Reporting about alcohol:

a guide for journalists

World Health Organization

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ACKNOWLEDGEMENTS

ABSTRACT

No amount of alcohol is safe to drink. Yet around the globe, there is low awareness of the negative impact of alcohol consumption on health and safety. This guide aims to support understanding and reporting on the harm to individuals, families and societies caused by alcohol con sumption. When it avoids moralizing and misplacing blame on individual alcohol consumers, media reporting on alcohol can help people to better understand the unacceptably high burden alcohol has on health and societies, as well as the root causes of the problem and how it can be largely prevented.

This guide presents ways for journalists to cover and think about alcohol consumption and its harms more broadly, as well as the proven solutions to this problem.

A global health problem hiding in plain sight

No amount of alcohol is safe to drink, yet around the globe, there is low awareness of the overall negative impact of alcohol consumption on health and safety. This guide aims to support understanding and reporting on the harm to individuals, families and societies caused by alcohol consumption.

Alcohol is a psychoactive substance with intoxicating and dependence-producing properties. The evidence that its consumption is creating a global public health epidemic has accumulated through repeated testing and retesting.

A top risk factor for ill-health and early death, alcohol consumption contributes to 3 million deaths each year globally and to millions more disabilities and incidents of poor health. It has a clear and convincing causal link with noncommunicable diseases (NCDs) such as liver cirrhosis, cancers and cardiovascular diseases. It is also associated with tuberculosis, HIV and other communicable diseases. In many countries, sharp increases in alcohol consumption during the COVID-19 pandemic is projected to cause thousands of additional deaths over the short- and long-term.

But alcohol hurts many more people than the individual drinker. Besides diseases, it causes injuries, and mental and social harm to family members, friends, coworkers and strangers. As a result, alcohol is an urgent problem for entire populations, with external impacts and costs that are considerably greater than those associated with tobacco and with illicit drugs.

News stories that cover accidents, crimes or injuries related to alcohol rarely mention its role or discuss the many ways that alcohol is a concern to public health and society. When reporting does try to expose the harmful effects of alcohol use, it usually emphasizes addiction and high-risk drinking habits, missing the story that most alcohol-related harms across the population come from the larger group of low-to-moderate risk drinkers.

When it avoids moralizing and misplacing blame on individual alcohol consumers, media reporting on alcohol can help people to better understand the unacceptably high burden alcohol has on health and societies, as well as the root causes of the problem and how it can be largely prevented.

The World Health Organization (WHO) promotes evidence-based public health policies and messaging that address alcohol as a widely shared general problem. This guide is part of that effort, presenting ways for journalists to cover and think about alcohol consumption and its harms more broadly, as well as the proven solutions to this problem.

How this guide was developed

This guide was developed by researching how alcohol is covered in media worldwide and how it can reflect and affect attitudes, practices and beliefs about alcohol consumption. The main steps for its development comprised:

- ► evaluating the reporting and framing of alcohol in recent advocacy tools developed by civil society organizations,

- ► scoping the coverage in major English-language media,

- ► studying the available data about alcohol consumption on national and global levels,

- ► reviewing the growing body of evidence-backed research about the determinants driving alcohol consumption and how it affects people and their communities and

- ► interviewing stakeholders in civil society and academia about the ways that alcohol is portrayed. This approach identified the evidence and techniques that are presented in this guide to help journalists strengthen their reporting about alcohol consumption, alcohol-related harm and policy responses.

Common questions about alcohol

Isn't drinking some alcohol good for your health?

No, there is no evidence for the common belief that drinking alcohol in moderate amounts can help people live longer by decreasing their risk of heart disease, diabetes, stroke or other conditions. It is inaccurate to say that "experts are divided" on whether there is no amount of healthy alcohol drinking. The scientific consensus is that any level of alcohol consumption, regardless of the amount, increases risks to health. While several past studies did suggest that moderate consumption could, on average, promote health benefits, newer research *(1)* shows that those studies used limited methodologies and that many of them were funded by the alcohol industry *(2)*. The dicussion about possible so-called protective effects of alcohol diverts attention from the bigger picture of alcohol harm; for example, even though it is well established that alcohol can cause cancer, this fact is still not widely known to the public in most countries *(3)*.

Takeaway

Comprehensive, systematic reviews of the evidence conclude that no level of alcohol is safe to drink. There are no known protective health effects from consuming alcohol, even at low levels.

But what about reports that a daily glass of red wine is good for your heart?

There is no good evidence for the pervasive myth that consuming red wine helps prevent heart attacks. Drinking even a small amount of red wine – just like beer, spirits or anything else containing alcohol – increases the risk of cardiovascular disease *(4)*, along with more than 200 other diseases and types of injuries. Previous studies that touted the health benefits of red wine would have benefited from more sceptical evaluation since many of them were based on observational research that did not consider pre-existing health conditions among non-drinkers when comparing them to drinkers.

Takeaway

Widely publicized claims that drinking a glass of red wine a day can protect against cardiovascular disease are wrong and divert attention from the many harms of alcohol use.

Why are national drinking guidelines different from WHO recommendations?

Many countries have issued low-risk guidelines, usually recommending no more than 10 standard drinks per week. WHO does not set particular limits because the evidence shows that the ideal situation for health is not to drink alcohol at all. Any alcohol use is associated with some risk, such as the risk of alcohol dependence, breast cancer (a linear relationship in women) or injury. While adhering to national alcohol guidelines may keep individual risk levels low, from a public health perspective and at the population level, there are no levels of consumption at which no risks are involved.

Takeaway

Drinking less alcohol is better for your health, but none is best.

If alcohol is so bad for you, why does nearly everyone drink it?

That nearly everyone drinks is a myth, supported by heavy alcohol industry marketing worldwide. This marketing makes alcohol – a psychoactive substance with carcinogenic and dependence-producing properties – look like a normal, if not essential, part of celebrations and socializing. Yet more than half of the world's population does not consume alcohol, with 57% of adults around the globe abstaining from the practice in 2016 *(5)*. For many people around the world, drinking alcohol is simply not part of their culture. They are a diverse range of people, but they are not often represented in the media. They have the right to be supported in their behaviour and protected from pressures to drink alcohol.

Takeaway

More than half of adults around the world do not drink alcohol; their perspectives are under-represented in the media, maintaining a common misconception that alcohol consumption is an inevitable part of life.

Doesn't drinking alcohol help people relieve stress?

As a depressant drug that can have a calming effect, alcohol may seem to provide short-term relief from stress, but it does nothing to remove the source of stress *(6)*. Moreover, drinking alcohol to relieve stress can cause hangovers, disrupt sleep, affect relationships and sometimes lead to financial difficulties, making feelings of stress, anxiety or depression even worse. Even at low levels, alcohol consumption increases the risk of mental disorders as well as cognitive impairment, dementia and alcohol dependence. Symptoms of depression, anxiety and insomnia can often be helped if people cut down on their alcohol consumption instead of using it as a self-medication.

Takeaway

Rather than relieving stress, drinking alcohol can cause psychological and physiological harm and can compound the effects of stress.

Isn't alcohol safe as long as you drink responsibly?

Across the population, any level of alcohol consumption, regardless of the amount, is associated with a greater risk of loss of healthy life *(1)*. The vague notion of "responsible drinking" *(7)* that is actively promoted by alcohol producers and marketers, does not define when to stop drinking or suggest the option of not drinking. It does, however, create a mistaken impression that the alcohol industry is part of the solution to harms from drinking rather than a driver of the problem. Moreover, the moralizing tone implicit in "responsible drinking" messages ignores the inherent risks in consuming alcohol, mischaracterizing its harms as the result of a small minority of individual drinkers who cannot control their intake. It also can perpetuate stigmatizing attitudes, wrongly blaming individual drinkers as the cause of all health or social problems linked to alcohol consumption, creating a sense of shame that stops them and their family members from seeking help when they need it.

Takeaway

Risks to health start from the first drop of any alcoholic beverage, so it is not possible to consume safely – no matter how responsibly the drinker behaves.

Doesn't most alcohol harm come from a minority group of heavy drinkers?

The common perception is that a small fraction of the population causes most of the harm linked to alcohol consumption. But alcohol-related cancers, accidents, injuries and violence are widely distributed across the population *(8)*, including among those who drink moderately. Even though heavy drinkers are undoubtedly at high risk of alcohol-related harm, they contribute only a minority to the total alcohol casualties. In this "prevention paradox", most alcohol-related harm occurs among low-to-moderate risk drinkers simply because they are more numerous in the population.

