



# Global status report on alcohol and health 2018

## EXECUTIVE SUMMARY



World Health  
Organization



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WHO/MSD/MSB/18.2

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**Cataloguing-in-Publication (CIP) data.** CIP data are available at <http://apps.who.int/iris>.

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Design & layout: L'IV Com, Villars-sous-Yens, Switzerland

Printed in Switzerland

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

- The harmful use of alcohol is one of the leading risk factors for population health worldwide and has a direct impact on many health-related targets of the Sustainable Development Goals (SDGs), including those for maternal and child health, infectious diseases (HIV, viral hepatitis, tuberculosis), noncommunicable diseases and mental health, injuries and poisonings. Alcohol production and consumption is highly relevant to many other goals and targets of the 2030 Agenda for Sustainable Development. Alcohol per capita consumption per year in litres of pure alcohol is one of two indicators for SDG health target 3.5 – “Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol”.

### Box 1. Health targets 3.3, 3.4, 3.5 and 3.6 for SDG 3

SDG health targets		Indicators for SDG health targets	
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1	Number of new HIV infections per 1000 uninfected population, by sex, age and key populations
		3.3.2	Tuberculosis incidence per 1000 population
		3.3.3	Malaria incidence per 1000 population
		3.3.4	Hepatitis B incidence per 100 000 population
		3.3.5	Number of people requiring interventions against neglected tropical diseases
3.4	By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being	3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
		3.4.2	Suicide mortality rate
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
		3.5.2	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1	Death rate due to road traffic injuries

- Alcohol frequently strengthens inequalities between and within countries, hindering the achievement of SDG 10 which calls for inequalities to be reduced. Harms from a given amount of drinking are higher for poorer drinkers and their families than for richer drinkers. This pattern of greater “harm per litre” is found for many different harms caused by alcohol.
- Economic development from a poorer society to a richer one may have potential in the longer term to mitigate alcohol-related harm, but more immediately it can bring about an increase in alcohol consumption and related harm as the availability of alcoholic beverages increases. Effective alcohol control measures in the interests of public health are especially important when rapid economic development is under way.
- Alcohol is often consumed before, along with, or after other psychoactive substance use, and the comorbidity of alcohol and tobacco dependence is strong and well documented. Public health policies, strategies and interventions should take into account the frequent association of alcohol consumption with the use of other psychoactive substances, particularly with opioids and benzodiazepines – for prevention of overdose deaths – and with cannabis – for road safety.



## CHAPTER 2. GLOBAL STRATEGIES, ACTION PLANS AND MONITORING FRAMEWORKS

- The harmful use of alcohol is mentioned in numerous global strategies and action plans, but WHO's Global strategy to reduce the harmful use of alcohol continues to be the most comprehensive international policy document providing guidance on reducing the harmful use of alcohol at all levels.
- With development and ratification of the Framework Convention on Tobacco Control, alcohol remains the only psychoactive and dependence-producing substance with significant global impact on population health that is not controlled at the international level by legally-binding regulatory frameworks.
- The update of the evidence on cost-effectiveness of policy options and interventions undertaken in the context of an update of Appendix 3 of the Global action plan on NCDs resulted in a new set of enabling and recommended actions to reduce the harmful use of alcohol. The most cost-effective actions, or "best buys", include increasing taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, and enacting and enforcing restrictions on the physical availability of retailed alcohol.

### **Box 2. Overarching and enabling actions, "best buys" and other recommended interventions to reduce the harmful use of alcohol**

#### **Overarching and enabling actions to reduce harmful use of alcohol**

- Implement the Global strategy to reduce harmful use of alcohol through multisectoral actions in the recommended target areas
- Strengthen leadership and increase commitment and capacity to address the harmful use of alcohol
- Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems

#### **"Best buys"**

- Increase excise taxes on alcoholic beverages
- Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)
- Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)

#### **Effective interventions**

- Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints
- Provide brief psychosocial interventions for persons with hazardous and harmful alcohol use

#### **Other recommended interventions**

- Carry out regular reviews of prices in relation to level of inflation and income
- Establish minimum prices for alcohol where applicable
- Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets
- Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people
- Provide prevention, treatment and care for alcohol use disorders and comorbid conditions in health and social services

