

This is an informal compilation of HIFA messages exchanged up to 8 March 2024 inclusive. For background on the project, see: www.hifa.org/news

Alcohol Use Disorders (1) A new HIFA thematic discussion starting 5 February 2024

10 January, 2024

Dear HIFA colleagues,

I am delighted to announce a new HIFA thematic discussion starting on 5th February.

We need your help to publicise this discussion over the coming days, so that we can welcome hundreds of new members with an interest in this topic.

Please forward this message to your contacts and networks, and post on social media. Further information here:

<https://www.hifa.org/news/hifa-announces-deep-dive-discussion-alcohol-us...>

New members can join us here: www.hifa.org/joinhifa

HIFA is grateful for sponsorship from the Ulrich and Ruth Frank Foundation for International Health known online as NextGenU.org. NextGenU.org offers free health science certificate courses, and a free/low-cost Master's degree in Public Health to learners in every country and provides over 800,000 learning sessions each month.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

Email: neil@hifa.org

Alcohol Use Disorders (2) Introduction and happy to be part of HIFA Working Group on Alcohol disorders

10 January, 2024

Dear HIFA Community,

I am pleased to extend my warm greetings to each member of the HIFA community and share the exciting news about my involvement in the HIFA Working Group on Alcohol Use Disorders.

[<https://www.hifa.org/projects/mental-health-meeting-information-needs-su...>]

My name is Enock Musungwini, and I am a passionate public health professional and advocate for alcohol policy, mental health, and well-being. I am thrilled to join the HIFA Working Group on Alcohol Use Disorders, a platform that aligns perfectly with my commitment to addressing the challenges posed by alcohol use and its impact on health. This group serves as a crucial space for collaboration, knowledge sharing, debates, discussions, and the development of strategies to enhance our understanding and response to alcohol-related issues within the HIFA community and beyond.

As a member of the working group, I am eager to engage in meaningful discussions, share insights, and contribute to the collective efforts aimed at promoting awareness, prevention, and intervention in the context of alcohol use disorders. I firmly believe that our combined expertise can lead to innovative solutions and contribute to the advancement of public health in this critical area.

I look forward to connecting with fellow working group members, broad HIFA members and community, learning from your experiences, and collectively making a positive impact on the discourse surrounding alcohol used isorders. Together, let us strive for a healthier and more informed global community.

Enock Musungwini

HIFA profile: Enock Musungwini is a distinguished public health professional, health management consultant, and development practitioner currently serving as a Programme Manager (Consultant) for an NGO called Pangaea Zimbabwe under the Wild4Life Health program responsible for program

management, oversight, supervision, coordination, and leadership. He holds an MSc in Public Health with a Research award from the London School of Hygiene and Tropical Medicine (LSHTM), achieved under the prestigious British Chevening scholarship (2018-19 cohort). His educational background also includes a Master's in Business Administration, BSc Hons in Psychology, Diploma in Nursing Science, Diploma in Public Relations and Communication, and a Postgraduate Certificate in Health Management and Leadership. Enock actively serve as a Reference Group Committee member for the Africa Evidence Network, Steering Committee member for the International Network for Government Science Advice Africa Chapter, member of the Consortium for Universities of Global Health and Country Representative for Healthcare Information for All (HIFA).

Alcohol Use Disorders (3) A new HIFA thematic discussion starting 5 February 2024 (2)

10 January, 2024

Dear Neil, Enoch and Colleagues,

I will post news of this thematic discussion in the next few days. [*see note below]

Just to highlight again the utility of Hodges' model in this context (across addictions):

health education - prevention; therapeutic approaches - motivational interviewing ...; physical - cognitive impacts ... legal aspects and policy (national - global); forensic psychiatry - addiction - domestic violence - crime; determinants of health -- 'health career' as 'life chances in-patient - community teams - primary care; medication - prescribing - out of hours; socio-economics of alcohol; demographics - epidemiology...

Hodges' model is *situated*.

In 1987 I visited community alcohol services in Salford, Preston ... for a study (unpublished) we had no provision locally in Chorley, UK.

I have nursed several individuals in the community with Korsakoff's syndrome and in residential - nursing homes.

alcohol <https://hodges-model.blogspot.com/search?q=alcohol>

Peter Jones

Community Mental Health Nurse and Researcher

CMHT, Prescott House, Salford NW England, UK

Blogging at "Welcome to the QUAD"

<http://hodges-model.blogspot.com/>

<http://twitter.com/h2cm>

HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges' model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>). h2cmuk AT yahoo.co.uk

[*Note from HIFA moderator (NPW): Thanks Peter, I invite others to do the same. You can point people to our news item here: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-alcohol-us...>]

Alcohol Use Disorders (4) Introduction and happy to be part of HIFA Working Group on Alcohol disorders (2)

15 January, 2024

Dear Enock,

Many thanks indeed for your introduction message: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-2-introduction-an...>

Thanks to you and other volunteers on the HIFA Working Group on Alcohol Use Disorders. <https://www.hifa.org/projects/mental-health-meeting-information-needs-su...>

We are planning to launch the discussion on 5th February.

In the meantime we would like to enrol at least 100 new people on the HIFA forum with an interest in Alcohol Use Disorders, and I shall soon be asking from help from HIFA members at large.

A note to all HIFA members: HIFA working groups welcome volunteers from the HIFA membership to join the working group. If you have a professional interest in this topic, please let me know.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.
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Alcohol Use Disorders (5) Introduction: Eduardo Bianco, Uruguay

18 January, 2024

Dear Members of the HIFA Community,

My name is Eduardo Bianco, I am a doctor from Uruguay and I currently serve as the Director of the Addiction Training Program for Health Professionals at the Frank Foundation for Health International/NextGenU (NGU).

I have worked for more than 25 years in Tobacco Dependence Treatment and Tobacco Control Policies in my country, in the Region of the Americas and internationally. I also worked on the issue of NCDs and their Risk Factors, and of course I have been involved with the problem of alcohol, which I consider an important and worrying issue and to which as health professionals we have not dedicated the time it deserves due to its social importance, health and economic impact.

The Frank Foundation and NGU are supporting the development of the HIFA Alcohol Discussion Forum and I am very pleased to be part of the HIFA Working Group that is organizing it. [*see note below]

I am very much looking forward to participating in the discussion and debates, sharing experiences and learning about this important topic, in which we all have a responsibility.

I hope that the outcome of this debate will contribute to improving the current (insufficient) efforts to address this worrying issue, that health professionals will become more involved (and engaged) with it and help to raise awareness among society and politicians, to promote the necessary actions. to reduce the impact of alcohol consumption on our lives.

Best regards,

Eduardo

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco@nextgenu.org

[*Note from HIFA moderator (NPW): Thank you Eduardo. The discussion will take place here on HIFA for 6 weeks, starting 5th February. For further information see our news item here: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-alcohol-us...>

You can see more about our series of discussions on Substance Use Disorders, and meet the current members of the working group, here:

<https://www.hifa.org/projects/mental-health-meeting-information-needs-su...>]

Alcohol Use Disorders (6) What measures can be taken to prevent alcohol abuse?

19 January, 2024
Greetings to all,

Here's the question a propose for the alcohol discussion.

What measures can be taken to prevent from alcohol abuse in the society?

What can be the role of parents? What can be the role of politics? NGO?
Religious representatives?

Marileine KEMME

MD. Addiction and Harm Reduction Consultant

Prevention and Care Center in Addictology - Yaounde Central Hospital.

MEDCAMER - Cameroon Medical Doctors association President

contact - (+237) 675 297 626

HIFA profile: Marileine Kemme is a Doctor, graduated from the National Memorial University of Pirogov in Ukraine in 2012. She is fluent in five languages (Bankôn, French, English, Russian and Ukrainian) and currently practices at the Central Hospital of Yaounde specifically at the Support and Prevention center in Addictology as an Addictologist. She is passionate about issues of mental health in general, addictions and substance use disorders.
Marileine.kemme AT medcamer.org

Alcohol Use Disorders (7) Tobacco control

20 January, 2024

Welcome to the HIFA forum Eduardo Bianco. I agree that efforts towards tobacco control are insufficient and engaging with a variety of stakeholders is good way forward. I was involved with a national study in Nigeria exploring the factors responsible for the use of Shisha through a mixed methods study and some of our findings results have just been accepted for publication on PLOS Global Public Health. It is a multi factorial and complex issue that has been further complicated by the hard push back from the tobacco companies.

I look forward to a robust discussion especially suggestions on ways forward.
[*see note below]

Regards,

Dr Ranti Ekpo

HIFA profile: Ranti Ekpo is Program Manager/Researcher at the dRPC in Nigeria. Professional interests: Health Advocacy, Child Health, Child diarrhoea, Childhood Pneumonia, Child Nutrition, Routine Immunisation, Family Planning. She is a member of the CHIFA steering group. <https://www.hifa.org/support/members/oluranti> ekpooy AT yahoo.co.uk

[*Note from HIFA moderator (NPW): There are strong parallels regarding the role of the alcohol industry as compared with the tobacco industry. We shall explore this in more depth in our upcoming discussion officially starting February 5, but the floor is open now for comments: hifa@hifaforums.org]

Alcohol Use Disorders (8) Starts 5 Feb! (1) HIFA sponsored discussions in 2024

30 January, 2024
Dear all on HIFA,

It's just 6 days to go before the official launch of our deep-dive discussion on Alcohol Use Disorders, 5 February to 17 March 2024.

Please forward this message to your contacts and networks and invite them to join! www.hifa.org/joinhifa

More information here: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-alcohol-us...>

HIFA is grateful for sponsorship from the Ulrich and Ruth Frank Foundation for International Health known online asNextGenU.org.

Note: We have opportunities for further sponsored discussions in 2024. We have 20 working groups on standby to plan and implement a discussion [<https://www.hifa.org/projects>]. Or we can start a new group to address a topic that is important to you. Also new in 2024 there is the option to have live webinars to complement our forum discussions.

To discuss possibilities, please contact: neil@hifa.org

With thanks, Neil

HIFA Partnerships and Projects working group: <https://www.hifa.org/projects/partnerships-and-projects>

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

Email: neil@hifa.org

Alcohol Use Disorders (9) Invitation to HIFA and participate in Alcohol Use disorders discussion

30 January, 2024

Dear Dr Machando,

Good day,

As I announced today at the HIV and mental health integration meeting between WHO and partners in Zimbabwe. Kindly share with the participants who were at the meeting today, also invite your professional colleagues and contacts that might be interested.

I would like to invite you to join HIFA (free) in readiness for a global conversation starting on 5 February 2024.

'Alcohol consumption contributes to 3 million deaths each year globally as well as to the disabilities and poor health of millions of people. Overall, harmful use of alcohol is responsible for 5.1% of the global burden of disease.' World Health Organization

HIFA is bringing together all stakeholders with an interest in alcohol use disorder to explore how to build a world where *every* person has access to reliable information on the prevention, diagnosis and management of alcohol use disorder. We shall be looking at the information needs of health workers, the general public, patients and policymakers.

The discussion will take place on the HIFA forums, a global health community of more than 20,000 stakeholders in 180 countries, representing all parts of the global evidence ecosystem, interacting in four languages, and working in official relations with WHO.

We shall explore the following questions (among others):

1. Do people understand the health, socio-economic and environmental harms of alcohol? What matters to them? How can they be better informed? How to reduce stigma?
2. Do health workers have adequate knowledge to prevent and manage alcohol use disorders among their patients? What matters to them? How can they be better informed?
3. What is the role of the alcohol industry? What can be done to address misinformation from the alcohol industry?
4. Do public health professionals and policymakers have adequate knowledge to prevent and treat alcohol use disorders in their country? What are current national policies and what more can be done to fully implement those policies?
5. How can we define and measure alcohol use disorders?

To join the discussion, if you are not already a HIFA member, please join us! www.hifa.org/joinhifa

We shall host parallel discussions on HIFA-French, HIFA-Portuguese and HIFA-Spanish, as well as our dedicated child health forum (CHIFA) in English. Please see our website for details: www.hifa.org The discussion will continue for 6 weeks to allow thorough exploration of the issues.

Acknowledgement: HIFA is grateful for sponsorship from the Ulrich and Ruth Frank Foundation for International Health known online as NextGenU.org. NextGenU.org offers free health science certificate courses, and a free/low-cost Master's degree in Public Health to learners in every country and provides over 800,000 learning sessions each month.

Kind regards,

Enock

HIFA profile: Enock Musungwini is a distinguished public health professional, health management consultant, and development practitioner currently serving as a Programme Manager (Consultant) for an NGO called Pangaea Zimbabwe under the Wild4Life Health program responsible for program management, oversight, supervision, coordination, and leadership. He holds an MSc in Public Health with a Research award from the London School of

Hygiene and Tropical Medicine (LSHTM), achieved under the prestigious British Chevening scholarship (2018-19 cohort). His educational background also includes a Master's in Business Administration, BSc Hons in Psychology, Diploma in Nursing Science, Diploma in Public Relations and Communication, and a Postgraduate Certificate in Health Management and Leadership. Enock actively serve as a Reference Group Committee member for the Africa Evidence Network, Steering Committee member for the International Network for Government Science Advice Africa Chapter, member of the Consortium for Universities of Global Health and Country Representative for Healthcare Information for All (HIFA).

Enock has received numerous accolades including being appointed Brand Ambassador and receiving the Growth and Innovation award for Pangaea Zimbabwe (June 2023), Country Representative of the Year by HIFA (April 2023), Chevening Volunteers Gold Award by the British Foreign and Commonwealth Office (June 2019), and the Zimbabwe Achievers Chairman's Award (Nov 2019). His academic excellence is reflected in awards such as the Amanda Jacklyn Berger Prize for his MSc Research project by LSHTM (Feb 2020) and the Marie Stopes Clinics Champion Award (Jan 2017). Enock's dedication to personal development led to his nomination for Ten Outstanding Young Persons in Zimbabwe under the Personal Improvement Category by Junior Chamber International (Oct 2019). Enock Musungwini has made presentations at national, regional, and international conferences and contributed significantly to public health discourse through his blogs and opinion pieces on various topics.

Alcohol Use Disorders (10) Starts 5 Feb! (2)

31 January, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-8-starts-5-feb-1-...>]

Dear Neil and All,

I will post this news on Friday, so it is listed for the month of February, and will look to pick up a thread as a further prompt for 1st March also.

Of course, obvious to note the individual and collective 'reality' of alcohol use disorders and impact/role of identity - addiction and addictive - self-harming behaviours as previously posted here: <https://hodges-model.blogspot.com/search?q=alcohol>

But also to assert and rejoice in human potential - cognition, reasoning and physical - "Identity: Self, person, client, patient ... player":

<https://hodges-model.blogspot.com/2024/01/identity-nfl-morphism.html>

All best for the discussion.

Peter

Peter Jones

Community Mental Health Nurse and Researcher

CMHT, Prescott House, Salford NW England, UK

Blogging at "Welcome to the QUAD"

<http://hodges-model.blogspot.com/>

<http://twitter.com/h2cm>

HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges' model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>). h2cmuk AT yahoo.co.uk

Alcohol Use Disorders (11) Alcohol Use Disorders in Zimbabwe

31 January, 2024

Good morning to you. I hope to find you well.

I'm matron Muroiwa Wellington, working at Parirenyatwa Annexe mental health department. Alcohol Use Disorders are our main concern these days. To discuss issues related to it is greatly appreciated.

I am ready available if needed to share our experience.

Regards

Wellington

HIFA profile: Wellington Muroiwa is Senior Nursing Officer with the Parirenyatwa Group of Hospitals-Annex, Zimbabwe. Professional interests: mental health nursing. welliemuroiwa AT gmail.com

Alcohol Use Disorders (12) Welcome to the HIFA Alcohol Discussion Forum - What are the health consequences of alcohol?

4 February, 2024

Hello friends. Welcome to the HIFA Alcohol Discussion Forum.

My name is Eduardo and I am a member of the HIFA working group on Alcohol Use Disorders.

We are starting the first week of our Forum and we want to know your opinions on different aspects related to alcohol consumption.

Let's start with these ones:

WHAT ARE THE HEALTH CONSEQUENCES OF ALCOHOL?

According to WHO, these consequences are enormous: 'Alcohol consumption contributes to 3 million deaths each year globally as well as to the disabilities and poor health of millions of people. Overall, harmful use of alcohol is responsible for 5.1% of the global burden of disease. (1)

The WHO Fact Sheet on Alcohol also reminds us that 'The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions'.

Evidence suggests that alcohol plays a causal role in many health and social problems, including coronary heart disease, some cancers, liver disease, HIV/AIDS, suicide, and interpersonal violence. The harm caused by alcohol consumption is not limited to the individuals who drink, but can affect third parties, causing deaths or injuries due to: violence, traffic accidents, fetal alcohol syndrome due to prenatal exposure and child abuse. (2)

However, the epidemiological trend shows continued growth in both alcohol consumption and alcohol-related problems in many countries in all regions of the world.

DO PEOPLE FULLY UNDERSTAND THESE HEALTH CONSEQUENCES?

I am convinced that the answer is No.

In my experience, there is a pervasive lack of understanding about the consequences of alcohol on health. This is the case in the general population, among policymakers, and even among health professionals.

Why are people unaware of the risks?

One reason is that we don't talk about it. In many countries, alcohol consumption is totally embedded in social life. There are deeply socially rooted beliefs and myths that naturalize this consumption, even when it is excessive or risky.

About 2 billion people worldwide drink alcohol, and many of them do so regularly or even daily. A staggering 280 million of them have Alcohol Use Disorders.

Alcohol use disorder (AUD) involves frequent or excessive alcohol use that becomes difficult to control and causes problems in relationships, work, school, family, or other areas. This terminology comes from the DSM-V and integrates two disorders, alcohol abuse and alcohol dependence (DSM-IV), with mild, moderate and severe subclassifications. American Psychiatric Association. (3)(4)

Another reason is that alcohol use disorders are hidden.

It is only when a person enters the most severe stages of alcohol dependence that the situation becomes visible. Physical illness such as cirrhosis is slow to develop and can be symptom-free until it is well-advanced. A person who drinks and drives may not be apparent until he or she causes the death of an innocent person as a result of alcohol.

Indeed, it can be argued that alcohol use disorders are the single most important cause of harm to others (accidents, violence, gender-based violence).

What do you think about it?

References

1. <https://www.who.int/health-topics/alcohol>
2. <https://global.oup.com/academic/product/alcohol-no-ordinary-commodity-97...>

3. <https://www.psychiatry.org/patients-families/alcohol-use-disorder>
4. <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol...>

Dr. Eduardo Bianco

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Web: NextGenU.org

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. [ebianco AT nextgenu.org](mailto:ebianco@nextgenu.org)

Alcohol Use Disorders (13) Welcome to the HIFA Alcohol Discussion Forum (2)

4 February, 2024
Dear Eduardo,

Many thanks for your welcome message. On behalf of HIFA, it's great to be working with you and NextGenU.org on this project.

I would like also to welcome all new members worldwide who have joined us in the past few days for this discussion. Please feel free to introduce yourself by sending an email to: hifa@hifaforums.org

Here again are the five guiding questions for the discussion (these questions are intended only as a guide - you are welcome to discuss other aspects of alcohol use):

1. Do people understand the health, socio-economic and environmental harms of alcohol? What matters to them? How can they be better informed? How to reduce stigma?
2. Do health workers have adequate knowledge to prevent and manage alcohol use disorders among their patients? What matters to them? How can they be better informed?
3. What is the role of the alcohol industry? What can be done to address misinformation from the alcohol industry?
4. Do public health professionals and policymakers have adequate knowledge to prevent and treat alcohol use disorders in their country? What are current national policies and what more can be done to fully implement those policies?
5. How can we define and measure alcohol use disorders?

This week I invite everyone to consider Q1: Do people understand the health, socio-economic and environmental harms of alcohol? What matters to them? How can they be better informed? How to reduce stigma?

Each week we shall explore a subsequent question, but if you would like to comment about any of the questions above at any time, feel free to do so.

We especially look forward to hear your personal or professional experience and observations.

PS Do you know anyone who may like to participate in this discussion? Invite them to join here: www.hifa.org/joinhifa

With thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

Email: neil@hifa.org

Alcohol Use Disorders (14) Alcohol consumption in Uruguay

5 February, 2024

Dear colleagues,

To continue breaking the ice, I would like to share information about alcohol consumption in my country, Uruguay.

Uruguay is a small South American country that was recently classified as high income by the World Bank.

According to PAHO, Uruguay has the highest per capita alcohol consumption in the region of the Americas, both in adults and young people, both in men and women.

In adults, the general average is 10.9 liters of alcohol, in men it is 17.1 liters and in women it is 5.3 liters. In young people, the general average per capita is 7.1 liters, in men it is 9.6 liters and in women it is 4.6 liters. (1)

According to the Ministry of Health of Uruguay, annual alcohol consumption is distributed as follows: 44% wine, 35% beer and 21% distilled spirits. It is estimated that an average person in Uruguay drinks 77 liters of beer, 41 liters of wine and 6 liters of distilled spirits per year. (2)

The average alcohol consumption in Uruguay is higher than the world average. (3)

Uruguay is also the country in the Americas with the highest episodic excessive alcohol consumption, defined as the consumption of at least 5 standard units of drink per occasion, once a month. In 2016, this type of consumption was observed in 39.7% of men and 10.5% of women. According to WHO, 9.6% of men and 3.4% of women in Uruguay have an alcohol use disorder. (4)

At the base of this is a low perception of risk with respect to alcohol, especially at early ages, and social permissiveness of adolescent consumption despite the clear evidence that the earlier one begins to drink alcohol, the greater the risk of problematic consumption. (5)

Unfortunately, at the national level, alcohol control policies are weak, with the exception of a "zero alcohol" policy while driving.

All of which determines that alcohol consumption is a serious problem in Uruguayan society, which is not being properly addressed.

We encourage you to share what is the situation in your country and, if you dare, some personal or professional experience linked to alcohol.

References:

1. Regional Status Report on Alcohol and Health in the Americas, 2020. PAHO.

https://iris.paho.org/bitstream/handle/10665.2/52705/9789275122211_eng.pdf

2. MSP communication.

<https://www.gub.uy/ministerio-salud-publica/comunicacion/noticias/baja-p...>

3. WHO (2019) <https://data.who.int/indicators/i/EE6F72A>

4. <https://www.paho.org/es/noticias/3-3-2021-uruguay-rereference-region-por...>

5. Communication from the Ministry of Health.

<https://www.gub.uy/ministerio-salud-publica/comunicacion/noticias/baja-p...>

https://www.canva.com/design/DAFGWrgplok/Yzg_h-Lf-fVounDwDTzg7Q/view

Dr. Eduardo Bianco

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<<https://www.tiktok.com/@nextgenu.org>> <<http://www.nextgenu.org/>>

<<https://aptp.nextgenu.org/>> <<https://phu.nextgenu.org/>>

<https://nextgenu.org/steps/> <<https://humanitarianu.org/>>

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco AT nextgenu.org

Alcohol Use Disorders (15) Alcohol consumption in Uruguay (2) Stigma

5 February, 2024

Dear Eduardo and all,

Thank your for your message on alcohol consumption in Uruguay.

"We encourage you to share what is the situation in your country and, if you dare, some personal or professional experience linked to alcohol."

Your words "if you dare" are a reflection of the stigmatisation of those who have alcohol use disorders (AUD). This stigmatisation is deeply rooted. It prevails in any community, including the 20,000 members of the HIFA community.

Also, it is notable that stigmatisation only applies to those with visible AUD, who form the minority of the total AUD population.

To take this further, it seems to me that there is a large number of people with AUD whose disorder is not (yet) visible, but who are seeking to deny to themselves and others that they have a problem. Stigma plays a part here too. A person may deny they have a problem because it is hard for them to accept this, given society's stigmatisation of those with AUD. And the person may hide their problem from others because of shame, rooted in stigma.

There is also stigma against those who do NOT drink. When I was a medical student at St George's London in the early 80s, our pharmacology lecturer was Professor Joe Collier. He puts it like this:

'I am a teetotaler... What bugs me, however, is how society so often tries to paint me as someone with something wrong, as an object of suspicion, as an outsider ripe for enquiry. As a teetotaler, I regularly have to explain why I don't drink. Ten minutes at a dinner party can be spent defending my position. I often feel that if I were to say that I was either a reformed alcoholic, or taking a medicine that interacts with alcohol or was a devout muslim, these would satisfy. Not having a "legitimate" reason for abstaining seems worrying. Perhaps, they conjecture, I am mad, or frightened, or even a Puritan. Whatever I say there might well be demands for me to drink anyway. "Go on, try some, it won't do you any harm"; "it's an acquired taste so give it a whirl," "fill your glass and have a sip, how can we all enjoy toasting someone if you don't join in?" and so on. Somehow if I don't drink I will spoil the atmosphere for others.'

<https://blogs.bmj.com/bmj/2009/09/21/joe-collier-a-drink-for-mr-teetotal...>

In the UK there is stigma against the person with visible AUD and stigma against the person who doesn't drink at all. Those at risk of developing severe AUD are, by contrast, encouraged on that path, especially among young men. Here is Joe Collier again: 'Finally, and bizarrely, alcohol is used as a right of passage to adulthood. Telling of last night's "bender," coming to college with a hangover, describing the more unsavoury events of a "pub crawl," or being able to drink umpteen pints of beer in an hour without collapsing (the capacity to "hold drink" is a classical challenge among some students), are all the stuff of bravado and greeted by peers with a certain sense of admiration.'

I look forward to hearing the experience in other countries.

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Alcohol Use Disorders (16) Popular beliefs about alcohol

5 February, 2024

Hello friends.

Is Eduardo, again.

Now, I would like to invite you to discuss some popular beliefs about alcohol consumption.

Below is a list of beliefs frequently associated with alcohol consumption.

Are they true or false?

- "Alcohol causes less harm than other drugs"
- "Having a good tolerance to alcohol implies that one has more resistance to its damage."
- "Drinking beer or wine is safer than drinking liquor (spirits)."
- "Beer before wine and you'll feel fine; wine before beer and you'll feel queer"
- "Even if I drink a lot, I can sober up quickly with a cold shower or drinking coffee."
- "Red wine in moderation is good for the heart"
- "Alcohol improves creativity."
- "Men and women react the same to the same amount of alcohol"
- "Alcohol is a stimulant."
- "Drinking alcohol helps to warm the body on cold days"
- "Alcohol is a good way to relax and reduce stress."
- "Eating fatty foods or drinking milk helps prevent a person from getting drunk."

- "If a person is very drunk and confused, you should let them sleep it off."

What do you think?

I'll start with something personal. When I was young, in my country Uruguay, drinking alcohol was one of the "rites of passage to adulthood." Currently, it seems to be a "rite of passage from childhood to adolescence" due to the early age at which young people begin to use alcohol.

What is the current situation in your country?

Can you share any other beliefs about alcohol that you have heard in your country?

Kind regards,

Eduardo

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Alcohol Use Disorders (17) Popular beliefs about alcohol (2)

5 February, 2024

Hi Eduardo,

Thanks for sharing. I can definitely identify with some of what you have shared.

“Some alcoholic drinks were reported to improve red cell level-haemoglobin”, “the definition of a man is his ability to tolerate his alcohol (which could be in large quantities) without getting drunk”. “Some Alcoholic drinks in certain cultures were reported to act as an aphrodisiac hence used to improve sexual function”. In other context I have been in “alcohol is a socialization agent and enables people to trust you and feel like they could develop relationships (corporate) and do business with you”.

Wonder what other people think?

Best wishes

Bunmi

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Alcohol Use Disorders (18) Stigma (2) Do people understand the harms of alcohol? (1)

5 February, 2024

Dear All,

I'm Miriam Chickering, CEO of NextGenU.org. We aim to democratize education across critical areas, including health and addiction.

Firstly, I'd like to extend my gratitude to Eduardo for initiating our discussion with a comprehensive overview of the health consequences associated with alcohol use underpinned by WHO data and relevant literature. His message serves as a crucial foundation for our forum's work.

Reflecting on Eduardo's points, it's clear that despite significant evidence of the harms caused by alcohol, there remains a pervasive lack of understanding among the public, policymakers, and even health professionals. This gap in awareness is concerning, especially considering the

socio-economic and environmental ramifications of alcohol use. From my experience, practical education and open dialogue can play pivotal roles in enhancing understanding and changing perceptions.

One aspect that strikes me is the role of stigma in perpetuating alcohol use disorders. Stigma not only prevents individuals from seeking help but also silences the conversation around alcohol's broader impacts. How can we, as a community, work towards destigmatizing alcohol use disorders and encourage a more informed and empathetic approach to addressing this challenge?

I invite all members to share their insights, experiences, and suggestions on increasing public awareness, improving education, and reducing stigma. Together, we can foster a more informed society that understands the multi-dimensional harms of alcohol and supports those affected.

At NextGenU.org, we have free materials addressing various aspects of the prevention and treatment of alcohol use disorders. Today, I'll share information about one of our free courses on this topic, and I'll share others as they are updated.

Substance Use Disorders in Primary Care

<<https://courses.nextgenu.org/course/view.php?id=390>>, see module three for alcohol-specific information.

<https://courses.nextgenu.org/course/view.php?id=390>

Thank you for being so dedicated to this important cause. I look forward to a lively and insightful discussion.

Warm regards,

Miriam Chickering

CEO, NextGenU.org

<https://www.canva.com/design/DAFGWrgplok/Yzg_h-Lf-fVounDwDTzg7Q/view>

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HIFA profile: Miriam Chickering, RN, is the CEO of NextGenU.org and the Founder of Nurses International. Mrs. Chickering specializes in globally scaled solutions for healthcare and education. The programs she directs have and continue to make a lasting impact worldwide: NextGenU.org provides learning materials through 300 universities, Nurses International creates critically needed learning materials for nurses in 147 countries, HumanitarianU.org has trained over 30,000 humanitarians globally, and Public Health U trains 140 Masters-Level Public Health students each year from 50 countries. Mrs. Chickering received the 2021 Humanitarian Service Award for Transformative Global Leadership in Democratizing Education from NHSD/Humanitarian Pakistan and was a co-recipient of a 2021 award for Translating Science into Nursing Education from Sigma Theta Tau.

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Alcohol Use Disorders (19) What is the definition of Alcohol Use Disorders?

6 February, 2024

WHO estimates that there are 280 million people worldwide who have Alcohol Use Disorders. This suggests that there is a clear definition of Alcohol Use Disorders, but I have found this to be elusive. I located a paper called Classification of Alcohol Use Disorders from 2003. This did not itself propose a definition, but referred to various definitions described by others.

The US National Institute on Alcohol Abuse and Alcoholism defines AUD as 'a medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences'.

DSM-5 criteria are as follows: 'A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 2 or more of the following, occurring at any time in the same 12-month period:

Alcohol is often taken in larger amounts or over a longer period than was intended.'

The above definitions would appear to exclude most people who are heavy social drinkers - those who drink well over the recommended limits, but who do not (as yet) show significant impairment or distress. Our local pub/bar is full of such people, and I often drink a pint there myself after work (it is just across the road from my office!)

Is there an agreed definition that we can all use?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.
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Alcohol Use Disorders (20) Self-care: Empowering individuals to prevent and manage AUD

6 February, 2024

Below are extracts from a new paper in the WHO Bulletin. Although not specifically about alcohol, it raises questions. 'WHO defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker.' How does this apply to Alcohol Use Disorders? I suspect that 'the ability of individuals...' is *especially* important in AUD?

Read

online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10835638/?report=classic>

CITATION: Bull World Health Organ. 2024 Feb 1; 102(2): 140-142.

doi: 10.2471/BLT.23.290927

Self-care interventions and universal health coverage

Manjulaa Narasimhan et al.

'Self-care is not a new concept, but the public health sector has only recently started actively promoting tools that provide greater autonomy and agency to people without formal health training to manage their health for themselves and those in their care (Box 1). Self-care interventions that can be provided as additional options to facility-based care include diagnostics such as pregnancy, coronavirus disease 2019 (COVID-19) or human immunodeficiency virus self-tests; devices to self-monitor blood glucose and/or blood pressure; and drugs such as emergency contraception or for self-management of medical abortions...