Takeaway

Alcohol consumption causes considerable harm to millions of people across the world, not just the heaviest users, which is why strong global action that protects the entire population is needed.

Isn't alcohol consumption good for the economy?

Since alcohol consumption can sustain jobs and generate tax revenue, some assume it positively affects economic development. However, the resulting harm decreases worker productivity and increases health-care, criminal justice and social services costs. The net effect is a lower gross domestic product (GDP) *(9)*. The latest economic analysis undertaken under the auspices of WHO estimated that every additional US$ 1 invested in the most cost-effective alcohol interventions per person per year will yield an estimated economic return of US$ 9.13 by 2030 *([10])*. Reducing alcohol harm contributes directly and indirectly to economic development *(11)*, with demand and jobs created in other sectors. The output and employment provided by alcohol consumption can be replaced in other parts of an economy, while reducing alcohol use will help attain a number of the Sustainable Development Goals (SDGs), including the goals on ending poverty, quality education, gender equality, economic growth and reducing inequalities between and within countries.

Takeaway

Despite being a low priority in many countries, reducing alcohol consumption improves economic development.

In this day and age, why is it said women should drink less alcohol than men?

Alcohol is quite simply more damaging to women *(12)*. The smaller percentage of water in a woman's body than in a man's body means that alcohol will reach a higher concentration faster and, therefore, more significant toxicity. In addition, the enzyme that breaks down alcohol is produced in smaller quantities in a woman's body, which means alcohol will take longer to leave her system. As a result, women have a higher risk of liver cirrhosis, heart disease and nerve damage than men do when they drink the same amount of alcohol *(13,14)*. Alcohol also poses some harms that are unique to women. It raises estrogen levels, creating a particular risk of breast cancers known as estrogen receptor-positive, in which estrogen fuels tumour growth. Many people, including women, are unaware that breast cancer is the most common cancer caused by alcohol among women globally.

Takeaway

Because alcohol is more harmful to women, if they begin to drink more like men (who currently consume the majority of alcohol and suffer most of the alcohol-related harms), they will experience far more negative health effects than men.

@ ingimage

How alcohol harms the body

The risks and harms associated with drinking ethyl alcohol (ethanol) – the toxic, psychoactive and dependence-producing substance in alcoholic beverages – have been systematically evaluated and are well documented. Irrespective of whether it is cosumed in the form of wine, beer, spirits or anything else, no level of alcohol is safe for health.

When someone drinks alcohol, it is rapidly absorbed into their blood via the stomach and small intestine and moves through nearly every part of the body. Its intoxicating effects can be felt in as little as 5 minutes as it surpresses neural activity in the brain, altering thoughts, judgement, decision-making and behaviour while reducing physical coordination, balance and reaction times.

Alcohol consumption, especially heavy use, weakens the immune system and thus reduces the ability to cope with infectious diseases.

The risk of damage to health increases with each drink of alcohol consumed, due to its toxic effects – short- and long-term – on almost every organ of the body.
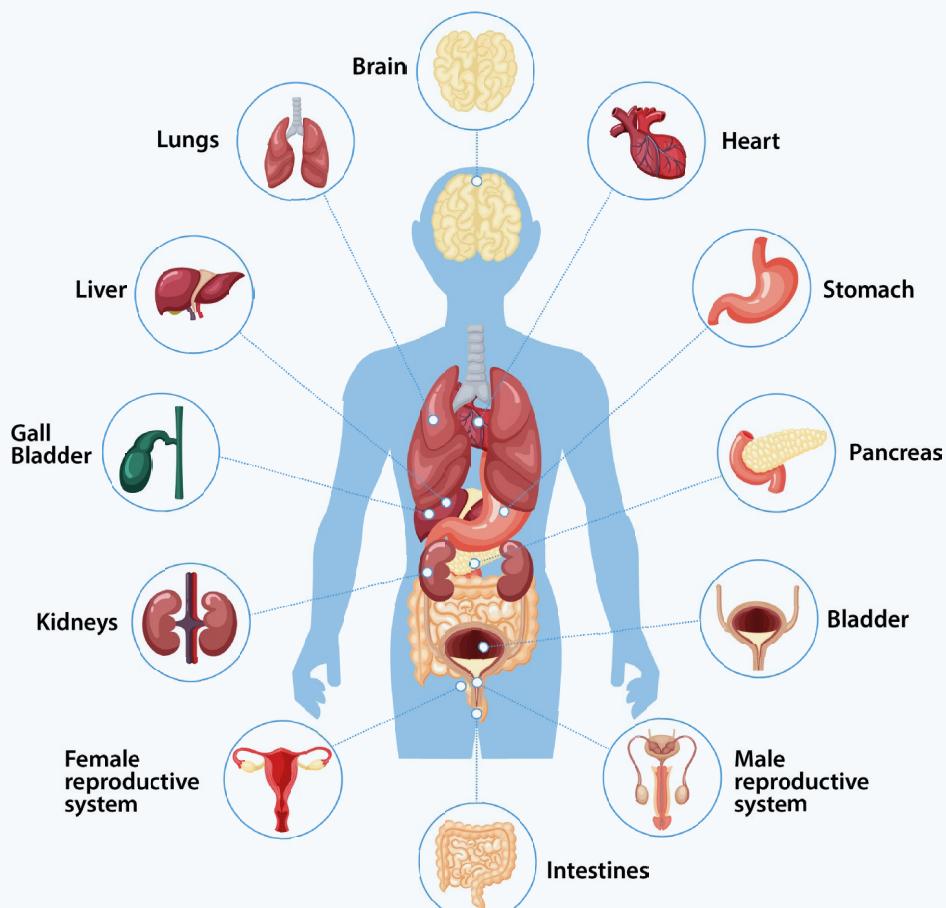
Classified as a Group 1 carcinogen by the International Agency for Research on Cancer, alcohol is known to cause at least seven types of cancer – even in minimal amounts. It is recognized as a cause of more than 200 diseases and types of injuries in the International Classification of Diseases, with at least 40 diseases and types of injuries being 100% attributable to alcohol *(8)*.

For pregnant drinkers, alcohol, even in small amounts, is a risk to the unborn child at any time during pregnancy.

Cancers associated

Mouth and throat. Voice box (larynx). Esophagus. Colon and rectum. Liver. Breast (in women).

Alcohol-associated organ damage

How alcohol
harms society

As an intoxicant, alcohol affects a wide range of structures and processes in the central nervous system; as such, it is a risk factor for intentional and unintentional injuries to consumers and those around them – whether household members, relatives and friends, colleagues or people encountered on the street. The harms may be to health (e.g. drink–driving injuries, suicide, homicide, prenatal alcohol exposure, a family member's anxiety or depression, the transmission of infection to a sexual partner) or may be social (e.g. assault, community nuisance) or economic (e.g. reduced job performance and absenteeism, damage to property, money for family necessities spent on drinking) *(8)*.

The extent of alcohol's harm on society is not fully known, but several studies have assessed alcohol's harm to others. Surveys from Australia, Chile and New Zealand report that people's heavy drinking negatively affects the health and well-being of those around them *(15,16,17)*. In the European Union, very conservative estimates of harm to others (based mainly on drink–driving, homicides and fetal alcohol syndrome) suggest that 3–4% of overall alcohol-attributable deaths are due to others' drinking.

Categories of alcohol-related social harm *(18)*:

- ► violence
- ► vandalism
- ► public disorder
- ► property damage
- ► family problems: divorce/marital problems
- ► child maltreatment
- ► other interpersonal problems
- ► financial problems
- ► work-related problems
- ► work accidents
- ► educational difficulties
- ► social costs.

The burden of alcohol problems seldom falls evenly across socioeconomic groups. For poor communities and individuals, the purchase of alcohol takes a larger toll on personal and family income than in other social groups. In the finding known as "the alcohol harm paradox", it is observed that people with low incomes tend to experience more alcohol-related harms than more affluent drinkers even though they tend to drink less alcohol *(19)*. In addition, since harm from alcohol consumption is often passed on through generations, it creates a vicious circle of poverty and social deprivation.

THE GLOBAL GOALS

Alcohol adversely impacts the possibility of achieving 13 of the 17 SDGs and a total of 52 targets, effectively intersecting all three dimensions of the 2030 Agenda for Sustainable Development (economic, social and environmental). It directly impacts many health-related targets within the SDGs, including those for maternal and child health, infectious diseases (HIV, viral hepatitis and tuberculosis), NCDs, mental health and road injuries *(11)*.

