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Contemporary Drug Problems

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# Abstract

High levels of wine, beer, and spirits consumption have historically characterized Slovenian drinking culture. The geographical location of the country provides an ideal environment for wine production, historical ties with the Austro-Hungarian Empire contribute to the tradition of beer drinking, and the custom of home distilling has resulted in a considerable level of spirits consumption. This combination of factors contributes to the high level and cultural acceptance of alcohol consumption in Slovenia. Alcohol-related harm in Slovenia was recognized as a problem as early as 1834, and since then Slovenian public health experts have implemented various programs and policies in an attempt to reduce alcohol-related harm and alcohol consumption in general. A report published by Slovenian public health experts and presented to the Slovenian Ministry of Health in the late 1990s showed that alcohol consumption and related harm were among the highest in the European region, and that there was a need for a policy to reduce consumption and alcohol-related harm in the country. This article outlines the events leading up to this policy. Although business interests and some politicians and public health experts opposed the policy, it was passed by the Slovenian National Assembly on January 28, 2003. Descriptive data revealing a subsequent decrease in the rate of registered alcohol consumption and in deaths due to liver disease, cirrhosis, and suicide may represent preliminary indicators of the effective implementation of the Act.

On many occasions throughout the 20th century, medical professionals and religous clergy have worked together with the local Slovenian government, as well as the federal Yugoslavian government, to implement measures that would curtail alcohol consumption among Slovenians. These measures included wine legislation, traffic safety education, and a ban on advertising alcoholic beverages, all with the goal to reduce harm caused by alcohol misuse. The first measure implemented in the 21st century, and the topic of this article, was created with the similar goal of reducing alcohol-related harm by limiting availability of alcohol products, especially among young people. Zakon o omejevanju porabe alkohola (ZOPA) (Act Restricting the Use of Alcohol) was approved by the Slovenian National Assembly (the lower house of the parliament of the Republic of Slovenia) on January 28, 2003. This Act is an example of international collaboration between local government, public health professionals, law enforcement, the economic sector, public media, the World Health Organization, and the European community. This article first contextualizes this law by discussing earlier legal measures aimed at reducing alcohol-related harm in Slovenia, then describes the arguments of supporters and opponents of the policy leading up to its enactment, and finally briefly examines the enforcement and effectiveness of the policy in reducing alcohol-related harm.

# Background

Slovenia is a small central European country with an historically high rate of alcohol consumption. With over 200 square kilometers of vineyards in three Slovenian wine growing regions, Slovenia is a supplier of top quality specialty wines. Meals in the country are often accompanied by a generous serving of Slovenian wine, the favorite national spirit (called "rakija" or "zganje), or the Slovenian beers "Lasko" and "Union."

The winemaking tradition in the Slovenian region dates back to at least the 1st century A.D., as Slovenia's geographical location provides an ideal climate for viticulture (Alkalaj, 1996). Podravje, Posavje and Primorje are the three wine growing regions of Slovenia. They are located in different parts of the country and as such have different microclimates, soil compositions, and viticultural traditions that contribute to the wide range of wines available (Preseren, 2003).

In addition to wine's ties to the culture, Slovenia's historical connections with the Austro-Hungarian Empire contribute to a tradition of beer brewing and heavy beer drinking in the country. With two different beer breweries in the small nation, one located in the town of Lasko and the other in Ljubljana, Slovenes do not have to look hard for their beer of choice. The Lasko brewery was established in 1825, while the Union brewery dates to 1864.

Aside from wine and beer, spirits are also commonly consumed in Slovenia. Rakija (or zganje) is the most common type of spirit in Slovenian houses, and it is often offered as a sign of hospitality. It is made of fermented fruit juices from apples, pears, plums, and sometimes grapes. Like in other South Slavic countries, rakija, and alcohol in general, is an important part of the culture and is often associated with many cultural rituals and festivals (Cebasek-Travnik, 2007). During funerals, for example, the family of the deceased person is obliged to offer zganje to every visitor (Lozar-Podlogar, n.d.).

Living in a small country that produces each of the three main forms of alcoholic beverages influences the degree to which alcohol consumption is socially accepted. Assessing the state of alcohol drinking and alcohol culture in Slovenia, where expansion of wine consumption as well as of other alcoholic beverages is a sort of national pride, scholars have noted that many factors influence social acceptability of alcohol consumption. Some of these factors include a social atmosphere in Slovenia where traditionally: 1. Alcoholic beverages were more accessible to youth relative to non-alcoholic beverages (especially fruit juices) since the former cost less; 2. Alcohol was sold in hospitality establishments from the time the establishments open (in some instances this is in early morning hours); 3. Prohibiting the sale of alcohol beverages to minors, intoxicated persons and drivers of motor vehicles was rarely practiced; 4. It was not uncommon for alcohol to be consumed at work; 5. Unrestricted private production and distillation of alcohol was often beyond the reach of sanitary and taxation control (see Nolimal & Premik, 1994).

The Slovenian population's low level of awareness of alcoholrelated harm continues to contribute to the positive cultural beliefs associated with drinking alcoholic beverages (Cebasek-Travnik, 2007). Therefore, it is not surprising that any effort to educate the public of alcohol-related harms may be unwelcome and that attempts to legislate alcohol policy will be protested and, if passed, possibly ignored.

