PAHO Webex seminar

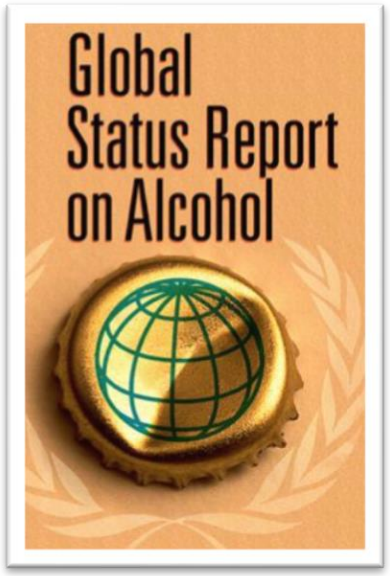
Global status report on alcohol and health

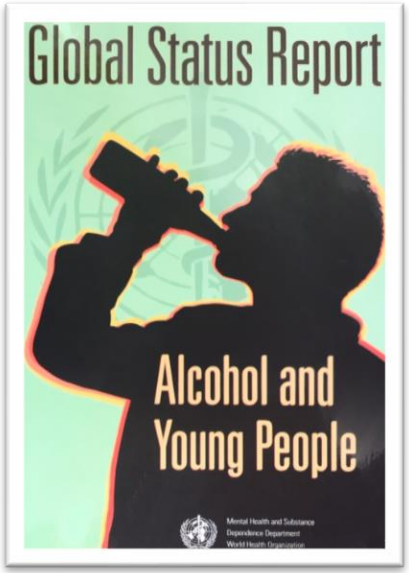
Mr Dag Rekve, Senior technical officer

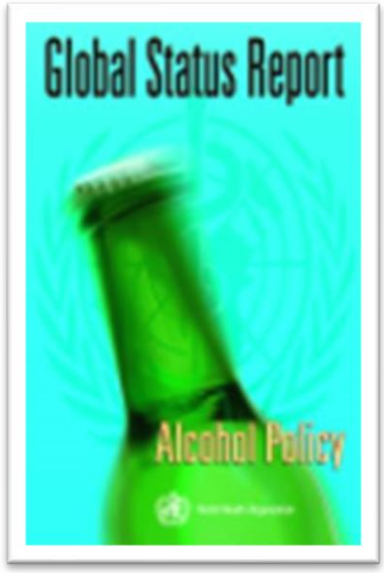
13 March 2019

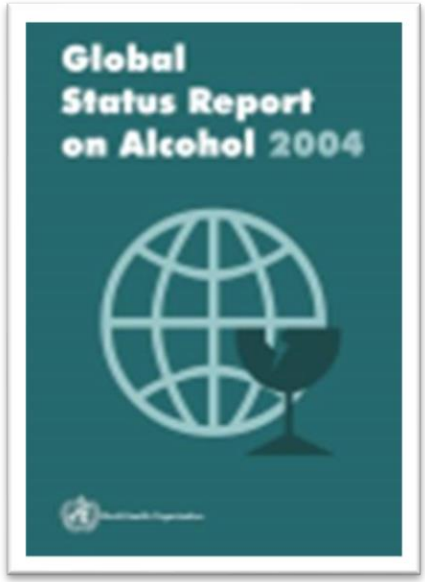
World Health Organization

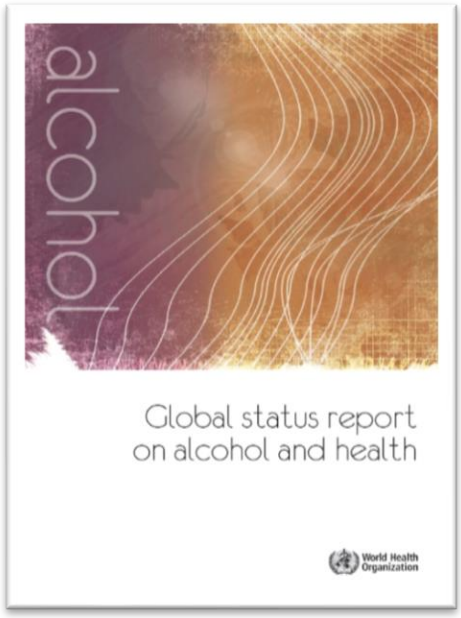
Series of WHO global status reports on alcohol since 1999











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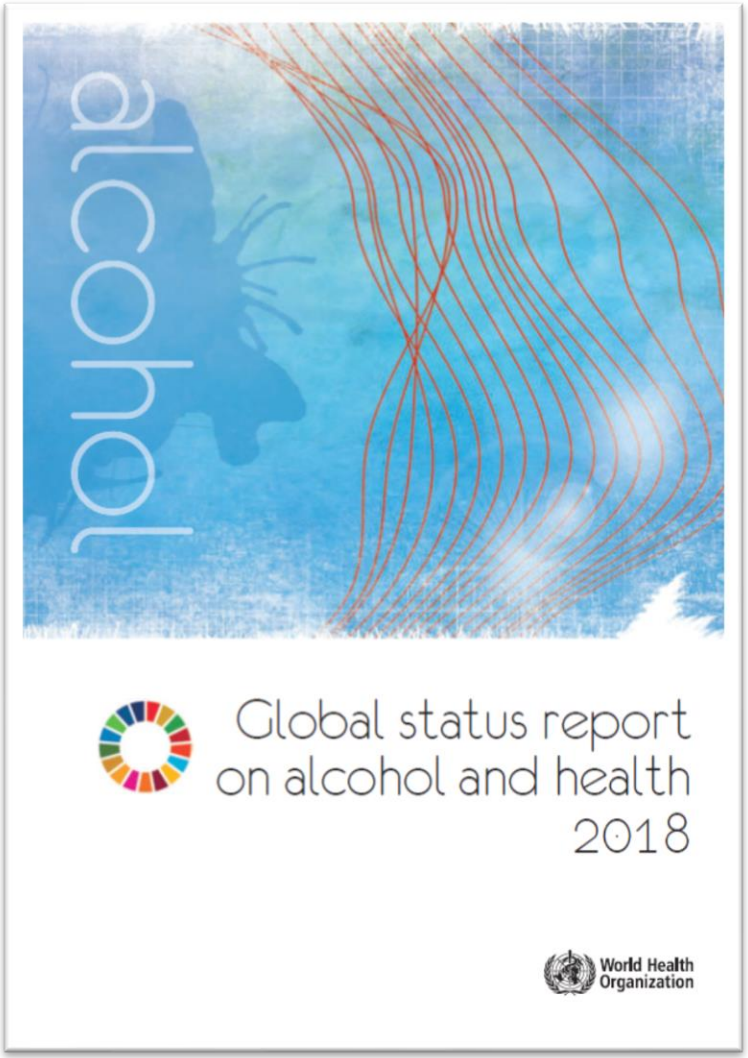


“Far too many people, their families and communities suffer the consequences of the harmful use of alcohol through violence, injuries, mental health problems and diseases like cancer and stroke. It’s time to step up action to prevent this serious threat to the development of healthy societies”.

Dr Tedros Adhanom Ghebreyesus,
Director-General of WHO

Geneva, 21 September 2018

1. REDUCING THE HARMFUL USE OF ALCOHOL: A KEYSTONE IN SUSTAINABLE DEVELOPMENT

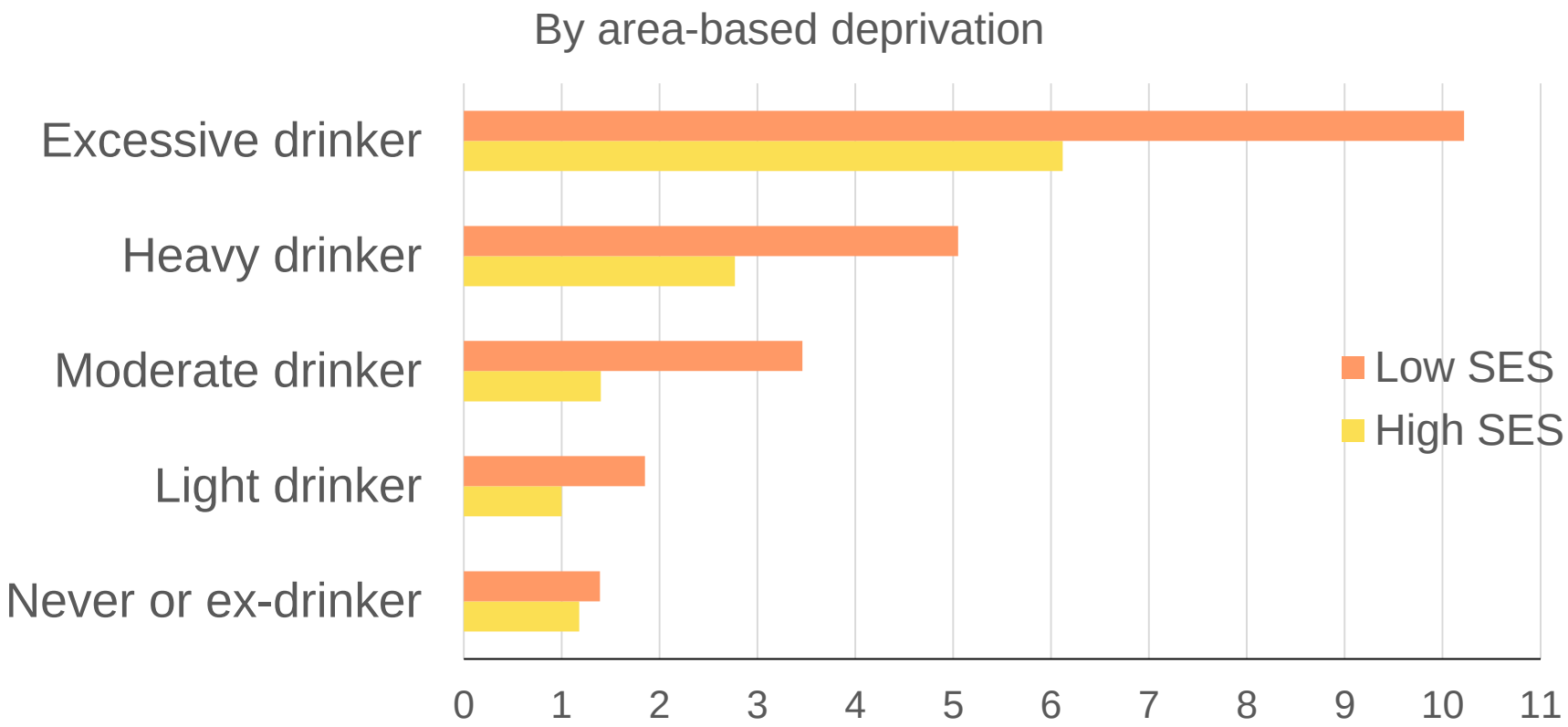
Chapter overview

- Alcohol in the context of the United Nations 2030 Agenda for Sustainable Development
- Alcohol and SDG 2030 health targets
- Alcohol and inequalities – across countries and within society
- Alcohol and use of other psychoactive substances

Box 1.1 The United Nations Sustainable Development Goals (UN, 2015)

Target 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Risk of alcohol-attributable admission or death in Scotland according to drinking status, by socioeconomic status



Source: Katikireddi SV et. al. 2017

Table 1.1 Major mental, behavioural or neurodevelopmental disorders caused by alcohol in the 11th revision of the International Classification of Diseases (ICD-11) (WHO, 2018c)

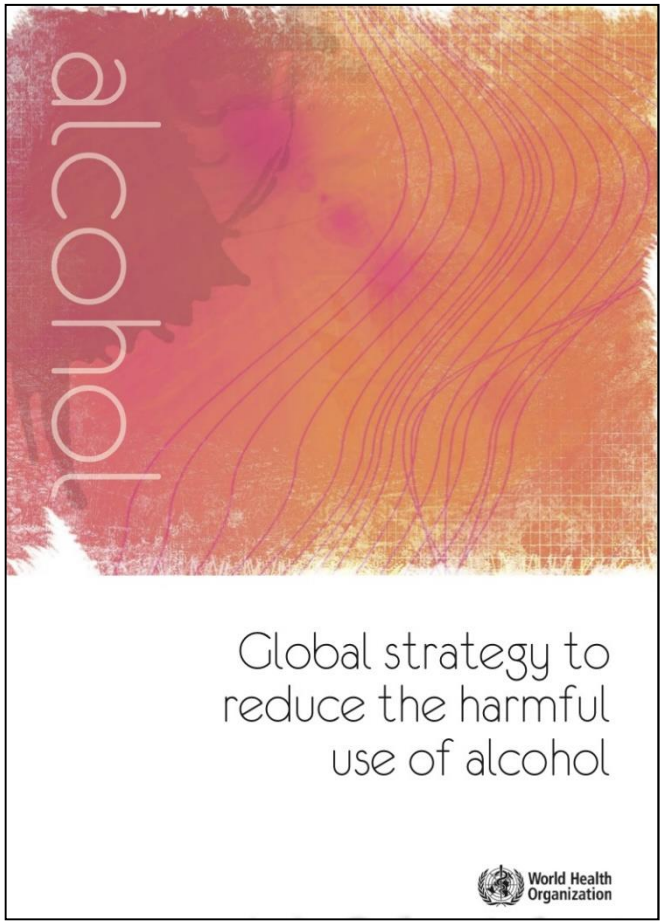
ICD-11 Mental, behavioural or neurodevelopmental disorders caused by alcohol	
6C40.0	Single episode of harmful use of alcohol
6C40.1	Harmful pattern of use of alcohol
6C40.2	Alcohol dependence
6C40.3	Alcohol intoxication
6C40.4	Alcohol withdrawal
6C40.5	Alcohol-induced delirium
6C40.6	Alcohol-induced psychotic disorder
6C40.7	Other alcohol-induced disorders
	6C40.70 Alcohol-induced mood disorder
	6C40.71 Alcohol-induced anxiety disorder
6D84.0	Dementia due to use of alcohol
6D72.10	Amnestic disorder due to use of alcohol
6C40.Y	Other specified disorders due to use of alcohol
6C40.Z	Disorders due to use of alcohol, unspecified

2. GLOBAL STRATEGIES, ACTION PLANS AND MONITORING FRAMEWORKS

Global policy frameworks

- The first international treaty to control psychoactive substances was concerned with alcohol.
- Neither alcohol nor tobacco was included in the modern international drug control treaties when they were adopted during 1961–1988.
- With development and ratification of the Framework Convention on Tobacco Control (FCTC) in response to the globalization of the tobacco epidemic, alcohol remains the only psychoactive and dependence-producing substance with significant global impact on population health that is not controlled at the international level by legally-binding regulatory frameworks.

WHO Global strategy to reduce the harmful use of alcohol (2010)



The global strategy:

- complements and supports public health policies in Member States;
- gives guidance for action at all levels;
- sets priority areas for global action;
- contains a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level

Definition of "harmful use of alcohol" in the WHO global strategy

- Drinking that causes detrimental health and social consequences for
  - the drinker
  - people around the drinker and
  - society at large.
- Patterns of drinking that are associated with increased risk of adverse health outcomes

What actions are needed to reduce the harmful use of alcohol?

Global, regional and national actions on:

- levels of alcohol consumption
- patterns of alcohol consumption
- contexts of alcohol consumption
- wider social determinants of health

➢Special attention needs to be given to reducing harm to people other than the drinker and to populations that are at particular risk from harmful use of alcohol.

