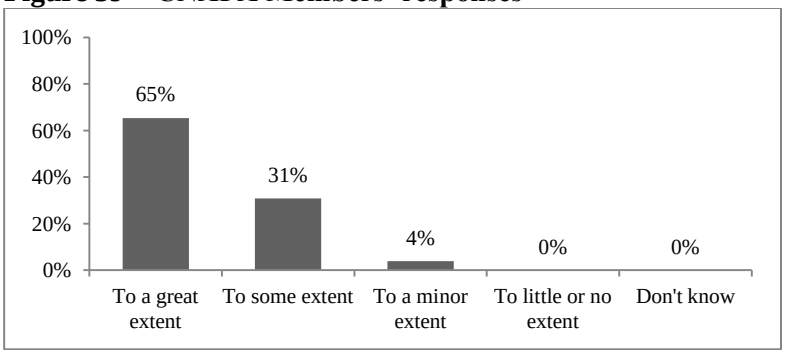
As shown in the set of figures below, in each of the three surveys, over 75% of the respondents indicated that the Strategy addresses themes of concern to a great extent or to some extent. Responses were strongest for CNAPA members, 65% of whom responded that the Strategy addressed such themes to a great extent.

Figure 38 EAHF Members' responses*



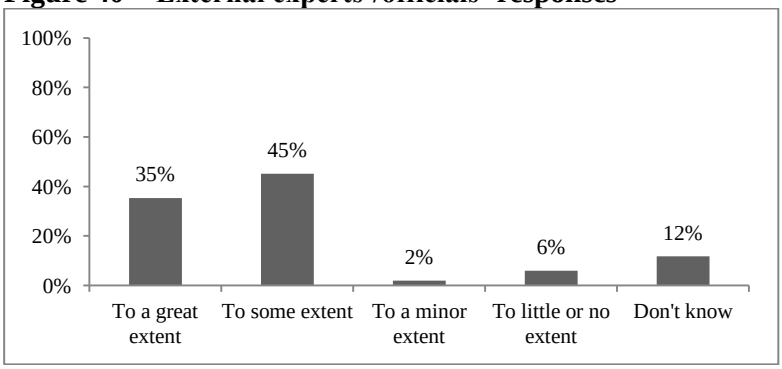
*n=44

Figure 39 CNAPA Members' responses*



*n=26

Figure 40 External experts'/officials' responses*



*n=51

Interview of CNAPA members

In the interviews, CNAPA members had few comments on further areas that would merit attention. Illegal and unregistered alcohol production was mentioned as a national concern. Several respondents welcomed the discussions in CNAPA on taxation issues, including with the participation of DG Taxation and Customs Union.

3.2 Assessment Criterion 2.2: The EU Alcohol Strategy has adequately addressed the priority areas

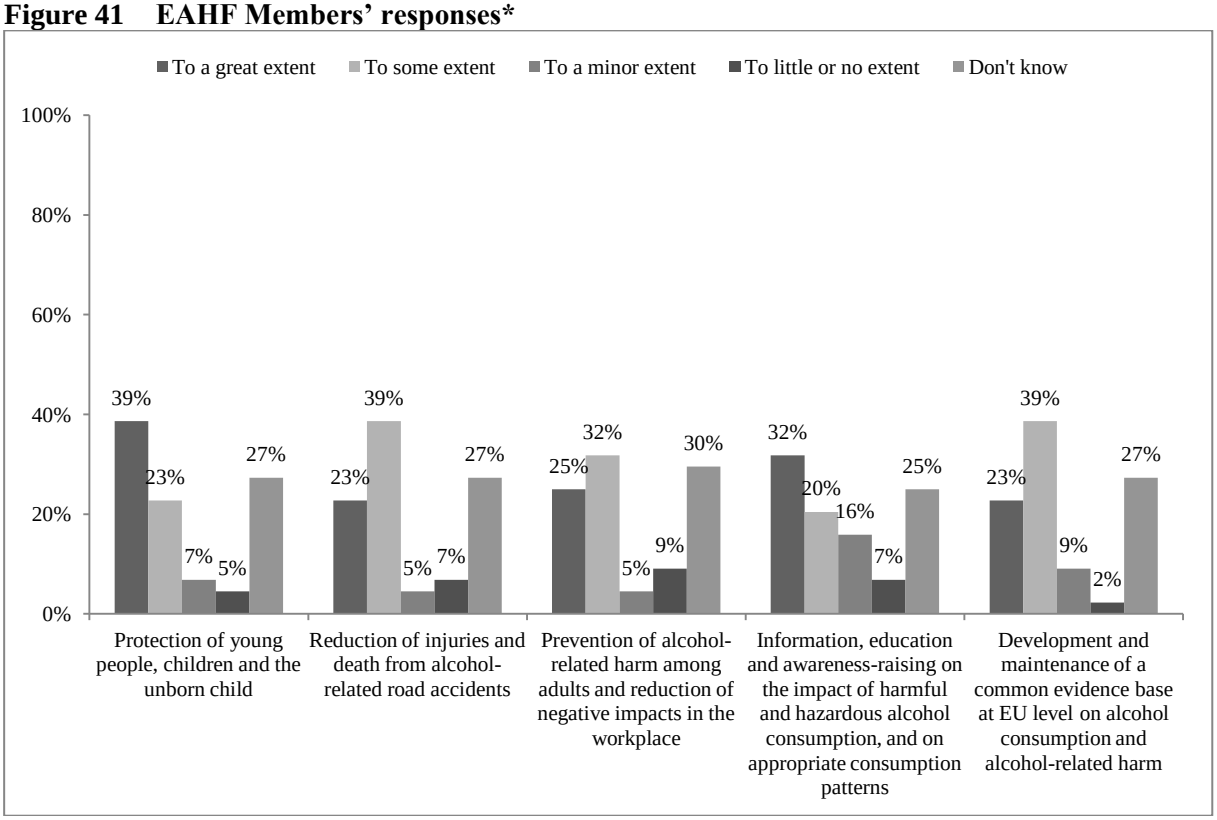
Indicator	Research Techniques
2.2.1 Contribution of the EU alcohol strategy to the development of policies, actions and strategies in the Member States	Survey

3.2.1 Indicator 2.2.1: Contribution of the EU alcohol strategy to the development of policies, actions and strategies in the Member States

In their responses, a majority of respondents to all three surveys indicated that the EU strategy had contributed to a great extent or to some extent to the development of policies, actions and strategies in their Member State to reduce alcohol-related harm in each of the five priority themes. As the set of figures below shows, here too, CNAPA respondents were the most positive. The external experts and officials were the least positive: for the most part, few of this group indicated that the alcohol strategy contributed to national policies, actions and strategies 'to a great extent'. Moreover, about 25% of EAHF respondents chose 'don't know' for these questions; a similar share was seen in the respondents to the survey of external experts and officials.

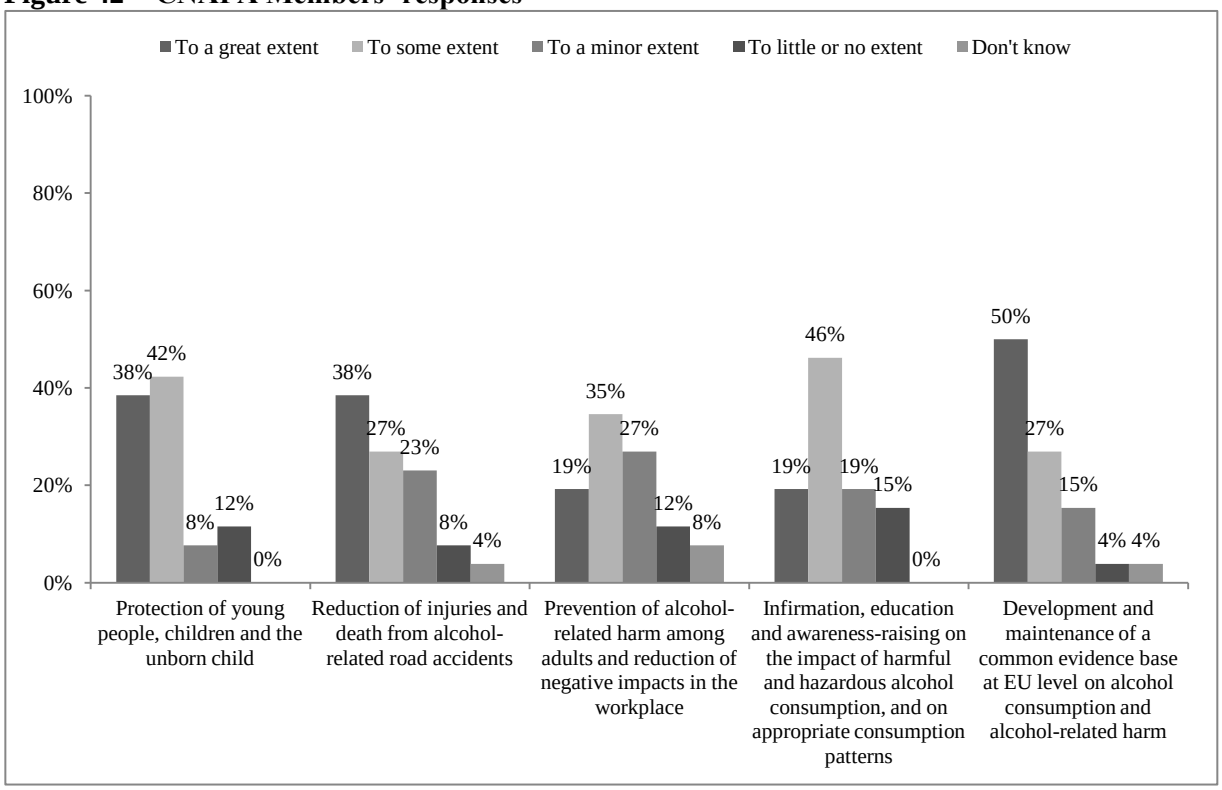
Among the different priorities of the strategy, the responses from CNAPA members were most favourable for the *development and maintenance of a common evidence base*, followed by the *protection of young people, children and the unborn child*. The latter priority was judged most favourably by EAHF respondents and external experts and officials.

Figure 41 EAHF Members' responses*



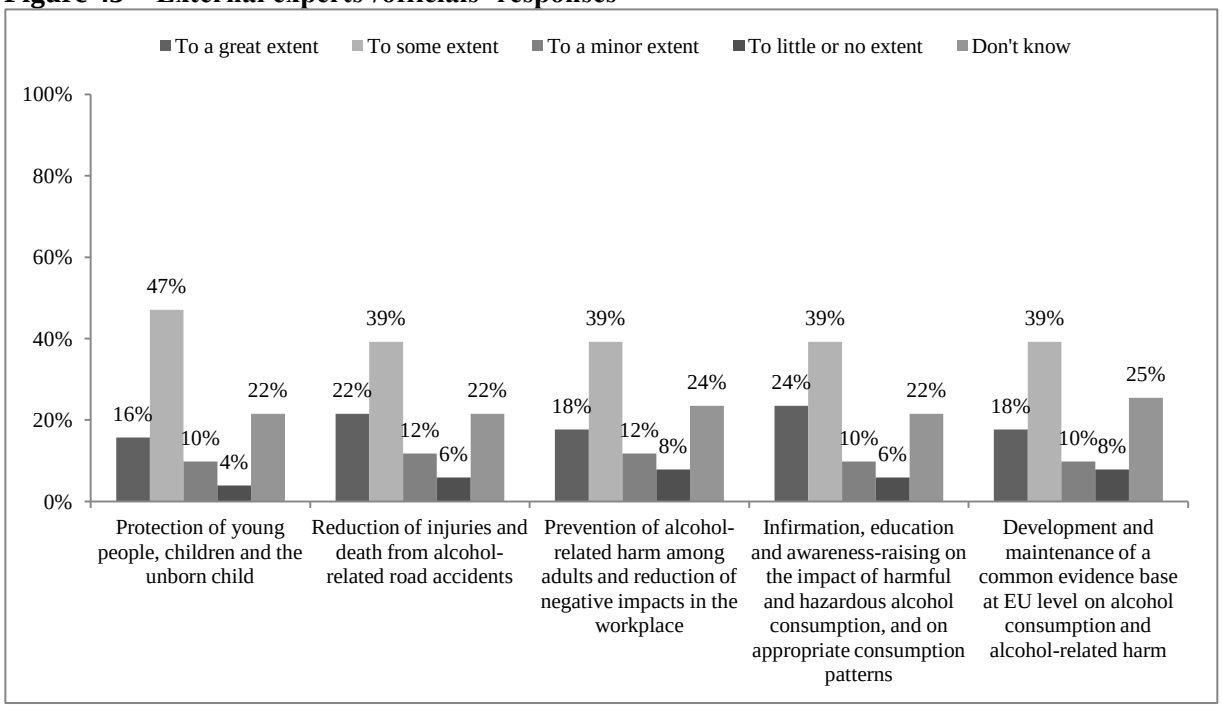
*n=44

Figure 42 CNAPA Members' responses*



*n=26

Figure 43 External experts'/officials' responses*



*n=51

3.3 Assessment Criterion 2.3 The views expressed by stakeholders, MS representatives, observers or other experts contacted in the context of the assignment reflect an acknowledgement of a positive contribution from the EU alcohol strategy, at national level or beyond, to the process towards reducing alcohol-related harm

Indicators	Research Techniques
2.3.1 Index of responses to questionnaire	All surveys
2.3.2 Comments of EAHF representatives and external experts and officials on the role of the EU alcohol strategy	Surveys and interviews

3.3.1 Indicator 2.3.1: Contribution of the EU alcohol strategy to the development of policies, actions and strategies in the Member States

This indicator was constructed using the responses to all the questions in the surveys: for each question, the most positive response was given a score of 4; the most negative, a score of 1. Many questions also allowed a 'don't know' response, and these were tallied separately.

The results are presented separately for the questions in each task.

Task 1 asked CNAPA members a range of questions that focused on the role of this committee. On average, the responses for Task 1, across all respondents and all questions, is 3.2 on a scale of 1 to 4. There were relatively few 'don't know' responses: the highest for any question was 7%.

Table 50 Index of survey responses for Task 1

Task 1 CNAPA	
Average score	**3.20**
Range of 'don't know' responses	0% - 7%

The average across the survey questions for Task 2, which was sent to EAHF respondents, is rather lower: 2.87 on a scale of 1 to 4. Here, one question had a very high level of 'don't know' responses (49%); as this was an outlier, the second-highest level of 'don't know' responses was used. These questions focused on the role of EAHF, and the average supports the conclusions drawn in Task 2: there are differences in opinion on Forum members regarding its value.

Table 51 Index of survey responses for Task 2

Task 2 EAHF	
Average score	**2.87**
Range of 'don't know' responses	0% - 30%*

* 49% for the question on CDCID

For Task 3, and specifically its assessment criteria 2.1 and 2.2, questions were asked in all three surveys: that of CNAPA respondents, EAHF respondents and external experts.

These questions addressed the role of the EU strategy as a whole in terms of supporting action within Member States. Here it is notable that the three scores are quite similar, including the opinions of the experts external to the process. A high share, 12 to 25%, responded 'Don't know' to the questions, however.

Table 52 Index of survey responses for Task 3

	CNAPA respondents	EAHF respondents	External experts
Average score	**3.28**	**3.22**	**3.10**
Range of 'don't know' responses	0% - 8%	11% - 30%	12% - 25%

3.3.2 Indicator 2.3.2: Perceptions of EAHF representatives and external experts and officials of the role of the EU alcohol strategy

CNAPA members commented on the role of the EU alcohol strategy, in particular with reference to its links with national policies (see section 2.1.1 above).

This indicator instead gathers comments made by EAHF representatives, as well as those by external experts and officials.

EAHF representatives

Representatives of EAHF members made several written comments about the strategy as a whole in the context of the survey.

One respondent, representing an economic operator, wrote that:

> *The Strategy itself covers all the main priority areas with regard to alcohol-related harm: underage drinking, drink-driving, binge drinking, alcoholism etc. The Strategy also led to the establishment of Forum-like structures in Portugal, Austria and other countries.*

A representative from the NGOs and health professionals category reported that:

> *The strategy has been important for raising the knowledge of alcohol policy in all member states. However, the WHO Global Alcohol Strategy as well as the WHO European Alcohol Action Plan 2012-2020 provide for a more far reaching strategy than the EU Alcohol Strategy. It encourages using pricing policies, such as higher taxes, to reduce alcohol related harm. The action plan also stresses that the impact of alcohol marketing should not be underestimated....*

In interviews, EAHF respondents provided some further comments. One representative of an economic operator stated that:

> *The EU Strategy is changing policies, but we cannot comment on the extent it is doing so in each Member State. It is raising awareness, changing attitudes and involving a broad range of stakeholders.*

A representative from NGOs and professionals stated that the strategy has focused on prevention, has stepped up action in Member States and has had direct impacts in areas including: drink driving, age limits and alcohol and pregnancy.

