AlHaMBRA Project Thematic Capacity Building Workshop

***Working Together to Prevent Harm due to Alcohol in the Workplace***

# Workshop 6 – Draft Report and Conclusions

## Contents

## Background

The AlHaMBRA Project workshop *Working Together to Prevent Harm due to Alcohol in the Workplace* was organised as part of a broader strategy on alcohol at workplace to support the European Member States in knowledge-gathering, sharing best practice and capacity building in the prevention of alcohol at workplaces. It was supported by a scientific review of the topic and a stakeholder mapping and ongoing consultation survey work with the ultimate aim of strengthening evidence-based alcohol policy to reduce alcohol-related harm across multiple sectors, adopting a Health in all Policies approach. This workshop was the sixth in a linked series of events in collaboration with the DEEP SEAS and FAR SEAS contracts.

The workshop, 'Working Together to Prevent Harm due to Alcohol in the Workplace' comprised three interlinked sessions aimed at exploring different actors' perspectives and identifying effective action to tackle alcohol use and promote safe and healthy working contexts at different policy levels (European, national and local) and a variety of work settings and industries:

- Session 1, Tuesday 12th May 2022, *Context and evidence for tackling alcohol in European workplaces.*
- Session 2, Thursday 17th May 2022, *Coordination for alcohol prevention at work – perspective exchange to overcome barriers.*
- Session 3, Friday 20th May 2022: *Challenges in implementing alcohol prevention in work settings – moving towards EU recommendations.*

### Alcohol and workplace

In people aged 15 to 65, alcohol is the seventh leading risk factor for death and disability-adjusted life years (DALYs) (1) and the first risk factor for ill health and premature death (2). Europe has the highest alcohol consumption per capita worldwide[1] and the European Commission has set a target of achieving a relative reduction of at least 10% in the harmful use of alcohol by 2025, as agreed by Member States as part of the Sustainable Development Goals[2].

According to European national surveys, between 5% and 20% of workers are either "addicted to alcohol or at risk of becoming addicted to alcohol" (3) but the results vary greatly by country, sector, type of occupation, level of educational attainment and employment situation. Alcohol is associated with poorer workplace outcomes such as accidents, low productivity, absenteeism, presenteeism, and a higher risk of unemployment (2).

Some industries (construction, farming, ICT, transportation) and occupational categories (blue-collared workers, managers) appear to be particularly prone to high levels of alcohol consumption, and different workplace psychosocial factors can also increase risk (long working hours, work travel); while, at the same time, the workplace can be an ideal environment for the introduction of health promotion and alcohol prevention activities (4). Thus, the implementation of such strategies are still rare and evidence shows that part of the reason are the tensions and competing interests among the stakeholders involved in workplace

[1] https://www.oecd-ilibrary.org/sites/82129230-en/1/3/2/2/4/index.html?itemId=/content/publication/82129230-en&_csp_=e7f5d56a7f4dd03271a59acda6e2be1b&itemIGO=oecd&itemContentType=book#

[2] https://www.europarl.europa.eu/doceo/document/E-9-2021-002908-ASW_EN.html

prevention. Interventions involving alcohol and health in the workplace can be hampered by organisational and other barriers such as privacy concerns, fear of punishment and lack of awareness of the dangers of alcohol at work (5).

In this context, one of the five priority themes in the EU strategy to support Member States (MS) in reducing alcohol-related harm (6), was to "prevent alcohol-related harm among adults and reduce the negative impact on the workplace." This priority theme's goal was to "contribute to the reduction of alcohol-related harm in the workplace and promote workplace-related actions." This EU strategy called for action measures such as a policy to prevent alcohol-related harm, including information and/or education campaigns in all workplaces, as well as assistance and specialised care for employees with alcohol-related issues.

In addition, the European action plan to reduce the harmful use of alcohol 2012–2020 (7) outlined a variety of strategies for addressing alcohol-related harm at the local level: policies promoting alcohol-free workplaces, a managerial style that reduces job stress and increases job reward, and optional workplace interventions, available on request, such as psychosocial skills training, brief advice, and alcohol information programs.

The level of implementation varies from country to country. According to data from the WHO database from 2018, 17 European MS have national guidelines for the prevention and counselling of alcohol problems in the workplace, and testing for alcohol in the workplace is governed by legislation in 11 MS. In addition, social partners representing employers and employees are involved at the national level in action to prevent and address alcohol-related harm in the workplace in 19 MS (8).

## References

1. Griswold MG, Fullman N, Hawley C, Arian N, Zimsen SRM, Tymeson HD, et al. Alcohol use and burden for 195 countries and territories, 1990-2016: A systematic analysis for the Global Burden of Disease Study 2016. The Lancet. 2018;392(10152):1015-35.
2. Anderson P. Evidence Review - Alcohol and the Workplace. European Workplace and Alcohol; 2011.
3. Eurofound. Use of alcohol and drugs at the workplace. 2012 Available from: http://www.eurofound.europa.eu/sites/default/files/ef_files/docs/ewco/tn1111013s/tn1111013s.pdf.
4. Schouw D, Mash R, Kolbe-Alexander T. Changes in risk factors for non-communicable diseases associated with the 'Healthy choices at work' programme, South Africa. Global Health Action. 2020;13(1). Available from: https://doi.org/10.1080/16549716.2020.1827363
5. Roche AM, Chapman J, Duraisingam V, Phillips B, Finnane J, Pidd K. Construction workers' alcohol use, knowledge, perceptions of risk and workplace norms. Drug and Alcohol Review. 2020.
6. European Commission. An EU strategy to support Member States in reducing alcohol related harm. 2006. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52006DC0625&from=EN
7. World Health Organisation Regional Office for Europe. European action plan to reduce the harmful use of alcohol 2012–2020. 2012.
8. World Health Organization Regional Office for E. Policy in Action - A tool for measuring alcohol policy implementation. Copenhagen; 2017 Available from: https://movendi.ngo/wp-content/uploads/2019/11/WHO_Policy-in-Action_indh_VII-2.pdf.

## Workshop structure

This AlHaMBRA Project workshop took place within the frame of the prevention strand of the EU beating cancer plan, focusing on national policy measures to support effective workplace strategies to tackle alcohol consumption and harm. The three interlinked sessions, as part of the Capacity-building Thematic Alcohol Policy Workshop Series, explored different actors' perspectives, priorities, barriers and solutions in designing and implementing effective action to tackle alcohol use in workplaces at different policy levels (European, national and local) and a variety of work settings and industries.

Outputs include a peer-reviewed scientific summary; a set of presentations or short videos introducing the evidence and on-going European initiatives and experiences; a host country report and this workshop report, including key messages and conclusions from the event.