Box 2.1 Target areas for policy options and interventions and key components for global action to reduce the harmful use of alcohol (WHO, 2010)

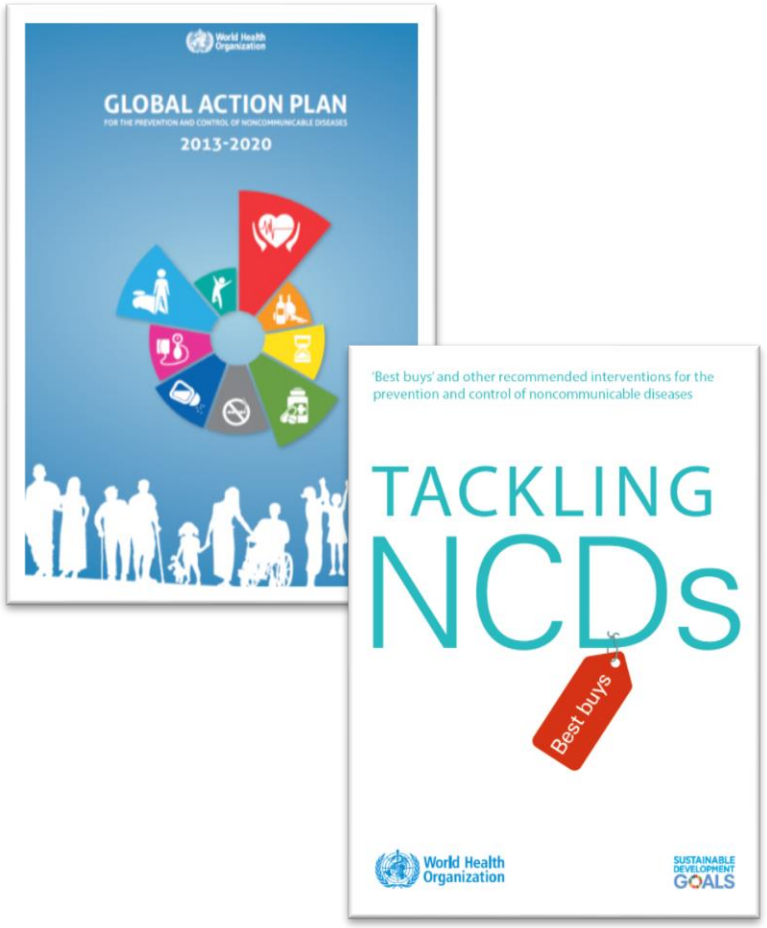
Target areas

Area 1. Leadership, awareness and commitment
Area 2. Health services' response
Area 3. Community action
Area 4. Drink–driving policies and countermeasures
Area 5. Availability of alcohol
Area 6. Marketing of alcoholic beverages
Area 7. Pricing policies
Area 8. Reducing the negative consequences of drinking and alcohol intoxication
Area 9. Reducing the public health impact of illicit alcohol and informally produced alcohol
Area 10. Monitoring and surveillance.

Key components for global action

- Public health advocacy and partnership;
- Technical support and capacity building;
- Production and dissemination of knowledge; and
- Resource mobilization.

WHO Global NCD Action Plan 2013-2020



Key risk factors

- **Tobacco use**
- **Harmful use of alcohol**
- **Unhealthy diet**
- **Physical inactivity**

Key cost-effective interventions (updated appendix 3, WHA70.11)

Harmful use of alcohol

- **Increase excise taxes on alcoholic beverages**
- **Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)**
- **Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)**
- Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints
- Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use

Monitoring frameworks

- Global monitoring frameworks
  - Global and regional information systems on alcohol and health
  - The NCD Global Monitoring Framework
  - Tracking progress in achieving the Sustainable Development Goals
- Key indicators for global monitoring frameworks on alcohol and health
  - Consumption, consequences and policy responses
- National monitoring systems and their key components

3. ALCOHOL CONSUMPTION

Indicators of levels of alcohol consumption

Current drinkers: the percentage of those in the population aged 15 years and older who have consumed alcoholic beverages in the previous 12-month period.

Total alcohol per capita consumption (APC) is defined as the total (recorded plus estimated unrecorded) alcohol per capita (i.e. persons aged 15 years and older) consumption within a calendar year in litres of pure alcohol, adjusted for tourist consumption.

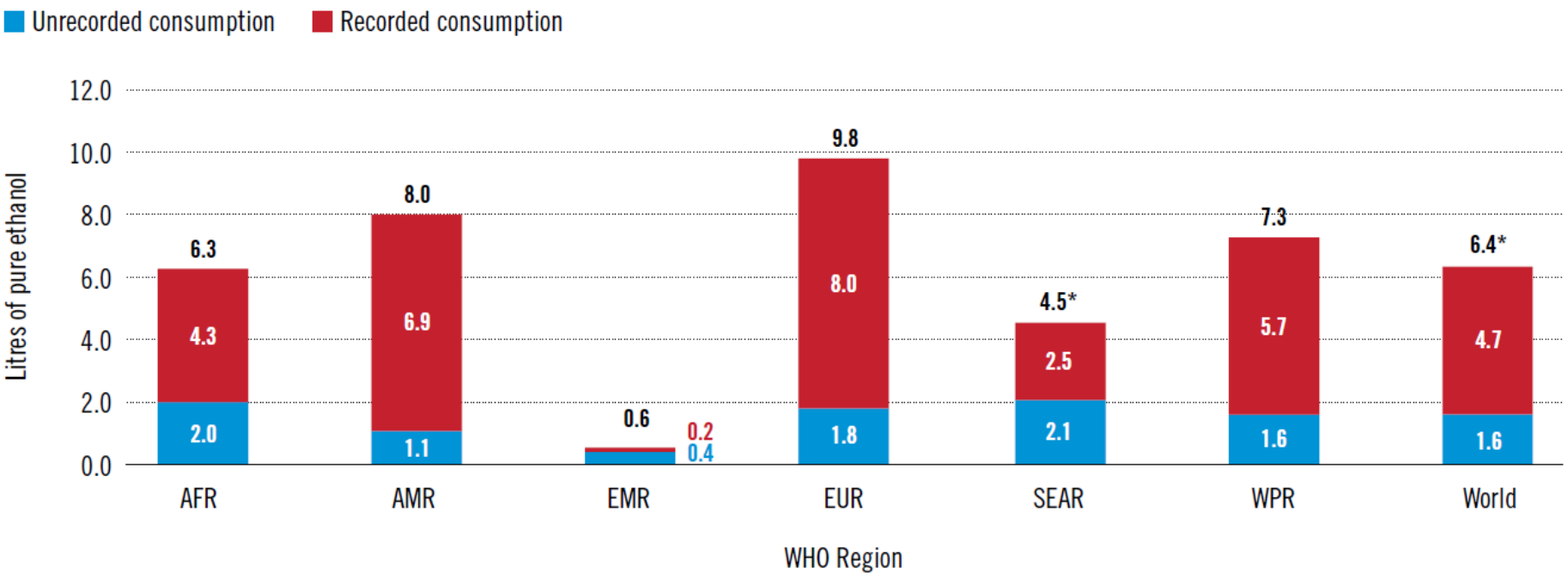
Unrecorded alcohol refers to alcohol that is not accounted for in official statistics on alcohol taxation or sales in the country where it is consumed because it is usually produced, distributed and sold outside the formal channels under government control.

Heavy episodic drinking (HED) is defined as drinking 60 or more grams of pure alcohol on at least one single occasion at least once per month)

Types of abstainers

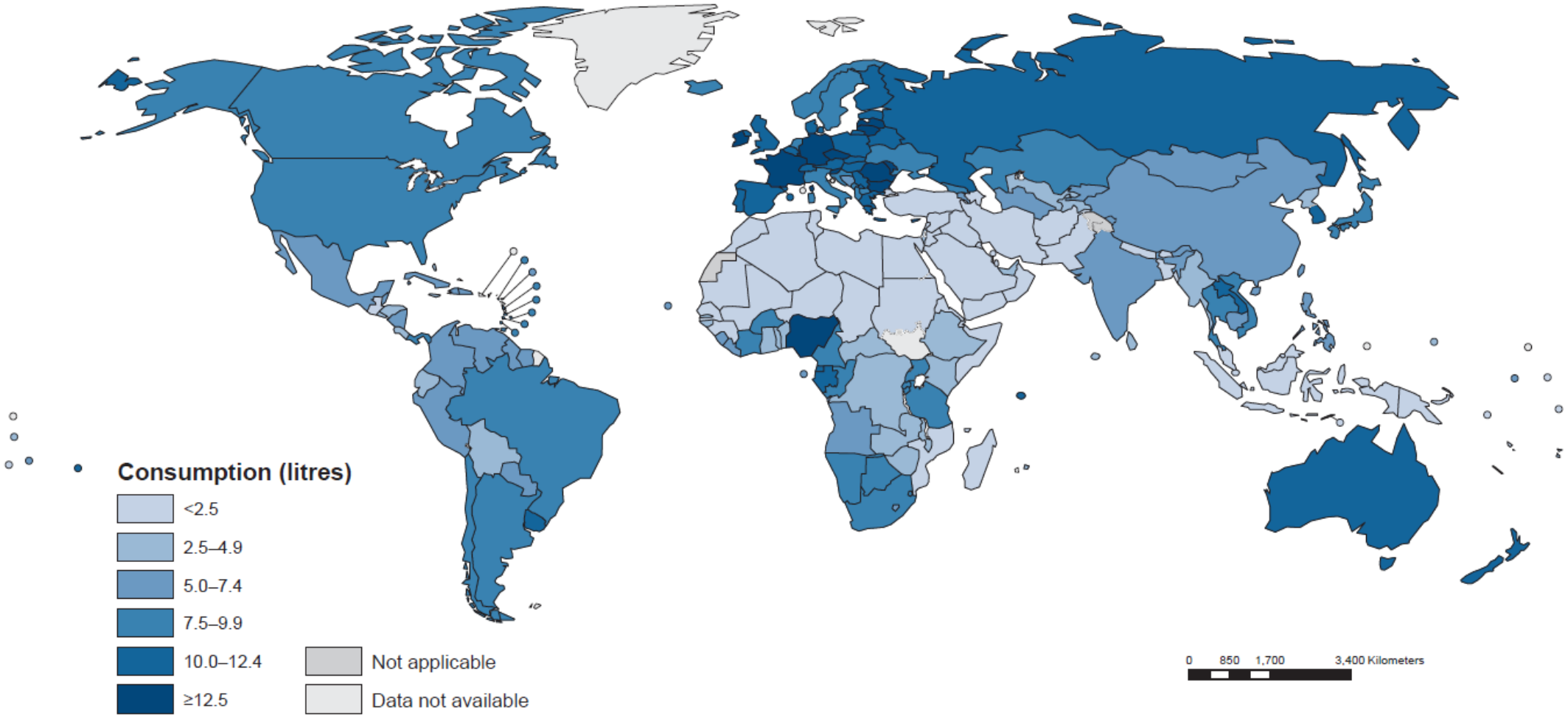
- **Lifetime abstainers: people** who have never consumed alcohol.
- **Former drinkers:** people who have previously consumed alcohol but who have not done so in the previous 12-month period.
- **Past 12-month abstainers:** people who did not drink any alcohol in the previous 12-month period. This includes former drinkers and lifetime abstainers.
- WHO uses rates of abstention to refer to the percentage of people in a given population aged 15 years or older who are lifetime abstainers, former drinkers or past 12-month abstainers

Total, unrecorded and recorded alcohol per capita consumption (APC) (15+ years) in litres of pure alcohol by WHO region and the world, 2016

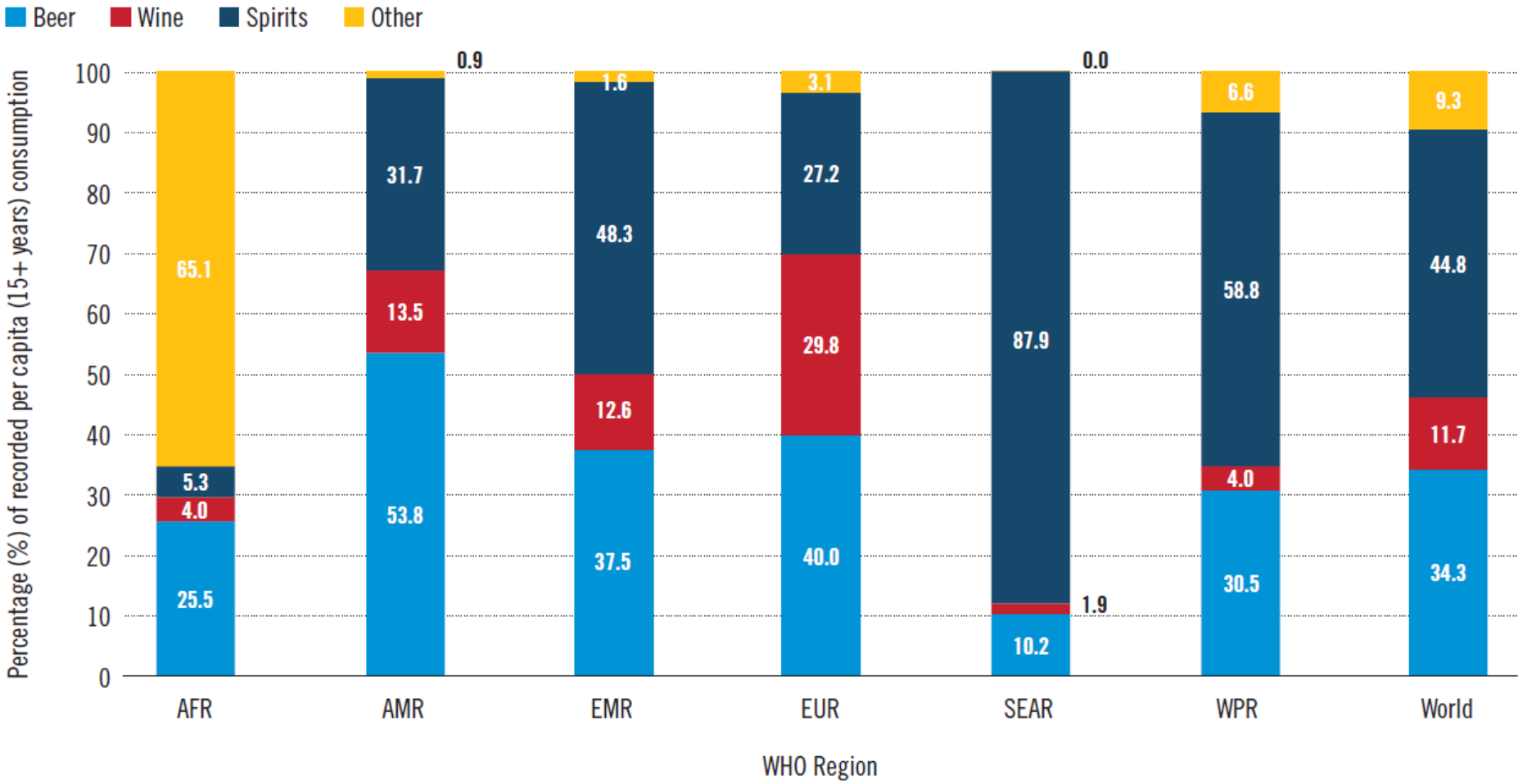


* Note: The discrepancy between categories and total number can be explained due to rounding of numbers.