Another representative from this sector said that '*if we compare it to the alternative of not having a strategy at all, the benefits are huge...*' However, this interviewee said that greater policy integration is needed in the next phase:

> *There could be more input and interaction with different DGs that could be relevant—for example DG Trade for cross border trade, DG AGRI for the links between alcohol and the CAP, and DG TAXUD for the taxation of alcohol*

Few EAHF interviewees made comments on specific impacts in Member States. Notably, a respondent from an economic operator and another from NGOs and professionals both stated that the strategy had a positive effect on their EU15 Member State.

Participants in the Open Forum

The respondents who had attended the Open Forum had a number of comments. One participant wrote: '*The Strategy has been a very important instrument to raise [attention to] alcohol related harm*'.

An official working at local level, however, wrote: '*The issues raised in the strategy are the same issues raised at a local level but I'm not sure it's had a major impact on the work we do – but maybe that should change*'.

Another official at local level commented:

> *'Despite working in the Alcohol field (public health) since November 2009 I have only become aware of the EU work in the last 6 months.'*

A member of a national industry association in the alcohol sector reported:

> '*...we have developed partnerships at local level amongst wide ranges of stakeholders [national ministries, consumer associations and health organisations are cited]. This is in no small part due to the support given by the Strategy to multi-stakeholder actions*'

Another Open Forum participant called for ensuring that all stakeholders are '*brought on board*' and also called for '*further facilitating the formation of public-NGO-private partnerships to deliver input and commitments*'.

Participants of the Open Forum also made several suggestions for the EU strategy. These include greater attention to the following:

- Alcohol and sponsorship in sport
- Border issues related to sales
- Production and use of cheap alcohol in Eastern Europe and the harm it creates locally

External experts and officials

This group provided a few written comments in the surveys.

One external expert from southern Europe praised the EU strategy, as they noted that in their country, '*...where alcohol misuse is now emerging as a social problem, can benefit from common and well documented strategies and actions*'. An external expert from an EU12 Member State reported, however, that in their country alcohol-related problems are '*a completely neglected field for policy'*.

Several officials from non-health sectors referred to specific areas they felt deserved further attention. One official in southern Europe highlighted the role of responsible consumption campaigns by producers; another underlined the need to inform consumers and young people in particular regarding moderation in the consumption of wine. An EU15 official in northern Europe highlighted problems related to binge drinking by young people and adolescents.

3.4 Assessment Criterion 2.4 Alcohol-related harm has fallen in the EU over the period of the alcohol strategy

Indicators	Research Techniques
2.4.1 Harm resulting from alcohol during pregnancy 2.4.2 Alcohol-attributable deaths 2.4.3 Prevalence of alcohol-attributable chronic physical/mental disorders	Desk research

WHO's 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases highlights the harmful use of alcohol is one of the main risk factors for non-communicable diseases, along with tobacco use, physical inactivity and unhealthy diets.[193] It is estimated that in 2004, alcohol was responsible for 3.8% of deaths worldwide and 4.5% of the global burden of disease.[194] The EU strategy, citing WHO research, states that harmful and hazardous alcohol consumption 'is a net cause of 7.4% of all ill-health and early death in the EU, and has a negative impact on labour and productivity'.

Drawing on available sources of reliable and comparable data across the EU, the Committee on Alcohol Data, Indicators and Definitions (CDCID) selected a set of common indicators for monitoring health outcomes relevant to the priority themes of the EU alcohol strategy.[195]

Directly applicable information is at the moment regularly and systematically gathered across all Member States only for part of the common indicators. A summary of the most recent available information is presented in Appendix to Annex 4, including data on total alcohol consumption and harmful consumption patterns.

For the purposes of the present evaluation, three direct indicators of alcohol related harm were identified. The choice of these indicators, which belong to the CDCID set, was agreed with DG SANCO during the inception phase of this evaluation. Limitations in the availability of data make it very difficult to establish clear trends in levels of alcohol-related harm across the EU.

This information focuses on health aspects of alcohol-related harm. The EU strategy notes that harmful and hazardous alcohol consumption has a 'negative impact on labour and productivity'. Other authors refer also to social impacts, including on violence and crime. The total tangible costs of alcohol to EU societies have been estimated at up to EUR 125bn[196], or 1.3% of GDP.[197] WHO has estimated that costs for some EU Member States may have reached 3% of their GDP; WHO also highlights links between alcohol and poverty and social exclusion, as alcohol-related harm affects socially disadvantaged people disproportionately. [198]

[193] WHO, 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, 2008.
[194] WHO, Global strategy to reduce the harmful use of alcohol, 2010
[195] Alcohol-related Indicators: Report on the work of the Committee on Alcohol Data, Indicators and Definitions. February 2010. Directorate-General Health and Consumers.
[196] Estimation of 2006 based on figures from 2003, see First Progress Report on the implementation of the EU Alcohol Strategy, p. 8.
[197] Anderson P. and Baumberg B. (2006), Alcohol in Europe, a public health perspective, Institute of Alcohol Studies, London, 2006, p. 47.
[198] Alcohol in the European Union. Consumption, harm and policy approaches. WHO Regional Office for Europe, 2012.

3.4.1 Indicator 2.4.1: Harm resulting from alcohol during pregnancy

For monitoring harm resulting from alcohol during pregnancy, the CDCID selected as indicator the incidence of foetal alcohol syndrome (ICD-10 code Q86.0) among newborn children, as registered in the EUROCAT register (European Surveillance of Congenital Anomalies). The Committee noted, however, drawbacks related to this indicator and called for further work to identify additional data sources and to develop additional indicators.

Information gathered by the WHO from EU Member States in 2011 indicates that both national registry data on the incidence of FAS and estimates of the prevalence of FAS are extremely variable across the EU. In most Member States, no data is available (Appendix to Annex 4.)

In sum, neither the level nor trends in harm resulting from alcohol during pregnancy can be established because of lack of reliable data across the EU.

3.4.2 Indicator 2.4.2: Alcohol-attributable deaths

For monitoring alcohol-attributable deaths, the CDCID selected as indicator alcohol-attributable death rates for four categories: infectious diseases, chronic diseases, unintentional external causes, and intentional external causes.

WHO has estimated that alcohol-attributable mortality in the EU in 2004 accounted for 11.8% of all deaths in the working-age population (i.e. aged 15-64 years), with a higher share for men (13.9%) than for women (7.7%). Alcohol can have beneficial effects, primarily related to ischaemic heart disease in men; however, as indicated in table 53 below, alcohol-related mortality outweighs the protective influences.[199]

Table 53 Alcohol-attributable deaths in Europe by broad disease categories, in the group aged 15 to 64 years, 2004.

	Men		Women	
Effects	**No. of deaths**	**% of alcohol-attributable deaths**	**No. of deaths**	**% of alcohol-attributable deaths**
Detrimental effects (alcohol-attributable deaths)				
Cancer	17 358	15.9	8 668	30.7
Cardiovascular diseases other than IHD	7 914	7.2	3 127	11.1
Mental and neurological disorders	10 868	9.9	2 330	8.3
Liver cirrhosis	28 449	26.0	10 508	37.2
Unintentional injury	24 912	22.8	1 795	6.4
Intentional injury	16 562	15.1	1 167	4.1
Other detrimental	3 455	3.2	637	2.3
Total detrimental	109 517	100.0	28 232	100.0
Beneficial effects (deaths prevented)				
Ischaemic heart disease (IHD)	- 14 736	97.8	- 1 800	61.1
Other beneficial	- 330	2.2	- 1 147	38.9
Total beneficial	- 15 065	100.0	- 2 947	100.0

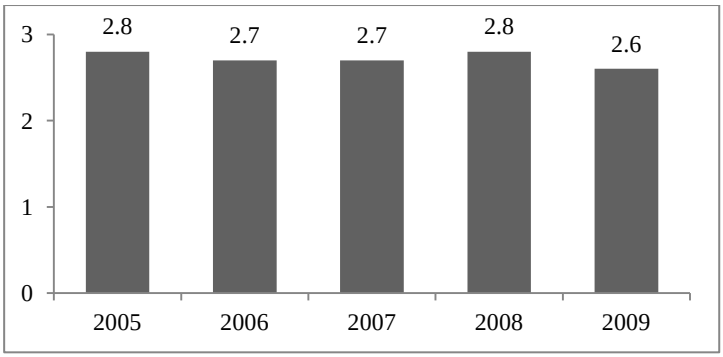
Source: Alcohol in the European Union. Consumption, harm and policy approaches. WHO Regional Office for Europe, 2012

[199] Alcohol in the European Union. Consumption, harm and policy approaches. WHO Regional Office for Europe, 2012.

Eurostat also collects data on alcohol-attributable deaths. Eurostat uses a narrow definition, while noting that different definitions may be used at national level. The Eurostat definition uses the following causes of death[200]:

- malignant neoplasm of lip, oral cavity, pharynx
- malignant neoplasm of oesophagus
- alcohol abuse (including alcoholic psychosis)
- chronic liver disease

Figure 44 Death due to alcoholic abuse, standardised death rate by 100 000 inhabitants, EU27



Source: Eurostat

Eurostat data provides a series through 2009 on 'death due to alcohol abuse' (see Figure 44 above). The figures show little variation over time. Although a decrease can be seen from 2008 to 2009, data for a longer period would be needed to establish whether this is indeed an EU-wide trend. The national data collected by Eurostat (Appendix to Annex 4) show that alcohol-related deaths have decreased in 10 Member States, but increased in 6 others.

3.4.3 Indicator 2.4.3: Prevalence of alcohol-attributable chronic physical or mental disorders

For monitoring alcohol-attributable physical disorders the CDCID selected as indicators hospital discharge rates for alcoholic liver disease (ICD-10 code K70) and for pancreatitis (ICD-10 codes K85-87) as proxy for alcohol-attributable disease. For monitoring mental disorders, hospital discharge rates for alcohol-attributable mental disorders was selected as the indicator.

Hospital discharge rates for patients with alcoholic liver disease indicate opposing trends in EU Member States over the past years. The discharge rates decreased in 15 of the reporting Member States, with a decrease between 1 to 18 inpatients per 100,000 inhabitants in the period from 2007-2009. In 7 Member States the rates increased between 1 to 15 inpatients per 100,000 inhabitants.

Similarly opposing trends were noted in a report by the OECD on health in Europe. Regarding liver disease, the report highlighted that: *"In general, countries with high levels of alcohol consumption tend to experience higher death rates from liver cirrhosis. In most EU countries, death rates from liver cirrhosis have fallen over the past two decades, following quite closely the overall reduction in alcohol consumption."*[201]

Hospital discharge rates of patients with acute or chronic pancreatitis increased in the period of 2007-2009 in 18 of the reporting Member States in the period of 2007-2009, and decreased in two Member States.

[200] Eurostat, Glossary:Alcohol-related death (consulted August 2012):
http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Glossary:Alcohol-related_deaths
[201] OECD: Health at a glance: Europe 2010.
http://ec.europa.eu/health/reports/docs/health_glance_en.pdf

Hospital discharge rates of patients with mental diseases due to alcohol use increased in the period of 2007-2009 in 12 of the reporting Member States and decreased in 10.

At country level, however, it not been possible to link these short-term trends in hospital discharge rates in any consistent manner linked with trends in overall alcohol consumption. For example, hospital discharge rates for the three conditions examined above show increases Germany or Malta, where the consumption of alcohol shows a downward trend, and decreased in countries Hungary or the Netherlands, where alcohol consumption has remained fairly stable.

3.5 Key findings for Evaluation Question 2

In each of the three surveys (CNAPA, EAHF and external experts and officials), over 70% of respondents indicated that the EU alcohol strategy addressed themes of concern to their Member State to a 'great' or 'some' extent. In each, the majority of respondents indicated that the EU strategy had contributed to the development of policies, actions and strategies in each of the priority themes.

A number of representatives of EAHF members across different categories stated in interviews that the EU strategy has had an important overall effect. Several participants in the Open Forum and officials from non-health fields also provided positive comments on the overall impact of the EU strategy. However, some of the Open Forum participants reported little information on the EU strategy at local level.

In terms of data on alcohol-related harm, the available statistics do not enable to establish whether the changes observed represent short-term fluctuation or longer-term trends.

The limited availability of data for monitoring possible changes highlights the need to continue the development of research and information systems and to widen the use of common indicators, in order to obtain comparable information on alcohol consumption and alcohol related harm to feed into the evaluation of the impacts of actions and policies to reduce harm, including the added value of actions at EU level.

The EU strategy to support Member States in reducing alcohol related harm targets a complex social phenomenon, where a range of social, cultural and economic factors come to play alongside public health policies, and where public health policies interact with policies in other sectors and with actions by a broad range of stakeholders. Moreover, time lags between actions and impacts may play an important role.

4 Overview and discussion

This section summarises the results of Task 3, also considering the strength of the evidence base.

Progress on *policy developments at national level* is seen across the priority themes of the EU strategy, but the extent of progress varies, both in terms of specific issues and also between Member States. Progress appears to have been strongest in areas where clear policy targets have been set at EU level, such as the prevention of drink-driving.

At the same time, there are key policy areas that could receive greater attention. These include policies that address affordability as well as those regulating marketing: analysis cited by WHO points to high cost/benefit ratios for action in these areas. Other areas for further attention include strengthening

counselling activities and workplace programmes (non-existent in about one-third of Member States), as well as server training to support age restrictions.[202]

Overall, the EC/WHO survey provides a comprehensive and robust overview of national policies. There are perhaps two limitations: first, most data only extends to the end of 2010; second, the report presents an overview across the EU (plus Norway and Switzerland) and does not distinguish between Member States achieving less or more progress and does not highlight examples of best practice.

The results of the EC/WHO survey show progress across many areas, and thus they are coherent with and support survey and interview results of this evaluation.

At this point, however, there is only indirect evidence that *the EU alcohol strategy has contributed to progress in reducing alcohol-related harm.* Available indicators of alcohol-attributable mortality and morbidity do not show significant changes in the years since the launch of the EU strategy. However, as there is limited availability of timely EU-wide data, evidence of the added value of EU level action may only become available in the long term.

The survey results show, however, that the EU strategy has addressed themes of concern in Member States. Moreover, the strategy has contributed to the development of Member State policies to address alcohol – in other words, it has played an important role in supporting the progress documented in the EC/WHO survey.

Assessments on the contribution of the EU strategy were invited from three groups of survey respondents: CNAPA members, EAHF members and external experts and officials. The responses across all three groups were broadly similar, supporting the validity of the results. A caveat to be mentioned is that about 25% of the EAHF members and external experts and officials chose 'don't know' answers, indicating that these groups are further removed from the processes of alcohol policy development than CNAPA members.

The areas of good practice set out in the Strategy, and those assessed in the EC/WHO survey, have been linked to reductions in alcohol-related harm in studies at national and local levels.[203] Member State progress in introducing such good practices shows that policies and measures potentially effective in addressing alcohol-related harm are being implemented. Over the long-term, these actions can be expected to lead to reductions in alcohol-related harm. This inference, of course, depends on a number of factors. One is the effectiveness of implementation, a topic that was not studied and is likely vary across Member States. Another is that a long-term perspective is needed to distinguish clear trends in alcohol consumption patterns and alcohol-related harm from shorter-term fluctuations.

Despite progress, it should nonetheless be noted that WHO estimates that the burden of alcohol-related harm has been high, linked to an estimated 11.8% of deaths in the EU working-age population in 2004, and remains high. Moreover, social costs are considerable, notably in terms of unemployment and lost productivity, with estimates as high as 3% of GDP for individual Member States, and links also to poverty and social exclusion.[204]

The above results indicate that further strengthening the evidence base is a key area for cross-cutting work that will support other measures. Moreover, achieving greater synergies and setting targets for EU action on alcohol-related harm can both decisively contribute to EU policy objectives in this area. A number of ways forward corresponding to these two main lines of action.

[202] Alcohol in the European Union. Consumption, harm and policy approaches. WHO Regional Office for Europe, 2012.
[203] Many of these studies are cited in Alcohol in the European Union. Consumption, harm and policy approaches. WHO Regional Office for Europe, 2012.
[204] Alcohol in the European Union. Consumption, harm and policy approaches. WHO Regional Office for Europe, 2012.

