producers and marketers of unhealthy commodities to ‘directly lobby’ the public.

OP94 HOW DOES THE ALCOHOL INDUSTRY DEFINE “RESPONSIBLE DRINKING”? A QUALITATIVE ANALYSIS

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Background Alcohol is the third largest risk factor for disease burden worldwide, after hypertension and tobacco use. Although there is an extensive evidence base on the most effective interventions to reduce alcohol harms at a population level (through targeting marketing, availability and price), the main focus of alcohol industry initiatives has been on providing information and education. “Responsible drinking” messaging (e.g. “Drink [product] Responsibly”) which frequently appears on product labels and adverts is a central element of such corporate social responsibility (CSR) activities. It has been argued that such messaging is vague, and potentially part of broader CSR activities to protect industry interests at the expense of public health. This study aimed to identify how industry defines responsible drinking, and in what contexts it is used.

Methods Qualitative documentary analysis A document search was carried out to identify publicly available documents (annual reports, shareholder communications, press releases and website content), published or available between January 2014 and July 2016, from two representative multinational alcohol producers (Diageo and AB InBev), Diageo’s DrinkIQ website, the Portman Group, the International Alliance for Responsible Drinking, the International Centre for Alcohol Policy or ICAP, and the DrinkAware Trust (all organisations funded by alcohol producers). These were compared to alcohol-related documents from Public Health England, WHO, Alcohol Concern and Addaction during this period.

Coding was performed iteratively using NVivo 11 (version 11.2.2), and analysed using the hermeneutic approach, which involves reading and understanding meanings of individual texts, identifying sub-themes or ‘codes’, identifying thematic clusters of codes, triangulation between sources, checking reliability/validity, and illustrative use of representative case material.

Results In total, 321 documents were evaluated, of which 101 referred to responsible drinking and were therefore included in the analysis.

The term “responsible drinking” was used almost exclusively by industry or industry-funded organisations. Responsible drinking was not clearly defined with relation to any particular level of alcohol consumption, and government alcohol guidelines were rarely referenced. Long-term health harms (such as non-communicable diseases) were not mentioned in association with responsible drinking. Instead, responsible drinking was typically linked to behaviours (such as underage drinking).

Conclusion Responsible drinking is a strategically ambiguous, industry-affiliated term allowing multiple interpretations. Industry sources rarely reference government drinking guidelines in the context of responsible drinking, instead stressing individual responsibility and risk management. Public health practitioners should be aware of these distinctions, and the industry

framing of ‘responsible’ drinking, and use clear language regarding lower-risk drinking.

OP95 QUANTIFYING THE POTENTIAL US HEALTH AND ECONOMIC EFFECTS OF THE FDA VOLUNTARY SALT REFORMULATION PROPOSAL

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Background Salt consumption is a major modifiable risk factor for cardiovascular disease (CVD), the leading cause of mortality and morbidity in the US. Voluntary reformulation policies targeting salt have been deployed in several countries with varying effectiveness—high in Finland and the UK, low in Australia. The US Food and Drug Administration (FDA) has proposed voluntary salt reduction goals targeting processed and commercially prepared foods. We aim to quantify the potential CVD and economic impact of the FDA reformulation policy.

Methods We extended the previously validated US IMPACT Food Policy Model. We then estimated the CVD cases averted, Quality Adjusted Life Years (QALYs) generated and cost-effectiveness from 2017–2036 of the proposed FDA reformulation policy. We used datasets including the National Health and Nutrition Examination Survey, cost information from the National Sodium Reduction Initiative and meta-analysis for salt consumption effects upon blood pressure and CVD.

Costs included government costs to administer and monitor the policy and industry reformulation costs, under the assumption that estimated 75% of food products would be applicable for the salt reduction targets. Savings included healthcare and productivity costs. All costs were inflated to 2017 dollars and outputs were discounted at 3%.

We modelled the 10 year reformulation targets under 2 scenarios: a) Full industry compliance in all applicable food groups b) 50% compliance in applicable food groups

We then conducted a rigorous probabilistic sensitivity analysis.

Results Achieving the salt reduction targets under a full compliance scenario could prevent approximately 516,000 CVD cases (95% uncertainty intervals 300,000–752,000) and gain some 2.7 (2.4–3.1) million discounted QALYs between 2017 and 2036. The policy could produce discounted cost savings of approximately \$62bn (\$35.3bn–\$86.2bn), with total net costs of approximately +\$15.7bn (policy), \$37.6bn (healthcare), and \$41.3bn (indirect costs) over the same period.

Under the 50% compliance scenario, health gains would be approximately half as large, approximately 1.4 (1.3–1.7) million QALYs with discounted savings of \$33bn (\$19.4bn–45.9bn).

From a societal cost perspective, both scenarios would have an 80% chance of being cost effective after 4 years (Willingness to pay of \$50,000/QALY) and cost saving after 10 years.

