

A summary of

Global Status Report on Alcohol



Management of Substance Dependence
Non-Communicable Diseases
World Health Organization
June 2001

Executive Summary

There is sufficient evidence to indicate that alcohol is a significant threat to world health.

- Alcohol consumption is declining in most of the developed countries, and rising in many of the developing countries and the countries of Central and Eastern Europe.
- Males dominate the drinking in these countries, and in nearly every nation are more likely to drink heavily.
- Dangerous patterns of heavy drinking exist in most countries.
- Alcohol causes as much death and disability as measles and malaria, and far more years of life lost to death and disability than tobacco or illegal drugs.
- In parts of Central and Eastern Europe, alcohol use is contributing to an unprecedented decline in male life expectancy.
- While there is much that remains to be learned about alcohol use and problems around the world, there is sufficient evidence to indicate that alcohol is a significant threat to world health.
- Production of various forms of alcohol for domestic consumption is widespread and decentralized in many developing countries.
- Production of beer and distilled spirits for export is concentrated in the hands of a few large companies mostly based in developed countries.
- These corporations spend heavily on marketing to stimulate demand for alcoholic beverages, and to maintain high barriers to entry into the alcohol trade.
- With the decline in consumption in developed countries, these companies have intensified their efforts to establish new markets in developing countries and countries in transition, and among constituencies such as women and young people who have traditionally abstained or drunk very little.
- In many of these new markets, alcohol is recognized for its revenue-generating potential, but the substantial costs of alcohol-related problems are uncoun- ted.
- Measures that have been shown to be most effective in reducing and preventing alcohol-related harm include restrictions on physical availability (including prohibitions, minimum age laws, monopoly and licensing systems), alcohol taxes and restrictions on discounting, and policies such as maximum BAC laws that seek to reduce the harm caused by drinkers.

- Other policy tools include warning labels on alcohol containers, restrictions on alcohol advertising and promotion, and provision of brief intervention and other forms of treatment.
- Public health-oriented technologies to reduce demand are far more prevalent in developed than developing countries, and are in danger of being swept aside by free market reforms.
- WHO encourages its Member States to improve their monitoring of alcohol consumption and problems.
- WHO Member States also need to adopt comprehensive national programmes to prevent alcohol-related problems, consistent with local cultures and mores.
- The serious harms from alcohol use experienced by millions of people, drinkers and non-drinkers, across the globe and documented in this report can are not inevitable.
- Increased attention to alcohol and a commitment to implementing comprehensive programmes of education, treatment and regulation will help to reduce and avert an epidemic of alcohol-related disability, disease and death worldwide.

The serious harms from alcohol use experienced by millions of people across the globe are not inevitable.

Introduction

Alcohol exacts a toll on world health on a par with unsafe sex, measles and malaria, and greater than tobacco: a total of more than three-quarters of a million deaths in 1990, 80 percent of which occurred in developing countries.

Table 1

Global burden of disease and disability attributable to selected risk factors, 1990. (Source: Murray & Lopez 1996)

Risk factor	Deaths (000s)	As % of total deaths	Years of life lost (000s)	As % of total years of life lost	Years of life disabled (000s)	As % of total years of life lost	Disability-adjusted life years (DALYs) (000s)	As % of total DALYs
Malnutrition	5 881	11.1	199 486	22	20 08		219 57	15
Poor water supply, sanitation and personal hygiene	2 668		85 520		7 8		93 3	
Unsafe sex	1 095		27 602		21 100		48 702	
Tobacco	3 038		26 217		9 965		36 182	
Alcohol	774		19 287		28 400		47 687	
Occupation	1 129		22 493		15 394		37 887	
Hypertension	2 918		17 665		1 411		19 076	
Physical inactivity	1 991		11 353		2 300		13 653	
Illicit drugs	100		2 634		5 834		8 467	
Air pollution	568		5 625		1 630		7 254	

Alcohol exacts a toll on world health on a par with measles and malaria, and greater than tobacco.

The recent and unprecedented drop in life expectancy among males in the Russian Federation offers a warning of the health dangers inherent in an alcohol market out of control. Monitoring alcohol's role in world health and disseminating effective methods of controlling and reducing alcohol-related harm are central to the mission of the World Health Organization. To this end, WHO created the Global Alcohol Database and published the *Global Status Report on Alcohol*, the first comprehensive review of alcohol problems and policies since 1980.