Including a specific target on the harmful use of alcohol (SDG 3.5: strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol) demonstrates the critical role of alcohol within the global development agenda. If implemented, a wide range of policies – particularly those related to taxation, availability control and advertising regulation – would not only to reduce the social harms and health problems experienced by drinkers, but to also protect and assist those affected by their drinking *(18)*.

Alcohol acceptability in cultures

Around the globe, a wide variety of cultural factors influence and shape what constitute "normal" alcohol consumption practices. These factors include:

► when, where, why and how people drink alcohol

► how much alcohol people drink

► expectations about the effects of different amounts of alcohol

► the behaviours people engage in before, during and after drinking alcohol.

While predominant alcoholic beverage types tend to change relatively slowly in a culture, imported industrial alcoholic beverages have replaced traditional home-fermented beverages (unrecorded alcohol) amid recent economic development in many low- and middle-income countries *(18)*.

Cultures of alcohol consumption are not homogeneous or static – they are numerous, fluctuate and are part of a network of interacting factors, including gender, age, social class, government policies and industry marketing *(20)*.

A place where alcohol is easily accessible, readily available and accepted without question as a part of most adult social activities, is considered an "alcogenic environment". In such places, multipronged approaches that recognize the need for coordinated actions tackling acceptability, availability and affordability have been shown to be effective in preventing alcohol-related harm *(18)*.

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Alcohol consumption history and trends

Alcohol is produced from a wide variety of plants by fermentation, and then by distillation for spirits; the control of these processes is at the heart of alcohol industries. While traditional home or craft production of alcoholic beverages continues, most alcoholic beverages are produced commercially and transferred to retailers for sale to consumers.

The traditional mode of production, in batches initially from local vegetation, was practiced from before recorded history in many (though not all) parts of the world and continues today. The industrial production of beer and spirits from raw agricultural materials started early in the industrial revolution. For the last century and more, it has been the dominant mode of production of all primary forms of alcoholic beverages.

In the 19th century, the production and long-distance transport of alcoholic beverages and their ingredients became globalized, along with the growth of the European empires and cross-ocean trade (21, 22, 23). As of now, however, alcoholic beverages are generally most often consumed in the same area where they were produced.

The globalization of alcohol has only increased with the advent of sophisticated marketing and transnational corporations. Today, 10 companies market and sell two thirds of the world's beer, and 10 companies sell nearly half the world's distilled spirits. In a significant change from earlier eras, these companies spend heavily on marketing worldwide; in 2017, the world's largest beer maker alone spent US$ 6.2 billion (24). As a comparison, WHO's strategic communications budget was US$ 40 million that year. In 2022, six alcohol companies ranked among the 100 largest advertisers in the world (25).

About three quarters of the alcohol consumed worldwide is recorded alcohol, which is roughly equivalent to it being commercial and taxed, with much of the rest produced informally on a relatively small scale (26).

Although alcohol consumption in low-income countries is generally lower than in high-income countries, the rate of alcohol-attributable harm is higher. The "harm per litre" is also much higher for poorer people than for richer ones (8). In terms of health equity, there are solid arguments for limiting the marketing and promotion of alcohol more stringently where the target consumers are poorer and have fewer resources. As such, WHO is particularly concerned by the targeting of new markets in developing and low- and middle-income countries with a low prevalence of alcohol consumption and high abstinence rates.

Similarly, while three quarters of the alcohol is consumed by males (8), globally, alcohol marketers tend to see the lower rate of women drinking as an opportunity to encourage more to drink, often depicting drinking by women as a symbol of empowerment and equality (27). Studies of domestic violence show that violence against women is more likely to occur when a man and woman have been drinking (28), which may decrease rather than increase a woman's power in an intimate relationship.

@ inigimage

What works to reduce alcohol consumption

There are well-known, evidence-based and population-wide interventions to reduce alcohol consumption and tackle its harms, see Fig 1 The SAFER initiative. To effectively improve health and social outcomes for individuals, families and communities, these interventions need to be applied concurrently as the comprehensiveness of the approach enhances their effects.

However, people often need to be shown evidence of how change is possible to support alcohol interventions. Here are examples of what can help, what might, and what won't.

Most cost-effective: raising taxes on alcohol

Taxation offers the most cost-effective strategy for minimizing alcohol harm in most countries. WHO recommends that countries establish and enforce a taxation system that considers the alcohol content of the beverage, ban or restrict sales below cost and other price promotions, and institute minimum prices for alcohol. Studies repeatedly find that increasing the price of alcohol is associated with reductions in alcohol consumption and alcohol-related morbidity and mortality, including liver cirrhosis deaths, violence, drink–driving and sexually transmitted infections (29). A small part of the literature also suggests that the benefits of higher alcohol prices also extend to the education sector, increasing the likelihood of secondary school graduation and post-secondary enrolment. A 2022 study found that raising taxes on alcohol to a minimum of 15% in the WHO European Region, which has the highest prevalence of drinkers globally, could avert more than 130 000 deaths per year (30). Increasing taxes on alcohol has the added benefit of generating more revenue for strengthening health systems or other critical public services.

Highly cost-effective: regulating alcohol marketing

Banning or comprehensively restricting alcohol marketing, advertising, sponsorships and promotion is a cost-effective way to eliminate one of the causes of underage drinking (31). Alcohol is the leading killer of young people world wide (32). Stopping young people from consuming alcohol eliminates a high risk of dependence later in life. While the alcohol industry maintains that advertising does not affect consumption and is not aimed at young people, industry data shows that alcohol advertising emphasizes recruiting drinkers (33), particularly younger

ones (31). Ubiquitous alcohol marketing also creates an environment that makes a recovery from alcohol dependence more difficult. A common finding is that around half of the alcohol consumed by a population is drunk by 10% of current drinkers (34), making heavy and dependent drinkers a crucial target for alcohol sales and advertising. Alcohol-dependent patients frequently report a stronger urge to drink alcohol when confronted with alcohol-related cues. With the advent of algorithmic online marketing techniques targeting individuals based on their past behaviours, unchecked alcohol marketing can also interfere with individuals' efforts to reduce or eliminate their drinking.

Highly cost-effective: restricting the availability of alcohol

As a highly cost-effective "best-buy" intervention, WHO recommends countries enact and enforce regulations on the physical availability of alcohol by reducing the hours of sale, fixing an appropriate minimum age for purchase or consumption of alcoholic beverages and reducing the density of outlets. The widespread existence of licensing systems regulating alcohol shows the potential for effective restriction. In practice, it is common for countries to increase the availability of alcohol by increasing the number of licences to produce, distribute and sell alcohol. Across the globe, increased hours and days of sale have been linked to increased alcohol consumption and its associated harm. For example, the 2003 introduction of 24-hour alcohol availability in the United Kingdom saw increased levels of crime and antisocial behaviour between 03:00 and 06:00, increased police expenditure and resource allocation during the early hours, and increased alcohol-related hospital admissions (35). Conversely, reducing the opening hours of bars from 24 hours a day to closure at 23:00 in Diadema, Brazil, was associated with a 44% drop in homicides (36).

Effective: enacting drink–driving countermeasures

Drivers with a blood alcohol concentration (BAC) of 0.02–0.05 g/dl have at least a three times greater risk of dying in a vehicle crash. This risk increases at least six times with a BAC of 0.05–0.08 g/dl. In recent decades, many countries have successfully reduced drink–driving-related crashes, using evidence-driven, context-relevant legislation, consistently enforced and well understood by enforcement officials and the public. Best practice for drunk–driving laws includes a BAC limit of 0.05 g/dl for the general population and a BAC limit of 0.02 g/dl

for young or novice drivers. Australia is one country that has adopted the legal 0.05 g/dl limit, introducing it in the 1980s with large-scale police enforcement through random breath testing. This was supported by various other interventions, including publicity, community activity programmes, and variations in licensing and distribution arrangements for alcohol. While drink–driving is still a significant cause of death and injury on the country's roads, alcohol as a factor in crashes was almost halved in Australia over 30 years *(37)*, and there is now a strong community view that the behaviour is socially irresponsible and unacceptable.