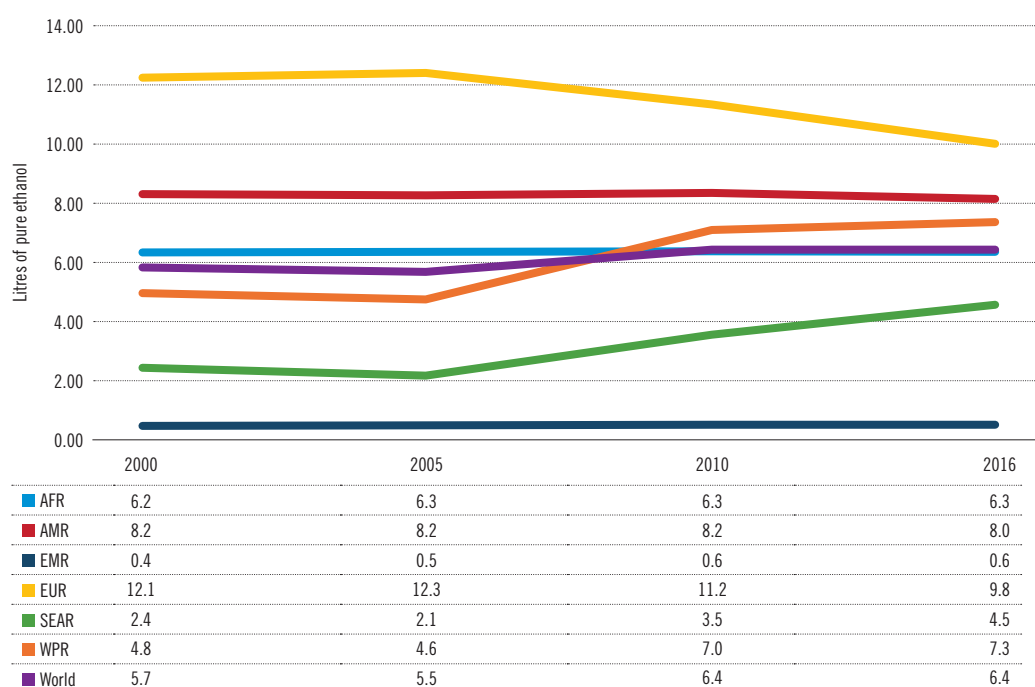


- The growing evidence of a contributing role of harmful use of alcohol to the disease burden of infectious diseases such as HIV, tuberculosis, viral hepatitis and sexually transmitted infections has not yet been sufficiently recognized and addressed in the relevant global strategies and action plans.
- There has been a significantly increased demand for global information on alcohol consumption, alcohol-attributable harms and policy responses. WHO's Global Information System on Alcohol and Health (GISAH) is a global repository for all key alcohol-related indicators included in the 2030 Agenda for Sustainable Development and in global monitoring frameworks for noncommunicable diseases (NCDs).
- Monitoring and surveillance systems on alcohol and public health should cover three overall domains of key indicators, namely those on alcohol consumption, health and social consequences, and policy and programme responses. International comparability of data generated by countries is essential for global monitoring. Assessment and monitoring of unrecorded alcohol consumption continues to be a challenge for national monitoring systems.

## CHAPTER 3. ALCOHOL CONSUMPTION

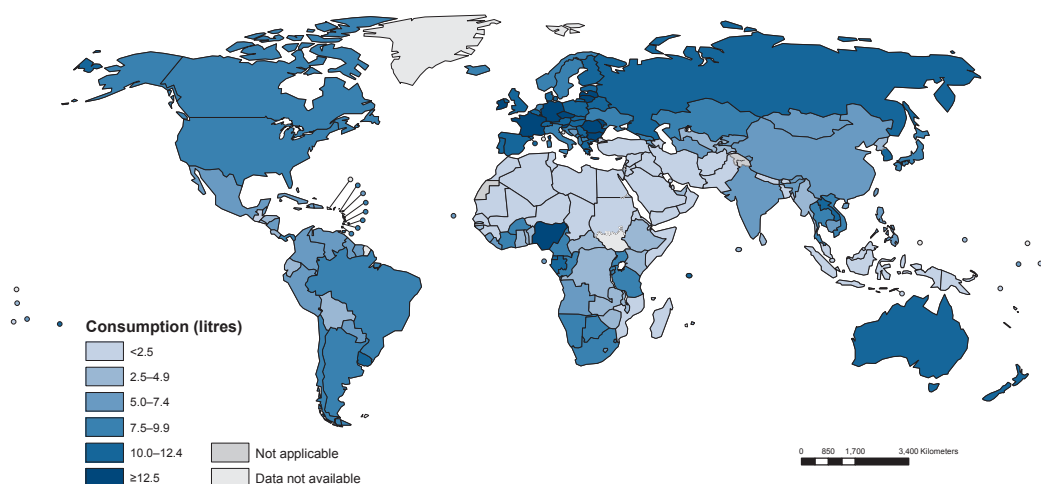
- Worldwide in 2016, more than half (57%, or 3.1 billion people) of the global population aged 15 years and over had abstained from drinking alcohol in the previous 12 months. Some 2.3 billion people are current drinkers. Alcohol is consumed by more than half of the population in only three WHO regions – the Americas, Europe and Western Pacific.
- In the African, Americas, Eastern Mediterranean and European regions, the percentage of drinkers has declined since 2000. However, it increased in the Western Pacific Region from 51.5% in 2000 to 53.8% today and has remained stable in the South-East Asia Region.
- Total alcohol per capita consumption in the world's population over 15 years of age rose from 5.5 litres of pure alcohol in 2005 to 6.4 litres in 2010 and was still at the level of 6.4 litres in 2016. The highest levels of per capita alcohol consumption are observed in countries of the WHO European Region.

**Figure 1.** Trends in total alcohol per capita consumption (APC) (15+ years) in litres of pure alcohol in WHO regions, 2000–2016



- Whereas in the WHO African Region, the Region of the Americas and the Eastern Mediterranean Region alcohol per capita consumption remained rather stable, in the European Region it decreased from 12.3 litres in 2005 to 9.8 litres in 2016. The increase in per capita alcohol consumption is observed in the WHO Western Pacific and South-East Asia regions.

**Figure 2.** Total alcohol per capita consumption (APC) (15+ years; in litres of pure alcohol), 2016



- Current drinkers consume on average 32.8 grams of pure alcohol per day, and this is some 20% higher (40.0 g/day) in the African Region and about 20% lower (26.3 g/day) in the South-East Asia Region. Drinkers increased their alcohol consumption since 2000 in almost all regions except the WHO European Region.
- One quarter (25.5%) of all alcohol consumed worldwide is in the form of unrecorded alcohol – i.e. alcohol that is not accounted for in official statistics on alcohol taxation or sales as it is usually produced, distributed and sold outside the formal channels under governmental control.
- Worldwide, 44.8% of total recorded alcohol is consumed in the form of spirits. The second most consumed type of beverage is beer (34.3%) followed by wine (11.7%). Worldwide there have been only minor changes in beverage preferences since 2010. The largest changes took place in Europe, where the share of total recorded consumption of spirits decreased by 3% whereas that of wine and beer increased.