'WHO defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker.

'What are self-care interventions? WHO defines self-care interventions as tools that support self-care. Self-care interventions include evidence-based, quality drugs, devices, diagnostics and/or digital technologies which can be provided fully or partially outside of formal health services and can be used with or without the support of a health worker.

'Self-care interventions can meet many health needs, including for quality, reliable, evidence-based and age-appropriate health information; for the availability and accessibility of quality, regulated self-care interventions; and for cost-effective care that does not place clients at financial risk.

'To make self-care interventions sustainable and equitable, government public health policies must be focused on ensuring that evidence-based, quality self-care options are available and health workers are trained to promote them...'

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Alcohol Use Disorders (21) What is the definition of Alcohol Use Disorders? (2) Alcohol consumption in Malawi

6 February, 2024

Interesting discussion about alcohol disorders. From what I read this is a self-reported diagnosis hence highly subjective, the scale being that from alcohol abuse to alcoholism.

I wanted to share something about use of Alcohol in Malawi. Home brewed beer has a long tradition in African countries. A self respectable traditional chief would be a heavy beer drinker. (As an anecdote: the Senior Staff room at the university has a functioning bar/pub open throughout the day.)

Alcohol is one of the key causes of road accidents and deaths by road accidents (drunk pedestrians and drivers). In Malawi 6.45% of total deaths are due to road traffic accidents.

This is an older study (2008) among the student population in Malawi that found that almost 50% of male students qualified as 'suffering' from alcohol related disorders defined as such by scoring above the threshold at the Alcohol Use Disorders Identification Test (AUDIT) <https://auditscreen.org/~auditscreen/cmsb/uploads/audit-english-version-...>

Alcohol drinking among the youth (and female population too) seems to be on the increase (informal sources). Alcohol intake is high among the working age population (men especially). Linking the lack of food and alcohol poisoning (drinking on an empty stomach) is frequently reported in the social media.

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Alcohol Use Disorders (22) Do people understand the harms of alcohol? (2)

6 February, 2024

Q1. Do people understand the health, socio-economic and environmental harms of alcohol? What matters to them? How can they be better informed? How to reduce stigma?

My Contribution:

There might be emerging evidence that people understand the health, socio-economic and environmental harms of alcohol, that it matters to them, that they are better informed (even though more can be done to improve the communication about the harms and benefit), and drinking less reduces stigma provoked by overuse of alcohol.

Though the socio-economic and cultural factors that impact alcohol use are well known, including discrimination and stigmatisation of the overusers, the ill-effect on their mental and physical health of abuse, and the ever-rising cost of alcohol, the public health message about alcohol does not seem to have changed for many decades. The message has remained that 'moderate drinking seems to be good for the heart and circulatory system, and probably protects against type 2 diabetes and gallstones. As recently as 2021 several studies concluded that moderate use leads to lower risk of dementia or decreased cognitive decline over time with mild to moderate alcohol intake, and also to reduced risk of developing gallstones. Other studies point to positive social effects of alcohol because many people 'perceive it to be a social lubricant that improves mood, reduces self-consciousness and enhances social skills, increased social bonding among strangers', coping with problems, having fun, looking mature, and social image such as fitting in, being more popular, and looking cooler amongst peers and generally. (The public perception of the risks and benefits of alcohol consumption. 1992 Mar;16(1):38-42. doi:10.1111/j.1753-6405.1992.tb00023.x.).

It is also true that the long-standing public health message points out the harms, it says that 'heavy drinking is a major cause of preventable death in most countries. That in the U.S., alcohol is implicated in about half of fatal traffic accidents.' And that 'over time, excessive alcohol use can lead to chronic diseases, including high blood pressure, heart disease, stroke, liver disease, and various cancers: breast, mouth, throat, esophagus, voice box, liver, colon, rectum, female gynaeco-urinary organs and male genitourinary organs.

Anecdotes and research findings support this view, for instance the understanding of the health, socio-economic and environmental harms of alcohol seems to be influenced by generational factors. The public health message has not really changed much, but every younger generation seems to be less inclined to drink alcohol than their older one. Anecdotes from within families and from exchanges with patients, the younger generations

tend to drink less than the older ones. For instance 40% of Generation Z (Gen Zers born between 1997 - 2012, aka Gen Z, iGen, or centennials) are being labelled 'the sober curious generation' as they are less likely to drink, when compared to, half of over65s who did not limit their alcohol consumption in 2023. The Generation Zers follow the millennials, have been raised on the internet and social media, and the oldest finished college by 2020 and entering the workforce. Amongst them health concerns, changing tastes, a lack of effective marketing, and price (cost) are all factors why they drink less alcohol. Other factors include, a reflection of their attitudes towards health and wellness, and they are the fastest growing demographic of non-alcoholic drinks consumers. Gen Zers prioritize healthy eating and regular exercise, their mental health and managing stress, more.

But, sadly, as these younger people are turning away from alcohol and overconsumption, they are turning to cannabis use, according to reports, this switch seems to coincide with increased legalization of cannabis and the feeling of lower risk, in the USA. A discussion topic for another day!

Following the trend the Millennials (born between 1981 and 1996) - are more health-conscious than preceding generations, even though they are seeing their health decline faster than that of their parents as they age. (according to a 2020 study from medical insurer Blue Cross Blue Shield in the United States). In the UK they are among the heaviest generations, at least seven in 10 people millennials will be overweight or obese before they reach middle age, when compared to the Baby boomers rates of five in 10.

However, Baby boomers I and II (born 1946-54; 1955-64) are more likely to suffer chronic conditions than earlier and later generations.

As with many other conditions and public health situations, there is a big divide between the Global North (mostly high income countries-HIC) and Global South (mostly lower, low, and middle income countries- LLMIC). In most countries in Africa, for instance, a general perception persists that there are more urgent public health problems than harmful use of alcohol', even though Alcohol consumption has been identified as the leading risk factor for death and disability in sub-Saharan Africa and the leading risk factor for disability-adjusted life-years (DALYs) among African male adolescents aged 15-24 years. In the North alcohol use is part of the daily life of the people used, especially during everyday meals, in Africa alcohol tends to be used mostly during rituals, marriage ceremonies, clan/family festivities. This may be changing with urbanization and westernization of cultures and attitude.

Therefore, more needs to be done globally but more in LLMIC to re-orientate peoples perception and understanding about alcohol, in communicating facts

about alcohol use, benefits and harms, and avoiding alcohol altogether as the default position, because quitting alcohol protects physical, mental and psychological well-being.

Sources:

(i) <https://www.beresfordresearch.com/age-range-by-generation/> ...

(ii): <https://health.clevelandclinic.org> >why-gen-z-is-drinkin...

(iii) <https://www.cdc.gov> > alcohol > fact-sheets > alcohol-use.

(iv) foodbeverageinsider.com. <https://www.foodbeverageinsider.com> >millenni als-drive.... and

(v) texashealth.org <https://www.texashealth.org> >Health-and-Well-Being > S...

(vi) <https://www.google.com/search?q=perception+of+alcohol+in+africa&oq=perce...>

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Alcohol Use Disorders (23) Stigma (3) How to reduce stigma?

7 February, 2024

Dear friends,

Miriam has introduced into the discussion the important issue of stigma linked to alcohol consumption.

Alcohol-related problems are among the most stigmatized conditions, adding additional burdens of prejudice and discrimination. (1) Socially, people with problematic alcohol consumption are attributed greater responsibility and generate greater social rejection than consumers of other substances. (2)

Social stigma and self-stigma are two sides of the same coin. Social stigma is defined as negative perceptions and stereotypes of the majority of the population towards a specific social group. When the person who is part of this group internalizes these perceptions, self-stigma arises. (2)

Stigma not only accentuates the problems of these people but also discourages them from seeking treatment or receiving appropriate help. (3)
As a result, only a minority of people with AUD seek treatment.

Reducing stigma is an important step in helping people recover. (3)

To achieve this, it is important that health professionals learn to use non-pejorative, non-stigmatizing, and person-centered language.

Alcohol use disorder (AUD) is the name used since the DSM-5, and replaces alcohol abuse, alcohol dependence and alcoholism.

Instead of alcoholic or alcohol addict, use person with alcohol use disorder.
Instead of recovering alcoholic, use recovering person. (3)

What else should we do?

Eduardo

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2. Public stigma and treatment preferences for alcohol use disorders
<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-0...>
3. When It Comes to Reducing Alcohol-Related Stigma, Words Matter
<https://www.niaaa.nih.gov/alcohols-effects-health/reducing-alcohol-relat...>

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Alcohol Use Disorders (24) Stigma (4) How to reduce stigma? (2)

7 February, 2024

Thank you Eduardo for highlighting the importance of using the right terminology: alcohol use disorders. You ask "What else should we do?" to combat stigma.

I asked ChatGPT and top of the list was 'Education and Awareness: Increase public awareness and understanding of alcoholism as a medical condition rather than a moral failing. Provide information about the causes, symptoms, and treatment options for alcohol addiction.'

Do people have adequate access to reliable information about the causes, symptoms, and treatment options for alcohol addiction, in a language they can understand?

ChatGPT also highlighted the importance of 'Share Personal Stories: Encourage individuals who have overcome alcohol addiction to share their stories of recovery. Personal narratives can help reduce stigma by humanizing the experiences of those affected by alcoholism and demonstrating that recovery is possible.'

What information is available for the individual with alcohol use disorder, their loved ones, and the general public? It's likely that many will first seek information online. What are the best sources of information? The National Institute on Alcohol Abuse and Alcoholism (should this be renamed as the National Institute on Alcohol Use Disorders?) has a booklet in English and

Spanish: https://www.niaaa.nih.gov/sites/default/files/publications/NIAAA_Treatme... The UK National Health Service has similar advice for individuals: <https://www.nhs.uk/conditions/alcohol-misuse/>

To my non-expert eye, the NIAAA and NHS advice looks good, but they are both text-heavy and may not be accessible for people with low literacy. What other information is available for the general public? Videos? How easy is it for people to find the information they need?

Later, when alcohol use disorder is more severe, perhaps a different kind of information is needed to encourage the person to recognise their problem and take action, for example to see their doctor. Or the clinician may identify alcohol use disorder incidentally as part of a health check. How the clinician immediately responds to or addresses this situation will be very important. We'll be looking at this more in Q2: Do health workers have adequate knowledge to prevent and manage alcohol use disorders among their patients?

Best wishes, Neil

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Alcohol Use Disorders (25) Stigma (5) Personal experience

7 February, 2024

WHO estimates there are 280 million people worldwide with an alcohol use disorder. This is 1 in 20 of the world population. Extrapolating this to the HIFA community (20k members) it seems likely that around 800 of us have an alcohol use disorder.

The number may be even higher because the largest professional group on HIFA are healthcare providers, and healthcare providers have higher than average rates of alcohol disorder (at least this is the case in the UK and US)

I have been lucky. Like most of my friends, I drank a lot of beer when I was at medical school back in the late seventies and early eighties. At medical school, drinking beer was part of our self-identity. The same was true of smoking cigarettes. Social groups would form around these habits, perhaps more so than any other characteristic.

I rode a Honda 400 Four motorbike at the time, and I confess there were times when I was over the limit and could have got myself (or someone else) killed. In putting this message together I learned that I was typical of young male drivers at the time. Research carried out in 1979 showed that nearly two thirds of young male drivers admitted drink driving on a weekly basis. <https://www.lookers.co.uk/blog/drink-driving---how-attitudes-have-change...>

If we go back further, to before 1967, we find - amazingly - that people were able to drive under the influence of alcohol with impunity, provided they could 'handle it'. A policeman might ask you to "step out of the car sir and walk in a straight line". If you could do that, you might be deemed 'capable'. In 1967 the roadside breathalyser was introduced and the emphasis changed from walking a straight line to measurement of alcohol level.

In childhood and adolescence, alcohol was very much part of my life, including at home where my mother and stepfather frequently had parties, always lubricated with wine and beer. My stepfather gradually drank more and more, and this led to the breakdown of the marriage. He continued to get worse over subsequent years and died from a head injury after a drunken fall. He had been taken to hospital but he refused admission. They let him go and he died 2 days later alone, likely from a subdural haematoma.

I expect most of us know a relative or a friend whose life has been wrecked by alcohol. What can we learn from it?

I have learned that alcohol use disorder is insidious and is driven by social norms and expectations. Some individuals are more prone to develop severe disorder than others, for many different reasons. We need better ways of encouraging people to recognise they have a problem and to seek a solution, without stigma or shame.

Best wishes, Neil

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Alcohol Use Disorders (26) Personal experience (2)

7 February, 2024

Wow, Neil this is a powerful contribution to this discussion, especially your recount of very personal and family unfortunate experience caused by alcohol use disorder. Thank you for the decision to share it because it brings the issue to the human level. Often when we quote statistics they are mere numbers whereas Infact each statistic is about people: individuals, families, the society.

Your reference to the medical student life on the UK reminds me of when I landed in UK for postgraduate specialist medical education in the 1980s and quickly observed that alcohol was so pervasive in every medical meeting and conference. It was different where I came from in Nigeria whether by medical students or qualified doctors. Surely there are many reasons for the difference, cultural, religious, but also economic! Nigeria is a low income country whereas UK is a high income one. But even then the harm of alcohol was similar in both countries especially regarding death from road traffic accidents. I recall that fast forward to 1997 after we started publishing the BMJ West Africa edition in Lagos, Nigeria we received a manuscript from the surgeons in Calabar on the impact of motor cycle accidents often ridden by drunk persons.

There is the paradox in the difference in behaviour between how the rich and poor use alcohol, which needs explaining because one often hears that poverty predisposes people to drink more alcohol.

But is that really the case, or is it just that poor people drink cheaper, less refined more concentrated alcohol, whilst the richer people drink the reverse. But both cohorts are over drinking alcohol.

The message it seems to me should be to highlight the fact that no alcohol is the best status that everyone should aim for.

Joseph Ana

HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for PACK Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which also suitable for lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicom & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member, National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the Working Group on HIFA-WHO Collaboration (<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

Alcohol Use Disorders (27) Popular beliefs about alcohol (3) Alcohol consumption in Russia

8 February, 2024

I am forwarding this on behalf of a HIFA member in Russia. It describes a specific myth about alcohol consumption in nuclear workers. We look forward to hear examples and observations in other countries.

Dear All,

I'm a Radiologist with the specialization in Evident-Based Medicine and Biostatistics, working in the field of Radiation Epidemiology. The scope of our research interest is the cancer and non-cancer deseases risk assessment among nuclear workers exposed to external and internal exposure to professional radiation, over the background risk resulted from radiation and non-radiation risk factors, such as age at exposure, gender, tobacco smoking and alcohol consumption, etc.

Among nuclear workers at early time of nuclear program, when the occupational radiation doses were high, there were an opinion that alcohol helps to eliminate the radiation from the body, so there were large amount of radiation workers who were regular alcohol drinkers.

Measuring the individual dose of alcohol consumption to assess the related health risks is complicated due to several factors, mostly because of time-dependent process. The estimates of risk related to alcohol consumption are often biased due to uncertainty when use the survey data on alcohol consumption dependent on the psychology of respondents, so the methodology of measuring the true level of individual alcohol consumption must developed.

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HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.
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Alcohol Use Disorders (28) Do people understand the harms of alcohol? (3)

8 February, 2024

Hello, colleagues

I thank and appreciate the discussion so far going on regarding this topic.

Below is my take:

Certainly, misuse or harmful use of alcohol can be destructive not only to health but also to the general social life of the drinker, as the community around the drinker gets involved or associated with increased consequences or risks of adverse health and social outcomes.

According to the World Health Organization, the harmful use of alcohol is one of the world's leading risk factors for illness, disability, and death, and it is a primary cause of more than 200 diseases and injuries and globally results in approximately 3.3 million deaths each year, greater than HIV/AIDS, violence or tuberculosis.

Moreover, NCD Alliance reports that more than half of all alcohol-related deaths (1.7 million) are due to a noncommunicable disease (NCD). Besides, alcohol is one of the significant risk factors for a wide array of NCDs like cancer, digestive diseases, cardiovascular diseases (CVD), and mental health disorders.

It has been reported that ethanol contained in alcohol is classified as one of the highest carcinogens by the International Organization for Research on Cancer. Besides, the most common cancers caused by alcohol are cancers of the oral cavity, pharynx, larynx, esophagus, liver, breast, or colorectal cancer.

Additionally, high blood pressure, heart disease, stroke, liver disease, and digestive problems are all partly due to the dangerous use of alcohol, alongside breast cancer, mouth, throat, esophagus, colon, and rectum, as alcohol weakens the immune system, increases the chances of getting sick, notwithstanding other problems such as learning and memory problems, including dementia and poor school performance.

All said alcohol intake should be substantially controlled, for its effects are short and long-term in nature.

Regards,

James

HIFA profile: James Mawanda is accredited with the European Forum for Disaster Risk Reduction (EFDRR), and UN Global Platform for Disaster Risk Reduction (GP2022) and a Member of the UNDRR Stakeholder Engagement Mechanism. James is an Associate Partner, at the Interdisciplinary Centre on Climate Change and Health (ICCH), University of Hamburg, Germany. Member, Global Consortium on Climate and Health Education, Columbia University. A member of the Global Health Hub, Germany. Also, a Mentor,

International Network for Government Science Advice, Africa Chapter (INGSA-Africa), South Africa, and Mentor, Land Accelerator Africa by World Resources Institute (WRI), A Research Associate, Uganda Red Cross Society. James is a member of the Research4life User Group. He is also a Country Expert (Uganda & Rwanda) for Varieties of Democracy (V-DEM), University of Gothenburg, Sweden, since 2020. An Executive Director of African Forum for International Relations in Research and Development (AFIRRD). A member of the African Climate Policy Centre (ACPC) & United Nations Economic Commission for Africa (ECA). James holds a Ph.D. in Diplomacy & International Affairs. James' research interests span; International Organizations (IOs), particularly their conceptual prescriptions to the developing world; non-government organizations (NGOs) and their socio-political work in the developing world; and global climate policy and health dynamics, diplomacy and negotiations. He is an International Research and Project Assistant, EUCLID University, An Editorial Board Member, International Peer-Reviewed Journals and Books (IPRJB), USA. He is a reviewer at Global Council for Science and the Environment (GCSE), Washington DC; and VOLUNTAS: International Journal of Voluntary and Non-profit Organizations. Uganda's "ambassador" on The Council on Educational Standards and Accountability in Africa; Member, Platform for African - European Partnership in Agricultural Research for Development Phase II (PAEPARD II); Human Development & Capability Association (HDCA)- HDCA Southern African Network; Member, Africa Community of Practice (CoP) on Forgotten / Underutilized Food, by the Forum for Agricultural Research in Africa (FARA); Member, FAO's Global Forum on Food Security and Nutrition (FSN Forum).

Alcohol Use Disorders (29) Do people understand the harms of alcohol? (4) How can they be better informed?

8 February, 2024

Thanks to James Mawanda (Uganda) for reminding us that alcohol is linked to more than 200 diseases. In terms of comprehensive knowledge, there are few if any who could describe all of them, and probably none in any detail. Even if it were possible to have that knowledge, this does not equate to a deep understanding of the implications. Arguably it is this deep understanding - linked but not equivalent to knowledge - that enables an informed choice. Understanding may be strengthened by personal experience, such as being witness to how alcohol can wreck a loved one's life, and perhaps especially so for the individual who is recovering from an alcohol use disorder.

A deep understanding of the harms of alcohol is arguably less likely among adolescents and young adults. When we are young there is a tendency not to

look far into the future, to live for the day, as if immortal. We may hear and see about the harms of alcohol (and tobacco) and just ignore them, thinking 'this may happen to other unfortunate people, but it won't happen to me'.

I would be very interested to hear what approaches work to promote understanding of the harms of alcohol, especially among young people. How can they be better informed?

Best wishes, Neil

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Alcohol Use Disorders (30) Do people understand the harms of alcohol? (5) How can they be better informed? (2)

8 February, 2024

Perhaps people would be better informed if there were more consistency among healthcare information providers?

1. The World Health Organization says 'when it comes to alcohol consumption, there is no safe amount'.

<https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-cons...>

2. By contrast the Mayo Clinic (one of the most respected centres in the US) says this in a recent article on their website (Sept 2023):

'If you already have a glass of red wine with your evening meal, drinking it in limited amounts may improve your heart health.

'Antioxidants in red wine called polyphenols may help protect the lining of blood vessels in the heart. A polyphenol called resveratrol is one part of red

wine that's gotten noticed for being healthy... But study results on resveratrol are mixed...

'Many studies have shown that drinking regular, limited amounts of any type of alcohol helps the heart. It's not just red wine...

'Researchers keep studying whether red wine and other alcoholic drinks can help the heart. Those who drink regular, limited amounts of alcohol, including red wine, seem to have a lower risk of heart disease. Drinking regular, limited amounts is called drinking in moderation.

'But there might be other reasons for the lower risk of heart disease in people who drink red wine in moderation. For instance, they might eat a healthier diet and be more active than those who don't drink red wine. And they might have higher incomes and better access to health care as well.

'More research is needed about whether red wine is better for the heart than other types of alcohol, such as beer or hard liquor.

Full text: <https://www.mayoclinic.org/diseases-conditions/heart-disease/in-depth/re...>

3. A recent (2023) Lancet Rheumatology editorial notes: 'Many studies have shown that low or moderate amounts of alcohol (particularly red wine) can reduce risk for cardiovascular disease, diabetes, and even death—possibly due in part to a tendency to reduce systemic inflammatory mediators. These benefits might be limited to adults older than 40 years, according to a 2022 analysis from the Global Burden of Disease study, which found no such benefit at younger ages.

'Potential benefits of light to moderate alcohol consumption have also been reported among patients with rheumatoid arthritis...

'WHO calls for increased education on the cancer risks associated with alcohol consumption—perhaps including health warnings on alcohol labels—and few would argue against better-informing the public with regard to health. But the absolute risks of light to moderate drinking are small, and while there is no known safe level of drinking, it seems reasonable that the quality of life gained from an occasional drink might be deemed greater than the potential harm.'

[https://www.thelancet.com/journals/lanrhe/article/PIIS2665-9913\(23\)00073-5/fulltext](https://www.thelancet.com/journals/lanrhe/article/PIIS2665-9913(23)00073-5/fulltext)

4. There is no direct contradiction between the WHO stance ('there is no safe amount') and the stance of others. It is conceivable that small amounts of alcohol may increase risk of some of the 200+ diseases it is associated with, even if a real protective effect for heart disease were ever to be proved. It's also notable that alcohol is recognised as a carcinogen, which would imply that 'there is no safe amount'.

But it's understandable that there may be confusion among those responsible for health education (including frontline healthcare providers) and the general public that relies on them.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.
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Alcohol Use Disorders (31) Popular beliefs about alcohol (4)

8 February, 2024

Dear friends of HIFA,

Now, I want to share with you a series of "myths" related to alcohol consumption that it is important to take into account when advising our patients, friends and family, and the community in general.

I'll be waiting for your reactions.

Greetings,

Eduardo

Myths about Alcohol

Myth 1: You really have to admire a person who can hold his/her liquor.

The person who can drink large quantities of alcohol without feeling the "normal" effects may have developed a tolerance to alcohol. Tolerance comes from chronic use of alcohol that results in physical and mental

adaptation to its presence in the body. The development of tolerance is shown by an increase in the amount of alcohol required to produce the desired effects and can indicate the onset of physical dependence.

Myth 2: Alcohol can be used as a food supplement.

Alcohol has no nutritional value. It contains no vitamins, minerals or proteins. It does contain a significant number of calories, however. The calories can produce an immediate source of energy which causes food that is normally used for energy production to be changed into fat and stored in the body for later use.

Myth 3 Alcohol warms the body.

The direct action of alcohol causes a drop in the internal body temperature by the following process. The blood vessels are opened (dilated) on the skin surfaces and the blood is cooled by greater exposure to the outer environment. As the cooled blood circulates, the core temperature is lowered gradually, but significantly. This process is continued as long as alcohol is present in the body.

Myth 4: Alcohol is a stimulant drug.

Alcohol is a depressant; it sedates the central nervous system. One of the first areas of the brain to be affected is the cerebral cortex, which controls judgment, self-control and inhibitions. The depression on this part of the brain may result in excitable behavior, as inhibitions are lost.

Myth 5: Hangovers are caused by switching drinks.

Hangovers are caused by the amount of alcohol consumed and the rate at which it is consumed, not by the kind of alcohol consumed. While metabolizing alcohol, the liver cannot perform its normal functions, one of which is keeping the blood sugar at a normal concentration. The results of this state are called hypoglycemia, or lower than normal blood sugar. The change in blood vessels, as mentioned in Myth 3, can cause headaches. Lastly, a hangover is actually a "mini-withdrawal." When the central nervous system is released from the depressed state, the opposite state develops-feeling edgy and irritable. This effect is known as "rebound."

Myth 6 People with Alcohol Use disorders (AUD) drink every day.

There are many types of people with Alcohol Use Disorder: those who drink daily; those who drink on weekends; those who drink in binges which could occur weeks, months or even years apart. The measure of AUD is not when

or how often one drinks, but whether or not one can control the drinking once it begins.

Myth 7: You can't have AUD by drinking only beer.

Actually, Americans drink almost ten times as much beer as they do "hard" liquor. Although the content of alcohol in beer is relatively low, this means that one-half the alcohol drunk is consumed as beer. Given these facts, it seems reasonable to say that there are many alcoholics who are only beer drinkers.

Myth 8 Black coffee or a cold shower sobers a drunk.

Black coffee and cold showers only produce wide-awake drunks. Only time will rid the body of alcohol. There is no known way of speeding the metabolic process of eliminating alcohol from the body.

Myth 9 I Am Too Old to Have a Drinking Problem

You may think that drinking problems have to start early in life. In fact, some people develop problems with drinking at a later age.

One reason is that people become more sensitive to alcohol as they get older. Or they may take medicines that make the effects of alcohol stronger. Some older adults may start to drink more because they are bored or feel lonely or depressed.

Myth 10 Drinking is a Good Way to Take the Edge Off My Chronic Pain

People with long-term (chronic) pain sometimes use alcohol to help manage pain. There are several reasons why this may not be a good choice. Alcohol and pain relievers do not mix. Drinking while taking pain relievers may increase your risk of liver problems, stomach bleeding, or other problems. It increases your risk for alcohol problems. Most people need to drink more than a moderate amount to relieve pain. Also, as you develop a tolerance for alcohol, you will need to drink more to get the same pain relief. Drinking at that level increases your risk for alcohol problems. Long-term (chronic) alcohol use can increase pain. If you have withdrawal symptoms from alcohol, you may feel more sensitive to pain. Also, heavy drinking over a long time can actually cause a certain type of nerve pain.

Myth 11 A beer before bed helps you sleep.

Using any kind of alcoholic beverage to help you sleep is always going to backfire, even if in the moment it feels like it's helping.

“Drinking a beer before bed may get you to fall asleep more quickly,” says Dr. Janesz. “However, it interrupts your deep sleep, and you’ll wake later on feeling not rested and hungover.”

Normally, your body cycles through light and deep phases of sleep. Alcohol inhibits refreshing REM (rapid eye movement) sleep and later on causes “REM rebound,” with nightmares and trouble sleeping.

Repeated alcohol use seriously disturbs sleep and makes it difficult to re-establish a normal sleep pattern. Often, this leads to more drinking or to sedative abuse in the quest for sleep.

Myth 12 All sexes react to alcohol in the same way

Drinking tends to produce higher blood alcohol concentrations in women than men because of a difference in body weight and composition. This leads to a greater degree of intoxication for women.

Alcohol disperses in water, and women have less water in their bodies than men. So, if a woman and man of the same weight consume the same amount of alcohol, her blood alcohol concentration will usually rise more rapidly than his

Myth 13 Drinking reduces stress and anxiety While alcohol can initially make you feel looser and at ease (again, because it’s a depressant), the effects don’t last long. In fact, alcohol may actually cause more anxiety the day after.

So, while you may temporarily feel at ease in the moment, you can feel more stressed the day after.

If you use alcohol as a way to numb your symptoms of anxiety, this can also make the symptoms worse down the line – due to the fact that you’re not learning how to cope with your emotions properly.

Myth 14 Alcohol only hurts your liver

In addition to damaging the liver, drinking can affect other parts of your body as well. This includes your heart, blood pressure, kidneys and mental health. As alcohol is also inflammatory it increases your risk of cancer and other diseases.

Myth 15 Alcohol isn’t as harmful as other drugs.

The brain doesn't stop growing until about age 25, and drinking can affect how it develops. Plus, alcohol increases your risk for many diseases, such as cancer. It can also cause you to have accidents and get injured.

Myth 16 A person with strong willpower is less likely to develop alcohol use disorder Alcohol use disorder has nothing to do with willpower. You're not weak or less than if you have this condition.

Alcohol use disorder is a medical condition that cannot be overcome with willpower alone. However, willpower can be a strong tool for those in recovery from substance use disorder.

Myth 17 Alcohol makes sex better

Even though alcohol can lower your inhibitions, it's also considered a depressant. This means that alcohol can reduce sex drive and impact a person's ability to maintain an erection.

There's also a direct link between excessive drinking and the risk of committing sexual assault. Also, a person who is too intoxicated can't consent to sexual activity.

Myth 18 Giving minors alcohol under supervision is responsible A common myth around teens and young adults is that it's more responsible to give minors alcoholic drinks with adult supervision. This myth is based on the idea that kids will drink anyway, so they might as well be in the presence of a responsible adult.

This is false, and research suggests the opposite.

An Australian longitudinal study conducted between 2010 and 2016 concluded that there was no evidence behind the idea that parents supplying underage children with alcohol reduces alcohol-related harms.

A 2015 study involving 561 students found that children who drank alcohol before sixth grade were more likely to abuse alcohol when they reached ninth grade. The same study also notes that most students reported taking their first sip of alcohol at home, usually given to them by a parent.

Research from 2017 also suggests that kids who were allowed to drink alcohol with adults were more likely to engage in risky drinking in their teens.

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. [ebianco AT nextgenu.org](mailto:ebianco@nextgenu.org)

Alcohol Use Disorders (32) Do people understand the harms of alcohol? (6) How can they be better informed? (3)

9 February, 2024

Good day Neil

You posed a question:

"I would be very interested to hear what approaches work to promote understanding of the harms of alcohol, especially among young people. How can they be better informed?"

In my opinion when we seek out to educate young people about the harms of alcohol, it would be critical to

1. Create a safe space in which information can be freely exchanged with young people. I think it is important to establish what they know or believe and use this information as a guide of how to package information and approach the conversation
2. Peer to peer education is an approach that can be used
3. Some young people accept better information that comes from persons with lived experience

From my personal experience I have found that young people are better engaged on the sidelines of events they love, for example, at sports fixtures. The environment in which we engage them has an impact on how well we can communicate with them.

Also, when we design our interventions it may be critical to let the young people be part of the process from the onset - it is important to give them a voice.

Regards,

Venus Mushininga

HIFA profile: Venus Mushininga is a pharmacist with the Ministry of Health and Childcare in Zimbabwe. She is a founder and President of the Zimbabwe Society of Oncology Pharmacy and the Zimbabwean delegate to the European Society of Oncology Pharmacy. Professional interests: Oncology, Dissemination of information through to Health Professionals and the public, Research. vmushininga AT gmail.com

Alcohol Use Disorders (33) Do people understand the harms of alcohol? (7) How can they be better informed? (3)

9 February, 2024

Yesterday I asked: "Perhaps people would be better informed if there were more consistency among healthcare information providers?" I pointed to potentially confusing differences between, for example, WHO advice ('there is no safe amount') and Mayo Clinic ('If you already have a glass of red wine with your evening meal, drinking it in limited amounts may improve your heart health').