This is the atmosphere that Dr. Zdenka Cebasek-Travnik encountered when she took on the responsibilities of becoming a national leader for the European Alcohol Action Plan (EAAP) in 1994. Through the EAAP, the World Health Organization (WHO) helped 43 Member States, which had agreed to participate, to create programs aimed at preventing the health risks and negative social consequences resulting from alcohol use (EUROCARE, n.d.). Committed to the possibility of alcohol-related harm prevention, Dr. CebasekTravnik followed the proposed WHO strategies and worked to bring the issue of alcohol-related harm to the forefront of national discourse in Slovenia. The effort led to a law passed by the Slovenian government in 2003 in an attempt to limit the use of alcohol and reduce alcohol-related harm.

## Historical struggle with alcohol consumption

In an effort to reduce the increasingly visible health and social consequences resulting from alcohol use, large temperance movements spread across many parts of Europe in the late 19th and early 20th centuries (Anderson & Baumberg, 2006). The temperance movement was quite strong in the land of the South Slavs and in the Republics of Serbia, Croatia, and Slovenia until at least the early 1930s (Bennett, 1992). The temperance movement in Yugoslavia was led by medical professionals who were concerned with public health and who relied mainly on primary prevention measures, such as restrictions on alcohol availability, and on educational programs designed to inspire abstinence or moderation in drinking. Most of these professionals were not interested in outright legal prohibition because they recognized not only the futility of such an effort but also the important role that alcohol played in the economy (Bennett, 1992).

The first treatment for alcoholics in Slovenia was proposed in 1834 by Dr. Franz Wilhelm Lippich (Cebasek-Travnik, 2007). Dr. Lippich was of Slovene origin and worked as "the doctor for the poor" in Ljubljana for over 11 years. He believed that alcoholism is a disease, the difficult treatment of which requires establishing institutions and health care center (Cebasek-Travnik & Slavec, 2006). He was also among the few of his contemporaries who used a scientific approach to examine the state of public health (Cebasek-Travnik & Slavec, 2006). While Dr. Lippich was not in favor of prohibition of alcoholic beverages, he did suggest a need to decrease alcohol production by one-third (Cebasek-Travnik & Slavec, 2006) in order to reduce some of the harmful effects resulting from alcohol use. In 1904, Roman Catholic clergy provided the initial organizational momentum for the Slovenian temperance movement, and the first organization against alcohol consumption, "Society for Sobriety," was founded in the country (Bennett, 1992). The first Slovenian wine legislation came into force in 1905 (Cebasek-Travnik, 2007).

After World War II, Slovenia experienced rapid growth in the number of motorized vehicles, and this so-called "motorization outburst" gave rise to an epidemic of road accidents, some of which were alcohol-related (Eksler, Heinrich, Gyurmati. Hollo. Bensa, Bolko & Krivec, 2005). In 1965 the Road Safety Department initiated the First Fundamental Road Safety Act, mandating traffic safety education and focusing mainly on educating school children (Eksler, et al., 2005). In 1990, Slovenian police began extensive blood alcohol testing of motor vehicle drivers, which still represents one of the most important measures for assuring traffic safety in Slovenia (Eksler, et al., 2005). The Road Safety Act of 1998 contained even more restrictive provisions for road users and required a 0.0% blood alcohol concentration for drivers of public transport, drivers transporting goods or people, professional drivers, and driving instructors (Eksler, et al., 2005; Sesok, 2004). Shortly after the new Road Safety Act was implemented, morbidity and mortality from traffic accidents significantly decreased (Eksler, et al., 2005; Mujkic & Rovan, 2003). In 1998, for example, there were 310 road traffic fatalities, representing a 13% reduction from the prior year (Mujkic & Rovan, 2003). Similarly, the number of traffic accidents with injuries in 1998 dropped by 16% relative to 1997. Despite a small increase in road traffic fatalities in 1998, the general decline continued in 2000 and 2001, though the number of traffic accidents with injuries increased substantially between 1998 and 2001 (Mujkic & Rovan, 2003).

In 1973, when Slovenia was still a part of Yugoslavia, the Yugoslavian government passed a ban on advertising of alcohol (Sluzbeni List SFRJ, 3/1974), which was also in effect for Slovenian public information media (Cebasek-Travnik, 2003). Article 36 of this law forbid advertisements of hard alcohol (and tobacco) products in print, on radio or television, in cinema, on billboards, in neon lights, on stickers, in books and magazines, and on clothing (Sluzbeni List SFRJ, 3/1974). In 1999, Slovenia was one of the few European countries that had a total ban on alcohol advertisement (Rehn, Room & Edwards, 2001). The total ban on advertising of alcohol products restricted the advertising of all alcoholic beverages (beer, table wine, and spirits) on all public information media (radio, television, print media, and billboards). Although advertising restrictions are the most common type of alcohol policy in most nations (Hilton & Johnstone, 1988), this ban made Slovenia one of the few European countries to enforce such broad restrictions on alcohol advertising (Rehn, Room & Edwards, 2001). More recently, however, Slovenia has relied on the Advertisement Code (Oglasevalski Kodeks) to regulate alcohol advertisements (Jovic, 2005). Article 21 of this Code forbids advertisements of alcoholic beverages that may have a positive message about the consumption of alcohol (i.e., the advertisement must not give an impression that alcohol consumption increases physical or psychological capabilities). In addition, the law forbids alcohol (and tobacco) advertisements that are aimed at youth that show youth consuming alcohol (and tobacco) products and it also forbids advertisements that stimulate consumption by showing youth heroes or other youth symbols with which youth may identify in association with the alcohol (and tobacco) products (Jovic, 2005). The Advertisement Code also limits the venues of alcohol-related advertising by banning such advertisements on programs aimed at youth via radio, television, billboards, print media, and in theaters (Jernej, n.d; Rehn, Room & Edwards, 2001). Currently, Slovenia has a total advertising ban on beer, wine, and spirits on billboard signs, partial restrictions on advertising beer and wine on national television, national radio, and print media, and a total ban on advertising spirits on national television, national radio, and print media (WHO, 2004).