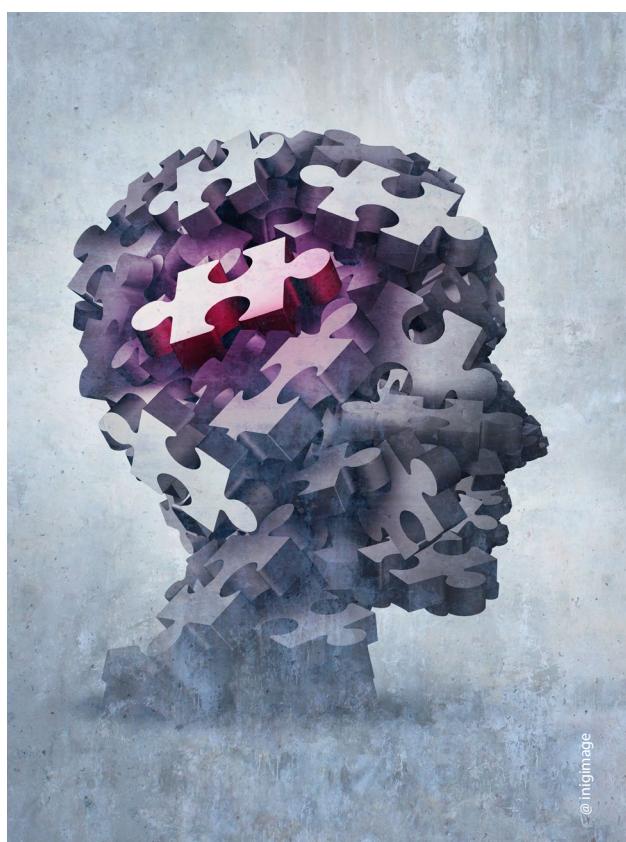## Effective: providing brief interventions

There is evidence that brief interventions – short, nonconfrontational conversations with nurses or other health-care providers – can motivate high-risk drinkers to think about or plan a change in their drinking behaviour *(38)*. Proactive approaches in health-care settings are essential to a comprehensive national alcohol policy. WHO's Alcohol Use Disorders Identification Test (AUDIT) was developed to screen excessive drinking and assist in brief assessment in primary care settings *(39)*. It can help identify excessive drinking as the cause of the presenting illness. It also provides a framework for intervention to help risky drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking.

Effective: minimum unit pricing

Where taxation is not considered a viable policy option, setting minimum prices for alcoholic beverages or regulating discount prices can help reduce economic availability. Increasing the price of alcohol has been found to reduce acute and chronic harm related to drinking among people of all ages, indicating that heavy or problem drinkers are no exception to the basic rule that alcohol consumers respond to changes in alcohol prices. After Scotland introduced minimum unit pricing in 2018, the research found that alcohol sales in the country fell by 7.7%, the reductions occurring mostly in households that bought the most alcohol *(40)*. The same study found an 8.6% decrease in alcohol sales in Wales after it introduced minimum unit pricing in 2020. Minimum unit pricing specifically targets low-cost products to protect drinkers at the most significant risk of harm, who tend to consume the cheapest alcohol.

Possibly effective: health warning labels

WHO recommends labelling alcoholic beverages with information about the harm caused by alcohol to increase awareness and ensure that consumers make informed decisions *(41)*. While the evidence is not robust that warning labels on alcoholic beverages reduce consumption or change individual behaviour, raising awareness cannot be discounted, as it is a preliminary step towards behaviour and policy change *(42)*. Moreover, comprehensive health warning labels on tobacco products have been consistently shown to influence social norms, improve health knowledge and reduce consumption behaviours. The first study to experimentally test evidence-informed alcohol health warning labels in the real world took place in the Yukon, a territory in northwestern Canada *(43)*. It found that adding warning labels to alcohol bottles decreased total sales by 6.9% compared with sales in regions without labels. "Over time, the people that we talked to in Yukon, they had increased knowledge of cancer risk from alcohol, better ability to estimate what one standard drink is, they had good recall of drinking guidelines, and their knowledge improved over time," one of the study's lead researchers told the Canadian Broadcasting Corporation *(44)*.
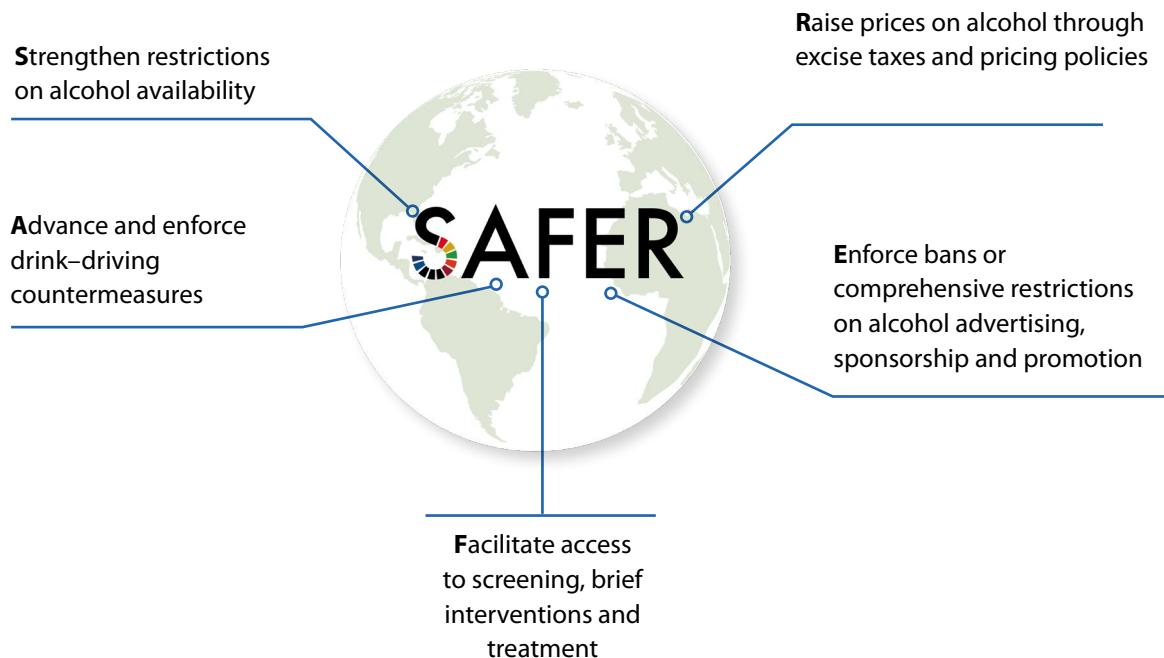
@ inigimage

SAFER is an acronym for the five most cost-effective interventions to prevent and reduce alcohol-related harm.

This WHO-led initiative and alcohol policy blueprint helps countries with the practical steps to accelerate progress in reducing alcohol consumption.

Fig 1. The SAFER initiative

Strengthen restrictions on alcohol availability

Raise prices on alcohol through excise taxes and pricing policies

Advance and enforce drink–driving countermeasures

Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion

Facilitate access to screening, brief interventions and treatment

Source: The SAFER initiative *(45)*.

Ineffective: public service announcements

Messages dealing with responsible drinking, the hazards of drink–driving and related concerns have been a largely ineffective counter-response to the frequent, high-quality, pro-drinking advertisements individuals are exposed to through the mass media. Moreover, when the alcohol industry sponsors nongovernmental organizations' road safety campaigns, it has been found to boost alcohol brand reputation instead of effectively addressing drink–driving *(46)*. Research shows that while public service announcements and other education and information campaigns have led to some improved knowledge about alcohol's harms, they have little impact on alcohol use [47]. To succeed at the individual level, public service announcements likely require a corresponding public policy to support the introduction of more effective measures to reduce alcohol consumption *(18)*.

Ineffective: corporate social responsibility initiatives

There are irreconcilable differences between the goals of governments to protect and promote people's health and well-being and the economic operators pursuing maximum profit through increased alcohol consumption. Corporate social responsibility initiatives by the alcohol industry are a strategy to legitimize its participation in the public health agenda and divert attention from evidence-based strategies that reduce alcohol harm *(48)*. Presenting the industry as a reliable and necessary public health actor implies that the consumption of alcohol and its related harm result solely from an individual choice rather than being the product of contextual conditions, such as investment and marketing.

Alcohol industry corporate social responsibility has been shown to promote mixed messages about alcohol-related harm and undermines scientific evidence *(49)*. Meanwhile, some alcohol industry-sponsored educational programmes have increased alcohol-related

harm and have been linked with efforts to circumvent or prevent regulation. Further, there is little or no evidence for the effectiveness of designated driver campaigns, which constitute the cornerstone of the industry's strategy to reduce impaired driving *(50)*. As promoted by the industry, responsible drinking campaigns can be interpreted as a marketing tool and a tactic to influence public beliefs about the alcohol industry *(51)*. Countries should consider developing a framework for managing conflicts of interest that builds on the work in nutrition and tobacco *(52)*.