5 Considerations for EU action as a whole

Strengthening the evidence base

A broad range of experts and officials contacted in the course of the assessment underlined the importance of the evidence base for the EU strategy. This has included the work of CDCID on indicators, cooperation with WHO on data gathering and information systems, the activities of the EAHF Science Group, and research and projects supported by the European Commission. It will be useful to consider ways of strengthening these actions.

- Projects and research supported by the European Commission have provided valuable support for Member State policies and stakeholder action. Continuing this work under the new EU Health Programme and in the framework of the next EU Research Framework Programme would be valuable. Moreover, Member States could be given a wide role via CNAPA in proposing issues to address, in particular under the new Health Programme, thus enhancing the link between projects and policy goals.
- Further channels for disseminating outputs of EU-financed projects and research should be explored, including effective use of the Heidi tool,[205] in cooperation with CNAPA and relevant DGs, agencies and units of the Commission.
- Further efforts are needed in Member States and at EU level to ensure the implementation of common EU indicators for monitoring alcohol consumption and related harm and ensure for better and timelier EU-wide statistics on alcohol consumption, harmful alcohol use and alcohol-related harm. Options to consider include wider involvement of Eurostat and of the EMCDDA in alcohol data collection at EU level; within Member States, designating national focal points could be designated to take forward work on common approaches.
- Joint EC/WHO work on alcohol data gathering has been valuable for Member States and its continuation should be considered; it would be useful to coordinate timing and data needs at national, regional and global levels so as to ease the burden for Member States and ensure efficient use of resources.
- The role of the Science Group as well as its composition should be reconsidered. Scientific evidence is important throughout the implementation of the EU alcohol strategy, including both the work of EAHF and CNAPA. In this light, the Science Group could instead be re-created as a body independent of the EAHF, with a mandate to provide support across EU work on alcohol-related harm. It may be useful, moreover, to consider widening the focus of the group to encompass related topics such as other key risk factors of chronic non-communicable diseases.

Clarifying linkages and synergies

A further point that cuts across the evaluation results concerns the need to clarify linkages and synergies across the priority themes, across the pillars of implementation, and across the multitude of actions and initiatives.

Defining concrete targets at EU and Member State level for the aims under the priorities could help position individual initiatives within the wider framework of action and contribute towards a sharper focus on outcomes. This could focus attention of EAHF on benchmarks for good practice and on approaches for the evaluation of commitments. Moreover, it could ensure that CNAPA discussions address key areas where impacts can be expected.

[205] See: https://webgate.ec.europa.eu/sanco/heidi/index.php/Main_Page

6 Appendix: Review of data on alcohol-related harm in the EU

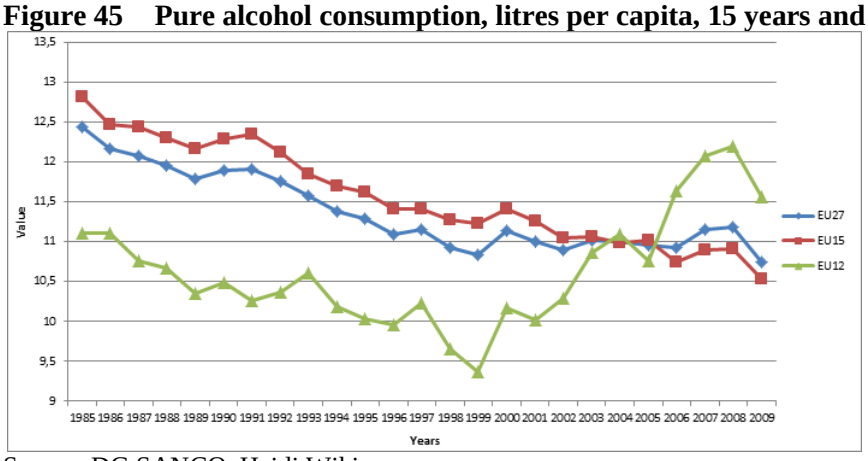
In its summary report, the Committee on Alcohol Data, Indicators and Definitions (CDCID) presented a list of indicators for monitoring progress relating to the priority themes of the EU strategy to support Member States in reducing alcohol related harm.[206] The most recent data related to those indictors for which comparable data across the EU is available are presented in this appendix. Where possible, data from 2007 are presented; however, for alcohol-attributable deaths, data is only available for the EU for 2004.

Volume of alcohol consumption

For monitoring the volume of alcohol consumption the CDCID selected as indicator total alcohol consumption, defined as recorded and unrecorded per capita (15 years+) alcohol consumption in litres pure alcohol for a calendar year.

At the moment information is available for recorded per capita consumption of pure alcohol, included (ECHI 46) in the list of European Community Health Indicators as proxy for the overall level of alcohol related harm.[207] Recorded alcohol consumption in the EU has remained stable since the turn of the millennium, with a slight drop from 11.6 litres per adult per year in 2006 to 10.8 litres in 2009. The apparent stability hides considerable variation across Member States and over time, as exemplified in the graphs below.[208]

Figure 45 Pure alcohol consumption, litres per capita, 15 years and over, 2006-2009 (EU27)



Source: DG SANCO, Heidi Wiki

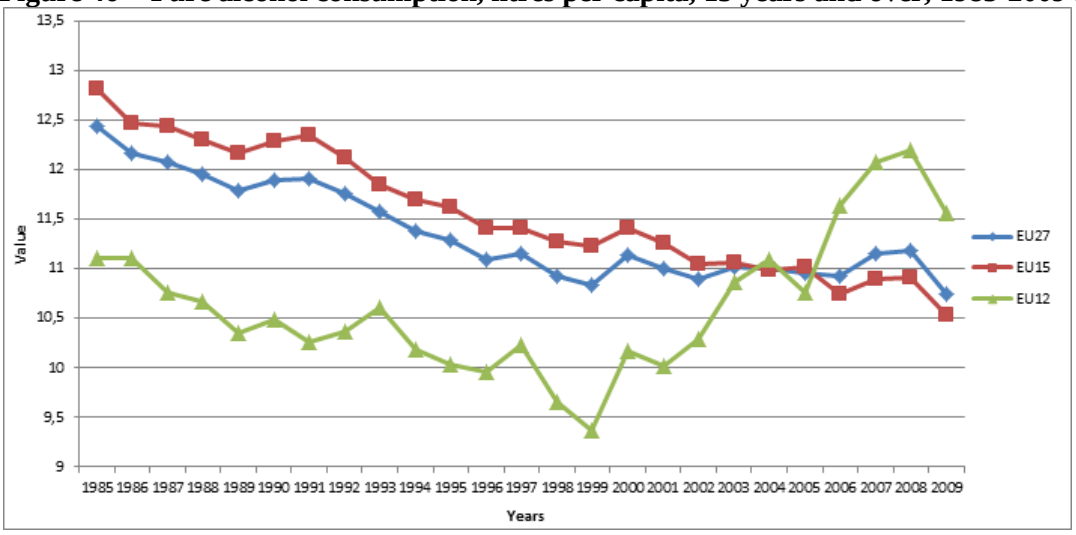
Within this period, all three categories (EU12, EU15 and EU27) saw an increase in consumption from 2006 to 2008, followed by a decrease from 2008 to 2009. For the whole period from 2006 to 2009, the EU12 Member states saw a 0.7% decrease in total consumption, while the EU15 saw a 2% decrease.

Despite an overall decreasing trend, at least seven countries saw an increase of alcohol consumption from 2006 to 2009: Bulgaria, France, Malta, Poland, Slovakia, Sweden and the United Kingdom (2009 data are not available for three Member States).

Over a 25-year period, the EU15 have seen a decrease in alcohol consumption, while the EU12 saw a broad decrease to 1999, and then an increase to 2008. However, data over this longer time period are not complete for all Member States.

[206] Alcohol-related Indicators: Report on the work of the Committee on Alcohol Data, Indicators and Definitions. February 2010. European Commission, Health and Consumers Directorate-General.
[207] http://ec.europa.eu/health/indicators/echi/list/index_en.htm
[208] The graphs are produced using the Heidi Data Tool of the European Commission. http://ec.europa.eu/health/alcohol/indicators/index_en.htm

Figure 46 Pure alcohol consumption, litres per capita, 15 years and over, 1985-2009 (EU27)



Source: DG SANCO, Heidi Wiki

Alcohol-related deaths

Member State data is collected by Eurostat using a narrow definition of alcohol-related deaths, and specifically the following causes of death: [209]

- malignant neoplasm of lip, oral cavity, pharynx,
- malignant neoplasm of oesophagus,
- alcohol abuse (including alcoholic psychosis) and
- chronic liver disease

The Table below presents national data. The same series was used for the EU27 data presented in section 3.3. Eurostat notes that national definitions can vary, and this may account for some of the differences in deaths reported across Member States.

Table 54 Death due to alcoholic abuse, by sex, standardised death rate by 100 000 inhabitants, 2005-2010, EU27

Member State/Country	2005	2006	2007	2008	2009	2010
Austria	3.5	3.6	3.9	4.3	4.9	n/a
Belgium	2.7	2.5	n/a	n/a	n/a	n/a
Bulgaria	0.6	0.5	0.3	0.4	0.4	0.3
Czech Republic	2.3	1.4	1.3	1.8	1.2	1.2
Denmark	11.9	12.6	13.5	13.5	11.5[p]	n/a
Germany	5.1	4.7	4.7	4.7	4.6	4.7
Estonia	13.5	10.1	15.8	10.9	7.9	n/a
Ireland	1.9	2.3	1.9	1.1[p]	n/a	n/a
Greece	0.2	0.2	0.3	0.3	0.2	0.2
Spain	0.6	0.6	0.5	0.5	0.5	0.5
France	4.6	4.5	4.3	4.4	4.1	n/a
Italy	n/a	0.3	0.3	0.3	0.3	n/a
Cyprus	3.2	3.4	3.5	3.7	4.0	n/a
Latvia	3.2	3.4	3.5	3.7	4.0	n/a
Lithuania	0.6	0.9	1.2	1.1	0.8	n/a
Luxembourg	4.5	3.0	2.9	n/a	n/a	1.4

[209] Eurostat, Glossary:Alcohol-related death (consulted August 2012): http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Glossary:Alcohol-related_deaths

Member State/Country	2005	2006	2007	2008	2009	2010
Hungary	4.9	4.5	3.7	3.6	3.3	3.5
Malta	0.5	0.4	0.9	0.2	0.4	0.2
Netherlands	1.2	1.1	1.0	1.1	1.1	0.9
Poland	4.0	4.6	5.0	4.7	4.2	4.0
Portugal	0.8	0.8	1.0	1.2	1.1	4.0
Romania	2.7	2.2	2.2	2.3	2.3	n/a
Slovenia	3.7	3.0	2.6	4.4	4.3	5.3
Slovakia	n/a	n/a	n/a	n/a	0	n/a
Finland	2.8	2.9	2.4	2.4	2.6	2.6
Sweden	3.1	2.8	2.8	2.6	2.6	n/a
United Kingdom	1.6	1.6	1.3	1.6	1.5	1.6

P = provisional
Source: Eurostat

As noted in the main text, the CDCID has selected an indicator for monitoring alcohol-attributable deaths based on a broader approach with four categories: infectious diseases, chronic diseases, unintentional external causes, and intentional external causes.

Using a similar, broad approach, WHO estimates[210] that almost 95 000 men and over 25 000 women aged between 15 and 64 years died of alcohol-attributable causes, corresponding to 11.8% of all deaths in this age category, meaning that 1 in 7 male deaths and 1 in 13 female deaths in this age category were caused by alcohol. See also graph below.[211]

Alcohol-related chronic physical and mental disorders

Hospital discharge rates for patients with alcoholic liver disease indicate opposing trends in EU Member States over the past years. The discharge rates decreased in 15 of the reporting countries with a decrease between 1 to 18 inpatients per 100,000 inhabitants in the period from 2007-2009[212]. In 11 of the reporting countries the rates increased in the period of 2007-2009 with an increase between 1 to 15 inpatients per 100,000 inhabitants[213].

Table 55 Hospital discharge rates of patients with alcoholic liver disease: Number of in-patients per 100,000 inhabitant, 2007-2009 (EU27 plus Norway and Switzerland)

Member State/Country	2007	2008	2009
Belgium	36.2	35.0	:
Bulgaria	1.7	0.4	0.6
Czech Republic	40.6	40.9	39.8
Denmark	40.7	:	:
Germany	43.2	44.8	:
Estonia	62.0	59.0	44.2
Ireland	26.4	23.9	22.6
Spain	25.2	26.1	24.7
France	40.5	39.1	34.7
Italy	30.5	28.2	26.6
Cyprus	1.0	:	:
Latvia	:	20.9	:
Lithuania	31.0	31.0	23.1

[210] Alcohol in the European Union. Consumption, harm and policy approaches. WHO Regional Office for Europe, 2012
[211] Data were constructed based on earlier per capita measures and combined with death and DALY estimates of 2004. Source: Møller, L: Presentation on the alcohol situation, ppt-presentation. The High level meeting of the Committee on National Alcohol Policy and Action, sent from the DG SANCO to Milieu 4 January 2012.
[212] Austria, Belgium, Bulgaria*, Czech Republic, Estonia, Ireland, Spain, France, Italy, Lithaunia, Hungary, Portugal, Slovakia*. Finland, Sweden and Norway. *Data missing for 2007, 2008 or 2009.
[213] Germany*, Luxembourg, Malta, Poland, Romania, Slovenia, UK*, Iceland*, Netherlands, Switxerland, Croatia* and Turkey*. *Data missing for 2007, 2008 or 2009.

Member State/Country	2007	2008	2009
Luxembourg	43.5	40.1	46.6
Hungary	84.4	78.6	72.3
Malta	2.2	5.4	6.0
Netherlands	7.2	8.5	8.1
Austria	26.6	25.3	26.2
Poland	24.8	29.6	36.0
Portugal	51.7	49.1	45.4
Romania	165.5	150.1	166.9
Slovenia	51.2	57.9	54.3
Slovakia	:	38.3	33.6
Finland	51.2	50.9	50.8
Sweden	20.1	20.3	17.4
United Kingdom	28.8	:	29.6
Norway	20.3	20.3	17.8
Switzerland	16.8	17.5	31.1

Source: Eurostat

Hospital discharge rates of patients with diseases of pancreas (acute or chronic pancreatitis) have increased in the period of 2007-2009 in most of the reporting countries[214] but to a varying extent, from 1 to 34 patients more per 100,000 inhabitants. Only in 5 countries show a slight decrease (0.1-4 patients more per 100,000 inhabitants) in the period of 2007-2009[215].

Table 56 Hospital discharge rates of patients with diseases of pancreas: Number of in-patients per 100,000 inhabitants, 2007-2009 (EU27 plus Norway and Switzerland)

Member State/Country	2007	2008	2009
Belgium	61.5	63.7	:
Bulgaria	:	:	:
Czech Republic	87.0	86.6	89.6
Denmark	59.3	:	:
Germany	81.1	82.5	:
Estonia	:	:	:
Ireland	40.0	42.1	41.9
Spain	59.3	60.0	61.3
France	50.3	52.4	55.8
Italy	43.1	43.9	44.1
Cyprus	30.5	:	:
Latvia	:	186.1	:
Lithuania	194.8	200.0	195.1
Luxembourg	46.7	48.1	55.6
Hungary	91.3	89.0	86.9
Malta	13.4	23.2	22.7
Netherlands	32.7	33.4	35.8
Austria	73.7	76.8	78.1
Poland	78.2	80.4	87.8
Portugal	70.4	72.8	73.3
Romania	66.2	82.4	88.2
Slovenia	61.4	65.0	63.7
Slovakia	:	94.9	91.7
Finland	99.6	103.1	100.2
Sweden	58.3	60.3	63.8
United Kingdom	49.6	:	54.6

[214] Belgium*. Czech Republic, Germany*, Spain, France, Italy, Lithuania, Luxembourg, Malta, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Finland, Sweden, United Kingdom*, Switzerland, Croatia* and Turkey*. * data missing for 2007, 2008 or 2009.

[215] Hungary, Slovakia*, Iceland*, Norway and Croatia*. * Data missing for 2007,2008 or 2009

Member State/Country	2007	2008	2009
Norway	49.1	49.7	49.0
Switzerland	38.8	42.7	71.6

The table below presents hospital discharge rates of patients with mental diseases due to alcohol use. It shows a great variation in the discharge rates and an increase in the rates is reported in the period of 2007-2009 in 16 of the reporting countries.[216] In 11 of the reporting countries[217] a decrease in the discharge rates is reported.