In 1991, the Slovenian government set a goal of reducing alcohol consumption in the country by 25% by the year 2000 (Hovnik Kersmanc, n.d.). Since alcohol consumption in Slovenia oscillated between 12.9 and 9.2 liters of pure ethanol alcohol per capita from 1980 to 1996, and in 1997 was 1 1.77 liters per capita, some experts were skeptical about Slovenia's ability to realize this goal as it meant reducing consumption to 8.9 liters per capita by the year 2000 (see Hovnik- Kersmanc, n.d.). Although the Slovenian government's goal was not met, there was a reduction in consumption to 9.56 liters per capita in 2000 (WHO, 2007a).

## Alcohol-caused and alcohol-related harm in Slovenia: An indicator of a need for action

Reducing alcohol consumption and raising public awareness about harm caused by alcohol is especially important in the context of Slovenia, where consumption levels are high. Consumption began increasing during the mid-1980s, and in 1997 Slovenia had the highest level of alcohol consumption among its reference countries (i.e., Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, and Slovakia), at almost 1 2 liters of pure ethanol alcohol per person per year (WHO, 2001), or over 14 liters of pure ethanol alcohol per person older than 15 years (WHO, 2007a). According to official statistics in 1997, the average Slovenian citizen (including those younger than 15 years) consumed 0.74 liters of pure ethanol alcohol in the form of spirits per capita, 6 liters of pure ethanol alcohol in form of wine per capita, and 5 liters of pure ethanol alcohol in form of beer per capita (WHO, 2007a). In addition, unregistered alcohol use is also high in Slovenia, and according to experts it exceeds 5 liters of pure alcohol consumed per capita (Hovnik Kersmanc, n.d.). With such a high alcohol consumption rate it was necessary to implement measures to reduce the adverse health effects related to alcohol consumption, as well as the other social and economic consequences related to harmful and hazardous alcohol consumption (WHO, 2006c).

In Europe, harmful and hazardous alcohol consumption is one of the main causes of premature death and avoidable disease (WHO, 2006c). From the early 1980s, cirrhosis mortality rates in Eastern Europe surpassed those of Europe as a whole. Data suggest that in the East European population the increase in mortality rates observed in the 1980s will most likely continue in the future, as the generations born between 1940 and 1960 reach the age that puts them at a higher risk of death from cirrhosis (Corrao, 1998). In Slovenia, the Standardized Death Rate (SDR) for liver diseases and cirrhosis for all ages is one of the highest among the reference countries mentioned above and double the rate of the European Union (WHO, 2001). Before the implementation of the 2003 alcohol policy, for example, the SDR for liver diseases and cirrhosis for all ages in Slovenia in 2002 was 29.51 per 100,000. Among all causes of death, including but not limited to alcohol-caused and alcohol-related deaths, liver disease mortality and suicide mortality were respectively the fourth and fifth most frequent causes of deaths in Slovenia in 1994 (Hovnik Kersmanc & Cebasek Travnik, 1998). Liver disease and suicide mortality accounted for 3.6% and 3.4% of all deaths in Slovenia in 1994 (Hovnik Kersmanc & Cebasek Travnik, 1998). Among all the alcohol-related deaths in Slovenia in 2005, alcoholic liver cirrhosis was the most frequent single cause (in 62% of cases), followed by alcohol-related mental and behavioral disorders (24%), and alcoholic cardiomyopathy (10.0%) (Sesok, 2004; Sesok, Sedlak & Simoncic, 2006). The aggregate number of years per life lost (YPLL) due to alcohol-related premature deaths for 2005 was 4,025, or 12.3 YPLL per prematurely deceased person (Sesok, Sedlak & Simoncic, 2006). Further, while the number of suicides have decreased in the country in recent years, the suicide rate for Slovenia has been among the highest in the world for the last two decades, with over 30 suicides per 100,000 inhabitants per year (Albreht, Cesen, Hindle, Jakubowski, Kramberger, Petric, Premik & Toth, 2002). This is important since recent research has revealed a strong association between alcohol and suicide in other Eastern European nations (Pridemore, 2006; Pridemore & Chamlin, 2006).

The incidence of alcohol-related traffic accidents is another example of adverse health effects related to alcohol consumption. During the 1990s, the incidence of alcohol-related traffic accidents increased in Slovenia, while Hungary and Austria experienced a gradual decline in road traffic accidents that involved alcohol. For example, in 1990 Slovenia had 28 alcohol-related road traffic accidents per 100,000 inhabitants per year, while Hungary had 41 and Austria had 39. In 1994, the Slovenian alcohol-related road traffic accident rate was 66 per 100,000 inhabitants per year, while the rate in Hungary was 26 and in Austria 36 (WHO, 2007a). The number of alcohol-related traffic accidents in Slovenia peaked in 1997, with 89 alcoholrelated road traffic accidents per 100,000 inhabitants, and declined the following year to 64 per 100,000 (WHO, 2007a) following the implementation of the Road Safety Act of 1998.