Ineffective: industry self-regulation

While the alcohol producers maintain they can regulate their own marketing activities, researchers have found that guidelines are routinely not followed, causing excessive alcohol marketing exposure to young people and other vulnerable populations *(53)*. Studies find that young people who are more exposed to alcohol marketing appear to be more likely to start drinking alcohol early and engage in binge and hazardous drinking *(54)*. WHO has also found that the lack of regulations to address cross-border marketing of alcohol has led to a growth in sophisticated online marketing that targets children and adolescents, women and heavy drinkers *(55)*. While the alcohol industry also participates in developing alcohol policy in many countries, research has found it has extensively misrepresented evidence of alcohol-related cancer risks *(56)*. Alcohol marketing regulation is one of WHO's three "best buys" for cost-effective policies to prevent and control the harmful use of alcohol as a risk factor for NCDs. Regulations must be coherent, strategic and adaptable, and all related regulatory bodies and processes must be independent of the alcohol industry, given the commercial interests that often conflict with those of public health.

@ Johnstocker

SIX TIPS FOR COVERING ALCOHOL'S EFFECTS ON PUBLIC HEALTH AND SOCIETY

When covering alcohol:

Look for context

Behind everyone's experiences involving alcohol, you can find an angle that provides your audience with a complete story, explaining the broader impacts of alcohol on their lives and society.

Minimize harm

Even from a "lifestyle" or business perspective, you can inform your audience that there is no safe limit on alcohol consumption and list some of its harms, such as mental health issues, cancers, heart disease, strokes, liver disease and digestive problems.

Use the evidence

Weigh the merits of competing claims and research, familiarizing yourself with the lengthy and rigorous process of professional scepticism and criticism undertaken to reach a scientific consensus about alcohol's harms.

Be mindful of potential conflicts of interest

Be aware of and avoid pressure from commercial alcohol operators, including industry-funded journalism awards, advertising, industry-owned media outlets, industry-funded thinktanks and conflicts of interest that can divert you from providing reliable, unbiased reporting.

Watch your language

Avoid stigmatizing words or framing alcohol use as an individual failing or a moral or criminal issue without discussing its many other societal and commercial factors. Using terms such as "alcoholic" instead of "someone with an alcohol use disorder" can implicitly create negative perceptions, making people less likely to support alcohol control policies.

Orient those in need

Provide information about where to seek help in cases of difficulty or mental distress due to alcohol (e.g. contact information for local centres for treating alcohol dependence and local organizations that assist in recovery or assist people in households suffering the consequences of living with people with alcohol problems).

Alcohol story ideas

Stories about alcohol and its impact on public health and societies can be complex, but there are many potential angles to cover that can deeply engage your audience. Here is a list of ideas for stories to help you think of different ways to approach your reporting.

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WHAT IS MY STORY'S FOCUS?

Youth drinking

WHO SHOULD I TALK TO?

Youth workers, educators, young people, local authorities leading youth programmes, public health experts and alcohol treatment professionals

WHAT SHOULD I ASK?

What increases the risk of youth drinking? Are there efforts to prevent the initiation of drinking among children and adolescents? If there are none, what efforts or initiatives can be introduced? What is the effect of alcohol consumption on this specific group? Why are they different from other alcohol consumers? What data are available on this group? Can specific legislation or policies protect this group? What are the best practices in this area? What initiatives (e.g. youth projects) are currently in place? What is the role of civil society organizations? What are the city and other local authorities' roles and initiatives? What is the evidence for them? Are best practices applicable to the reality in your country? How and why?

WHAT IS MY STORY'S FOCUS?

A health, safety or criminal incident involving alcohol

WHO SHOULD I TALK TO?

Police and other first responders at the scene, victims' rights organizations, health ministry, ministry of justice

WHAT SHOULD I ASK?

What caused this incident? What are the risk factors related to this incident? Is there anything that could have prevented the incident? What are the authorities doing to prevent these kinds of incidents? What should the authorities do? What type of data systems are in place to record alcohol-related fatalities? Are these data systems interlinked with those of other relevant entities?

WHAT IS MY STORY'S FOCUS?

Alcohol and maternal health

WHO SHOULD I TALK TO?

Midwives, health ministry, teachers and others working with children and young people affected by family drinking, nongovernmental organizations that work with people who have fetal alcohol spectrum disorder, mother's groups

WHAT SHOULD I ASK?

What advice is given to pregnant women about drinking alcohol? Are there specific drinking guidelines? If so, do pregnant women in your community have ready access such advice and information? How can alcohol consumption during pregnancy affect children? What services are available for people with fetal alcohol spectrum disorder? Are there efforts to prevent pregnant women from drinking alcohol? If there are none, how can such efforts begin? Are there specific health warnings on alcoholic drink labels?

WHAT IS MY STORY'S FOCUS?

Home-made, informally or illicitly produced (unrecorded) alcohol

WHO SHOULD I TALK TO?
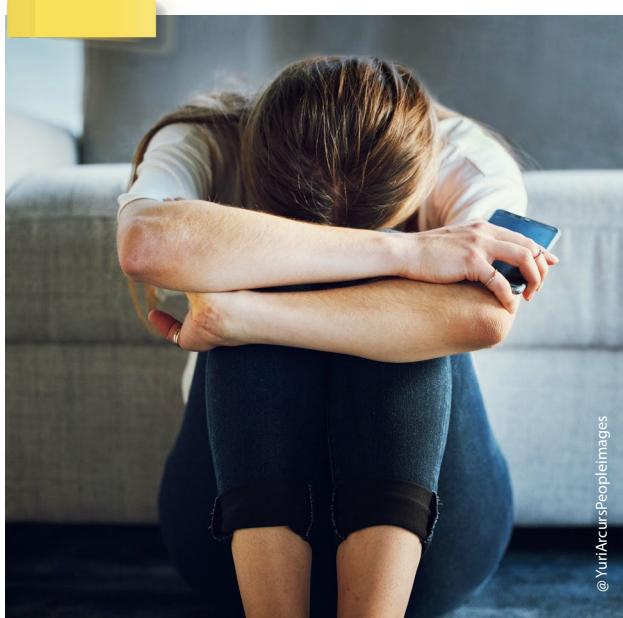
Government ministries of commerce or trade or health, health-care workers, treatment professionals, police, producers of unrecorded alcohol, current or former consumers

WHAT SHOULD I ASK?

How much of the alcohol consumed in your community is unrecorded? Is it produced in your community or is it smuggled? What is its social and economic role in your community? What are the potential harms linked to its consumption? Has it grown or decreased over the past decade, and if so, what has been the effect? How are different groups of people affected by it, and how could they be better protected? How have other communities prevented harm from unrecorded alcohol? Are their approaches applicable in your community?

@ Istock

WHAT IS MY STORY'S FOCUS?

Alcohol-related inequalities or alcohol consumption and poverty/marginalization

WHO SHOULD I TALK TO?

Government ministries of health and social affairs, social justice organizations, regional and local authorities, and civil society organizations

WHAT SHOULD I ASK?

Which groups have the heaviest burden of alcohol-related inequality in your community or country? What should the government do to address these inequities? What is the "harm per litre" of alcohol consumption in the community or country compared to others? Do the government's alcohol policies focus on populations who need support?

@YuriArcursPeopleimages

WHAT IS MY STORY'S FOCUS?
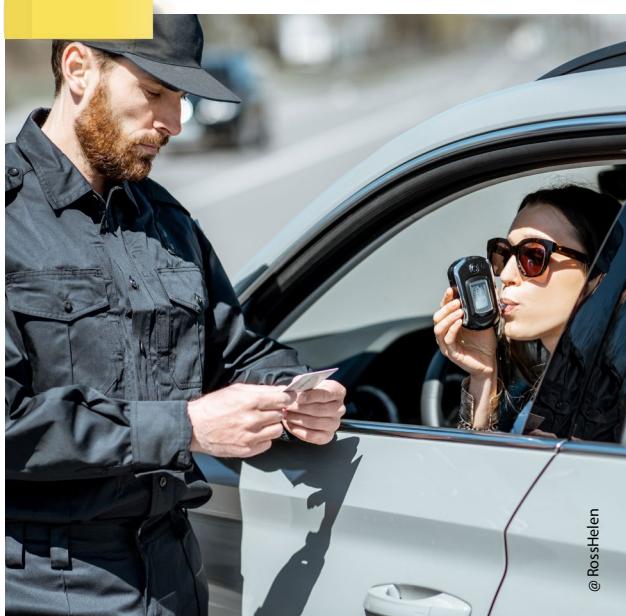
Alcohol and mental health

WHO SHOULD I TALK TO?