Here is a related statement from the website of the Harvard TH Chan School of Public Health: 'More than 100 prospective studies show an inverse association between light to moderate drinking and risk of heart attack, ischemic (clot-caused) stroke, peripheral vascular disease, sudden cardiac death, and death from all cardiovascular causes... For a 60-year-old man, a drink a day may offer protection against heart disease that is likely to outweigh potential harm (assuming he isn't prone to alcoholism)':

<https://www.hsph.harvard.edu/nutritionsource/healthy-drinks/drinks-to-co...>

'The idea that moderate drinking protects against cardiovascular disease makes sense biologically and scientifically. Moderate amounts of alcohol raise levels of high-density lipoprotein (HDL, or "good" cholesterol), [37] and higher HDL levels are associated with greater protection against heart disease. Moderate alcohol consumption has also been linked with beneficial changes ranging from better sensitivity to insulin to improvements in factors that influence blood clotting, such as tissue type plasminogen activator, fibrinogen, clotting factor VII, and von Willebrand factor. Such changes would tend to prevent the formation of small blood clots that can block arteries in the heart, neck, and brain, the ultimate cause of many heart attacks and the most common kind of stroke.'

The inconsistency in information presents a challenge to health communicators and frontline healthcare providers who are trying to provide the best possible advice for the public and for patients.

By contrast there is consensus that excessive alcohol intake is harmful. The UK National Health Service recommends that men and women do not drink more than 14 units of alcohol per week (1 unit is equivalent to 10ml pure alcohol), spread across three days or more.

We come back to the question: Do people understand the harms of alcohol? Do they understand the potential benefits (if any) of 'light to moderate drinking'? Are people aware of the recommended maximums of weekly intake? Do they truly understand the potential consequences of exceeding those limits?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (34) Do people understand the harms of alcohol? (8) How can they be better informed? (4)

9 February, 2024

I was interested to read this letter from Professor Sir Ian Gilmore, chair of the Alcohol Health Alliance and special adviser on alcohol to the Royal College of Physicians (UK). It was written in 2016 - what has changed since then? Is there similar action in other countries?

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Communicating the health harms of alcohol to the public

14 November 2016

<https://www.rcplondon.ac.uk/news/communicating-health-harms-alcohol-public>

As Alcohol Awareness Week 2016 begins, Professor Sir Ian Gilmore, chair of the Alcohol Health Alliance and special adviser on alcohol to the RCP, explains what the government should do to communicate the harms associated with alcohol to the public.

The public have the right to know about the health risks associated with alcohol, so that they are empowered to make informed choices about their drinking.

Yet worryingly, awareness of the risks is very low. For example, only 1 in 10 people in the UK are aware of the link between alcohol and cancer.[1]

[...]

Following Alcohol Awareness Week, however, more needs to be done to make sure the public are aware of the risks associated with alcohol. We need action at governmental level, where the resources exist for sustained national initiatives.

[New guidelines] advise that, to keep risks low, you are safest to drink no more than 14 units per week, with these units spread out over 4-5 days.

Specifically, the government should do two things to communicate the risks, and the new guidelines:

The government should develop mass media campaigns outlining the risks. These could include TV and radio advertisements, social media campaigns, and messages on public transport.

The government should introduce mandatory labelling of all alcoholic products, containing clear and legible health information about the harms associated with drinking.

Once introduced, these measures will lead to a population more in control of their health, and better able to avoid the health harms associated with alcohol. There can be no rationale for withholding from the public information to help them make more informed choices - the government should introduce these measures now.

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I have written to Sir Ian to invite him to join us.

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nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (35) Do people understand the harms of alcohol? (9) How can they be better informed? (5)

9 February, 2024

Thanks for sharing this 2016 news on alcohol use ignorance in the UK.

Frankly, considering the high literacy rate of UK population and the excellent work that the NHS UK has been doing for 75 years, I am surprised to read that, 'Yet worryingly, awareness of the risks is very low. For example, only 1 in 10 people in the UK are aware of the link between alcohol and cancer.[1]'. That sounds more like what one expects of LLMICs.

But even then, I think it is time to reconsider the public health advice/guideline about safe alcohol drinking. The current advice as also quoted in the 2016 report is that, '[New guidelines] advise that, to keep risks low, you are safest to drink no more than 14 units per week, with these units spread out over 4-5 days.'

I feel that the advice misses a crucial starting point, which is abstinence, that is 'no alcohol at all'. It may sound draconian and impossible to some, but actually a no alcohol status gives the person a 'no risk' position, better than 'low risk'.

I am reminded about the Public Health advice given in HIV campaigns: 'A.B.C.'" (A: Abstinence from sex; B: Be faithful to one partner, if you cannot abstain, C: Use the condom if you cannot do A or B). And over the years it has worked, along with other measures of course, and not without opposition from especially religious groups and alcohol business (both manufacturers and sellers).

'no drinking of alcohol is the best advice ----' and therefore the Public Health advice on Alcohol use should be revised to start with emphasizing the fact. It may not be easy to stop for those who drink already, but the public health advice should state the facts fully.

Joseph Ana

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HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for PACK Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which also suitable for lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicem & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member, National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the Working Group on HIFA-WHO Collaboration

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Alcohol Use Disorders (36) Alcohol consumption in Ethiopia

9 February, 2024

Dear all,

Abenezer here. I'm excited about this platform and the so many vibrant discussions. I would like to highlight the burden of alcohol use disorder in my country, Ethiopia.

WHO defines alcohol as a psychoactive substance. This simply means that it is a substance that affects the workings of the brain in terms of mood, feelings, and behavior. It is one of the common substances known to cause chemical dependence. This dependence reaches beyond behavioral changes extending injuries to physical and organ damage, both physiological and chemical effects.

In Ethiopia, the national survey (DHS 2016) showed that the burden is up to forty-six percent in the community. Another study post-covid showed it to be about thirty percent. A systematic review also showed a prevalence similar to this data which was 44.16. This shows that the prevalence of alcohol use in our community is high. From personal experience, I believe this may have to do with the social implications of use especially in the youth. Casual alcohol use is seen as a sign of social status and a sign of success and enjoyment of life. This may be some inclinations that may propel the use of alcohol use.

Look forward to interacting with all of you on this conversation.

Reference

1. Ayano G, Yohannis K, Abraha M, Duko B. The epidemiology of alcohol consumption in Ethiopia: a systematic review and meta-analysis. *Substance Abuse Treatment, Prevention, and Policy*. 2019 Jun 11;14(1):26.
2. Endashaw Hareru H, Kaso AW, Debela BG, Abebe L, Sisay W/tsadik D, Kassa Abebe R, et al. Alcohol use disorder and its associated factors among residents in Southern Ethiopia during the era of COVID-19. *SAGE Open Med*. 2022 Jun 20;10:20503121221105031.

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Best of regards,

Abenezer Dereje, MD

HIFA profile: Abenezer Dereje is a medical doctor and general practitioner currently doing her MPH at NexGen U in substance use.

Alcohol Use Disorders (37) Do people understand the harms of alcohol? (9) How can they be better informed? (5)

9 February, 2024

Thank you Neil for bringing up the topic of cardio protection by consuming low amounts of alcohol, especially wine. [<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-30-do-people-unde...>]

As a cardiologist I would like to add my " 2 cents" to this topic.

A 2022 review article from the World Heart Federation (<https://world-heart-federation.org/wp-content/uploads/WHF-Policy-Brief-A...>) has cast doubt on this claim.

The article states that the controversy over the role of low to moderate alcohol use and future heart attack relates to inconsistent results among the many studies on the topic.

Historically, studies have shown a J-shaped distribution of outcomes. The lowest rates of heart attacks have been in those with low to moderate alcohol consumption and higher rates in those who did not drink or have high rates of alcohol consumption.

However, new research has challenged this interpretation by not confirming the J point relationship in Chinese and Indian populations , where alcohol consumption is relatively lower, binge drinking is common and among people less than 55 years of age. Furthermore, there has been heterogeneity in the type and pattern of alcohol consumption in most parts of the world.

Research in the latest decade has led to major reversals in the perception of alcohol in relation to health in general and CVD in particular. These developments have prompted health authorities in a number of countries,

e.g. the Netherlands, England and Australia, to lower their recommended amount of alcohol for low-risk drinking.

The WHF revision also states that: the use of red wine has been promoted through various diets as a “heart-healthy” beverage for the longest time. The presence of resveratrol in wine has been known for its cardioprotective characteristics in light to moderate drinkers. However, there are multiple reasons that the belief that alcohol is good for cardiovascular health is no longer acceptable:

- Such evidence has been based on observational studies
- No randomized controlled trials (RCTs) have confirmed health benefits of alcohol
- The presence of unaccounted confounding factors further weakens the quality of evidence
- Studies misclassify unhealthy exdrinkers as abstainers
- Most evidence is observed only in the Caucasian population
- Studies that show positive effects are funded by the alcohol industry.

The alcohol industry has also perpetuated misleading information about the benefits of drinking alcohol. This interference by the alcohol industry closely reflects the universally vilified activities of tobacco companies. Alcohol industries deceptively promote their products under the labels of “healthy” and “safe”. Portrayal of alcohol in print and electronic media as necessary for a vibrant social life has diverted attention from the harms of alcohol use. Youth-targeted advertisement and encouraging alcohol as “heart-healthy” have created a conducive environment for young adults to relate alcohol with ‘having a good time’. Contrary to this belief, evidence from all around the world exists to link alcohol with a range of non-communicable and infectious diseases.

In the same sense, the page of a prestigious US University such as John Hopkins University, raises doubts about the protective effect of wine.

<https://www.hopkinsmedicine.org/health/wellness-and-prevention/alcohol-a...>

Despite some studies have shown an association between moderate alcohol intake and a lower risk of dying from heart disease. It is very hard to determine cause and effect from those studies.

Perhaps people who sip red wine have higher incomes, which tend to be associated with more education and greater access to healthier foods. Similarly, red wine drinkers might be more likely to eat a heart-healthy diet.

There is some evidence that moderate amounts of alcohol might help to slightly raise levels of “good” HDL cholesterol. Researchers have also suggested that red wine, in particular, might protect the heart, thanks to the antioxidants it contains.

But you don’t have to pop a cork to reap those benefits. Exercise can also boost HDL cholesterol levels, and antioxidants can be found in other foods, such as fruits, vegetables and grape juice.

Therefore, I think we should be cautious when recommending the consumption of low amounts of wine to protect cardiovascular health.

Eduardo

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. [ebianco AT nextgenu.org](mailto:ebianco@nextgenu.org)

Alcohol Use Disorders (38) Personal experience (3)

10 February, 2024

As a teenager you were very aware of peer pressure (as a social expectation) to drink.

The media played a key role - advertising "Tetley Bitter-men", "Double Diamond - works wonders", Babycham, Advocaat, Martini Rosso... and many of the popular TV series we consumed (pardon the pun).

Getting in the pub AND served was a right of passage.

In the family the harms and risks of alcohol were explained.

Sometimes they were demonstrated at parties, weddings, the aunt, uncle - relative who was notorious for having to much.

Studying literature at school did have a role to play - although less directly.

Although on reflection when there were school assemblies I wonder if 'drink' (Church of England) was mentioned?

Interesting perhaps - the change in daily school routine.

I remember at a birthday party for a fellow class pupil at a social club, the birthday boy was sick all over the table - yes - had been drinking.

Tempered my attitude early on - c.15.

As a nursing asst. and student nurse you realised the other - dark - side. The key being the contradiction that alcohol represents:

- Drink to relax, socialise, be friendly, enjoy yourself;
- Impact of your health, risk of addiction, violence, (brewer's droop was an early lesson - tho not practically);
- IF YOU develop a drink problem - you're on your own and so is your family (there are of course agencies in developed nations - but the funding disparity - like gambling, tobacco...??).

In a 'local' - public house - pub it was known in 1970s for some regulars (invariably men) to down c.12 (more?) pints in a night - even after drinking hours: they were heavy goods vehicle drivers.

I may have posted before - how in 1987-88 I completed a study of alcohol intervention teams. The consultant psychiatrist made the point about use of economic levers to help reduce alcohol consumption.

Scotland have just updated their intervention:

<https://www.theguardian.com/society/2024/feb/08/scotland-raises-minimum-...>

As a student nurse - I was already aware of some of the inorganic molecules that have been found in space - a primordial soup!

The names still remind me of a chemical plant such as the former ICI plant at Widnes / Runcorn, Cheshire, England, e.g.:

<https://thumbs.dreamstime.com/b/heavy-industry-panorama-night-panoramic-...>

This in-turn takes me to the miracle that is the liver - the biological chemical plant - with a potential powerful message in how 'alcohol' is broken down:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6527027/>

Sometimes insight into this can work wonders in terms of motivation for change - the facts - not trying to scare (waste of time)...?

Which brings me to the obvious 'contradiction' in caring for people with a primary / secondary problem with alcohol.

Having a liver function test.

If it's OK that *means* I can carry on!!

I have over the years developed what imho I consider to be potentially therapeutic relationships with people affected by alcohol.

I say potentially as I - with due supervision - have had to withdraw input and discharge them being unwilling to support them in their damaging alcohol consumption and related behaviours.

Alcohol, tobacco - vapes, the 'mental pollution' that can be passed as legitimate 'advertising', fake news ... still calls for a generic model, a universal conceptual framework for personal and global health - across literacies and forms of informatics:

'alcohol'

<https://hodges-model.blogspot.com/search?q=alcohol>

Just to close I saw an item (I will try to find...) on the preponderance of 'smoking' in films 1940s - present day.

Still a problem now.

Of course: advocacy for health requires constant vigilance.

Peter Jones

Community Mental Health Nurse and Researcher

CMHT, Prescott House, Salford NW England, UK

Blogging at "Welcome to the QUAD"

<http://hodges-model.blogspot.com/>

<http://twitter.com/h2cm>

HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges' model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>). h2cmuk AT yahoo.co.uk

Alcohol Use Disorders (39) Do people understand the harms of alcohol? (10) Does alcohol have health benefits?

11 February, 2024

Hi Neil

I do want to contribute to this highly interesting set of issues around the harms of alcohol, especially about the impact on others (especially family members) of the heavy or harmful use of alcohol. I am in the middle of a very busy time, so will make that contribution later.

For now, I will respond about the issue of conflicting or inconsistent information [*see note below], by drawing attention to an important current debate, internationally and within the pages of the Journal of Studies on Alcohol and Drugs - see here for a summary of one position in the debate:

<https://www.jsad.com/doi/10.15288/jsad.23-00193>

and then here for the other side and further commentaries:

<https://www.jsad.com/doi/abs/10.15288/jsad.23-00293>

<https://www.jsad.com/doi/abs/10.15288/jsad.23-00262>

<https://www.jsad.com/doi/abs/10.15288/jsad.23-00411>

The fundamental reason for the conflicting information is that the science is not yet clear (although both 'sides' in this debate argue that it IS clear).

I hope that reading through these (quite short) papers will clarify some of the issues.

Best wishes

Richard Velleman

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Trustee and Treasurer, AFINet (Addiction and the Family International Network)

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HIFA profile: Richard Velleman is Emeritus Professor/ C-Director, Addictions and related Research Group. Organisation: Sangath, Goa, India/University of Bath, UK. Professional interests: Addiction; families; mental health. Email address: r.d.b.velleman AT bath.ac.uk

[*Note from HIFA moderator (NPW): Thank you Richard Velleman. All: Richard refers to recent messages on HIFA that highlight inconsistencies in the way that the potential benefits of alcohol are communicated. The choice of words for this new subthread - Does alcohol have benefits? - is mine. We look forward to further contributions on this topic, which illustrates a number of important aspects of how we interpret and communicate evidence.]

Alcohol Use Disorders (40) Alcohol consumption in Indonesia

11 February, 2024

Introduction

Indonesia, a country with a Muslim majority, holds a unique perspective on alcohol consumption, reflected in its low per capita consumption and strict regulations. Analyzing data from 1970 to 2022 unveils interesting dynamics on how alcohol consumption has fluctuated over time, influenced by social, economic factors, and government policies. This writing aims to understand consumption trends, social and health impacts, and the policies regulating alcohol in Indonesia.

Data and Statistics Overview

1996 Alcohol Consumption Summary: The year 1996 marked a notably low per capita alcohol consumption in Indonesia, at just 0.13 liters. This analysis reveals a dominance of spirit consumption over beer, with virtually no wine consumption, illustrating the strong influence of religion and social norms.

Alcohol Consumption Trends 1970-1996: This period saw a 57.14% increase in consumption, though the levels remained low. This indicates socioeconomic changes and possible relaxation in social norms or policies.

Alcohol Consumption Trends 2015-2022: This era witnessed a decrease in consumption both in urban and rural areas, reflecting the effectiveness of public policies and a shift in health awareness.

Health and Social Impact

Domestic Violence (DV) and alcohol consumption are closely linked, with women more likely to experience DV if their partner uses alcohol or tobacco. The treatment costs for cancers related to alcohol consumption account for about 1.71% of the total cancer treatment costs, highlighting the importance of controlling alcohol consumption to minimize economic impacts.

Causes and Effects

Factors influencing alcohol consumption among teenagers include age, gender, and lack of parental attention to academic achievements. Alcohol is

also frequently used before sexual intercourse among sex workers in Eastern Indonesia, increasing risky sexual behavior.

Policies and Regulations

Indonesia demonstrates strong control over alcohol advertising, promotion, and sponsorship, with tobacco receiving more policy attention over the last 15 years. Alcohol-related policies have received less focus, reflecting the influence of religious and social norms on alcohol consumption.

Conclusion and Recommendations

The analysis of alcohol consumption trends in Indonesia shows significant effects of government policies, social norms, and health awareness in reducing alcohol consumption. The decrease in consumption indicates the success of these initiatives, but it remains crucial to maintain and enhance prevention efforts, especially among teenagers and other at-risk groups. It is recommended that the government continues to strengthen alcohol control policies, raise awareness about health risks, and integrate education on the dangers of alcohol into the national education program.

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Alcohol Use Disorders (41) A definition of Alcohol Use Disorders

11 February, 2024

Reflections

I think the issue of alcohol use is a bit tricky when we consider the two sides of its use. We all have met people who are fun and good to be around after one bottle of beer yet still if taken out of limits alcohol use can end up being a culprit to relationships and health. So, the same drink can be a facilitator of social status and a detriment to it. How do we know the difference? The difference is addiction. [*see note below] The inability to stop using is associated with negative social and health consequences. Even if this difference may seem clear in theory it is a complicated experience for those suffering from such dependence.

HIFA profile: Abenezer Dereje is a medical doctor and general practitioner currently doing her MPH at NexGen U in substance use.

[*Note from HIFA moderator (NPW): I have used the words 'A definition of Alcohol Use Disorders' to start a subthread on this topic.]

Alcohol Use Disorders (42) Do people understand the harms of alcohol? (11) How can they be better informed? (6)

11 February, 2024

Do people understand the harms of alcohol? It depends on age and education. Young people may understand that alcohol is harmful in terms of acute effects, but they are willing to take chances, and the chronic effects (e.g., liver disease) are too far in the future to affect their drinking. And most people do not know much about the chronic effects, such as oral cancer, breast cancer, heart disease and several hundred more health conditions that are partially attributable to alcohol consumption, even at low doses like one drink a day.

How can they be better informed? Graphic warning label could help. A study in Canada showed that when people were informed that “alcohol causes cancer” they purchased less alcohol at the point of sale. Dietary guidelines promoted by national health authorities can inform consumers on a regular basis about alcohol-related harms, the benefits of not drinking, and the sensible limits that could minimize problems. They can also be better informed if the alcohol industry was forced to cease all advertising, which presents drinking as fun, healthy, and beneficial to social relationships, without informing consumers about the harms.

HIFA profile: Thomas Babor is Emeritus Professor at the University of Connecticut School of Medicine, United States. Professional interests: Screening, diagnosis, early intervention, and treatment evaluation, as well as alcohol and drug policy; alcohol industry as an inducer of alcohol-related problems. babor AT uchc.edu

Alcohol Use Disorders (43) Q2: Do health workers have adequate knowledge to prevent and manage alcohol use disorders?

11 February, 2024

Dear friends,

Welcome to the second week of the Forum.

We want to thank you for your participation during the first week and we encourage you to continue doing so.

Alcohol use disorders (AUD) are widely prevalent, affecting 5.1% of people worldwide (8.6% among men and 1.7% among women). AUDs are associated with high morbidity and mortality, resulting in a reduction in life expectancy of more than 20 years compared to the population average. (1)

However, literature reviews report that there is ample evidence that patients with AUD generally go undiagnosed and untreated. (2) It has been estimated that in the best case scenario 17.3% would be treated, so there would be a treatment gap of 82.7%. (3)

There would be several reasons or barriers that would explain this situation, including: institutional culture, individual and systemic bias against those with AUD, the poor and insufficient preparation of health professionals at the Primary Care Level, and healthcare infrastructural deficits, especially the separation of medical and behavioral treatment. (2)(4)

Not much information is available on the proportion of healthcare professionals who are trained in the management of AUD. But several studies carried out in Spain revealed that the knowledge of health professionals about addressing alcohol consumption was low, mainly due to a lack of training.

Therefore, although AUD is a highly widespread health problem, there would not be enough properly trained human resources to address the gap between the magnitude of the problem and the treatment offered in different countries.

Added to this is that in most countries, the AUD treatment would be in the hands of the few health professionals specialized in addiction medicine or mental health. When in reality, the majority of people with early alcohol-related problems consult primary health care (PHC) doctors, mainly for physical health problems related to this consumption, who have not been properly trained to identify and intervene on AUD patients, and many express a stigma regarding these people.

References:

1. <https://www.cambridge.org/core/journals/global-mental-health/article/clo...>
2. <https://www.racgp.org.au/afp/2013/may/obstacles-to-alcohol-and-drug-care>
3. <https://www.cambridge.org/core/journals/global-mental-health/article/clo...>
4. <https://journals.sagepub.com/doi/10.1177/25160435221117952?icid=nt.sj-f...>
5. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0216199>

Therefore, this week we would like to know what you think about:

- Do healthcare workers in your country have adequate knowledge to prevent and intervene in AUD?
- What matters to them?
- How could they be better informed and trained?

We look forward to your comments and contributions.

Kind regards,

Eduardo

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years

in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco AT nextgenu.org

Alcohol Use Disorders (44) Q2: Do health workers have adequate knowledge to prevent and manage alcohol use disorders? (2) AUD and patient safety

12 February, 2024

I would like to see more patient safety concepts applied to the improvement of AUD treatment.

See: <https://journals.sagepub.com/doi/10.1177/25160435221117952> [*see note below]

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[*Note from HIFA moderator (NPW): Thank you Lorri. All: Lorri is the lead author of this 2022 paper. Here is the abstract:

'Alcoholism, more professionally termed alcohol use disorder (AUD), is a widespread and costly behavioral health condition. The aims of this paper are draw attention to systemic gaps in care for patients with AUD and advocate for patient safety leaders to partner with both the mainstream medical and substance abuse treatment communities to reduce harm in this patient population. The authors performed a narrative review of the literature on the current state of AUD treatment and patient safety, finding extensive evidence that patients with AUD usually go undiagnosed, unreferred and untreated. When they do receive AUD treatment, little evidence was found to indicate that a patient safety approach is incorporated into their care. Behavioral medicine is virgin territory for the

patient safety movement. Medical care and behavioral medicine in the United States currently constitute two separate and unequal systems generally lacking in pathways of communication or care coordination for AUD patients. Significant barriers include institutional culture, individual and systemic bias against those with AUD, and health care infrastructure, especially the separation of medical and behavioral treatment. It is the authors' conclusion that care of patients with AUD is unsafe. We advocate for the patient safety approach common in American hospitals to be extended to AUD treatment. Experienced patient safety leaders are in the strongest position to initiate collaboration between the mainstream medical and substance abuse treatment communities to reduce harm for this patient population.']

Alcohol Use Disorders (45) The single most important cause of harm to others?

13 February, 2024

Eduardo Bianco has noted: "It can be argued that alcohol use disorders are the single most important cause of harm to others (accidents, violence, gender-based violence)."

[<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-12-welcome-hifa-a...>]

There are other (non-medical) causes, such as war and social injustice, that would arguably take the top spot in terms of causing harm.

But I agree that if we consider specifically medical causes, alcohol use disorders are indeed near the top, alongside medical errors and low-quality health care.

We are fortunate to have several experts in alcohol use disorders who have joined HIFA for this discussion. I would like to ask them (and others):

What are the global estimates for harm to others caused by alcohol use disorders?

How does this compare with other medical causes of harm?

How might this harm be categorised (eg accidents, violence, gender-based violence) and quantified?

What is the picture in different countries?

What attempts (if any) are being made to measure harm to others?

What measures can be taken at national, community and individual level to better protect people from harm?

If alcohol is indeed one of the greatest causes of harm to others, is this truly understood by the general public, by health professionals, and by policymakers?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (46) How to identify people with AUD (1) Global trends

13 February, 2024

Dear HIFA colleagues,

We are having a parallel discussion about Alcohol Use Disorders on our sister forum CHIFA (global child health and right). In one message paediatrician Efe Obasohan (Nigeria) makes a point that is relevant beyond child health:

"Alcohol and other substance use disorders are rising globally. The developing countries suffer disproportionately due to competing priorities from infections and other diseases. With available resources already very stretched, the regular use of the CAGE questionnaire may be of help, especially in community health setting. There is also the need to partner with schools and NGOs to reduce excessive alcohol consumption."

My response:

"Many thanks for mentioning the CAGE Questionnaire. This is a tool for use by health professionals and consists of four questions:

Have you ever felt you should Cut down on your drinking?

Have people Annoyed you by criticising your drinking?

Have you ever felt bad or Guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

<https://patient.info/doctor/cage-questionnaire>

"A total score of 2 Yes or greater is considered clinically significant (sensitivity of 93% and a specificity of 76% for the identification of problem drinking);[3] compared with GGT liver function test which detected only a third of patients having more than 16 'drinks' per day.'

"Has anyone used this questionnaire in their work? Can you give examples of how you have used it?

"The questionnaire is offered as a 'screening test'. Is it feasible to apply it to everyone, or might it be applied to selected people when a problem is suspected.

"How honest are people when answering these questions?"

In terms of global alcohol consumption this graph indicates that there was a decrease in 2020-2022 (presumably COVID-related?) but an increase since then, and predictions are that consumption will continue to rise over the coming years. <https://www.statista.com/forecasts/726990/alcoholic-beverage-consumption...>

Follow the discussion on CHIFA: <https://www.hifa.org/forums/chifa-child-health-and-rights>

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (47) Do people understand the harms of alcohol? (12) Does alcohol have health benefits? (2)

13 February, 2024
Dear Richard Velleman,

Thank you for your valuable comments on the lack of consistency of messages on whether small quantities of alcohol may have health benefits.

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-39-do-people-unde...>

You make a really vital point:

"The fundamental reason for the conflicting information is that the science is not yet clear (although both 'sides' in this debate argue that it IS clear)."

I would be very interested to unpack this observation.

It seems that when the evidence is unclear, there is a tendency to 'take sides'. Many of us look at the evidence (cursorily or in depth) and, with misplaced authority, we may say to our patients (or whoever) that "small quantities of alcohol have health benefits" or we may say "there are no health benefits of small quantities of alcohol". In either case, as you say, they may argue that the evidence is clear. The same patient is very likely to hear both statements (and many more besides) from different sources. No wonder they are confused.

Isn't this where the problem lies, at least in part? That we (whether we are health workers, journalists, health communicators) tend to adopt an inappropriate stance of certainty? Some of us appear unable or unwilling to accept that 'the science is not yet clear'.

The patient has a right to know that the science is not clear. Any taking of sides is disingenuous and potentially harmful.

What, if anything, can be done to address this issue?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare

information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (48) Does alcohol have health benefits? (3) Contradictory advice from professionals: Why, what, how?

14 February, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-47-do-people-unde...>]

Hi Neil

I'll respond to the other posts (re harm to others, and re the CAGE) when I can, but this is quick. It is not solely that people "adopt an inappropriate stance of certainty? Some of us appear unable or unwilling to accept that 'the science is not yet clear'" - it is also that all scientific data is open to interpretation - the myth has been well exploded over the past decades of the scientist as a purely objective being, not influenced by a huge number of internal and external factors. In fact, all data and conclusions deduced from them are theory-laden, and influenced by a wide range of factors; and I think that this issue of relativism is also being played out in this debate.

All the best

Richard

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[*Note from HIFA moderator (NPW): Thank you Richard. This is a really interesting topic. I have added the words: Contradictory advice from professionals: Why, what, how? - so that we can explore Why different professionals come to such wildly different conclusions about the available evidence (as you have started to address); What impact this has on people's understanding and on efforts to address AUDs; and How we can address these issues so that people (patients, the public, HWs, policymakers) are better informed and less confused.]

Alcohol Use Disorders (49) Compilation and summary

14 February, 2024

Dear HIFA colleagues,

A lot of information is exchanged during HIFA discussions and we know it can be challenging to read and digest it all. This note is to provide help should you need it.

First, I'd like to remind everyone that all HIFA messages are available on our RSS feed: <https://www.hifa.org/rss-feeds/17>

In addition, we have compiled two documents:

1. A compilation of all 47 messages to date (in full) is available here (74 pages):

https://www.hifa.org/sites/default/files/publications_pdf/Alcohol_Use_Di...

2. An edited version of the 47 messages is available here (34 pages):

https://www.hifa.org/sites/default/files/publications_pdf/Alcohol_Use_Di...

General information about this discussion is available here:

<https://www.hifa.org/news/hifa-announces-deep-dive-discussion-alcohol-us...>

Finally, if you would like to join or follow this discussion on HIFA-French, HIFA-Portuguese, HIFA-Spanish, or CHIFA (child health), you can do so here: www.hifa.org/forums

With thanks to all and we look forward to your contributions!

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (50) "Evidence-based alcohol care is easy"

14 February, 2024

While we were preparing this discussion last month, Eduardo shared a quote with us:

"We want healthcare professionals to know three things about evidence-based alcohol care: that it is important, that they can do it, and that it's easy," says Raye Litten, PhD, co-developer of The Healthcare Professional's Core Resource on Alcohol (HPCR) and Director of the US National Institute on Alcohol Abuse and Alcoholism Division of Treatment and Recovery.

Easy? I'm not sure that all health workers would agree. What do you think?

Perhaps what Raye Litten means is that there are some simple steps that can be taken to provide care. "They can quickly screen, provide a diagnosis, give advice, prescribe FDA-approved medications, and give referrals to a specialist if the case is severe."

'The Healthcare Professional's Core Resource on Alcohol consists of 14 interconnected articles covering the basics of what every healthcare professional needs to know about alcohol.'... The Core articles are aimed broadly at all practicing healthcare professionals...

'The Core was designed to help address common barriers to optimum alcohol-related healthcare by providing:

'Knowledge to fill common gaps in training about addiction, including the neuroscience of addiction, evidence-based AUD behavioral healthcare and medications, and the varied paths to recovery

Quick, validated alcohol screening and assessment tools that address time constraints while providing a definitive picture of drinking levels and, in those who drink heavily, any AUD symptoms

Clarity about what constitutes heavy drinking, AUD severity levels, and recovery to build confidence in providing brief advice to patients and collaborating on their plans for a healthier future

Steps to reduce stigma surrounding alcohol-related problems and encourage greater patient acceptance of alcohol treatment when needed...'

We would be interested to hear from frontline health professionals whether you find it easy to provide evidence-based alcohol care. Can you give any examples from your clinical experience?

What guidance have you found to be helpful to identify and manage patients with Alcohol Use Disorders?

A quick glance at the Healthcare Professional's Core Resource on Alcohol suggests it is targeted to US health professionals (not 'all practicing healthcare professionals). For example, on page 1 the reader is recommended to 'advise patients who choose to drink to follow the U.S. Dietary Guidelines'.

What has been the impact of this resource in the US? What are the key resources for clinicians in other countries?

We look forward to learn from your experience.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare

information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (51) Compilation and summary (2)

14 February, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-49-compilation-an...>]

Hello Neil, Thank you for this summary. The work that you and your very small team, overworked, poorly resourced, to produce the summary is appreciated. You are right, with all the other mails / post that we receive, it can be daunting.