Table 57 Hospital discharge rates of patients with mental and behavioural disorders due to alcohol use: number of in-patients per 100,000 inhabitants (EU27 plus Norway and Switzerland)

Member State/Country	2007	2008	2009
Belgium	114.2	111.5	:
Bulgaria	44.9	47.7	49.0
Czech Republic	141.3	142.1	143.5
Denmark	131.9	:	:
Germany	356.4	374.0	:
Estonia	:	:	:
Ireland	71.6	68.0	69.1
Spain	24.9	23.8	22.1
France	136.2	146.4	152.7
Italy	30.2	27.7	25.3
Cyprus	3.6	:	:
Latvia	:	492.7	:
Lithuania	281.5	256.5	217.0
Luxembourg	316.3	336.8	313.8
Hungary	127.3	125.2	108.2
Malta	20.8	22.9	55.3
Netherlands	21.4	21.7	23.6
Austria	253.1	272.7	269.1
Poland	222.8	255.4	248.8
Portugal	22.0	27.3	24.4
Romania	105.7	120.0	134.5
Slovenia	125.9	125.9	119.5
Slovakia	:	217.5	216.4
Finland	341.4	325.7	303.5
Sweden	250.5	258.0	259.4
United Kingdom	62.9	:	72.9
Norway	80.0	88.1	85.7
Switzerland	168.7	178.3	294.8

Source: CDCID

Harm resulting from alcohol during pregnancy

Table 58 Incidence of foetal alcohol syndrome in European countries, 2007-2009 (EU27)

Incidence of foetal alcohol syndrome per 10.000 births	2007	2008	2009
Total cases/ 10.000 births	48	42	46

[216]Bulgaria, Czech Republic, Germany*, France, Malta, Netherlands, Austria, Poland, Portugal, Romania, Sweden, United Kingdom*, Norway, Switzerland, Croatia* and Turkey*. * Data missing for 20097, 2008 or 2009.

[217] Belgium*, Ireland, Spain, Italy, Lithuania, Luxembourg, Hungary, Slovenia, Slovakia*, Finland and Iceland*. * Data missing for 2007, 2008 or 2009.

Source EUROCAT.[218]

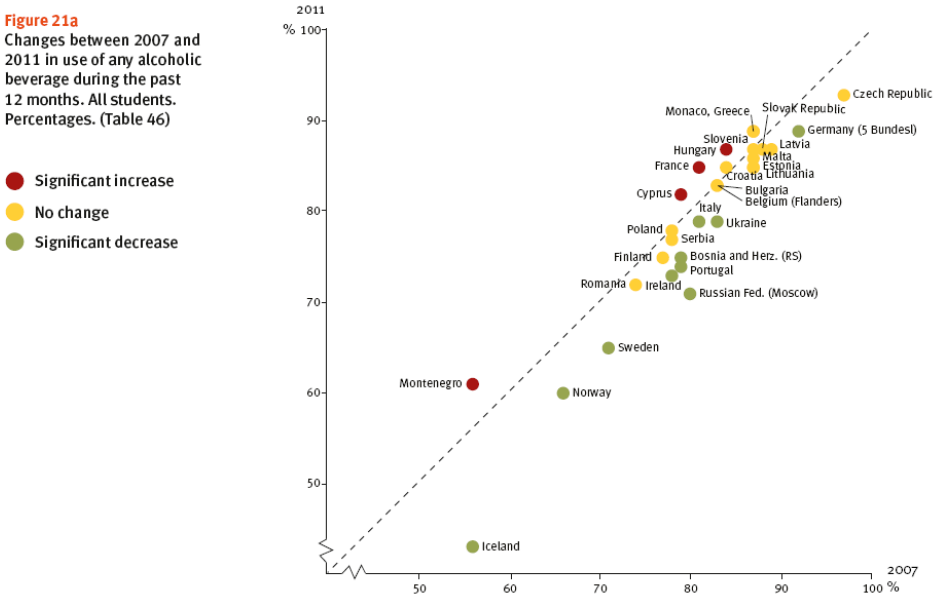
Hazardous and harmful drinking among young people

For monitoring under-aged drinking the CDCID selected four indicators based on data collected in the ESPAD survey (European School Survey Project on Alcohol and Other Drugs). Two of the indicators are related to young people's access to alcohol, and two to alcohol consumption.

The ESPAD survey is carried out at 4-year intervals with 15 to 16 year-old students in most European countries. The most recent survey was carried out in 2011 in 36 countries, with a total of more than 100 000 respondents. The data below stems from the summary report published in June 2012.[219]

For monitoring **the share of adolescent alcohol consumers**, the proportion of adolescents who have drunk alcohol in the last 12 months (ESPAD Q11) was selected as the indicator. From 2007 to 2011, the share of 15-16-year-old students who had consumed alcohol in the past months decreased significantly in 5 EU Member States[220] and increased significantly in 3 Member States.[221] In most Member States no significant changes were observed. Figure 47 below summarises the trends.

Figure 47 Changes in use of alcohol beverages in the past 12 months, students



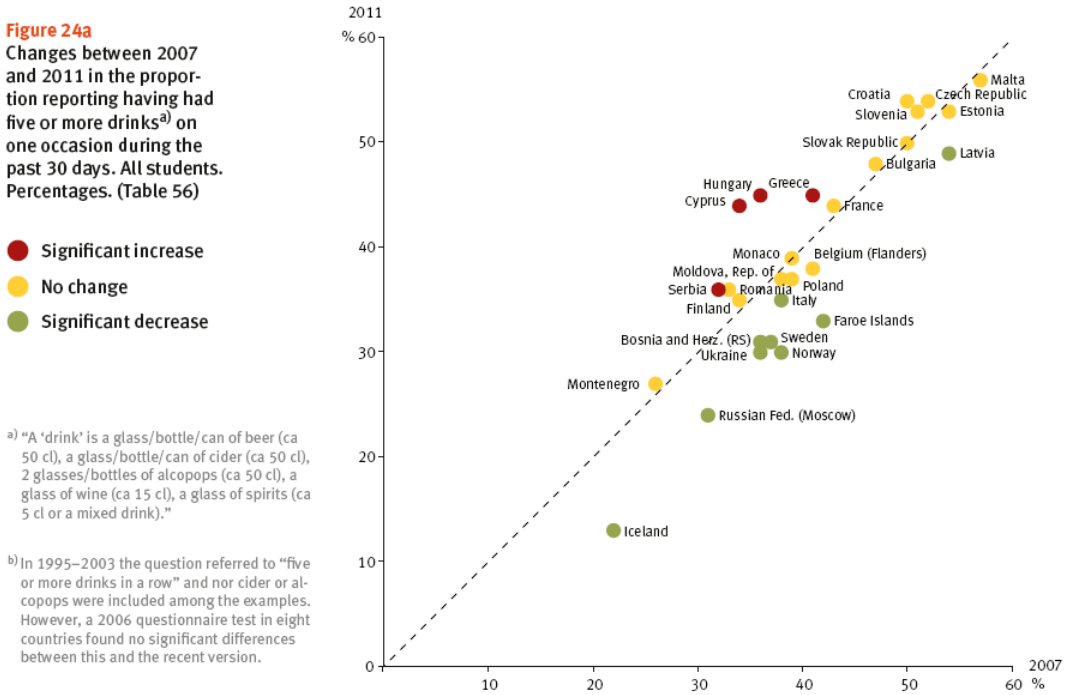
Source: ESPAD

For monitoring **binge drinking among adolescents**, the proportion of adolescents who have had 5 or more drinks on one or more occasions in the last 30 days (ESPAD Q17) was selected as the indicator. In 3 EU Member States binge drinking among 15-16 year old students decreased significantly from 2007 to 2011.[222] Binge drinking increased significantly in 3 Member States.[223] In the vast majority of

[218] February 2012, based on most recent registrations: Austria, Belgium, Croatia, Czech Republic, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, Malta, Moldova, Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden, Switzerland, Ukraine, United Kingdom.
[219] The 2011 ESPAD Report. Substance use among students in 36 European countries. CAN. 2012. http://www.espad.org/en/Reports--Documents/ESPAD-Reports/
[220] Germany, Italy, Portugal, Ireland, Sweden.
[221] Cyprus, France, Hungary.
[222] Latvia, Italy, Sweden.
[223] Cyprus, Hungary, Greece.

Member States, the prevalence of binge drinking among 15-16-year-olds remained unchanged. The figure below summarises the trends.

Figure 48 Changes between 2007 and 2011, proportion of students reporting have had five or more drinks on one occasion during the past 30 days



Source: ESPAD

Annex 5: Web-based questionnaires for the surveys

Survey to CNAPA members

Indicator (I) 1.1.3. Perceived value of information exchange

Survey question
4: Has information provided within CNAPA been useful for policy development in your Member State (e.g. did they inspire further action, helped you improve your work, etc.)?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

I 1.3.2. Extent to which relevant areas of alcohol policy are addressed during CNAPA meetings

Survey questions
1: To what extent have the following priority areas of the EU Alcohol Strategy been addressed in CNAPA meetings?

Answer options:

	To a great extent	*To some extent*	*To a minor extent*	*To little or no extent*	*Don't know*
Protection of young people, children and the unborn child;					
Reduction of injuries and death from alcohol-related road accidents;					
Prevention of alcohol-related harm among adults and reduction of negative impacts in the workplace;					
Information, education and awareness-raising on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;					
Development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm;					
Other relevant areas of alcohol policy.					

2: If you chose 'other relevant areas', please provide further information:

Answer options:
Free text box

EQ 2: To what extent has the CNAPA contributed to further policy development?

I 2.2.1. Perceptions of impact of work within CNAPA on good practice/alcohol policy within Member States

Survey questions[224]

5: To what extent has work within CNAPA in the area of *the protection of young people, children and the unborn* had an impact on the development of policies and good practices in your Member State, in particular regarding the following topics:

Answer options:

	Substantial impact	*Moderate impact*	*Limited impact*	*Little or no impact*	*Don't know*
Enforcement of restrictions on sales, on availability and on marketing likely to influence young people;					
Broad community-based action to prevent harm and risky behavior, involving teachers, parents, stakeholders and young people themselves, and supported by media messages and life-skills training programmes.					

6: To what extent has work within CNAPA in the area of *the reduction of injuries and death from alcohol-related road accidents* had an impact on the development of policies and good practices in your Member State, in particular regarding the following topics:

Answer options:

	Substantial impact	*Moderate impact*	*Limited impact*	*Little or no impact*	*Don't know*
Introduction and enforcement of frequent and systematic random breath testing, supported by education and awareness campaigns involving all stakeholders;					
Lower blood alcohol content (BAC) limits for young and novice drivers and for categories of professional drivers					

7: To what extent has work within CNAPA in the area of *the prevention of alcohol-related harm among adults and the reduction of negative impacts in the workplace* had an impact on the development of policies and good practice in your Member State, in particular regarding the following topics:

Answer options:

	Substantial impact	*Moderate impact*	*Limited impact*	*Little or no impact*	*Don't know*
Improved enforcement of current regulations, codes and standards;					
Licence enforcement;					

[224] Change in wording following pilot testing and single question split into separate questions (5 through 9). Original: How much impact has CNAPA's work had on good practice development in your Member State?

Server training;					
Pricing policies;					
Education, information, activities and campaigns promoting moderate consumption, or addressing drink-driving, alcohol during pregnancy and under-age drinking;					
Advice by doctors or nurses in primary health care to people at risk;					
Treatment of alcohol addition.					

8: To what extent has work within CNAPA in the area of *information, education and awareness-raising on the impacts of harmful and hazardous alcohol consumption, and on appropriate consumption* had an impact on the development of policies and good practices in your Member State, in particular regarding the following topics:

Answer options:

	Substantial impact	*Moderate impact*	*Limited impact*	*Little or no impact*	*Don't know*
Health and life-skills education programmes, beginning in early childhood and continued throughout adolescence;					
Media campaigns.					

9: To what extent has work within CNAPA in the area of *the development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm* had an impact on the development of policies and good practices in your Member State, in particular regarding the following topics:

Answer options:

	Substantial impact	*Moderate impact*	*Limited impact*	*Little or no impact*	*Don't know*
Development of a standardised definition for data on alcohol use and alcohol-related harm;					
Research to estimate the costs and benefits of policy options;					
Bridge research gaps on alcohol-related health and social harm, on the causes of harmful and hazardous alcohol consumption, and on its role in widening the health gap between socio-economic groups.					

I 2.3.1. Extent to which CNAPA members perceive that the topics addressed in CNAPA have been the most relevant and useful

Survey question

3: Have the topics addressed within CNAPA been useful for policy development in your Member State (e.g. did they inspire further action, helped you improve your work, etc.)?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

EQ 5: Has the work at EU level to develop school data gathering and strengthen the knowledge base been useful from the Member States' perspective?

I 5.1.1. Extent to which MS representatives feel that the development of common indicators and methods for comparative research has been helpful

Survey question
10: Has joint work on the development of common indicators and methods for comparative research, including the work of the Committee on Alcohol Data, Indicators and Definitions, been useful for your Member State?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

I 5.2.1. Extent to which MS representatives feel that collaboration between the EC and the WHO to develop joint alcohol data gathering has been helpful

Survey question
11: Has joint work on data gathering between the European Commission and the WHO been useful for your Member State?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

12. How would you assess the CNAPA dialogue and interaction with EAHF?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

EQ 6: Have EU-funded projects and research on alcohol been relevant from the MS' perspective?

I 6.1.2. Perception that the topics of EU-funded projects have provided good practices, evidence and guidance—by type of respondent (CNAPA members, stakeholders)

Survey question
13: How would you assess the contribution of EU-funded projects and research on alcohol to the availability of good practices, evidence or guidance on how to reduce alcohol related harm?

Answer options:
Substantial impact
Moderate impact
Limited impact
No impact
Don't know

I 6.2.1. Perception that the results have been adequately disseminated to MS experts and policy makers

Survey question

14: How would you assess the dissemination of EU-funded projects and research on alcohol to Member State experts and policy makers?

Answer options:
Adequate (i.e. timely and comprehensive)
Fairly adequate
Not very adequate
Poor
Don't know

Questions for Task 3: Assessment of the overall EU alcohol strategy process and added value

I 2.1.1. Perception that Member States' concerns (as reflected by their national policies) have been addressed by the Alcohol Strategy

13. To what extent does the EU Alcohol Strategy address themes of concern for your Member State?[225]

Answer options:
To a great extent
To some extent
To a minor extent
To little or no extent
Don't know

I 2.1.1. Contribution of the EU alcohol strategy to the development of policies, actions and strategies in the Member States

Survey question[226]

[225] *Change in wording following pilot testing. Original: To what extent have Member States' concerns (as reflected by national policies) been addressed by the Alcohol Strategy?*
[226] Change in wording following pilot testing. Original: To what extent has the Alcohol Strategy contributed to a greater emphasis on the reduction of alcohol-related harm at EU or national levels in the following areas? Thus the question focuses only on the Member State level.

14. To what extent has the EU Alcohol Strategy contributed to the development of policies, actions and strategies in your Member State that can reduce alcohol-related harm? Please indicate your answer for each of the following priority areas of the EU Alcohol Strategy:

	To a great extent	*To some extent*	*To a minor extent*	*To little or no extent*	*Don't know*
Protection of young people, children and the unborn child;					
Reduction of injuries and death from alcohol-related road accidents;					
Prevention of alcohol-related harm among adults and reduction of negative impacts in the workplace;					
Information, education and awareness-raising on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;					
Development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm;					
Other relevant areas of alcohol policy.					

17. If you chose 'other relevant areas', please provide further information:

Open text response

Final open question and follow-up

18. Please feel free to elaborate on the issues raised in the previous questions and to share any additional comments concerning CNAPA's role as an implementation structure of the EU Alcohol Strategy:

Open text response

19. Please provide your name and contact details (optional):

Open text response

20. Would you agree to a follow-up interview with a member of the evaluation team (optional)?

Yes/no

Survey to EAHF members

Categorizing questions

1. You are representing a:

Answer options:
Non-governmental organisation or health professional organization
Advertising-, marketing-, media-sector or a sponsorship organization
Production and/or sales organisation
Research institute or other

2*. Your organisation's activities are carried out at (please select all that apply):

Answer options :
The EU level
Member State level
Local level
If MS level, in which MS do you operate?