Profiling alcohol use, problems and policies in 175 countries, the *Global Status Report on Alcohol* summarizes the information available to date from published reports and articles, expert informants, WHO central and regional offices, other UN agencies, and governmental and private sources. While the picture it paints is far from complete, this is in part a reflection of a global failure to monitor alcohol use and problems, and mount a comprehensive response to them. It is WHO's hope that the report will stimulate further research and data collection which will improve the comprehensiveness of later editions. WHO's alcohol database may be found on the world-wide web at www.alcoholinfo.org. **Any information, comments or suggestions may be sent directly to: Management of Substance Dependence, WHO, 20 Avenue Appia, 1211 Geneva 27, Switzerland.**

The recent and unprecedented drop in life expectancy among males in the Russian Federation offers a warning of the health dangers inherent in an alcohol market out of control.

What and how much people drink

It is possible to produce alcoholic beverages from an extremely wide range of fruits, vegetables or grains. Home, village or small commercial producers use a wide variety of inputs, while a fairly small group of large global corporations produce the bulk of the world's beer from barley, approximately half of its distilled spirits, and approximately 10 per cent of wine from grapes.

Alcohol availability, defined as production plus imports and additional stocks minus exports, is a rough proxy measure for adult per capita consumption of alcohol. Figure 1 below shows a drop in alcohol availability per adult since its peak in 1983, the result of an increase in global population combined with decreasing alcohol consumption in the wealthy countries.

Figure 1

Alcohol Availability per Adult (age 15+) (in litres of pure alcohol)
Sources: *FAO Statistical Databases, 1998; Produktschap voor Distilleerde Dranken, 1997; United Nations Population Division, 1997.*

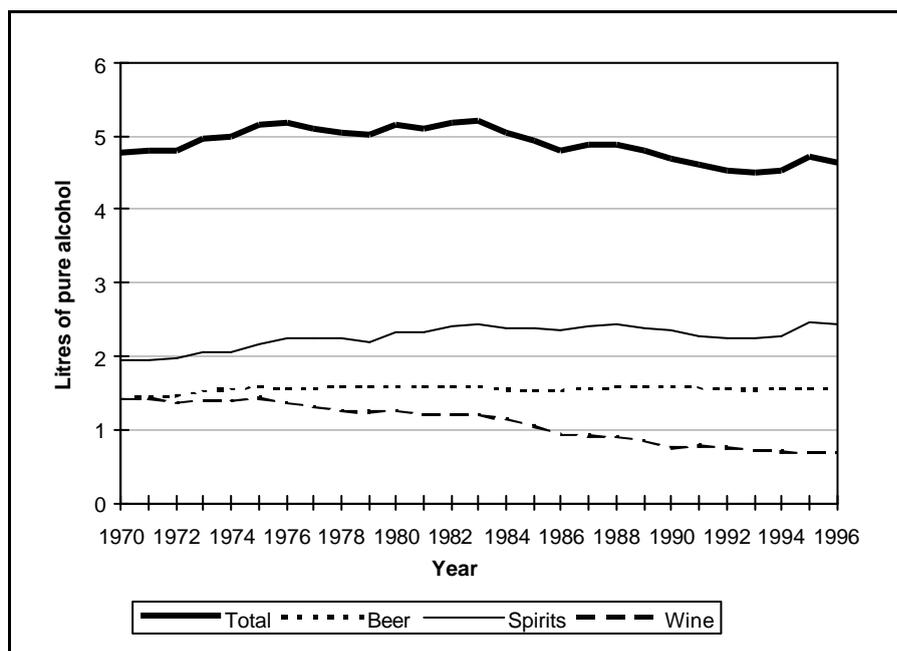
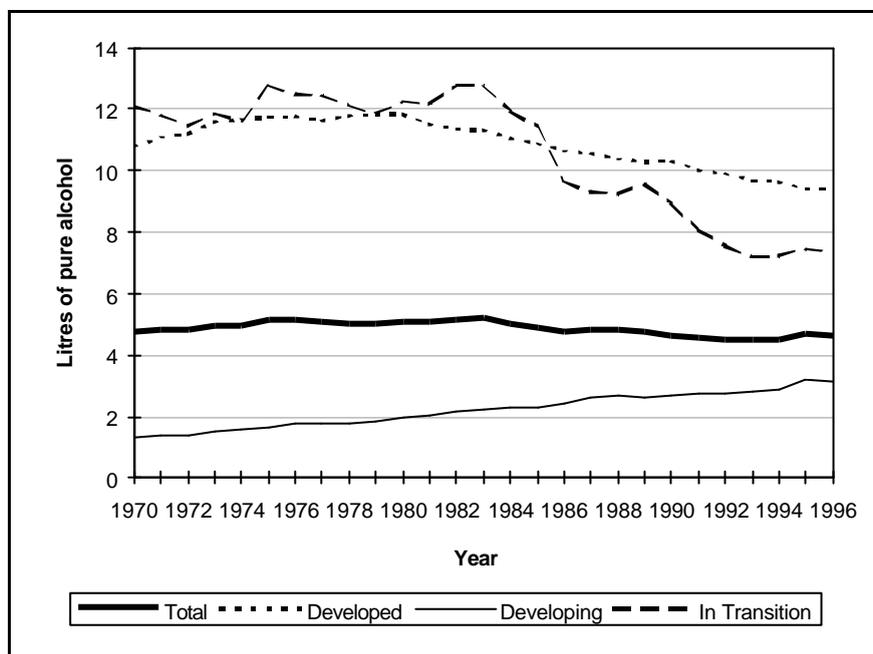