In terms of economic harm attributable to hazardous alcohol consumption, the most important example is lost production. In Slovenia, in 2005 there were 190 instances of temporary absences from work directly attributable to alcohol use per 100,000 employed individuals, with most absences (82%) due to the consequences of mental and behavioral disorders caused by consumption of alcohol (Sesok, Sedlak & Simoncic, 2006). In 2004, the average Slovenian employee was absent for more than 13 days due to alcohol-related illness (WHO, 2007b).

# The Slovenian alcohol policy of 2003

Policies that control alcohol production, distribution, and consumption exist in nearly every nation (Mäkelä, Room, Single, Sulkenen, Walsh, et al., 1981). Widely varying strategies have been adopted by different societies in their attempt to control the consumption and effects of drinking alcoholic beverages. Nonetheless, common themes among most nations include a concern about drinking by young people and the goal to reduce harm caused by alcohol misuse (Crombie, Irvine, Elliott & Wallace, 2007). At the beginning of 2003, the Slovenian lower house of parliament approved a policy that would regulate alcohol consumption and limit the availability and use of alcohol by adults and youth alike. Even though alcohol-related harm was very high for Slovenia and the level of alcohol consumption was one of the highest in the European region (WHO, 2001), a segment of Slovene people opposed the enactment of this policy. On the other hand, the international community, namely the World Health Organization and the European community, worked together with Slovenian health experts and the local government to play a prominent role in assisting Slovenia to pass this law.

There are three general mechanisms that regulate alcohol markets and that can be employed in an attempt to alter consumption and reduce harm (Anderson & Baumberg, 2006). These include price and tax measures, restrictions on availability, and restrictions on advertising, promotion, and sponsorship (Anderson & Baumberg, 2006). Until recently, Slovenia did not have laws that limited alcohol consumption by youth, so health experts in Slovenia focused their efforts on restricting the availability of alcoholic beverages. Slovenia had already passed laws on advertising, promotion, and sponsorship in 2000. Increasing excise tax on alcohol products was not viewed as a long-term goal due to the addictive nature of alcohol (Anderson & Baumberg, 2006), even though evidence reveals that an increase in price results in reduced consumption (Cook & Moore, 2002).

On January 28, 2003, the National Assembly (the lower house of the parliament of the Republic of Slovenia, called Drzavni zbor) approved the Zakon o omejevanju porabe alkohola ("Act Restricting the Use of Alcohol"), which is also known by the name of ZOPA (Uradni list RS, st 15/2003). The Act is a country-specific example of a more general framework for alcohol policy in the WHO European Region, and it was the result of an eight year collaboration of Slovene public health experts and the World Health Organization. ZOPA includes measures for reducing alcohol consumption and for preventing alcoholrelated harm. Specifically, the Act established a minimum age limit of 18 years for drinking and purchasing alcoholic beverages (Zakon o omejevanju porabe alkohola, 2003; Sesok, 2004), and it limited when and where alcohol products can be purchased. For example, alcohol shops, grocery stores, and gas stations are prohibited from selling alcohol between the hours of 9 p.m. and 7 a.m., and the sale of alcohol products is absolutely prohibited in buildings where education and healthcare activities take place, regardless of the time (Zakon o omejevanju porabe alkohola, 2003). Additionally, pubs and other hospitality establishments are prohibited from selling distilled spirits from opening time until 10 a.m., and they are required to sell at least two different types of non-alcoholic drinks that have an equal or lower price than the cheapest alcoholic drink (Eksler et al., 2005; Zakon o omejevanju porabe alkohola, 2003; WHO, 2006b). The Act also imposes legal sanctions against individuals and establishments that sell alcohol beverages to persons who display obvious signs of alcohol intoxication (Zakon o omejevanju porabe alkohola, 2003).

Since this Act prohibits the purchase and consumption of alcohol by individuals who are younger than 18 years, and because this Act prohibits the sale of alcohol where youth congregate, many view this Act as being mainly aimed at youth (see Cebasek-Travnik, 2007, and Sesok, 2004). This is important, given that 47 percent of 15-16 year old Slovene students have reported instances of binge drinking (five drinks or more [four for women] on a single occasion) during the past 30 days (Bjarnason, Anderson, Choquet, Elekes, Morgan & Rapineh, 2003). However, while the ultimate goal of this Act is to reduce alcohol consumption among youth (STA, 2003), many experts hope the Act will also bring about a general change in attitudes toward drinking as people begin to learn about harm related to alcohol misuse (Cebasek-Travnik, 2007; SesOk, 2004). Thus, the impact of the Act should extend beyond youth to the entire Slovenian population. In the next two subsections, we name the key advocates and opponents in the debate that led up to the enactment of the law, and briefly summarize their arguments.

## Advocates of the alcohol policy

A survey of Slovene and Western news media reports suggests that the number of proponents of the 2003 alcohol policy in Slovenia was large. Among the key players in bringing about the alcohol policy were local actors interested in the health of the Slovene people and international organizations that offered support.