Alcohol and mental health treatment facilities, health ministry, psychiatric organizations, alcohol users and their families and friends

WHAT SHOULD I ASK?

Which mental disoders are linked to alcohol consumption? What is missing in the public conversation about alcohol and mental health? What are the preventable aspects of this problem? What are the services available for those in need? What type of follow-up support is in place? Is it possible to take the stigmatization of people into account? Are health workers trained to recognize and treat these issues? Is the safety of health workers accounted for?

@RossHelen

@ ingimage

WHAT IS MY STORY'S FOCUS?

Alcohol control as a political and development priority

WHO SHOULD I TALK TO?

Government ministries of health, social development and human resources; civil society organizations; politicians; social justice organizations; subnational authorities

WHAT SHOULD I ASK?

What is the socioeconomic impact of alcohol consumption in your society? Which groups of people incur the highest costs of alcohol consumption? What data is available on alcohol's impact on productivity? What data is available on alcohol's impact on health-care costs? What data is available on alcohol's impact on other costs related to criminal justice? What data is available on alcohol's impact on motor vehicle crashes? Does the community recognize alcohol as a problem? Is there outrage or concern in the community? If so, what is being done about it? Who is accountable for this problem? What are the standards or policies adopted to address this? How do new approaches compare with existing alternatives elsewhere? Who gains from alcohol controls that do not promote public health and well-being?

WHAT IS MY STORY'S FOCUS?

Alcohol marketing, advertising

WHO SHOULD I TALK TO?

Independent experts and researchers, marketers, industry representatives, advertising companies, civil society organizations

WHAT SHOULD I ASK?

What are current alcohol sales in the community or country? Are they growing, and what are the industry sales targets? What is the portrayal of alcohol use in the media? What messages are used to market different alcoholic beverages? What is the impact of marketing and the media portrayal of alcohol on your community? What (if any) are the existing media reporting guidelines in your country or elsewhere? What is the effect on consumption, and by which groups of people? Does the alcohol industry self-regulate, and how effective is this? Does a code for marketing alcoholic beverages exist? Does social media play a role? Are influencers regulated? Is there a legally-binding measure that regulates traditional and digital alcohol marketing? Have any studies been conducted in the country/community? Does my media outlet have editorial guidelines on alcohol marketing or publishing alcohol advertisements? Does my media outlet accept alcohol industry sponsored content or alcohol industry commissioned content?

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WHAT IS MY STORY'S FOCUS?

Academic research on alcohol

WHO SHOULD I TALK TO?

Relevant independent experts with a credible academic record and no commercial or personal interests that could risk their impartiality

WHAT SHOULD I ASK?

What is the strength of the evidence? How significant are the results? What was the source of funding for the research? Is this study consistent with other research and scientific consensus? Which facts are up for debate, and which are not? What is the alcohol industry saying? What are civil society and public health organizations saying?

GLOSSARY

A core responsibility of advocates and journalists is to use language that is accurate and not harmful to their audience or the individuals on whom they are reporting.

Abstinence – The absence of substance use, which is the case with alcohol for the majority of the global population.

Addict (Stigma alert!) – The term used to describe a person who exhibits impaired control over engaging in substance use (or other reward-seeking behaviour, such as gambling) despite suffering severe harm caused by such activity. It is recommended to use "person first" language; instead of describing someone as an "alcohol addict", describe them as "a person with, or suffering from, alcohol use disorder" to decrease the stigma associated with these conditions.

Alcogenic – The term used to describe contexts or environmental configurations where alcohol is easily accessible and available (e.g. places with a high density of alcohol outlets) and/or acceptable (e.g. contexts where alcohol is heavily advertised/marketed and promoted).

Alcohol – In this guide, alcohol is a synonym for alcoholic beverage(s). "Alcohol" or "alcoholic beverage" refers to a product that contains ethanol (ethyl alcohol) and is primarily intended for human consumption (mainly through drinking).

Alcohol by volume (ABV) – The measure of pure alcohol as a percentage of a drink's total volume of liquid. ABV is usually listed on cans and bottles of alcoholic beverages.

Alcohol harm paradox – Individuals living in lower socioeconomic conditions experience harm related to alcohol consumption at levels disproportionately greater than those living in less socioeconomically deprived conditions, even when the amount of alcohol consumed is the same or less.

Alcoholic beverage – In most countries with a legal definition of "alcoholic beverage", a threshold for ethanol content by volume is set at ≥ 0.5% or 1.0%. Alcoholic beverages include (but are not limited to) beers, wines and spirits, including those commercially, informally or illegally produced for consumption. Some countries apply the term "beverage of moderation" to certain alcoholic beverages, according to their volume of pure alcohol. Different approaches to regulation depending on the concentration of alcohol per volume often result in less strict regulations for products with a lower concentration of alcohol by volume. Given that the ethanol content of any beverage is the primary substance causally linked to harmful effects from drinking alcoholic beverages, these "beverages of moderation" should also be included in the definition of an alcoholic beverage.

Alcohol industry – Includes alcohol manufacturers, wholesale distributors, importers, marketers and retail sellers of alcoholic beverages. This definition captures a diversity of actors, and for each of these, certain restrictions may be more relevant than others.

Alcoholism (Stigma alert!) – The term traditionally used to identify chronic excessive drinking by individuals who are physically and psychologically dependent on alcohol. While this stigmatizing word remains in everyday use, it has not been a diagnostic term for several decades; the term "alcohol use disorder" is recommended instead.

Alcohol's harm to others – The negative consequences of alcohol consumption on individuals other than drinkers themselves, including health and social problems. Several terms have been used to refer to this concept, including, for instance: "the second-hand effects of drinking", "social harm from others' drinking", "collateral damage from alcohol", "negative externalities" and "alcohol-related social harm".

Alcohol use disorder – Characterized by heavy alcohol use and loss of control over alcohol intake. Even though alcohol use disorders are among the most prevalent mental disorders globally, they are also the most stigmatized. This term is recommended instead of "alcohol addict", "alcohol dependence", and "alcoholism". Alcohol use disorders exist along a continuum that ranges from mild to severe. They are treatable; however, they are also associated with lasting changes in the brain that can make individuals vulnerable to relapse.

Binge drinking – Similar to "heavy episodic drinking" or "occasional heavy drinking", this term refers to excessive alcohol consumption within a short period, which is a harmful risk behaviour associated with severe injuries and multiple diseases. Definitions of binge drinking vary, depending on the country and/or the study. For example, the United States of America defines binge drinking as the consumption of five or more standard drinks for a man or four or more standard drinks for a woman within a single session of about 2 hours. The United Kingdom defines it as eight or more units of alcohol for a man and six or more units of alcohol for a woman consumed within a single session. Traditionally, binge drinking refers to a bout of heavy drinking for more than one day at a time.

Blood alcohol concentration (BAC) – The percentage of ethanol in the blood, based on the mass of alcohol per mass of blood.

Brief intervention – Short conversation or counselling session in which health-care providers typically offer feedback and advice to motivate individuals identified as at-risk for substance-related harm to become more aware of the risk, reduce or eliminate substance use or seek treatment.

Clean (Stigma alert!) – A reference to the state of a person being abstinent from drug or alcohol use. The term has been viewed as potentially stigmatizing because of its pejorative connotation, with the opposite being "dirty". Instead, many in the field advocate using proper medical terminologies, such as describing someone as an individual in remission or recovery.

Co-dependency (Stigma alert!) – Immoderate emotional or psychological reliance on a partner. Often used concerning a partner requiring support due to an illness or disease (e.g. alcohol use disorder). The term has been viewed as stigmatizing as it tends to pathologize family members' concern and care for their loved one and may increase their shame.

Commercial determinants of health – Private sector and commercial activities that impact public health – either positively or negatively – and enable political economic systems and norms. Achieving health for all requires addressing commercial determinants of health through management of conflicts of interest, and regulative, legal, economic, whole-of-government and geopolitical reforms.