Figure 2 shows that the apparent decline in global alcohol consumption masks regional differences of substantial concern from a health perspective. The wealthy countries, with technology and services in place to mitigate some of the damage caused by alcohol, are reducing their consumption. But drinking in poor and developing states as well as in the economies in transition is clearly on the rise, at the same time that public health infrastructures either do not exist or have been thrown into disarray as a result of economic instability and change.

Figure 2

Recorded Adult (15+) Per Capita Consumption 1970-1996 by Economic Region (in litres of pure alcohol). Sources: *FAO Statistical Databases, 1998; Produktschap voor Distilleerde Dranken, 1997; United Nations Population Division, 1997.*



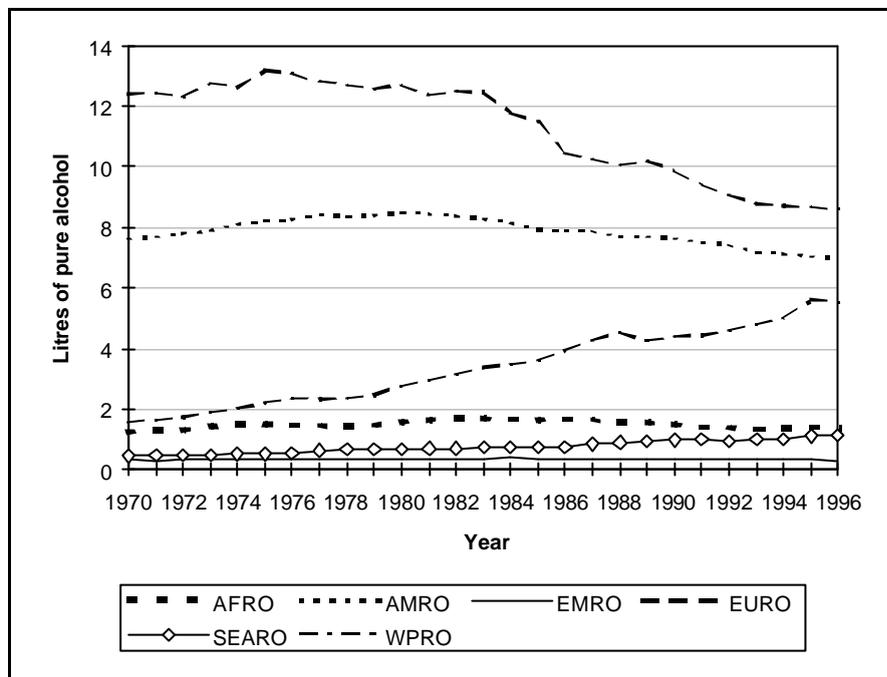
The wealthy countries are reducing their consumption, but drinking in poor and developing states as well as in the economies in transition is clearly on the rise.