Thank you

Joseph Ana

–

Prof Joseph Ana

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Alcohol Use Disorders (52) The single most important cause of harm to others? (2)

14 February, 2024

Yes it's true some people use alcohol to harm others.

Men take cheap back street alcohol to get high faster and go home to cause violence to the spouse and children to avoid being asked for daily bread provision by the family.

Others will use alcohol to settle scores with friends and they end up being harmed because they have no strength to fight back yet they caused the problem.

HIFA profile: Jeniffer Yula Musyoka is a Nurse in Machakos County, Kenya. Professional interests: Nursing; Palliative care. jeniffersomba15 AT gmail.com

Alcohol Use Disorders (53) Do health workers have adequate knowledge to prevent and manage alcohol use disorders? (3)

14 February, 2024

Health workers have little knowledge on handling alcohol abuse. Most consider alcohol abuse as a behaviour caused by poverty and other social economical problems in the society and not as a medical condition that needs medical intervention. Awereness is needed to health care workers for better handling of alcohol abusers.

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Alcohol Use Disorders (54) The single most important cause of harm to others? (3)

15 February, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-45-single-most-im...>]

Dear Neil,

You have raised some very provocative questions, based on the phrase I included in my first welcome message.

I must confess that I took that phrase from an article (that I cannot locate now, despite having tried hard) and it caught my attention powerfully.

I agree with you that “I can argue” this assertion, but it is very difficult to prove.

I have tried to look for causes of damage to the health of others, even through artificial intelligence, but I have not gotten satisfactory answers.

In addition to the causes you mentioned, there are many other behaviors and consumption that can harm others, such as:

- Environmental pollution, including SHS.
- The spread of Infectious diseases due to not having responsible behaviors such as washing hands, wearing face masks, or not going to work or going to public places when having an infectious process

I hope that some other colleague can provide us with information regarding your questions.

Now, returning to the topic of alcohol, there is no doubt that it is a significant cause of damage to the physical and mental health of others, due to the mechanisms that we have mentioned before. And this is relevant as a reason for the justification of HCP interventions: people with AUD are not just damaging to them, but also to others, including to those they love the most.

Regards,

Eduardo

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and

cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco AT nextgenu.org

Alcohol Use Disorders (55) How to identify people with AUD (2) The CAGE Assessment

15 February, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-46-how-identify-p...>]

In answer to your questions about the CAGE, here is a reply (I have attempted to reference most things, after each paragraph).

CAGE: "Has anyone used this questionnaire in their work? Can you give examples of how you have used it?"

I do not think that we have used the CAGE in our work in India, but some studies in India have used the CAGE - see our review: Nadkarni A et al (2022) Alcohol use among adolescents in India: a systematic review.

As Nadkarni (2018) argues (my underlining [*see note below]): "Two commonly used screening tools include the CAGE questionnaire and the Alcohol Use Disorders Identification Tool (AUDIT). They serve two different purposes; *the CAGE questions (Cut Down, Annoyed, Guilty and Eye Opener) are better suitable to identify patients with alcohol dependence* while the AUDIT is more sensitive for hazardous and harmful drinkers. It is feasible to use AUDIT in settings where time allows for more in depth interviewing, while *the much shorter CAGE is more suitable in busy clinical settings*."

References:

Nadkarni A. Increasing access to psychosocial interventions for alcohol use disorders: Home based interventions. Indian J Psychiatry 2018;60:564-570. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_25_18

Nadkarni A et al (2022) Alcohol use among adolescents in India: a systematic review. Global Mental Health 9, e1, 1-25. <https://doi.org/10.1017/gmh.2021.48>.

"The questionnaire is offered as a 'screening test'."

The CAGE certainly CAN be used as a screening test (see eg Cherpitel et al, 2005), but as stated above, it is better at screening for alcohol DEPENDENCE than for hazardous and harmful drinkers, where the AUDIT is better. In our work on the PREMIUM project in India (Nadkarni et al, 2017 a, b), we used the AUDIT to screen before recruiting harmful drinkers to enter our bespoke intervention (Counselling for Alcohol Problems), delivered by trained lay health workers / counsellors.

References:

Cherpitel, C.J., Ye, Y., Moskalewicz, J., Swiatkiewicz, G., 2005. Screening for alcohol problems in two emergency service samples in Poland: comparison of the RAPS4, CAGE and AUDIT. *Drug Alcohol Depend.* 80, 201-207.)

Nadkarni, A., Weobong, B., Weiss, H.A., McCambridge, J., Bhat, B., Katti, B., Murthy, P., King, M., McDaid, D., Park, A.L., Wilson, G.T., Kirkwood, B., Fairburn, C.G., Velleman, R., Patel, V., 2017a. Counselling for Alcohol Problems (CAP), a lay counsellor-delivered brief psychological treatment for harmful drinking in men, in primary care in India: a randomised controlled trial. *Lancet* 389, 186-195.

Nadkarni, A., Weiss, H.A., Weobong, B., McDaid, D., Singla, D.R., Park, A.L., Bhat, B., Katti, B., McCambridge, J., Murthy, P., King, M., Wilson, G.T., Kirkwood, B., Fairburn, C.G., Velleman, R., Patel, V., 2017b. Sustained effectiveness and cost-effectiveness of Counselling for Alcohol Problems, a brief psychological treatment for harmful drinking in men, delivered by lay counsellors in primary care: 12-month follow-up of a randomised controlled trial. *PLoS Med.* 14, e1002386.]

"Is it feasible to apply it to everyone, or might it be applied to selected people when a problem is suspected." If screening for alcohol dependence, then it is feasible to only use on selected people (as the signs of dependence are somewhat more obvious than for harmful drinking). But you would miss a great proportion if you only screened the more 'obvious' cases, as often dependence is NOT obvious, so I think that, if feasible, universal screening is much better. In our PREMIUM work (above), we screened almost 15,000 primary care patients, many of whom screened positive for dependence.

"How honest are people when answering these questions?"

In my experience, generally pretty honest, but as with getting people to answer any questions, it all depends on the level of engagement you have

built up between yourself and whoever is answering. Also, it is not only people with alcohol problems who are not completely honest when asked about alcohol consumption (see eg Knibbe et al, 2001) - in population studies, the amount of alcohol claimed to have been drunk is far lower than the amount of alcohol known to have been sold (although there are a number reasons for this, with not answering honestly being only one).

Reference:

Knibbe R. et al (2001) Alcohol consumption estimates in surveys in Europe: comparability and sensitivity for gender differences. *Substance Abuse*, 22(1), 23-38.

Honesty continued: Evidence has also been available for a long time that many people are even more honest if they are assessed by a computer (or now an app) - see: eg

Lucas, R., et al (1977) Psychiatrists and a Computer as Interrogators of Patients with Alcohol-Related Illnesses: A Comparison. *British Journal of Psychiatry*, 131, 160-167.

Duffy, J. and Waterton, J. (1984) Under-reporting of alcohol consumption in sample surveys: the effect of computer interviewing in fieldwork. *Addiction*, 79 (3), * 303-308. <https://doi.org/10.1111/j.1360-0443.1984.tb00278.x>

Bungey, J., et al (1989) Screening alcohol & drug use in a general practice unit: comparison of computerised and traditional methods. *Australian and New Zealand Journal of Public Health*, 13 (4), 471-483. <https://doi.org/10.1111/j.1753-6405.1989.tb00706.x>

Hope this is useful

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[*Note from HIFA moderator (NPW): HIFA is a plain-text forum. I have indicated the underlines with asterisks [*]. For more information about the CAGE Assessment see <https://www.webmd.com/mental-health/addiction/whats-the-cage-assessment>]

Alcohol Use Disorders (56) How to identify people with AUD (3) The CAGE Assessment (2)

15 February, 2024

I used CAGE in my practice for over 40 years and found it to be extremely helpful, and it can be administered in a very short period of time. Of course, it worked best if I had some positive rapport with the patient.

Best wishes

Dan

HIFA profile: Dan Mayer is a retired Professor of Emergency Medicine who was previously at the Albany Medical College. He has taught Evidence Based Health Care from 1993 to 2014 and has a special interest in education of all types of medical personnel and the lay public in a critical thinking approach to evidence (particularly in health care). It seems that access to good accurate health information is a major problem around the world. A big part of this is the dissemination of that information and its ability to be understood by practitioners all over the world. Education in the basic concept underlying Evidence-Based Medicine ought to be part of a worldwide medical curriculum. opidanmayer AT gmail.com

Alcohol Use Disorders (57) The single most important cause of harm to others? (4) Alcohol consumption in Nigeria

15 February, 2024

Eduardo Bianco makes very important points here. [Eduardo Bianco has noted: "It can be argued that alcohol use disorders are the single most important cause of harm to others (accidents, violence, gender-based violence)."
<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-12-welcome-hifa-a...>]

On the question, 'Causes of gender based violence compared to alcohol use disorder in Nigeria':

A systematic review and meta-analysis (DOI: 10.3390/ijerph18094407 in Int J Environ Res Public Health) revealed that Alcohol consumption was associated to genderbased violence in the home and society. It is pertinent to list some of the other confounding factors: low educational attainment, higher alcohol consumption, substance use, history of child and family abuse, limited decision-making skills, experiencing depression, males having multiple sexual partners, and younger age were found to be individual - and family-associated factors that increase the experiences of GBV. Other factors still include community tolerant attitudes to violence generally, women's unemployment, lower socioeconomic class, being younger, a history of child and family abuse. The authors recommend 'the need to develop a multipronged approach of intervention, such as socio-behavioural change communication interventions at individual and community levels to eliminate all forms of alcohol misuse and violence.

On the question 'Causes of road traffic accidents compared to alcohol use disorder in Nigeria':

As with health data in many LLMICs, accuracy is a challenge in Nigeria but even then the magnitude and nature of the drink-drive problem in Nigeria is decreasing from 34,000 in 2007, to 9572 in 2008, according to police statistics. However, according to World Health Organization statistical modeling, this figure is likely to be much higher (Traffic Inj Prev . 2012;13(2):115-9.doi: 10.1080/15389588.2011.645097). Data from the police and the Federal Road Safety Commission (FRSC) are not reliable for the drink-drive problem mainly because of the lack of alcohol testing equipment, attitude of drivers of commercial vehicles (67.2 percent of drivers admitting to drinking alcohol during the working day, especially toward the end of the year when there is increased vehicular traffic due to

people travelling to celebrate the Christmas and New Year holidays), poor enforcement of Laws because alcohol testing equipment is unavailable. Recommended actions to control the problem include focused and targeted publicity campaigns against drinking and driving with private sector support; leveraging on opportunities provided by supporters, such as the World Bank project supporting safe road corridor and giving priority to strengthening the road crash and injury database and drink-drive enforcement, especially for drivers of commercial vehicles.

On the questions, 'What is the picture in different countries? What attempts (if any) are being made to measure harm to others? What measures can be taken at national, community and individual level to better protect people from harm':

Excessive use of alcohol is reported in many studies to be associated with violent crimes and domestic violence across many nations. . In total harmful alcohol use is reported to account for about 5.1% of the global burden of disease, desegregated into 7.1% and 2.2% of the global burden of disease for males and females, respectively. (Harmful use of alcohol - World Health Organization (WHO) www.who.int/health-topics/alcohol). Studies from the USA reveal that adults experienced harm because of someone else's drinking such as threats or harassment, ruined property or vandalism, physical aggression, harms-related-to-driving, financial and family problems. They also report gender differences in the type of harm, women being more likely to report financial and family problems, whereas the men report ruined property, vandalism, and physical aggression. Women are afflicted by heavy drinkers in their home/family, and the men and young people under 25 years of age harmed more by drinkers outside the home. For both sexes people who drank heavily face two to three times more risk of harassment, threats, and driving-related harm, compared with abstainers (Teetotalers). (Alcohol's Secondhand Harms in the United States: New Data on Prevalence and Risk Factors. *Journal of Studies on Alcohol and Drugs*, 2019; 80 (3): 273 DOI: 10.15288/jsad.2019.80.273.)

In Nigeria, the steady rise in the consumption of alcohol (and drugs) has been linked with rising crime, violence and public disorder. The fact that Nigeria is the most populous country in Africa and home for majority of black people on the Globe makes the report of increased in excessive alcohol use worrying and concerning. (<https://theconversation.com/offences-committed-under-the-influence-of-al...>). The country is trying to control the situation but laws alone cannot solve the problem. Even though poverty rate is worse the farther one goes from the cities, it is interesting that reports from Nigeria reveal that harmful alcohol use was higher in rural settings (40.1%, 24.2-56.1) compared to urban settings (31.2%, 22.9-39.6). The number of harmful alcohol users

aged ≥ 15 years increased from 24 to 34 million from 1995 to 2015. (Meta-Analysis. Am J Drug Alcohol Abuse . 2019;45(5):438-450. doi:10.1080/00952990.2019.1628244. Epub 2019 Jun 27).

On the question 'if alcohol is indeed one of the greatest causes of harm to others, is this truly understood by the general public, by health professionals, and by policymakers?

Health practitioners know that alcohol is a psychoactive and addiction-producing substance, but they still consume it in many countries for centuries. They also know that alcohol abuse is a major cause of high burden of disease, significant social and economic consequences, and harm to other people, including family members, friends, co-workers, but they consume it. In this regard, there is much similarity in health worker attitude to the problem of smoking. It has been difficult to locate studies specifically about alcohol effect on health workers but we found some reporting from USA. In a study that asked 'Do doctors' alcohol use affect their professional practices with their patients?', it revealed that 'the doctors' own personal alcohol use had a significant effect on their professional practices with their patients. However, there appeared to be no relationship between the kind of advice provided and the doctors' alcohol use in these two studies'

(www.ncbi.nlm.nih.gov/pmc/articles/PMC3924442/)

Reports from Nigeria reveal that harmful alcohol use was higher in rural settings (40.1%, 24.2-56.1) compared to urban settings (31.2%, 22.9-39.6). The number of harmful alcohol users aged ≥ 15 years increased from 24 to 34 million from 1995 to 2015. (Meta-Analysis. Am J Drug Alcohol Abuse . 2019;45(5):438-450. doi:10.1080/00952990.2019.1628244. Epub 2019 Jun 27).

It may sound like a cliché but what is needed is multi-faceted, multisectoral interventions across sectors and disciplines from civil and community stakeholders, to the relevant health and social professions, to the economic and political authorities. For example, in Canada, measures include "Control policies, such as alcohol pricing, taxation, reduced availability, and restricting advertising, may be the most effective ways to reduce not only alcohol consumption but also alcohol's harm to persons other than the drinker." (Alcohol's Secondhand Harms in the United States: New Data on Prevalence and Risk Factors. Journal of Studies on Alcohol and Drugs, 2019; 80(3): 273 DOI: 10.15288/jsad.2019.80.273).

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(<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

Alcohol Use Disorders (58) The single most important cause of harm to others? (5)

16 February, 2024

["It can be argued that alcohol use disorders are the single most important cause of harm to others (accidents, violence, gender-based violence)."]

Eduardo, you said: "I must confess that I took that phrase from an article (that I cannot locate now, despite having tried hard) and it caught my attention powerfully."

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-12-welcome-hifa-a...>

In fact, it wasn't in an article but came from me :-). Whenever we come together on projects like this, it can be thought-provoking, which is one reason I enjoy these discussions so much. Our colleagues at WHO call it "Share, Spark, Challenge" for mutual learning.

I'm sure my thought isn't original. Many must have articulated this before. But I suspect it is neglected and could be an interesting line of enquiry for our discussion. I do wonder what research has been done to support (or refute) the assertion, and to ask whether alcohol control efforts could be framing this in a way that could be beneficial. (Taken literally the assertion doesn't hold because clearly there are other non-medical factors such as war that do more harm. And yet it may hold true as the most important *medical* cause of harm to others.)

"I have tried to look for causes of damage to the health of others, even through artificial intelligence, but I have not gotten satisfactory answers.

Yes, I had also done a very brief google search and similarly didn't find good answers. If any HIFA member has the time to do a little desk research on this subject, we would be very grateful.

Some questions to explore (from my previous message):

What are the global estimates for harm to others caused by alcohol use disorders?

How does this compare with other medical causes of harm?

How might this harm be categorised (eg accidents, violence, gender-based violence) and quantified?

What is the picture in different countries?

What attempts (if any) are being made to measure harm to others?

What measures can be taken at national, community and individual level to better protect people from harm?

If alcohol is indeed one of the greatest causes of harm to others, is this truly understood by the general public, by health professionals, and by policymakers?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (59) Do health workers have adequate knowledge to prevent and manage alcohol use disorders? (4) What health workers need to know

17 February, 2024

Dear friends, [*see note below]

Now, I would like to comment about a number of evidence-based practices that can improve the care of patients with alcohol problems, including alcohol use disorder (AUD), that should be taught to all health professionals, especially those at the Primary Care Level:

1. Strategies to manage stigma. Both that of the patient themselves (self-stigma) and that of the health professional towards the person with AUD. Of course, if this stigma exists, the HCP must first identify and become aware of it.

The second step would be to change the “language” used in interacting with these people, avoiding the words alcoholic, alcoholism and replacing them with alcohol use disorders. This can already facilitate interaction and encourage patient openness.

2. Using simple tools to detect people with alcohol consumption problems, such as:

- The Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) that consists of three questions related to drinking frequency and quantity

- The NIAAA Single Alcohol Screening Question (SASQ) , where you have to ask “How many times in the past year have you had (4 for women, or 5 for men) or more drinks in a day?” A response of one or more warrants follow-up. Before asking the SASQ, you can ask for a prescreen along the lines of “How often did you have a drink containing alcohol in the past year?” <https://assets.publishing.service.gov.uk/media/6357a857e90e0777aa2cfe98/...>

- Routinely integrating an Alcohol Symptom Checklist [PDF - 147.8 KB] into primary care may make it easier for healthcare professionals to hold comfortable, patient-centered, non-judgmental conversations about alcohol that help destigmatize AUD and its treatment

Who should conduct screening?. Any healthcare professional in medical or mental health fields can easily screen for heavy drinking as part of a comprehensive assessment or health history. In primary care, teams that include nurses and other non-physician providers are increasingly used for alcohol screening.

3. After assessing for AUD, your next steps could be :

- For patients who drink heavily and do not have AUD: Offer brief advice. You can find some examples on how to provide Brief Advice in this links:

<https://www.youtube.com/watch?v=PaSKcfTmFEk>

<https://www.youtube.com/watch?v=b-ilxvHZJDc>

- For patients who have AUD: Advise abstinence and emphasize that it's important to cut down gradually because suddenly stopping can result in alcohol withdrawal, which can be risky. Be cautious and consider the need for medically managed withdrawal. Again, if the patient is hesitant to abstain, then negotiate individualized drinking goals. If you don't feel secure to manage the patient and he/she accepts, refer to a specialized program.

4. Knowing and managing FDA-approved medications for AUD—naltrexone, acamprosate, or disulfiram—can help many patients reduce or quit drinking. Healthcare professionals at Primary Care Level can prescribe these non-addicting medications in primary care without specialized training, or can refer to a specialty prescriber

Reference

<https://www.niaaa.nih.gov/health-professionals-communities/core-resource...>

What do you think?

What else will you add to these basic steps?

Kind regards,

Eduardo

Dr. Eduardo Bianco

Director, Addiction Training Program for Health Professionals (ATHP)

Email: ebianco@nextgenu.org

Web: NextGenU.org

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and

former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco AT nextgenu.org

[*Note from HIFA moderator (NPW): The original contained formatting (bold, italic, underline) that is not carried by HIFA, which is a plain-text forum.]

Alcohol Use Disorders (60) A definition of Alcohol Use Disorders (2) 280m people with AUD

17 February, 2024

The American Psychiatric Association says: 'Alcohol use disorder (AUD) involves frequent or heavy alcohol drinking that becomes difficult to control and leads to problems such as in relationships, work, school, family, or other areas.'

More specifically, the APA publishes the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which defines Alcohol Use Disorders as 'anyone meeting any 2 of the 11 criteria below] during the same 12-month period.

The severity is defined as:

Mild: The presence of 2 to 3 symptoms

Moderate: The presence of 4 to 5 symptoms

Severe: The presence of 6 or more symptoms

Had times when you ended up drinking more, or longer, than you intended?

More than once wanted to cut down or stop drinking, or tried to, but couldn't?

Spent a lot of time drinking? Or being sick or getting over other aftereffects?

Wanted a drink so badly you couldn't think of anything else?

Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?

Continued to drink even though it was causing trouble with your family or friends?

Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?

More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?

Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?

Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?

Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

ChatGPT indicates that the Diagnostic and Statistical Manual of Mental Disorders (DSM) is widely used by mental health professionals worldwide, not just in the United States. It also notes that 'the World Health Organization (WHO) publishes the International Classification of Diseases (ICD), which includes a section on mental and behavioral disorders. In some regions, the ICD may be used as the primary diagnostic reference instead of or alongside the DSM'. I had a look at the ICD and it appears to use the terms 'abuse' and 'dependence' as used in older versions of the DSM. I found the ICD difficult to use: hundreds of results when I use the search term "alcohol" and I couldn't readily find definitions.

Would anyone like to comment on definitions and the extent to which there is international consensus?

Also, WHO estimates that there are 280 million people globally with Alcohol Use Disorders. It would be interesting to know how this estimate was reached.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based

nonprofit in official relations with the World Health Organization.
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Alcohol Use Disorders (61) Do health workers have adequate knowledge? (5)

18 February, 2024

In relation to Question 2 (Do health workers have adequate knowledge to prevent and manage alcohol use disorders among their patients? What matters to them? How can they be better informed?) I have identified a few interesting papers, some of them written by HIFA members (Abhijit Nadkarni, Richard Velleman, Erica Frank...). Below is a helpful overview paper by Abhijit Nadkarni, a member of our working group on AUD, Richard Velleman and colleagues:

<https://www.hifa.org/projects/mental-health-meeting-information-needs-su...>

<https://www.hifa.org/support/members/abhijit>

Closing the treatment gap for alcohol use disorders in low- and middle-income countries

<https://www.cambridge.org/core/journals/global-mental-health/article/clo...>

Published 09 December 2022

ABSTRACT

The alcohol-attributable disease burden is greater in low- and middle-income countries (LMICs) as compared to high-income countries. Despite the effectiveness of interventions such as health promotion and education, brief interventions, psychological treatments, family-focused interventions, and biomedical treatments, access to evidence-based care for alcohol use disorders (AUDs) in LMICs is limited. This can be explained by poor access to general health and mental health care, limited availability of relevant clinical skills among health care providers, lack of political will and/or financial resources, historical stigma and discrimination against people with AUDs, and poor planning and implementation of policies. Access to care for AUDs in LMICs could be improved through evidence-based strategies such as designing innovative, local and culturally acceptable solutions, health system strengthening by adopting a collaborative stepped care approach,

horizontal integration of care into existing models of care (e.g., HIV care), task sharing to optimise limited human resources, working with families of individuals with AUD, and leveraging technology-enabled interventions. Moving ahead, research, policy and practice in LMICs need to focus on evidence-based decision-making, responsiveness to context and culture, working collaboratively with a range of stakeholders to design and implement interventions, identifying upstream social determinants of AUDs, developing and evaluating policy interventions such as increased taxation on alcohol, and developing services for special populations (e.g., adolescents) with AUDs.

SEKECTED EXTRACTS

The evidence about treatment interventions for AUDs in LMICs is limited...

Brief interventions are generally characterised by a few short sessions involving an assessment of individual risk with feedback and advice, followed by provision of structured advice, or brief motivational interviewing that takes a more patient-centred approach, or a combination of both. BIs are the most tested interventions for AUDs in LMICs, most commonly using motivational interviewing techniques delivered by non-specialist health workers or through digital platforms. There is substantial evidence on the effectiveness of BIs on a range of short- and long-term drinking outcomes, in healthcare and community settings, in men as well as women, and when delivered by NSHWs, or digitally. Compared to a range of other public health policies designed to reduce alcohol-related harm (e.g., regulation of alcohol advertising) BIs achieve larger effects as measured by DALYs.

Despite the high burden of AUDs and availability of evidence-based interventions, outlined above, access to appropriate treatment remains low. The pooled treatment rate of AUD from any source of treatment is 17.3%. This effectively means that four out of five individuals with AUD do not have access to appropriate care for their drinking problems. [*see comment below]

Treatment gap refers to the proportion of individuals who require treatment for a particular condition but do not receive it;

The treatment gap may be explained by some combination of (1) limited access to general health and mental health care, (2) poor accessibility of evidence-based treatments, (3) limited availability of and clinical skills among health care providers, (4) lack of political will and/or financial resources, (5) historical stigma and discrimination against people with AUDs,

and (6) poor planning and implementation of policies (Connery et al., Reference Connery, McHugh, Reilly, Shin and Greenfield2020).

In summary, in many LMICs, prevention in earlier stages of problem drinking is mostly non-existent and alcohol-related problems are first addressed when they are already severe and difficult to treat.

COMMENT (NPW): The paper defines the treatment gap as 'the proportion of individuals who require treatment for a particular condition but do not receive it'. Does this include all people with an Alcohol Use Disorder, as defined by the DSM-V, whether or not they seek treatment? It would be interesting to have an idea of [number of people with AUD] vs [number of people with AUD who seek medical help but cannot get it] vs [number of people with AUD who seek medical help and receive it]. Clearly, the picture is blurred also by the quality of help provided, and by whom. I expect perhaps that many people bypass the health system in the first instance and seek help from non-medical sources. It would be very interesting to hear some case studies of people with AUD and their experiences of seeking help for their condition.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.
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Alcohol Use Disorders (62) Q3. What is the role of the alcohol industry? (1) Alcohol and breast cancer

18 February, 2024

Thank you for your contributions so far to the discussion. We now enter our third week and I invite you to consider Q3: What is the role of the alcohol industry? What can be done to address misinformation from the alcohol industry?

Here is an example. Please do share any examples you know about:

How Industry-Sponsored Messaging About Alcohol Manufactures Doubt

Posted on December 24, 2021

<https://movendi.ngo/science-digest/how-industry-sponsored-messaging-about...>

From this website we learn that the misinformation effects are greatest in relation to the links between alcohol and breast cancer... The overall effect of industry misinformation is large, increasing the odds of an inaccurate perception of the risk by around 60%.

Fact: Alcohol is a Group 1 Carcinogen. It increases the risk of breast cancer.

Alcohol industry supported message: "It's important to put the risks from drinking alcohol into context. There are many other factors that increase the risk of developing breast cancer, some of which we can't control, like:

- Age: you're more likely to develop it as you get older
- A family history of breast cancer
- Being tall
- A previous benign breast lump

However, in addition to alcohol, other lifestyle factors such as being overweight and smoking are thought to increase your risk of developing breast cancer."

Fact: The Chief Medical Officers advise: Alcohol can cause cancer, including breast and colon cancers

Alcohol industry supported message: "Some studies show a link between alcohol and breast cancer among both pre-menopausal and post-menopausal women. However, no causal relationship has been shown between moderate drinking and breast cancer."

In both examples, we see how the alcohol industry aims to downplay the role of alcohol in breast cancer. In the first example, it emphasises other risk factors in order to make alcohol seem unimportant; in the second it makes what sound like a scientific and compelling statement "no causal relationship has been shown between moderate drinking and breast cancer". This is highly misleading and is very similar to the tactics of the tobacco industry in relation to lung cancer.

I look forward to hear of other examples where the alcohol industry has misled the general public, health workers or policymakers.

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Alcohol Use Disorders (63) Do people understand the harms of alcohol? (13) Popular beliefs about alcohol (5)

18 February, 2024

Dear Eduardo,

Thank you for your message with 18 myths about alcohol.

[<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-31-popular-belief...>] Other HIFA member have since added more.

I did a quick Google search on "public understanding of the impact of alcohol on health". I was surprised that only 1/50 hits said anything about the subject. And this is a 2018 study from England, which found (unsurprisingly) that most people are unaware of the link between alcohol and cancer:

CITATION: Awareness of alcohol as a risk factor for cancer is associated with public support for alcohol policies

Sarah Bates, John Holmes, Lucy Gavens, Elena Gomes de Matos, Jessica Li, Bernadette Ward, Lucie Hooper, Simon Dixon & Penny Buykx

BMC Public Health volume 18, Article number: 688 (2018)

<https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-018-55...>

ABSTRACT

Background

Globally, alcohol is causally related to 2.5 million deaths per year and 12.5% of these are due to cancer. Previous research has indicated that public awareness of alcohol as a risk factor for cancer is low and this may contribute to a lack of public support for alcohol policies. The aim of this

study was to investigate the relationship between awareness of the alcohol-cancer link and support for a range of alcohol policies in an English sample and policy context.

Methods

A cross-sectional survey of 2100 adult residents in England was conducted in which respondents answered questions regarding awareness of the link between alcohol and cancer and support for 21 policy proposals. Principal component analysis (PCA) was used to reduce the 21 policy proposals down to a set of underlying factors. Multiple regression analyses were conducted to estimate the relationship between awareness of the alcohol-cancer link and each of these policy factors.

Results

Thirteen per cent of the sample were aware of the alcohol-cancer link unprompted, a further 34% were aware when prompted and 53% were not aware of the link. PCA reduced the policy items to four policy factors, which were named price and availability, marketing and information, harm reduction and drink driving. Awareness of the alcohol-cancer link unprompted was associated with increased support for each of four underlying policy factors: price and availability (Beta: 0.06, 95% CI: 0.01, 0.10), marketing and information (Beta: 0.05, 95% CI: 0.00, 0.09), harm reduction (Beta: 0.09, 95% CI: 0.05, 0.14), and drink driving (Beta: 0.16, 95% CI: 0.11, 0.20).

Conclusions

Support for alcohol policies is greater among individuals who are aware of the link between alcohol and cancer. At the same time, a large proportion of people are unaware of the alcohol-cancer link and so increasing awareness may be an effective approach to increasing support for alcohol policies.

--

COMMENT (NPW): Why is there such low awareness of the link between alcohol and cancer? One of the reasons is that the alcohol industry deliberately obfuscates. Another reason is that governments are simply failing in their obligation under human rights law (as demonstrated by HIFA and the New York Law School) to meet the reliable healthcare information needs of their populations.

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Alcohol Use Disorders (64) Do people understand the harms of alcohol? (14) How can they be better informed? (7)

18 February, 2024

Dear Joseph,

A few days ago you wrote: "I feel that the advice misses a crucial starting point, which is abstinence, that is 'no alcohol at all'. It may sound draconian and impossible to some, but actually a no alcohol status gives the person a 'no risk' position, better than 'low risk'...

no drinking of alcohol is the best advice ----' and therefore the Public Health advice on Alcohol use should be revised to start with emphasizing the fact. It may not be easy to stop for those who drink already, but the public health advice should state the facts fully."

[<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-35-do-people-unde...>]

My understanding is that if a person does not drink alcohol, there is certainly no reason to encourage them to start, even if only small quantities. But as a general public health message, especially in countries where alcohol is socially embedded, then it might be more effective to say "If you do drink alcohol, be sure to limit your intake to 14 units per week". Alongside this, it is important to make people aware of the health risks of alcohol, especially the link with cancer (we should be moving from a situation where 10% are aware of the link, to one where 90% are aware).

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Alcohol Use Disorders (64[65] What is the role of the alcohol industry? (2)

19 February, 2024

I asked ChatGPT for examples of misinformation by the alcohol industry. It identified five types of misinformation:

1. Downplaying Health Risks
2. Promotion of Moderate Drinking
3. Targeting Vulnerable Groups
4. Misleading Advertising
5. Funding Biased Research

With regard to #1, we have already mentioned how the industry rebuts the link between alcohol and cancer [<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-62-q3-what-role-a...>]

On the question of #2. It is easy to see why the industry promotes moderate drinking. In most countries, moderate drinkers are the majority of consumers and therefore the main target source of income for the industry. Alcohol is culturally engrained and an integral part of socialising in many cultures. It would be very much in the industry's interest (profit) to increase the percentage of moderate drinkers in the population. We can imagine that it must have been music to the alcohol industry's ears when research suggested that moderate drinking might protect against heart disease.