Questions from Task 2: Assessment of the European Alcohol and Health Forum (EAHF)

Evaluation Question (EQ) 1: To what extent has the EAHF process been effective in mobilising stakeholders and stepping up action to reduce alcohol related harm?

Indicator (I) 1.2.2: Perception that the membership has led to new or substantially revised action[227]

13. Looking at your own organisation's commitments, to what extent were these a direct result of its participation in the EAHF?

Answer options:
None of our commitments would have happened at all without the EAHF
Some of our commitments would have happened without the EAHF
All of our commitments would have happened without the EAHF, but not in exactly the same way
All of our commitments would have happened in exactly the same way with or without the EAHF
Don't know

Indicator (I) 1.4.2: Perception that monitoring has seen progress

Survey questions:
3. Approximately how many of the 2011 monitoring reports from other EAHF members have you personally read?

Answer options:
None
0 - 10
10 - 25
25 - 50
> 50

[227] This question was indicated in the inception report for the interviews and part of it was brought into the survey. The formulation was modified, drawing on similar language used in the survey for the evaluation of the Platform for Action on Diet, Physical Activity and Health.

4. How useful have these monitoring reports been in improving your knowledge and awareness of other members' commitment-related activities?

Answer Options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

EQ 2: To what extent has the EAHF process been effective as a platform for dialogue, exchange and cooperation?

I 2.1.1: Perceived understanding of the issues by Forum members

Survey question:
5. To what extent has participation in EAHF helped you personally gain a deeper understanding of the following areas listed in the Forum's Charter?[228]

Answer options:

	To a great extent	*To some extent*	*To a minor extent*	*To little or no extent*	*No answer*
Strategies aimed at curbing under-age drinking;					
Information and education programmes on the effect of harmful drinking and on responsible patterns of consumption;					
Development of efficient common approaches throughout the Community to provide adequate consumer information;					
Actions to better enforce age limits for selling and serving alcohol;					
Interventions promoting effective behavioral change among children and adolescents;					
Cooperation to promote responsibility in and prevent irresponsible commercial communication and sales.					

I 2.2.1: Perceptions of the EAHF process

Survey question:
6. To what extent has participation in the EAHF helped your organisation or its national networks pursue further cooperation with other members of the Forum on actions to reduce alcohol-related harm?[229]

Answer options:
To a great extent
To some extent

[228] Change in wording of the question following pilot testing. Original: Has participation in EAHF helped you gain a deeper understanding of the following areas?

[229] *In the inception report this was indicated as an interview question, and we included it in the survey.*

To a minor extent
To little or no extent
Don't know

I 2.3.2: Perception by Forum members that the process has brought to light useful elements that can be applied in their own field

Survey question:
7. To what extent has participation in the EAHF provided examples of good practice that your organisation has applied in its policies, actions and strategies?[230]

Please answer for each of the following areas listed in the Forum's Charter:

Answer options:

	To a great extent	*To some extent*	*To a minor extent*	*To little or no extent*	*Not applicable*
Strategies aimed at curbing under-age drinking;					
Information and education programmes on the effect of harmful drinking and on responsible patterns of consumption;					
Development of efficient common approaches throughout the Community to provide adequate consumer information;					
Actions to better enforce age limits for selling and serving alcohol;					
Interventions promoting effective behavioral change among children and adolescents;					
Cooperation to promote responsibility in and prevent irresponsible commercial communication and sales.					

I 2.4.1: Perception of Open Forum

Survey questions:
8. How successful have the Open Forum meetings been in showcasing members' activities?

Answer options:
Very successful
Moderately successful
Of little success
Not successful
Don't know

9. How successful have the Open Forum meetings been in engaging a wider range of stakeholders in discussion?

Answer options:
Very successful
Moderately successful
Of little success

[230] *Change in wording following pilot testing. Original: Has participation in the EAHF provided you with examples of good practices that you will apply in your action area?*

Not successful
Don't know

EQ 7: Has there been cross-fertilisation and interactions between the EAHF, the CNAPA and other structures? What forms of interaction would bring added value?

I 7.1.1: Perception that dialogue has been adequate, by members of each organization[231]

Survey questions:
10. How would you assess the EAHF's dialogue and interaction with the Committee on National Alcohol Policy Action (CNAPA)?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

11. How would you assess the EAHF's dialogue and interaction with the Science Group?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

12. How would you assess the EAHF's dialogue and interaction with the Committee on Data Collection Indicators and Definitions (CDCID)?

Answer options:
Very useful
Moderately useful
Of little use
Of no use
Don't know

Questions from Task 3: Assessment of the overall EU alcohol strategy process and added value

14. To what extent does the EU Alcohol Strategy address themes of concern for your Member State?[232]
Answer options:
To a great extent
To some extent
To a minor extent
To little or no extent
Don't know

[231] *Following pilot testing, the original question was split into three separate questions. Original: How would you assess dialogue and interaction among EAHF, CNAPA and other relevant structures?*
[232] *Change in wording following pilot testing. Original: To what extent have Member States' concerns (as reflected by national policies) been addressed by the Alcohol Strategy?*

15. To what extent has the EU Alcohol Strategy contributed to the development of policies, actions and strategies in your Member State that can reduce alcohol-related harm? Please indicate your answer for each of the following priority areas of the EU Alcohol Strategy:[233]

	To a great extent	*To some extent*	*To a minor extent*	*To little or no extent*	*Don't know*
Protection of young people, children and the unborn child;					
Reduction of injuries and death from alcohol-related road accidents;					
Prevention of alcohol-related harm among adults and reduction of negative impacts in the workplace;					
Information, education and awareness-raising on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;					
Development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm;					
Other relevant areas of alcohol policy.					

Final open question and follow-up

16. Please feel free to elaborate on the issues raised in the previous questions and to share any additional comments concerning the EAHF's role as an implementation structure of the EU Alcohol Strategy:

Open text response

17. Please provide your name and contact details (optional):

Open text response

18. Would you agree to a follow-up interview with a member of the evaluation team (optional)?

Yes/no

[233] *Change in wording following pilot testing. Original: To what extent has the Alcohol Strategy contributed to a greater emphasis on the reduction of alcohol-related harm at EU or national levels in the following areas? Thus the question focuses only on the Member State level.*

Science Group survey questions

1. To what extent is the membership of the Science Group appropriate to the work it performs?
   Answer options:
   To a great extent
   To some extent
   To a minor extent
   To a little or no extent
   Don't know

2. To what extent are the working methods in the Science Group appropriate?
   Answer options:
   To a great extent
   To some extent
   To a minor extent
   To a little or no extent
   Don't know

3. How would you assess dialogue and interaction between the Science Group and the Committee on National Alcohol Policy and Action (CNAPA)?
   Answer options:
   Very useful
   Moderately useful
   Of little use
   Of no use
   Don't know

4. How would you assess dialogue and interaction between the Science Group and the European Alcohol and Health Forum (EAHF)?
   Answer options:
   Very useful
   Moderately useful
   Of little use
   Of no use
   Don't know

5. Please feel free to elaborate on the issues raised in the previous questions and on your responses:

6. To what extent does the EU Alcohol Strategy address themes of concern for your Member State?
   Answer options:
   To a great extent
   To some extent
   To a minor extent
   To a little or no extent
   Don't know

7. To what extent has the EU Alcohol Strategy contributed to the development of policies, actions and strategies in your Member State that can reduce alcohol-related harm? Please indicate your answer for each of the following priority areas of the EU Alcohol Strategy:
   Protection of young people, children and the unborn child;
   Reduction of injuries and death from alcohol-related road accidents;
   Prevention of alcohol-related harm among adults and reduction of negative impacts in the workplace;
   Information, education and awareness-raising on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
   Development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm;

Other relevant areas of alcohol policy.

Answer options for each priority area:
To a great extent
To some extent
To a minor extent
To a little or no extent
Don't know

8. If you chose 'other relevant areas', please provide further information:

9. Please feel free to elaborate on the issues raised in the previous three questions on the impact of the EU Alcohol Strategy and to share any additional comments:

External experts/officials survey questions

1. Have you worked on policies or undertaken research for the reduction of alcohol-related harm? (Please check all answers that apply)
   Answer options:
   Yes, at EU level
   Yes, at Member State level
   Yes, at local/regional level
   Yes, in EU projects and/or research
   No
   If yes, please describe briefly:

2. To what extent does the EU Alcohol Strategy address themes of concern for your Member State?
   Answer options:
   To a great extent
   To some extent
   To a minor extent
   To a little or no extent
   Don't know

3. To what extent has the EU Alcohol Strategy contributed to the development of policies, actions and strategies in your Member State that can reduce alcohol-related harm? Please indicate your answer for each of the following priority areas of the EU Alcohol Strategy:
   Protection of young people, children and the unborn child;
   Reduction of injuries and death from alcohol-related road accidents;
   Prevention of alcohol-related harm among adults and reduction of negative impacts in the workplace;
   Information, education and awareness-raising on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
   Development and maintenance of a common evidence base at EU level on alcohol consumption and alcohol-related harm;
   Other relevant areas of alcohol policy.

   Answer options for each priority area:
   To a great extent
   To some extent
   To a minor extent
   To a little or no extent
   Don't know

4. If you chose 'other relevant areas', please provide further information:

5. Please feel free to elaborate on the issues raised in the previous questions and to share any additional comments on the EU Alcohol Strategy:

Annex 6: List of interviewees

CNAPA

MS	Name	Affiliation
AT	Franz Pietsch	Bundesministerium für Gesundheit, Familie und Jugend
BE	Mathieu Capouet	Ministry of Health
DK	Kit Broholm	The National Board of Health
DE	Sandra Dybowski	Bundesministerium für Gesundheit und Soziale Sicherung
EE	Triinu Täht	Ministry of Social Affairs
HU	Erika Vandlik	National Center for Addictology
PT	Manuel Cardoso	Institute on Drugs and Drug Addiction
UK	Crispin Acton	Department of Health

EAHF

Name	Affiliate	Type of Member
Stefan Brost	Association of European Professional Football Leagues - German Football League (DFL)	NGOs and Health professionals
Conor Murray, Hussain Sadaf	Association of Television and Radio Sales Houses (Egta)	Advertising, marketing, media and sponsorship org.
Simon Spillane	Brewers of Europe	Production and Sales Organisations
Steve Leroy	Anheuser-Busch InBev (ABI)	Production and Sales Organisations
Rutger Goethart	Heineken (International)	Production and Sales Organisations
Gabor Garamszegi	SAB Miller	Production and Sales Organisations
Abad Aurora, Fernandez José Ramón, Filopoulos Stylianos,	Comité Européen des Entreprises Vin (CEEV)	Production and Sales Organisations
Mariann Skar	EUROCARE	NGOs and Health professionals
Cliona Murphy	Alcohol Action Ireland	NGOs and Health professionals
Ella Sjödin	IOGT-NTO	NGOs and Health professionals
Avalon de Bruijn	National Foundation for Alcohol Prevention (STAP)	NGOs and Health professionals
Valverde Lopez Marina	EUROCOMMERCE	Production and Sales Organisations
Margaret Walker	European Association for the Study of the Liver	NGOs and Health professionals
Carole Brigaudeau	European Forum for Responsible Drinking (EFRD)	Production and Sales Organisations
Doriane Fuchs	European Public Health Alliance	NGOs and Health professionals
Sheron Nick	Royal College of Physicians, London	NGOs and Health professionals
Fanny Galvis	European Social Insurance Platform (ESIP)	Research institutes and others
Laure Alexandre	European Spirits Organisation (CEPS)	Production and Sales Organisations
André Hemard	Pernod-Ricard S.A.	Production and Sales Organisations
Peeter Luksep	The Absolut Company (also known as V&S Group)	Production and Sales Organisations
Douglas Meikle	The Scotch Whiskey Association	Production and Sales Organisations
James Doorley	European Youth Forum - National Youth Council of Ireland	NGOs and Health professionals
Jim Cathcart	HOTREC - British Beer and Pub Association	Production and Sales Organisations
Sarada Das	Standing Committee of European Doctors (CPME)	NGOs and Health professionals
Malte Lohan	World Federation of Advertisers (WFA)	Advertising, marketing, media and sponsorship org.

Annex 7: Interview questions

Questions for the CNAPA interviews

To what extent have discussions within CNAPA contributed to the development of alcohol policies in your Member State? In what ways? Please provide examples
To what extent have discussions within CNAPA led to greater consensus on the most promising policies to reduce alcohol-related harm among Member States?
To what extent has CNAPAs composition been appropriate for the work it was intended to do (policy coordination and further development)?
Should the high-level CNAPA meetings become permanent? Why/Why not?
Have CNAPA working methods (i.e. frequency of meetings, circulation of information, etc.) been appropriate for its goals? (in what way/why)
Has CNAPA's focus of work been appropriate for its goals?
How useful has the work to identify common indicators and develop methods for comparative research been for your Member State?
Has work at EU level led to any change in alcohol data gathering at national level in your country?
Has EU-funded research provided good practice, evidence or guidance relevant in your Member State? In what areas of the EU Strategy? Please provide examples. Which areas of research do you consider the most relevant for your country?
To what extent are you aware of work within the Alcohol and Health Forum? To what extent are you aware of the actions (commitments) of Alcohol and Forum Members carried out in your country? Should there be stronger links between CNAPA and the Forum? (Do you have suggestions?)
To what extent has the EU Alcohol Strategy process inspired new action or helped to step up action to reduce alcohol-related harm in your country? In which way or in which area?
To what extent has there been a convergence in Member States' approaches to reducing alcohol-related harm? In what ways? How as the EU alcohol strategy played a role in this convergence?
To what extent have your Member State's concerns been addressed by the EU Alcohol Strategy? What concerns should receive more attention?
Do you have any further comments

Questions for the EAHF interviews

To what extent has the EAHF process been effective in mobilising stakeholders and stepping up action to reduce alcohol-related harm?
Looking at the composition of the Forum members, is the balance appropriate for the aims of the EU Strategy? (please elaborate on the balance between different sectors; between umbrella and national/local organisations)
Could you think of new actors or sectors that would be valuable for the Forum?
For your organisation, has membership in the Forum led to new or substantially revised actions to reduce alcohol-related harm?
Has there been any change over time in your organisation's commitments under the Forum? Have they evolved in terms of breadth, depth or duration?
Do new commitments build on previous ones or are they separate actions?
In your opinion, are there priorities under the alcohol strategy that could receive greater attention in the Forum?
On a scale from 1-4, do you find the Forum being effective in mobilising stakeholders? (4 being very effective)
On a scale from 1-4 do you find the Forum being effective in stepping up action to reduce alcohol-related harm?
To what extent has the Forum process been effective as a platform for dialogue, exchange and cooperation?
Has participation in the Forum been helpful in putting forward your organisations views?
Has it been helpful in providing you with better understanding of other members' views?
What could be done to enhance dialogue within the Forum?
To what extent has your organisation cooperated with Forum members from other sectors on commitments? Please give examples.