Much of the challenge of estimating how much people are drinking lies in assessing the magnitude of home, illegal and small-scale commercial production and trade. These sources may account for as much as 80 per cent of a country's consumption, particularly in Eastern Europe, the Commonwealth of Independent States (CIS) and developing countries such as Ecuador and Kenya (see e.g. Harkin, 1995; PAHO, 1990; Partanen, 1993). In the absence of adequate means of accurately estimating this so-called "unrecorded" consumption, trends in recorded production must serve as proxies for overall consumption.

Level of economic development and religion appear to be the most influential determinants of national alcohol consumption. WHO's regions are economically diverse, and so trends by region, shown in Figure 3 below, tend to mask the differences between developed and developing countries, at the same time that the relatively small amount of drinking in the largely Muslim Eastern Mediterranean Region (EMRO) reflect religion's role in patterns and levels of alcohol consumption.

Figure 3

Adult Per Capita Consumption (age 15+) by WHO Region (in litres of pure alcohol). Sources: FAO Statistical Databases, 1998; Produktschap voor Distilleerde Dranken, 1997; United Nations Population Division, 1997.



Men suffer the bulk of direct consequences of drinking, while women are the primary sufferers of such indirect effects as domestic violence, abandonment and household poverty.

Who does the drinking

An accurate assessment of alcohol's role in health requires going beyond regional or national averages to the patterns of drinking prevalent in each country. For example, South Africa ranked 45th in adult per capita alcohol consumption at 7.72 litres of pure alcohol in 1996. However, since a majority of black South African adults do not drink at all (Roche, 1990), average yearly intake of absolute alcohol among those who do is closer to 20 litres of absolute alcohol, a much higher level than the statistics would initially suggest.

Moving to this kind of analysis again underscores the seriousness of the health threat in developing countries and countries in transition. While women in most nations tend to drink less than men, the differences are far greater in this group of countries than in the developed world. This creates a situation where men suffer the bulk of direct consequences of drinking, while women are the primary sufferers of such indirect effects as domestic violence, abandonment and household poverty.

Looking at patterns of drinking by WHO region, again the diversity within each region is apparent in Table 2, as is the paucity of drinking surveys from some regions of the world.

Table 2

Median and range of recorded per capita consumption of alcohol per adult 15 years of age and over and geographic coverage of survey data, by WHO region

Region	Consumption (litres)	Range	Median	Countries with survey data/ total number of countries	Per cent of population covered
AFRO	1.37	0.02 - 7.72	0.95	7/46	34
AMRO	6.98	1.66 - 14.03	5.74	19/36	95
EMRO	0.30	0.05 - 10.00	0.53	2/22	19
EURO	8.6	0.85 - 15.12	8.26	22/52	45
SEARO	1.15	0.004 - 8.64	0.99	2/10	67
WPRO	5.54	0.34 - 18.39	1.95	9/28	93

In the African Region (AFRO), men tend to drink and to become intoxicated more frequently than women. Older drinkers tend to prefer traditional beverages such as sorghum-based beer and palm wine, while the young and those with a more European or American cultural orientation are more likely to prefer barley-based beers. Reflecting the role of economics in drinking, higher occupational groups tend to drink more heavily.

In the Region of the Americas (AMRO), although more women tend to drink in affluent Canada and the United States, men are six times more likely than women to drink heavily in both the United States and Mexico. Relatively small groups of heavy drinkers account for the majority of alcohol consumption. Drinking among young people and young adults has fallen in the US, although this group still tends to drink more heavily than the rest of the population. Elsewhere in the region, for example in Brazil and Chile, evidence suggests that alcohol consumption among young people as well as among young women is rising.

The strong influence of Islam throughout much of the Eastern Mediterranean Region (EMRO) has led to quite low alcohol use in most countries, with the exception of those nations with substantial Christian or guest worker populations. Some evidence suggests that in Morocco and Sudan, European or American influences are contributing to increasing alcohol consumption among younger drinkers.