Even GPT supports the industry in this respect: "While moderate alcohol consumption may indeed have some health benefits, such as a reduced risk of heart disease, critics suggest that the alcohol industry sometimes exaggerates these benefits while understating the risks. This can lead to confusion among consumers about what constitutes moderate drinking and its actual health effects."

Regrettably, as we have already learned from this discussion, different health professionals give different advice on this point, and the same is true of academic websites. As Richard Velleman has said, "The fundamental reason for the conflicting information is that the science is not yet clear

(although both 'sides' in this debate argue that it IS clear)" Health professionals (and even whole academic institutions) are failing to communicate uncertainty. The result is confusion and loss of trust in health professionals and institutions.

I would be interested to know whether and how we can improve our collective communication so that the general public has more consistent and objective information.

Throughout, every person has a degree of confirmation bias: taking note of things that confirm our existing beliefs and behaviour. Moderate alcohol drinkers will hear "moderate drinking may have a cardioprotective effect" and will happily take this as fact. The picture is complicated further by popular understanding of "moderate drinking". The UK definition is an average of two units per day maximum (one can of beer, or one large glass of wine). I suspect many people see moderate drinking as more than this, and will happily continue accordingly.

'If you already have a glass of red wine with your evening meal, drinking it in limited amounts may improve your heart health.' Mayo Clinic

'There is no known safe level of drinking, it seems reasonable that the quality of life gained from an occasional drink might be deemed greater than the potential harm' World Health Organization

DrinkAware is a service funded mainly by the alcohol industry, that provides 'impartial, evidence-based information, advice and practical resources; raising awareness of alcohol and its harms and working collaboratively with partners.

I looked up their information on Alcohol and heart health, expecting to find a claim that small amounts of alcohol can be cardioprotective, and instead found this:

"Regularly having just a couple of pints of lager can weaken your heart and shrink your arteries. This makes it harder for blood to be pumped and pass through, which increases your blood pressure. That same pressure can lead to blood clots - which can cause strokes and brain damage." (!)

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare

information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (66) Do people understand the harms of alcohol? (15) How can they be better informed? (8)

19 February, 2024

Hello Neil,

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-64-do-people-unde...>]

Thank you for your comment on my view about adding 'no drinking alcohol' which is risk free (no risk) to the public health advice. Presently the advice starts from low drinking to moderate drinking to high drinking (low risk, moderate risk and high risk, respectively.) My suggestion is that the No risk should be the starting advice. If we are to achieve the 90% awareness my succession may help the effort. There are people who do not drink alcohol at all, they need to know that they should not start at all because they fall in the no risk category. They need to be so encouraged to stay Teetotaler.

Joseph Ana.

HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for PAKC Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which also suitable for lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicom & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books

on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member, National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the Working Group on HIFA-WHO Collaboration (<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

Alcohol Use Disorders (67) What is the role of the alcohol industry? (3) The failure of public health messaging

19 February, 2024

Neil and Eduardo, I agree that alcohol manufacturers confuse people on the facts by their advertising. But I don't think that anybody is surprised by that, after all every business wants to paint a good image of its product for more and more profit to share with the shareholders.

In my view it is the failure of public health message and messaging that should be held accountable for: low awareness of harms of alcohol use, not effectively countering the misleading adverts, and not effectively countering misinformation generally about health including on alcohol misuse.

Joseph Ana.

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Alcohol Use Disorders (68) Stigma (6) Sources of reliable information for the general public

19 February, 2024

Dear HIFA colleagues,

I'd like to highlight a couple of questions from our first 2 weeks that are waiting for your answers (or comments):

"How can we, as a community, work towards destigmatizing alcohol use disorders and encourage a more informed and empathetic approach to addressing this challenge?" (Miriam Chickering, USA)

"What information is available for the individual with alcohol use disorder, their loved ones, and the general public? It's likely that many will first seek information online. What are the best sources of information?" (Neil Pakenham-Walsh, UK)

On the subject of stigma, Eduardo has emphasised the importance of language, for example using the term Alcohol Use Disorders and not alcoholism. The name of the main US body on AUD therefore seems anachronistic: National Institute on Alcohol Abuse and Alcoholism.

It would be interesting also to learn about cultural and geographical determinants of stigma around Alcohol Use Disorders, and how these have shifted over time. Stigma is perhaps highest in countries with strict controls on alcohol, such as some Islamic countries, although presumably the numbers of people with AUD are much lower in such countries.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (69) Do people understand the harms of alcohol? (16) How can they be better informed? (9)

19 February, 2024

In 2016, the chair of the UK Alcohol Health Alliance Sir Ian Gilmore said the UK Government should do two things:

1. The government should develop mass media campaigns outlining the risks. These could include TV and radio advertisements, social media campaigns, and messages on public transport.
2. The government should introduce mandatory labelling of all alcoholic products, containing clear and legible health information about the harms associated with drinking.

<https://www.rcplondon.ac.uk/news/communicating-health-harms-alcohol-public>

Are these the two most important things that governments should do in terms of meeting the information needs of the general public? Has the UK Government taken action since 2016?

What are other governments doing (or not doing) in terms of mass media campaigns and mandatory labelling?

Best wishes, Neil

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Alcohol Use Disorders (70) What is the role of the alcohol industry? (4) WHO Global Alcohol Action Plan 2022-2030

19 February, 2024

WHO has a Global Alcohol Action Plan 2022-2030, which is available here in pre-print (I cannot find a final version, can anyone help?)

<https://cdn.who.int/media/docs/default-source/alcohol/final-text-of-aap-...>

The Plan has six objectives:

1. Increase population coverage, implementation and enforcement of high-impact policy options and interventions to reduce the harmful use of alcohol worldwide for better health and well-being, taking into account gender perspective and a life-course approach.
2. Strengthen multisectoral action through effective governance, enhanced political commitment, leadership, dialogue and coordination of multisectoral action.
3. Enhance the prevention and treatment capacity of health and social care systems for disorders due to alcohol use and associated health conditions as

an integral part of universal health coverage and aligned with the 2030 Agenda and its health targets.

4. Raise awareness of the risks and harms associated with alcohol consumption and its impact on the health and well-being of individuals, families, communities and nations, as well as of the effectiveness of different policy options for reducing consumption and related harm.

5. Strengthen information systems and research for monitoring alcohol consumption, alcohol-related harm, their determinants and modifying factors, and policy responses at all levels, with dissemination and application of information for advocacy in order to inform policy and intervention development and evaluation.

6. Significantly increase the mobilization of resources required for appropriate and sustained action to reduce the harmful use of alcohol at all levels.

I tried to find out what the Action Plan says in terms of addressing misinformation by the alcohol industry, but all I could find was this:

'The continuing global dialogue with economic operators in alcohol production and trade should focus on industry's contribution to reducing the harmful use of alcohol in their roles as developers, producers and distributors/sellers of alcoholic beverages. This dialogue should also aim for the implementation of comprehensive restrictions or bans on traditional, online or digital marketing (including sponsorship), as well as on the role of economic operators in the regulation of sales, e-commerce, delivery, product formulation and labelling and on providing data on production and sales. The dialogue should engage, as appropriate, economic operators in other sectors of the economy that are directly involved in the distribution, sales and marketing of alcoholic beverages.'

Shouldn't this read: 'should focus on addressing industry's contribution to *increasing* the harmful use of alcohol in their roles as developers, producers and distributors/sellers of alcoholic beverages'?

I look forward to any comments from those who have been involved in the development of the Plan, as well as any who have had the chance to read it.

The plan does seem to have been developed using a robust and participatory approach. Would anyone like to comment on its strengths and weaknesses?

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together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.
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Alcohol Use Disorders (71) What is the role of the alcohol industry? (5)

20 February, 2024

Thank you, Neil, for this important message.

[<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-62-q3-what-role-a...>]

But I think you have pointed out just one of the “tips of the iceberg” [the alcohol industry and breast cancer]. There are others, and above all, there is an immense part of the problem that is hidden “below the surface”.

I am sharing here the first part of my reflection on the subject.

Prof. Babor in the title of one of his books highlights something very important: Alcohol is not an ordinary commodity.

The most recent scientific evidence on the burden of disease attributable to alcohol indicates that it plays a causal role in a wide range of health conditions and social problems, including coronary heart disease, breast and other cancers, liver diseases, HIV/AIDS, suicide and interpersonal violence. In states of intoxication or dependence, people's ability to act rationally is hindered, and the likelihood of harming others is substantial. (1)

Why has the obvious conclusion that alcohol is not an ordinary commodity failed to convince policymakers to take effective measures to limit the harm it causes? (2)

This happens because it is not just about the product, the alcohol industry is not an ordinary industry, and because there is also an inherent and substantial conflict of interest between public health and the alcohol industry. (3)

The main objective of the alcohol industry, like any industry, is to increase profits for its shareholders. To do this, it must necessarily increase alcohol sales, it must attract new customers and make those who already consume,

to consume more. By achieving its goal, it necessarily increases the health and social harms related to alcohol.

The goal of Public Health is to reduce the burden of death and disease related to alcohol consumption. To be successful, it is necessary to reduce the total amount of alcohol per capita consumed in a country. If Public Health is successful, alcohol sales will decrease.

Therefore, there cannot be a “meeting point” between both parties; measures and strategies that are effective for public health harm the alcohol industry. Measures that are effective for the alcohol industry's objectives harm public health.

What do we talk about when we talk about the alcohol industry? (4)

CONSOLIDATION. Like the tobacco industry, the alcohol industry is dominated by a small group of transnational companies that control more than half of the world market. Corporations of this magnitude present a significant challenge to governments seeking to implement evidence-based measures to prevent and reduce harm caused by alcohol.

The alcohol market and the alcohol industry are part of the commercial determinants of health, defined as “strategies and approaches used by the private sector to promote products and options that are harmful to health” and spread the non-communicable disease pandemic.

ALCOHOL ADVERTISING, PROMOTION AND SPONSORSHIP. The alcohol industry uses advertising to achieve two main objectives: attract and recruit new customers and normalize and promote alcohol consumption in new markets, thereby increasing overall consumption and profits.

Marketing and corporate social responsibility (CSR) programs also improve the industry's standing with the public and policymakers and can undermine efforts to regulate its activities. Alcohol corporations have huge marketing budgets, some of them larger than the GDP of some low- and middle-income countries.

THE INDUSTRY SAYS it uses marketing and advertising to build brand loyalty, but **SCIENCE TELLS US** that alcohol ads stimulate and encourage alcohol consumption and attract new customers by targeting two groups in particular: women and young people .

YOUTH. Research has shown that exposure to alcohol advertisements increases the likelihood, frequency, and volume of alcohol consumption

among youth. Alcohol ads also create false expectations about how alcohol will make people feel and be perceived by others: The ads promise what is important to young people: to be happy, glamorous, successful, brave, mysterious, adventurous and funny, popular, sexy and modern. The industry also sponsors sporting events and teams, as a way to attract young people.

WOMEN. The industry aims to make alcohol use and consumption more socially acceptable among women, who consume less alcohol than men in most parts of the world. This strategy has proven successful and, as a result, alcohol consumption by women, especially those of higher socioeconomic status, is catching up to alcohol consumption by men.

CORPORATE SOCIAL RESPONSIBILITY .Another creative marketing strategy employed by the alcohol industry is corporate social responsibility (CSR), which ranges from “responsible drinking” school programs for children, to transportation services for intoxicated adults. These tactics have been found to have limited effectiveness in reducing alcohol harm, but offer a highly visible branding strategy.

Alcohol corporations are also seeking to partner with civil society to improve their standing with the public and policymakers. An example is the 2017 “Beers for Africa” campaign, which positioned alcohol as an aid against poverty.

SELF-REGULATION. Globally, self-regulation is the most common method of regulating the promotion and sale of alcohol, but voluntary codes have been shown to have limited effectiveness. For example, the industry has its own codes against marketing to young people, but alcohol ads often feature elements that appeal to young people

INDUSTRY SAYS : Voluntary codes and guidelines and responsible alcohol campaigns can be used instead of regulatory policies.

SCIENCE TELLS US: Voluntary codes, guidelines and responsible use campaigns are insufficient and do not replace legally enforceable measures.

Another important strategy, which we will address in the second part of my comments, is about how the alcohol industry controls “the narrative” about alcohol consumption.

For all these reasons, the former director general of the WHO, Margaret Chan, in 2013, expressed: “The alcohol industry cannot sit at the table or have a voice when the WHO defines its standards and preventive strategies,

and cannot supplant the role of the government in formulating policies for alcohol control."

What do you think about these topics?

What is the situation regarding them in your countries?

Kind regards,

Eduardo

Referencias

- (1) <https://academic.oup.com/book/45328>
- (2) <https://academic.oup.com/book/45328/chapter/389221591>
- (3) <https://www.jsad.com/doi/full/10.15288/jsad.23-00070>
- (4) <https://troublebrewingreport.org/the-alcohol-industry>

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. [ebianco AT nextgenu.org](mailto:ebianco@nextgenu.org)

Alcohol Use Disorders (72) What is the role of the alcohol industry? (6)

20 February, 2024

Dear Eduardo, you said: "Thank you, Neil, for this important message. But I think you have pointed out just one of the "tips of the iceberg" [the alcohol industry and breast cancer]."

Yes indeed. As you say, alcohol 'plays a causal role in a wide range of health conditions and social problems, including coronary heart disease, breast and other cancers, liver diseases, HIV/AIDS, suicide and interpersonal violence'. What do we know about the role of the alcohol industry in misleading the general public about these links?

With alcohol and breast cancer, we have seen that the 'alcohol industry aims to downplay the role of alcohol in breast cancer... it emphasises other risk factors in order to make alcohol seem unimportant... it makes what sound like a scientific and compelling statement "no causal relationship has been shown between moderate drinking and breast cancer". This is highly misleading and is very similar to the tactics of the tobacco industry in relation to lung cancer."

A 2018 paper concludes: 'The Alcohol Industry appears to be engaged in the extensive misrepresentation of evidence about the alcohol-related risk of cancer. These activities have parallels with those of the tobacco industry. This finding is important because the industry is involved in developing alcohol policy in many countries, and in disseminating health information to the public, including schoolchildren. Policymakers, academics, public health and other practitioners should reconsider the appropriateness of their relationships to these AI bodies.'

Unfortunately the full text is behind a paywall and therefore not available to most of us. This is a micro-example of the difference in power between the alcohol industry and public health researchers. In this case, it appears likely that the public health researchers were unable to pay the author processing charge for open access, in turn limiting the dissemination of their message.

Can anyone comment on misinformation (or biased information) by the alcohol industry in relation to the role of alcohol in different diseases?

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Alcohol Use Disorders (73) The single most important cause of harm to others? (6)

20 February, 2024

We have raised the question of whether alcohol is the single most important medical cause of harm to others. If anyone has any information that can inform this discussion, please email: hifa@hifaforums.org

One possible approach is through the Global Burden of Disease Study.

In 2018 The Lancet published a paper on Alcohol use and burden for 195 countries. Citation, summary and a comment from me below.

CITATION: Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016

GBD 2016 Alcohol Collaborators

The Lancet Articles | volume 392, issue 10152, p1015-1035, september 22, 2018 download full issue

Open Access Published: August 23, 2018 DOI: [https://doi.org/10.1016/S0140-6736\(18\)31310-2](https://doi.org/10.1016/S0140-6736(18)31310-2)

SUMMARY

BACKGROUND

Alcohol use is a leading risk factor for death and disability, but its overall association with health remains complex given the possible protective effects of moderate alcohol consumption on some conditions. With our comprehensive approach to health accounting within the Global Burden of Diseases, Injuries, and Risk Factors Study 2016, we generated improved estimates of alcohol use and alcohol-attributable deaths and disability-adjusted life-years (DALYs) for 195 locations from 1990 to 2016, for both sexes and for 5-year age groups between the ages of 15 years and 95 years and older.

METHODS

Using 694 data sources of individual and population-level alcohol consumption, along with 592 prospective and retrospective studies on the risk of alcohol use, we produced estimates of the prevalence of current

drinking, abstinence, the distribution of alcohol consumption among current drinkers in standard drinks daily (defined as 10 g of pure ethyl alcohol), and alcohol-attributable deaths and DALYs. We made several methodological improvements compared with previous estimates: first, we adjusted alcohol sales estimates to take into account tourist and unrecorded consumption; second, we did a new meta-analysis of relative risks for 23 health outcomes associated with alcohol use; and third, we developed a new method to quantify the level of alcohol consumption that minimises the overall risk to individual health.

FINDINGS

Globally, alcohol use was the seventh leading risk factor for both deaths and DALYs in 2016, accounting for 2.2% (95% uncertainty interval [UI] 1.5–3.0) of age-standardised female deaths and 6.8% (5.8–8.0) of age-standardised male deaths. Among the population aged 15–49 years, alcohol use was the leading risk factor globally in 2016, with 3.8% (95% UI 3.2–4.3) of female deaths and 12.2% (10.8–13.6) of male deaths attributable to alcohol use. For the population aged 15–49 years, female attributable DALYs were 2.3% (95% UI 2.0–2.6) and male attributable DALYs were 8.9% (7.8–9.9). The three leading causes of attributable deaths in this age group were tuberculosis (1.4% [95% UI 1.0–1.7] of total deaths), road injuries (1.2% [0.7–1.9]), and self-harm (1.1% [0.6–1.5]). For populations aged 50 years and older, cancers accounted for a large proportion of total alcohol-attributable deaths in 2016, constituting 27.1% (95% UI 21.2–33.3) of total alcohol-attributable female deaths and 18.9% (15.3–22.6) of male deaths. The level of alcohol consumption that minimised harm across health outcomes was zero (95% UI 0.0–0.8) standard drinks per week.

INTERPRETATION

Alcohol use is a leading risk factor for global disease burden and causes substantial health loss. We found that the risk of all-cause mortality, and of cancers specifically, rises with increasing levels of consumption, and the level of consumption that minimises health loss is zero. These results suggest that alcohol control policies might need to be revised worldwide, refocusing on efforts to lower overall population-level consumption.

COMMENT (NPW): In the full text, the authors note: 'We were unable to find robust data about the harm caused to others from alcohol-attributable interpersonal violence, a major potential source of health loss. More retrospective studies are needed to assess the harm to others caused through an individual's alcohol use'. In fact, there was only one category with data, and this was deaths caused to others by drink-driving, and only one country (USA) had data on this.

'More retrospective studies are needed to assess the harm to others caused through an individual's alcohol use.' Indeed, the apparent failure to measure and document the harm caused to others by alcohol is an indictment of public health. If you are aware of any research on this topic, or can share relevant personal or professional experience, please send to HIFA: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (75) Contradictory advice from professionals: Why, what, how? (2) What is the role of the alcohol industry? (7)

20 February, 2024

Richard Velleman writes: "It is not solely that people "adopt an inappropriate stance of certainty? Some of us appear unable or unwilling to accept that 'the science is not yet clear'" - it is also that all scientific data is open to interpretation - the myth has been well exploded over the past decades of the scientist as a purely objective being, not influenced by a huge number of internal and external factors. In fact, all data and conclusions deduced from them are theory-laden, and influenced by a wide range of factors; and I think that this issue of relativism is also being played out in this debate."

Yes, each health professional looks at the same data (for example, the data around the possible cardioprotective effect of alcohol in moderation), comes to a different conclusion, and projects a very different message to the general public. The end result is a confused public and reduced trust in health professionals' advice.

Worse, as Richard says, health professionals do this with an air of certainty. We have seen the same is true for health organisations and academic institutions such as Harvard and the Mayo Clinic.

It can therefore be argued that individual health professionals, health organisations and academic institutions are part of the problem. Their inconsistency and failure to acknowledge uncertainty has led to chaos in public health communication.

By contrast, the alcohol industry is focused and consistent (misleading but consistent) in their approach to messaging on alcohol and health.

The question then arises: how can health professionals and health organisations be stronger together in their health messaging? How might they be encouraged to be more honest with the general public and acknowledge uncertainty?

On the question of 'the role of the alcohol industry', how can health professionals and health organisations speak with a more united voice in the face of alcohol industry misinformation?

Best wishes, Neil

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Alcohol Use Disorders (76) The role of the alcohol industry (8) Alcohol consumption in different countries

21 February, 2024

Dear HIFA colleagues,

In this discussion we have learned about alcohol consumption in Uruguay, Malawi, Ethiopia, Nigeria and Indonesia:

1. Uruguay has the highest per capita alcohol consumption in the region of the Americas... alcohol control policies are weak. (Eduardo Blanco, Uruguay)

2. This is an older study (2008) among the student population in Malawi that found that almost 50% of male students qualified as 'suffering' from alcohol related disorders. (Amelia Taylor, Malawi)

3. In Ethiopia, the national survey (DHS 2016) showed that the burden is up to forty-six percent in the community. (Abenezer Dereje, Ethiopia)

4. In Nigeria, the steady rise in the consumption of alcohol (and drugs) has been linked with rising crime, violence and public disorder. (Joseph Ana, Nigeria)

5. This period saw a 57.14% increase in consumption [in Indonesia], though the levels remained low. (Jum'atil Fajar, Indonesia)

These snapshots are really helpful for us to collectively understand the problem.

I would like to invite other HIFA members to share their observations about alcohol consumption in their country.

Also, what is the role of the alcohol industry in different countries?

We saw in our previous NextGenU-supported discussion on Tobacco last year that industry is focusing more and more on persuading people in LMICs to smoke, as people in HICs abandon the product. Is something similar happening with alcohol?

What policies does each country have to defend its public health? LMICs may have weak policies on alcohol control, driven partly by alcohol industry lobbying. What examples do we have of the alcohol industry influencing legislation?

Even if they have robust national policies, there may be a huge gap between the written policy and the situation on the ground. This gap is likely to be largest in LLMICs, where there are few resources to implement policy. For example we heard from Joseph Ana that there is poor enforcement of drink drive laws on alcohol in Nigeria, because of a lack of breathalysers.

The net effect is that the alcohol industry is able to act in LLMICs in ways that are no longer possible in HICs. This could have devastating consequences on public health in LMICs as they face a huge and increasing non-communicable disease burden with very limited healthcare resources.

We look forward to read your comments. Please send email to: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (77) Alcohol consumption in Zimbabwe

22 February, 2024

Alcohol Use in Zimbabwe: A Closer Look

Alarming statistics from the World Health Organization's 2018 Global Alcohol status report shed light on the pervasive issue of alcohol misuse, a significant risk factor affecting global population health and directly impacting several Sustainable Development Goals (SDGs). Zimbabwe, unfortunately, finds itself on the high end of the spectrum for years of life lost due to alcohol-related causes, painting a grim picture of the nation's health landscape.

Key Findings:

1. Youth Binge Drinking: Shockingly, 54.1% of Zimbabwean youths who consume alcohol engage in binge drinking, reflecting a troubling trend in adolescent alcohol consumption.
2. Alcohol Use Disorder: More than 11% of Zimbabwean men grapple with alcohol use disorder, highlighting the pervasive nature of alcohol dependency among males in the country.
3. Per Capita Alcohol Intake: Zimbabwean men exhibit an alarmingly high per capita alcohol intake, averaging a staggering 33 liters per individual, underscoring the extent of alcohol consumption within the population.

Insights into Youth Alcohol Consumption

A comprehensive 2022 study conducted by UNICEF and local partners delved into the complex dynamics of drug and substance abuse among Zimbabwean adolescents and young adults. The study revealed troubling statistics:

- Prevalence: Among youths, 41% of girls and 59% of boys reported alcohol, drug, and substance abuse, signaling a pervasive trend across gender lines.
- Substances of Choice: Cannabis emerged as the most commonly abused substance, with 67% of respondents admitting to its use, followed by cough syrup (47%), crystal meth (36%), and other illicit substances.
- Root Drivers: The report identified various social and economic factors driving substance abuse, including parental loss, poverty, absenteeism, broken homes, and social influence, highlighting the multifaceted nature of the problem.

Consequences of Substance Abuse:

The ramifications of alcohol and substance abuse extend far beyond individual health, permeating various facets of Zimbabwean society:

- Violence and Crime: Substance abuse contributes to 70% of gang violence among school children and 15% of Intimate Partner Violence (IPV) and Gender-Based Violence (GBV) cases involving adolescents and young people.
- Mental Health Crisis: Substance abuse is implicated in 40% of suicide attempts among youths and 60% of school dropouts, underlining the urgent need for targeted intervention and support mechanisms.

The findings underscore the urgent need for concerted efforts from policymakers, healthcare professionals, and civil society to address the root causes of substance abuse and implement effective prevention and intervention strategies to safeguard the well-being of Zimbabwe's youth and mitigate the broader societal impact of alcohol misuse.

HIFA profile: Enock Musungwini is a distinguished public health professional, health management consultant, and development practitioner currently serving as a Programme Manager (Consultant) for an NGO called Pangaea Zimbabwe under the Wild4Life Health program responsible for program management, oversight, supervision, coordination, and leadership. He holds an MSc in Public Health with a Research award from the London School of Hygiene and Tropical Medicine (LSHTM), achieved under the prestigious British Chevening scholarship (2018-19 cohort). His educational background also includes a Master's in Business Administration, BSc Hons in Psychology, Diploma in Nursing Science, Diploma in Public Relations and Communication,

and a Postgraduate Certificate in Health Management and Leadership. Enock actively serve as a Reference Group Committee member for the Africa Evidence Network, Steering Committee member for the International Network for Government Science Advice Africa Chapter, member of the Consortium for Universities of Global Health and Country Representative for Healthcare Information for All (HIFA).

Enock has received numerous accolades including being appointed Brand Ambassador and receiving the Growth and Innovation award for Pangaea Zimbabwe (June 2023), Country Representative of the Year by HIFA (April 2023), Chevening Volunteers Gold Award by the British Foreign and Commonwealth Office (June 2019), and the Zimbabwe Achievers Chairman's Award (Nov 2019). His academic excellence is reflected in awards such as the Amanda Jacklyn Berger Prize for his MSc Research project by LSHTM (Feb 2020) and the Marie Stopes Clinics Champion Award (Jan 2017). Enock's dedication to personal development led to his nomination for Ten Outstanding Young Persons in Zimbabwe under the Personal Improvement Category by Junior Chamber International (Oct 2019). Enock Musungwini has made presentations at national, regional, and international conferences and contributed significantly to public health discourse through his blogs and opinion pieces on various topics.

Alcohol Use Disorders (78) The role of the alcohol industry (9) Alcohol consumption in different countries (2)

22 February, 2024

Dear Neil,

Thank you for sharing the comprehensive report detailing alcohol consumption trends in Uruguay, Malawi, Ethiopia, Nigeria, and Indonesia. It was enlightening to gain insights into the varying dynamics of alcohol use across different regions.

In particular, I found the study from Malawi intriguing, despite its age, as it provides valuable insights into alcohol consumption patterns in neighboring Southern African countries like Zimbabwe. The parallels drawn between rising alcohol consumption and its correlation with crime, violence, and public disorder in Nigeria resonate with the challenges faced by many African nations.

Presence of strong, legally binding alcohol policies is key as they not only contribute to effective alcohol control but also serve to mitigate the

influence of alcohol industry lobbying—a concern that plagues many African countries where robust policies are often lacking.

I want to extend my appreciation to everyone contributing to the discussion on Alcohol Use Disorders. Your insights and perspectives enrich our understanding of this complex issue and pave the way for meaningful dialogue and collective action.

Kind regards,

Enock

HIFA profile: Enock Musungwini is a distinguished public health professional, health management consultant, and development practitioner currently serving as a Programme Manager (Consultant) for an NGO called Pangaea Zimbabwe under the Wild4Life Health program responsible for program management, oversight, supervision, coordination, and leadership. He holds an MSc in Public Health with a Research award from the London School of Hygiene and Tropical Medicine (LSHTM), achieved under the prestigious British Chevening scholarship (2018-19 cohort). His educational background also includes a Master's in Business Administration, BSc Hons in Psychology, Diploma in Nursing Science, Diploma in Public Relations and Communication, and a Postgraduate Certificate in Health Management and Leadership. Enock actively serve as a Reference Group Committee member for the Africa Evidence Network, Steering Committee member for the International Network for Government Science Advice Africa Chapter, member of the Consortium for Universities of Global Health and Country Representative for Healthcare Information for All (HIFA).

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Alcohol Use Disorders (79) The role of the alcohol industry (10) Alcohol industry and misinformation

22 February, 2024

There are many online alcohol checks where any person can enter how much alcohol they drink, and then they are given health advice on that basis.

Two of the main checks available in the UK are Unit Calculator (by AlcoholChangeUK recommended by the National Health Service) and Drinking Check (by DrinkAware, funded by the alcohol industry)

I have just done an experiment to see what advice each tool would give me, for the same level of alcohol intake. For the test, I indicated an alcohol intake of 1 large glass of wine (250ml) every day, equivalent to 21 units per week. The NHS recommends that men and women should not drink more than 14 units per week.

The difference in the advice given is *shocking*.

1. AlcoholChangeUK: "Watch out! You are drinking at levels that could put your health at risk and you would benefit from cutting down"

2. DrinkAware: "Great news! You are at lower risk of alcohol-related problems. This means you are at lower risk of serious diseases such as stroke, heart and liver disease, and seven types of cancer and may already be noticing the benefits of lower risk drinking such as deeper sleep, more energy and brighter moods."

DrinkAware claims to 'support you with the advice and information you need'. And yet it is clear from this experiment that DrinkAware, which is very widely used across the UK, is providing inappropriate reassurance to people who are drinking unsafe amounts of alcohol.

The source of this misinformation is clear: DrinkAware is funded largely by the alcohol industry.

As Eduardo and others have said, the alcohol industry wants people to drink more alcohol so they can make more profits. In fact, in the UK a staggering 40% of adults drink more than 14 units per week. These are the main source of profit for the alcohol industry and we now see that they are being inappropriately advised to carry on drinking as they are!

And it gets worse! Let's say I drink 2 glasses of wine every day, equivalent to 42 units per week.

1. AlcoholChangeUK says: "Drinking at this level is likely to be harming your health. You may wish to speak to your GP or an alcohol professional to look at your options for taking back control of your drinking."

2. DrinkAware says again: "Great news! You are at lower risk of alcohol-related problems."

Something is *very* wrong here.

I noticed another big difference between the AlcoholChangeUK and the DrinkAware test. The former focuses on number of units of alcohol, whereas the latter also asks 7 questions such as "How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?". None of the questions would be answered in the affirmative unless someone had a very serious alcohol dependence. In my opinion, these questions were deliberately designed by the alcohol industry so that the majority of respondents would say "No" to each one and thereby feel reassured and motivated to carry on drinking 14-42 (or more) units per week.

DrinkAware's own website claims to be reliable: 'An independent review' concluded: 'No evidence was found within the 50 pages reviewed that the Drinkaware website is intentionally misleading the public. When compared to similar types of site, the content on the Drinkaware website was found to be of similar level of accuracy and well-tailored to the 'general public' audience at which it is aimed.'

I do the experiment a third time. Let's try *3* large glasses of wine (=1 whole bottle of wine every day), equivalent to 63 units per week.

1. AlcoholChangeUK says: "Drinking at this level is likely to be harming your health. You may wish to speak to your GP or an alcohol professional to look at your options for taking back control of your drinking."

2. DrinkAware: "Ready to make a change? You are at increasing risk of alcohol-related problems"

It seems that Drinkaware only advises change when the alcohol consumption is very dangerously high.