### *The Slovenian government*

The distinctive socio-economic and health effects of alcohol make governments responsible for promoting programs that regulate the misuse of alcohol and its harmful effects (Nolimal & Premik, 1994). Although many European countries lack systematic and clear alcohol policies, the existence of such policies at the national level are a necessary step toward establishing effective alcohol policy at other levels (Nolimal & Premik, 1994). While the overall responsibility for regulating alcohol is placed on the national government, a wide array of measures to reduce alcohol-related harm can be implemented in individual communities (Nolimal & Premik, 1994), especially because local community involvement is crucial in preventing or reducing alcohol-related harm (WHO, 2006a). Even at the time when Slovenia was a part of Yugoslavia, scholars who were writing on alcohol problems recognized that the implementation of alcohol policy depended on active and informed citizen support at the community level. Seen from this perspective, decisions about alcohol policies can be made at the lowest level of the goverment, where the role of the individual is supplemented by the role of the local community in shaping the policy outcome (Nolimal, 1989).

Although it took a few years for the local government to respond to the advice of public health experts regarding responsible alcohol use, Slovenian alcohol policy gained its momentum with the new government and the new Minister of Health, Dr. Dusan Keber (Cebasek-Travnik, 2003). As a former professor at the School of Medicine, Dr. Keber was interested in hearing what the national leader of the EAAP, Dr. Cebasek-Travnik, had to say about alcohol-related harm. The idea for a new alcohol policy was beginning to receive greater public support, especially after a report on public health in Slovenia showed evidence of the country's drinking problem. According to a report from 2001, per capita alcohol consumption had increased by more than one-fifth since the mid-1980s, Slovenia had the highest alcohol consumption among the reference countries in 1997, and the SDR for liver diseases and cirrhosis for all ages was one of the highest among the reference countries and double the Europena Union (EU) rate (WHO, 2001). Given the effectiveness of Gorbachev's antialcohol campaign in Russia in the mid-1980s in terms of reducing alcohol- related harm1 (Nemtsov, 1998; Nemtsov, 2005; Reitan, 2001), the new Minister of Health was interested in doing something similar in Slovenia.

### *Health care professionals and public health institutions*

Health care professionals and public health institutions are inherently interested in reducing alcohol-related harm given their respective roles in the provision of health care in society (WHO, 2006a). Moreover, health professionals have a respon- sibility to prevent alcohol-related problems, promote healthy lifestyles, raise the quality of living, emphasize prevention and early intervention, and provide medical treatment and health services that are available to everyone (Nolimal, 1989). The Slovenian Institute of Public Health was a strong supporter of a policy that would improve and protect public health, espe- cially since the most important activities of the Institute of Public Health consist of: 1. Implementing national programs of health promotion and illness prevention; 2. Collecting and analyzing data on the health of the population and health care services; 3. Preparing health policy documents and suggesting measures to improve and protect public health (Albreht, et al., 2002).

As in the past, especially at the beginning of the twentieth century, medical professionals took the lead in the attempt to reduce alcohol misuse by bringing issues related to the negative aspects of alcohol consumption to the forefront of public discourse and by educating the Slovenian people about the harmful aspects of alcohol consumption. In her interview with the Soncek magazine, for example, Dr. Cebasek-Travnik explained how society has a distorted picture of the effects of even small quantities of alcohol, provided examples of the physiological dangers of misuse, and discussed how alcohol use can easily become hazardous, especially since it is often consumed when people feel angry, sad, or under pressure. Dr. Cebasek-Travnik also provided examples in which alcohol consumption is less hazardous (e.g., when a healthy adult male drinks fewer than two drinks of alcohol per day on average and no more than five drinks on any one occassion; and when a healthy adult woman who is not pregnant, not planning on being pregnant, and not breastfeeding, drinks no more than than one drink per day on average and no more than three drinks on any one occassion), and pointed out that the typical drink on which this information is based contains 10 grams of ethyl-alcohol, which is the amount contained in 100 grams of wine, 0.5 liters of beer, or 33 grams of spirits (for more information about the interview see Gavez, 2003).

### *Civil society*

The participation of civil society is essential in preventing, treating, and reducing alcohol-related problems (WHO, 2006a). Organized civil society groups such as Non- Governmental Organizations (NGOs) can play an important advocacy role to ensure that Member States develop and implement effective alcohol policies (WHO, 2006a). EURO- CARE, a European alliance of nongovernmental organizations advocating the prevention of alcohol-related harm in Europe (WHO, 2006a), together with other NGOs in Slovenia (some of which are supported by the Ministry of Health) have estab- lished many nationwide programs that target young people (WHO, 2006b) and are active in their attempt to bring the issue of alcohol-related harm to the forefront (Rehn, Room & Edwards, 2001; WHO, 2006b). One of the most influential NGOs in Slovenia is Z glavo na zabavo (meaning "Mindful partying"), which organizes responsible public activities for youth (Cebasek-Travnik, 2003). Similarly, the NGO "Be smart, don't drink" organizes alcohol-free concerts, parties, and other social gatherings for youth and is said to be very successful (WHO, 2006b). Another NGO, "A message in the bottle," actively includes young people in implementing nationwide programs that target youth (WHO, 2006b). The activity is cofinanced by the Ministry of Health and encourages youth to engage other young people in youth-organized and alcohol-free events, exhibitions, and workshops. These activities are often covered by broadcast media (WHO, 2006b).

### *Law enforcement*

On the local level, law enforcement agencies were also strong advocates for the alcohol policy, as such a policy was expected to reduce the number of alcohol-related crimes and to increase traffic safety (STA, 2003). Law enforcement also supported the policy because of the anti-social effect alcohol misuse has on public order and peace (see Sesok, Sedlak, & Simoncic, 2006).