The sessions opened with a welcome message from the hosting Member State, Spain and the AlHaMBRA Project leader, from SICAD, Portugal. This was followed by a series of presentations grouped into three session topics and continued with breakout small group discussions focusing on a set of pre-prepared questions. Feedback from groups was then shared with all the participants by the rapporteurs in each group, wrapped up with a brief summary by the Chair and topic experts/presenters. The workshop agenda is attached as Annex 1.

| | Session one | Session two | Session three |
|---|---|---|---|
| Welcome | Welcome and introduction | | |
| Presentations and Q&A around key topics | • *European context on alcohol prevention in workplaces*, (EU-OSHA, WHO Global Occupational Health)<br>• *State of the art and best practices at EU Level* | • *Alcohol prevention at workplace: the main actors' perspectives*<br>• *Stakeholders' perspectives – coordination of prevention efforts* | • *Key implementation challenges – Promoting disclosure and health in different work contexts* |
| Breakout small group discussions and feedback to main group | ***Intersectoral priorities***<br>*1. Specific regulations (transport, education etc.)*<br>*2. Intersectoral coordination (Labour/Health/Road Safety)*<br>*3. Coordination among health actors (occupational health/health system)* | ***Overcoming barriers***<br>*1. The impact of working conditions and psychosocial risks on alcohol consumption at work*<br>*2. Increasing awareness of alcohol-related risk in the workplace*<br>*3. Embedding alcohol prevention at the workplace – from promotion/prevention to occupational health*<br>*4. Improving coordination to support workers through prevention, treatment and reintegration initiatives* | ***Implementation challenges***<br>*5. Self-employed, small and medium companies*<br>*6. Large companies and multinationals*<br>*7. Risky, high-impact and sensitive work areas*<br>*8. New working conditions after COVID (teleworking, safety measures)* |
| Close | Summary and wrap up | | |

## Attendance

The sessions brought together over 95 participants from the EU and beyond.

Session 1 brought together 92 participants, and Session 2 brought together 69 participants. Across both sessions, participants represented 19 EU and 14 non-EU countries, and came from diverse sectoral backgrounds – public administration, academic, enterprise, clinical and civil society.

See Annex 2 for a breakdown of participation by session, country and sector.

## Lessons learned and conclusions from the workshop

During the online sessions panellists presented their knowledge, perspectives, and experiences, through short videos and live question and answer sessions. Then, in small-group discussions, with a pre-assigned moderator and rapporteur, participants were instructed to reach a level of consensus on responses to a concrete policy question. Their discussion and points for further consideration were reported back to and discussed with the whole group to arrive at key messages and proposed actions to address alcohol-related harm in the workplace. The main take-home messages raised and supported by participants are summarized in *Table 1* below.

**Table 1. Main messages/conclusions coming out of workshop sessions**

- There is robust evidence of the **high impact of alcohol on workplace** health and safety and **loss of productivity.**
- The workplace is a good setting to reach **adults and implement addiction prevention strategies**, but there is wide variation around Europe, and harmonisation is needed.
- All actors **need to be involved** when designing the initiatives, **health professionals, employees, employers and more**.
- It is more cost-effective to prevent alcohol problems than to replace workers with alcohol use disorders.
- Major barriers to alcohol prevention at the workplace include **stigma, cultural attitudes and how alcohol is often viewed as a private behaviour**.
- Health roles are split among different actors (even between different health systems - general health and occupational health), with suboptimal communication systems, which cannot ensure worker privacy.
- There is a **lack of data and statistics**, and a lack of resources (especially acute for SMEs and freelance workers)
- It is essential to **clarify roles and responsibilities** and to improve coordination between stakeholders, involving unions at all stages of design and planning.
- One important step forward is to have a **national framework/alcohol policy, including a zero alcohol in the workplace** clause, and involve workers in the process;
- On the other hand, action is most effective when implemented at the local level and embedded in the local community and coordinated with the general and specialised health services.
- We need to **consider multiple levels of risk** (not an individual problem) – collective aspects of alcohol need to be addressed collectively
- **Testing can be a tool in a wider prevention policy**, but it is important to not have a punitive approach and to protect workers' privacy and confidentiality of outcomes
- **Training:** Occupational health professionals and workplace risk-prevention specialists need in-depth training, as well as educational and training initiatives for managers and co-workers to help with prevention strategies
- Further research is needed to support the knowledge base on the impact of alcohol and ongoing **prevention initiatives in companies of different sizes**, sectors and in different national contexts, including cost analysis, implementation research ineffective interventions, and possible links between alcohol and workplace violence and sexual assault (in-company and 3rd party).

## Workshop evaluation

At the end of each session participants were invited to complete an online evaluation survey provided in the session and immediately afterwards in a follow-up email. The brief survey was designed to be quick and easy and participants could choose to remain anonymous. A summary of the workshop evaluation is shown in Annex 3.

Participants were asked to give four quantitative scores to the session they had attended:

- Overall evaluation - How would you rate the session overall? (score between 1 to 10)
- The topics and aspects covered by the speakers were relevant for the overarching theme of the session (1 to 5)
- I learned actionable information for my work and/or consolidated my understanding/ knowledge (1 to 5)
- There was enough time and opportunities allocated for interaction with the speakers and between participants (1 to 5)

Participants were also invited to give feedback in three free text questions:

- Which speakers of the session did you find the most interesting/informative/engaging? (name, organisation or topic)
- Did you find any topic missing which you would have liked to see covered in relation to this session's theme?
- Do you have any comments or suggestions you would like to share?

## Evidence review / background briefing document

The workshop was supported by a background paper, to **introduce the key points and issues for debate in the capacity building workshop**.

## Presentations and discussions

### Session 1, Thursday 12th May: Context and evidence for tackling alcohol in European workplaces?

*Welcome and introduction to the session.*

Chair: Manuel Cardoso/Toni Gual

Participants were welcomed to the session by Joan Ramon Villalbí, Government Delegate for National Plan on Drugs, Spanish Ministry of Health. (Video presentation).

*European context on alcohol prevention in the workplace - Live Q&A with presenters*

Silvia Matrai, Coordinator of public health projects, Addictions Unit, Hospital Clínic, Barcelona gave an overview of digital behavioural health approaches to tackle alcohol problems, obesity and sedentarism. (Video presentation).

- William Cockburn, Interim Executive Director of EU-OSHA, outlined the Frame of the EC occupational health initiatives, and some considerations on the topic.
- Ivan Ivanov, Head of the Occupational and Workplace Health department at the World Health Organization, explained the WHO Global Occupational Health Programme
- Marica Ferri, Head of Support to Practice sector, of the Public Health Unit in the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) & Inês Hasselberg, Scientific Writer, at the Support to Practice Sector of the Public Health Unit (EMCDDA), presented the EMCDDA work, and tools and lessons from the recent webinar on the topic of addictions in the workplace.