- Prevalence of heavy episodic drinking (HED) (defined as 60 or more grams of pure alcohol on at least one occasion at least once per month) has decreased globally from 22.6% in 2000 to 18.2% in 2016 among the total population, but remains high among drinkers, particularly in parts of Eastern Europe and in some sub-Saharan African countries (over 60% among current drinkers).

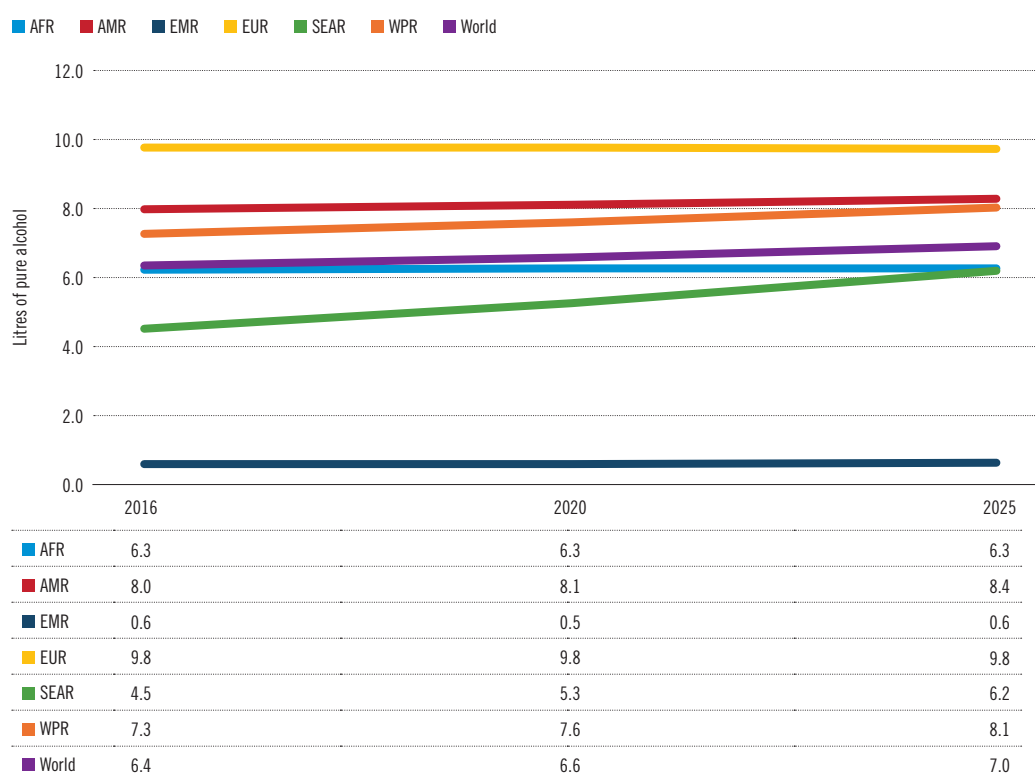
**Table 1.** Total alcohol per capita consumption (in litres of pure alcohol) and prevalence of heavy episodic drinking (HED) (in %) among the total population aged 15+ years and among drinkers (15+ years) by WHO region and the world, 2016

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

- Worldwide, more than a quarter (26.5%) of all 15–19-year-olds are current drinkers, amounting to 155 million adolescents. Prevalence rates of current drinking are highest among 15–19-year-olds in the WHO European Region (43.8%), followed by the Region of the Americas (38.2%) and the Western Pacific Region (37.9%).
- Results of school surveys indicate that in many countries of the Americas, Europe and Western Pacific alcohol use starts before the age of 15 years and prevalence of alcohol use among 15-year-old students can be in the range of 50–70% with remarkably small differences between boys and girls.
- Worldwide and in all WHO regions, prevalence of HED is lower among adolescents (15–19 years) than in the total population but it peaks at the age of 20–24 years when it becomes higher than in the total population. Except for the Eastern Mediterranean Region, all HED prevalence rates among drinkers of 15–24 years are higher than in the total population. Young people of 15–24 years, when they are current drinkers, often drink in heavy drinking sessions. Prevalence of HED is particularly high among men.
- In all WHO regions, females are less often current drinkers than males, and when women drink, they drink less than men. Worldwide, the prevalence of women's drinking went down in most regions of the world, except in the South-East Asia and Western Pacific Regions, but the absolute number of currently-drinking women has increased in the world.

- The economic wealth of countries is associated with higher alcohol consumption and higher prevalence of current drinkers across all WHO regions. The prevalence of HED among drinkers is fairly equal in most regions for higher- and lower-income countries, except in the WHO African Region where it is higher in lower-income countries compared with higher-income countries, and in the WHO European Region where, conversely, it is lower in low-income countries than in high-income ones.
- Until 2025, total alcohol per capita consumption in persons aged 15 years and older is projected to increase in the Americas, South-East Asia and the Western Pacific. This is unlikely to be offset by substantial declines in consumption in the other regions. As a result, total alcohol per capita consumption in the world can amount to 6.6 litres in 2020 and 7.0 litres in 2025 unless projected increasing trends in alcohol consumption in the Region of Americas and the South-East Asia and Western Pacific Regions are stopped and reversed.