Total alcohol per capita consumption (APC) (15+ years; in litres of pure alcohol), 2016

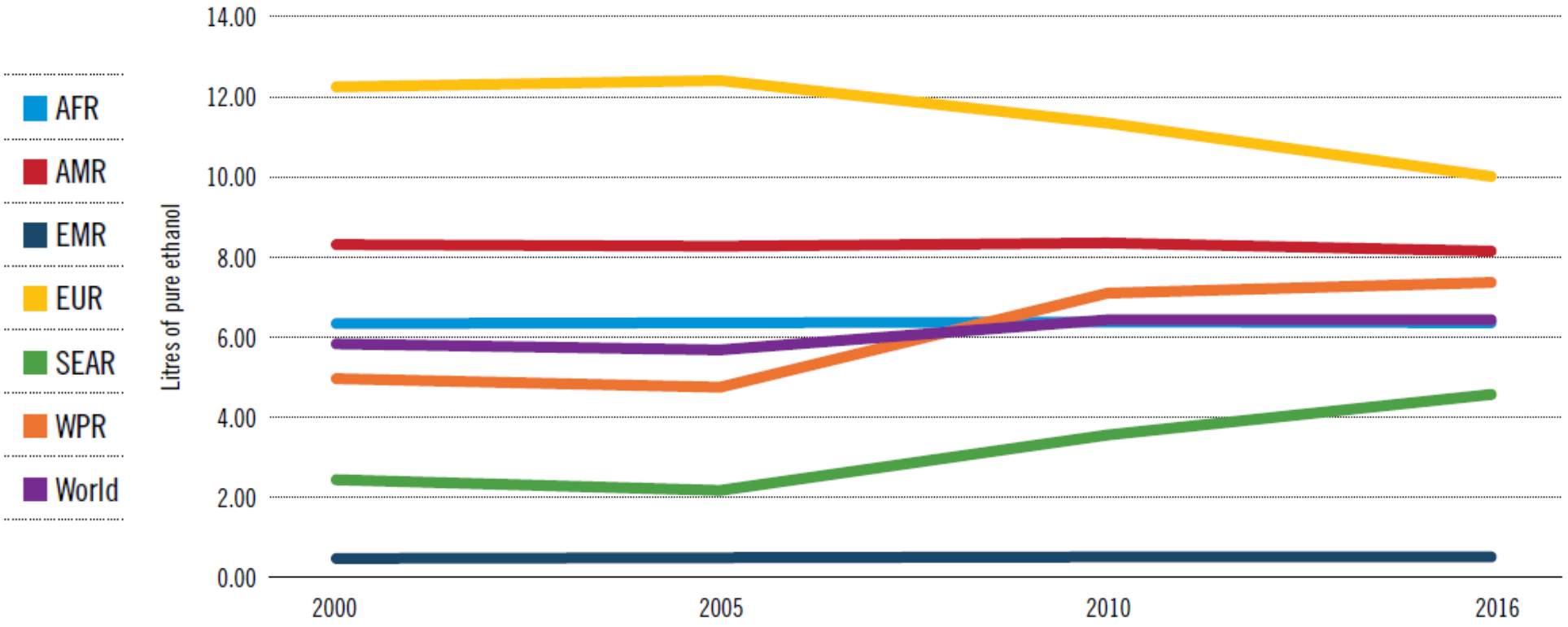


Percentage (in %) of recorded APC (15+ years) in the form of beer, wine, spirits and other types of alcoholic beverages*

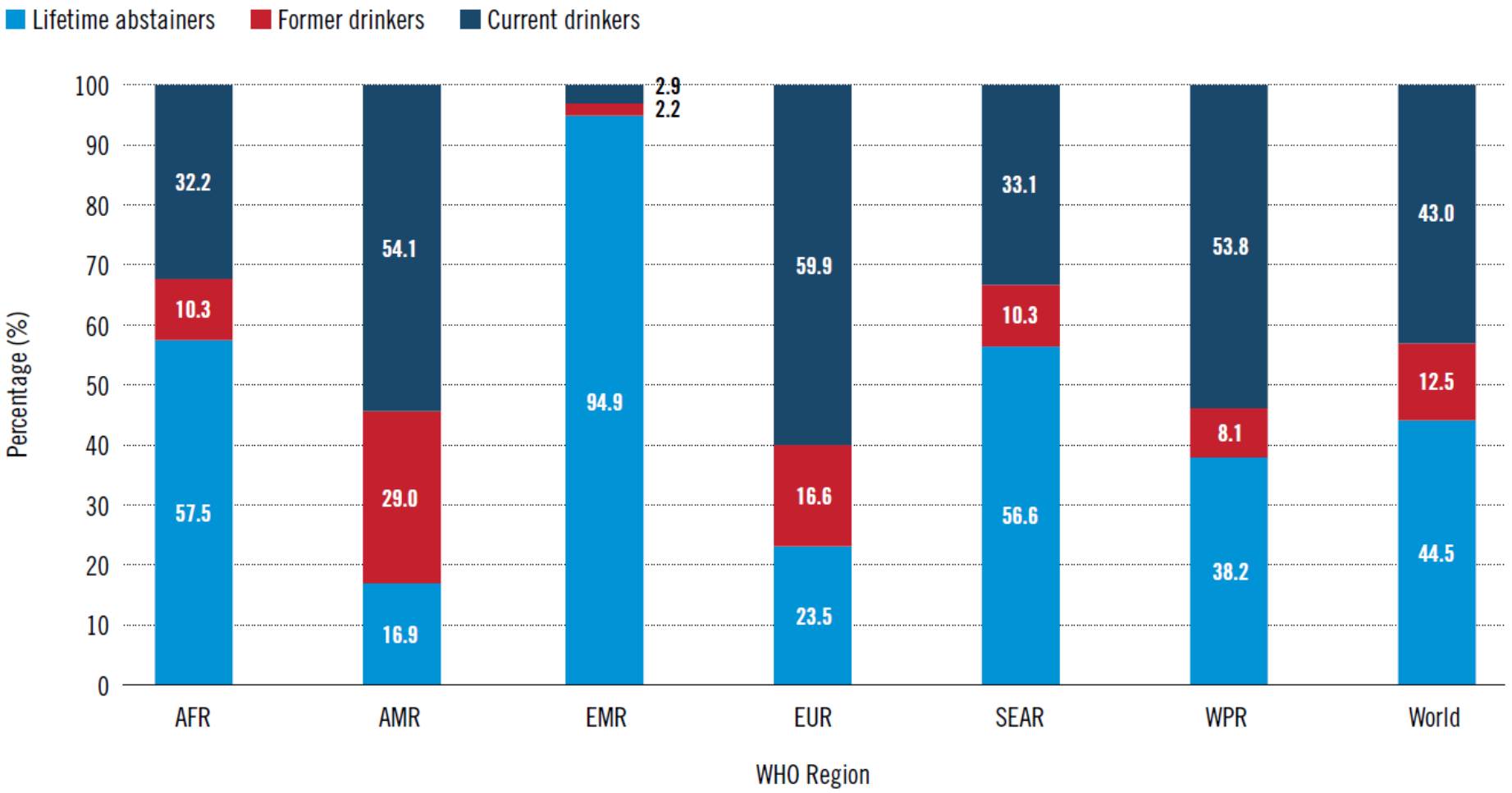


*Other beverages include fortified wines, rice wine, palm wine or other fermented beverages made of banana, sorghum, millet or maize.

Trends in total alcohol per capita consumption (APC) (15+ years) in litres of pure alcohol in WHO regions, 2000–2016



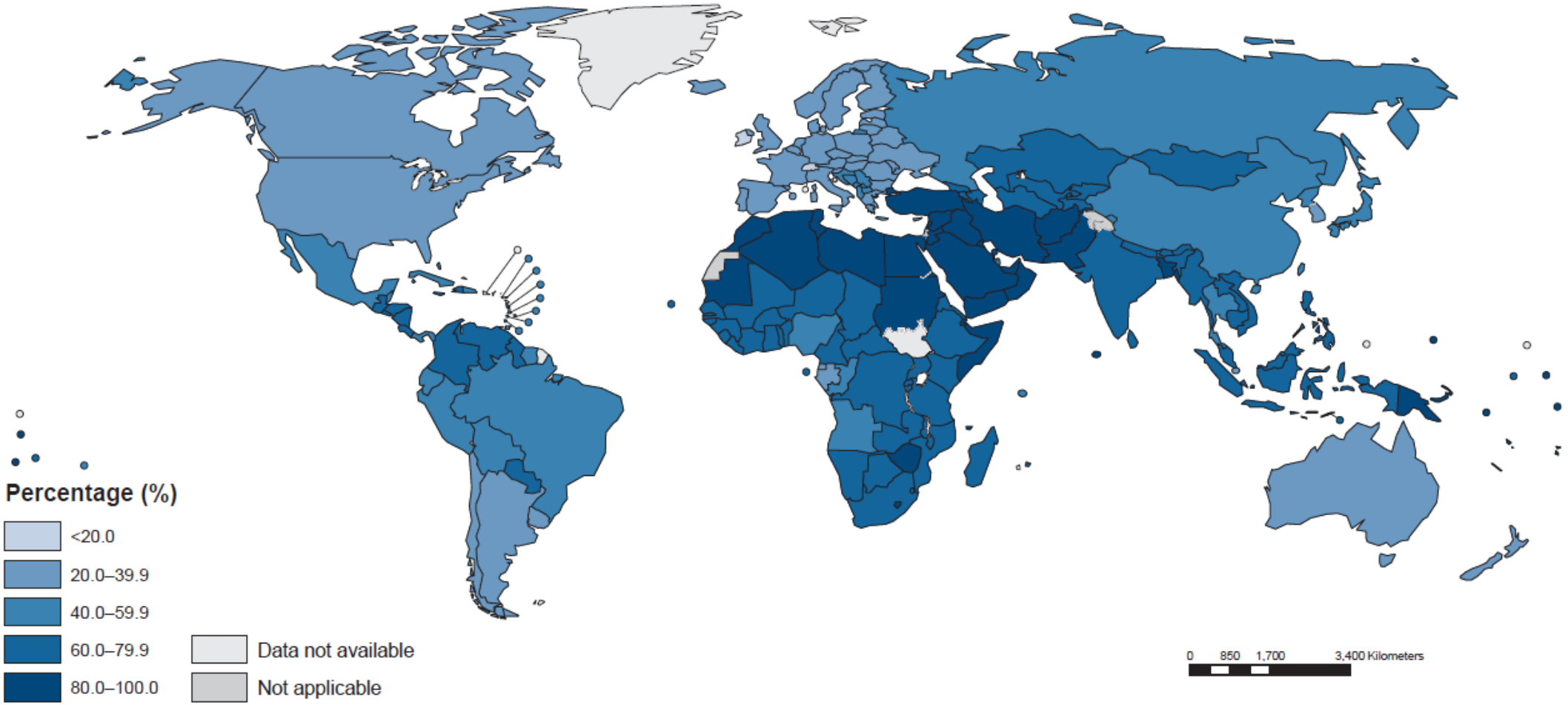
Percentage of current drinkers, former drinkers and lifetime abstainers



Trends in women's and men's prevalence rates (in %) of current drinking

WHO Region		2000	2005	2010	2016
AFR	Men	50.9	48.3	46.1	43.6
	Women	27.6	25.5	23.4	21.0
AMR	Men	75.7	72.9	70.6	66.8
	Women	51.9	48.7	45.6	41.9
EMR	Men	6.2	5.7	5.3	4.6
	Women	1.7	1.5	1.4	1.2
EUR	Men	78.8	77.2	74.4	69.2
	Women	62.1	60.4	55.6	51.4
SEAR	Men	44.4	44.0	45.2	44.5
	Women	21.5	20.0	21.8	21.3
WPR	Men	63.4	61.0	67.4	66.5
	Women	39.3	36.4	42.0	40.7
World	**Men**	**57.9**	**55.7**	**56.2**	**53.6**
	Women	**37.3**	**34.7**	**34.8**	**32.3**

Prevalence of past 12-month abstention (in %; 15+ years), 2016



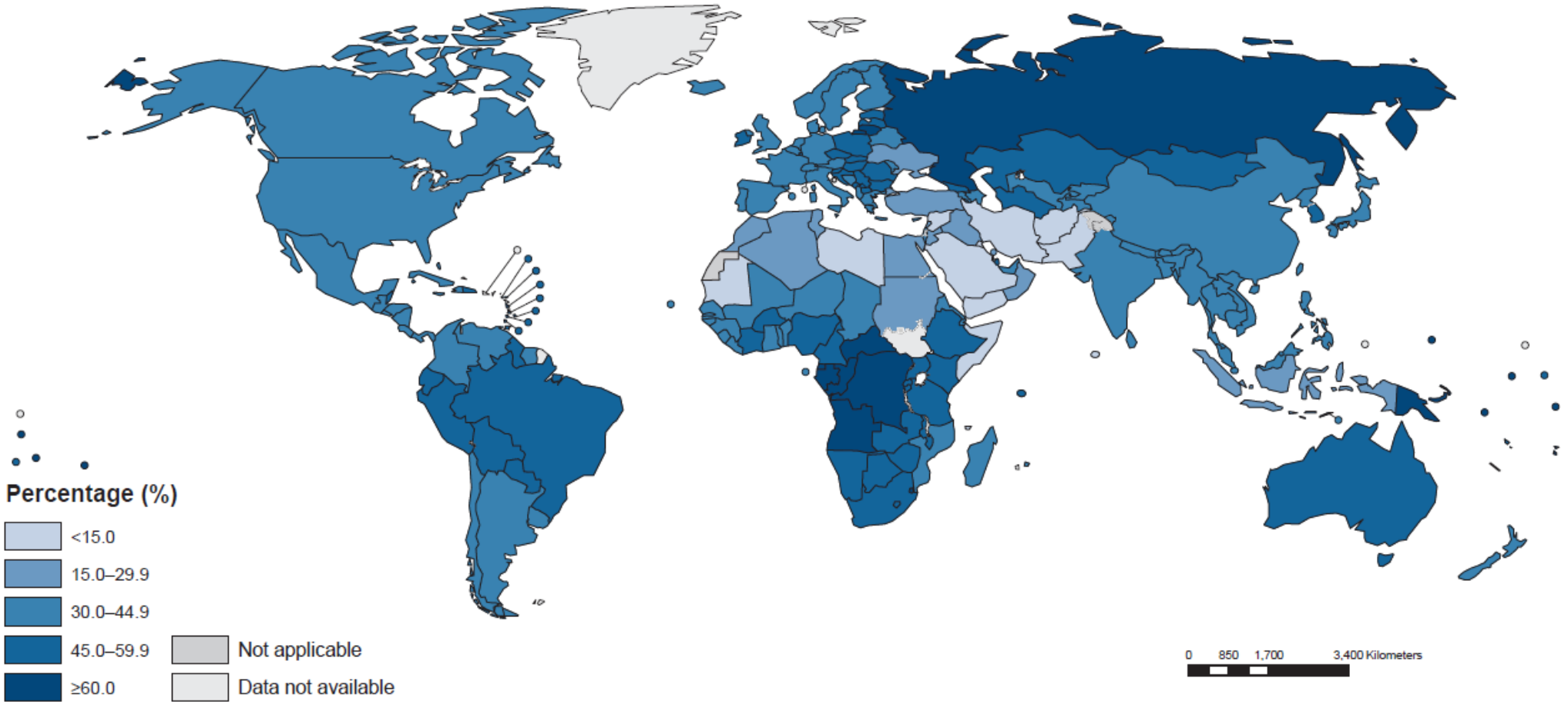
Prevalence (in %) of heavy episodic drinking

	HED among all (%)				HED among drinkers (%)			
WHO Region	**2000**	**2005**	**2010**	**2016**	**2000**	**2005**	**2010**	**2016**
AFR	23.1	21.2	19.4	17.4	55.5	53.9	52.3	50.2
AMR	29.4	26.7	24.4	21.3	47.2	45.2	43.3	40.5
EMR	0.8	0.7	0.6	0.5	12.6	11.6	11.5	10.4
EUR	37.9	35.7	31.6	26.4	52.8	50.7	47.6	42.6
SEAR	14.4	13.5	14.3	13.9	43.1	41.6	41.5	40.7
WPR	22.4	20.0	23.9	21.9	43.0	40.4	43.4	40.6
World	**22.6**	**20.5**	**20.5**	**18.2**	**44.4**	**42.2**	**41.9**	**39.5**