*State of the art and best practices at European Level - Live Q&A with presenters*

Chair: Toni Gual

- Gemma Rabal, Research Assistant at ESADE Business School in Barcelona, Spain, she presented the AlHaMBRA Project Review of workplace alcohol interventions.
- Norway: Best practice examples:
    - Randi Wågø Aas, Head of the research group of Societal Participation in School and Work in the University of Stavanger, Norway & Hildegunn Sagvaag, Head of the research group for the Program for Social Scientific Research on Alcohol and Addiction at the University of Stavanger, presented the WIRUS project, Preventing risky alcohol use and sick leave, interventions and study findings.
    - Camilla Lynne Bakkeng, Head of Advisory and Communication in AKAN Advisory Centre in Norway, talked about the AKAN project, and practices for working with managers and employees.
- Joan Colom, Director of the Programme on Substance Abuse at the Public Health Agency of Catalonia (ASPCAT), Spain and Lidia Segura, leader of the Alcohol Group, Catalan Public Health Agency (ASPCAT), they discussed the EU & Catalan initiatives: EWA and “At work, alcohol + drugs 0,0” (a la feina..)

## *Breakout discussion Groups: intersectoral priorities*

Chair: Fleur Braddick

Alcohol in all policies: according to WHO, the most frequently mentioned barriers on implementation of the strategy to reduce harmful use of alcohol were: (a) lack of a national alcohol policy (b) alcohol's low political priority in any sector as contributing to weak stakeholder involvement and public apathy, (c) and lack of coordination between sectors, including the absence of a central coordinating agency.

Following a short break, participants were placed in three different discussion groups

*1. Specific regulations (transport, education etc)*
*2. Intersectoral coordination (Labour/Health/Road Safety)*
*3. Coordination among health actors (occupational health/health system)*

Each group had a very short context explanation by the facilitator, and then a moderated group discussion.

**The questions used as a guide for each group were:**

Group 1. Specific regulations (transport, education etc)

a) In your country/region, what are the key alcohol-specific regulations in other sectors that can directly and indirectly help in tackling workplace alcohol consumption and alcohol related problems?
b) What are the main barriers to improving these specific regulations?
c) … and what would be the first steps to overcoming them?

Group 2. Intersectoral coordination (Labour/health/Road Safety)

a) Which sectors need to coordinate better in your country in order to contribute directly and indirectly to tackle workplace alcohol consumption and related problems?
b) What are the main barriers to intersectoral coordination?
c) … and what would be the first steps to overcoming them?

Group 3. Coordination among health actors (occupational health/health system)

a) How does occupational health coordinate/communicate with the general health system in your country?
b) What are the main barriers to effective coordination between health actors on alcohol workplace policy?
c) …and what would be the first steps to overcoming them?

## *Feedback from small group discussions and wrap-up*

Chair: Toni Gual

Points coming out of the small group discussions included:

- On the issue of specific regulations:
  - The main barrier identified is the existence of different legislations within Europe and the difficulties in reaching the sectors which are at most risk.
- On the intersectoral coordination:
  - There is a lot of variation between countries, and it is key to create common platforms.
  - Stigma is the main barrier to seeking help, but an additional challenge is that alcohol is a cultural issue and very often considered a private behaviour and not under the influence of the workplace.
  - One important step forward is to have a national framework, involving the workers themselves in the process to develop this.
- On the issue of coordination among health actors (occupational health/health system)
  - The main barrier identified was that, in the majority of countries, health roles are split among different actors and the privacy of workers cannot always be ensured. It is key to have an in-depth knowledge of the role professionals have, and the existing circuits to support health, and to ensure consent for communication of worker/patient information to protect his/her privacy.
  - It was identified that it is key that occupational health professionals have access to patient health records and improve communication channels.

Wrap-up messages

- There is robust evidence on the high impact that alcohol has on the workplace (not only causing health and safety problems to workers but also loss of productivity), and also growing evidence of the impact that psychosocial risk factors, such as poor leadership and lack of support to workers, have on the use of alcohol. In this regard, alcohol and drug use could be used as a red flag of psychosocial risks in a company. In this area, it will be important to follow the developments and outputs generated by the 4-year research which EU-OSHA will implement in the coming years.
- Speakers representing different European and international agencies committed to addressing alcohol at work through their political agendas and future plans, frameworks and research projects; and there were examples reported to indicate improving collaborations between key actors.
- There is a wide variety across Europe in the level of implementation of awareness activities on the risk of addictions at work
- There is agreement that the workplace is a good setting to reach adults and to implement addiction prevention strategies; and there is also agreement on the importance of helping workers with alcohol use problems, implementing early detection strategies, providing support and job reintegration.

- There is general concern about the impact that the ongoing changes in working conditions (such as covid-related teleworking and digitalisation) can have on the mental health of workers including risk of addictions.
- The experiences in Norway show that workers' profiles vary considerably from company to company and also the alcohol consumption patterns, therefore it is important to tailor initiatives to all these particularities.
- There is agreement on the need to involve all actors when designing the prevention and health promotion initiatives, it is important to see how some countries have advanced in that direction but others have a lot to do.
- Testing cannot be the core of the Prevention actions, they can be helpful but only if not punitive and embedded in a broader program, including alcohol policies,
- It is important to raise awareness that, according to the AKAN model, it is more cost-effective to prevent alcohol problems than replacing AUD workers.

## Session 2, Tuesday 17th May: Coordination for alcohol prevention at work – perspective exchange to overcome barriers

### *Welcome and introduction to the session- Live Q&A with presenters*

Chair: Joan Colom

Participants were welcomed to the session by Joan Villalbí, the Government Delegate for National Plan on Drugs, Spanish Ministry of Health who introduced the Session's topic and outline initiatives and approaches taken in Spain.

- Guiseppe Masanotti, Medical Doctor, Professor, Faculty of Medicine, University of Perugia Italy, and Secretariat of the European Network on Workplace Health Promotion (ENWHP) talked about alcohol prevention within broader workplace health promotion, based on experiences in the ENWHP. (Video presentation).

### *Alcohol prevention at workplace: the main actors' perspectives + live Q&A with presenters*

Chair: Toni Gual

- Alenka Škerjanc Assistant Professor, in Ljubljana University Medical Centre, and member of the Union of European Medical Specialists (UEMS) Section in Occupational Medicine, introduced the perspective of occupational health professionals (Video presentation).
- Mario van Mierlo, Policy Secretary, Confederation of Netherlands Industry and Employers (VNO-NCW) & Chair of Social Protection Working Group for BusinessEurope, presented the employers' views on how to advance alcohol prevention at work, and gave examples of Dutch initiatives.

## *Stakeholders' perspectives – coordination of prevention efforts + live Q&A with presenters*

Chair:Toni Gual

- Emília Telo, from the Portuguese Working Conditions Authority (ACT), & EU-OSHA European Union information Agency for Occupational safety and health focal point for Portugal, she presented the Portuguese experience and tools developed in collaboration across departments and actors' representatives.
- Alberto Salomone, President of the European Workplace Drug Testing Society, EWDTS, & Associate Professor at the University of Turin, Italy, explained the role of the EWDTS and how alcohol testing can be used to support effective practice.