To what extent has your organisation - due to the Forum -cooperated on commitments with other sectors at national or local levels? Please give examples?
Have your commitments been linked to national or local government policies to address alcohol-related harm?
On a scale from 1-4, to what extent has the Forum process been effective as a platform for dialogue, exchange and cooperation (among members)?
To what extent has the EAHF process contributed to the development of responsible business practices across the EU in the sales and marketing of alcoholic beverages?
On a scale of 1-4, to what extent has the Forum process contributed towards enhanced compliance with age limits? Please elaborate on your answer.
On a scale from 1-4, to what extent has the Forum process contributed to the development of responsible business practices for the marketing of alcohol beverages? Please elaborate on your answer.
To what extent can the commitments be related to impacts on alcohol related harm reduction?
In your organisation's commitments, have you evaluated and measured the results of the actions? If so, can you provide examples on impacts?
Do you find that Forum activities have provided support for the monitoring and evaluation of commitments? If yes, in what way? If no, why not?
To what extent can the commitments be benchmarked in relation to the best available practices in the area?
Does your organisation refer to good/best practices for addressing alcohol-related harm when it prepares commitments? If yes, please provide examples.
After completing commitments, have you tried to compare them to good/best practice examples? If yes, please share your conclusions.
How could the Forum further encourage good and best practices for commitments?
Has there been cross-fertilisation and interactions between the EAHF, the CNAPA and other structures? What forms of interaction would bring added value?
In your view, has there been useful interactions between the Forum and the Member States Committee (CNAPA)? Please elaborate on your answer.
Do you have suggestions of interactions between the stakeholder Forum and the Member States' Committee (CNAPA) that could useful for advancing actions to reduce alcohol related harm?
What are the lessons learned regarding composition, focus and working methods including the Forum sub-groups?
Has your organisation participated in any of the sub-groups: 1. Task Force on youth specific aspects of alcohol 2. Task Force on marketing communication?
On a scale from 1-4, to what extent was the Task Force on youth-specific aspects of alcohol useful in advancing work related to the Forum? Please explain. Could a different approach for youth issues be useful?
On a scale from 1-4, to what extent was the Task Force on marketing communication useful in advancing work related to the Forum? Please explain. Could a different approach for marketing issues be useful?
On a scale from 1-4, to what extent were the two Science Group's opinions - one on the impact of marketing on drinking by young people, one focused on alcohol and work - useful in any way? Please explain. Could a different approach be useful?
(If applicable) As someone who also participated in the work of a sub-group, do you have any suggestions on how to modify composition, working methods or tasks so as to make the most of such groups?
What is your perception of the working methods of the Forum - such as meeting agendas, communication to members and to external parties, possibilities for discussion etc.? Do you have suggestions for improvements?
For Individual organisations: How has the alcohol strategy overall changed policies and actions in your Member State? Can you give examples?
For Umbrella organisations: How has the alcohol strategy overall changed policies and actions in Member States overall? Can you give examples?
Please provide any further comments

Annex 8: Advisory Group Members

Membership of the CNAPA Advisory Group

NAME	AFFILIATION
BELLO Pierre-Yves	Ministry of Health, France
CAPOUET Mathieu	Federal Public Service Public Health, Belgium
CARDOSO Manuel	Institute on Drugs and Drug Addiction, Portugal
DYBOWSKI Sandra	Federal Ministry for Health, Germany
FURTUNESCU Florentina	National Institute of Public Health, Romania
McCORMACK Liam	Department of Health, Ireland
RENSTRÖM Maria	Ministry of Health, Sweden
SCAFATO Emanuele	National Health Institute, Italy
TUOMINEN Ismo	Ministry of Health, Finland
TÄHT Triinu	Ministry of Health, Estonia

Membership of the EAHF Advisory Group

NAME	AFFILIATION
ALEXANDRE Laure	CEPS
CARLSSON Sven-Olof	IOGT
CATHCART Jim	BBP
FERNANDEZ Jose Ramon	CEEV
LOHAN Malte	WFA
SHERON Nick	RCP
SKAR Mariann	Eurocare
SPILLANE Simon	BoE
WALKER Margaret	EASL
WOODFORD Emma	ECL

Annex 9: Advisory Group meetings: summary reports

EAHF Workshop, 25 April 2012, Brussels: Summary report

The meeting was chaired by Michael Hübel, Head of Unit for Health Determinants, DG Health and Consumers.

- The Chair thanked Advisory Group members for volunteering to provide feedback to the evaluation process. The number of volunteers was larger than a manageable size for the group but everybody will have the opportunity to contribute in the EAHF plenary meeting where the interim findings will be discussed. A similar procedure, including Advisory Group and plenary discussion, was used with CNAPA members. The overall evaluation process is followed by an Inter-Service Steering Group composed of representatives of relevant DGs of the Commission.
- The Chair stressed that his role is to see that the meeting runs smoothly and stays on schedule. The meeting will be organised as an interactive workshop in which COWI, the contractor for the independent evaluation, will share main results so far and ask questions on aspects on which they find important to obtain feedback or clarification.
- Tony Zamparutti from Cowi highlighted that the evaluation is midway through, with interim results based on desk research and online surveys. The discussion based on the findings so far will also help focus the interviews to be carried out in the next phase.
- The workshop was focussed in particular on the following aspects: the composition of the EAHF membership; changes in the number of active commitments; the role of EAHF membership in mobilising new action; usefulness of monitoring reports; dialogue, cooperation and partnerships; development and use of good practice; assessing impacts; working methods within the EAHF.
- The workshop was carried out under the Chatham House Rule with COWI noting down the comments relating to the evaluation questions.
- As regards the overall evaluation process the following points were raised:
    - It would be useful to look at: the whole period of the activity of the EAHF, starting from 2007; the whole range of activities, including the Task Forces; beyond the actual membership at the cooperation partners involved in the implementation of the commitments.
    - While a range of specific topics might merit a case study, available resources only enable to carry out one. The case study will focus on further development of responsible advertising because that is an important area of the Forum's work, although one where demonstrating concrete results in terms of reducing alcohol related harm would be difficult. The Chair invited members to provide input for the case study by taking contact directly with COWI.
    - The Chair announced the interim report will be circulated for written comments which should be sent by the 4th of May.
    - Given that the holiday period is not ideal for discussing the draft for final report, SANCO will look into the possibility of prolonging the time span of the evaluation so as to allow more time and opportunities for discussing the findings.

The Chair encouraged the Advisory Group to choose among themselves rapporteurs to share impressions from the evaluation so far and from the workshop with participants of the EAHF plenary meeting.

CNAPA Workshop, 18 April 2012, Luxembourg: Summary report

The meeting was chaired by Michael Hübel, Head of Unit for Health Determinants, DG Health and Consumers.

- The Chair thanked participants and described briefly how the evaluation process is organised. He stressed that the Commission provides technical support to the independent evaluator COWI but does not participate in the evaluation exercise. The Advisory Group's meeting will take the form of an interactive workshop in which COWI will share main results so far and ask questions on aspects on which they find important to obtain feedback or clarification.
- Tony Zamparutti from Cowi highlighted that the evaluation is midway through and that the preliminary results presented in the interim report are based on desk research and online surveys. Interaction with the Advisory Group is an integral part of the evaluation process, intended to give further insight into key issues and help focus the next phase of the work. To encourage free discussion the meeting will be held under the Chatham House Rule.
- The workshop was focussed in particular on the following aspects: the attention given in CNAPA to different policy levels (from global to local) and across policy issues; the role of CNAPA in informing and supporting national policy processes; the role of CNAPA towards consensus, coordination and action at EU level; interaction with other bodies and strands of work at EU level; and support for national level through work to develop indicators and data gathering and through EU funded projects.
- The Chair encouraged the Advisory Group to choose among themselves rapporteurs to share impressions from the evaluation so far and from the workshop with participants of the CNAPA meeting.
- The Chair announced the interim report will be circulated for written comments, to be sent by 4 May 2012 directly to COWI. SANCO will look into the possibility of organising another Advisory Group meeting to discuss findings before the evaluation report is finalised.

CNAPA Advisory Group for the evaluation of the EU strategy to support Member States in reducing alcohol related harm

Workshop, 11 September 2012, Luxembourg: Draft Summary report

The meeting was chaired by Michael Hübel, Head of Unit for Health Determinants, DG Health and Consumers.

- The Chair thanked Advisory Group members for active input in various stages of the evaluation in the capacity of experts who have been involved in the alcohol strategy process. As in the previous meeting, notes will be taken following the Chatham House rule of not identifying speakers.
- The Chair highlighted that this was the first in a series of meetings to provide input for the final evaluation report. Meetings of the Advisory Board comprising EAHF members and of the Inter-Service Steering Group will be held later in September.
- The draft final report will be circulated to both Advisory Groups and to the ISSG at the same time. At that time Advisory Group members are invited to provide written comments in the capacity of informed experts. The final version of the report is due in October.
- Tony Zamparutti from COWI started with a recap of the steps in the evaluation process, of the three evaluation tasks focussed respectively on the CNAPA, the EAHF and the strategy as a whole, and of the continuum of methods used across the tasks. On some questions addressed mainly through interviews in order to clarify or get more in-depth views, quantification of the responses is not possible due to the small number of interviewees.
- He then presented the main findings and conclusions relating to assessment of the CNAPA as an instrument for coordination at EU level and assessment of the EU alcohol strategy as a whole, also summarising main points relating to the assessment of the EAHF.
- Overall the evaluation indicates broad support, in particular among the new Member States, for a renewed or updated EU alcohol strategy and a call to strengthen the implementation structures, notably the coordination bodies and arrangements for monitoring trends in alcohol consumption and harm.
- Possible ways to enhance effectiveness in the CNAPA's work were presented for discussion, with focus on ways to increase the political visibility of the Committee, to enhance consistency and continuity in the Committee's work, and on further development of the common evidence base. Feedback was invited in particular on whether the tentative suggestions for ways forward were considered viable, challenging or not strong enough.

Main points made in the discussion:

- The evaluator's work relating to Task 1 was found to correspond and capture fairly well Advisory Group members' overall assessment of CNAPA and the work process, although there were also points that spurred discussion. A wish was presented to obtain a synthetic report on the replies to some of the free format questions.

Possible ways to increase the political visibility of CNAPA, thereby of the political weight of the EU alcohol strategy

- There was broad support for continuing high-level meetings, but not annually. High level meetings could be organised bi-annually or on *ad hoc* basis when there are important steps to be considered at political level or new developments that may help move on the political process.
- The possibility of linking CNAPA meetings to EU Presidencies was found worth consideration and it was noted that issues related to illicit drugs are discussed at Council level under each Presidency.
- While working toward further consensus on key policy issues was considered important, it was highlighted that aiming at consensus statements would profoundly change the nature of the Committee and of the high-level meetings and that policy recommendations should be agreed upon at high political level. Alternative ways for CNAPA to contribute toward consensus could be

to support consensus conferences on priority issues or to focus on priority issues one at a time in the context of EU Presidencies.

- Giving further attention to cross policy links was considered important. It was considered that cross policy dialogue should take place in regular CNAPA rather than high level. The practice of inviting other DGs should be continued. Other MS ministries could be invited to mini-seminars focussed on cross policy issues or to participate in round table dialogue style meetings. It was highlighted that focussed discussion is likely to be more useful than broad deliberations, that the focus in CNAPA meetings should stay on public health issues, and that the objectives of cross policy discussion should be clarified (better understanding / consensus / identifying opportunities for synergy…).

Possible ways to enhance consistency and continuity in CNAPA's work

- Outlining a bi-annual or multi-annual work plan for CNAPA was considered potentially useful, providing its preparation does not take too much time or increase workload.
- Drawing up concise yearly reports was considered potentially useful for work at national level.
- Horizontal linkages with other public health issues were highlighted as important for future planning: 1) linkage to the prevention of NCDs through addressing their common risk factors; 2) linkage to mental health with focus on co-morbidity and on addressing addiction in the broader context of psychiatric disorders.

Further development of common evidence base

- Coordination and joint work on alcohol data gathering and implementation of common indicators for monitoring were considered a crucial area although involving many complexities. It was pointed out that a lot of work to select and agree on common health indicators has already been done, including through the ECHIM Joint Action, and the focus should be on harmonising national data gathering accordingly.
- The importance of coordination and leadership at both European and national levels was highlighted as well as the need to identify the bodies to be involved for moving forward. Joint work with WHO for data gathering should be continued and cooperation should be developed with EMCDDA for monitoring. Identifying national focal points could be helpful for coordination at national level and for consistency at European level.
- On some topics further work is called for in order to harmonise definitions or operationalisations; different approaches by Eurostat, WHO and OECD to alcohol related mortality data was mentioned as an example.
- Scientific evidence and European research projects were highlighted as important underpinnings for the development of health policies on alcohol. Evidence of the economic impact of alcohol related harm was mentioned as an example. European research and projects were considered an investment the results of which should feed into policy processes and be disseminated to further policy actors, including the European Parliament.
- Possible roles for the Science Group were discussed in the light of the importance of a solid evidence base for the EU alcohol strategy as a whole. Positioning the independent Science Group as a body to support the implementation of the strategy overall, rather than just the Alcohol and Health Forum, was considered an approach worth considering.

Multi-sector approach

- The observation made in the evaluation that relatively little attention has been given in CNAPA to actions at sub-national level gave rise to comments highlighting that the meeting documents do not provide a full picture of actions and developments at national level. In contrast, local and regional levels are prominent in many national alcohol strategies the analysis of which fell outside the evaluation.
- A related point raised by COWI concerns commitments under the EAHF, many of which are implemented at sub-national level, sometimes in cooperation with local government bodies. Nevertheless, apart from the Committee of the Regions being counted as an observer in the EAHF, the sub-national government level is not involved in coordination activities at EU level.

- As regards experiences of setting up multi-sector platforms at national level, it was stressed that national level coordination activities fall entirely under MS competence.

Relationships with the Alcohol and Health Forum

- The idea of a yearly summary report showing the breakdown of EAHF commitments by MS was welcomed as a mechanism for informing CNAPA members on work undertaken by stakeholders especially at national level.
- Concern expressed in the previous AG meeting and in the high level CNAPA meeting over economic operators' involvement in health communication was reiterated. There was a general feeling that the primary area for action by economic operators concerns responsibility in their own sphere of business.
- The Chair confirmed that the validation of an initiative as a commitment to action under the EAHF does not amount to endorsement of the initiative by the Commission and that the Commission would expect initiatives such as school-based alcohol education to be carried out in coordination with MS.
- Overall the discussion highlighted the need for better information and more clarity regarding stakeholders' work in the context of the EAHF.

Strengthening the overall EU strategy

- Lack of timely, up-to-date and reliable data across the EU on trends in alcohol consumption and related harm was confirmed to be a concern for the Commission and MS alike. For example the latest report based on the joint EC/WHO survey presents alcohol harm data from 2006 and only looks at the development of national alcohol policies till the end of 2010.
- The suggestion to strengthen the EU strategy by setting targets at EU level and translating those to national level targets received support while some caveats were mentioned as well. Setting common targets were considered useful for focussing action, for building consensus and for engaging other policy sectors. While CNAPA could contribute by identifying priorities and emerging issues, agreeing on targets is up to the political level and would be a crucial step in the next phase of work on alcohol and health at EU level. Advisory group members stressed the need to align target setting related to the EU alcohol strategy with the work to implement the WHO global alcohol strategy across Europe, and with target setting in other public health areas, notably the prevention and reduction of NCDs.

List of participants

NAME	AFFILIATION
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GALLO Giulio	DG SANCO
MONTONEN Marjatta	DG SANCO
BELLO Pierre-Yves	Ministry of Health, France
CAPOUET Mathieu	Federal Public Service Health, Belgium
CARDOSO Manuel	Institute on Drugs and Drug Addiction, Portugal
DYBOWSKI Sandra	Federal Ministry for Health, Germany
McGOVERN Shay	Department of Health, Ireland
NILSSON-KELLY Karin	Ministry of Health, Sweden
SCAFATO Emanuele	National Health Institute, Italy
TUOMINEN Ismo	Ministry of Health, Finland
TÄHT Triinu	Ministry of Health, Estonia
ZAMPARUTTI Tony	COWI
HERNANDEZ Guillermo	COWI
Excused	
FURTUNESCU Florentina	National Institute of Public Health, Romania

EAHF Advisory Group for the evaluation of the EU strategy to support Member States in reducing alcohol related harm

Workshop, 19 September 2012, Brussels: Draft Summary report

The meeting was chaired by Michael Hübel, Head of Unit for Health Determinants, DG Health and Consumers.

- The Chair welcomed participants and highlighted that the meeting will be run by COWI in an interactive fashion in order to obtain further input to the independent evaluation. Since the previous Advisory Group meeting, focussed on the interim report, COWI has carried out structured interviews, done a case study on progress in the development of self-regulation in alcohol marketing communication, and undertaken further analysis of the material. The report still requires some work. The draft final report will be circulated to both Advisory Groups and to the Inter-Service Steering Group. At that time Advisory Group members will be invited to provide written comments. The final evaluation results will be presented in the high level meeting of the Committee on National Policy and Action and in the plenary meeting of the Alcohol and Health Forum. At the moment details of evaluation should be considered at draft stage and respected as confidential.
- Tony Zamparutti from COWI thanked Advisory Group members for active input in the evaluation process and reminded that notes will be taken following the Chatham House rule of not identifying speakers. He then presented main findings and conclusions relating to assessment of the Alcohol and Health Forum as an instrument for coordination at EU level, also summarising main points relating to the assessment of the Committee on National Alcohol Policy and Action and the overall strategy. Given that the EAHF was set up as an experiment and now needs to move on, feedback was invited in particular on the suggestions for enhancing effectiveness.