I would welcome other HIFA members to replicate my findings:

<https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calcul...>

<https://www.drinkaware.co.uk/tools/drinking-check#/>

What tools are available for the public in other countries? What advice do they give for people who are consuming much higher quantities of alcohol than is safe (eg 21, 42, 63 units per week)?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (80) Alcohol consumption in Nigeria (2)

22 February, 2024

I searched 'What advice are people who consume or are planning to start consuming alcohol in Nigeria given?', and here are some of the results that popped up, most of them very disturbing:

i) 'Solution to drinking problems. The current lack of alcohol policies in Nigeria only serves the interests of alcohol producers to the detriment of public health. Even though alcohol is a...'

ii) 'World Health Organization (WHO) say di use of alcohol don reduce for Africa and Europe. Di...' <http://www.bbc.com> > pidgin > articles

iii) 'Are young Nigerians drinking too much alcohol? Many young people in Western countries are abstaining from alcohol consumption, but their Nigerian counterparts are adopting lifestyles that valorize alcohol use and heavy drinking rituals. This study explored heavy drinking practices and alcohol-related harms among young Nigerians (students and nonstudents) who use alcohol.'

iv) 'Is alcohol the most commonly used drug in Nigeria? It has been reported that alcohol is the most commonly used drug in Nigeria characterized by "heavy episodic drinking". Alcohol consumption by females in Nigeria has been on the increase and this has been associated with civilization, globalization and the expansion of women's liberation in the country.

v) 'Is alcohol control a low priority in Nigeria? This is a fall-out of the low priority for alcohol control in Nigeria, unless the issue of poor government funding is addressed strongly and consistently, the possibility of the alcohol policy gaining the required thrust is doubtful. This should be an issue on the agenda at global and national meetings on alcohol control'.

vi) 'Alcohol is a common feature in social ceremonies in Nigeria, with heavy episodic drinking (HED) as the preferred pattern of consumption. Among drinkers ages 15-19 years, 60.3% report engaging in HED, consuming at least 60 g or more of pure alcohol on at least one occasion in the past 30 days (World Health Organization [WHO], 2018).'

vii) 'Many young people in Western countries are abstaining from alcohol consumption, but their Nigerian counterparts are adopting lifestyles that valorize alcohol use and heavy drinking rituals. This study explored heavy drinking practices and alcohol-related harms among young Nigerians (students and nonstudents) who use alcohol.'

These extracts are troubling or should be for Public Health authorities in Nigeria. The Government may be suffering the effect of 'penny wise, pound foolish', as it proudly announces the increased revenue from taxing alcohol producers and sellers but fails to directly fight the root causes of and health damage to the population of the increasing alcohol misuse in the country.

It may be a good idea for HIFA, using its country representatives especially in LLMICs like Nigeria, to increase the decibel on its advocacy in countries on this topic (universal access to accurate information on alcohol use).

Joseph Ana.

HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for P-ACK Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-

IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which also suitable for lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicom & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member, National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the Working Group on HIFA-WHO Collaboration (<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

Alcohol Use Disorders (81) The role of the alcohol industry (11) Alcohol industry and misinformation (2)

23 February, 2024

Dear HIFA colleagues,

[DrinkAware]

I completed their Drinking Check as if I drank two large (250ml) glasses of wine every day.

Their response was: "Great news! You are at lower risk of alcohol-related problems. This means you are at lower risk of serious diseases such as stroke, heart and liver disease, and seven types of cancer and may already be noticing the benefits of lower risk drinking such as deeper sleep, more energy and brighter moods."

I describe my findings in full here:

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-79-role-alcohol-i...>

Two large glasses of wine every day is seriously heavy drinking. It is the equivalent of 42 units per week, when the UK Government recommends that a person should not drink more than 14 units per week.

I have just done the test again - 2 large glasses of wine per day - and got the same astounding result: "Great news! You are at lower risk of alcohol-related problems."

I find this really shocking, don't you?

To see if this is reported elsewhere, I searched on "Drinkaware encourages heavy drinkers to continue drinking" and I was unable to find anything on the subject.

I learned that DrinkAware prides itself in saying "In 2021, 250,991 people completed the Drinkaware Self-Assessment Tool" and it has 'since been shortlisted for an award in the 2022 European Search Awards' (!)

PLEASE DO THE TEST YOURSELF AND REPORT BACK

I invite all HIFA members to try the test yourself:

<https://www.drinkaware.co.uk/tools/drinking-check#/>

Please let us know what you entered, and the result. If it corresponds to the result I am getting, we need to bring this to the attention of the media to protect potentially millions of people who are currently being misinformed.

With thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (82) The role of the alcohol industry (12) Impact of alcohol industry on policy

23 February, 2024

Alcohol industry attempts to influence alcohol policies, evidence from research and Zimbabwean experience.

There is some evidence of the pervasive influence of the alcohol industry on regulatory decisions. Even in Africa, concerns are mounting about the undue sway that alcohol corporations wield in shaping public health policies. The alcohol industry has vast resources and powerful lobbying machinery which they use to influence policymakers (Governments) to enact regulations that align with their business interests. The alcohol industry lobbying includes advocating for lenient advertising restrictions, resisting measures aimed at curbing alcohol consumption and influencing policy discussions agenda. The industry enters strategic alliances, make financial contributions, use of celebrities to promote alcohol, sponsorship deals with sports, and use sophisticated marketing campaigns to shape the narrative around alcohol use and minimize the implementation of stringent regulations like WHO Best buys. The industry leverage on their economic clout and political connections to sway policymakers in their favor.

Evidence from selected publications highlighting the attempts by the alcohol industry to influence alcohol policies in different settings including the UK.

McCambridge, J., Mialon, M., and Hawkins, B. (2018) Alcohol industry involvement in policymaking: a systematic review. *Addiction*, 113: 1571-1584

Ferreira-Borges C, Esser MB, Dias S, Babor T, Parry CD. Alcohol Control Policies in 46 African Countries: Opportunities for Improvement. *Alcohol Alcohol*. 2015 Jul;50(4):470-6.

Sama TB, Hiilamo H. Alcohol industry strategies to influence the reform of the Finnish Alcohol Law. *Nordic Studies on Alcohol and Drugs*. 2019;36(6):556-568.

Barlow P, Gleeson D, O'Brien P, Labonte R. Industry influence over global alcohol policies via the World Trade Organization: a qualitative analysis of discussions on alcohol health warning labelling, 2010-19. *Lancet Glob Health*. 2022 Mar;10(3):e429-e437.

The Zimbabwean picture

A study done by the author as part of MSc Public health at London School of Hygiene and Tropical (2019) showed that there is no legally binding National Alcohol Policy, and the industry is regulated by various legal instruments under different organisations. The Zimbabwe national alcohol policy making process started in 2008, first draft was completed in 2009 and final draft completed in 2010 (WHO, 2010). The draft policy is not legally binding. The policy making process was dominated by alcohol industry players with 19 out of 45 (42%) stakeholders involved (actors) in the Zimbabwe National Alcohol policy making being linked to the Alcohol industry (Zimbabwe National Alcohol Policy, 2010).

It is imperative for policymakers, public health advocates, and concerned citizens to remain vigilant against the undue influence of the alcohol industry. By advocating for evidence-based policies, promoting transparency in decision-making processes, and raising awareness about the tactics employed by the industry, we can safeguard public health interests.

Stay informed, stay engaged, and join the conversation on alcohol use disorders!

Enock Musungwini, Zimbabwe

HIFA profile: Enock Musungwini is a distinguished public health professional, health management consultant, and development practitioner currently serving as a Programme Manager (Consultant) for an NGO called Pangaea Zimbabwe under the Wild4Life Health program responsible for program management, oversight, supervision, coordination, and leadership. He holds an MSc in Public Health with a Research award from the London School of Hygiene and Tropical Medicine (LSHTM), achieved under the prestigious British Chevening scholarship (2018-19 cohort). His educational background also includes a Master's in Business Administration, BSc Hons in Psychology, Diploma in Nursing Science, Diploma in Public Relations and Communication, and a Postgraduate Certificate in Health Management and Leadership. Enock actively serve as a Reference Group Committee member for the Africa Evidence Network, Steering Committee member for the International Network for Government Science Advice Africa Chapter, member of the Consortium for Universities of Global Health and Country Representative for Healthcare Information for All (HIFA).

Enock has received numerous accolades including being appointed Brand Ambassador and receiving the Growth and Innovation award for Pangaea Zimbabwe (June 2023), Country Representative of the Year by HIFA (April 2023), Chevening Volunteers Gold Award by the British Foreign and Commonwealth Office (June 2019), and the Zimbabwe Achievers Chairman's Award (Nov 2019). His academic excellence is reflected in awards such as the

Amanda Jacklyn Berger Prize for his MSc Research project by LSHTM (Feb 2020) and the Marie Stopes Clinics Champion Award (Jan 2017). Enock's dedication to personal development led to his nomination for Ten Outstanding Young Persons in Zimbabwe under the Personal Improvement Category by Junior Chamber International (Oct 2019). Enock Musungwini has made presentations at national, regional, and international conferences and contributed significantly to public health discourse through his blogs and opinion pieces on various topics.

Alcohol Use Disorders (83) The role of the alcohol industry (13) Alcohol industry and misinformation (3)

24 February, 2024

Yesterday I sent a message [URL below] to HIFA saying that a UK alcohol charity 'actually encourages heavy drinkers to continue drinking'. As described in the rest of the message, this observation was based on my test of their online drinking check tool, whereby I posed as if I were a drinker of two large glasses of wine daily. I withdraw the above comment and replace the wording with 'on the basis of my observation, appears to encourage heavy drinkers to continue drinking. This needs to be confirmed by others in case I have somehow made an error'. I do not yet have confirmation on this. I encourage HIFA members to do the test themselves and let us know the result.

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-81-role-alcohol-i...>

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (84) The role of the alcohol industry (14) Alcohol industry and misinformation (4)

24 February, 2024

Neil and HIFA Colleagues

Tried the test. Result same as yours. Shocking!

Geoff

HIFA profile: Geoff Royston is an Independent Health Analyst and Researcher, former Head of Strategic Analysis and Operational Research in the Department of Health for England, and Past President of the UK Operational Research Society. His work has focused on informing the design, implementation and evaluation of policies and programmes in health and social care, and on fostering the capabilities of others to work in these areas. Associated activities have included modelling for understanding the performance of complex systems, analysis and communication of risk, and horizon scanning and futures thinking. He has also worked on information and communication technology in the health sector, notably in leading the design and national launch of the telephone and online health information and advice service NHS Direct. He has served on both scientific and medical UK Research Council panels, and as an impact assessor for the UK higher education Research Excellence Framework. He is a member of the editorial board for the journal Health Care Management Science and in 2012 was Guest Editor for its special issue on Global Health. He has been a consultant for the World Health Organisation, is a long standing member of the EURO Working Group on Operational Research Applied to Health Services, and is an expert adviser to the mHIFA (mobile Healthcare Information for All) programme. <http://www.hifa.org/projects/mobile-hifa-mhifa> He is also a member of the main HIFA Steering Group and the HIFA working group on Evaluating the Impact of Healthcare Information.

<http://www.hifa.org/support/members/geoff>

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Alcohol Use Disorders (85) Disinformation is a public health crisis (2) Contradictory advice from professionals (3)

24 February, 2024

<https://www.aol.com/news/column-disinformation-public-health-crisis-1100...>

I would like to highlight one comment in this Los Angeles Times article, from Tara Kirk Sell of Johns Hopkins University's Center for Health Security:

"Public health needs to be transparent about the reasons why advice is changing," Sell says, "explaining that if you didn't change with new evidence, you would be doing a disservice to the public. Maybe we didn't do a good enough job in this pandemic in saying we're going to learn more, and our advice

may change. And we'll do our best to keep you as informed as possible as that advice changes."

This is relevant to the discussion we have been having in the past 2 weeks about the huge inconsistency of advice to the general public that is given by health professionals and health organisations.

The key problem, as highlighted by Richard Velleman, is that they assume a level of certainty or - at least - fail to communicate the uncertainty of the cumulative evidence.

This is an indictment of all such health professionals and organisations. By assuming certainty, or not communicating uncertainty, they are part of the problem rather than part of the solution.

How can we support health professionals to recognise uncertainty and to see the importance of communicating this to their patients and the general public?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (86)

25 February, 2024

This morning on Times Radio UK, Hugo Rifkind 1000-1300 from 10.58:30 UTC:

<https://www.thetimes.co.uk/radio/show/20240224-26978/2024-02-24>

- there was mention of research in Germany on language, finding that there are over 540 words for 'drunkenness' being drunk. Apparently, the key is adding -ed to many words.

https://www.research-in-germany.org/idw-news/en_US/2024/2/2024-02-19__l_...

This stood out for me as Hodges' model can potentially encompass the full corpus of a language, with the various contexts in which language is applied/used.

Significant of course informationally, in evidence-based practice, and research, were 'definition of terms' are (usually?) essential.

Also reminded of national variation in clinical/medical terminology. Scottish slang for injection includes 'jag'.

For health communication and HIFA, clearly language is fundamental and presents a real 'can of worms' (sorry!) in sense-making, creating 'noise' in the communication channels.

Should health services/systems effect a (gradual) change (shift) of emphasis to education and prevention - with the requisite policy support (utopic?) then this will need to be addressed.

In checking this news, it appears Germany has a more acute problem with alcohol. Can anyone 'local' - please shed any light on this?

I will post again about the HIFA discussion with a week left and highlight the above.

Many thanks

Peter Jones

Community Mental Health Nurse and Researcher
CMHT, Prescott House, Salford NW England, UK (Mon-Tues)
Blogging at "Welcome to the QUAD"
<http://hodges-model.blogspot.com/>
<http://twitter.com/h2cm>

HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges' model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>).
h2cmuk AT yahoo.co.uk

Alcohol Use Disorders (87) Do health workers have adequate knowledge? (7)

25 February, 2024

Health workers do not have adequate knowledge on alcohol use disorders since it is not considered as a medical condition.

Unfortunately health workers are victims of abusing alcohol due to pressure at work caused by staffing poorly paid income and poor working condition with no supply to perform there duties without improvisation.

HIFA profile: Jeniffer Yula Musyoka is a Nurse in Machakos County, Kenya. Professional interests: Nursing; Palliative care. Email: jeniffersomba15 AT gmail.com

Alcohol Use Disorders (88) Alcohol industry and misinformation (5)

25 February, 2024

I am getting further reports of people being misinformed by DrinkAware's Drinking Check tool.

I have tried the test again, entering that I drink 5-6 units of alcohol per day (which is seriously heavy drinking), and being told "Great news! You are at lower risk of alcohol-related problems"

We have established there is a big problem. What is the cause? It seems unbelievable that this is deliberate misinformation. I suspect there is an error in the software. If so, this has continued for at least 3 days, potentially misinforming up to 900 people per day who reportedly take the test.

I invite you to take the test yourself - enter 5-6 units per day and let us know the result.

The URL is:

<https://www.drinkaware.co.uk/tools/drinking-check#/>

The tool invites you to enter your (UK) postcode. To complete the test, you can enter the HIFA postcode OX7 3PN (O=letter 'o', not zero).

Share your findings and comments by email to: hifa@hifaforums.org

I look forward to resolving this with your help.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (89) Alcohol industry and misinformation (6)

25 February, 2024

Dear all,

After reading Neil's message, my very first reaction was indignation.

I even maintained that feeling after taking the Drinkaware test where I was supposed to be a consumer 4 or more times a week and 3 or 4 units of alcohol in a typical day. Marking "never" in the rest of the questions.

Because the final result, even though I could have consumed between 12 and 28 units in the week, it gave me a Lower Risk of alcohol-related problems.

But when I performed the AUDIT score, marking similar options, it gave me a result of 5 points, which implies a low risk, as the Drinkaware result.

Reflecting on the result I think that:

- I must emphasize that my answer was "fictitious", and although the number of weekly units of alcohol per week may exceed 14, and this in itself is "risky consumption",

- It is very likely that a person who "regularly" drinks 3 or 4 units of alcohol per day will not mark "never" in the rest of the questions. There is a good chance that a person with such a level of alcohol consumption may consume more units on some days, and therefore, must respond positively to one of the other answers that increase the score. This would easily make him reach 8, placing him in a higher risk situation.

The AUDIT score, which is the basis of Drinkaware, not only evaluates the amount consumed, but also other elements that together constitute the alcohol use disorder.

Therefore, there appears to be no significant difference between the results of Drinkaware and Audit.

However, it strikes me that "the UK's leading alcohol charity" acknowledges that it "works with the alcohol industry", when there is an inherent conflict of interest between the alcohol industry (whose primary interest is to increase sales and consumption) and that of public health (whose main interest is to reduce the damage caused by alcohol, and to do so they must necessarily reduce both consumption and sales)

What do other colleagues think about this?

Kind regards,

Eduardo

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco.

ebianco@nextgenu.org

Alcohol Use Disorders (90) Alcohol industry and misinformation (7)

25 February, 2024

Dear Eduardo and all,

"It is very likely that a person who "regularly" drinks 3 or 4 units of alcohol per day will not mark "never" in the rest of the questions. There is a good chance that a person with such a level of alcohol consumption may consume more units on some days, and therefore, must respond positively to one of the other answers that increase the score. This would easily make him reach 8, placing him in a higher risk situation."

I know a lot of people who drink 3 or 4 units of alcohol per day (or even more) and who would answer Never to the seven questions in the DrinkAware Drinking Check. These questions are only likely to be answered yes by someone who has a very serious drinking problem (ie more than 6 units per day). Here are the questions:

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

Have you or somebody else been injured as a result of your drinking?

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

How often during the last year have you had a feeling of guilt or remorse after drinking?

How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

How often during the last year have you failed to do what was normally expected from you because of your drinking?

How often during the last year have you found that you were not able to stop drinking once you had started?

I have done another test, again posing as a man who drinks 5-6 units per day (eg 2 large glasses of wine). This time I admitted to occasionally needing an alcoholic drink in the morning to get myself going after a heavy drinking session.

The result: "Great news! You are at lower risk of alcohol-related problems" (!)

This implies that if I drink 42 units a week (3X the maximum recommended by the UK National Health Service) and I occasionally need an alcoholic drink in the morning to get going, then I should celebrate that I am at lower risk of alcohol-related problems!?!??

Here's the link for the test in case anyone would like to confirm:

<https://www.drinkaware.co.uk/tools/drinking-check#>

If you are outside the UK, you will need to put in a recognisable UK postcode to get access (for example you can use the HIFA postcode: OX7 5PN)

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Alcohol Use Disorders (91) The role of the alcohol industry (15) The alcohol industry controls the narrative to undermine alcohol control policies

26 February, 2024

Dear friends,

I would like to introduce another topic in relation to the role of the alcohol industry in the alcohol problem.

The alcohol industry has understood the influence of narrative and has designed a strategy to control the conversation and influence what people think about alcohol consumption. (1)

Messages about responsible consumption are a central element of its corporate social responsibility (CSR) activities.

To do this, use terms like:

- Alcoholism, problem drinking and alcohol abuse, which are non-specific terms, describe excessive and harmful consumption of alcohol and suggest that alcohol is only a problem when consumed excessively. It has been shown that there is no minimum level of alcohol consumption that is free of health risk. (2)

- Drink responsibly. In this way, it focuses the responsibility of consumption on the individual, and removes that from the alcohol industry. This approach has not been effective in controlling alcohol consumption. Advertising and other marketing strategies strongly stimulate consumption and influence adolescents (who have not yet fully developed the brain capacity for self-control) and those adults who already have a dependent relationship with consumption, and cannot control it either.

The term “responsible drinking” is strategically ambiguous, and allows for multiple interpretations, given that it is not clearly defined in relation to a particular level of alcohol consumption. (3)

- Designated driver. It is another intervention encouraged by the industry with the intention of transmitting the message that drinking too much alcohol is not a problem, as long as a driver has abstained from drinking.

Large alcohol companies systematically use the terms “harmful use of alcohol”, “abuse”, “misuse” and “excessive use” and aggressively hold the “consumer” responsible for alcohol-related problems. (4)

The term “harmful use” per se does not convey the fact that there is no safe or healthy consumption of alcohol. At first glance, it communicates the idea that there is a “harmful” and a “normal” alcohol consumption.

This term does not illustrate that the primary cause of the global alcohol burden is the products and practices of the alcohol industry, but rather intuitively appears to focus on the consumer who consumes alcohol in harmful ways.

The term “harmful use”, which is included in the WHO Global Alcohol Strategy, is questioned by some, because it is a term that is not based on evidence, and that in reality, resulted from a political commitment to ensure that approve the strategy itself.

They see it as a victory for the big alcohol lobby in adopting the WHO's Global Alcohol Strategy, because they argue that the term is a key strategy for

promoting ambiguity about the alcohol harms and related regulatory solutions.
(4)

Big alcohol is trying to delay and derail a comprehensive understanding of the alcohol harms (health, social, economic and developmental) and in doing so question the effectiveness of the Best Buys in alcohol control policies, which are also elements key to the strategy.

The goal is to distract attention away from scientifically proven, cost-effective, high-impact policy solutions aimed at regulating the alcohol industry.

The power of industry interference to hinder evidence-based policies in alcohol regulation should not be underestimated.

References

1. <https://troublebrewingreport.org/the-alcohol-industry>
2. <https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-cons...>
3. <https://academic.oup.com/jpubhealth/article/40/1/90/3111234>
4. <https://movendi.ngo/blog/2021/03/17/exposed-the-strategies-big-alcohol-d...>

Dr. Eduardo Bianco

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco.

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Alcohol Use Disorders (92) The alcohol industry controls the narrative to undermine alcohol control policies (2) Q4 Do public health professionals and policymakers have adequate knowledge? (1)

26 February, 2024

Dear HIFA colleagues,

Welcome to week 4 of our deep-dive discussion. Thank you for all your 91 contributions to date. You can review them here: <https://www.hifa.org/rss-feeds/17>

Background information: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-alcohol-us...>

To contribute, send email to hifa@hifaforums.org

We now turn our attention to Question 4:

"Do public health professionals and policymakers have adequate knowledge to prevent and treat alcohol use disorders in their country? What are current national policies and what more can be done to fully implement those policies?"

Eduardo's latest message (Alcohol Use Disorders (91)) suggests that policymakers are manipulated by the alcohol industry. The implication is that policymakers are manipulable by the industry whether they (policymakers) have adequate knowledge or not. There is a matter of how easily the policymakers can be manipulated. If they (policymakers) have inadequate knowledge and understanding about the harms of alcohol (health, societal, environmental, economic...) then they *might* be more able to stand up to attempted manipulation. What do you think?

Adequate knowledge about alcohol among public health professionals and policymakers may be a prerequisite for evidence-informed policymaking, but knowledge alone is not sufficient. Even the architects of the WHO Global Alcohol Strategy - by definition the global experts on alcohol - were apparently manipulated by the industry, as indicated by Eduardo, who said:

'The term "harmful use", which is included in the WHO Global Alcohol Strategy, is questioned by some, because it is a term that is not based on evidence, and that in reality, resulted from *a political commitment to ensure that approve the strategy itself* [my emphasis]. They see it as a victory for the big alcohol lobby in adopting the WHO's Global Alcohol Strategy, because they argue that the term is a key strategy for promoting ambiguity about the alcohol harms and related regulatory solutions. (4)'

Looking at reference 4, I was shocked to see how much pervasive influence the alcohol industry has had in the development of WHO's Global Alcohol Strategy.

[4] refers to a news article. The author notes: 'In addition to the concept of "harmful use of alcohol" this paragraph of giving the alcohol industry any role in tackling alcohol harm is the second big flaw of the Global Alcohol Strategy. The alcohol industry, exactly like the tobacco industry, should be kept at bay from any engagement with WHO and from any role whatsoever in implementing the WHO Global Alcohol Strategy.'

<https://movendi.ngo/blog/2021/03/17/exposed-the-strategies-big-alcohol-d...>

The article describes how the alcohol industry wants to be seen as a partner and being part of the solution (while at the same time resisting any policy or legislative changes that might reduce consumption).

The WHO Global Action Plan itself can be downloaded from the WHO website:

<https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-...>

Curiously, despite being dated 2022, the only version I could find was a 'pre-print copy'. Can anyone find the final version?

We look forward to learn more about the role of the alcohol industry in manipulating global, national and local policy.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (93) Alcohol industry and misinformation (8)

26 February, 2024

Hello Neil,

I did the test and below is my result according to the 'audit-check': I entered: drinking 5-6 units per day, with no bingeing, and no symptoms of addiction/dependence :

'Your result: Lower risk

You've successfully completed the Self-assessment test to understand more about your drinking. Find out more about your result.

Great news! You are at lower risk of alcohol-related problems

This means you are at lower risk of serious diseases such as stroke, heart and liver disease, and seven types of cancer and may already be noticing the benefits of lower risk drinking such as deeper sleep, more energy and brighter moods.'

Joseph Ana

HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for PACE Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which is suitable for lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicom & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member, National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the Working Group on HIFA-WHO Collaboration
(<http://www.hifa.org/support/members/joseph-0>)

<http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

Alcohol Use Disorders (94) Do people understand the harms of alcohol? (17)

26 February, 2024

Dear Joseph,

Although I also continue thinking that the public health message is very important to adequately inform the population and policy makers about the risks of certain products, I painfully learned that only increasing people's knowledge: does not enough.

I used to think like you, but many decades of experience in tobacco control have made me see that no matter how much public health efforts were made, it was not possible to counteract the influence of the tobacco industry on consumers and society just with education. It was necessary to counteract the tobacco industry strategies to influence consumers and the society as a whole.

That industry, like the alcohol industry currently does, spares no effort and resources, through advertising, promotion and sponsorship of its products, lobbying governments, hiring health professionals and financing biased research for their misinformation campaigns, and even threatening governments with litigations to counteract public health efforts.

It is true (and legal) what you say that every industry seeks to "paint a good image of its products for more profit", but when it comes to large multinationals with enormous economic resources that, through hiring excellent and expensive marketing teams, generate marketing campaigns. misinformation and deception, against which the vast majority of countries cannot compete due to lack of resources and technical capabilities, that is an abuse of power.

In short, healthcare professionals must continue to inform the public, not only on the harmful effects of alcohol consumption, but also on the practices of global industries to prevent the public health message from having an impact.

Kind regards,

Dr. Eduardo Bianco
Director, Addiction Training Program for Health Professionals (ATHP)
Email: ebianco@nextgenu.org
Web: NextGenU.org

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of

Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco.
ebianco@nextgenu.org

Alcohol Use Disorders (95) The alcohol industry controls the narrative to undermine alcohol control policies (3)

26 February, 2024

Dear Eduardo,

Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-71-what-role-alco...>

You said:

"Therefore, there cannot be a "meeting point" between both parties; measures and strategies that are effective for public health harm the alcohol industry. Measures that are effective for the alcohol industry's objectives harm public health."

and

"For all these reasons, the former director general of the WHO, Margaret Chan, in 2013, expressed: "The alcohol industry cannot sit at the table or have a voice when the WHO defines its standards and preventive strategies, and cannot supplant the role of the government in formulating policies for alcohol control."

Earlier today I sent a message that referenced the influence of the alcohol industry on the WHO Global Alcohol Action Plan, suggesting that in the past 10 years the alcohol industry is now indeed sitting at the table:

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-92-alcohol-indust...>

There are a lot of reasons that the alcohol industry should not have a role in global policy. Are there any reasons why they should be given a voice?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (96) The role of the alcohol industry (16) Alcohol consumption in different countries (3)

26 February, 2024

What countries have the highest alcohol consumption? Here they are:

1. Latvia 13.19 (litres of pure alcohol per capita per year)
2. Moldova 12.85
3. Germany 12.79
4. Lithuania 12.78
5. Ireland 12.75
6. Spain 12.67
7. Uganda 12.48
8. Bulgaria 12.46
9. Luxembourg 12.45
- 10 Romania 12.34

Ref: <https://worldpopulationreview.com/country-rankings/alcohol-consumption-b...>

All of these countries are in Europe with the exception of Uganda.

Can anyone comment on why these countries have such high consumption? What is the role of the alcohol industry? Is legislation inadequate or poorly enforced? Is there insufficient taxation on alcohol? Do the populations of these countries have an especially low understanding of the harms of alcohol?

Why does Uganda, in particular, have such a high consumption?

I invite all HIFA members to have a look at the table, which gives figures for every country (even North Korea) and comment on the situation in their country.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare

information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (97) Please retweet

27 February, 2024

Dear HIFA colleagues,

I would like to invite you to retweet the following that I have just sent on our X/Twitter account:

"Pls RT: I just took the DrinkAware test as if I drank 3 pints a day (well over the recommended limit). The result was "Great news! You are at lower risk of alcohol-related problems". We invite others to check. Thx NPW

<https://www.drinkaware.co.uk/tools/drinking-check#/> "

You can see the tweet and retweet here:

https://twitter.com/hifa_org/status/1762399130154885617

We are unsure why the test - which is taken by 900 people every day - is providing such misinformation.

DrinkAware is funded by the alcohol industry.

Thank you for your help to publicise this issue.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (98) Please retweet (2)

27 February, 2024

RT'd as requested.. [*see note below]

Reply from twitter ...

This evergreen article was written 10 years ago

"Be aware of @Drinkaware "

ncbi.nlm.nih.gov/pmc/articles/P... via @peter_g_miller et al

Full link...

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3992896/>

Peter Jones

Wigan

NW England

Community Mental Health Nurse and Researcher

CMHT, Prescott House, Salford NW England, UK (Mon-Tues)

Blogging at "Welcome to the QUAD"

<http://hodges-model.blogspot.com/>

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HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges' model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>).

h2cmuk AT yahoo.co.uk

[*Note from HIFA moderator (NPW): Thanks Peter, I invite everybody to retweet: https://twitter.com/hifa_org/status/1762399130154885617 Thanks]

Alcohol Use Disorders (99) Do health workers have adequate knowledge? (8)

27 February, 2024

Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-87-do-health-work...>

Dear Jeniffer,

You made an important observation: "Health workers do not have adequate knowledge on alcohol use disorders since it is not considered as a medical condition"

Please can you say a bit more about this in your context (Kenya)?

The implication is that some health workers do not see it as their responsibility to prevent or manage Alcohol Use Disorders. Is that the case? Can you give any examples of how this looks in practice?

Health workers clearly have an important role to play in the prevention and management of AUD. What do they do (or fail to do) when they have a patient with obvious AUD?

And what treatment is available for people with very severe AUD?

It would also be valuable to learn what care is provided for AUD by different cadres of primary health worker (eg CHWs, nurses, doctors), and by staff in a district or national hospital?

What can be done to improve health worker attitudes (and therefore care for) patients with AUD? What can be done to help students recognise AUD as a medical disorder during training?

Is it possible to change the mindset of health workers who are already established? How?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (100) Alcohol industry and misinformation (9) A call to action

27 February, 2024

Dear Eduardo and colleagues,

You said: "But when I performed the AUDIT score, marking similar options, it gave me a result of 5 points, which implies a low risk, as the Drinkaware result."

Yes, I confirmed this also.

According to DrinkAware, if I enter 3 pints of beer per day (42 units per week), then I get the response: "Great news! You are at lower risk of alcohol-related problems"

And according to AUDIT, if I enter 3 pints of beer per day, I get this response: "Your score is 6 and places you in the low risk category for alcohol problems."

Congratulations on this... ensuring it [your consumption] remains within the low risk range represents a great investment for your future."

Neither the DrinkAware test nor the AUDIT test advise you to reduce your intake. In fact the AUDIT test advises you to 'ensure your consumption remains within the low risk range'. In other words, carry on drinking 3 pints of beer a day!

The corresponding links are:

<https://www.drinkaware.co.uk/tools/drinking-check#>

<https://auditscreen.org/check-your-drinking/?num=19&num=19>

42 units of alcohol per week is defined as very heavy drinking by most authorities.

For example the (anachronistically named) US National Institute on Alcoholism and Alcohol Abuse defines heavy drinking as more than 15 units per week. And the UK National Health Service advises people not to drink more than 14 units per week. So our fictitious drinker is drinking 3X more than the recommended maximum.

When we first started to discuss this, I assumed that perhaps there was a temporary fault with the DrinkAware software. But no, I am shocked to learn this is not a fault, it is REAL deliberate advice. People who drink three times the recommended amount of alcohol are advised to celebrate and carry on, without even a hint of encouragement to cut down, and without any guidance on the fact that 42 units of alcohol per week is associated with an increased risk of cardiovascular disease and cancer. The alcohol industry must be laughing all the way to the bank, gleefully adding to their \$1 trillion global turnover.