## *Breakout small group discussions: overcoming barriers*

Chair: Fleur Braddick

Following a short break, participants were placed in breakout rooms for small group discussions. The overall theme was "Overcoming barriers", focusing on different elements of prevention.

1. *The impact of working conditions and psychosocial risks on alcohol consumption at work*
2. *Increasing awareness of alcohol-related risk in the workplace*
3. *Embedding alcohol prevention at the workplace – from promotion/prevention to occupational health*
4. *Improving coordination to support workers through prevention, treatment and reintegration initiatives*

Each group had a very short context explanation by the facilitator, and then a moderated group discussion.

*Group 1. The impact of working conditions and psychosocial risks on alcohol consumption at work*

Recent research shows a relation between work-related stressors and elevated alcohol consumption and problem drinking. There are specific job-related influences associated with problem drinking, including job stressors and participation in work-based drinking networks. Some work-related reasons may positively influence the use of alcohol among workers such as:

- Arduous working conditions, for example, cold or hot weather associated with alcohol use
- Irregular working practices: travelling abroad, highly variable working hours
- Psychological stress at work: mobbing associated with the use of alcohol and drugs. A meaningless, boring or uncommitted job has also been found as a reason behind the use of alcohol.

The questions used as a guide were:

a) How can we raise awareness among key target groups on the impact of psychosocial risks on alcohol consumption? Are there good examples from your country?
b) What measures should alcohol prevention policies (national or sub-national level) include in order to tackle this negative impact?
c) …and what mechanisms should be put in place to support companies in addressing the issue of working conditions and identify individuals at special risk early on?

*Group 2. Increasing awareness of alcohol-related risk in the workplace*

This is one of the most repeated barriers, appearing often in the literature as well as in the interviews with the different stakeholders. Companies do not always identify the problem (especially in the case of SMEs), and only excessive consumption (tertiary prevention) is considered as the potential problem. There is a lack of preventive culture and awareness on the subject, and a lack of awareness of the tools that are available to help with the issue, and addiction is not considered an occupational disease.

The questions used as a guide were:

a) How can we raise awareness among key target groups on the impact of alcohol related risk at the workplace? Are there examples from your country?
b) What mechanisms should governments or local authorities put in place to raise awareness of these risks?
c) How can companies be encouraged to promote awareness and solutions to these alcohol-related risks in the workplace?

*Group 3. Embedding alcohol prevention in the workplace – from promotion/prevention to occupational health*

From the interviews with occupational doctors, it was pointed out that their initiatives are limited if they can only perform as advisors and cannot do anything without the permission of the company board. There is a lack of training for technicians from occupational health services and a lack of awareness among occupational health doctors in companies and external occupational health services.

The questions used as a guide were:

a) What are the main barriers to embedding alcohol prevention at workplaces in your country?
b) Are there best practices in your country regarding the implementation of embedded alcohol prevention programs in the workplace?
c) …and what mechanisms could governments or local authorities put in place to help companies embed alcohol prevention in workplaces?

*Group 4. (Improving coordination to support workers through prevention, treatment and reintegration initiatives )*

Coordination between different stakeholders can be an obstacle to the implementation of prevention strategies. The different interests and barriers between, workers, employers and occupational health services can hinder the actions of preventing committees and protocols.

In addition, fears of stigmatisation and issues around alcohol declaration at work have appeared as a barrier both in the literature and interventions and in the interviews with representatives from companies and trade unions. Regarding interventions, it can be a barrier to recruitment and can affect the number of people who complete the interventions. It is important to make sure that high-risk employees are confident in the process to share their issues. From the point of view of companies, many do not want their customers to think they might have alcohol consumption problems among their employees. Representatives of the trade unions also pointed out that often the worker does not want to acknowledge the problem and/or hide it.

The questions used as a guide were:

a) What coordination tools should be put in place both at company and at country/regional level in order to help the implementation of alcohol prevention in the workplace? Are there examples from your country?
b) What measures should be put in place in order to facilitate early detection of alcohol problems at work?
c) What measures should be put in place in order to reintegrate workers with alcohol use disorders or alcohol-related problems back into the workplace?

## *Feedback from small group discussions and wrap-up*

### Chair: Toni Gual

Points coming out of the small group discussions included:

- On the issue of *the impact of working conditions and psychosocial risks on alcohol consumption at work*
    - There is a need to raise awareness of how psychosocial risks influence alcohol consumption.
    - There is a lack of data and statistics

- On *the issue of Increasing awareness of alcohol-related risk in the workplace*
    - The lack of awareness leads to stigma
    - Alcohol consumption is not an individual problem, changing the culture of punishment is important to solve the problem.
    - We need to consider multiple levels of risk (not an individual problem) – collective aspects of alcohol need to be addressed collectively.
    - There is a lack of resources (especially for SMEs and freelancers)

- On *the issue of embedding alcohol prevention at the workplace – from promotion/prevention to occupational health*
    - It is important to think about how stigma affects prevention interventions
    - Employees and managers have an important role to play in training and detection of alcohol problems.
    - Testing can be a tool in a wider prevention policy, BUT it is important to not have a punitive approach and to protect workers' privacy and confidentiality of outcomes
    - It is important to clarify to workers how and when to ask for help.
    - It is important to have assessment tools and to establish early warning indicators for alcohol problems.

- *On the issue of improving coordination to support workers through prevention, treatment and reintegration initiatives:*

- Consideration should be given to returning to work after intervention in the best conditions and without stigmatisation.
- The social component is important as well as the integration of work adjustment is part of the treatment.

Wrap up messages

- Good evidence is essential to establish adequate public policies, there is a lack of statistics and registers in most countries.
- Interventions should be tailored taking into account workers' needs but also the sector, the size of the companies and the country context and legislations. .
- Roles and responsibilities: Occupational doctors need proper training, role of managers to help with prevention strategies, involving unions at all stages of design and planning
- There is a need for a national strategy, but local coalitions and action roles and responsibilities: Occupational health professionals and workplace risk-prevention specialists need in-depth training, as well as educational and training initiatives for managers and co-workers to help with prevention strategies
- Harmonized protocols (prevention and integration at work) and training packages should be promoted at European level
- Companies should be encouraged and incentivized to support workers to prevent problem drinking and ultimately solve the problem
- Replacement is more costly than rehabilitation, and rehabilitation is more costly for businesses and society than prevention.
- The connection between occupational health and general health can support good management in the identification and prevention of alcohol problems in the working population.
- We need to consider the person, individual risk and occupational risk, not an individual problem, collective aspect of alcohol, to be addressed collectively
- Testing wider prevention policy but it is important to not have a punitive approach
- Important to think about how stigma affects prevention interventions
- There is a lack of data and statistics, and a lack of resources (especially acute for SMEs and freelancers)