Discussion Achieving the FDA salt reduction targets in processed foods could generate substantial health gains and cost savings in the US, assuming industry compliance. Policy makers should therefore focus on encouraging high compliance by

industry to ensure that the powerful effects of salt reformulation are realised.

OP96

YOUNG PEOPLE'S EXPERIENCES OF NON-BROADCAST ADVERTISING OF UNHEALTHY FOOD

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Background Critics argue that regulation of non-broadcast advertising for foods high in fat, sugar and salt (HFSS) offers less protection to children than regulation of broadcast advertising. This is concerning as viewing habits now exist across a range of media platforms. There is a lack of research engaging with young people about the shifting nature of advertising for foods HFSS, particularly those aged 12–15 as they are often not included in industry self-regulatory initiatives. The study aims were to identify: 1) where young people experience advertising for foods HFSS; 2) their perceptions of this form of advertising; 3) the ways in which they believe they are influenced by this advertising.

Methods We interviewed 65 UK 12–15 year olds in 15 focus groups. Participants were recruited using snowball sampling techniques from initial local adult contacts. Potential participants were provided with a study summary sheet, and those who agreed to participate were asked to recruit a group of friends to take part in a discussion. Participants were drawn from a range of social backgrounds. Groups were held within participant's homes or within the University. All focus groups were audio-recorded. Topics included leisure time, viewing habits, and the perceived impact of advertising. Young people were shown a range of broadcast and non-broadcast advertising to stimulate discussion. Interview transcripts were analysed thematically.

Results Young people reported that they rarely watched live television, and instead engaged in leisure activities that included watching programming via subscription services, and watching and socialising on digital platforms (such as video websites and social media). They recalled seeing extensive advertising for foods HFSS in non-broadcast media, both on- and offline. Participants reported scepticism and mistrust towards the healthfulness of many advertised foods. Nonetheless they believed they were influenced to purchase foods HFSS based on emotive techniques, such as togetherness, and were attracted to high quality advertising campaigns that made use of various techniques such as music, colour and humour.

Conclusion Young people encounter advertising of foods HFSS across a wide range of non-broadcast media. It both attracts and frustrates them. Many young people believed advertising influenced their purchasing of food and drink. Regulation of non-broadcast advertising for foods HFSS must be updated to reflect these new and diverse viewing practices.

Cardiovascular disease

OP97

THE BURDEN OF HYPERTENSION AND ITS ASSOCIATED FACTORS IN THE GAMBIA: DATA FROM A NATIONAL HEALTH EXAMINATION SURVEY USING THE WORLD HEALTH ORGANISATION (WHO) STEPWISE APPROACH

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Background Non-communicable diseases are increasing in sub-Saharan Africa (SSA). They are estimated to account for 32% of deaths in The Gambia according to the WHO. Worldwide, prevalence of hypertension is highest in the African region (46%) and a very high proportion is undiagnosed. There is very limited up-to-date information on the burden of diagnosed and undiagnosed hypertension and associated risk factors in The Gambia. This study aims to examine cardiovascular risk factors in in The Gambia adult population, with a particular focus on diagnosed and undiagnosed hypertension.

Methods Data was collected from a random, nationally-representative sample of 4111 participants aged 25–64 years (78% response rate) in 2010 using the WHO STEPwise survey methods. Analysis was restricted to non-pregnant participants with three valid blood pressure (BP) measurements ($n=3573$). All analysis were weighted and adjusted for complex survey design using STATA14. The mean of the second and third BP measurements was used in the analysis. Hypertension was categorised into measured (SBP ≥ 140 mmHg and/or DBP ≥ 90 mmHg) and total (SBP ≥ 140 mmHg and/or DBP ≥ 90 mmHg and/or self-reported hypertension). Among people with total hypertension, we also looked at undiagnosed hypertension (proportion of participants with hypertension not aware of their status). Univariate and multivariate regression models were run to identify the most important factors associated with hypertension including sex, age, rural/urban residence, socioeconomic and anthropometric factors. Smoking status and fruit and vegetable intake were additional covariates.

Results One third of adults were hypertensive; this was higher in rural regions (40%, $p<0.001$). Multivariate analysis revealed increased odds of total hypertension among the overweight/obese and rural residents. Abdominal obesity (OR1.8 [95% CI, 1.2–2.7]), rural residence (3.0 [1.6–5.5]), and age were the most important predictors among men while in women it was generalised obesity (2.4 [1.6–3.7]), rural residence (2.5 [1.4–4.5]), and age. More than three-quarters of hypertensive participants were undiagnosed: this was higher among males (86% vs 71%, $p<0.001$). Men (3.1 [1.7–5.6]) and participants aged 25–34 years (4.8 [1.4–3.5]) had higher odds of undiagnosed hypertension after adjusting for other factors. However, obesity was protective for undiagnosed hypertension (0.4 [0.2–0.6]).