Trends in prevalence (in %) of heavy episodic drinking

		Among all (%)				Among drinkers (%)			
	WHO Region	2000	2005	2010	2016	2000	2005	2010	2016
15–19 years	AFR	17.3	15.7	14.3	12.7	59.7	58.3	56.8	55.1
	AMR	25.8	23.4	21.4	18.5	55.7	53.5	51.8	49.3
	EMR	0.4	0.3	0.2	0.2	13.3	12.0	11.9	10.9
	EUR	35.1	33.5	29.0	24.1	61.7	60.0	56.3	51.2
	SEAR	10.2	9.6	10.4	10.2	48.1	46.9	47.3	46.8
	WPR	18.1	16.2	20.3	18.8	48.9	46.6	50.7	49.0
	World	**17.1**	**15.6**	**15.6**	**13.6**	**49.3**	**47.4**	**47.5**	**45.7**
20–24 years	AFR	26.9	24.8	22.9	20.8	62.1	60.6	59.3	57.4
	AMR	36.3	33.4	31.2	28.0	57.9	56.0	54.4	51.8
	EMR	0.9	0.8	0.7	0.5	15.6	14.2	14.2	13.0
	EUR	46.0	44.2	40.0	33.9	64.0	62.5	60.2	54.7
	SEAR	17.4	16.6	17.8	17.6	51.0	49.9	50.2	49.9
	WPR	27.2	24.7	29.9	28.2	52.0	49.7	53.5	51.8
	World	**25.8**	**23.7**	**24.2**	**21.8**	**52.3**	**50.3**	**50.4**	**48.5**

Prevalence (in %) of heavy episodic drinking (HED) among current drinkers (15+ years), 2016



Total alcohol per capita consumption and prevalence of heavy episodic drinking

	Among all (15+ years)		Among drinkers (15+ years)		
WHO Region	Total APC	HED prevalence (%)	Total APC	HED prevalence (%)	Number of HED drinkers (in thousands)
AFR	6.3	17.4	18.4	50.2	100 881
AMR	8.0	21.3	15.1	40.5	163 853
EMR	0.6	0.5	21.2	10.4	2 262
EUR	9.8	26.4	17.2	42.6	197 913
SEAR	4.5	13.9	12.1	40.7	195 746
WPR	7.3	21.9	13.8	40.6	332 368
World	**6.4**	**18.2**	**15.1**	**39.5**	**993 023**

Further important issues in the chapter

- Alcohol use and women
- Alcohol use and youth
- Economic wealth
- Projections

4. HEALTH CONSEQUENCES

Terminology related to burden of disease and injury

Burden of disease is defined as the gap between current health status and an ideal situation in which everyone lives to old age free of disease and disability. Premature death, disability and risks that contribute to illness and injury are the causes of this health gap.

Disability-adjusted life years (DALYs) represent a time-based measure of overall burden of disease for a given population. DALYs are the sum of years of life lost due to premature mortality as well as years of life lost due to time lived in less than full health.

Alcohol-attributable deaths are defined as the number of deaths attributable to alcohol consumption. They assume a counterfactual scenario of no alcohol consumption. Thus, alcohol-attributable deaths are those deaths that would not have happened without the presence of alcohol.

Age-standardized (or age-adjusted) alcohol-attributable deaths or DALY rates refer to a weighted average of the age-specific death or DALY rates per 100 000 persons, where the weights are the proportions of persons in the corresponding age groups of the WHO standard population.

Alcohol-attributable fraction (AAF) is the proportion of all diseases and deaths that are attributable to alcohol. AAFs are used to quantify the contribution of alcohol as a risk factor to disease or death. AAFs can be interpreted as the proportion of deaths or burden of disease which would disappear if there had not been any alcohol. AAFs are calculated on the basis of the level of exposure to alcohol and the risk relations between the level of exposure and different disease categories.

Causes of death and disability causally related to alcohol consumption

Diseases and injuries included in the analysis

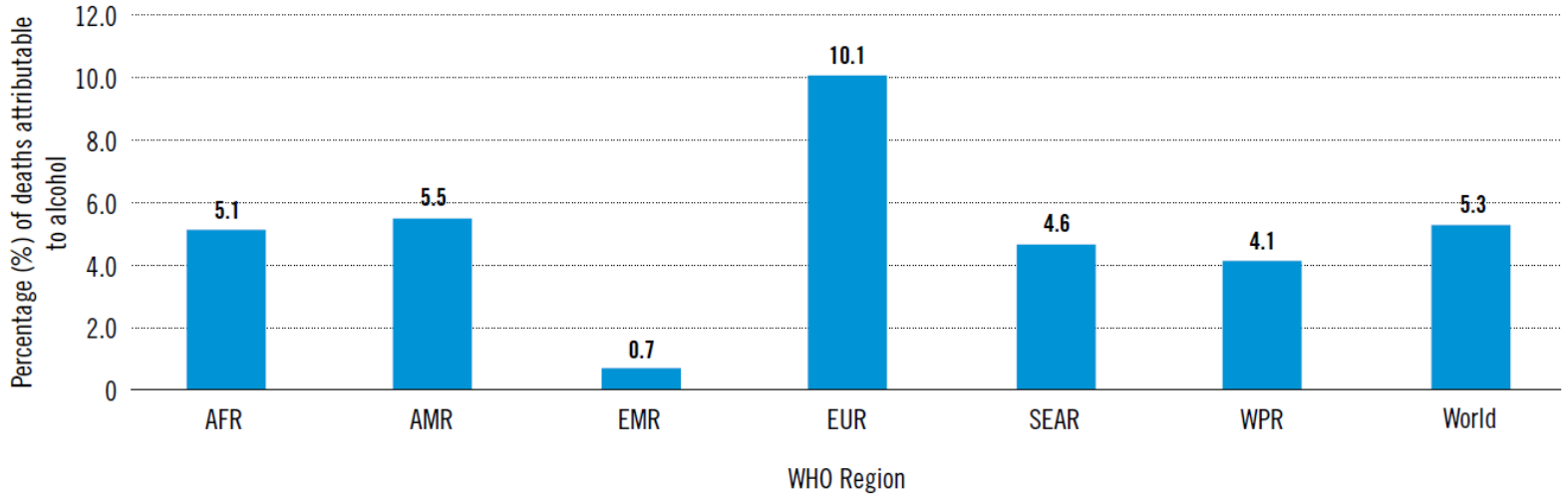
Detrimental (included)
- Communicable, maternal, perinatal and nutritional conditions
  - Tuberculosis, HIV/AIDS, lower respiratory infections
- Noncommunicable diseases
  - Lip and oral cavity, pharyngeal cancers (exluding nasopharyngeal), oesophagus cancer, colon and rectum cancers, liver cancer, breast cancer, larynx cancer, alcohol use disorders, epilepsy, hypertensive heart disease, haemorrhagic stroke, alcoholic cardiomyopathy, cirrhosis of the liver, pancreatitis
- Injuries
  - Unintentional injuries
    - Road injury, poisonings, falls, fire, heat and hot substances, drowning, exposure to mechanical forces, other unintentional injuries
  - Intentional injuries
    - Self-harm, interpersonal violence

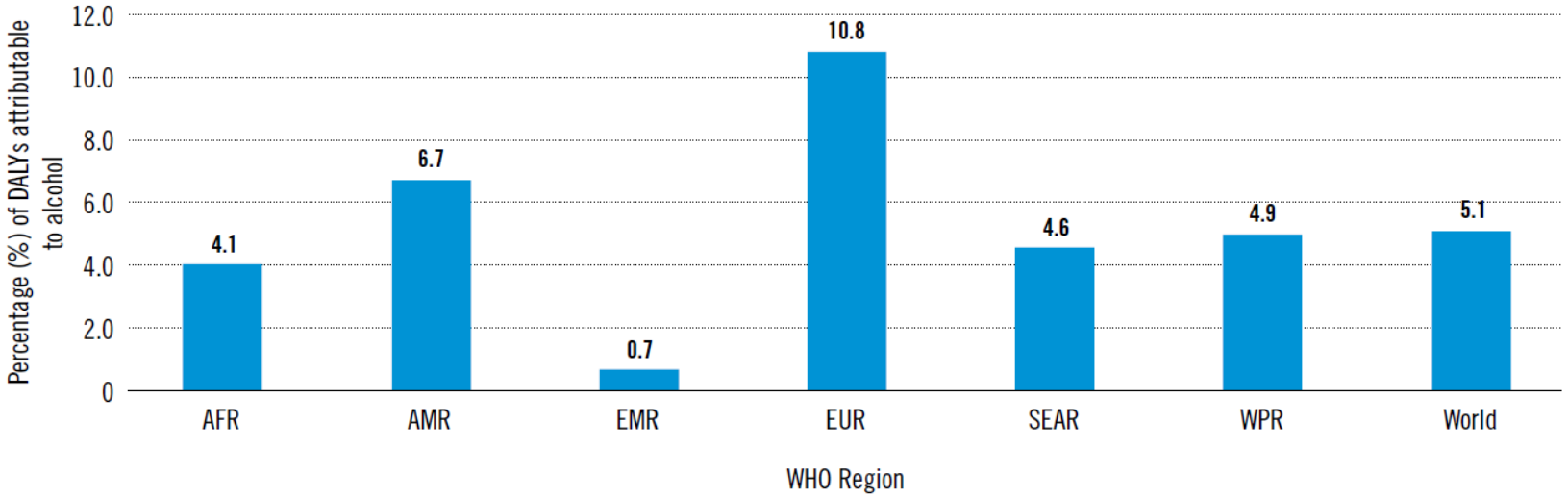
Beneficial (at low levels of alcohol consumption*)
- Noncommunicable diseases
  - Diabetes mellitus, ischaemic heart disease, ischaemic stroke

* No health benefit is seen for people who engage in binge drinking.

Not included in the analysis (however, alcohol has been shown to have an impact causally related to): major depressive disorder, atrial fibrillation and flutter, oesophageal varice, psoriasis.

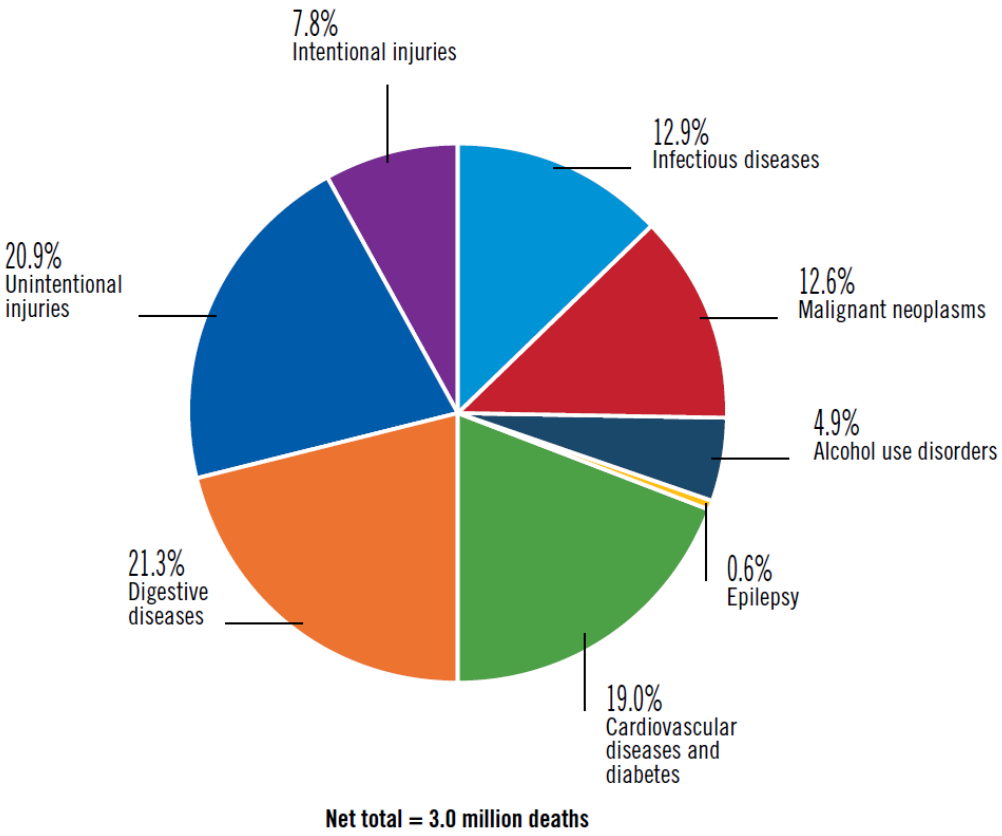
Share of all deaths and DALYs (in %) attributable to alcohol consumption, by WHO region, 2016





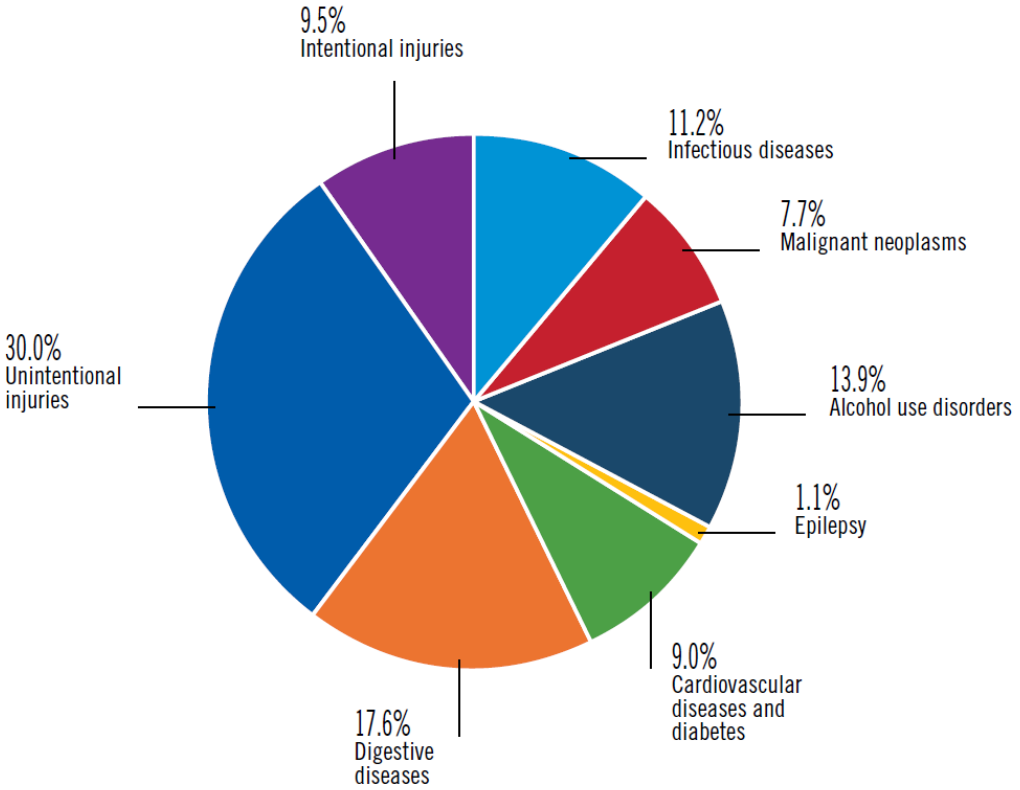
Percentage (in %) of alcohol-attributable deaths, as a percentage of all alcohol attributable deaths and DALYs, by broad disease category, 2016