## Session 3, Friday 20th May: Challenges in implementing alcohol prevention in work settings – moving towards EU recommendations

*Welcome and introduction to the session*

### Chair: Manuel Cardoso

Participants were welcomed to the session by Manuel Cardoso,

- Ana Catalina Ramírez, Technical Specialist, Occupational Safety and Health, ILO, outlined recent initiatives and approaches taken in the International Labour Organisation and gave international context and points to consider in the discussions during the day

*Key implementation challenges – Promoting disclosure and health in different work contexts + live Q&A with presenters*

### Chair: Lidia Segura

- Ella Arensman Professor of Public Mental Health and Chief Scientist, National Suicide Research Foundation (NSRF) University College Cork, Ireland, talked about the large European MENTUPP project on mental disorders and alcohol prevention in the workplace, which she leads.
- Beatriz Olaya Guzman, post-doctoral researcher, Sant Joan de Deu Research Institute, Spain, introduced the EMPOWER initiative (European e-health workplace project, focusing on mental health), and draw out lessons for tackling stigma in alcohol prevention programmes
- María Dolores Braquehais Conesa, clinical Director, Inpatient Psychiatric Unit of the Integral Care Program for Impaired Health Professionals (ICIHP), Vall d'Hebron Hospital, Barcelona, Spain, explained the Catalan/Spanish programme PAIMM – Integral Care for Sick Physicians, addressing one of the key groups of the EU study.

*Breakout small group discussions*

### Chair: Fleur Braddick

Following a short break, participants were placed in breakout rooms for small group discussions. The overall theme was "implementation challenges", with groups focusing on different working contexts:

1. *Self-employed, small and medium companies*
2. *Large companies and multinationals*
3. *Risky, high-impact and sensitive work areas*
4. *New working conditions after COVID (teleworking, safety measures)*

Each group had a very short context explanation by the facilitator, and then a moderated group discussion.

Group 1. Self-employed, small and medium companies

Self-employed or temporary workers– difficult to reach (like general population, workers unions do not reach them either) and long hours of work (they have to manage themselves with safety and Health at work, and Health is the last issue).

Small companies – close relationships (they do not want to bother their friends, family members); lack of standards and policies (not enough human resources to deal with it); employee problems have a greater impact on the company (difficult to replace workers).

Medium companies – external occupational Health and preventive services and difficulties to communicate and coordinate with them, no privacy or confidentiality.

The questions used as a guide were:

a) How can we raise awareness among self-employed workers on the importance of alcohol prevention and the impact of alcohol in their work? Are there good examples from your country?
b) What measures should small and medium enterprises include in order to improve alcohol prevention? Are there good examples from your country?
c) …and what mechanisms should be put in place by all the stakeholders (governments, employers and employees unions) to support self-employed and small and medium companies in addressing the issue of alcohol prevention?

Group 2. Large companies and multinationals

They can impulse workers assistance programs including specific strategies to help them cope with addictions intramural or extramural, but not all does. Employees working in multinationals might not live close to the premises; therefore, receiving healthcare from external resources might interfere in a normal workday.
Multinationals might have to have into account different country legislations in order to harmonize alcohol prevention programs.
Job reintegration is easier.
Difficulties for temporary workers hired externally that might not have access to workers assistance programs (as an example: if an external worker is identified with alcohol intoxication signs when entering the premises and his company does not provide him support, he or she might be in risk of losing his/her job)

The questions used as a guide were:

a) How can programmes in large companies best support and help workers with alcohol problems, and ensure job reintegration for example, to reconcile continuing work (not asking for sick leave) and receiving specialist treatment for AUD? Are there good examples from your home context?
b) What are the implications for a multinational of having premises in different countries with different “regulations” on the implementation of alcohol prevention programs? What measures can companies put in place to overcome these differences and minimise inequalities?
c) What measures can other stakeholders (governments, public authorities and workers and unions) adopt to encourage equitable good practice across different locations in large companies?

Group 3. Risky, high-impact and sensitive work areas

High physical risk sectors (chemistry, construction, driving, pilots, etc): These sectors with high-risk situations (usually physical) are more regulated and testing will be more possible to be implemented throughout, but usually companies tend to distinguish between blue- and white-collar workers and implement only testing for blue collar workers, therefore there is a sense of inequity in implementation. The problem is that the sectors "with no physical risk" tend to be immobilised and do nothing, only general health promotion programs not realising about the importance of other risk (financial, psychological, etc)

High accessibility to alcohol sectors (breweries, hospitality, night-life, etc): Those are more in danger but workers might be embarrassed to ask for help and companies will be reluctant to explain the programs they have in place. In addition, job reintegration is much harder.

High impact (police, security, health workers, etc): are exposed to more restrictive and punitive regulations and experience more discrimination if they develop problems. Therefore, workers do not ask for help and co-workers might not inform due to the negative consequences for their colleagues.

The questions used as a guide were:

a) How can we raise awareness of alcohol risks and good practice prevention (or improve idea sharing) across the different 'sensitive' working areas? Are there good examples from your home context?
b) What measures should companies in these different areas put in place in order to ensure job reintegration of their workers after alcohol problems (please consider the 3 different types)?
c) What measures can other stakeholders (governments, public authorities and workers and unions, occupational medicine) use to encourage good practice in these specific work contexts?

Group 4. New working conditions after COVID (teleworking, safety measures)

Difficulties to promote zero tolerance when there are no control measures possible to be put in place

Better work/life balance but higher psychosocial risks (stress and isolation, blurred definitions of working and non-working spaces).

Exacerbates inequalities (studies suggest that those with higher risk drinking behaviours have tended towards drinking more during the pandemic changes, while those low or moderate drinkers have reduced consumption).

The questions used as a guide were:

a) What can we do to reach teleworkers and raise awareness of the possible risks around alcohol consumption? Are there good examples from your home context?
b) What measures can companies put in place in order to ensure the same health and safety measures for teleworkers, especially regarding alcohol prevention and successful reintegration?
c) What can other stakeholders (governments, public authorities and workers and unions, occupational medicine) do to ensure good practice and support for teleworkers or others whose situations have altered with the pandemic?

## *Feedback from small group discussions and wrap-up*

*On self-employed, small and medium companies,*

- There is no identified best practices in Europe in order to reach self-employed or temporary workers, they are solely reached as general population
- Self-employed or temporary workers have to manage themselves with safety and Health at work, and Health is, usually, the last issue and psychosocial risk are very high (long working hours, stress, etc)
- Guilds may play an important role in reaching self-employed and temporary workers
- Self-employed workers are difficult to incorporate into programs or legislation for assistance and intervention programmes and have a lot of difficulties to follow and adhere to treatment.
- Small companies may have a lack of occupational health and safety resources and information to manage the prevention of harm to workers' health.
- Close relationships in small companies make it difficult to manage alcohol-related problems, and there is also the problem of stigma.
- Managers and co-workers from small companies have an essential role in motivating their colleagues to ask for help but they should have the needed skills and training is key
- Medium companies usually have external occupational Health and preventive services and have difficulties to communicate and coordinate with them keeping privacy or confidentiality for the worker.