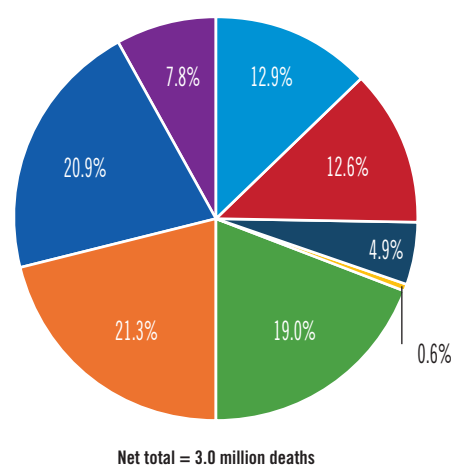
**Figure 3.** Projections of total alcohol per capita consumption (APC) (15+ years) in litres of pure alcohol by WHO region, 2016–2025



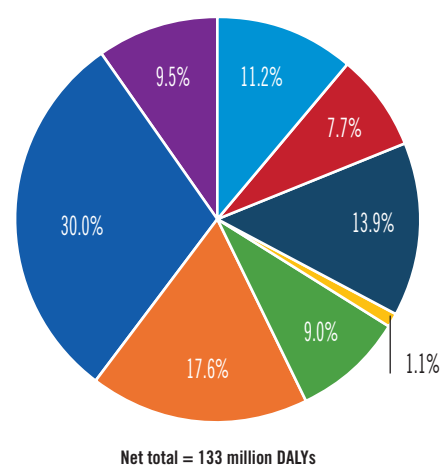
## CHAPTER 4. HEALTH CONSEQUENCES

- In 2016, the harmful use of alcohol resulted in some 3 million deaths (5.3% of all deaths) worldwide and 132.6 million disability-adjusted life years (DALYs) – i.e. 5.1% of all DALYs in that year. Mortality resulting from alcohol consumption is higher than that caused by diseases such as tuberculosis, HIV/AIDS and diabetes. Among men in 2016, an estimated 2.3 million deaths and 106.5 million DALYs were attributable to the consumption of alcohol. Women experienced 0.7 million deaths and 26.1 million DALYs attributable to alcohol consumption.
- The age-standardized alcohol-attributable burden of disease and injury was highest in the WHO African Region whereas the proportions of all deaths and DALYs attributable to alcohol consumption were highest in the WHO European Region (10.1% of all deaths and 10.8% of all DALYs) followed by the Region of the Americas (5.5% of deaths and 6.7% of DALYs).
- In 2016, of all deaths attributable to alcohol consumption worldwide, 28.7% were due to injuries, 21.3% due to digestive diseases, 19% due to cardiovascular diseases, 12.9% due to infectious diseases and 12.6% due to cancers. About 49% of alcohol-attributable DALYs are due to noncommunicable and mental health conditions, and about 40% are due to injuries.

**Figure 4.** Percentage (in %) of alcohol-attributable deaths, as a percentage of all alcohol-attributable deaths, by broad disease category, 2016



**Figure 5.** Distribution of the alcohol-attributable burden of disease, as a percentage (in %) of all alcohol-attributable disability-adjusted life years (DALYs), by broad disease category, 2016