Except for the far eastern part of the region, countries in the European Region (EURO) have the highest adult prevalence of drinking in the world, due in part to smaller differences between male and female patterns of drinking than in other parts of the world. However, men are still between three and 16 times as likely to drink large amounts of alcohol on a regular basis. In countries such as Italy or Spain, heavy drinkers tend to spread their consumption over the week, reducing the risk of acute but not of chronic consequences of drinking. By contrast, in Ireland or the United Kingdom drinkers are more likely to drink heavily once or twice per week, increasing the risk of acute consequences.

Most European young people have tried alcohol, but young males in Western Europe are the most likely to have drunk to intoxication by age 15 and, except in Scandinavia, are more likely to drink heavily than females their age.

Countries in the European Region have the highest adult prevalence of drinking in the world. However men are still far more likely to drink heavily.

Although there are no national survey data available for India, the largest country in the Southeast Asian Region (SEARO), regional surveys in both southern and northern regions of the country as well as in Sri Lanka have found extremely low rates of alcohol use among women, while between a third and slightly over half of men reported current use. Among Indian young people, use appears to increase with age and educational level. Elsewhere in the region, the influence of Islam has kept drinking prevalence low in Indonesia and Maldives, while caste and ethnic grouping are influential in Nepal and Bhutan. In predominantly Buddhist Thailand, drinking is more common but still not the norm: less than a third of all adults reported that they consumed alcohol, while only 2.2 percent drank daily.

Australia and New Zealand in the Western Pacific Region (WPRO) conform to the global patterns in wealthy nations of little difference between male and female drinking prevalence, and declining alcohol consumption overall. Those under 25 are the heaviest drinkers, while the predominantly male heaviest drinking 10 per cent in New Zealand consumes nearly half the alcohol sold. Elsewhere in the region, men are far more likely than women to use alcohol. On island states such as Papua New Guinea, the goal of male drinking is drunkenness, and drinkers report consuming 10 drinks or more per occasion. Japan shows a link between rising incomes and increasing prevalence of drinking: in the 1980s the percentage of men drinking grew by 15, while the percentage of women drinkers tripled. Drinking has risen steadily among young people in Japan and Korea. In the former, more than half of schoolchildren between the ages of 13 and 17 have drunk to intoxication or unconsciousness.

Alcohol industry and trade

Only approximately 10 per cent of alcoholic beverage production enters into international trade. The bulk of that trade occurs between developed countries, and thus alcohol sales generally add little to developing country export earnings. The ten countries exporting the most spirits, beer and wine account for 70, 75 and 84 per cent of global exports of these products, respectively. The largest importing and exporting countries are all developed nations. However, when ranked by percentage of import or export costs, the Russian Federation and the Republic of Moldova head the respective lists. Products and profits in the international alcohol trade thus flow primarily into the developed countries and countries in transition.

These flows are dictated and protected by the structure of the international alcohol industry. There are three main global alcohol industries: beer, spirits and wine. They share a common trend away from labour-intensive products with little brand identity and decentralized production, and towards capital-intensive production of global brands heavily supported by marketing budgets. Increasing concentration of ownership is another general trend, most visible in the beer and distilled spirits industries. The leading alcohol marketing companies are nearly all headquartered in developed nations, rank among the world's largest transnational corporations, and rely on large marketing budgets to dominate the market and extract oligopoly profits.

The phenomenon of women gaining crucial income from low-technology, labour-intensive production of alcoholic beverages of sometimes uneven

The leading alcohol companies rely on large marketing budgets to dominate the market and extract oligopoly profits.

quality still dominates in many developing countries, particularly in Africa. The decentralized nature of these markets and the loss of control over formal markets in many Eastern and Central European countries pose a significant challenge to efforts to control alcohol problems.

Where industrialization has taken hold, marketing techniques honed in Europe and North America have furthered the popularity of imported industrialized alcoholic beverages, which have then become candidates for import substitution. However, import substitution in this industry has brought fewer economic benefits than might have been anticipated. Global brand owners have maintained tight control over recipes and marketing while decentralizing production. Concentration of ownership, control and profit in their hands lends them substantial political and economic influence, which may in turn hinder the implementation of effective alcohol controls. This results in international marketers using in at least some developing country markets campaigns and tactics that would be unacceptable in their home markets, such as marketing alcohol as a health beverage, as a pathway to success and popularity, or as a drug of intoxication.