*On large companies and multinationals*

- Large companies and multinationals are in a privileged position to promote integral prevention approaches covering early identification, facilitating the access to treatment and job reintegration.
- It is key to  have into account that multinationals might have to deal with harmonisation problems resulting from different regulations in different countries
- Large companies have a responsibility with supporting subcontractors in order to ensure that prevention programs are also provided to external staff working in their facilities
- It is important that employees assistance programs are built to promote motivation and behaviour change among workers (not confrontation) and include the peer-to-peer approach
- Lack of reliable data, comparable and detailed data across work types (sector company size etc) to leverage adequate resources

*On risky, high-impact and sensitive work areas*

- One key element in convincing companies to adopt a more supportive and less punitive approach to tackling workers' drinking, as illustrated by an initiative with air traffic controllers in Cyprus, is to clearly present the cost-effectiveness argument of rehabilitation and prevention
- Spot checking high impact sectors (such as hospitals and schools), can only be effective when combined with comprehensive supportive action, and aligned with a broader culture to tackle alcohol;

- The wider cultural context interacts with company culture in defining the motivation for effective action - for example, a very low unemployment rate, and shortage of workers, can lead to a permissive company culture, in a bid to retain workers.
- In collaborations with multiple stakeholders, including academic institutions can be fruitful to produce national data and communicate findings in specific high-risk groups (e.g. about drink driving among students in Portugal, supported by the Alcohol Health Forum), raising public awareness
- It is important to encourage a level of self-reflection among key professionals regarding their drinking behaviour (e.g., among health professionals, teachers, in the hospitality sector), including teaching this as a part of accredited training courses.
-

*On new working conditions after COVID (teleworking, safety measures)*

- Telework (increasing since covid) means that alcohol use is harder to detect and prevent
- Telework provides more opportunities for unhealthy behaviours but also in some countries lunch times in the office were an occasion to drink with work colleagues, so for some people it might have reduced alcohol consumption. There is a lack of data on the habits of teleworkers or specific surveys.
- Telework changes working conditions and could produce mental health problems including addictions of the workers.
- Suggestions on what measures be implemented include
    - From the companies: a change in corporate culture towards a zero-tolerance policy, as with tobacco, especially in European context where alcohol is socially acceptable.
    - From public authorities and occupational medicine: Occupational health services to offer alcohol prevention and alcohol treatment resources.

**Wrap up from the session**

- Taking into account that the problem is complex: occupational health and public health must work together
- It is important to fight against stigma in general and in workplaces in particular to be able to implement effective prevention strategies. Embedding alcohol actions in both promotion of healthy lifestyles and promotion of mental health is key.
- When treating the alcohol problems, we should not separate work life from private life. It is a whole problem and family support could help workers a lot.
- Early detection of working conditions and factors that are affecting negative behaviours related to alcohol consumption is an effective form of prevention and could reduce the incidence of alcohol-related negative behaviours.
- Cultural, religious and linguistic diversity must be taken into account in the establishment of programmes
- Workplaces (including governmental workplaces and parliaments) should be totally alcohol-free.

- The main barriers include:
- The Lack of coordination or alignment between the main actors: Employers, workers and occupational health
    - The Lack of harmonisation across EU Member States regarding, roles and responsibility, testing and privacy
    - Stigma of addiction leading to a lack of conversations about alcohol problems
    - Cultural attitudes towards alcohol (that it is a private matter and an integral part of work events or the working schedule
    - Lack of reliable, comparable, and detailed data across work types (sector company size etc) to leverage adequate resources
    - It is important to increase resources aimed at reaching self-employed and also supporting prevention strategies in SME.

Mapping EU initiatives

## Best practices

**WIRUS (Workplace Interventions preventing Risky Use of alcohol and Sick leave)**[3] is a research project funded by the Norwegian Directorate of Health, with the goal to provide knowledge about alcohol consumption, develop workplace interventions and learn about its implementation barriers and facilitators and cost benefit and cost-effectiveness analysis of them. It includes a systematic literature review on sickness absence and alcohol consumption a Randomized control trials on alcohol interventions to evaluate alcohol consumption, sickness absence and presenteeism (60). It is focused on employees who are risky drinkers, i.e., employees who drink more than the World Health Organization (WHO) recommends, without having developed serious health consequences or alcohol addiction (secondary prevention).

**AKAN Advisory Centre** was created in Norway to prevent drug and alcohol abuse at workplaces. They guide companies to provide help to employees with a cooperation between the Confederation of Norwegian Trade Unions, the Confederation on Norwegian Enterprises and the state.

- They provide with interventions that revolve around three elements:
- Policy and guidelines for preventing and to deal with problems at workplace
- Early interventions, focus on prevention of problems.
- Individual Akan-contracts that are offered to employees that disclose an alcohol or drug problem, allowing them to maintain their occupation, treatment and follow-up.

**EMPOWER**[4]**: an eHealth Platform to Reduce the Impact of Mental Health Problems at the Workplace.** The objective of EMPOWER is to develop, pilot and evaluate a eHealth platform to promote health and wellbeing, to reduce the negative impact of mental health problems in the workplace. It is funded by the European Union's Horizon 2020

## Tools and Guidelines

The **European Workplace and Alcohol** (EWA) project co-funded by the European Commission had the aim of creating effective methods for raising awareness of the risks associated with alcohol consumption and to effect organizational change that results in a reduction in alcohol-related absenteeism and injuries. To achieve this, they developed and disseminated a workplace toolkit and guidelines for safer alcohol consumption among European employees. They also created a report on best practices with recommendations for policymakers at the EU, national, regional, and local levels.

Recommendations from the toolkit:

- have a comprehensive, written workplace alcohol policy
- where resources allow, adopt a comprehensive health-related alcohol program
- review working practices, leadership styles and other factors that can cause work-related stress and, potentially, lead to alcohol heavy drinking
- make workplaces "alcohol-free"

[3] https://presenter.no/en/wirus-information/
[4] https://empower-project.eu/empowered-while-working/empower-an-ehealth-platform-to-reduce-the-impact-of-mental-health-problems-at-the-workplace/

This toolkit is organized into three levels of intervention based on the elements introduced and the resources invested in by the organization: basic, intermediate, and comprehensive

**Online interactive Risk Assessment (OiRA) Tools**[5]

This is an initiative from Safety and health at work (EU-OSHA) that enable micro and small enterprises to carry out risk assessments. The tools are free to download and can be easily accessed by clicking on the relevant link. Each link is accompanied by a short description of the tool and the name of the OiRA partner who developed it. Tools can be searched by country, language and sector.