Conflict of interest – When a secondary interest interferes with a primary interest concerning alcohol. Increased consumption leads to increased adverse health and development impacts, and it also leads to increased sales for the alcohol industry. This places public health and development interests in an inherent and direct conflict with alcohol industry interests.

Co-regulation – Voluntary or nonbinding compliance with government-set standards.

Cross-border marketing – Refers to marketing activities that originate in one legal jurisdiction but are accessible to people in jurisdictions different to the place of origin. This is particularly an issue with the internet and mobile-based marketing, which do not generally respect national boundaries.

Delirium tremens – A severe form of alcohol withdrawal involving sudden mental or nervous system changes resulting in varying degrees of mental confusion and hallucinations. Onset typically occurs 24 hours or more following cessation of alcohol use. It is often preceded by physiological tremors and sweating following acute cessation in severely alcohol-addicted individuals.

Depressant – Psychoactive substance that decreases levels of physiological or nervous system activity; decreasing alertness, attention and energy through lowered heart rate, blood pressure and respiration rates. Informally referred to as "downers" (e.g. alcohol, benzodiazepines, barbiturates).

Deterrence – The use of punishment as a threat to deter people from committing offences. It is often contrasted with retributivism, which holds that punishment is a necessary consequence of a crime and should be calculated based on the gravity of the wrong done.

Detox – Short for "detoxification", it is the medical process focused on treating the physical effects of withdrawal from substance use and comfortably achieving metabolic stabilization, a prelude to longer-term treatment and recovery.

Drink–driving – Driving or operating a motor vehicle while impaired or while one's blood alcohol concentration is above the limit set by law.

Drunk (Stigma alert!) – A state of functional impairment caused by alcohol. Use "intoxicated" or "intoxication" instead. Also, it is often used in a stigmatizing way to describe a person who engages in unhealthy or hazardous alcohol use.

Dry drunk (Stigma alert!) – The presence of actions and attitudes that characterize the individual with the alcohol use disorder prior to recovery. Widely adopted by Alcoholics Anonymous and peer-support communities, this term identifies individuals who no longer use alcohol but continue to behave dysfunctionally (e.g. express rage/anger or intense fear) or regress in personal growth or within their recovery programme. This term is not evidence-based and perpetuates the stigma placed on people in recovery.

Evidence-based public health – Making public health decisions based on the best available scientific evidence, using data and information systems systematically, applying programme-planning frameworks, engaging the community in decision-making, conducting sound evaluations and disseminating what is learned.

Fetal alcohol spectrum disorders – A group of conditions that occur in a person whose mother drank alcohol during pregnancy.

Fetal alcohol syndrome – A condition in a child that results from alcohol exposure during the mother's pregnancy. Fetal alcohol syndrome causes brain damage and growth problems. The problems caused by fetal alcohol syndrome vary from child to child, but most defects are irreversible.

Hangover – The immediate after-effects of drinking alcohol in excess, which may include fatigue, headache, nausea, vomiting, insomnia, acute anxiety, guilt, depression, irritability and extreme sensitivity, among other symptoms. The amount of alcohol needed to produce a hangover varies with the individual. In general, the higher the blood alcohol level during intoxication, the more intense the subsequent symptoms.

Harm prevention – In terms of alcohol, policies and interventions to reduce drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, and to reduce the patterns of drinking associated with increased risk of adverse health outcomes.

Harm reduction – Policies, programmes and practices to reduce the harm resulting from risky behaviour, for instance, the use of alcohol, without necessarily reducing the behaviour per se. Examples include programmes that offer free rides home to people who are too intoxicated to drive their cars, or using plastic glassware in bars to reduce the risk of serious injury should fighting break out. The term is used mainly in the context of illicit drug policies, though harm reduction is a general strategy in public health policy.

Harmful use of alcohol – WHO's Global Strategy to Reduce the Harmful Use of Alcohol *(57)* defines the harmful use of alcohol as drinking that causes detrimental health and social consequences for the drinker (harmful drinking), the people around the drinker and society at large, as well as patterns of drinking that are associated with increased risk of adverse health outcomes (hazardous drinking). Many independent organizations that work on alcohol control policies contest this term, preferring terms such as "alcohol-related harm" or "harm due to alcohol use" because they make it clear that harm comes from the product not the user, and because, at the population level, any level of alcohol consumption is associated with preventable net harm due to multiple health conditions such as injuries, alcohol use disorders, liver diseases, cancers and cardiovascular diseases, as well as harm to people other than drinkers.

Heavy episodic drinking (HED) – WHO uses this term to refer to the consumption of at least 60 g (approximately five standard drinks) or more of pure alcohol on one occasion, at least once in the past 30 days. Other definitions of HED may apply depending on the country or the study.

Intoxication – A state of functional impairment caused by alcohol. Use instead of pejorative "drunk" or "drunkenness".

Korsakoff's syndrome – A chronic memory disorder associated with amnesia, caused by a severe deficiency of thiamine (vitamin B_1), most commonly associated with severe alcohol use disorder and also known as "Korsakoff's psychosis".

Meta-analysis – Statistical analyses in which data from several studies are culled and reanalysed. The approach is useful when there is a specific question to answer and at least a few relatively strong studies that come to different conclusions. A meta-analysis differs from a synthesizing review in that the data from the earlier studies are brought together into a new analysis. In contrast, a synthesizing review looks across (and may calculate summary statistics across) the reported analyses of the primary studies it draws on.

Minimum legal drinking age and minimum legal purchase age – Legal restrictions on the age at which young people may be sold, purchase, possess or consume alcohol in public settings. Restrictions vary widely, ranging from 13 to 25 years of age, although they are most commonly set at 18 years old. In general, the terms "minimum legal drinking age" (MLDA) and "minimum legal purchase age" (MLPA) are used interchangeably, and in many jurisdictions, they are set at the same level. MLPA implies that enforcement will be focussed on the sellers of alcohol, which is likely to be more effective at reducing underage access to alcohol than the consumer-level enforcement implied by MLDA restrictions.

Noncommunicable diseases (NCDs) – An array of conditions not caused by acute infection and, therefore, not transmissible directly from one person to another. They result in long-term health consequences and often require long-term treatment and care. Physical health conditions include cancers, cardiovascular disease, cirrhosis and diabetes. Also known as chronic diseases, they are usually the result of a combination of genetic, physiological, environmental and behavioural factors. The global rise of NCDs has been driven primarily by four major risk factors: tobacco use, physical inactivity, alcohol use and unhealthy diets. The WHO global action plan on NCDs, released in 2013, did not include mental disorders (including alcohol use disorders) within the category of NCDs, but they have been included since 2018.

Person-first language – A linguistic prescription structuring sentences to name the person first and the condition or disease from which they suffer second. It is recommended to use person-first language; instead of describing someone as an "addict", for instance, describe them as "a person with, or suffering from, addiction or *a substance use disorder*". Person-first language articulates that the disease is a secondary attribute and not the primary characteristic of the individual's identity.

Prevention paradox – The notion that most of the alcohol-related problems in a population are not associated with drinking by those with alcohol use disorders but rather with drinking by a larger number of "social" or "moderate" alcohol drinkers.

Public health approach – An approach to alcohol policy that builds on the public health model of disease prevention to consider three elements in alcohol problems: the host (the individual drinker), the agent (alcohol) and the environment (the conditions that permit the agent to interact with the host in a harmful way). A public health approach involves a coordinated, comprehensive effort that balances public health and safety to create safer, healthier communities, measuring success by the impact of alcohol and related policies on the public's health.

Random breath-testing – Roadside checks of randomly selected drivers to assess blood alcohol levels based on breath alcohol content, also called "compulsory breath testing" in some countries.

Recovery – The process of improved physical, psychological and social well-being and health after a substance use disorder.

Regulatory capacity – Qualities such as authority, governance, and availability of human and financial resources, and established mechanisms, with solid legal support, for intra- and intersectoral coordination that allow the health authority to issue, enforce and evaluate regulations (laws, acts, decrees, rules or resolutions).

Responsible drinking (Stigma alert!) – Drinking alcoholic beverages in moderation; drinking that does not lead to misbehaviour and health-related or other harm to the drinker or others. The term is not defined more concretely and is favoured by alcohol industry interests. However, it points to the behaviour of the consumer rather than their product as the source of any harm. It puts the entirety of the blame for alcohol problems on individual drinkers rather than more prominent environmental factors such as advertising, pricing or availability.

Scientific consensus – The position generally agreed upon by most scientists specializing in a given field. Concerning alcohol, the scientific consensus is that the risk of death from a chronic alcohol-related condition is found to increase linearly from zero consumption in a dose-response manner with the volume of alcohol consumed.