Health effects of alcohol use

Various meta-analyses have established alcohol's causal role in a wide range of physical, mental and social harms, with practically no organ in the body immune from alcohol related harm. The level of alcohol problems is related both to the overall amount of drinking in the country (per capita alcohol consumption) and to the particular patterns of drinking. Such problems will include conditions which by definition are caused by alcohol use, including alcoholic psychosis, alcohol dependence syndrome, alcohol abuse, alcoholic polyneuropathy, alcoholic cardiomyopathy, alcoholic gastritis, alcoholic liver cirrhosis, and ethanol toxicity and methanol toxicity; as well as conditions in which alcohol may play a crucial causal role, such as oesophageal varices, unspecified cirrhosis, chronic pancreatitis, road injuries, fall injuries, fire injuries, drowning, suicide and homicide. Alcohol use can also have harmful effects on non-users, for example victims of alcohol-related motor vehicle crashes or violence, or families of drinkers whose health may suffer due to economic harm to the household caused by the drinker's actions.

The level of alcohol problems is related both to the overall amount of drinking and the particular patterns of drinking.

Although large-scale epidemiological studies have found evidence of a protective effect of levels of drinking as low as one drink per week, this effect is relevant only in populations where such low levels of drinking are the norm, and where the diseases of the heart and circulatory system against which alcohol may be protective are prevalent, i.e. primarily in the developed countries among males over 45 years of age and post-menopausal women. There are far less risky ways to prevent these diseases than by drinking alcohol, and while research data at this writing support the existence of a protective effect, general clinical opinion is far from giving these findings the status of a prescription to non-drinkers to begin drinking.

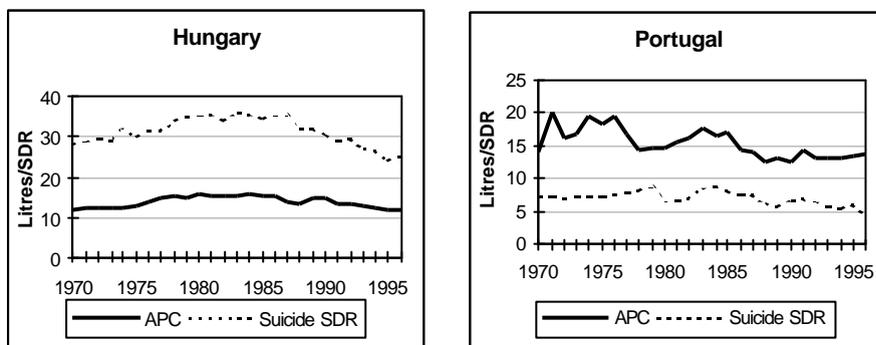
WHO's Global Alcohol Database tracks mortality and morbidity from 20 alcohol-related causes. Calculation of age-standardized death rates for

alcohol dependence syndrome and chronic liver disease and cirrhosis not surprisingly reveals highest levels of harm in the heavy alcohol consuming countries of Eastern and Central Europe. A wide range of individual studies has demonstrated close correlations between levels of alcohol use and suicide, homicide and other violent crime. These studies have been replicated across cultures and continents. Research in North America and Europe has also found a close correlation between changes in the alcohol supply, such as industrial strikes, increased taxes, or limitations on places of sale, and violent crime and domestic disturbances.

Studies replicated across cultures and continents have found close correlations between alcohol use and suicide, homicide and other violent crime.

Figure 4

Adult per capita alcohol consumption (APC) and standardized death rate per 100 000 population (SDR) from suicide in Hungary and Portugal
 Source: WHO Global Programme on Evidence and Information for Health Policy



The Global Burden of Disease study concluded that alcohol tends to kill and disable at young ages and protect from cardiovascular diseases at older ages, a pattern which results in a high number of years of potential life lost to death and disability despite alcohol's protective effect.

Table 3

Global burden of disease and injury attributable to alcohol use in 1990
 Source: Murray & Lopez, 1996.