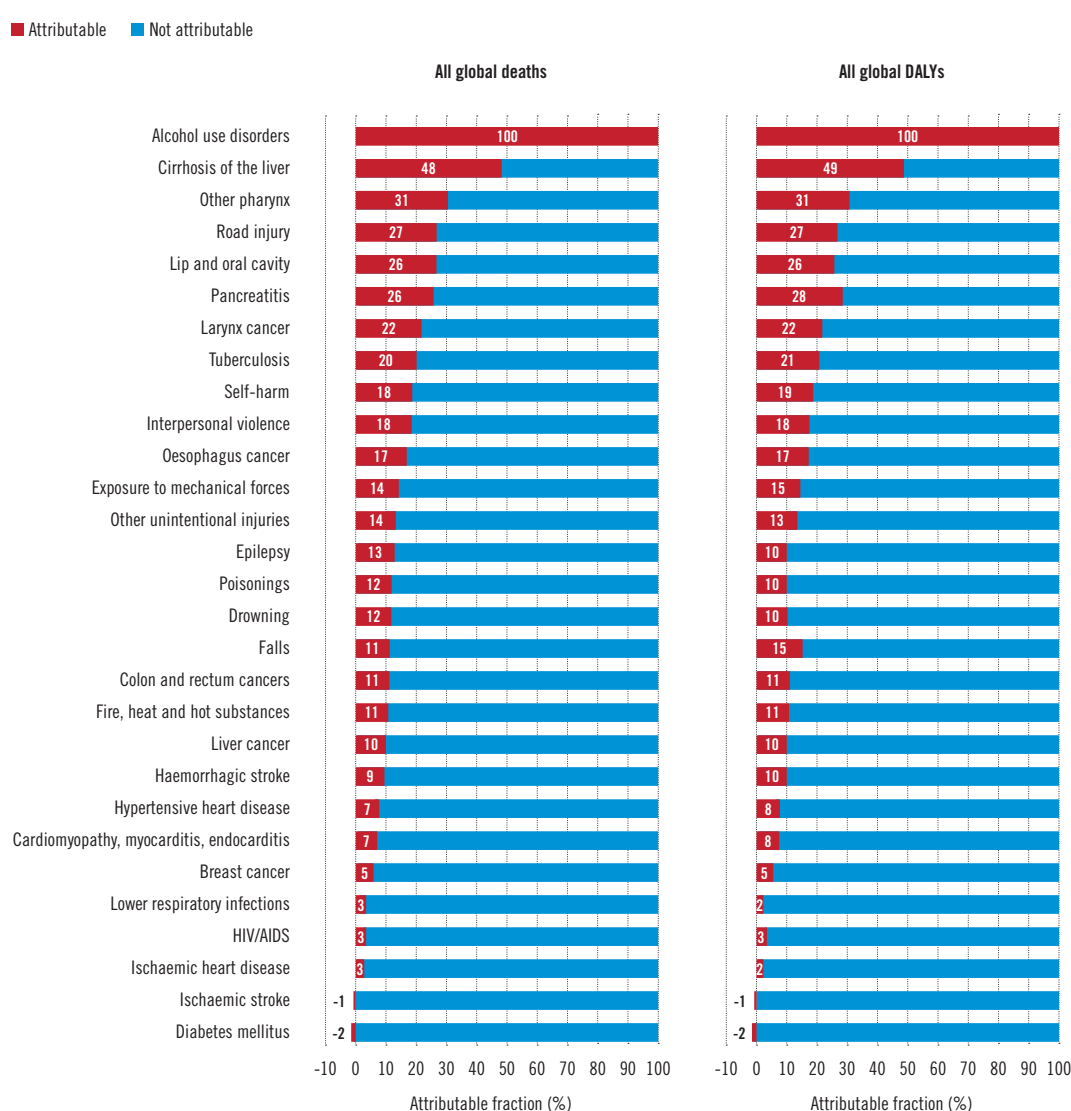


■ Infectious diseases   
 ■ Malignant neoplasms   
 ■ Alcohol use disorders   
 ■ Epilepsy   
 ■ Cardiovascular diseases and diabetes  
■ Digestive diseases   
 ■ Unintentional injuries   
 ■ Intentional injuries

- Worldwide, alcohol was responsible for 7.2% of all premature (among persons 69 years of age and younger) mortality in 2016. People of younger ages were disproportionately affected by alcohol compared to older persons, and 13.5% of all deaths among those who are 20–39 years of age are attributed to alcohol.

- Alcohol caused an estimated 0.4 million of the 11 million deaths globally in 2016 which resulted from communicable, maternal, perinatal and nutritional conditions, representing 3.5% of these deaths.
- Harmful use of alcohol caused some 1.7 million deaths from noncommunicable diseases in 2016, including some 1.2 million deaths from digestive and cardiovascular diseases (0.6 million for each condition) and 0.4 million deaths from cancers. Globally an estimated 0.9 million injury deaths were attributable to alcohol, including around 370 000 deaths due to road injuries, 150 000 due to self-harm and around 90 000 due to interpersonal violence. Of the road traffic injuries, 187 000 alcohol-attributable deaths were among people other than drivers.

**Figure 6. Alcohol-attributable fractions (AAFs) for selected causes of death, disease and injury, 2016**



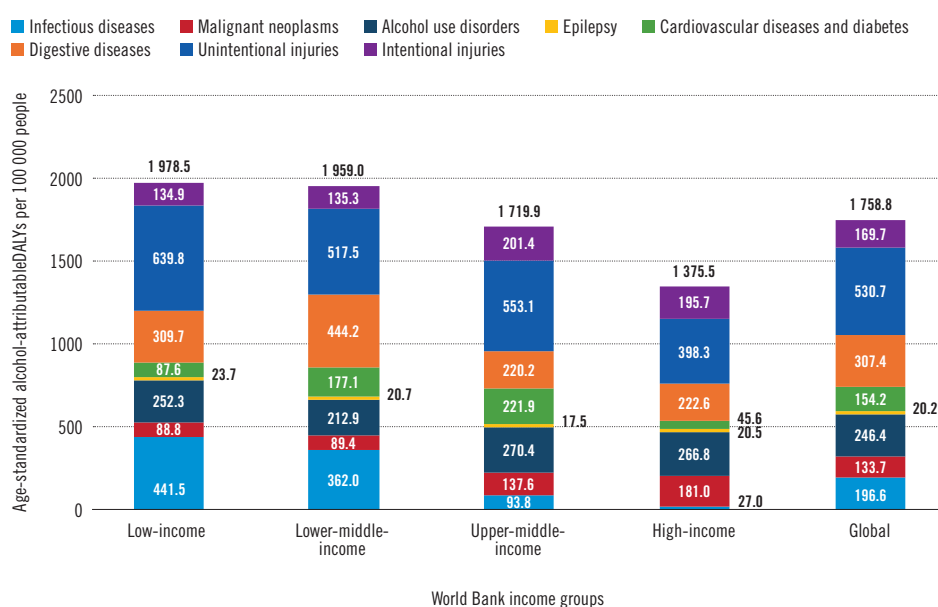
DALYs = Disability-adjusted life years.

Note: For ischaemic stroke and diabetes mellitus, the AAFs were negative, meaning that, overall, alcohol consumption has a beneficial effect on these diseases.



- In 2016 the leading contributors to the burden of alcohol-attributable deaths and DALYs among men were injuries, digestive diseases and alcohol use disorders, whereas among women the leading contributors were cardiovascular diseases, digestive diseases and injuries.
- There are significant gender differences in the past 12-month prevalence of alcohol use disorders. Globally an estimated 237 million men and 46 million women have alcohol use disorders, with the highest prevalence of alcohol use disorders among men and women in the European Region (14.8% and 3.5%) and the Region of Americas (11.5% and 5.1%). Alcohol use disorders are more prevalent in high-income countries.
- In 2016 the alcohol-attributable disease burden was highest in low-income and lower-middle-income countries when compared to upper-middle-income and high-income countries.