Deaths

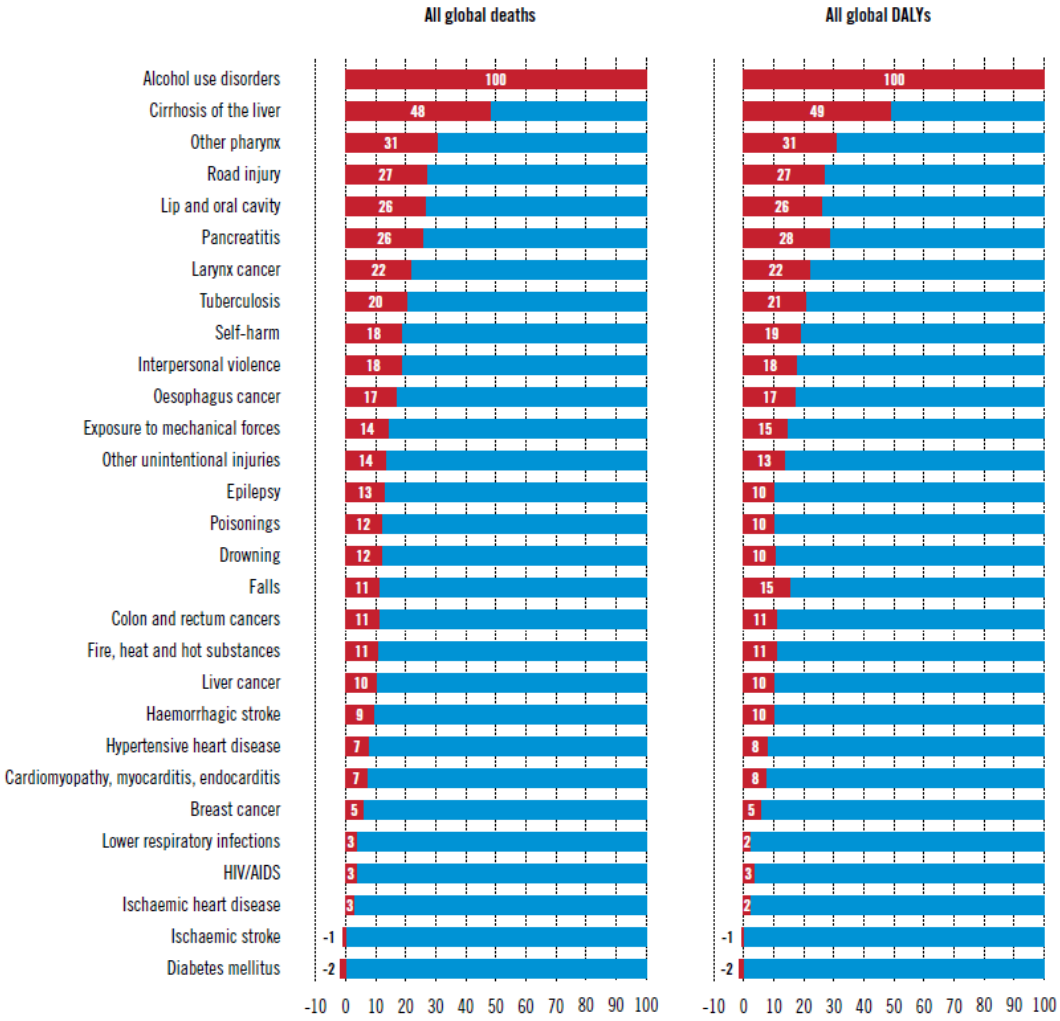


Net total = 3.0 million deaths

DALYs



Alcohol-attributable fractions (AAFs) for selected causes of death, disease and injury, 2016



World Health Organization

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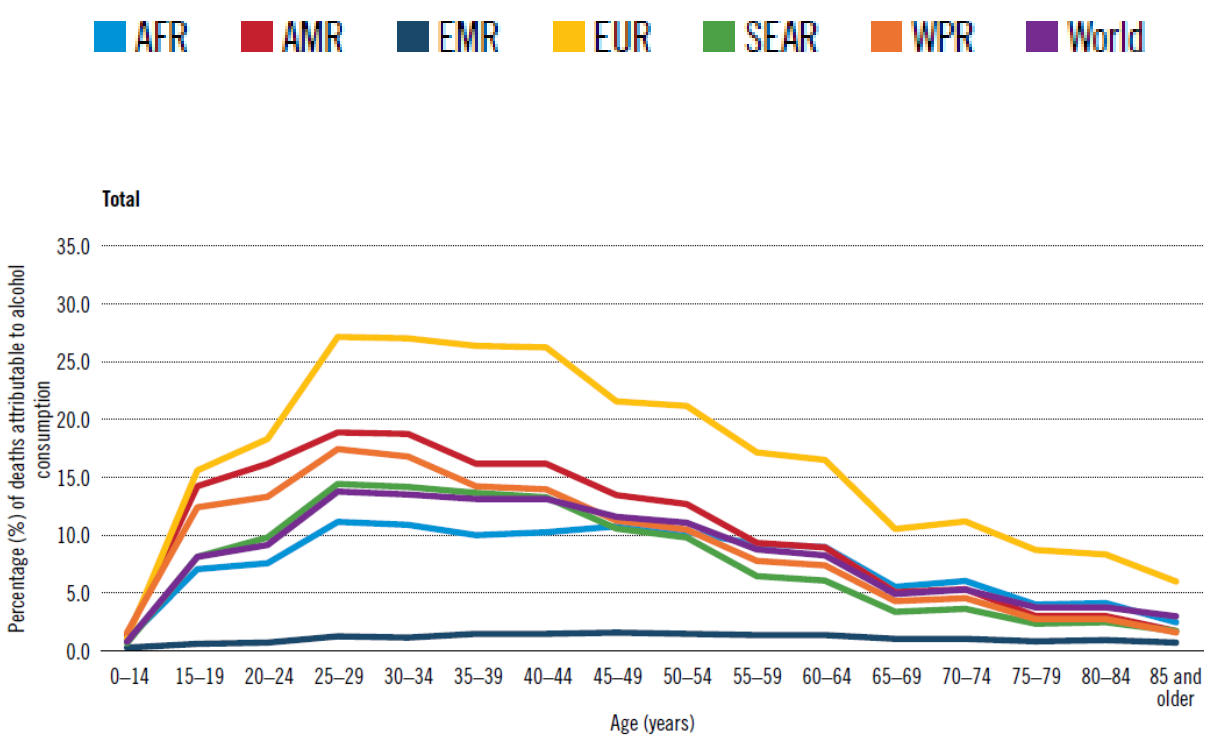
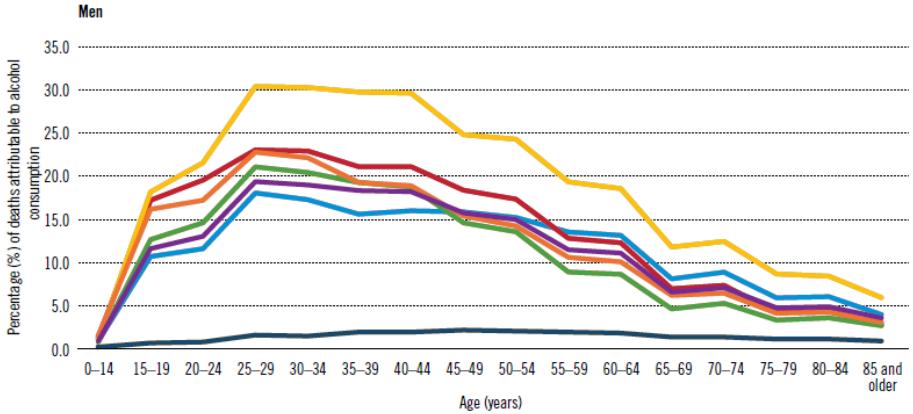
3.5

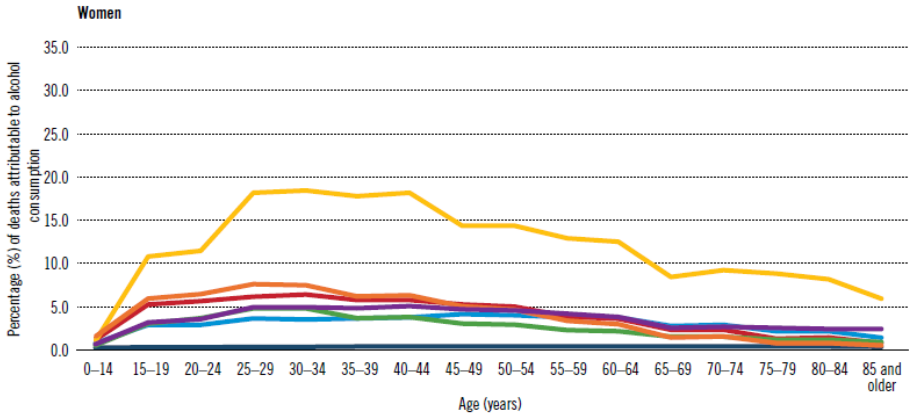
Factors that have an impact on health consequences

- Impact by age
- Impact by gender
- Impact by economic status

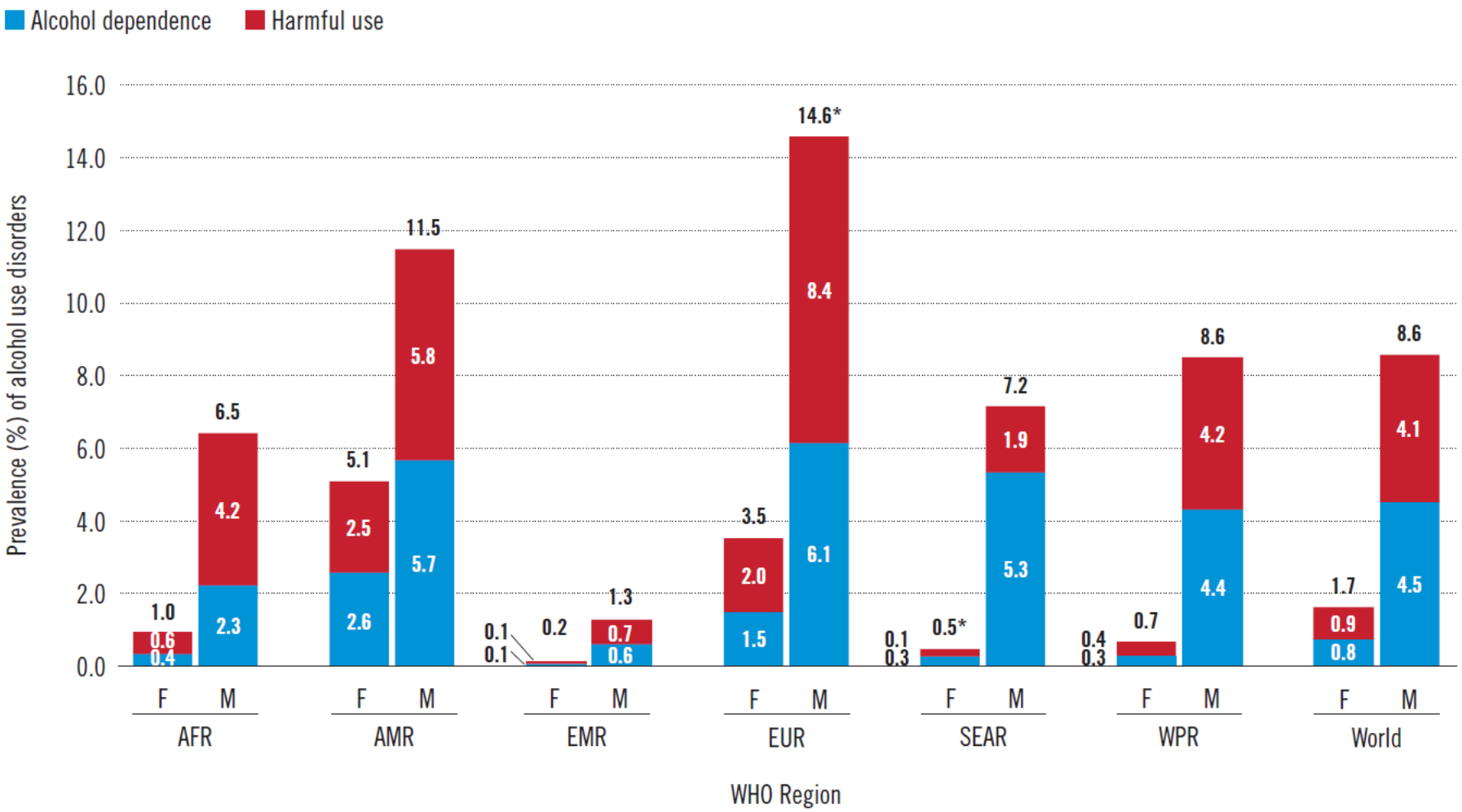
Percentage (in %) of total deaths attributable to alcohol, by age group, 2016



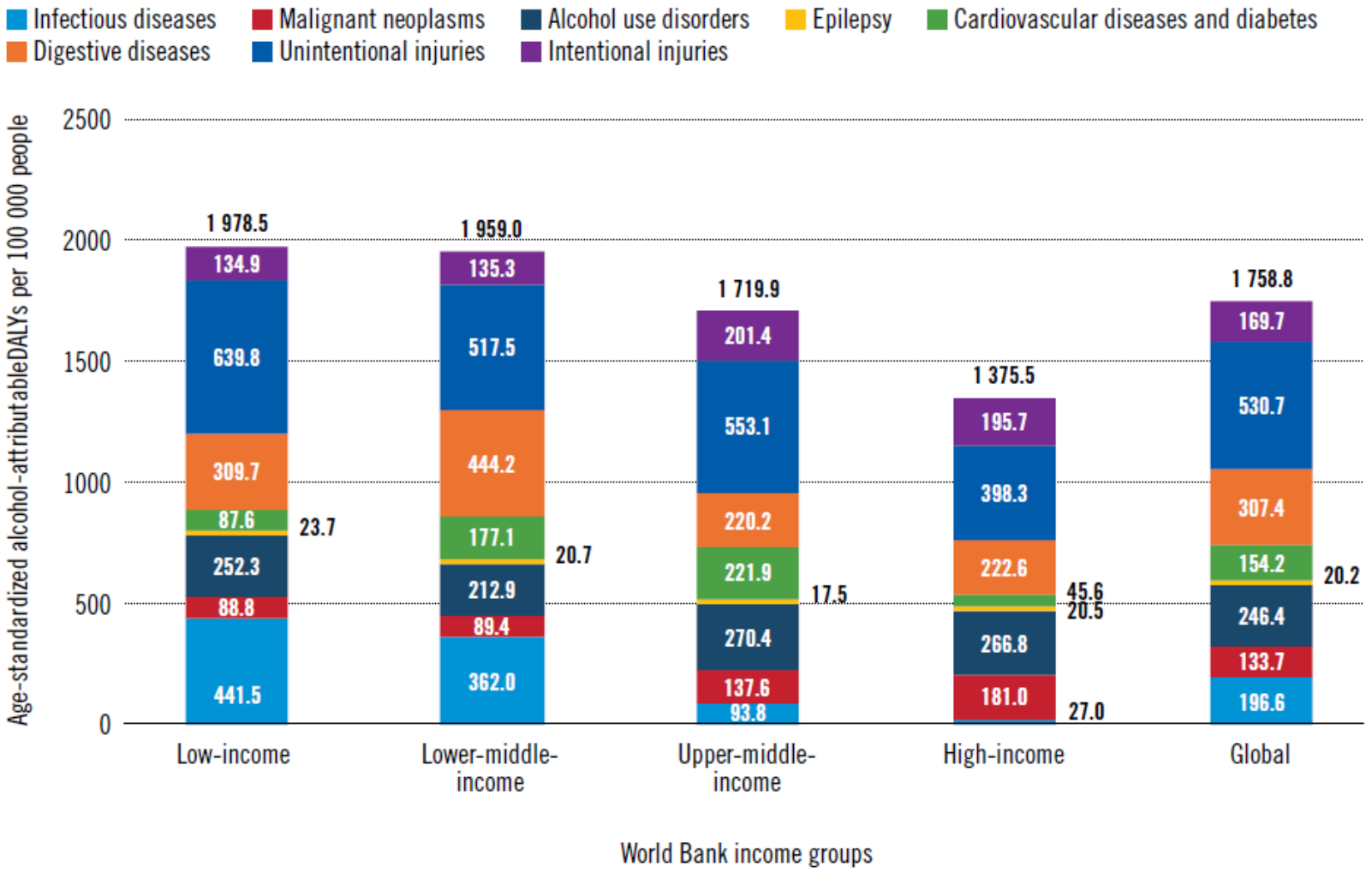




Prevalence (in %) of alcohol use disorders (AUDs), by sex, and by WHO region and the world, 2016