Self-regulation – Voluntary or non-binding compliance with industry-set standards.

Sick-quitter effect – Many people abstain from alcohol because they are already sick, often making abstainers look less healthy than light or moderate drinkers.

Sober – A state in which one is not intoxicated or affected by the use of alcohol or other drugs.

Social aspects public relations organizations (SAPROs) – Organizations funded by alcohol industry sources whose ostensible purpose is to provide information and conduct corporate social responsibility activities on behalf of the alcohol industry. SAPROs have been found to seek to forestall effective regulation and prioritize industry profits over public health by promoting ineffective industry-friendly interventions such as school-based education, public service announcements or responsible drinking campaigns and creating doubt about interventions that have a strong evidence base such as higher taxes on alcoholic beverages.

Standard drink – 12.5 ml or 10 g of pure ethanol, according to the WHO definition. Roughly equivalent to 250 ml of beer, 230 ml of cider, 110 ml of wine or 31 ml of distilled spirits. The definition of a standard drink varies from country to country. The United Kingdom uses "units of alcohol" to quantify the content of beverages.

Stigma – An attribute, behaviour or condition that is socially discrediting. Stigma is known to decrease treatment-seeking behaviours in individuals with substance use disorders.

Sustainable Development Goals (SDGs) – The collection of 17 global goals set by the United Nations to end poverty and increase human health and prosperity *(58)*. Alcohol adversely impacts 13 of the 17 SDGs and a total of 52 targets. The inclusion of a specific target on alcohol as an obstacle to development (SDG 3.5: strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol) demonstrates the key role of alcohol within the global development agenda.

Systematic review – A published review article whose purpose is to summarize available primary research in response to a research question. Authors attempt to identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria to answer a specific research question.

Treatment – The management and care of a patient to combat a disease or disorder. It can take the form of medicines, procedures, counselling and psychotherapy.

Unit of alcohol – 10 ml or 8 g of pure ethanol. This is the amount an average adult can process in one hour. Units are used in the United Kingdom to quantify the amount of alcohol contained in a beverage to provide guidance on total consumption. WHO and other countries use the concept of a "standard drink".

Unrecorded alcohol – Alcohol that is produced or distributed via informal markets. It may include "home brew", "illicit alcohol" or other non-recorded alcoholic beverages.

Warning labels – Messages printed on alcoholic beverage containers warning drinkers about potential harm from drinking, including the harmful effects of alcohol on health. There are currently no international standards for the labelling of alcohol; it is not treated like other packaged foods under the Codex food labelling system and it does not fall under the labelling requirement for psychoactive drugs under the International Drug Control Conventions. In 2017, the Codex Committee on Food Labelling accepted a WHO proposal to consider setting standards for the labelling of alcohol products, with health warnings as well as consumer information such as ingredients, alcohol content level, standard drinks, calories and allergens. This proposal, however, is opposed by alcohol industry bodies and no decision has yet been made by Codex.

Wernicke's encephalopathy – Neurological symptoms caused by biochemical lesions of the central nervous system after exhaustion of thiamine (vitamin B1), most commonly associated with alcohol use disorder.

Withdrawal – Physical, cognitive and affective symptoms that occur after chronic drug use is reduced abruptly or stopped among individuals who have developed a tolerance to alcohol or another drug.

Sources

- Addictionary *(59)*
- Lexicon of alcohol and drug terms *(60)*
- Alcohol: no ordinary commodity *(18)*
- Alcohol – harmful, helpful language. Movendi International, unpublished internal document, 2022.
- AP Stylebook, 56th Edition *(61)*
- Trouble brewing: glossary *(62)*

RESOURCES

Where to find data

▶ Global Information System on Alcohol and Health *(5)*

▶ OECD Health Policy Studies: Preventing harmful alcohol use (2021) *(34)*

WHO policies

▶ Draft action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority *(63)*

▶ European framework for action on alcohol 2022–2025 (2022) *(64)*

▶ Global strategy to reduce the harmful use of alcohol (2010) *(57)*

▶ Pan American Health Organization plan of action to reduce the harmful use of alcohol (2011) *(65)*

▶ Regional action plan to implement the global strategy to reduce the harmful use of alcohol for the South-East Asia Region 2014–2025 (2020) *(66)*

▶ Regional framework for action to strengthen the public health response to substance use (2019) *(67)*

▶ Reduction of the harmful use of alcohol: a strategy for the WHO African Region (2011) *(68)*

▶ WHO Regional Office for the Western Pacific Regional Strategy to reduce alcohol-related harm (2007) *(69)*

WHO reports

▶ Alcohol consumption and sustainable development (2020) *(11)*

▶ Digital marketing of alcohol: challenges and policy options for better health in the WHO European Region (2021) *(70)*

▶ Global status report on alcohol and health (2018) *(8)*

▶ Harm to others from drinking: patterns in nine societies (2019) *(71)*

▶ Reducing the harm from alcohol by regulating cross-border alcohol marketing, advertising and promotion (2022) *(55)*

▶ Regional status report on alcohol and health in the Americas (2020) *(72)*

▶ Voice of the children: alcohol in the eyes of the young (2019) *(73)*

WHO Less Alcohol Unit snapshot series on alcohol policies and practice

▶ Addressing alcohol consumption and socioeconomic inequalities: how a health promotion approach can help (2022) *(74)*

▶ Addressing and managing conflicts of interest in alcohol control policies (2022) *(7)*

▶ A health promotion model for addressing alcogenic environments (2023) *(75)*

▶ A public health perspective on alcohol establishments: licensing, density and locations (2022) *(76)*

▶ A public health perspective on zero- and low-alcohol beverages (2023) *(77)*

▶ Digital marketing of alcoholic beverages: what has changed? (2022) *(78)*

▶ Health warning labels on alcoholic beverages: opportunities for informed and healthier choices (2022) *(41)*

▶ Policy response to alcohol consumption and tobacco use during the COVID-19 pandemic in the WHO South-East Asia Region: preparedness for future pandemic events (2022) *(79)*

▶ Policy, system and practice response to alcohol consumption during the COVID-19 pandemic in seven countries of the WHO African Region (2022) *(80)*

▶ Population-wide interventions for reducing alcohol consumption: what does the per capita consumption indicator say? (2022) *(81)*

▶ Unrecorded alcohol: what the evidence tells us (2022) *(82)*

WHO tools

▶ PAHO Virtual Course on Alcohol Policy and Public Health *(83)*

▶ The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): manual for use in primary care and brief intervention (2010) *(84)*

▶ The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care (2010) *(85)*

▶ The SAFER technical package (2019) *(86)*

▶ WHO alcohol brief intervention training manual for primary care (2017) *(39)*

WHO infographics

▶ Factsheet: 5 facts about alcohol and cancer *(87)*

▶ PAHO alcohol and health fact sheets series *(88)*

WHO web pages on relevant health topics

▶ Alcohol *(89)*

▶ Commercial determinants of health *(90)*

▶ Drugs (psychoactive) *(91)*

▶ Health promotion *(92)*

▶ Health taxes *(93)*

▶ Noncommunicable diseases *(94)*

▶ Mental health *(95)*

▶ Road traffic injuries *(96)*

▶ Suicide prevention *(97)*

▶ Tobacco *(98)*

▶ Violence against children *(99)*

▶ Violence against women *(100)*

Independent organizations working to reduce alcohol-related harms

▶ Alcohol and Drug Information Centre (ADIC) *(101)*

▶ Alcohol Health Alliance *(102)*

▶ Asia Pacific Alcohol Policy Alliance *(103)*

▶ Coalición Amèrica Saludable *(104)*

▶ Dutch Institute for Alcohol Policy (STAP) *(105)*

▶ European Alcohol Policy Alliance (Eurocare) *(106)*

▶ Foundation for Alcohol Research and Education (FARE Australia) *(107)*

▶ Global Alcohol Policy Alliance *(108)*

▶ Healthy Caribbean Coalition (HCC) *(109)*

▶ Institute of Alcohol Studies (IAS) *(110)*

▶ Movendi International *(111)*

▶ NCD Alliance *(112)*

▶ Southern African Alcohol Policy Alliance (SAAPA) *(113)*

▶ US Alcohol Policy Alliance *(114)*

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World Health Organization

Less alcohol

- ✅ **More taxes**
- ✅ **Less availability**
- ✅ **No advertising**

Best buys o