**Figure 7.** Alcohol-attributable disability-adjusted life years (DALYs), by income group and globally, 2016



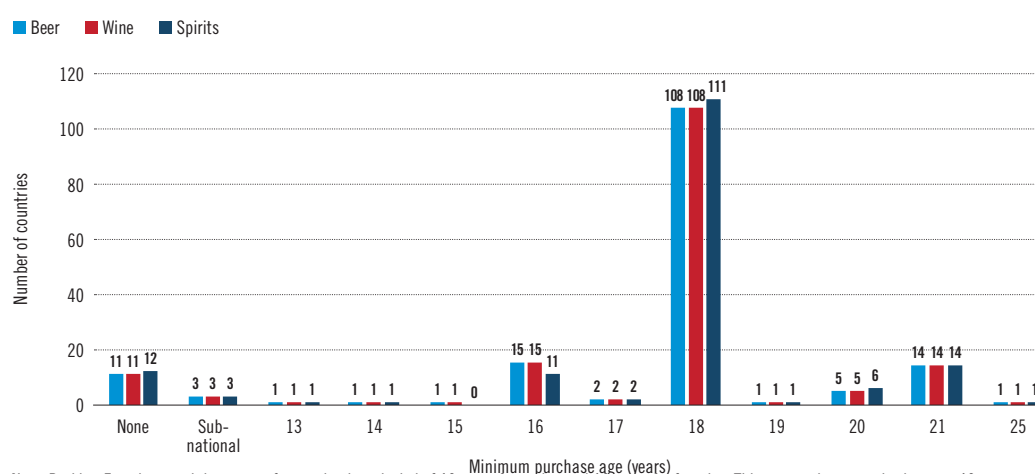
- The proportion of alcohol-attributable deaths in total deaths decreased slightly between 2010 (5.6%) and 2016 (5.1%), but the proportion of alcohol-attributable DALYs remained relatively stable (5.3% of all DALYs in 2010 and 2016).

## CHAPTER 5. ALCOHOL POLICY AND INTERVENTIONS

- In 2016, 80 countries reported having written national alcohol policies, while a further eight countries had subnational policies and 11 others had a total ban on alcohol. The percentage of countries with a written national alcohol policy steadily increased from 2008, and many countries have revised their policies since the Global strategy to reduce the harmful use of alcohol was released. The majority of countries in Africa and the Americas do not have written national alcohol policies. The presence of national alcohol policies is highest among reporting high-income countries (67%) and lowest among low-income countries (15%). Principal responsibility for the policy lies with the health sector in 69% of countries with a national policy.
- Levels of treatment coverage for alcohol dependence (calculated as the proportion of alcohol-dependent persons who are in contact with treatment services) varied widely in 2016 from close to zero in low- or lower-middle-income countries to relatively high (more than 40%) in high-income countries. Results of the survey indicate that the level of treatment coverage in most countries is not known. About half of reporting countries indicated that they increased the level of screening and brief interventions for hazardous and harmful drinking in primary health care settings since 2010, but most of this progress was confined to high-income and upper-middle-income countries.
- The majority (97) of responding countries have a maximum permissible blood alcohol concentration (BAC) limit to prevent drink-driving at or below 0.05%. However, 37 responding countries have a BAC limit of 0.08, and 31 responding countries have no BAC limits at all. Seventy countries (41%) reported using sobriety checkpoints and random breath-testing as prevention strategies, but 37 (22%) used neither strategy. The number of countries reporting these measures increased substantially between 2008 and 2016.
- The most common legal age limit for on-premise and off-premise alcohol purchase is 18 years, followed by 21 and 16 years. Countries without a legal minimum tend to be low-income or lower-middle-income countries.

**Figure 8. Minimum age limits for on-premise sales of beer, wine and spirits, by number of countries, 2016**

(n = 164 reporting countries)

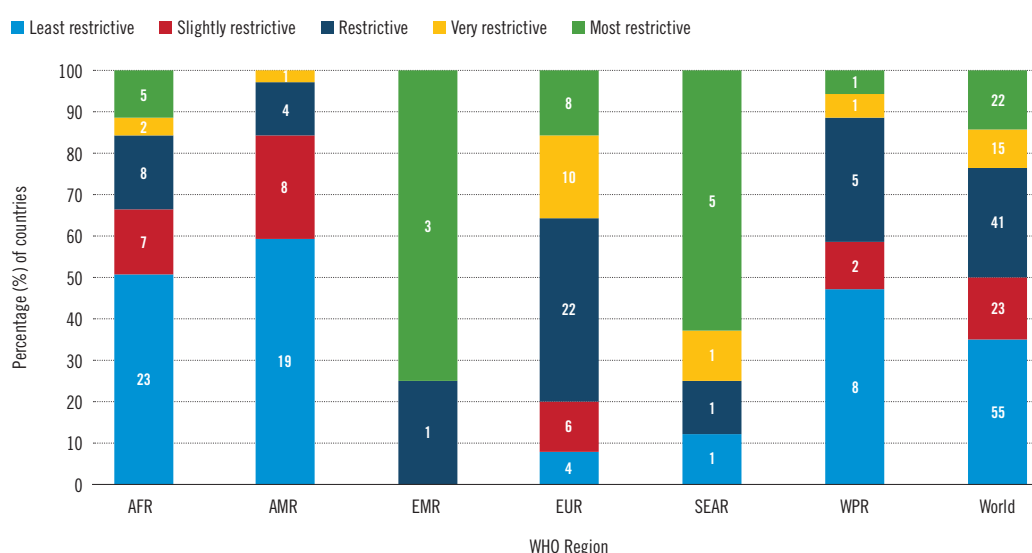


Note: Burkina Faso has a minimum age for purchasing alcohol of 13 years for males and 16 years for females. This country is categorized as age 13.

- Licensing systems are the commonest means of restricting alcohol availability, and 47 countries have a licensing system along with a government monopoly in at least one level of the alcohol market. Of the countries with an alcohol licensing system, most reported an increase in the number of licences to distribute and sell alcohol, particularly in the African and South-East Asia regions. Two in every five countries reported growth in the number of licences to produce alcohol. Increases in the number of licences for alcohol production and distribution is concentrated in low-income countries.
- The majority of countries have some type of restrictions on beer advertising, with total bans most common for national television and national radio. Almost half of countries reported no restrictions on the Internet and social media, suggesting that regulation in many countries lags behind technological innovations in marketing. Thirty-five countries had no regulations on any media type. Most of the countries that reported no restrictions across all media types were located in the African (17 countries) or Americas regions (11 countries).