Region (World Bank)	Deaths (000s)	As % of total deaths	Years of life lost (000s)	As % of total of years of life lost	Years of life disabled (000s)	As % of total of years of life disabled	Disability-adjusted life years (DALYs) (000s)	As % of total DALYs
EME			2 537		7 667	15	10 204	10
FSE			2 063		3 130	11	5 193	
IND	11		2 723		1 974		4 697	
CHN	11		2 118		2 737		4 856	
OAI			1 862		3 191		5 053	
SSA	17		4 435		3 169		7 603	
LAC	13		3 319		6 201	14	9 520	
MEC			229		437		666	
World	77		19 287		28 400		47 687	

Benefits and costs of alcohol

Benefits to individuals from drinking alcohol may include conviviality, sociability and in some cases social solidarity. Governments receive more tangible benefits, in the form of tax revenues that range from a small percentage to as much as 23 per cent of government revenues. While few countries have calculated the social costs of alcohol, studies in several developed countries have found them to be substantial, in the form of lost productivity, health care and treatment costs, property damage and law enforcement costs.

Alcohol control policies

Substantial effort by WHO and numerous researchers has led to a body of work over the past thirty years testing and documenting the effectiveness of policies designed to control alcohol problems. The prevention of alcohol-related problems requires a comprehensive approach, combining information and awareness programmes and treatment services with preventive policies adopted at national or local levels. This in turn usually requires collaboration among a diverse array of government ministries. The European Alcohol Action Plans, developed by WHO's European Regional Office, offer a model of providing guidance to governments in developing such model plans.

Effective policy strategies include alcohol taxation and other price mechanisms, controls over physical availability, and policies targeting drinking in particular contexts such as drink-driving. Although there is little scientific evidence of their efficacy in the absence of other control measures, many countries have implemented alcohol educational and health promotion programmes, most often targeting young people. Mass media campaigns regarding specific problems such as drink-driving are also common. However, such general health-oriented messages about drinking are often poor competitors to the onslaught of commercial and persuasive messages in the environment intended to sell alcohol.

Prohibition Prohibition is the most obvious form of control over physical availability, but complete prohibition of alcohol is found only in a few countries. Far more common are partial prohibitions, particularly on purchase by and sales to young people. Such restrictions are effective at reducing motor vehicle crash fatalities among young people, even at relatively low levels of enforcement. At least 67 countries have some kind of minimum age legislation in place. The most common minimum age for legal purchase of alcoholic beverages is 18, although at least 8 countries require drinkers to wait until age 21 years, while 15 permit drinking at age 16 years.

Monopolies Full or partial monopolies over production, wholesale and/or retail sale of alcohol are another effective control measure. At least 18 countries have some form of monopoly in place. Although there is

Effective policy strategies include alcohol taxes and limits on physical availability.

substantial pressure on many states to privatise, research suggests that privatisation, if it causes an increase in the number of outlets and hours of sale, will cause increased levels of alcohol consumption and problems.

Licensing A more common method of restricting physical availability is through licensing, both of production and sale of alcohol. More than 40 countries operate some kind of licensing system. Such restrictions, if enforced, can influence alcohol consumption patterns and reduce problems. However, in areas lacking strong central authorities, social consensus in favour of restrictions, or both, restrictions on availability may have little impact on actual production or sale of alcohol.

Taxation Alcohol taxes may be a potent tool of prevention policy, especially for price-sensitive young drinkers, and increases in them have been shown to reduce negative outcomes as diverse as traffic casualties, cirrhosis deaths, violence and sexually transmitted diseases. Restricting the use of “happy hours” and other discounts can also influence drinking and negative outcomes. Taxes that are based on a flat amount per unit of alcohol rather than on a percentage of the sale price have the disadvantage of losing value with inflation, causing alcohol prices to decline relative to other beverages because the effective tax rate is falling.

Effective use of taxation as a preventive policy requires that the state have a certain degree of control over the alcohol market. If substantial home or informal production or sale of alcohol exists, as is the case in many developing countries and in some regions of the former Soviet Union and Eastern Europe, then increases in alcohol taxes taken for preventive purposes may simply transfer alcohol sales from the licit to the illicit market.