### *Economic sector*

Many private companies and public sector employers were supporters of the policy because of the extremely high number of working days lost due to alcohol-related sickness or accidents in the country (Gaube, 2003b). Alcohol-related absenteeism and drinking during working hours negatively influence work performance, which then influences competitiveness and productivity (WHO, 2006c). Empirical studies elsewhere have shown that higher quantity of drinking per average drinking day is a major barrier both to being employed and to remaining in full employment (Booth & Feng, 2002).

### *Public media*

Although it is suggested that communication, and particularly popular communication, is often ignored and cannot signifi- cantly contribute to public health discourse (WHO, 2006a), Slovenian media helped carry the message about the need for alcohol policy. At first journalists were not interested in alcohol issues, but many eventually aided in raising public awareness of alcohol-related harm (Cebasek-Travnik, 2003). In addition, some Slovenian movie directors also voiced their views on alcohol policy and related them to the public via film plots that negatively portrayed the impact of alcoholism on families (Abbott, 2003).

### *The World Health Organization*

While local organizations are vital for successful implementation of alcohol policy, international support is also important. The World Health Organization Regional Office for Europe provides leadership for action on alcohol issues at the international level across the region, including technical and other support for national plans and actions (WHO, 2006b). It also supports all countries in the region in:

1. Developing and sustaining their own health policies, systems, and programs

2. Preventing and overcoming threats to health

3. Preparing for future health challenges

4. Advocating and implementing public health activities (WHO, 2006a).

The World Health Organization has been working on issues of alcohol-related problems since 1983, when the World Health Assembly declared that problems related to alcohol consumption were among the world's major public health challenges (Crombie, et al., 2007). When Slovenia became a member of the European Alcohol Action Plan in 1994, the World Health Organization (through its Regional Office for Europe) provided Slovenia with a framework that would guide the efforts toward realization of the alcohol policy that was finally enacted in 2003. The framework for alcohol policy provided Slovenia with guiding principles and policy goals (e.g., to reduce alcohol consumption to 6 liters per capita by the year 2015), encouraged common understanding of the need to reduce or prevent alcohol-related harm, and provided a rationale and ongoing guidance for continuous review of policies and programs at the local, national, and international levels (WHO, 2006a).

### *The European community*

As stated in Article 152 of the European Commission (EC) Treaty (WHO, 2006c), the European Union has the responsibility to address public health problems, including harmful alcohol use, by complementing national actions (WHO, 2006c). Other international and intergovernmental organizations, such as the European Commission, the Council of Europe, the World Bank, and others, also provide a multilateral platform to prevent or reduce alcohol-related harm in Europe (WHO, 2006a). Together, all these organizations work with local counterparts in Slovenia, including NGOs and public health experts, to encourage active learning methods that discourage adolescents to start experimenting with harmful alcohol consumption (WHO, 2006a). For example, in 2004 the Slovenian Ministry of Health launched a media campaign "Drink or live" that is organized around educational messages aimed at drinking and driving (WHO, 2006b). In addition, the EU funded a project in 2002 to support the European Charter on Alcohol and the European Action Plan of the World Health Organization (European Commission, 2002). This project provided health care professionals in member states, including Slovenia (a candidate for EU membership in 2002), with the necessary instruments to promote health interventions for hazardous and harmful alcohol consumption (European Commission, 2002).

## Opponents of the alcohol policy

Proposed alcohol policy measures must also be acceptable to the general population and other interests (Crombie, et al., 2007). Slovenians have historically been opposed to restrictive alcohol policies for several reasons, including resistance from rural dwellers who wanted to produce rakija without paying taxes (Bennett, 1992). The most severe criticism against the 2003 alcohol policy, though, came from the alcohol and catering industries (Cebasek-Travnik, 2007, 2003; Vrecar, 2003), who were concerned with the impact that such a law would have on their profit.

### *The alcohol industry*

The alcohol industry and associated businesses have an important role in ensuring that the production, distribution, promotion, and retail of alcoholic beverages meets the highest standards of business ethics (WHO, 2006a). On the other hand, public health policies regarding alcohol need to be formulated without interference from commercial interests (WHO, 2006a). However, public concern about alcohol-related harm is part of cultural norms and as such is affected by private interests and government regulation (Cook & Moore, 2002).

Many former Soviet countries, especially the Slavic nations, have cultural traditions and drinking patterns that favor high levels of alcohol consumption, and thus present a large market potential for alcohol beverage industries (Simpura, 1995). Therefore, the alcohol industry seeks to influence public opinion and the design of alcohol policy by opposing policies that advocate price increases of alcohol products, reduce access to alcohol, or place controls on the marketing of such products. International trade agreements also constrain alcohol control measures at the national level (Crombie, et al., 2007). In 2001, while the Act on alcohol was still in draft form within the Slovenian Ministry of Health, the chairman of a retailers' association announced on behalf of the association that the Act was unconstitutional because it would ban the sale of alcohol beverages at gas stations, and thus would introduce discrimination between economic entities (STA, 2001). Such legal restriction would only cause more problems, opponents claimed, by introducing the sale of prohibited products "under-the-counter" (STA, 2001).

Trade agreements, common markets, and increased globalization have also increased the difficulty of maintaining effective alcohol policies at the national level (WHO, 2006a). For example, the General Agreement on Trade and Services (GATS) allows governments to regulate the supply of alcohol as long as the regulation is not discriminatory against foreign goods (WHO, 2002). In 2004 Slovenia was able to exempt alcohol restrictions from advertising committments under GATS (Anderson & Baumberg, 2006). For all these reasons, state measures that control alcohol production, distribution, and trade are not welcomed by the alcohol beverage industry. As Simpura (1995) suggested, a delicate balance between fiscal, public order, and health policy interests must be maintained when considering state involvement in the control of alcohol trade and production.