**Figure 9.** Stringency of overall statutory regulation of alcohol marketing, by WHO region and the world and percentage (in %) of countries, 2016

(n =156 reporting countries)

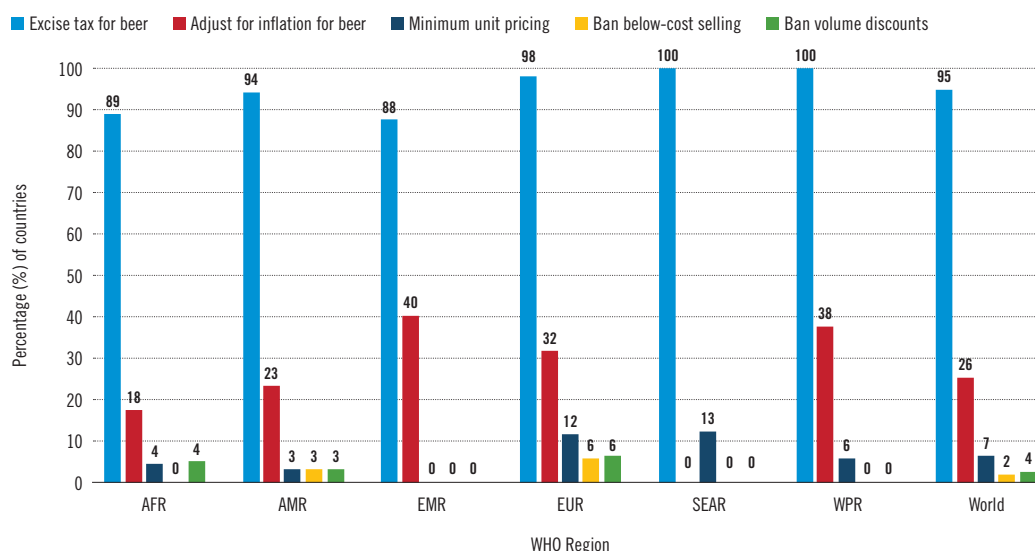


Note: The numbers in each coloured bar indicate the number of countries in that category, whereas the length of each coloured bar indicates the percentage of countries in the category.

- Almost all (95%) countries have alcohol excise taxes, but fewer than half of them use the other price strategies such as adjusting taxes to keep up with inflation and income levels, imposing minimum pricing policies, or banning below-cost selling or volume discounts.

**Figure 10.** Implementation of selected price and tax measures by WHO region and percentage (in %) of countries, 2016

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



- Disclosing the alcohol content on alcoholic beverage labels is required for beer, wine and spirits in a majority of countries, but only a minority of countries requires basic consumer information such as calories and additives. Only eight countries require that alcoholic beverage labels must indicate the number of standard drinks in the container. Less than a third of responding countries mandate health and safety warning labels on bottles or containers, and only seven countries require rotation of the warning label text.
- A total of 104 countries reported having a national legal definition of alcoholic beverages, and beverages containing at least 0.5% alcohol by volume was the most common definition. Fifty countries provided a definition of a standard drink in grams of pure alcohol with 10 grams as the most common size for a standard drink.
- National monitoring systems most commonly collect data on alcohol consumption and related health consequences and less commonly monitor social consequences and alcohol policy responses.
- Effective alcohol policies protect the health of populations. The highest population coverage for the most cost-effective alcohol policies (“best buys”) is observed for pricing policies, with excise taxes as the most common policy measure. However, reliable data indicate that population coverage of regulations on physical availability of alcohol and restrictions on alcohol marketing is significantly lower worldwide.

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

- Despite some positive global trends in prevalence of HED and alcohol-related mortality and morbidity since 2010, there is no progress in reducing total per capita alcohol consumption in the world, and the global burden of disease attributable to alcohol continues to be unacceptably high. The current trends and projections point to an increase in total per capita consumption worldwide in the next 10 years that will put the target of a 10% relative reduction by 2025 out of reach unless implementation of effective alcohol control measures reverse the situation in countries with high and increasing levels of alcohol consumption.

**Table 2.** Relative changes (2010–2016) in total alcohol per capita consumption (APC) and age-standardized prevalence of heavy episodic drinking (HED)

WHO Region	Total (recorded and unrecorded) alcohol per capita (APC) (aged 15+ years) consumption within a calendar year in litres of pure alcohol by WHO Region and the world, 2010 and 2016					Age-standardized prevalence (%) of heavy episodic drinking (HED) among the population by WHO Region and the world, 2010 and 2016				
	2010	95% CI	2016	95% CI	Relative change (%)	2010	95% CI	2016	95% CI	Relative change (%)
AFR	6.3	5.9-6.8	6.3	5.8-6.8	0	18.7	17.3-20.2	16.8	15.3-18.1	-10.2
AMR	8.2	7.8-8.7	8.0	7.6-8.4	-2.4	25.0	22.1-28.0	22.3	19.6-25.1	-10.8
EMR	0.6	0.4-0.7	0.6	0.4-0.7	0	0.6	0.5-0.7	0.5	0.4-0.6	-16.7
EUR	11.2	10.6-11.8	9.8	9.3-10.3	-12.5	33.8	27.6-38.1	28.9	23.3-33.3	-14.5
SEAR	3.5	3.0-4.0	4.5	3.7-5.4	28.6	14.0	12.4-15.6	13.8	12.2-15.4	-1.4
WPR	7.0	6.5-7.6	7.3	6.7-7.9	4.3	24.2	16.8-31.9	22.6	15.5-30.2	-6.6
<b>World</b>	<b>6.4</b>	<b>6.2-6.6</b>	<b>6.4</b>	<b>6.2-6.6</b>	<b>0</b>	<b>20.6</b>	<b>16.6-24.5</b>	<b>18.5</b>	<b>14.9-22.2</b>	<b>-10.2</b>