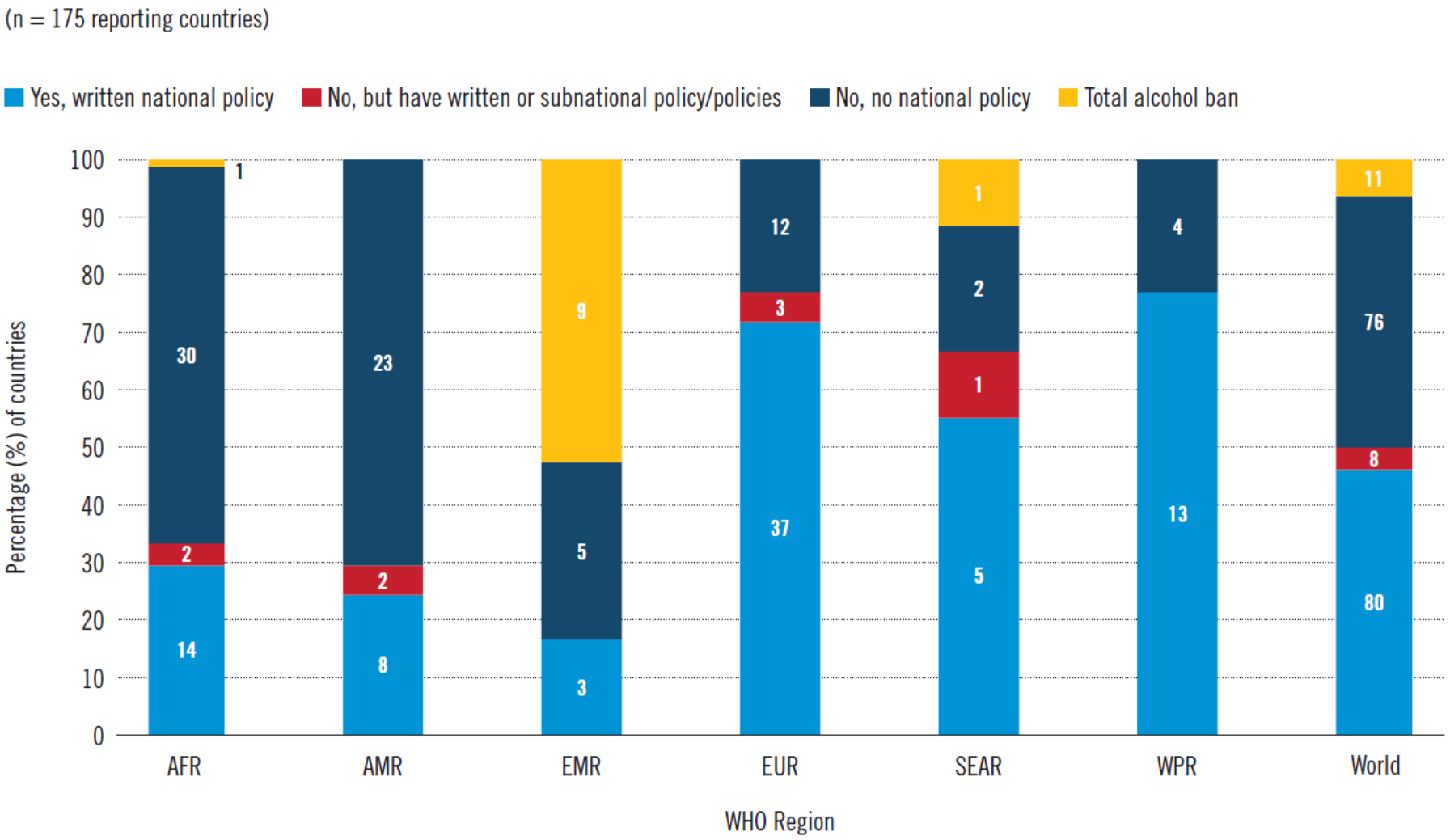


Alcohol-attributable DALYs per 100.000, by income group and globally, 2016



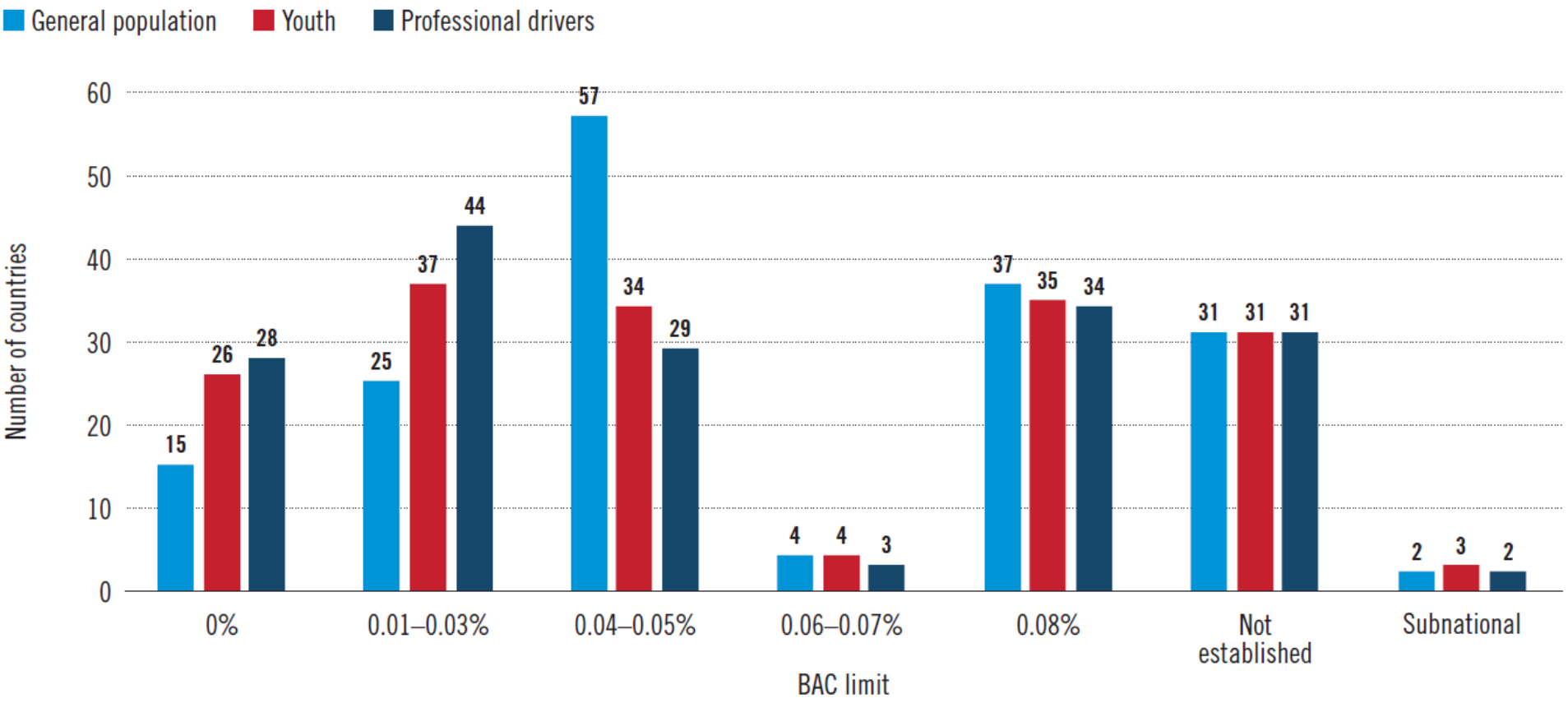
5. ALCOHOL POLICY AND INTERVENTIONS

Presence of a written national alcohol policy by WHO region and percentage (in %) of countries, 2016



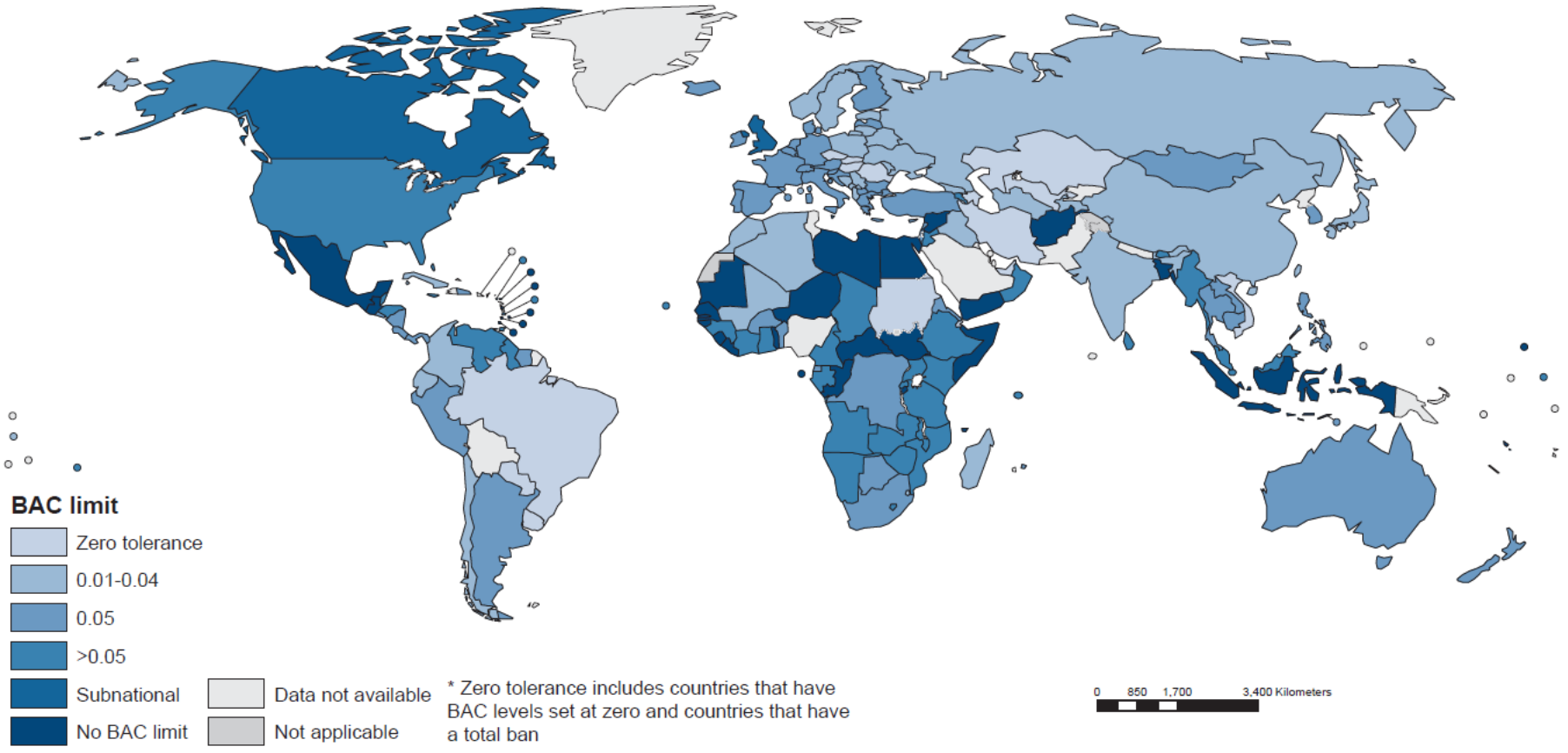
Blood alcohol concentration (BAC) limits by driver type and number of countries, 2016

(n = 171 reporting countries except youth BAC limit [170])

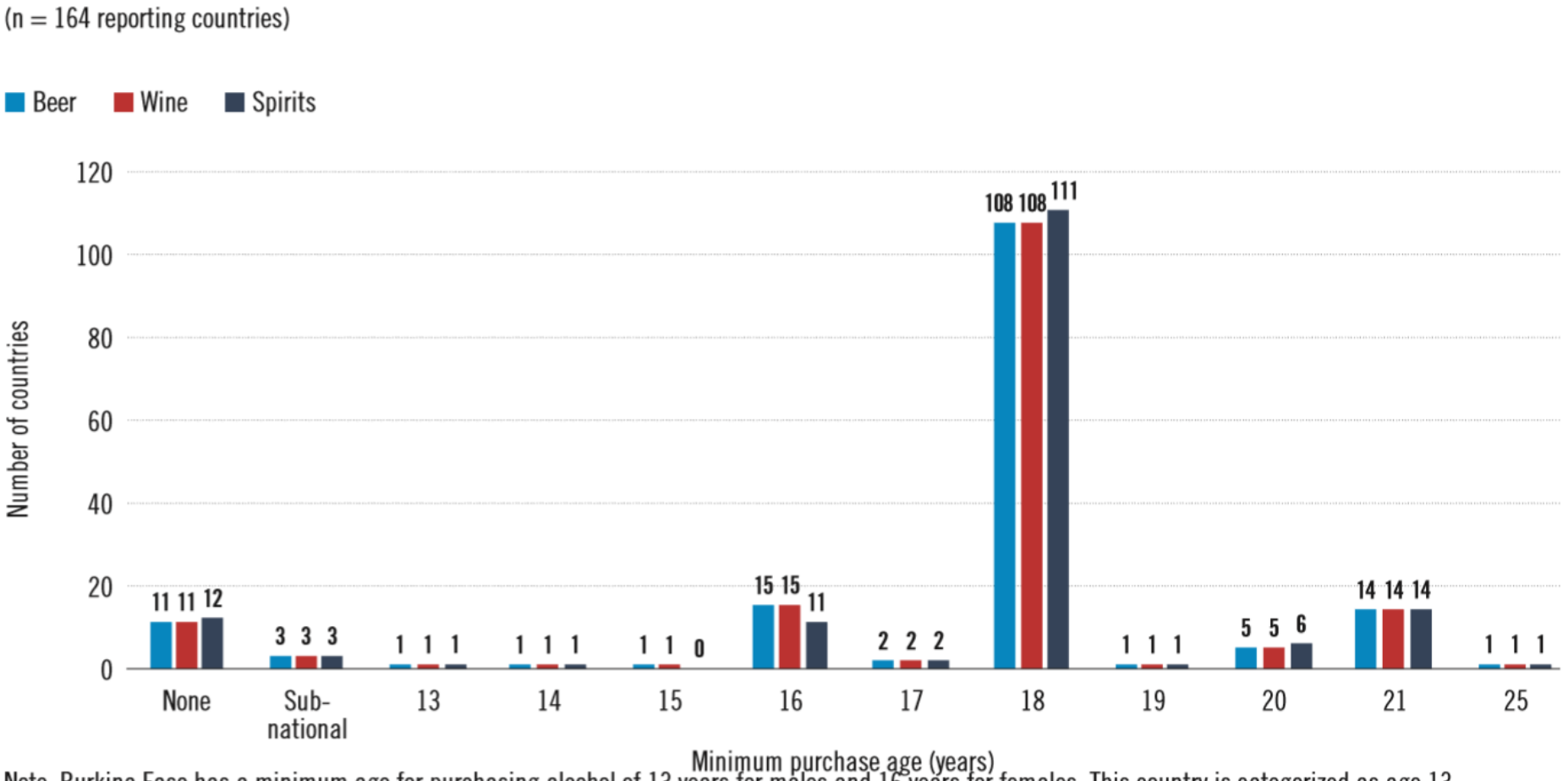


Blood alcohol concentration (BAC) limits for drivers in the general population, 2016