Main points made in the discussion

- Regarding the observation that commitments under the EAHF are concentrated on responsible commercial communication and sales and on information and education programmes while areas such as **underage drinking** seem to have received less attention, it was noted that for example work on responsible advertising and sales is basically about underage drinking.
- Regarding the observation that participation in the **EAHF has spurred new action** mainly among economic operators, it was pointed out that NGOs already working on alcohol-related topics have limited possibilities to deploy further resources to initiate new actions. A further point was that some of the economic operators' initiatives build on previous work but were influenced by Forum membership in that they were re-formulated as commitments.
- The observation that **evaluation of outcomes and impacts of commitments remains an under-developed area** gave rise to lively discussion. The crucial importance for the whole EAHF process of assessing the impacts of members' actions was stressed. The Chair reminded that at the start of the process it was possible to agree on process indicators only but it was hoped that work on outcome and impact indicators would progress in the course of time. Since there now seems to be general agreement that assessing outcomes and impacts is important, the time could be ripe for coming to an agreement about strengthening the approach on these aspects. While systematic peer review was not considered a good approach given the workload involved, joint work for developing outcome and impact indicators was considered feasible. A further point made in the discussion concerned the availability on data on alcohol related harm from public health authorities; it was highlighted that national level harm indicators would provide valuable information for assessing the impacts of activities.
- Regarding the observation that **making use of existing good practices or research findings when developing commitments does not seem common practice** – with the exception of self-regulation of advertising where the model outlined by the 2006 round table was used as benchmark - it was noted that plenty of evidence on what works is available and should be brought in the commitments process to enhance their value.

- Regarding the **lack of interaction between the EAHF and CNAPA** and for CNAPA members being divided in views on the usefulness of further interaction, an explanation put forward was that the EAHF has a limited role in the implementation of the EU strategy whereas CNAPA members have a broader range of policy interests. It was noted that, nevertheless, CNAPA members acknowledge the EAHF as one part of the structures for the implementation of the strategy and the need for better information flows between the two structures. The Chair stressed, moreover, that a prerequisite for carrying out broadly effective commitments at national level would be to have MS bodies on board.
- Regarding the **case study on self-regulation of alcohol advertising**, several minor details for clarification were identified. The topic gave rise to discussion on the contribution of self-regulation to reductions in alcohol-related harm and on the involvement of non-industry stakeholders in self-regulatory processes. It was highlighted, on the one hand, that self-regulatory schemes do not address the volume of alcohol advertising which in scientific research is identified as a decisive factor and, on the other, that the scale of the impact of alcohol advertising needs to be put in the context of wider drivers of youth drinking. Regarding the involvement of non-industry stakeholders in self-regulatory processes the discussants seemed in agreement that it should remain at the level of consultation: NGOs do not see themselves as co-drafting self-regulatory codes or co-managing self-regulatory schemes and economic operators stress that although it might be useful to open the code-writing process, the result should remain essentially an industry code.
- Suggestions for **expanding the EAHF membership** received support. The usefulness of involving enforcement authorities in particular was highlighted as actions on age limits have been found more effective when combined with law enforcement.
- **Options for the future of the Science Group -** reorienting the Science Group's work to topics directly relevant to EAHF members or re-creating the Science group as an independent body with mandate to support the strategy overall – were discussed and both were seen to involve merits. It was noted that if the Group would have an advisory role regarding the EAHF, it should be composed of other kinds of experts that scientists. Focusing the group's work on EAHF priority themes of action was considered more useful than addressing horizontal issues such as evaluation methodologies. On the other hand, the Science group's work so far has been helpful for NGOs, and there was support for continuation with a higher status and broader public health focus.
- Any **measures to encourage cross-sector collaboration** were considered welcome, including incentives in the form of project funding under the EU Health Programme. Concerns were, however, expressed regarding the criteria for the allocation of funding, in particular the need to ensure that funds are used for action rather than for advocacy and lobbying.
- The possibility **to revise EAHF membership requirements for NGOs** was raised. The fact that NGOs have limited resources for new action was recognised at the start of the EAHF process and it was envisaged that NGOs could have a watchdog or sparring role rather than being subjected to the same requirements as economic operators. In practice all members have been required to come up with new or intensified activities. The Chair commented that it is self-evident that commitments are in line with members' capacities and that exemption from the requirement to submit a commitment to specified action could only be considered for such NGOs whose main area of action concerns the reduction of alcohol related harm.
- At the start of the EAHF process areas of action were identified that were considered to offer opportunities for making progress. The Forum's priorities are therefore somewhat narrower than the priorities identified for the overall strategy. The suggestion to **reconsider the Forum's priorities** received support. Better aligning priorities with those of the overall strategy would clarify synergies. Re-focusing on fewer action areas and formulating **clearer guidelines for commitments** in them would contribute to enhancing effectiveness.

List of participants

NAME	AFFILIATION
HÜBEL Michael	DG SANCO
MONTONEN Marjatta	DG SANCO
ALEXANDRE Laure	CEPS
CARLSSON Sven-Olof	IOGT
CATHCART Jim	BBP
LOHAN Malte	WFA
SKAR Mariann	Eurocare
SPILLANE Simon	BoE
WOODFORD Emma	ECL
ZAMPARUTTI Tony	COWI
HERNANDEZ Guillermo	COWI
Excused	
FERNANDEZ Jose Ramon	CEEV
SHERON Nick	RCP
WALKER Margaret	EASL

Annex 10: Summary of the informal discussion with the EAHF Advisory Group on the case study

Case study meeting with EAHF Advisory Group members
Brussels, 11 July 2012

Summary of discussion

AG Participants	Others present
Sven-Olof Carlsson, *IOGT*	Oliver Gray, European Advertising Standards Alliance, *EASA*
Carole Brigaudeau, EFRD (replacing Laure Alexandre, *CEPS*)	Chiara Odelli, *EASA*
Malte Lohan, *WFA*	Betsy Thom, *Middlesex University* *
Jose Ramon Fernández, *CEEV*	Tony Zamparutti, *Milieu*
Mariann Skar, *Eurocare*	Guillermo Hernández, *Milieu*
Simon Spillane, *Brewers of Europe*	Liva Stokenberga, *Milieu*
Margaret Walker, *EASL* *	Paola Banfi, *Milieu*
Emma Woodford, *European Cancer Leagues*	Nick Sheron, *Royal College of Physicians, London**
Jim Cathcart**, *British Beer & Pub Association* *	

*Participating via conference call. The phone link did not work very well, and these participants did not take an active part in discussions.
**Replaces Martin Rawlings, *British Beer & Pub Association*

A document presented by Milieu provided a starting point for discussions. The following issues were covered at the meeting:

1. A holistic approach to understanding self-regulatory systems

- **An articulated landscape:** The different levels of policy making and action regarding self-regulation in marketing (supra-national, national, and industry/sector level regulatory frameworks) should be taken into account in drawing conclusions on self-regulation as a whole. Responsible practices is a multiple-stage process reaching both vertically and horizontally and involving namely the following steps: initiators (some leading companies) → all sectors (beer, wine, spirits) → all markets → implementation → enforcement and evaluation.
- **Policy and legal context**: self-regulatory systems act within the EU policy context as well as national policy and legal structures.
- **Benchmarking:** Alcohol self-regulatory systems in the EU have become an international benchmark. The 2006 Roundtable provided a clear set of criteria, though practices have evolved in some areas; notably, digital media.

2. Added value of the EU Alcohol Strategy and EAHF

- **New areas, broader scope:** Self-regulatory codes are being developed in areas where few or no self-regulatory initiatives existed before; e.g. wine sector and digital marketing communication.
- **Stakeholder involvement:** Some participants representing economic actors indicated that they had undertaken several stakeholder consultations with a view to reviewing their self-regulatory codes. They underscored that this occurred as a direct result of the Forum process.
- **Compliance monitoring:** This dimension of the systems appears crucial given the low numbers of complaints filed each year. Some participants (industry) representing EU umbrella organisations identified the Forum process and associated monitoring tools (e.g. *traffic light* systems) as an effective means to steering action among their constituencies. The Forum process was also underscored as having contributed to an effective peer review process. Compliance monitoring in the context of the Forum was also identified by some of the participants as a source of examples and ideas for engaging action at the national level.
- **EAHF as a driving force:** EU action, including through the EAHF, has helped to encourage national-level actions. There has been a convergence in the functioning of SROs across the EU. Regarding self-regulation, there is a two-way exchange of information between the EU level and the Forum members and national level SROs: the Forum is at the source of broad-based cooperation within the industry for the purpose of strengthening both the effectiveness of codes and adherence rates.

3. Areas of disagreement

- **Involvement of non-industry actors in the monitoring of compliance and the review of self-regulation codes:** current venues for non-state actors and public entities to participate in the review of self-regulatory codes developed by the industry are not being fully used. Perception issues seem to be deterring participation. Composition of juries in SROs is an area where progress has been made but some participants deemed that the civil society was not adequately represented yet.
- **Definitions and parameters:** Agreement among EAHF stakeholders on a number of important definitions and parameters continues to be challenging (e.g. gate keeping, social expectations of responsibilities, "appeal to minors"…). The frontier between issues related to drinking by minors and those related to misuse of alcohol by the youth was also a source of disagreement.
- **Overall effectiveness of self-regulatory systems**: Here, the participants had differing opinions on the weight to be given to recent EU-funded projects, such as AMMIE.

Annex 11: Inter-Service Steering Group meetings

Kick-off meeting, 10 January 2011, Brussels: Summary report

The meeting was chaired by Michael Hübel, Head of Unit for Health Determinants, DG Health and Consumers.

- The Chair welcomed participants (list below), highlighting that the purpose of the meeting was to ensure that the perspectives of all interested DGs feed into the external evaluation of the EU strategy to support Member States in reducing alcohol related harm.
- After a round of introductions Michael Hübel presented key features of the strategy and the timeline for the evaluation.
- Despina Spanou, Principal Advisor for the Director-General for Health and Consumers and Chair of the European Alcohol and Health Forum, presented a brief overview of the international context, where the reduction of alcohol related harm is receiving increased political attention including through the UN Summit Declaration on non-communicable diseases in 2011, which recognises harmful use of alcohol as a key risk factor, and the Global Strategy to reduce the harmful use of alcohol adopted by the World Health Assembly in 2010.
- Tony Zamparutti and Guillermo Hernández of the COWI consortium, the contractor for the external evaluation, presented a concise summary of the evaluation approach. The terms of reference for the contract as well as an inception report drawn up COWI had been circulated to participants before the meeting.
- Points noted in the following discussion included:
    - Need for consistency in the use of the name of the strategy.
    - Need to clarify the mandates of the implementation structures.
    - Need to double-check that survey/interview questions are addressed to appropriate respondent groups.
    - Need to address impacts of the strategy in terms of added value for developments in Member States.
    - Need to reach beyond the sphere of immediate stakeholders for an overall assessment of the strategy, with sectors other than health and members of the Science Group mentioned as examples.
- Conclusions drawn by the Chair were the following:
    - Interested DGs should send as soon as feasible suggestions for further experts that could be contacted by COWI for input into the evaluation.
    - Any further specific comments relating to the evaluation plan should be sent by email by the end of the week.
    - The planned date for the next meeting of the ISSG, 11 April 2012, will be confirmed as soon as possible.
- The meeting ended at 12h00.

Participants

NAME	AFFILIATION
SPANOU Despina	DG SANCO
HÜBEL Michael	DG SANCO
MONTONEN Marjatta	DG SANCO
FERRIERE Jean	Secretariat-General
MOLITERNO Ersilia	DG AGRI
LEKESOVA Lucie	DG EAC
VALKOVA Marcela	DG EAC

NAME	AFFILIATION
SCHERER Daphne	DG EAC
ALVAREZ HIDALGO Francisco Jesus	DG EMPL
BOUTHORS Louis-Marie	DG ENTR
LEROY Victoria	DG INFSO
COLLA Claudia	DG MARKT
KERSTIENS Barbara	DG RTD
JONES Heather	DG TAXUD
HERNANDEZ Guillermo	COWI Consortium
RUNE JENSEN Martin	COWI Consortium
ZAMPARUTTI Tony	COWI Consortium
Through videolink	
GALLO Giulio	DG SANCO
DE CONINCK Pieter	DG SANCO
Excused	
FERNANDEZ GARCIA Jose	DG MOVE

Interim report meeting, 20 April 2012, Brussels

Summary report

The meeting was chaired by Michael Hübel, Head of Unit for Health Determinants, DG Health and Consumers.

- The Chair welcomed participants (list annexed). Apologies for absence were received from Jean Ferriere (SG) who had sent comments in writing prior to the meeting. It was agreed that ISSG members can send further comments in writing after the meeting.
- Tony Zamparutti of the COWI consortium presented results so far relating to the main evaluation questions, stressing that the interim report is based on desk research and online surveys. As follow up to the 1st ISSG meeting a third online survey (in addition to the surveys of CNAPA and EAHF members) was carried out, addressed to experts and officials not directly involved in CNAPA or EAHF. The next phase will include in-depth interviews and a case study on progress in the area of responsible marketing, followed by triangulation and synthesis for the final report. Main points raised during the discussion are summarised below.
- Survey addressed to CNAPA members:
    - Need to clarify which MS replied, including to establish geographic coverage.
    - Need to identify concrete examples of policy development to which the EU strategy has contributed.
- Survey addressed to EAHF members:
    - Need to better clarify why responses seem quite divergent between NGOs and industry members for some of the questions (for example role of EAHF membership in mobilising new action).
    - Need to distinguish between commitments (plans for action) as outputs of the EAHF process, and the concrete actions that have taken place as a result of the implementation of the commitments as the effects of the process.
    - Need to keep in mind and highlight in report that numerical analysis of the body of commitments is not an ideal approach because of differences in the types of commitments (scope, time span, structure) which also reflect differences in the nature of the member organisations (for example one/several members per sector).
    - The examination of commitments should preferably cover the full implementation period, starting from 2007-2008 and also including 2011.
- With regard to Task 3, assessment of the overall strategy, it was noted that the most recent data available, including on alcohol related harm, should be used in the final report. DG MOVE offered to contribute data on drink driving and policy developments, and DG EAC offered to provide data relating to young people.
- The Chair's conclusions with regard to the continuation of the work were the following:
    - Written comments should be sent by 27 April 2012.[234]
    - SANCO will work with COWI to shift resources so as to maximise the number of people to be interviewed, in particular to better reflect the breath and heterogeneity of the EAHF membership (civil society and private sector).
    - Given that the holiday period is not ideal for discussing the draft for final report, SANCO will look into the possibility of postponing the next ISSG meeting till September so as to provide minimum 10 days between distribution of the draft report and the meeting.

[234] Written comments were received from M Horodyska (SANCO 01), L Bouthors (ENTR) and E Moliterno (AGRI).

List of participants

NAME	AFFILIATION
HÜBEL Michael	SANCO
GIULIO GALLO	SANCO
MONTONEN Marjatta	SANCO (VIDEO)
HORODYSKA MAGDALENA	SANCO
MOLITERNO Ersilia	AGRI
BOUTHORS Louis-Marie	ENTR
VALKOVA Marcela	EAC
SCHERER Daphne	EAC
LEROY Victoria	NFSO
LOPEZ BENITO BENITEZ CASTO	MOVE
JONES Heather	TAXUD
HERNANDEZ Guillermo	COWI Consortium
ZAMPARUTTI Tony	COWI Consortium
Excused	
FERRIERE Jean	SG
ALVAREZ HIDALGO Francisco Jesus	EMPL
KERSTIENS Barbara	RTD
BERGOT Giles	MOVE

Final report meeting, 27 September 2012, Brussels

Summary report

The meeting was chaired by Michael Hübel, Head of Unit for Health Determinants, DG Health and Consumers.