**Table 3.** Relative changes (2010–2016) in age-standardized alcohol-attributable deaths and age-standardized alcohol-attributable disability-adjusted life years (DALYs)

WHO Region	Age-standardized alcohol-attributable deaths (all causes) by WHO Region and the world, 2010 and 2016					Age-standardized alcohol-attributable disability-adjusted life years (DALYs) by WHO Region and the world, 2010 and 2016				
	2010	95% CI	2016	95% CI	Relative change (%)	2010	95% CI	2016	95% CI	Relative change (%)
AFR	79.8	64.9-98.6	70.6	57.1-87.4	-11.5	3438.2	2834.3-4124.5	3043.7	2491.8-3659.6	-11.5
AMR	36.2	26.4-63.9	34.1	27.0-56.4	-5.7	1937.7	1595.7-2294.5	1821.9	1513.2-2158.4	-6.0
EMR	7.0	5.4-11.0	7.0	5.3-10.9	-0.3	327.2	276.2-438.6	322	267.7- 428.6	-1.6
EUR	84.1	78.5-89.0	62.8	58.3-67.1	-25.3	3554.7	3376.4-3723.0	2726.5	2563.3-2878.4	-23.3
SEAR	35.1	29.2-43.2	36.8	28.1-40.9	4.9	1664.4	1311.2-2392.6	1718.3	1335.9-2261.4	3.2
WPR	27.0	20.5-34.6	24.3	17.6-32.2	-10.1	1242.8	1035.6-1507.8	1132.9	929.1-1,390.9	-8.8
<b>World</b>	<b>44.6</b>	<b>39.3-52.2</b>	<b>38.8</b>	<b>33.8-45.8</b>	<b>-13.0</b>	<b>1967.7</b>	<b>1746.6-2270.3</b>	<b>1758.8</b>	<b>1543.5-2039.4</b>	<b>-10.6</b>

- Concerted actions are needed to achieve at least stabilization of increasing trends in alcohol consumption in the South-East Asia and Western Pacific regions, acceleration of the decreasing trends in the Region of the Americas, initiation of a decrease in alcohol consumption in the African Region, and continued support for positive changes in the European Region.
- In the WHO European Region, the target of a 10% relative reduction of total per capita consumption in comparison with the 2010 level was achieved in 2016, demonstrating the feasibility of a 10% relative reduction in alcohol consumption as envisaged by the NCD Global Monitoring Framework.
- Alcohol policy development and implementation have improved globally but are still far from accomplishing effective protection of populations from alcohol-related harm. The skewed prevalence of effective alcohol policies in higher-income countries raises issues of global health equity and underscores the need for greater resources and priority to be placed on supporting development and implementation of effective actions in low- and middle-income countries.
- Among the challenges in reducing the harmful use of alcohol are low levels of political commitment to effective coordination of multisectoral action to reduce harmful use, the influence of powerful commercial interests which go against effective alcohol control policies, and strong drinking traditions in many cultures.
- Among the opportunities for reducing the harmful use of alcohol worldwide are inclusion of alcohol-related targets in major global policy and strategic frameworks such as the 2030 Agenda for Sustainable Development, increased health consciousness in populations, decreased youth alcohol consumption as observed in a wide range of countries, recognition of the role of alcohol control policies in reducing health and gender inequalities, and accumulating evidence of effectiveness and cost-effectiveness of a number of alcohol control measures.
- Addressing the harmful use of alcohol requires “whole of government” and “whole of society” approaches with appropriate engagement of public health-oriented NGOs, professional associations and civil society groups. At the international level, the broad scope and magnitude of health and social problems caused by the harmful use of alcohol require coordinated and concerted actions by different parts of the United Nations system and regional intergovernmental organizations in the context of the 2030 Agenda for Sustainable Development.
- New partnerships and appropriate engagement of all relevant stakeholders are needed to support the implementation of practical and focused technical packages based on the evidence of effectiveness and cost-effectiveness of different alcohol-control measures that can ensure returns on investments by reducing the harmful use of alcohol.

- Streamlined and simplified data generation, collection, validation and reporting procedures, as well as methodological advances in the assessment of treatment coverage for substance use disorders, are needed for effective monitoring and reporting on the alcohol-related indicators included in the monitoring framework for the SDGs.
- The magnitude of alcohol-attributable disease and its social burden and the availability of a range of effective and cost-effective policy options and interventions are in sharp contrast with the resources available at all levels to reduce the harmful use of alcohol. The lack of resources to finance prevention and treatment programmes and interventions calls for innovative funding mechanisms to address the harmful use of alcohol within the context of 2030 Agenda for Sustainable Development.
- The report also contains country profiles for all 194 WHO Member States as well as data tables supporting the information provided in chapters 2–5 (Appendices I–III) and a section explaining data sources and methods used in this report (Appendix IV).





**Global status report on alcohol and health 2018**  
[https://www.who.int/substance\\_abuse/publications/global\\_alcohol\\_report](https://www.who.int/substance_abuse/publications/global_alcohol_report)

## Contact

Management of Substance Abuse  
Department of Mental Health and Substance Abuse  
20, Avenue Appia  
1211 Geneva 27  
Switzerland  
Tel: + 41 22 791 21 11  
Email: [msb@who.int](mailto:msb@who.int)  
[www.who.int/substance\\_abuse](http://www.who.int/substance_abuse)