(n = 171 reporting countries)

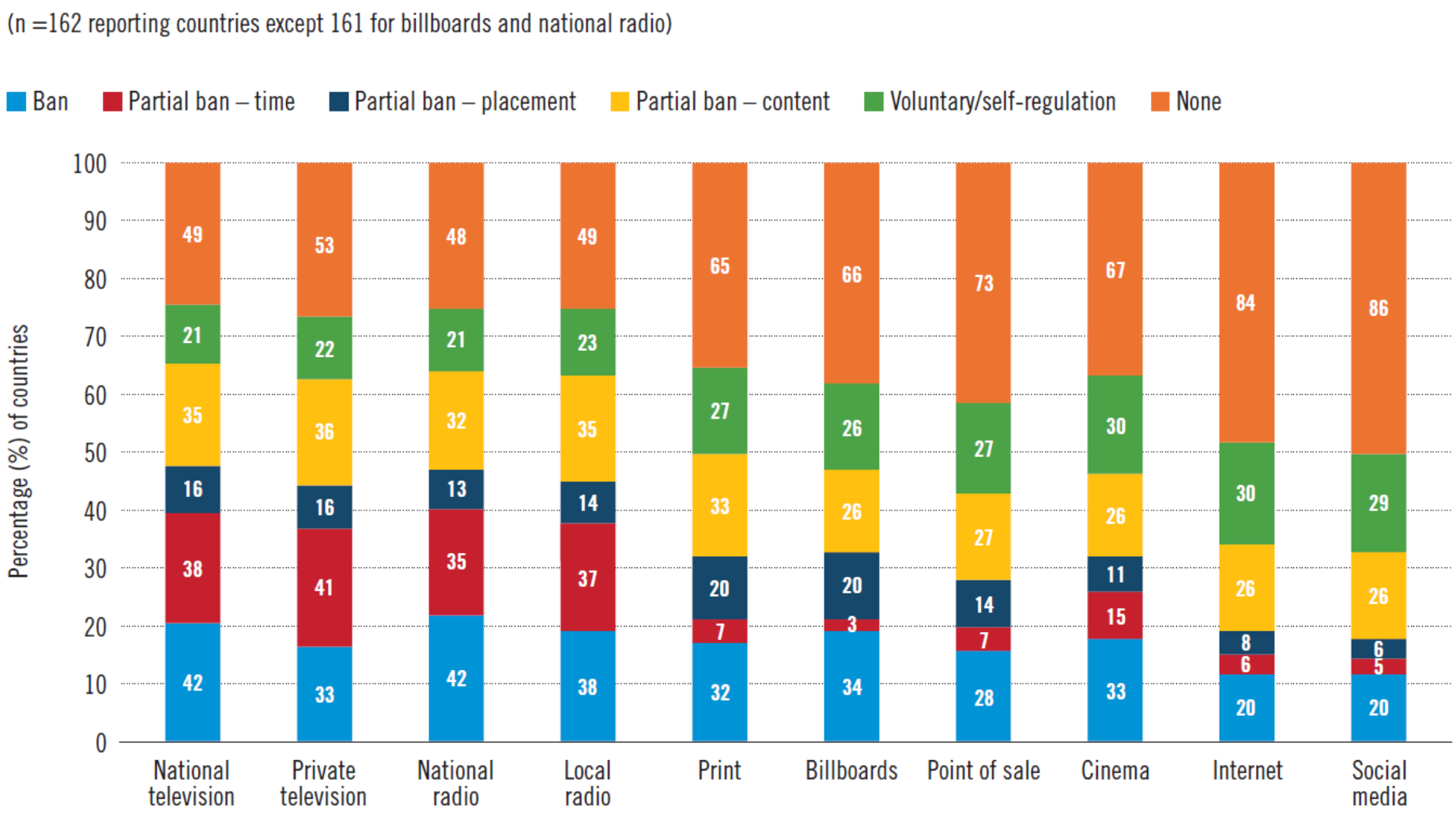


Minimum age limits for on-premise sales of beer, wine and spirits, by number of countries, 2016

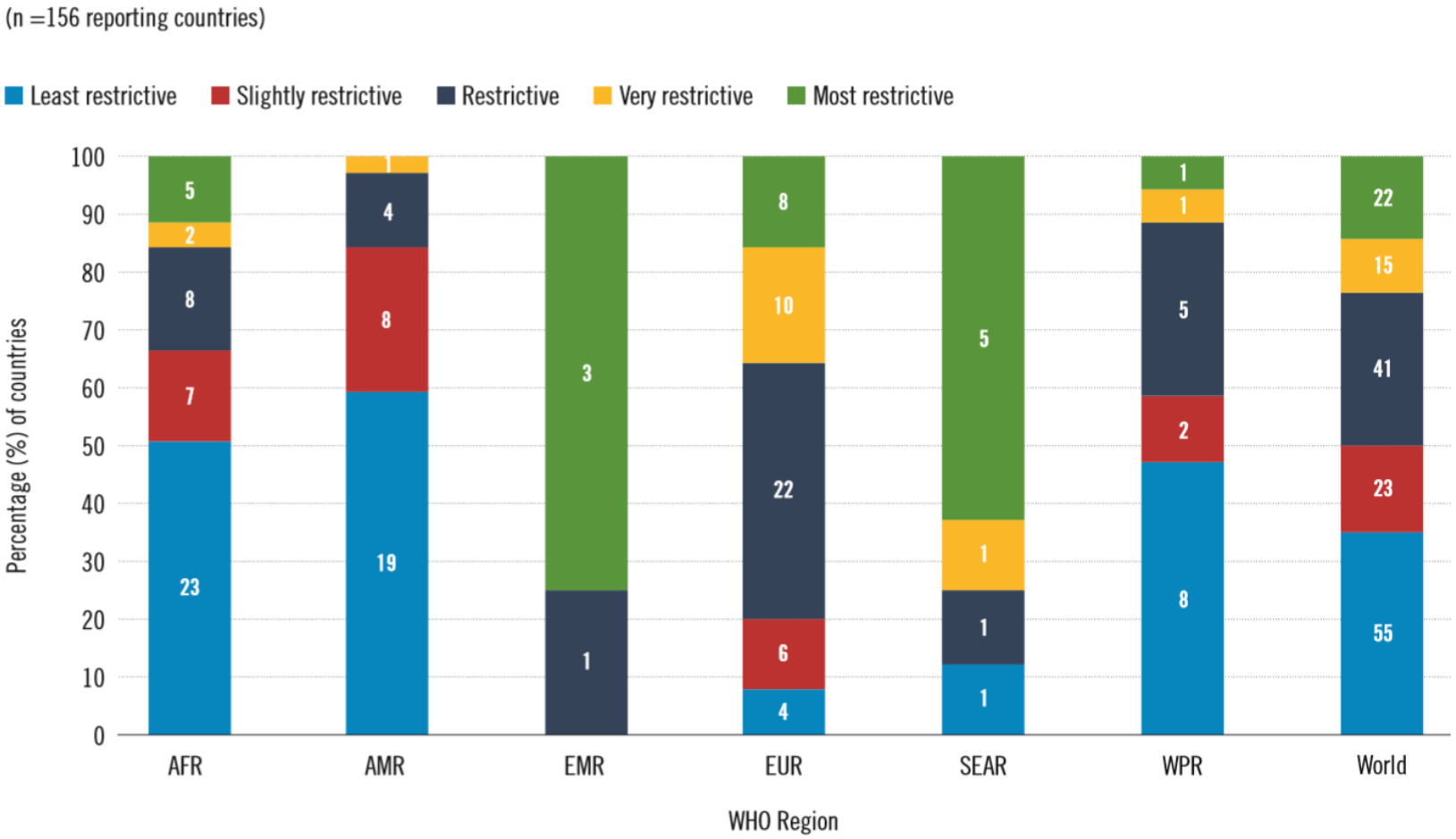


Note: Burkina Faso has a minimum age for purchasing alcohol of 13 years for males and 16 years for females. This country is categorized as age 13.

Restrictions on advertising for beer by media type and percentage (in %) of countries, 2016

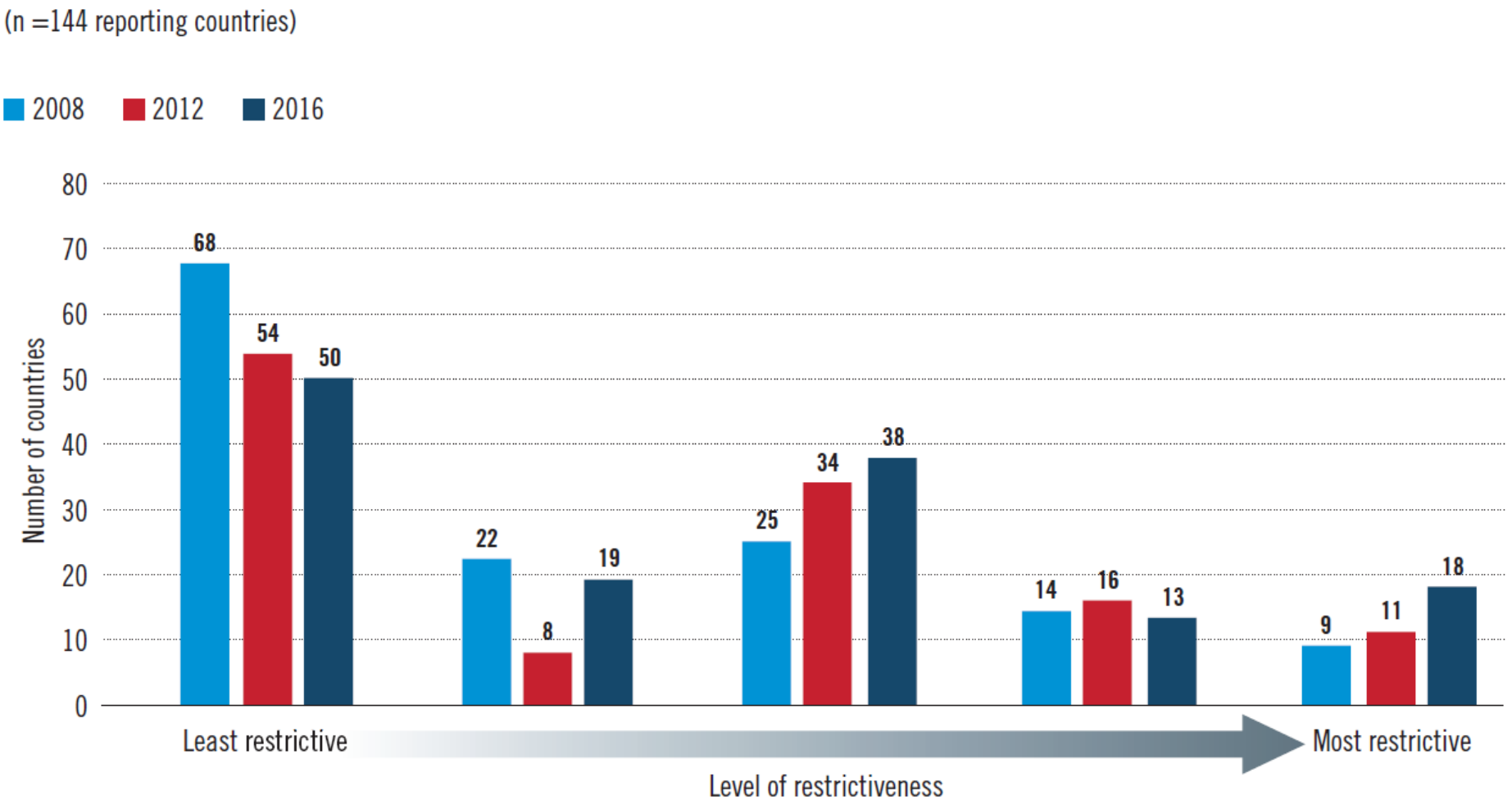


Stringency of overall statutory regulation of alcohol marketing, by WHO region and the world and percentage (in %) of countries, 2016



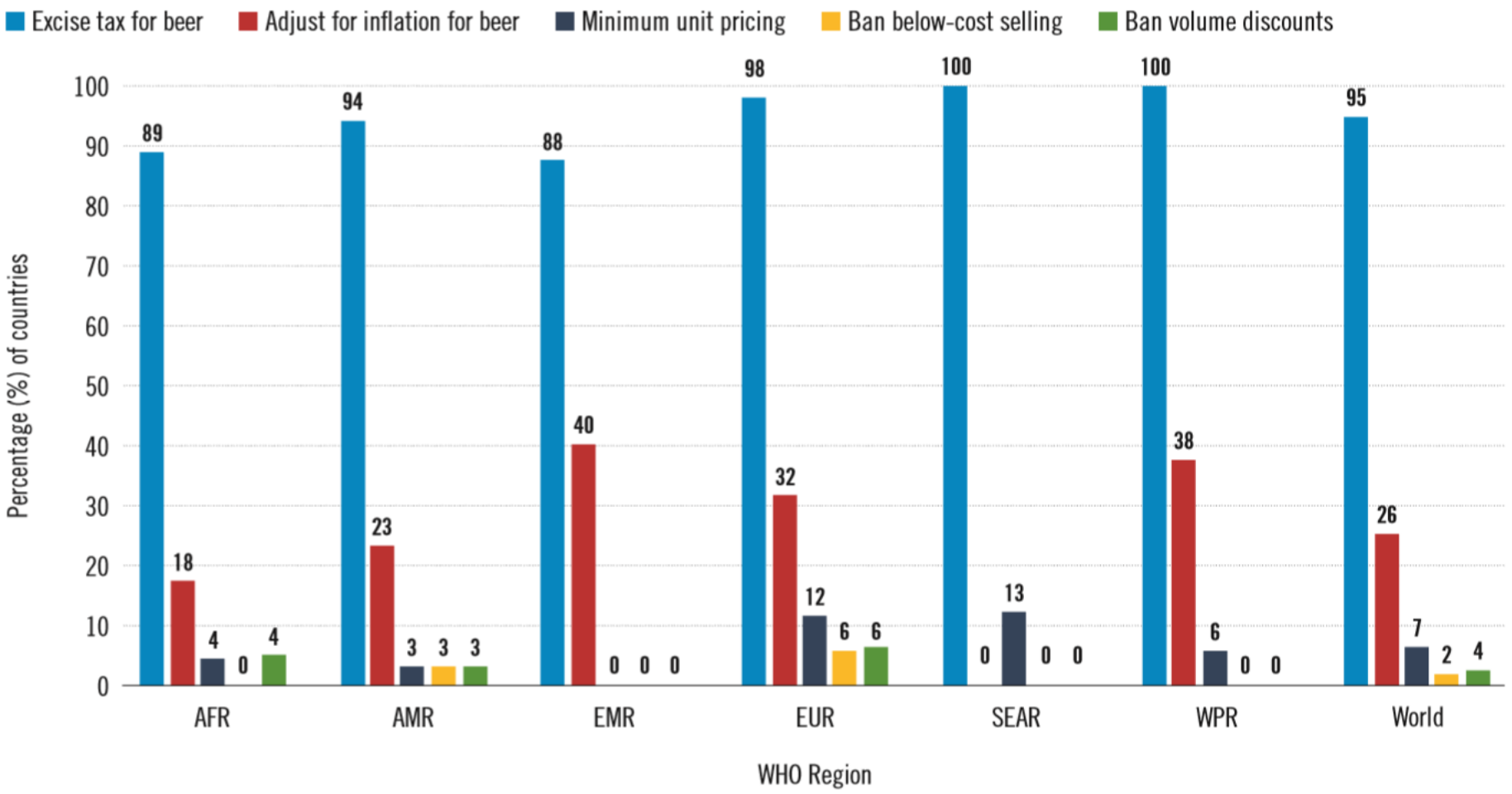
Note: The numbers in each coloured bar indicate the number of countries in that category, whereas the length of each coloured bar indicates the percentage of countries in the category.