**EMCDDA Guidelines**[6]

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the reference point on drugs and drug addiction information in Europe. The first edition of the EMCDDA guidelines was published in 1998, and was updated in 2012, with the objective to help drug prevention and evaluation methodologies and to provide prevention practitioners with an up-to-date framework. The guidelines are a step-by-step for professionals to plan and evaluate prevention activities.

**SICAD Guidelines**[7]

Health and safety at work and prevention of the use of psychoactive substances: Guidelines for the "Action in the Workplace" by the SICAD, Portugal

Alcohol and drug related harm are health issues and must be addressed as any other physical or psychological condition. To address low professional performance, accidents, absenteeism, health risks... "Action in the workplace" has the goal to promote healthy lifestyles and reduce accidents to foster health and safety at work.

## European data on alcohol and workplace

**Eurofound report**

After researching the presence of alcohol and drugs in the working population, the European Foundation for the Improvement of Living and Working Conditions, published their report "*Use of alcohol and drugs at the workplace"*. This report contains a list of sources, national statistics and figures on the prevalence of alcohol/drug use at the workplace in the EU27 Member States and Norway.

The Eurofound report analysed how substance use is addressed in workplace legislation in Europe:

- National labour codes and worker statutes (Bulgaria, the Czech Republic, France, Latvia, Lithuania, and Spain)
- Specific mention of impairment in laws regarding health and safety at work (Austria, Estonia, Ireland, Luxembourg, Slovakia, Slovenia, and Sweden)

[5] https://osha.europa.eu/en/highlights/successfully-managing-psychosocial-risks-europes-micro-and-small-businesses
[6] https://www.emcdda.europa.eu/publications/manuals/prevention_update_en
[7] https://www.sicad.pt/BK/Intervencao/meio_laboral/Documents/summary_safety.pdf

- Collective agreements between 'social partners' such as labour unions (Belgium, Germany, and Denmark
- General laws on drug use with specific mention of the workplace (Italy, Poland, Slovakia, and Slovenia)."

Eurobarometer

Regarding alcohol and workplace, the European Commission has carried out several Special Eurobarometer on EU citizen's attitudes towards alcohol, the most recent being the Special Eurobarometer 331 from 2010. The report from the European Foundation for the Improvement of Living and Working Conditions surveyed representatives from all Member States and listed all available country surveys on alcohol prevalence.

European Survey of Enterprises on New and Emerging Risks (ESNER)

The ESNER shows that 'reluctance to speak openly about the issue' is one of the major obstacles to tackling psychosocial risks in the workplace. A policy or procedure adopted by the employer in collaboration with workers helps by providing a framework and systematic approach.

Thousands of businesses and organisations across Europe are asked to respond to a questionnaire that focuses on:

- General safety and health risks in the workplace and how they are managed
- Psychosocial risks, such as stress, bullying and harassment
- Drivers of and barriers to OSH management
- Worker participation in safety and health practices.

## Annex 1: Workshop agenda

**Session 1** (Thursday 12th May)**: Context and evidence for tackling alcohol in European workplaces**

| | | |
|---|---|---|
| 13:50 | Connection of participants | |
| 14:00 | Welcome and opening<br>- Welcome from the hosting Member State – Spain | Chairs: Manuel Cardoso / Toni Gual<br>- Ministry of Health of Spain |
| 14:10 | European context on the alcohol prevention in the workplace<br>- Frame of the EU-OSHA occupational health initiatives<br>- WHO Global Occupational Health Programme<br>- EMCDDA: mini-guide - responses to drugs in the workplace | <br>- William Cockburn, EU-OSHA<br>- Ivan Ivanov, WHO International<br>- Marica Ferri & Inês Hasselberg, EMCDDA |
| 14:35 | State of the art and best practices at European Level<br>- AlHaMBRA Project Review of workplace alcohol interventions<br>- Norway: Best practice examples:<br>o WIRUS – Preventing risky alcohol use and sick leave<br>o AKAN – Working with managers and employees<br>- EU & Catalonia: EWA and "*At work, alcohol + drugs 0,0*" | <br>- Gemma Rabal, ESADE, ES<br><br>- Randi Wågø Aas & Hildegunn Sagvaag, UIS, NO<br>- Camilla Lynne Bakkeng, AKAN, NO<br>- Joan Colom, Lidia Segura, ASPCAT, ES |
| 15:10 | Break | |
| 15:20 | Explain groupwork | Fleur Braddick |
| 15:25 | Discussion Groups: intersectoral priorities<br>1. Specific regulations (transport, education etc)<br>2. Intersectoral coordination (Labour/Health/Road Safety)<br>3. Coordination among health actors (occupational health/health system) | |
| 16:10 | Feedback from groups and wrap up | Toni Gual & Lidia Segura |
| 16:40 | Close session | |

**Session 2** (Tuesday 17th May)**: Coordination for alcohol prevention at work – perspective exchange to overcome barriers**

| | | |
|---|---|---|
| 13:50 | Connection of participants | |
| 14:00 | Welcome, introduction and summary of last day<br>- Welcome from the hosting Member State – Spain<br>- EU Network on Workplace Health Promotion | Chairs: Joan Colom & Toni Gual<br>- Joan Villalbí, Ministry of Health, ES<br>- Guiseppe Masanotti, ENWHP |
| 14:25 | Alcohol prevention at workplace: the main actors' perspectives:<br>- Occupational Health – medical specialists<br>- Employers – Business Europe<br>- Workers & Unions - ETUC | <br>- Alenka Škerjanc, UEMS Occ med<br>- Mario Van Mierlo, VNO-NCW, NL<br>- Ignacio Doreste / Claes-Mikael Ståhl, representing ETUC |
| 14:55 | Stakeholders' perspectives – coordination of prevention efforts<br>- Case study: Portuguese collaboration across departments<br>- EWDTS: Using alcohol testing to support effective practice | - Emília Telo, ACT, EU-OSHA focal point, PT<br>- Alberto Salomone, EWDTS |
| 15:15 | Break | |
| 15:25 | Explain groupwork | Fleur Braddick |
| 15:30 | Discussion Groups: overcoming barriers<br>1. The impact of working conditions and psychosocial risks on alcohol consumption at work<br>2. Increasing awareness of alcohol-related risk in the workplace<br>3. Embedding alcohol prevention in the workplace – from promotion/prevention to occupational health<br>4. Improving coordination to support workers through prevention, treatment and reintegration initiatives | |
| 16:10 | Feedback from groups | Toni Gual |
| 16:40 | Wrap up and close session | |