### *Some politicians*

Some politicians, mainly from the Slovenian People's Party and the Slovenian Nationalist Party, strongly opposed the alcohol policy. Their main arguments stemmed either from the specific definitions used in the wording of the policy that made the articles of the law mutually inconsistent (e.g., Article 7 of the Act referred to "alcoholic beverages," while Article 15 referred to "alcohol beverages, or beverages to which alcohol was added"), or from their suspicion of the overall goal of the policy. Concerning the latter, Article 9 of the Act prohibits the sale of alcohol to individuals who may be reasonably assumed to be purchasing alcohol for those who are younger than 18 years or for those who are clearly intoxicated. A politician, Branko Kelemina, stated that it was practically impossible to know if a customer is buying alcohol for someone younger than 1 8 or for persons who are already intoxicated.

During the meeting of the National Assembly of Republic of Slovenia at which the law was passed, Zmago Jelincic, the head of the Slovenian Nationalist Party, announced that it made no sense to waste time discussing specific articles of the law, or the law in general, because he believed that such a prohibitionist alcohol policy would create more harm than good. It would, he said, give rise to black market production and thus increase overall alcohol consumption and negatively affect public health and safety, all while also hurting the Slovenian economy, citizens, and culture (Gaube, 2003a; DZRS, 2003). Jelincic's fears were not unreasonable given the history of home-made spirits elsewhere. In Russia, for example, Gorbachev's anti-alcohol campaign in the mid-1980s resulted in an increase in illegally distilled spirits (Nemtsov, 1998; Swiatkiewicz, 1997), while in Poland the rationing system became associated with the production of "moonshine" and the black market for alcohol coupons (Moskalewicz & Simpura, 2000). Even though the estimated alcohol consumption per capita in Russia, including registered and unregistered alcohol, was lower in 1990 than it was in 1984, the total unregistered alcohol production per capita had doubled in some Russian regions compared to the levels of unregistered alcohol production per capita in 1984 (Nemtsov, 2000). Also, empirical studies have found evidence that the low quality of homemade spirits have an impact on the high level of alcohol-related morbidity and mortality in central and Eastern Europe (McKee, Suzcs, Sarvary, Adany, Kiryanov, Saburova, et al., 2005; Szucs, Sarvary, McKee & Adany, 2005). Politicians like Jelincic and others focused on these issues in their arguments against the Act.

### *Some health experts*

Some public health experts in Slovenia disagreed with the alco- hoi legislation because they believed that the law would not be effective in reducing alcohol-related harm (Vrecar, 2003). They argued that while a wide range of interventions (from total pro- hibition to gradual restriction) had been carried out in many nations, none were truly successful (Vrecar, 2003). For exam- ple, Dr. Janez Rugelj, a controversial Slovene psychiatrist, commented that in reality the law was simply ". . . putting sand in the eyes of humanity" since the law did not propose a universal approach to health, such as reeducation and rehabili- tation of alcohol dependents and their families, but instead only resulted in a partial prohibition that the state would enforce via a repressive apparatus (Kojic, n.d.). Those like Rugelj, then, argued that alcohol consumption in Slovenia is a cultural ques- tion, a question of collective identity, and thus asking why Slovenes drink is not a concern for only the Health Ministry, but for all Ministries and for society (Vrecar, 2003).

### *Others*

Many Slovenian students saw this alcohol legislation to be an infringement on their personal liberty (Abbott, 2003). Since the law is aimed at reducing alcohol consumption by those younger than 18 years of age, education of youth about the harmful effects of alcohol is very important for successful enforcement of the law. However, this group of individuals is most likely to resent any actions aimed at limiting their behavioral patterns, and as such they are likely to see the alcohol law in Slovenia as a draconian piece of legislation (Abbott, 2003). Others claimed that adolescents may think of alcohol use as a mechanism for early transition into adult social roles via adoption of adult behavioral patterns, and therefore imposing behavioral rules on adolescents that are different than the rules to which adults adhere will likely be counterproductive and will produce more frequent and heavy alcohol use among adolescents (Bjarnason, et al. , 2003).

# The outcome

Dr. Dusan Keber, the Slovenian Minister of Health, first introduced the Act in draft form to the National Assembly on September 23, 2002. After four months of discussion over five different proceedings by Slovenian politicians and advocates for both sides in the Slovenian National Assembly, the Act was finally passed on January 28, 2003, with 37 votes in support of the Act and 12 votes against it (STA, 2001). It was enacted on March 16, 2003. Strong opposition, especially among some politicians, continues.

## Enforcement and effectiveness

The process of globalization, and specifically the growth of trade agreements and common markets in the European Union, has affected governments' ability to use some of the most effective tools to prevent and reduce alcohol-related problems that are specific to their own cultures (WHO, 2006a). During the national government's attempts to reduce alcohol production and consumption in Poland in the 1980s, for example, international businessmen took advantage of the shortage in alcohol supply by illegally selling their own products and smuggling these products to Polish consumers (Moskalewicz, 2000). Given the difficulty of maintaining effective alcohol policies at the national level, larger concerted action at the regional level will be necessary to address the problems of alcohol-related harm (WHO, 2006a). Regional and global solutions to the problems of alcohol must be explored, and Member States of the WHO European Region should acknowledge other countries' laws and regulations aimed at preventing and reducing alcohol-related harm (WHO, 2006a).