Stringency of overall statutory regulation of alcohol marketing, by number of countries, 2008–2016



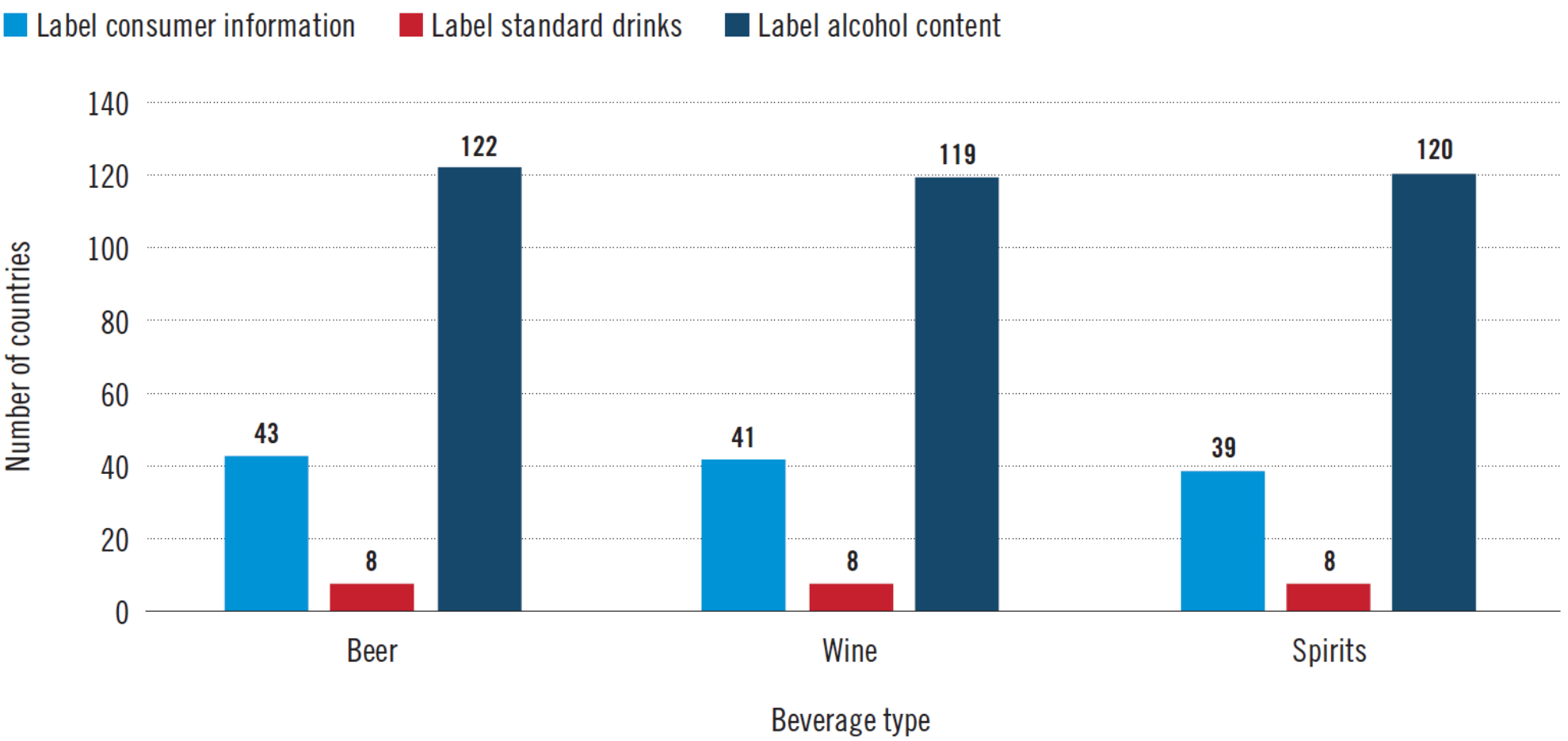
Implementation of selected price and tax measures by WHO region and percentage (in %) of countries, 2016

(n = 164 reporting countries, except 137 countries reported on inflation adjustment)



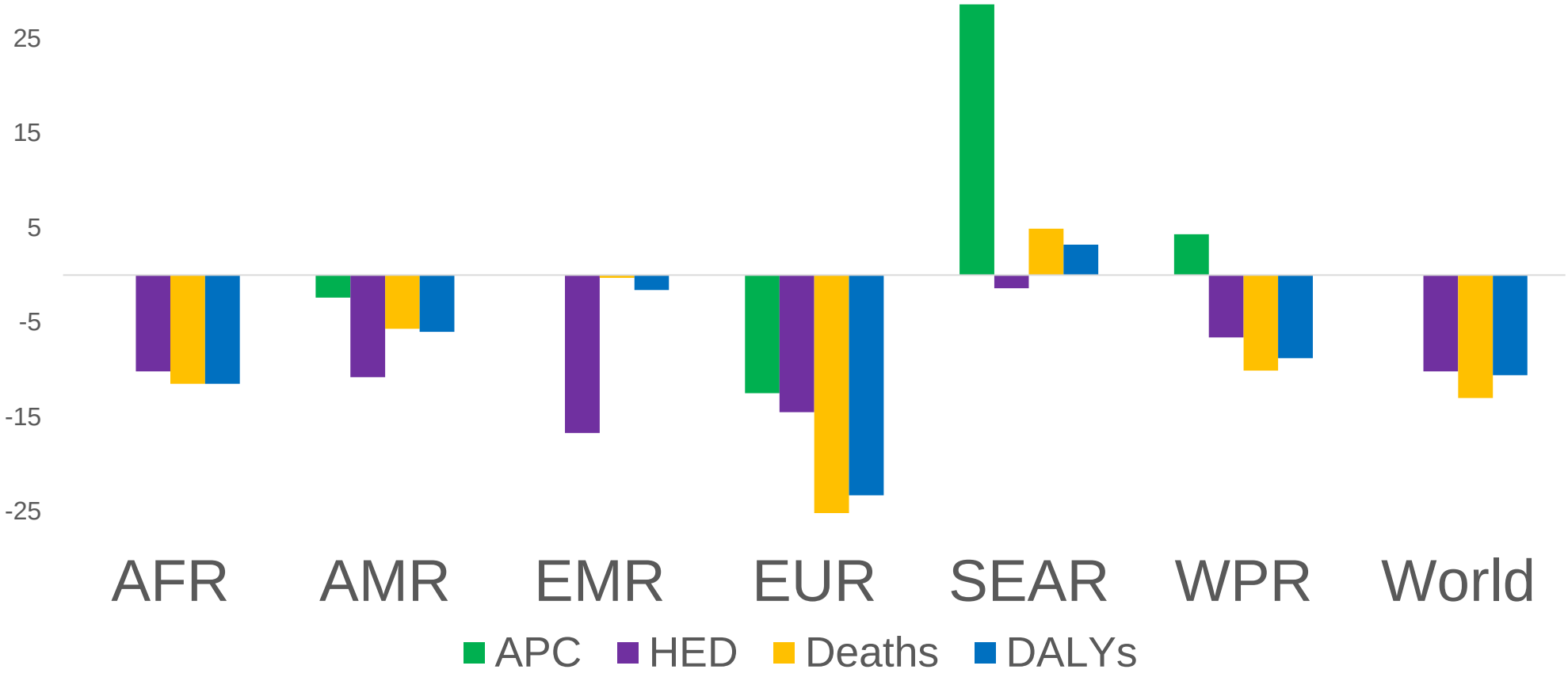
Required warnings and health-related information on labels by beverage type and number of countries, 2016

(n=163 reporting countries, except 162 for labeling standard drinks on wine and 160 for labeling alcohol content on beer, wine and spirits)



6. REDUCING THE HARMFUL USE OF ALCOHOL: A PUBLIC HEALTH IMPERATIVE

Relative change (in %) in total alcohol per capita consumption (APC), prevalence of heavy episodic drinking (HED) and alcohol attributable deaths and disability adjusted life years lost (DALYs) per 100 000 people from 2010 to 2016 by WHO region and in the world.



Challenges in reducing the harmful use of alcohol

- The challenges of a multisectoral approach, its coordination and focus on the role of health sector
- The growing concentration and globalization of economic actors and strong influence of commercial interest
- The cultural position of drinking and corresponding concepts and behaviours.

Opportunities for reducing the harmful use of alcohol

- Building on the decrease in youth alcohol consumption in many high- and middle-income countries and increased health consciousness in populations
- Building on recognition of the role of alcohol control policies in reducing
- health and gender inequalities
- Building on the evidence of cost-effectiveness of alcohol control measures

The way forward: priority areas at the global level

- Public health advocacy, partnership and dialogue
- Technical support and capacity-building
- Production and dissemination of knowledge
- Resource mobilization

Conclusion

- With 3 million alcohol-attributable deaths in 2016 and well-documented adverse impacts on the health and well-being of individuals and populations, it is a public health imperative to strengthen and sustain efforts to reduce the harmful use of alcohol worldwide.
- A significant body of evidence has accumulated on the effectiveness of alcohol policy options, but often the most cost-effective policy measures and interventions are not implemented or enforced, and the alcohol-attributable disease burden continues to be extraordinarily large.
- The wealth of data and analyses presented in this report can hopefully provide new grounds for advocacy, raising awareness, reinforcing political commitments and promoting global action to reduce the harmful use of alcohol.

COUNTRY PROFILES

WHO regions

AFR

AMR

EMR

EUR

SEAR

WPR

Appendixes

APPENDIX I

ALCOHOL CONSUMPTION

APPENDIX II

HEALTH CONSEQUENCES

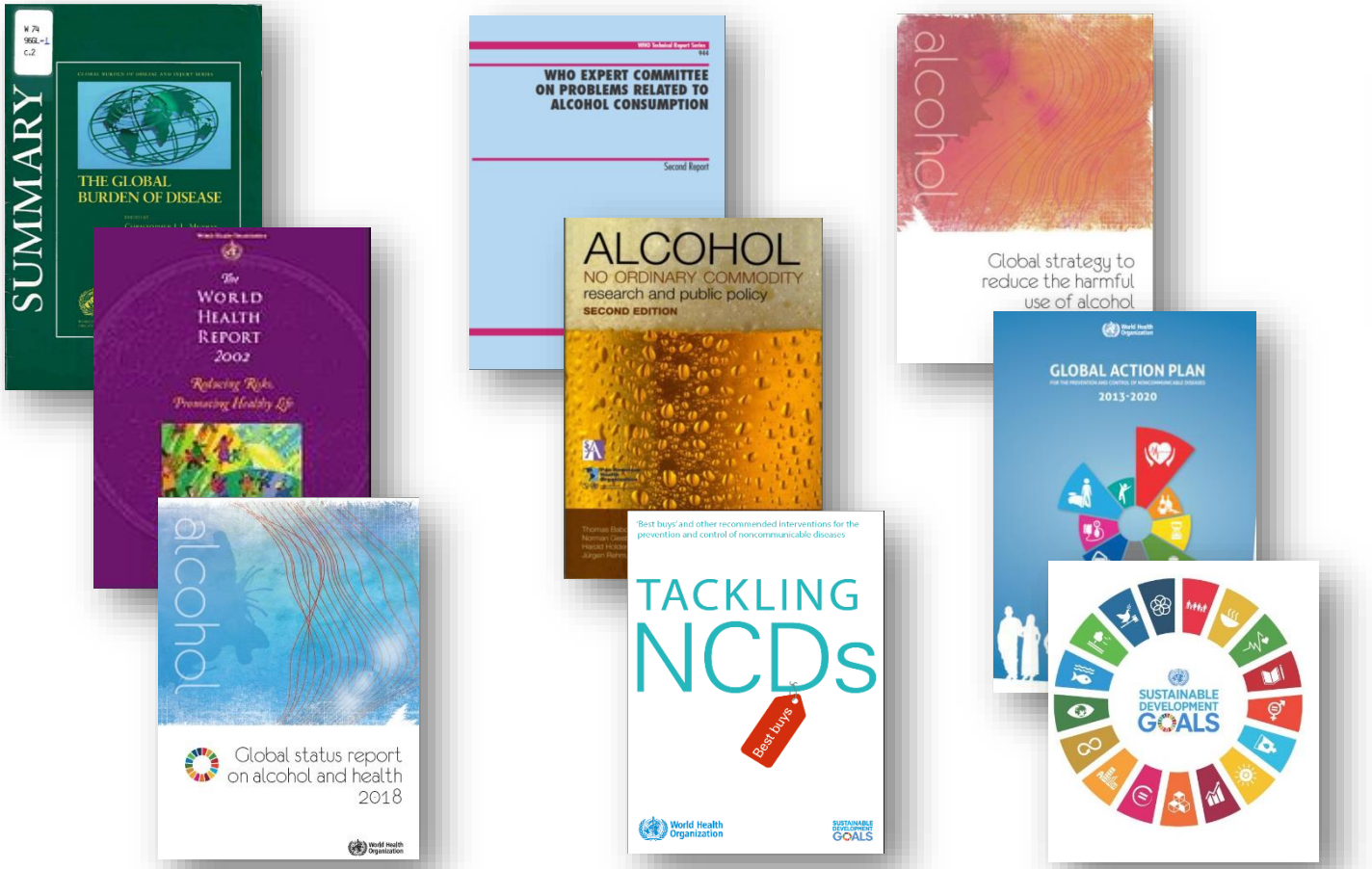
APPENDIX III

INDICATORS RELATED TO ALCOHOL POLICY AND INTERVENTIONS

APPENDIX IV

DATA SOURCES AND METHODS

The problem **The solutions** **The decisions** **The actions**



TIME TO DELIVER

#beatNCDs

SAFER

A WORLD FREE FROM ALCOHOL RELATED HARMS

SAFER – a new WHO led initiative

- The SAFER initiative was launched during a side event on alcohol at the 3rd HLM on NCDs 28 September 2018
- SAFER has been developed with supporters to meet global, regional and country health and development goals, and to reduce human suffering and pain caused by the harmful use of alcohol.
- The overall objective is to provide support for Member States in reducing the harmful use of alcohol by boosting and enhancing the ongoing implementation of the global alcohol strategy and other WHO and UN instruments.
- SAFER will focus on the most cost-effective priority interventions ("best buys") using a set of WHO tools and resources to prevent and reduce alcohol-related harm

“We are proud to introduce SAFER – a package of proven interventions to reduce the harms caused by alcohol, and a new partnership to catalyze global action. We need governments to put in place effective alcohol control policy options and public policies to reduce the harmful use of alcohol.”

Dr Tedros Adhanom Ghebreyesus,
Director-General of WHO

Geneva, 28 September 2018

Thank you for your attention

More info at:

https://www.who.int/substance_abuse/