- The Chair welcomed participants (list annexed). Apologies for absence were received from Moliterno Ersilia (AGRI) and Costa David Jorge (EMPL).
- The Chair thanked the participants, informed them on the meetings held with the two Advisory Groups comprising respectively members of the CNAPA and of the Alcohol and Health Forum. Both Advisory Groups were generally satisfied with the draft evaluation report and found that their feedback was reflected in it. The Chair clarified that the report on self-regulation of alcohol marketing produced by the University of Stirling was circulated to the ISSG upon specific request from some members but, as the report has not been published, it should be considered as confidential and not disseminated outside the group.
- Tony Zamparutti and Guillermo Hernandez of the COWI Consortium presented the main findings of the evaluation as well as conclusions and possible ways to enhance effectiveness in reaching the Strategy's objectives with focus on the main implementation instruments, the CNAPA and the EAHF.
- After the presentation the Chair opened the discussion asking participants to concentrate on main points and issues for clarification and inviting them to prepare more detailed comments in writing, with deadline on 8 October 2012. It was agreed that the PPT presented by COWI will be circulated to ISSG members to help focus written comments. Main points raised in the discussion are summarised below.
- ENTR stressed that the findings of the case study on alcohol marketing should be better reflected in the conclusions and in the suggested ways forward.
- SG expressed dissatisfaction with the report commenting in particular that it contains a number of political conclusions e.g. "*the evidence available shows that alcohol related harm remains an important concern for the EU. For this reason, the work of the EU strategy and its instruments, including CNAPA and EAHF, should continue*" He noted that some of the findings suggest lack of effectiveness and commitment..
- SG (Evaluation Unit) commented that the report describes outputs rather than outcomes and fails to address sufficiently questions of causality between actions and impacts. He also called for a discussion on effectiveness and efficiency. He noted that terms used to describe findings, such as "valuable" or "considerable", are subjective and called for more clarity. He pointed out the need for information on the costs of the exercise. Moreover, he felt the report would benefit from a shorter and more structured executive summary to better wrap up the findings.
- Relating to costs, the Chair clarified that the alcohol strategy is not an action programme with a designated budget but a policy approach that only entails operating costs at EU level.
- EAC called for conclusions to be presented by priority areas in order to better feed into discussion about the next steps, and by sectors in order to better integrate other policy areas in the report. EAC highlighted the usefulness of recommendations and concrete proposals on what could be improved in the future.
- CONNECT drew attention to emerging themes relating to communication technologies that could be better reflected in the formulation of commitments under the EAHF.
- MOVE also called for more focus on priorities, mentioning as example that it would be useful to know to what extend road safety has been addressed in CNAPA's work and to present concrete suggestions on regarding such areas of action.

- TAXUD noted that emerging topics such as minimum pricing of alcoholic beverages should receive more attention and said they will send written comments.
- SANCO 01 found the way the findings have been presented more suitable for an interim report and said that for the final report COWI should strive for a shorter and more synthetic presentation. Noting that conclusions are now presented mainly on Tasks 1 and 2 (assessment of CNAPA and EAHF), she highlighted that Task 3, the overall assessment of the EU strategy needs to be more prominent.
- The Chair stressed that assessing the contribution of the EU strategy to reductions in alcohol related harm is a challenge due to lack of timely data across the EU and that such limitations should be made explicit. He concluded there is clearly need to integrate findings and put more emphasis on the overall assessment of the strategy and its implementation. He thanked participants for comments helpful in particular to improve the overall coherence of the report and reminded them to send written comments by 8th October.

List of participants

NAME	AFFILIATION
HÜBEL Michael	SANCO
GIULIO GALLO	SANCO
MONTONEN Marjatta	SANCO (VIDEO)
HORODYSKA Magdalena	SANCO
FERRIERE Jean	SG
HUIJTS Brian	SG
BOUTHORS Louis-Marie	ENTR
VALKOVA Marcela	EAC
LEKESOVA Lucia	EAC
SCHERER Daphne	EAC
WRONA Joanna	CONNECT
LOPEZ BENITO BENITEZ CASTO	MOVE
JONES Heather	TAXUD
JENSEN Martin	COWI Consortium
HERNANDEZ Guillermo	COWI Consortium
ZAMPARUTTI Tony	COWI Consortium
Excused	
MOLITERNO Ersilia	AGRI
COSTA David Jorge	EMPL
KERSTIENS Barbara	RTD

Annex 12: Overview of triangulation and data reliability

Reliability and triangulation table

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
Task 1				
1. To what extent has the CNAPA contributed to the coordination of alcohol policies between MS and with the EU level?				
Desk research Survey AG workshop Interviews	• D: All but 1 MS has shared info on national policies; • S: 71% said moderately useful • D: documents have covered all 5 priority areas • AG and I: CNAPA discussions have influenced many MS policies • D: Little attention to local level	• CNAPA has provided extensive information to support MS policy development • Areas for greater attention identified, including actions at local level	• Survey results presented to AG workshop; AG discussions and interviews broadly support survey results • Task 3 shows general advance in MS policies, supporting CNAPA member's positive responses in surveys and interviews *These points are valid also for subsequent questions*	• Good survey response for Task 1, but non-responding members may have other opinions • Small number of interviews limits the role of this information source • CNAPA members know best the link between the Committee discussions and national policy actions – but could exaggerate CNAPA and thus their roles *These points are also valid for subsequent questions*
2. To what extent has the CNAPA contributed to further policy development?				
Desk research Survey AG workshop Interviews	• S: CNAPA has supported MS on policy development across the good practices in the strategy; its influence varies by topic • AG and I: CNAPA has supported consensus among members; less so across MS governments as a whole • S and I: CNAPA topics have been useful for policy development in MS	• CNAPA has played an important role in supporting public health policies and measures in MS • A stronger cross-policy approach would be valuable	• See EQ1 above	• Survey had a high number of questions on good practice: these provided information across many areas, but were too numerous to be followed up in interviews
3. What additional outputs of the CNAPA contribute to its added value as instrument at EU level?				
AG workshop Interviews	• AG: Work of CNAPA has not led to additional outputs such as Committee reports • AG and I: Informal network among members is valuable	• It could be useful to support the informal network	• AG workshop and interview comments on informal network are quite similar	• 'Additional outputs' in EQ not clearly defined. As such, this topic identified a topic not part of the evaluation plan

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
4. What are the lessons learned regarding composition, focus and working methods, with a view to enhance effectiveness in achieving the objectives?				
AG workshop Interviews	• AG and I: CNAPA members generally content with composition, focus, methods • I: Broader involvement of policy makers could strengthen policy role of Committee • AG and I: Views divided on yearly meetings HL meetings	• Continue thematic 'mini-seminars' • Continue high-level meetings	• Current CNAPA members appreciate Committee's work, as seen in EQ1, 2 and 3 – this supports their positive responses on EQ4	• Current CNAPA members may not be eager for changes, and thus could be slow to point out problems or propose new approaches
5. Has the work at EU level to develop alcohol data gathering and strengthen the knowledge base been useful from the MS perspective?				
Desk research Survey AG workshop Interviews	• D: CDCID has identified indicators; further work under SMART project • S: CNAPA members feel this work has been useful • AG and I: MS have been slow to implement indicators	• Work in this area is a priority under the EU strategy and needs a stronger approach	• Survey results and AG/interviews show a divergence between CNAPA members' opinions and slow MS implementation • While interviews identified reasons for slow implementation, this may reflect a limitation of voluntary strategy without target dates • Task 3 review of current data shows few comparable, EU-wide statistics currently exist, supporting the interview results	• Other MS officials may work more directly on data issues than CNAPA members
6. Have EU-funded projects and research on alcohol been relevant from the MS' perspective?				
Desk research Survey AG workshop Interviews	• D: projects and research across all areas of EU strategy have been undertaken • S and I: this work has supported MS policy development	• EU-funded projects and research have been an important and valuable element of the EU strategy • Further approaches to dissemination should be considered	• Surveys and interviews support each other in terms of the value of the projects and research	• CNAPA members appear to be a key interface providing project information to national governments – other data sources, however, might have provided more information on dissemination.

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
Task 2				
1. To what extent has the EAHF process been effective in mobilising stakeholders and stepping up action to reduce alcohol related harm?				
Desk research Survey Interviews	• D: EAHF membership has grown • I: areas for additional members identified • S: Many members, esp. econ. operators, indicate that commitments represent new action • D: commitments concentrated in 3 areas • D: Reviews of yearly monitoring show improvements, but not for evaluation work	• EAHF has mobilised diverse stakeholders • EAHF has stepped up action, in particular by economic operators • Progress on monitoring, but evaluation is under-developed	• Survey results discussed in AG • Survey responses on the extent of new action due to EAHF compared to results of Platform on Diet, Physical Activity and Health • Interviews support survey results on extent of new action	• EAHF members include umbrella groups as well as individual companies and NGOs: while members are used as the unit, they vary in size; however, main variations in responses appear across categories, not umbrella vs. individual members • Commitments vary in dimension from EU-wide to local • Good survey response rate strengthens validity of its results • Surveys and interviews cover EAHF categories in similar shares to overall membership, strengthening representativeness of results • While members not consulted may have other opinions, umbrella groups are well covered by surveys and interviews – most of these include other members *These points are also valid for subsequent questions*

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
2. To what extent has the EAHF process been effective as a platform for dialogue, exchange and cooperation?				
Desk research Survey Interviews	• D: EAHF meetings have addressed a wide range of thematic issues • S: Participation has led to new cooperation with other members • I: cooperation occurs mainly within categories; Econ. operators report cooperation with local/national NGOs and other groups • S: EAHF has provided examples of good practice, esp. for econ. operators • S: Open Forum has been successful in showcasing EAHF • D: External members a minority at Open Forum	• Forum has provided a platform for dialogue on issues among members with different interests and opinions • Open Forum meetings have had some success in showcasing EAHF, in particular to potential members, but have had limited success in reaching wider audiences	• Interviews show that survey results on greater cooperation refers mainly to contacts within, not across, member categories • In surveys and interviews, EAHF members see strong value of Open Forum, but desk research (participant lists) show engagement of external groups is not extensive	• Differences in opinions and interests within EAHF may have led some members to discount value of dialogue in their responses
3. To what extent has the EAHF process contributed to the development of responsible business practices across the EU in the sales and marketing of alcohol beverages?				
Desk research Interviews Case study	• D: A large share of econ. operators have carried out commitments for responsible business practices • I: Commitments/attention to age limits (under sales) have decreased • C: Econ. operators have put in place stronger self-regulation of marketing, taken 2006 Roundtable as a benchmark, at EU and national levels • C: Research has shown weak or unclear links between marketing self-reg. and reductions in harm	• Greater EAHF work on sales (age limits) may be warranted • EAHF has played an important role in strengthening self-regulation of marketing, based on 2006 Roundtable model • EAHF should continue to monitor self-regulation and its results	• Independent studies provide a core evidence base – however, EAHF members interpret key results in different ways in interview responses • EAHF member inputs via interviews and in case study workshop are coherent • Case study provides further desk research on marketing • Marketing is also an area for policy restrictions (Task 3). While policy and self-regulation are addressed separately here and under the EU strategy, it may be valuable to investigate examples where the two interact, and if there can be synergies	• As marketing touches on a core area for both economic operators as well as harm reduction: comments by EAHF members here may strongly reflect interests and value

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
4. To what extent can the commitments be related to impacts on alcohol-related harm reduction?				
Desk research Interviews	• D: EAHF commitments in areas directly linked to reductions in alcohol-related harm are unevenly distributed • I: A few EAHF members (mostly econ. operators) provided examples of detailed evaluation • I: Most interview respondents said they focused on outputs, not outcomes or impacts	• There is limited information linking EAHF commitments with impacts • Both methodological and resource constraints can limit measurement of impacts • Further work in this area is important for the EAHF generally, and desired by EAHF members	• Interview results are in agreement with desk study for EQ1: monitoring reviews found lack of progress on outcome/impact indicators • A difficulty in identifying impacts is also seen in the work of the Diet Platform • The problem of linking action with impacts for a complex social area is noted in Task 3	• EAHF members could be expected to want to show the results of their actions; however, they agree that this is a difficult area
5. To what extent can commitments be benchmarked in relation to the best available practices in the area?				
Desk research Interviews Case study	• D: Scientific evidence focuses largely on good/best practice for policy; however, some sources, including EU projects, are relevant for EAHF • C: For marketing self-regulation, econ. operators draw on the 2006 Roundtable as benchmark • D: Some EAHF commitments support good practice government actions • I: few EAHF members report referring explicitly to good/best practices in their commitments	• EU work under the strategy has brought forward knowledge on good practices • There is a need to clarify good/best practices for EAHF members and call on them to make stronger use of those identified, to link commitment design more clearly to causal pathways known to reduce harm	• Little use of good/best benchmarks is similar to limited information on impacts – in this case, links to known pathways resulting in reductions in harm are not clear. Results from EQ4 and EQ5 together highlight need for greater attention to the relation between commitments and impacts.	• EAHF members could be expected to see their commitments as good practice; however, few outside marketing self-regulation report this

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
6. What are the lessons learned regarding composition, focus and working methods, including of the EAHF sub-groups?				
Desk research Surveys Interviews	• I: EAHF respondents see plenary working methods as appropriate • I: EAHF respondents see Task Force on youth useful to a limited extent • I: Some EAHF respondents saw Task Force on marketing valuable, others felt it needed clearer objectives • D: Science Group members cover many topics and MS, but several have resigned • S: Half of EAHF members see dialogue with SG successful, but many, especially econ. operators, do not • I: mixed EAHF reactions to SG report on marketing • I: some EAHF respondents would like SG to focus more closely on issues applicable to their work/commitments	• Value of Task Forces has been mixed. However, work in smaller groups has been useful to tackle important issues • Task Force on marketing has kept attention on work in this area • Science Group has informed EAHF in two key areas; however, it has not directly supported members' work • The Science Group is at a crossroad, and its role should be reviewed.	• Case study has shown role of work on Task Force on marketing in this area • Survey and interview results both show mixed reaction of some EAHF members, especially econ. operators, to Science Group • Desk research and interviews both show limited SG experience in social science • Independent research on science/policy interfaces shows that scientific evidence can inform policy discussions but does not resolve policy differences rooted in interests and values	• Survey and interview responses on the Science Group are divided, and opinions appear to some extent linked to the reactions to its reports, in particular the one on marketing • Perceptions of the task forces and awareness of their work in general may be different between those who were members and those who were not.

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
7. Has there been cross-fertilisation and interactions between the EAHF, the CNAPA and the other structures? What forms of interaction would bring added value?				
Desk Research Surveys Interviews	• D: No formal joint activities are organised between CNAPA and EAHF; a few CNAPA members attend EAHF meetings • S: Mixed EAHF and CNAPA views on value of interaction • I: EAHF respondents wish stronger interaction • I: Mixed CNAPA views on interaction and on role of EAHF • I: Most CNAPA respondents not aware of EAHF commitments in their MS • D: limited CDCID presentations to EAHF • S: Most EAHF respondents 'Don't know' about CDCID interaction • I: Some members would like stronger links to CDCID	• Greater interaction between CNAPA, focused on strengthening commitments, could be valuable	• CNAPA attendance at EAHF and CNAPA responses indicate that only a few members of the Committee follow EAHF • Differences in CNAPA opinion on EAHF are also seen in MS: three have established EAHF-like bodies • As noted in EQ5, few commitments support government policy actions – this suggests limited links between EAHF and MS policies. • While desk research and survey respondents show little interaction between EAHF and CDCID, some members would like further links, to support work on indicators. This is a key area for attention, as identified in EQ4 (however, CDCID may not be the appropriate body to support EAHF here).	• CNAPA members have strong differences of opinion on EAHF: some follow its work, while other members question EAHF. These opinions influence views of interaction between CNAPA and EAHF.
Task 3				
1. Which developments at national level are moving in the directions outlined in the EU alcohol strategy				
Desk Research Interviews	• D: MS policies to address alcohol-related harm have developed in many of the areas set out in the EU strategy • I: A high share of CNAPA respondents indicate that the EU strategy has played a key but often indirect role in supporting policy development in their Member State	• Progress is seen across all the areas of the EU strategy, though to a varying extent	• Answers in Task 1 on the role of CNAPA, as an instrument of the EU strategy, are coherent with and match those for this EQ. • Answers for EQ2 on the role of the strategy are coherent with interview results here	• The EC/WHO survey on Member State policies provides a key and strong source of evidence for this EQ.

Evidence	Findings	Conclusions	Triangulation	Strengths and weaknesses
2. What evidence is there to show that the existence of the EU alcohol strategy as such has contributed towards progress in reducing alcohol related harm?				
Desk research Survey	• S: In all three surveys, a high share of respondents indicated that the EU strategy addressed themes of concern to their MS; and that the strategy has contributed to policy development there. • D: Available EU-wide data on alcohol-related harm are limited and do not show clear trends	• The EU strategy has contributed to the development of policies, actions and strategies across most Member States • The EU strategy has provided a baseline for action	• All three surveys (CNAPA, EAHF and external experts/officials) broadly agree in their results, though EAHF and external experts indicated a higher share of 'Don't know' answers • Positive answers here also are coherence with a positive role seen for CNAPA in Task 1 • The review of data here shows, as seen in Task 1, that work on common indicators remains an important gap.	• The lack of comparable, EU-wide data on alcohol-related harm is a major gap in terms of drawing conclusions • The links between the many actions under the strategy alcohol-related harm, which is affected by complex social factors, are complex, often direct, and time lags may be long – this needs to be considered in interpreting any data available in this field.

Notes:
D: Desk research
I: Interviews
S: Surveys
AG: Advisory Group