Warning Labels Warning labels on alcoholic beverage containers can transmit the message that alcohol is not an ordinary commodity. Such labels are required in at least nine countries, and in parts of two others. They have shown some effect on awareness and the likelihood of refraining from drinking and driving or operating heavy machinery. At least 40 countries require alcohol content to be listed on the label, while ingredient labeling is far less common

Restrictions on Advertising and Promotion At least 37 countries have placed restrictions of some kind on alcohol advertising and promotion. Such restrictions are often designed to protect young people, and evidence showing that alcohol advertising influences the drinking habits of young people and young adults is growing stronger. Advertising bans have also been correlated with fewer fatalities from motor vehicle crashes.

At least 29 countries have implemented bans on alcohol advertising in at least one medium. An additional ten countries have partial bans, most commonly on alcohol advertising during daytime and early evening hours when young people are likely to be in the viewing audience in substantial numbers. A handful of countries have also banned alcohol sponsorship of sporting events. At least two countries have tried to balance alcohol advertising by mandating public health counter-advertising. Voluntary codes of good advertising practice are in place in at least 14 countries, although enforcement of them is often ineffective.

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Deterrence Policies that seek to deter drinkers from harming others after drinking may be the most common policy response to alcohol problems, and drinking-driving laws are probably the most ubiquitous examples. Swift and certain sanctions, such as license revocation as the result of failing a random roadside breathalyser test, are the most likely to influence behaviour. At least 54 countries have established permissible levels for blood alcohol when driving. Although eight countries (mostly located in Central and Eastern Europe) have dictated that no amount of alcohol is permissible in the blood when driving, the most common upper limit is either 0.05 g% (14 countries) or 0.08 g% (18 countries). Such measures are only effective if drinkers can expect them to be well enforced.

Treatment In many countries, a wide variety of methods and programs exist for treating alcohol dependence and other mental health problems. Very few countries have systematically evaluated various forms of treatment and the resources allocated for treatment are often very scarce, if existent. Globally, access to affordable and effective treatment is still largely inadequate. Brief interventions have proven to be a cost-effective means of preventing individuals from experiencing further problems related to alcohol. Whether such an approach would have an impact on the aggregate levels of problems in a given society remains a question for future research.

Conclusion

Alcohol consumption is declining in most of the developed countries, and rising in many of the developing countries and the countries of Central and Eastern Europe. Alcohol's contribution to the global burden of disease is significant and growing in some regions, to the point that in parts of Central and Eastern Europe, alcohol use is contributing to an unprecedented decline in male life expectancy.

On the supply side, while production of various forms of alcohol for domestic consumption is widespread, production for export is concentrated in few of the mostly developed countries, and in the case of beer and distilled spirits, in the hands of a shrinking number of large global corporations. These corporations spend heavily on marketing designed to stimulate demand for alcoholic beverages, employing sophisticated technologies to integrate their products into new markets.

In many of these new markets, alcohol is recognized for its revenue-generating potential, but the substantial costs of alcohol-related problems are uncoun- ted. The most commonly used alcohol policies seek to limit alcohol-related harm, but public health-oriented technologies to reduce demand are far more prevalent in developed than developing countries, and are in danger of being swept aside by free market reforms.

While there is much that remains to be learned about alcohol use and problems around the world, the evidence marshalled in this report is sufficient to suggest that alcohol is a significant threat to world health. WHO encourages its Member States to improve their monitoring of alcohol consumption and problems. Member States also need to adopt comprehensive national programmes to prevent alcohol-related problems.

Public health technologies to reduce demand for alcohol are in danger of being swept aside by free market reforms.

Approaches to alcohol must be consistent with local cultures and mores. Each country will need to develop its own unique mix of strategies.

There is substantial evidence that the serious harms from alcohol use experienced by millions of people, drinkers and non-drinkers, across the globe are not inevitable. As the country profiles in this document demonstrate, numerous strategies are being used to prevent and contain alcohol-related problems. These technologies exist, and in many cases their efficacy has been scientifically demonstrated. Increased attention to alcohol and a commitment to implementing comprehensive programmes of education, treatment and regulation will help to reduce and avert an epidemic of alcohol-related disability, disease and death worldwide.

Increased attention to alcohol can avert an epidemic of alcohol problems worldwide.