Following the approval of the Slovenian alcohol policy of 2003, there was a concern in Slovenia that in spite of having the law on the books, enforcement would be ineffective due mainly to two obstacles: the lack of law enforcement inspectors and lengthy judicial procedures (Cebasek-Travnik, 2007). However, public health research shows that the policies that are effective in reducing alcohol-related harm are those policies that foster a supportive environment in which individuals are enabled to make healthy choices (Anderson & Baumberg, 2006). In other words, alcohol control measures can be effective only to the extent that they influence consumers' decisions about drinking (Cook & Moore, 2002), and thus are not necessarily dependent upon repressive measures. Such social change, which requires the inclusion of different social strategies in order to change the alcohol consuming behavior of the entire society, brings about an environment that is conducive to making healthy choices and behaviors (Nolimal, 1989). In this context, the two obstacles mentioned above may not be as important as once thought if educating people about establishing healthy lifestyle habits is successful. As such, an alcohol policy that both limits access to alcohol and raises public awareness about the harmful effects of alcohol consumption will be more likely to succeed.

An extensive search of Slovene and Western news media, academic publications, and World Health Organization documents was undertaken by the authors to identify discussions of the alcohol policy's effects since its implementation in 2003. Little of substance was found, though the World Health Organization did have something to say about the policy. In 2006, WHO and the Commission of the European Communities published a report on implementation of the European Council Recommendation on drinking of alcohol by young people in the WHO European Region Member States. The Recommendation urged Member States to develop efforts that would effectively control promotion, marketing, and retail of alcoholic beverages (WHO, 2006b). The Report pointed to Slovenia as an example of successful implementation of the recommendations of the European Council regarding the development of programs that would limit alcohol consumption and reduce harmful effects of alcohol consumption (WHO, 2006b). Beyond this, some preliminary evidence suggests the policy is working. For example, in 2003 registered alcohol consumption in Slovenia was 1 1 .7 liters per adult (older than 1 5 years) inhabitant (Sesok, Sedlak & Simoncic, 2006). In 2005, however, the registered alcohol consumption had dropped 12% to 10.3 liters per adult inhabitant (Sesok, Sedlak & Simoncic, 2006). In 2002, the SDR for liver diseases and cirrhosis for all ages in Slovenia was 29.5 per 100,000, while in 2005 it had dropped almost 26% to 21.9 (WHO, n.d.). In 2005, the SDR per 100,000 inhabitants for suicide and self-inflicted injury in Slovenia was 22, a reduction of 10% from 2002 when the SDR for suicide was 24.5 (WHO, 2007b). In 2005, there were 3,235 alcohol-related traffic accidents (Sesokk, Sedlak & Simoncic, 2006), a 12% decrease from the 3,691 alcohol-related traffic accidents in 2002. Finally, in 2005 the average Slovene employee was absent from work due to illness for 12.5 days per year, an 11% decrease from 2002 when the average employee was absent from work due to illness for 14 days per year (WHO, n.d.).

While interesting, these preliminary descriptive data are not enough. Formal empirical studies that examine the effects of this policy on alcohol-related harm are necessary in order to understand the impact that this policy may have on public health in Slovenia. This is especially important in a country that has a long tradition of alcohol production, where health awareness in terms of alcohol use is low, and where there are strong cultural beliefs in the positive health effects of alcohol consumption (Cebasek-Travnik, 2007).

# Conclusion

The Slovenian alcohol policy of 2003 was the product of eight years work by public health experts, the international community, and civil society. This policy was especially difficult to legislate because of the history and importance of alcohol in Slovene culture. Nonetheless, Dr. Zdenka Cebasek-Travnik and the Slovene Minister of Health, Dr. Dusan Keber, had the support of the larger international community, such as the European Council and the World Health Organization, in drafting and implementing the policy in an attempt to protect public safety and public health, as well as raise awareness of alcohol-related harm. The next step for scholars is to undertake rigorous analyses of the effects of this alcohol policy in order to understand its impact and to judge the efficacy of the ongoing efforts to raise public awareness about the harmful effects of alcohol consumption and to change the drinking culture of the Slovene people.

# Footnote

Note 1. In 1985. Mikhail Gorbachev approved a resolution to begin an anti- alcohol campaign in the Soviet Union in order to begin addressing a range of social and economic problems confronting Soviet society at the time (Nemtsov, 1998). Although there is a disagreement among scholars as to the success of Gorbachev's campaign (Reitan, 2001), the decrease in sales of alcoholic beverages by the Soviet State did have an influence on the decline in rates of alcohol-related harm and, consequently, on the increase of life expectancy among males by 3 years (Nemtsov. 1998; Nemtsov, 2005). Nemtsov (2002) estimates that more than one million lives were saved in Russia alone as a result of the anti-alcohol campaign (Nemtsov. 2002). In 1987, however, the Soviet government abolished its efforts at curbing alcohol consumption, largely so the state could recoup economic losses via production and taxation and thus boost economic profits generated through sales of alcohol beverages. Although such economic interests are often an important determinant of policies and can be seen as barriers to public health initiatives (WHO, 2006a), the Slovenian government does not collect excise tax on wine in order to encourage wine production and consumption (Cebasek-Travnik. 2007). However, the Slovenian government does collect 6.86 EUR per hectoliter of beer and 6.95 EUR per hectoliter of ethyl alcohol (Republic of Slovenia Ministry of Finance, 2007).

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