From where I see it, this is a gross case of misinformation. If you drink 42 units a week and you consult an online tool to check your drinking, then you should be told that your level of drinking is defined as 'heavy drinking', you should be told that you are at risk of cardiovascular disease and cancer, you should be advised to cut down. You should not be advised to celebrate and carry on.

These tests are used by thousands of people every day. Over a year, hundreds of thousands of people are probably being misinformed.

How on earth could public health professionals in the US and the UK have approved a tool that is so misleading?

Call to action: I invite HIFA colleagues to join me in calling for an urgent review of online drinking checks like DrinkAware and AUDIT. Currently they are surely not fit for purpose.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (101) Alcohol industry and misinformation (10)

27 February, 2024

Hi Neil,

Following your request the other day I had a go at completing the Drinkaware test. <https://www.drinkaware.co.uk/tools/drinking-check#/>

I tried it on my phone and on my laptop. I don't drink, so made up personal details and followed your suggestions.

On my first attempt the "traffic light" system said "lower risk" on both phone AND laptop. HOWEVER, the additional text that accompanied it on my phone said POSSIBLE DEPENDENCE. This made me think there might be a serious technical glitch rather than deliberate misinformation.

Therefore I tried again a little more systematically. I couldn't reproduce the issue of a different result on the phone vs laptop. In all cases I got 6 points and was categorised as lower risk - below is the summary of my exploration.

My answers (for the sake of testing the survey):

- How often do you have a drink containing alcohol? 4 or more times/week
- How many units of alcohol do you drink on a typical day when you are drinking? 5- 6 U/day
- All remaining questions - never

As I said above, I got the same result in each case:

Iphone 13 promax/chrome:

1. Age 21, female

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

2. Age 21, male

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

3. Age 60, female

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

4. Age 60, male

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

Laptop/windows 365/chrome

5. Age 21, female

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

6. Age 21, male

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

7. Age 60, female

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

8. Age 60, male

- Traffic light system: 6 points, green, lower risk
- Your result, additional text: relates to lower risk

It will be interesting to see what others find and to learn if this is a glitch, misinformation or the actual recommendations.

Best wishes

Julie

HIFA profile: Julie N Reza is a UK-based specialist in communications for biosciences, global health & international development (www.globalbiomedia.co.uk). She predominantly works with NGOs and not-for-profit organisations. Previously she was the senior science editor at TDR, based at the World Health Organization (WHO) in Geneva; prior to this she worked at the Wellcome Trust, UK, leading educational projects on international health topics including trypanosomiasis and trachoma. She has a PhD in immunology and a specialist degree in science communication. She also has several years research and postgraduate teaching experience. She is a member of the HIFA Steering Group and HIFA Social Media Working Group. www.hifa.org/people/steering-group www.hifa.org/people/social-media
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Alcohol Use Disorders (102) Alcohol industry and misinformation (11)

27 February, 2024

Thanks for surfacing this, Neil. I wonder what protocol the test is based upon? Since this test is open to the public, it should be based on public health recommendations and not on a protocol used by healthcare professionals to diagnose a substance use disorder. There is a big difference in tools or advice meant for the general public and a protocol used by physicians to diagnose a substance use disorder.

HIFA profile: Miriam Chickering, RN, is the CEO of NextGenU.org and the Founder of Nurses International. Mrs. Chickering specializes in globally scaled solutions for healthcare and education. The programs she directs have and continue to make a lasting impact worldwide: NextGenU.org provides learning materials through 300 universities, Nurses International creates critically needed learning materials for nurses in 147 countries, HumanitarianU.org has trained over 30,000 humanitarians globally, and Public Health U trains 140 Masters-Level Public Health students each year from 50 countries. Mrs. Chickering received the 2021 Humanitarian Service Award for Transformative Global Leadership in Democratizing Education from NHSD/Humanitarian Pakistan and was a co-recipient of a 2021 award for Translating Science into Nursing Education from Sigma Theta Tau. [mchickering AT nextgenu.org](mailto:mchickering@nextgenu.org)
<https://www.hifa.org/support/members/miriam-0>

Alcohol Use Disorders (103) Alcohol industry and misinformation (12)

27 February, 2024

Miriam asks: "I wonder what protocol the test is based upon? Since this test is open to the public, it should be based on public health recommendations and not on a protocol used by healthcare professionals to diagnose a substance use disorder. There is a big difference in tools or advice meant for the general public and a protocol used by physicians to diagnose a substance use disorder."

Thank you, I think we are getting to the nub of the issue and it is shocking.

The DrinkAware test is described as 'an alcohol self-assessment that can help you identify if the amount you drink could be putting your health at serious risk. We use a tool developed by the WHO, called 'AUDIT', that is used internationally by medical professionals to check for alcohol harm, including dependence'.

Whatever AUDIT is meant for, it is clearly NOT an appropriate tool for self-assessment. This is clear because we have seen that the tool congratulates people who drink more than the recommended level of alcohol per week (14-42 units per week), without indicating that such levels of consumption may be harmful.

It seems obvious to me that the result of a public self-assessment tool used by someone who drinks 42 units a week should *not* congratulate that person and encourage them to carry on (as DrinkAware clearly does). It *should* warn the person that this level of alcohol consumption is, by definition, heavy drinking and carries long-term risks in terms of cardiovascular disease and cancer. The result *should* also emphasise that the recommended maximum level of consumption is 14 units, and that an intake of 42 units is 3X the recommended maximum intake.

This is blatant misuse of a tool that should be used for clinical evaluation for Alcohol Use Disorders, and not for self-evaluation.

Hundreds of thousands of people self-assess their alcohol intake with DrinkAware every year. Many of them are drinking 14-42 units per week, and are being told "Good news, carry on!".

The winner in all this is the alcohol industry; the loser is the very large numbers of individuals who are being misinformed and encouraged to continue heavy drinking, predisposing them to cardiovascular disease, cancer and other serious health consequences, increased risk of harm to others, and all the other harms of alcohol that we have discussed: societal, economic, environmental...

This appears to be misinformation on an industrial scale.

Call to action: It seems to me that we need an urgent review of online self-evaluation drinking checks like DrinkAware. Currently they are not fit for purpose. What do you think? Email: hifa@hifaforums.org

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (104) Do people understand the harms of alcohol? (18)

27 February, 2024

Dear All,

The discussion, points, angles, questions ... are coming thick and fast it is difficult to keep up.

Many thanks for the summaries; and of course the discussion which archived also acts as a resource - repository.

I wonder whether the question: "Do people understand the harms of alcohol?" must always be placed in context?

It is radically different when asked of the tee-total, dry, safe drinker; and someone (still) actually in their alcohol drinking?

It occurs to me that alcohol, even more so than 'other' substance misuse (heroin...) represents what must be *the* contradiction, paradox in healthcare - except the tragic loss that is suicide.

Contrast substance misuse inc. alcohol, with 'help-seeking' and 'The Sick role'

<https://www.england.nhs.uk/blog/ed-mitchell-2/>

Decision to consult and how in mental health, the mental capacity act is actually being misapplied (policy-drift):

<https://www.lawsociety.org.uk/topics/blogs/are-mental-health-and-capacit...>

<https://www.communitycare.co.uk/2017/08/23/flawed-use-mental-capacity-ac...>

Previously, I highlighted how as a Community Psychiatric Nurse 1985-1995 (adult) .. if a patient/client was not working to control/reduce their alcohol consumption they may be 'counselled' re a pending discharge and referral back to their GP - family physician. In supervision with the team's manager they would want to know what is 'happening'. It being important not to create (social) dependency, or worse support someone in their alcohol misuse.

There was a sense, still is(?) that in substance misuse (across forms) - the individual has to reach 'rock-bottom', literally the 'gutter' that is the point they decide (really?)* to live, or carry on to die.

Is this is trope/myth?

<https://www.imdb.com/title/tt0048347/>

What is the current strategy?

In terms of 'HIFA' - and the person that counts*, not only do they not have the 'information'; they do not have the EXISTENTIAL INFORMATION as it relates to them: 'Health Information for YOU'!

-----Again in Hodges' model we can contrast the dichotomy/polarisation of INDIVIDUAL :: GROUP.

The model's being situated; and able to encompass data, information, knowledge (facts, for example, and their delivery) - wisdom (Multi-contextual / transdisciplinary..).-----

I admire people who work in these services (learning disability and palliative care); as they must be severely tested as they retain an ability - the humanity to 'see' the person whatever the patient's situation and their lack of awareness (capacity..?) of its critical salience.

(RTs greatly appreciated here too TY.)

Peter Jones

Community Mental Health Nurse and Researcher Blogging at "Welcome to the QUAD"

<http://hodges-model.blogspot.com/>

<http://twitter.com/h2cm> h2cmng at yahoo.co.uk

HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges' model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>).
h2cmuk AT yahoo.co.uk

Alcohol Use Disorders (105) Do health workers have adequate knowledge? (9)

28 February, 2024

The extent to which health workers see it as their responsibility to prevent or manage Alcohol Use Disorders would depend on their context. For instance, if

their training curriculums cover how to prevent, screen for or manage Alcohol Use Disorders, if guidelines on Alcohol Use Disorders are disseminated to guide those practising, and if there is clarity on when and where they can refer patients who need help. It is possible to change the mindset of already established health workers but this will need to be approached through various channels including making changes to policies, training curriculums and funding.

HIFA profile: Oluwakemi Akagwu is a public health physician and researcher who has worked on several public health projects aimed at optimizing reproductive, maternal and child health outcomes through enhanced population practice of positive health behaviors including utilization of health services and supporting health care workers to provide quality care. Her research interests include digital health interventions and understanding/addressing how social determinants of health, service provider behavior and patient experience of care influence population health outcomes. At present, she is undertaking research focused on enhancing a digital intervention model to reduce the harm caused by alcohol consumption before and during pregnancy at the University of Surrey. She is a member of the HIFA working group on Alcohol Use Disorders.
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Alcohol Use Disorders (106) Alcohol industry and misinformation (13)

28 February, 2024

Dear HIFA colleagues,

We have noted that DrinkAware, the leading alcohol charity in the UK, funded by the alcohol industry, appears to be encouraging heavy drinkers (42 units per week) to continue drinking heavily.

I have identified another self-evaluation website (whose financial support is not revealed) that does the same: www.auditscreen.org

Like DrinkAware, Auditscreen is based on the AUDIT tool.

Like DrinkAware, if I enter that I drink 42 units per week, the result is: "Your score is 6 and places you in the low risk category for alcohol problems. Congratulations"

This is clearly misinformation, and it is likely that huge numbers of people are being misinformed.

The same is true of a third site, Alcohol Change UK:

<https://alcoholchange.org.uk/> - I enter that I drink 42 units per week and am reassured this is fine: "Drinking at this level means that you are unlikely to be

putting yourself at risk of alcohol-related harm." Unlike DrinkAware, Alcohol Change UK is not funded by the alcohol industry.

Compare the above with a personal health check. If I said to my doctor that I am drinking 42 units a week, s/he would rightly remind me that the recommended upper limit is 14 units per week. They would tell me rightly that 42 units is defined as 'heavy drinking' and that this level of consumption will predispose me to cardiovascular disease, cancer and many other medical conditions. The doctor would strongly encourage me to reduce my alcohol intake.

Incidentally while considering 'what my doctor would say' I searched on "rapid advice to reduce alcohol intake" and I could not find it. I had assumed there was a package of agreed "rapid advice" that all health workers should apply, but I found there is a plethora of sites that give a multitude of different suggestions. Very confusing. I'm sure someone will be able to point us to the official consensus advice, but it's notable that I had such difficulty. The implication is that any health worker who had heard about rapid advice, like me, and wanted to check about it, would have difficulty in finding the information.

Please keep your contributions coming: hifa@hifaforums.org

Meanwhile, we encourage also your contributions on this week's focus question: Q4. Do public health professionals and policymakers have adequate knowledge to prevent and treat alcohol use disorders in their country? What are current national policies and what more can be done to fully implement those policies?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (107) Alcohol industry and misinformation (14) DrinkAware

28 February, 2024

I wish to thank Neil again for having "triggered" that exchange about Drinkaware's results, because it has forced us to review information and realize that "there is something wrong here."

My reflections come from the exchange we are having and a couple of excellent articles contributed by Ben Nicholls

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6217805/>)

and Peter Jones

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3992896/>), and are the following:

We started from doing an exercise, which from the beginning has “the bias” of being a fiction. As we showed up with a high alcohol consumption, and the rest of the answers we filled: never. Which is very unlikely to happen in the real world.

Anyway, I think we have identified a series of “errors”:

1. I begin by venturing to completely rule out “the technical error” in the Drinkaware results and advice.
2. The AUDIT is not a diagnostic tool but a rapid screening tool to be used in a clinical environment (along with other tools), and not at a population level.

Additionally, a diagnosis of alcohol use disorder requires the administration of a validated diagnostic interview, such as the Composite International Diagnostic Interview or evaluation by a trained specialist.

In our discussions we have mixed two different elements: the weekly alcohol consumption limit guide and the AUDIT that evaluates: Risky consumption, Dependence and Harmful consumption.

I want to remind you that to develop an instrument with international applicability, the creators of the AUDIT assumed that a standard drink contains 10 g. of alcohol.

The problem is that there is a divergence in standard drink sizes and recommended levels of low-risk consumption between countries, so the WHO AUDIT User Manual recommended that the AUDIT be adjusted to the alcohol content of the standard drink in the country in which it is used. Only with such an adjustment will the AUDIT total score accurately reflect the amount of alcohol consumed by the patient.

Ben's article (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6217805/>), describing the USAUDIT, suggests that most likely the classic WHO AUDIT should be revised. With which I agree.

Apparently, the USAUDIT would provide greater precision in measuring alcohol consumption than the AUDIT and would identify all alcohol consumption above recommended levels, with no false positives and only a few false negatives, so it would seem like an option more rational, and I think it would partially solve our discussion.

3. Drinkaware: So that everyone can draw their own conclusions, I want to dwell on Drinkaware, an institution that presents itself as the “main alcohol charity in the UK”.

The population and global use of the AUDIT tool, by Drinkaware, without properly taking into account the quantities consumed is a “gross error”. Firstly, because the AUDIT was not designed to be used at a “population” level but rather at a clinical level.

From what we saw in the exercise that many of us have carried out, Drinkaware also “forgot” to properly “highlight” the importance of the amount of weekly alcohol consumption, and only puts it in a “small symbol” in relation to the concept of “alcohol units”, which if the user does not click on it will not be clear what is being talked about when talking about units and what the limits are.

On the other hand, the results obtained with high alcohol consumption (42 units) and the resulting advice (low risk), constitute a scandalous way of misinforming the population.

The fact that the original AUDIT did not include the number of units of alcohol per week does not exempt Drinkaware, whose role is to “increase awareness of the risks/harms of alcohol”, from responsibility to provide “appropriate advice, based on scientific evidence”.

As Neil says: “it’s a serious case of misinformation.”

I was also annoyed that Drinkaware focuses only on “problem drinking” and “AUD”, leaving out the total amount of alcohol consumed per week. Which is key. The problem of alcohol is not only in “problematic and dependent consumers”, it is necessary to reduce the total amount consumed at the population level if we want to reduce the impact of alcohol on a health and social level.

Drinkaware approach is very much in line with the alcohol industry’s discourse: the problem is the “problematic consumer” not the amount of alcohol consumed per capita in each country.

Is Drinkaware “playing into the hands of the industry”? What information is there about it?

As I said before, Peter Jones has shared the following article:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3992896/> where it is clearly reported that Drinkaware is a tool of the alcohol industry:

In 2006, Drinkaware was established as a charity in the United Kingdom following a memorandum of understanding between the Portman Group and various UK government agencies. This debate piece briefly reviews the

international literature on industry social aspects organizations, examines the nature of Drinkaware's activities and considers how the public health community should respond.

Although the British addiction field and the wider public health community have distanced themselves from the Portman Group, they have not done so from Drinkaware, even though Drinkaware was devised by the Portman Group to serve industry interests.

Both long-standing and more recent developments indicate very high levels of industry influence on British alcohol policy, and Drinkaware provides one mechanism of influence.

We suggest that working with, and for, industry bodies such as Drinkaware helps disguise fundamental conflicts of interest and serves only to legitimize corporate efforts to promote partnership as a means of averting evidence-based alcohol policies. We invite vigorous debate on these internationally significant issues and propose that similar industry bodies should be carefully studied in other countries.

Therefore, two different types of actions would fit here:

In relation to AUDIT, I think it would be appropriate to have an exchange with the WHO to share with them what the HIFA Forum has identified and ask if they share our same concerns and if they are thinking about "updating" the AUDIT, as the US has done, and what would be the steps for it.

Regarding Drinkaware, I believe that we have to corroborate the evidence of the relationship with the alcohol industry and alert our audiences to avoid using this tool, because it is "misinforming" thousands of people, and putting their health and lives at risk.

What do you think?

Kind regards,

Dr. Eduardo Bianco

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and

tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco.

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DrinkAware (108)

28 February, 2024

Dear All

I agree with Eduardo's concerns about DrinkAware's use of the WHO AUDIT. It is not a diagnostic instrument and the scoring outside the UK should be adjusted to take into account differences among countries in standard drink sizes. I am cc-ing my colleague, John Higgins-Biddle, in case he wants to address some of the issues raised in the discussion.

If there is general agreement within the Forum that the AUDIT should be revised, perhaps we can reach out to WHO with some questions and a recommendation. We could ask WHO if DrinkAware ever asked for permission to use the AUDIT on their website, and whether they asked for WHO's opinion about the advice DrinkAware provides online. If the advice about a positive score was never reviewed by WHO experts, perhaps a direct letter to DrinkAware from WHO or from the Forum participants would be in order, asking them to make changes.

I would also like to know how many hits they get per month, what the average score is for people taking the test, etc.

Regards,

Tom Babor

HIFA profile: Thomas Babor is Emeritus Professor at the University of Connecticut School of Medicine, United States. Professional interests: Screening, diagnosis, early intervention, and treatment evaluation, as well as alcohol and drug policy; alcohol industry as an inducer of alcohol-related problems. babor AT uchc.edu

Alcohol Use Disorders (109) The role of the alcohol industry (17)

28 February, 2024

Regarding Eduardo's February 26 post about the alcohol industry [<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-91-role-alcohol->

i...], I am less concerned with the definitional issues on the WHO side than with the propaganda value of the “Responsible Drinking” concept on the industry side. Terminology at WHO and within the public health and psychiatric communities will continue to evolve to match the scientific evidence. Industry terminology is consistent with their corporate goals to generate more profit and to avoid mistakes that tarnish carefully crafted brand images. One thing the public health community could do to deal with terminology issues raised in the Forum is to co-opt the responsible drinking concept by defining it better in terms of lower risk drinking levels, explaining that risk begins with even small doses because of alcohol’s cumulative effects on many organ systems, and expand it to include responsible nondrinking. That brings me to the issue of NoLo alcohol products, which are gaining popularity in part because of the healthy lifestyle trend in a small but important part of the population in high and middle income countries. That trend was identified by the industry more than a decade ago, which led the big beer producers, as well as wine and spirits companies, to develop new product lines to prevent further erosion of their consumer base. Another part of that strategy was to use the healthy lifestyle trend to expand their product portfolio into “healthy alcohol” products and NoLo nonalcoholic drinks. The strategy had the added value of branding these products with well-known alcohol brand names to circumvent current or future marketing restrictions and to provide an opportunity to claim they are helping WHO to reduce global alcohol consumption, which is a way of using Corporate Social Responsibility as brand marketing.

We are now facing a situation where AB InBev, the world’s largest beer producer, has developed a partnership with the International Olympic Committee to allow them to promote a NoLo brand during the 2024 Summer Olympics. This is to be followed by promotions up to 2028 in subsequent Winter and Summer games of alcohol brands, one of which (Michelob Ultra) is targeted at athletes and exercise enthusiasts (see <https://apnews.com/article/olympics-ioc-beer-anheuser-busch-global-spons...>). This seems to contradict the IOC’s own stated policy to “not accept commercial associations with products that may conflict with or be considered inappropriate to the mission of the IOC or to the spirit of Olympism.” Because the Olympics are among the world’s largest media events, their advertising messages are likely to reach millions of children and young adults, as well as other vulnerable groups.

I would appreciate your thoughts about the potential risks (and benefits) of NoLo products in general, and of the IOC/AB InBev partnership deal in particular. Is it time for pushback from WHO and the international public health community?

Tom Babor

HIFA profile: Thomas Babor is Emeritus Professor at the University of Connecticut School of Medicine, United States. Professional interests: Screening, diagnosis, early intervention, and treatment evaluation, as well as alcohol and drug policy; alcohol industry as an inducer of alcohol-related problems. babor AT uchc.edu

Alcohol Use Disorders (110) The role of the alcohol industry (18) The alcohol industry controls the narrative to undermine alcohol control policies (4)

29 February, 2024

[Note from HIFA moderator: This was accidentally sent out in my name a few moments ago. I am sending it here in EDuardo's name, as intended]

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-95-alcohol-indust...>]

Dear Neil,

There can be no agreement between public health and the alcohol industry because the interests of both parties are frankly opposite.

Dr Chan is a professional who was given the responsibility of directing the WHO. As a technician and WHO-DG, her opinions had weight and influence when proposing options or suggesting instruments or measures, but the last word always lies with WHO- States Parties gathered at the World Health Assembly and on their own countries.

There is no reason for the Alcohol Industry to participate in the formulation of alcohol regulation policies, if the objective is to reduce the health and social problems linked to alcohol consumption.

The reasons why States do not regulate alcohol effectively would be several: the powerful lobby of the alcohol industry, the lack of knowledge of governments about the alcohol problem, the lack of knowledge and involvement of health professionals. health on the subject and corruption.

Kind regards,

Eduardo

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco AT nextgenu.org

Alcohol Use Disorders (111) Do health workers have adequate knowledge? (10)

29 February, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-105-do-health-wor...>]

I agree with Kemi Akagwu (UK) that context and country operating guidelines and policies matter. It also depends on which category of health workers - doctors, nurses, psychologists, mental health nurses, psychiatrists etc. Country policies differ in terms of scope of practice and health professionals' regulations governing the practice.

HIFA profile: Enock Musungwini is a distinguished public health professional, health management consultant, and development practitioner currently serving as a Programme Manager (Consultant) for an NGO called Pangaea Zimbabwe under the Wild4Life Health program responsible for program management, oversight, supervision, coordination, and leadership. He holds an MSc in Public Health with a Research award from the London School of Hygiene and Tropical Medicine (LSHTM), achieved under the prestigious British Chevening scholarship (2018-19 cohort). His educational background also includes a Master's in Business Administration, BSc Hons in Psychology, Diploma in Nursing Science, Diploma in Public Relations and Communication, and a Postgraduate Certificate in Health Management and Leadership. Enock actively serves as a Reference Group Committee member for the Africa Evidence Network, Steering Committee member for the International Network for Government Science Advice Africa Chapter, member of the Consortium for Universities of Global Health and Country Representative for Healthcare Information for All (HIFA).

Enock has received numerous accolades including being appointed Brand Ambassador and receiving the Growth and Innovation award for Pangaea Zimbabwe (June 2023), Country Representative of the Year by HIFA (April 2023),

Chevening Volunteers Gold Award by the British Foreign and Commonwealth Office (June 2019), and the Zimbabwe Achievers Chairman's Award (Nov 2019). His academic excellence is reflected in awards such as the Amanda Jacklyn Berger Prize for his MSc Research project by LSHTM (Feb 2020) and the Marie Stopes Clinics Champion Award (Jan 2017). Enock's dedication to personal development led to his nomination for Ten Outstanding Young Persons in Zimbabwe under the Personal Improvement Category by Junior Chamber International (Oct 2019). Enock Musungwini has made presentations at national, regional, and international conferences and contributed significantly to public health discourse through his blogs and opinion pieces on various topics.

Alcohol Use Disorders (112) Alcohol industry and misinformation (16) DrinkAware (3)

29 February, 2024

Dear Eduardo,

Many thanks for your message on HIFA yesterday:

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-107-alcohol-indus...>

You wrote: "In relation to AUDIT, I think it would be appropriate to have an exchange with the WHO to share with them what the HIFA Forum has identified and ask if they share our same concerns and if they are thinking about "updating" the AUDIT, as the US has done, and what would be the steps for it."

Yes I agree. What do others think?

HIFA has a lot of WHO staff among its membership. Would anyone at WHO like to comment?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (113) Alcohol industry and misinformation (17) DrinkAware (4)

29 February, 2024

Hello Neil and Eduardo,

I agree with the suggestion that our findings be shared as widely as possible. It may lead to action to revise the Audit to contain appropriate advice about alcohol use .

Joseph Ana

Prof Joseph Ana

Lead Senior Fellow/ medicalconsultant.

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HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for PAKC Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which also suitable for lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicom & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member, National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the

Working Group on HIFA-WHO Collaboration

(<http://www.hifa.org/support/members/joseph-0>

<http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

Alcohol Use Disorders (114) The role of the alcohol industry (19)

29 February, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-110-role-alcohol-...>]

If I may add to the reasons that governments do not regulate alcohol effectively ('the powerful lobby of the alcohol industry, the lack of knowledge of governments about the alcohol problem, the lack of knowledge and involvement of health professionals. health on the subject and corruption'), listed by Eduardo, it will be that governments see alcohol industry as a major contributor to its Tax revenue. But as I pointed out in one of my earlier contributions to this discussion, governments are misguided in neglecting the fact that what they gain through taxation of alcohol, they lose by what it takes the health system to manage the poorer health of the population from alcohol misuse, accidents including road traffic accident and so on. Governments also lose the revenues from taxation to the criminal and Justice management costs of dealing with alcohol misusers. 'Penny-wise, pound foolish' describes Governments' attitude to the alcohol problem.

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Alcohol Use Disorders (115) Do public health professionals and policymakers have adequate knowledge? (2) What are current national policies?

1 March, 2024

WHO has a lot of data relating to alcohol in different countries, through its Global Health Observatory:

'The Global Information System on Alcohol and Health (GISAH) is an essential tool for assessing and monitoring the health situation and trends related to alcohol consumption, alcohol-related harm, and policy responses in countries. The harmful use of alcohol results in the death of 3 million people annually. There are 230 different types of diseases where alcohol has a significant role. It also causes harm to the well-being and health of people around the drinker. In 2018, the worldwide total consumption was equal to 6.2 litres of pure alcohol per person 15 years and older. Unrecorded consumption accounts for 26% of the worldwide total consumption.'

<https://www.who.int/data/gho/data/themes/global-information-system-on-al...>

The above URL provides information on:

Levels of Consumption

Patterns of Consumption

Harms and Consequences

Economic Aspects

Alcohol Control Policies

Prevention, Research, Treatment

Youth and Alcohol

Key alcohol indicators relevant to Sustainable Development Goals (SDGs)

Key alcohol indicators relevant to noncommunicable diseases

Data sources for abstainers and heavy episodic drinkers

Data sources for alcohol use disorders and alcohol dependence

Information on Alcohol Control Policies is here:

<https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/alcho...>

This section is further subdivided into:

National Policy

Advertising and product placement restrictions

Age limits
Community action
Drink driving
Licensing requirements
Alcohol Control Policies - Price measures
Monopolies
Marketing
Price measures
Sales promotion
Selling off-premise
Selling on-premise
Sponsorship
Taxation measures
Use in public places
Warning and consumer information labels

I invite HIFA members to browse the above resource and let us know your observations.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (116) The role of the alcohol industry (20) Do public health professionals and policymakers have adequate knowledge? (3)

1 March, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-114-role-alcohol-...>]

Dear Joseph.

I fully agree with you. Most of the countries believe they are making money with the alcohol business, but reality is the opposite.

I took two paragraphs from this source:

<https://www.vitalstrategies.org/new-report-reveals-how-billions-of-dolla...>

that supports this reasoning.

"Most people don't realize that taxpayer money is fueling the alcohol industry which in turn creates a triple burden for countries—lost revenue, increased alcohol consumption, and overwhelmed public health systems, particularly in low- and middle-income countries with lower health protections and higher alcohol-attributable deaths," said report co-director, Nandita Murukutla, Vice President of Global Policy and Research.

Even as countries struggle to meet their health care needs, including the soaring costs of noncommunicable diseases like cancer and heart disease, that many of them continue to promote the very products (alcohol, unhealthy foods, and tobacco) that harm people's health by causing such diseases. They're also fueling a growing economic and social burden that strain health systems, harm people, and exert an unnecessary cost on societies

Kind regards,

Eduardo

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. [ebianco AT nextgenu.org](mailto:ebianco@nextgenu.org)

Alcohol Use Disorders (117) Q5 How can we define and measure alcohol use disorders?

3 March, 2024

Dear HIFA colleagues,

As we move into week 5 of our deep-dive on Alcohol Use Disorders, I invite you to consider Q5:

How can we define and measure alcohol use disorders?

I have had a look at the question of definition and it appears to be not very straightforward.

One of the challenges is that there are at least two official sources: the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

'The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association'

<https://en.wikipedia.org/wiki/DSM-5>

According to Wikipedia, DSM is used primarily in the US, while ICD is used elsewhere. It would be interesting to know which other countries use DSM. It seems likely there are different organisations within the same country that use one or the other source.

Searching for the DSM, I was signposted to the Internet Archive. I then had to register but was still unable to access to the full text. I note that the landing page contains only 2 reviews by users, and each of these is only a few words. One would expect hundreds of reviews for an important reference of this type. Perhaps HIFA members can point us to a better way of accessing this.

ICD is published by WHO and it is straightforward to access and search. The text includes: 'Disorders due to use of alcohol are characterised by the pattern and consequences of alcohol use. Alcohol – more specifically termed ethyl alcohol or ethanol – is an intoxicating compound produced by fermentation of sugars usually in agricultural products such as fruits, cereals, and vegetables with or without subsequent distillation. There are a wide variety of alcoholic drinks, with alcohol concentrations typically ranging from 1.5% to 60%. Alcohol is predominantly a central nervous system depressant. In addition to ability to produce Alcohol Intoxication, alcohol has dependence-producing properties, resulting in Alcohol Dependence in some people and Alcohol Withdrawal when alcohol use is reduced or discontinued. Unlike most other substances, elimination of alcohol from the body occurs at a constant rate, such that its clearance follows a linear rather than a logarithmic course. Alcohol is implicated in a wide range of harms affecting most organs and systems of the body (e.g., cirrhosis of the liver, gastrointestinal cancers, pancreatitis). Harm to others resulting from behaviour during Alcohol Intoxication is well recognized and is included in the definitions of harmful use of alcohol (i.e., Episode of Harmful Use of Alcohol and Harmful Pattern of Use of Alcohol). Several alcohol-

induced mental disorders (e.g., Alcohol-Induced Psychotic Disorder) and alcohol-related forms of neurocognitive impairment (e.g., Dementia Due to Use of Alcohol) are recognized.'

ICD also provides 'a list of specific diagnostic categories of that apply to alcohol:

6C40.0 Episode of Harmful Use of Alcohol
6C40.1 Harmful Pattern of Use of Alcohol
6C40.2 Alcohol Dependence
6C40.3 Alcohol Intoxication
6C40.4 Alcohol Withdrawal
6C40.5 Alcohol-Induced Delirium
6C40.6 Alcohol-Induced Psychotic Disorder
6C40.70 Alcohol-Induced Mood Disorder
6C40.71 Alcohol-Induced Anxiety Disorder
6C40.Y Other Specified Disorder Due to Use of Alcohol
6C40.Z Disorder Due to Use of Alcohol, Unspecified'

The list and the paragraph above are just one of many pieces of content on alcohol in the ICD.

My first impression is that neither the DSM nor the ICD are ideal for the primary care health worker, the former because I can't access it, and the latter because there is a lot of confusing detail.

In neither case was I able to find a consensus definition of Alcohol Use Disorders.

Can anyone help?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (118) How can we define and measure alcohol use disorders? (2)

4 March, 2024

Dear HIFA colleagues,

In my message yesterday I introduced the first part of this discussion: How can we define alcohol use disorders? There are more questions than answers and I invite your comments:

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-117-q5-how-can-we...>

I now introduce the second part: How can we measure alcohol use disorders?