**Session 3** (Friday 20th May)**: Challenges in implementing alcohol prevention in work settings – moving towards EU recommendations**

| | | |
|---|---|---|
| 13:55 | Connection of participants | |
| 14:00 | Welcome, introduction and summary of last day<br>- Frame of the International Labour Organisation | Chair: Manuel Cardoso / Fleur Braddick<br>- Ana Catalina Ramírez, ILO HQ |
| 14:10 | Key implementation challenges – Promoting disclosure and health in different work contexts:<br>- EU project: MENTUPP – Alcohol and mental health in 13 EU MS<br>- Case study: EMPOWER - Better mental health, better workplaces, better work.<br>- Case study: PAIMM - Integral Care Program for Sick Physicians | <br><br>- Ella Arensman, UCC, IE<br>- Beatriz Olaya, SJD Research Inst, ES<br>- Mª Dolores Braquehais Conesa, Galatea Foundation, ES |
| 14:40 | Summarise & Explain groupwork | Fleur Braddick |
| 14:45 | Discussion Groups: Implementation challenges<br>1. Self-employed, small and medium companies<br>2. Large companies and multinationals<br>3. Risky, high-impact and sensitive work areas<br>4. New working conditions after COVID (teleworking, safety measures) | |
| 15:20 | Break | |
| 15:30 | Get together – feedback from the working groups | Chair: Lidia Segura |
| 16:00 | Roundtable of international institutions<br>Working together for better workplace alcohol prevention at the European level – building recommendations | Chair: Fleur Braddick<br>- Discussants: ILO, EU-OSHA, EMCDDA, UEMS, WHO ENWHP |
| 16:30 | Final comments and conclusions | Lidia Segura & Manuel Cardoso |
| 16:40 | Wrap up and close session | |

# Annex 2: Participation by session, country and sector

## Attendance by session

| **Post-workshop attendance statistics** | **S1 - 12th May** | **S2 - 17th May** | **S3 - 20th May** |
|---|---|---|---|
| **Speakers** | **8** | **4** | **9** |
| *Recorded only* | 2 | 3 | 0 |
| **Attendees** | **57** | **49** | **40** |
| | | | |
| **Organisers (including Chairs)** | **9** | **8** | **8** |
| *AlHaMBRA Project* | *7* | *6* | *6* |
| *External (cEvents)* | *2* | *2* | *2* |
| ***Total (incl. organisers)*** | ***74*** | ***61*** | ***57*** |

## Attendance by country/region represented

| EU27 | Attended |
|---|---|
| Austria | |
| Belgium | *6* |
| Bulgaria | *1* |
| Croatia | *3* |
| Cyprus | *2* |
| Czechia | *3* |
| Denmark | |
| Estonia | *1* |
| Finland | |
| France | *1* |
| Germany | *3* |
| Greece | *1* |
| Hungary | *1* |
| Ireland | *8* |
| Italy | *5* |
| Latvia | |
| Lithuania | |
| Luxembourg | |
| Malta | |
| Netherlands | *3* |
| Poland | *1* |
| Portugal | *19* |
| Romania | *2* |
| Slovakia | |
| Slovenia | *4* |
| Spain | *19* |
| Sweden | *1* |
| Total EU | **84** |

| Candidate countries | Attended |
|---|---|
| Albania | 1 |
| Montenegro | |
| North Macedonia | |
| Serbia | 1 |
| Turkey | |
| Total Candidate EU | **2** |

| Potential candidates | Attended |
|---|---|
| Bosnia and Herzegovina | *1* |
| Kosovo* | |
| Total potential EU | *1* |

| Other European countries | Attended |
|---|---|
| Andorra | |
| Iceland | 1 |
| Liechtenstein | |
| Monaco | |
| Norway | 1 |
| Russia | 1 |
| San Marino | |
| Switzerland | 1 |
| United Kingdom | 2 |
| Vatican City | |
| Total other European | **6** |

| European Neighbourhood Policy | Attended |
|---|---|
| Algeria | |
| Armenia | |
| Azerbaijan | |
| Belarus | |
| Egypt | |
| Georgia | 1 |
| Israel | |
| Jordan | |
| Lebanon | |
| Lybia | |
| Moldova | |
| Morocco | |
| Palestine | |
| Syria | |
| Tunisia | 2 |
| Ukraine | 1 |
| Total Neighbouring | **4** |

| Other intl. countries | Attended |
|---|---|
| United States | 2 |
| India | 2 |
| Brazil | 1 |
| Total other Intl. | **5** |
| **Total** | **102** |

## Attendance by sector

| Primary Sector | Attended | | |
|---|---|---|---|
| Public health agency/authority - EU Commission | 2 | | |
| Public administration agency/authority (not health) - EU Commission | 1 | | |
| Public health agency/authority - International experts | 3 | | |
| Public health agency/authority - WHO (PAHO) | 2 | | |
| Public health agency/authority - National | 21 | | |
| Public administration agency/authority (not health) - National | 2 | | |
| Public health agency/authority - Local-regional | 12 | | |
| Public health agency/authority (not health) - Local-regional | 3 | **Health** | **Non-health** |
| **Public administration total** | **46** | 40 | 6 |
| Academia-higher education (European) | 1 | | |
| Academia-higher education (international) | 2 | | |
| Academia-higher education (national) | | | |
| Academia-higher education (national) - non-health | 1 | | |
| Academia-higher education (regional/local) | | | |
| Academia-research (European) | 2 | | |
| Academia-research (European) - non-health | | | |
| Academia-research (international) | 1 | | |
| Academia-research (national) | 2 | **Health** | **Non-health** |
| **Academia Total** | **3** | 8 | 1 |
| Civil society - capacity building and advocacy (European) | | | |
| Civil society - capacity building and advocacy (international) | | | |
| Civil society - capacity building and advocacy (national) | | | |
| Civil society - NGO (European) | | | |
| Civil society - NGO (international) | 1 | | |
| Civil society - NGO (national) | 11 | **Health** | **Non-health** |
| **Civil Society Total** | **12** | 12 | 0 |
| Healthcare - research (international) | 1 | | |
| Healthcare - clinical practice (national) | 18 | | |
| Healthcare - research (national) | 11 | | |
| Healthcare - research (Local-regional) | 5 | | |
| Healthcare - research (Local-municipal) | | **Health** | **Non-health** |
| **Healthcare Total** | **35** | 35 | 0 |
| ***TOTAL excluding organisers*** | ***102*** | ***95*** | ***7*** |

## Annex 3: Results of workshop 6 evaluation

| | **Overall evaluation** (1=terrible → 10=excellent) | **Please indicate to what extent you agree with the following items:** (1=strongly disagree, 3=neutral, 5=strongly agree) | | |
|---|---|---|---|---|
| | **On a scale of 1-10, how would you rate the session overall?** **/10** | **The topics and aspects covered by the speakers were relevant for the overarching theme of the session** **/5** | **I learned actionable information for my work and/ or consolidated my understanding/ knowledge.** **/5** | **There was enough time and opportunities for interaction with the speakers and between participants.** **/5** |
| **Average score: Session 1 n=33** | 8.6 | 4.5 | 4.2 | 4.5 |
| **Average score: Session 2 n=22** | 8.7 | 4.4 | 4.2 | 4.5 |