There are at least two ways of approaching this question: at the population level and at the individual clinical level.

At the population level WHO estimates that there are 280 million people living with alcohol use disorders worldwide. To make sense of this number, we need clarification of how WHO defines 'alcohol use disorder', so this links closely to our previous question. Can anyone help?

At the individual clinical level, we have the AUDIT toll which was developed by WHO. AUDIT stands for Alcohol Use Disorders Identification Test. The original tool was developed by WHO

Alongside with the companion publication on the AUDIT, WHO has also produced a manual to aid primary health care workers in administering brief interventions to persons whose alcohol consumption has become hazardous or harmful to their health. Together, these manuals describe a comprehensive approach to alcohol screening and brief intervention (SBI) that is designed to improve the health of the population and patient groups as well as individuals.

Here is a description from the 2001 Guidelines for Primary Care: 'The AUDIT was developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It can help in identifying excessive drinking as the cause of the presenting illness. It also provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. The first edition of this manual was published in 1989 (Document No. WHO/MNH/DAT/89.4) and was subsequently updated in 1992 (WHO/PSA/92.4). Since that time it has enjoyed widespread use by both health workers and alcohol researchers. With the growing use of alcohol screening and the international popularity of the AUDIT, there was a need to revise the manual to take into account advances in research and clinical experience.' <https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a>

'Alongside with the companion publication on the AUDIT, WHO has also produced a manual to aid primary health care workers in administering brief interventions to persons whose alcohol consumption has become hazardous or harmful to their health. Together, these manuals describe a comprehensive approach to

alcohol screening and brief intervention (SBI) that is designed to improve the health of the population and patient groups as well as individuals.'

<https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a>

This is freely available here:

[https://www.who.int/publications/i/item/brief-intervention-for-hazardous...\(audit\)](https://www.who.int/publications/i/item/brief-intervention-for-hazardous...(audit))

I would like to invite HIFA members to share their experience of using AUDIT and the WHO publications mentioned above. What other guidance are you aware of to help identify and manage people with Alcohol Use Disorders? Is the information you need readily available?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (119) Inappropriate use of AUDIT tool?

4 March, 2024

Dear HIFA colleagues,

As a result of our interactions on HIFA in the past few days, we have 'discovered' that the AUDIT tool is being widely used as a self-administered online drinking check for the general public. As a result, it appears that tens of thousands of heavy drinkers (alcohol intake up to 42U per week, or 3X the recommended maximum) are potentially being misinformed that they are at 'lower risk' and thereby encouraged to continue drinking at unsafe levels. This is our impression, but it needs formal verification by others. We have therefore today informed the World Health Organization of this observation and will keep you updated.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four

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Alcohol Use Disorders (120) Inappropriate use of AUDIT tool? (2) Understanding standard drinks/units

4 March, 2024

Thanks, Neil. That is helpful. The other main problem especially with the AUDIT tool and overall, is the understanding of standard drinks. This is a concept that is often mistaken for a bottle of beer etc. It is critical to ensure that alcoholic beverages are labeled appropriately in terms of standard drinks or pure alcohol content.

Best wishes,
Joel

HIFA profile: Joel Francis is an epidemiologist and a researcher at the University of the Witwatersrand, School of Clinical Medicine, Department of Family Medicine and Primary Care.

Prior to joining WITS, I worked as a research scientist with the National Institute for Medical Research in Tanzania and a research fellow with the Department of Global Health and Population at Harvard T.H.Chan School of Public Health, Harvard University.

I hold a Doctor of Medicine (MD) degree (equivalent to MBBCh) from the University of Dar es Salaam, Tanzania, and an MSc in Epidemiology from Harvard University, USA, and a Ph.D. in Epidemiology from the University of London (London School of Hygiene and Tropical Medicine), UK.

My current responsibilities include teaching (supervision of undergraduate, Master, and Ph.D. candidates), and Public Health research. I have over 13 years' experience in conceptualizing, designing, implementing, and analyzing rigorous quantitative observational (large surveys and classical epidemiological) and experimental studies (cluster-randomized trials, randomized clinical trials), systematic reviews, and meta-analysis, and implementation science studies. My substantive research interests have been on HIV, Alcohol and Other Drug Use, Noncommunicable Diseases, and Mental Health, and a more recent interest in the Global Burden of Diseases.

I am a member of editorial boards of three BMC series journals (BMC- Public Health & BMC - Global Health Research and Policy, BMC -Infectious Diseases), the PLOS One journal, a statistical editor for the Health Policy and Planning

journal and an editorial advisor at the BMJ Open journal.

I am a member of the Data Safety and Monitoring Board (DSMB) of two ongoing randomized trials in South Africa and Tanzania.

I serve as an honorary lecturer at the Department of Epidemiology and Biostatistics, Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam, Tanzania. And a member of the International AIDS Society. joelmfrancis AT gmail.com

Alcohol Use Disorders (121) Understanding standard drinks/units (2)

4 March, 2024

Dear Joel,

Many thanks for your message about people's understanding of standard drinks/units.

I was interested to see a paper about this:

CITATION: Drug Alcohol Rev. 2012 Mar; 31(2): 200-205.

Published online 2011 Nov 3. doi: 10.1111/j.1465-3362.2011.00374.x

Understanding standard drinks and drinking guidelines

William C. Kerr, Ph.D., Senior Scientist and Tim Stockwell, Ph.D., Scientist

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3276704/>

ABSTRACT

Introduction and Aims: For consumers to follow drinking guidelines and limit their risk of negative consequences they need to track their ethanol consumption. This paper reviews published research on the ability of consumers to utilise information about the alcohol content of beverages when expressed in different forms e.g. in standard drinks or units versus percentage alcohol content.

Design and Methods: A review of the literature on standard drink definitions and consumer understanding of these, actual drink pouring, use of standard drinks in guidelines and consumer understanding and use of these.

Results: Standard drink definitions vary across countries and typically contain less alcohol than actual drinks. Drinkers have difficulty defining and pouring standard drinks with over-pouring being the norm such that intake volume is typically underestimated. Drinkers have difficulty using percentage alcohol by

volume and pour size information in calculating intake but can effectively utilise standard drink labeling to track intake.

Discussion and Conclusions: Standard drink labeling is an effective but little used strategy for enabling drinkers to track their alcohol intake and potentially conform to safe or low risk drinking guidelines.

COMMENT (NPW): According to the full text, 'Many countries have a national standard drink or unit with alcohol contents ranging from 8 to 23.5 grams of ethanol'. This is almost a 3-fold difference among different countries. This can only add to everyone's confusion. Ideally a standard drink or unit should be truly standard - the same across countries. The paper says a little about why some countries choose different amounts, but it does seem surprising that the international health community has not reached a consensus.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (122) How can we define and measure alcohol use disorders? (3)

5 March, 2024

Dear HIFA colleagues,

Here are the top seven hits from a google search on 'definition of alcohol use disorders' and a comment from me below:

US Medline Plus: 'This means that their drinking causes distress and harm.'

<https://medlineplus.gov/alcoholusedisorderaud.html#:~:text=However%2C%20...>

UK NHS: 'Alcohol misuse is when you drink in a way that's harmful, or when you're dependent on alcohol'

<https://www.nhs.uk/conditions/alcohol-misuse/>

American Psychological Association: 'People with alcohol use disorders drink to excess, endangering both themselves and others.'

<https://www.apa.org/topics/substance-use-abuse-addiction/alcohol-disorders>

UK NICE: 'Harmful drinking (high-risk drinking) is defined as a pattern of alcohol consumption causing health problems directly related to alcohol'

<https://www.nice.org.uk/guidance/cg115/chapter/Introduction>

WebMD: 'Alcohol use disorder (AUD) is a chronic illness in which you can't stop or control your drinking even though it's hurting your social life, your job, or your health.'

<https://www.webmd.com/mental-health/addiction/what-is-alcohol-abuse>

Lancet paper 2019: 'Alcohol use disorders consist of disorders characterised by compulsive heavy alcohol use and loss of control over alcohol intake.'

<https://pubmed.ncbi.nlm.nih.gov/31478502/>

WHO: 'Adults (15+ years) who suffer from disorders attributable to the consumption of alcohol (according to ICD-10: F10.1 Harmful use of alcohol; F10.2 Alcohol dependence) during a given calendar year. Numerator: Number of adults (15+ years) with a diagnosis of F10.1, F10.2 during a calendar year.'

<https://www.who.int/data/gho/indicator-metadata-registry/imr-details/1388>

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders says someone has alcohol use disorder if they meet two or more of 11 criteria in one 12-month period. AUD may be mild, moderate, or severe, based on how many of the criteria are true. The criteria are:

Alcohol use in larger amounts or for a longer time than intended

A lasting desire or unsuccessful effort to cut down or control alcohol use

A lot of time spent getting alcohol, drinking it, or recovering from its effects

A craving for alcohol

Alcohol use that causes a failure to meet obligations at work, school, or home

Alcohol use that continues even though it leads to lasting or repeated personal problems

Giving up or cutting back on important activities because of alcohol

Repeatedly using alcohol in dangerous situations

Using alcohol even though you know it causes physical or psychological problems, or makes them worse

Alcohol tolerance, when you need more to have the same effect
Alcohol withdrawal

WHO: ICD-11 it [Hazardous Alcohol Use] is defined as: A pattern of alcohol use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals.

COMMENT (NPW): The above are to some extent consistent, but have differing emphasis on specific features such as harm and control. Three of the definitions describe alcohol use disorders (plural). For the latter there are different ways of describing the individual disorders. Does this variation matter? Should we be paying more attention to one or more definitions? And, most importantly, what criteria should frontline health professionals use when assessing a patient's alcohol consumption?

The overall terminology is quite confusing. Is it feasible to reach a point where everything is clear? From my perspective, this seems unlikely. Perhaps, for the individual health worker, there is a case for abandoning terminology that is not useful and instead focus on the number of units of alcohol consumed per week, together by a narrative description of the harms attributable to alcohol consumption in each case?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (123) How can we define and measure alcohol use disorders? (4)

6 March, 2024

"May the tree not make us lose sight of the forest"

Thank you very much Neil for the effort to review the definitions that describe the "different" alcohol use disorders. [<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-122-how-can-we-de...>]

I agree with your conclusion that the terminology is "quite confusing," and that does not contribute to a better understanding of when health professionals have to act.

Due to "professional deformation", although I am not a psychiatrist, I am inclined to favor the use of the APA [American Psychiatric Association] criteria, because it allows us to identify a wide range of problems linked to alcohol consumption.

It is also in line with my conviction that we must not only try to help those who have the "most serious disorders," but to do so we must reduce the population average alcohol consumption.

If we really want to reduce problems linked to alcohol at the population level, we must apply policies that reduce total consumption. Which will obviously reduce alcohol sales... and therefore will be strongly resisted by the alcohol industry, which only wants us to focus on the "heavy drinker."

Otherwise, we would be seeing only the tree, and not the forest.

I am sharing the following fragment from the 3rd edition of Babor's book Alcohol: No Ordinary Commodity, which summarizes what I am trying to say:

Why is per capita alcohol consumption important?

Relationship between APC [alcohol per capita consumption] and prevalence of heavy drinkers. There is a fairly consistent pattern of substantial effects of average alcohol consumption on population health and social harm rates.

Therefore, an increase in this average tends to be accompanied by an increase in population mortality and, in particular, mortality from specific causes in which alcohol usually plays an important role and also in violence rates.

Across all studies, there is no single definition of "heavy drinking" and various levels of drinking have been used to distinguish "heavy drinkers" from other drinkers.

However, whatever the criteria for "excessive drinking", there is strong evidence of a close connection between the APC per drinker and the prevalence of excessive alcohol consumption, that is, the higher the level of consumption, the greater the proportion of heavy drinkers.

When the average consumption changes, the consumption at low, medium and high levels also changes.

Changes in the APC per drinker can typically be described as collective changes in which the entire distribution of drinkers "tends to move up and down the consumption scale."

I hope this can contribute to our understanding of what should be the focus for the healthcare professionals to intervene.

Kind regards,

Eduardo

Dr. Eduardo Bianco
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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco@nextgenu.org

Alcohol Use Disorders (124) WHO Alcohol Action Plan 2022-2030

6 March, 2024

Dear Colleagues,

I have previously shared the WHO SAFER package and now I am sharing a summary of the WHO Alcohol Action Plan 2022-2030. (1)

This plan was developed in order to effectively implement the Global Strategy to reduce alcohol use. of alcohol as a public health priority (2), was endorsed by the 75th World Health Assembly in May 2022.

The plan contains six areas of action, in which global indicators are proposed to monitor its execution.

The success of the action plan depends on the actions taken by Member States, effective governance at the global and regional levels, and the due participation of all relevant stakeholders.

The objective of this plan is to achieve by 2030 a relative reduction, with respect to 2010 levels, in the following areas of action:

SPHERE 1. Application of high-impact strategies and interventions

Global goal 1.1: Reduction of at least 20% in the harmful use of alcohol.

Its indicators are: total consumption of pure alcohol per capita, prevalence by

age of episodes of massive alcohol consumption, burden of deaths attributable to alcohol, burden of disability-adjusted life years (DALYs)

Global goal 1.2: Achieve 70% of countries approve/implement high-impact regulatory interventions.

Its indicators are: number of countries that approved/apply measures that have a great impact on:

- a) Affordability of alcoholic beverages
- b) Advertising and marketing
- c) Availability of alcoholic beverages
- d) Driving under the influence of alcohol
- e) Detection and brief interventions on problematic alcohol consumption and treatment of alcohol use disorder

SPHERE 2. Promotion, awareness and commitment

Global goal 2.1.: Achieve that 75% of countries have developed and implemented national alcohol regulation policies.

Indicators: number of countries with a written national policy and enacted.

Global target 2.2: Have 50% of countries produce regular national reports on alcohol consumption and alcohol-related harm.

Indicators: number of countries that have prepared at least 2 national reports in the last 8 years

SPHERE 3. Association, Dialogue and Coordination.

Global goal 3.1: Achieve 50% of countries to develop a national multi-sector coordination mechanisms to implement and strengthen alcohol regulations.

Indicator: number of countries with a multi-sector national coordination mechanism established to regulate alcohol.

Global target 3.2: Achieve 50% of countries participating in WHO global and regional networks on alcohol regulation.

Indicator: number of countries actively represented in WHO global and regional networks.

SPHERE 4. Technical support and capacity building.

Global target 4.1: Achieve 50% of countries with greater capacity to implement effective strategies and interventions to reduce harmful use of alcohol at the national level.

Indicator: number of countries that have increased government resources to implement effective policies to regulate alcohol.

Global goal 4.2: Achieve 50% of countries with health services with greater capacity to provide interventions for the prevention and treatment of alcohol-related problems. Indicator: number of countries that have increased the capacity of the health system for prevention and treatment of conditions due to alcohol use.

SPHERE 5. Knowledge Creation and Information Systems.

Global goal 5.1. Achieve 75% of countries to periodically generate and present national data on alcohol consumption, related harms, and the application of measures.

Indicator: number of countries that generate and present national data.

Global target 5.2: Have 50% of countries regularly report on a national data set for monitoring.

Indicators: number of countries that have and present an agreed data set on the alcohol problem.

SPHERE 6. Resource mobilization.

Global Meta 6.1: Achieve at least 50% of countries to allocate resources to reduce the harmful use of alcohol.

Indicator: number of countries that have allocated resources to implement alcohol regulation policies at the national level, number of countries that have obtained resources to increase coverage and quality of alcohol interventions, and number of countries that allocate resources from tax revenues linked to alcohol.

Comment: Without failing to recognize the effort that countries make to advance in the regulation of alcohol, and that this Action Plan is a significant help, given that it is aimed to guide countries on what should be done...it leaves me with "little taste."

We have already talked about how powerful the alcohol industry is and how it has managed to influence the highest levels to "limit" or "slow down" regulatory advances, when it is not capable of "totally blocking" them.

I think there is a lot to do, and that health professionals have a great responsibility in the matter.

What do you think?

Can this action plan help you in your countries?

What other type of help would you need?

Kind regards,

Eduardo

References

1. <https://cdn.who.int/media/docs/default-source/alcohol/final-text-of-aap-...>

2. <https://www.who.int/publications/i/item/9789241599931>

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<<https://www.tiktok.com/@nextgenu.org>> <<http://www.nextgenu.org/>>

<<https://aptp.nextgenu.org/>> <<https://phu.nextgenu.org/>>

<<https://nextgenu.org/steps/>> <<https://humanitarianu.org/>>

HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. [ebianco AT nextgenu.org](mailto:ebianco@nextgenu.org)

Alcohol Use Disorders (125) How can we define and measure alcohol use disorders? (5)

6 March, 2024

[re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-122-how-can-we-de...>]

Dear Neil

Many thanks for this. I think you are correct - "Is it feasible to reach a point where everything is clear? From my perspective, this seems unlikely." There are many reasons for this, but it is mainly because different organisations DO focus on different issues - for example, some may focus on physical health and harms to health, others may focus on social problems, some on criminal justice consequences, etc.

Some of these definitions are throwbacks to a much older conceptualisation, where there was a simple binary distinction between being 'an alcoholic' and not being one (eg WebMD: 'Alcohol use disorder (AUD) is a chronic illness in which you can't stop or control your drinking even though it's hurting your social life, your job, or your health.'

<https://www.webmd.com/mental-health/addiction/what-is-alcohol-abuse>

Others are much more inline with current thinking, which is that alcohol-related problems exist on a continuum, from Mild through Moderate through to Severe, or from Hazardous (or Risky) drinking through to Harmful drinking through to Dependent drinking.

You suggest that "Perhaps, for the individual health worker, there is a case for abandoning terminology that is not useful and instead focus on the number of units of alcohol consumed per week, together with a narrative description of the harms attributable to alcohol consumption in each case?" I certainly would agree with this - and indeed, in my book 'Counselling for Alcohol Problems' [SAGE Publications Ltd; Third edition (18 Jan. 2011)] I have an entire chapter devoted to 'Understanding Alcohol Problems', which looks at how it is best to describe and think about alcohol problems. However, the idea of issue of "focus(sing) on the number of units of alcohol consumed per week" runs not the problems you have raised and discussed previously - there is no consensus over what a 'Unit' of alcohol (or a 'standard drink') consists of, nor over what is an amount which might be considered 'problematic'.

For me, the issue is whether a person's drinking is causing harm or problems to anyone - to the person drinking, or to others (eg their family or friends), or to wider society. So it is NOT about some fixed amount of alcohol consumed, it is about the consequences of the consumption. As I write in that chapter,

"My own definition of an alcohol problem is very simple: if someone's drinking causes problems for him or her, or for someone else, in any area of their lives, then that drinking is problematic. If someone's drinking causes problems with his or her health, finances, the law, work, friends or relationships, then that drinking is problematic; if it causes problems for husbands, wives, children, parents, bosses, or subordinates, then that drinking is problematic.

There are many implications of such a simple definition. It means that whether or not someone has a drinking problem is not determined by fixed quantities of alcohol, or fixed timings, but instead is a matter of negotiation by the individual with him or herself, family, friends, work place, and society as a whole.

The idea of negotiation within context may be illustrated with a few examples:

* Within a marital context, it might be the case of a person who drinks one pint of beer a week but is married to a confirmed teetotaler: the one pint may cause problems, and will need to be negotiated within the marital context.

* Within an employment context, someone might drink half a bottle of wine during a business lunch, or might visit the pub at lunch-time with colleagues. In some contexts, such drinking has been negotiated as acceptable behaviour; yet the same drinking may cause severe problems within an industry which has introduced an alcohol-at-work policy which forbids drinking during the working day.

* Within the social context, fifty years ago someone's ability to drive after drinking was determined by their ability to walk a straight line; now, someone's ability to drive after drinking has been re-negotiated by society such that it is determined by their blood-alcohol level, and if it exceeds a certain amount (and they are detected by the police!) they are automatically deemed unfit to drive, and will have their licence revoked.

Someone has an alcohol problem if their drinking causes them or anyone else a problem."

I hope that this is useful.

Best wishes, Richard Velleman

Professor Richard Velleman <r.d.b.velleman@bath.ac.uk>

Emeritus Professor of Mental Health Research, University of Bath

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Co-Director, Addictions and related Research Group, Sangath Community Health NGO, Goa, India

<https://sangath.in/addictions-research/>

Trustee and Treasurer, AFINet (Addiction and the Family International Network)

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Alcohol Use Disorders (126) Which interventions are effective in alcohol control?

6 March, 2024

Dear colleagues,

I would like to introduce the WHO SAFER technical package.

The World Health Organization (WHO), in collaboration with international partners, launched the SAFER initiative in 2018 alongside the United Nations third high-level meeting on prevention and control of noncommunicable diseases (NCDs).

The objective of the initiative is to provide support for Member States in reducing the harmful use of alcohol by strengthening the ongoing implementation of the Global strategy to reduce the harmful use of alcohol and other WHO and United Nations instruments - including WHO's Global action plan for the prevention and control of NCDs and the United Nations' Sustainable Development Goals (SDGs) target 3.5 (i.e. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol).

The technical package for the SAFER initiative focuses on five key alcohol policy interventions that are based on accumulated evidence of their impact on population health and their cost-effectiveness.

The SAFER interventions are:

STRENGTHEN restrictions on alcohol availability

ADVANCE and enforce drink-driving countermeasures

FACILITATE access to screening, brief interventions and treatment

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

RAISE prices on alcohol through excise taxes and other pricing policies

This SAFER technical package is aimed at government officials with responsibility for developing policy and action plans to reduce the harm done by alcohol.

Given that alcohol-related harm extends beyond public health, and that preventing and reducing such harm requires multicomponent action that

involves many stakeholders, this guidance should also be of use to those working in sectors other than health.

You can access to the WHO-SAFER technical package in :

<https://iris.who.int/bitstream/handle/10665/330053/9789241516419-eng.pdf...>

Kind regards,
Eduardo

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Alcohol Use Disorders (127) Communicating the benefits of abstinence versus light/moderate drinking

7 March, 2024

Dear All,

This discussion is turning out to be one of the most interesting on HIFA. [*see note below]

The confusion is not only on the definition of how much to drink safely, which Neil has highlighted, confusion extends to whether non-drinkers die earlier than moderate drinkers!. When a study asked, 'Why Do Moderate Drinkers Live Longer Than Abstainers? Or 'Do teetotallers live longer than light drinkers?', one gets answers that say, 'moderate drinkers live longer than lifetime teetotallers'. "The evidence from cancer research gives a different impression, with even light to moderate alcohol consumption linked increased risks of cancer. (www.medicalnewstoday.com > articles > 199398). That is the public is being

told that abstaining from drinking is means they might die earlier than if they consumed moderate level alcohol?

It gets worse when the public is told emphatically that ‘‘Teetotallers ‘die sooner’ than those who have the odd drink’’. (www.express.co.uk/life-style/health/976771/people-drink-alcohol-live-lon...); and that ‘Drinkers May Outlive Teetotalers’ according to - Business Insider (www.businessinsider.com/drinkers-may-outlive-teetotalers-2018-6). The same business groups urge the public not to abstain, even though ‘resorting to alcohol to feel better could actually be getting in the way of your self-development’, because if all the socio-economic-physical-psychological and mental risk that alcohol abuse leads to. This alcohol-business led advocacy for people to drink alcohol, flies in the face of evidence that ‘one of the benefits of teetotal living is that it may prompt you to dig deep into the resources you already have or could have to become stronger in the face of adversity.’

All said Governments have a choice to make to show leadership and commitment about eliminating or mitigating the adverse effects of alcohol use and abuse, that drains the health budget, or continue on the futile policy to increase tax on alcohol hoping that it will deter people from drinking or abusing alcohol. Even though they know that it does not work. The only thing it does is to increase government revenue at the risk of poor health of the alcohol abusers.

Joseph Ana

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HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for PACK Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation’s Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which also suitable for

lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicom & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member, National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the Working Group on HIFA-WHO Collaboration (<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

[*Note from HIFA moderator (NPW): Thank you Joseph for introducing this important topic. I have added the phrase 'Communicating the benefits of abstinence versus light/moderate drinking' into the Subject line]

Alcohol Use Disorders (128) Communicating the benefits of abstinence versus light/moderate drinking (2)

7 March, 2024

Dear Joseph,

Many thanks for your message. It seems the definition of 'moderate' drinking is also unclear. In the USA it is defined as not more than 1 standard drink per day for women and 2 standard drinks per day for men. The UK NHS website is unclear but implies that anything up to 14 units per day is 'moderate'.

Physicians in the US seem to have their own way of defining moderate drinking (!) 'Physicians operationally defined "light" drinking as 1.2 drinks/day, "moderate" drinking as 2.2 drinks/day, and "heavy" drinking as 3.5 drinks/day.' <https://pubmed.ncbi.nlm.nih.gov/9726266/>

This is further muddled by the fact that a US standard drink contains much more alcohol than a UK unit. 'In the US, a standard drink contains 14 grams of

alcohol, in Australia it's 10 grams and in the UK it's about eight grams. In some countries there is separate advice for men and women, while in others - including Australia - there is not.'

<https://www.theguardian.com/society/2023/jan/15/glass-too-full-why-safe-...>

And this describes the situation in just 3 countries.

The Guardian news notes that 'Belgium suggests 21 drinks a week is safe for men, while Australia recommends no more than 10 for anyone. What goes into the decision making?'

'Belgium labels up to 21 drinks a week for men and 14 for women as low risk, while Ireland goes with up to 17 drinks for men and 11 for women, with two alcohol-free days a week. France recommends no more than 10 standard drinks a week - the same as Australia - but never more than two standard drinks a day and at least one alcohol-free day a week. The UK advises no more than 14 units a week, over at least three days, and "some" alcohol-free days, while the US recommends no more than two drinks a day for men and one for women.'

<https://www.theguardian.com/society/2023/jan/15/glass-too-full-why-safe-...>

Why have different countries come to different conclusions on the same evidence?

What about other countries? I look forward to contributions from others:
hifa@hifaforums.org

Given that the definitions in different countries are so muddled, is there potential for more consensus and alignment?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (129) Do health workers have adequate knowledge? (11)

7 March, 2024

Dear Richard Velleman and all,

You make a good case that "the issue is whether a person's drinking is causing harm or problems to anyone - to the person drinking, or to others (eg their family or friends), or to wider society. So it is NOT about some fixed amount of alcohol consumed, it is about the consequences of the consumption".

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-125-how-can-we-de...>

Given that there is so much confusion and disagreement about standard drinks/units, a focus on 'whether a person's drinking is causing harm or problems to anyone' seems highly pragmatic and useful.

What harms are we talking about? The UK NHS says: 'As well as causing serious health problems, long-term alcohol misuse can lead to social problems for some people, such as unemployment, divorce, domestic abuse and homelessness. If someone loses control over their drinking and has an excessive desire to drink, it's known as dependent drinking (alcoholism).' These highly visible harms typically only occur among the heaviest drinkers.

Arguably the majority of those who drink excessively, say, 14-42 (8-24 standard drinks) units of alcohol per week will not be visibly manifesting such harms. And yet their alcohol consumption may well be harming their long-term health and wellbeing, and the health of others, including mental and physical health.

It seems that every health worker needs to be empowered to identify and address, in each patient, the hidden harms of alcohol (and how to prevent them) as well as the visible harms. How well are health workers able to do this currently, and what resources might assist them?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (130) WHO Alcohol Action Plan 2022-2030 (2) SAFER Initiative

7 March, 2024

Dear Eduardo,

Thank you for sharing the outline of the WHO Alcohol Action Plan 2022-2030, and the URL for the full text:

<https://cdn.who.int/media/docs/default-source/alcohol/final-text-of-aap-...>

I note 'The World Health Organization Global Alcohol Action Plan 2022–2030 was endorsed by the Seventy-fifth World Health Assembly in May 2022 to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority. You can download a pre-print copy of the final action plan. The final printed version is expected medio August.' (presumably August 2022 or 2023?)

The URL above is to a pre-print version. Is there a final version available?

Dissemination and uptake of the final version of a plan would be important to accelerate progress on the indicators.

As said above, Member States have endorsed the plan. To what extent are Member States adopting it, and how is it being used to inform national policy?

The Plan appears to be based on an earlier Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010.

The Plan makes several references to the SAFER initiative, which you highlighted in a separate message:

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-126-which-interve...>

STRENGTHEN restrictions on alcohol availability

ADVANCE and enforce drink-driving countermeasures

FACILITATE access to screening, brief interventions and treatment

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

RAISE prices on alcohol through excise taxes and other pricing policies

I have not been able to study the Action Plan in detail, but I note that it uses a different approach:

- 1: Implementation of high-impact strategies and interventions
- 2: Advocacy, awareness and commitment
- 3: Partnership, dialogue and coordination
- 4: Technical support and capacity building
- 5: Knowledge production and information systems
- 6: Resource mobilization

I'd be interested to hear how the Strategy (2010), SAFER (2019) and Global Alcohol Action Plan (2023) are being used by Member States, particularly to inform evidence-based policy.

We have learned previously on HIFA that much policymaking is not evidence-informed, due to lots of reasons including sociocultural influences. The latter are perhaps especially important in the case of alcohol policy. Alcohol policy is also highly vulnerable to influence by the alcohol industry in many (most?) countries.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (131) How can we define and measure alcohol use disorders? (6)

8 March, 2024

[Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-125-how-can-we-de...>]

Thank you very much Richard for your contribution. The approach is very interesting.

I have some comments:

You said:

1. "Is it feasible to reach a point where everything is clear? From my perspective, this seems unlikely." There are many reasons for this, but it is mainly because different organizations DO focus on different issues;"

If the problem is that different organizations focus on different issues, shouldn't we promote a global discussion on alcohol regulation that takes into account these various issues: health, social, economic and legal, to try to reach a consensus?

2. "Some of these definitions are throwbacks to a much older conceptualization, where there was a simple binary distinction between being 'an alcoholic' and not being one"

I completely agree, and this is in line with a topic that we discussed a few weeks ago: avoiding or reducing the stigma related to AUDs, if we want to help people who suffer from it.

3. "alcohol-related problems exist on a continuum, from Mild through Moderate through to Severe, or from Hazardous (or Risky) drinking through to Harmful drinking through to Dependent drinking"

I also agree with this statement, which is why the way the American Psychiatric Association handles the issue seems quite "logical" to me.

4. "...the idea of issue of "focus(sing) on the number of units of alcohol consumed per week" runs not the problems you have raised and discussed previously - there is no consensus over what a 'Unit' of alcohol (or a 'standard drink') consists of, nor over what is an amount which might be considered 'problematic'

It is true that only the "number of units of alcohol consumed per week" is not enough to address this complex issue, but it is a good marker, based on evidence.

I agree that different countries have different definitions regarding the unit of alcohol and the amount of alcohol in different drinks. That is part of the problem.

Isn't it time for a global discussion on this matter (and others)?

Something similar to the WHO- FCTC. [Framework Convention on Tobacco Control]

Probably very difficult, but it could be tried.

5. "So, it is NOT about some fixed amount of alcohol consumed, it is about the consequences of the consumption"

The problem with this statement is that the available evidence indicates that at the population level there IS a relationship between the amounts of alcohol consumed by the population and the problems linked to it. And when you want to have an impact on the health of the population, you have to apply population strategies.

6. "My own definition of an alcohol problem is very simple: if someone's drinking causes problems for him or her, or for someone else, in any area of their lives, then that drinking is problematic..."

I understand the reasoning and it seems rational, and it could apply to some individual consumers, my concern is that it places the “responsibility” of the problem exclusively on “the consumer”, as if he were oblivious to the influences of marketing and the influence of a social environment that openly promotes alcohol, and presents it as an essential tool for social life.

There is a clear responsibility of those who benefit from the alcohol business, (which is not assumed) and, therefore, it is the State that should protect people, starting with children and adolescents, from the strategies of the alcohol industry to promote a higher consumption for increasing their revenues.

Another concern I have with this definition is the issue of “causing problems”:

What would be the definition of a problem? What is the limit to define a situation as a problem? Who sets the limit?

We said that it is difficult to put a limit on the fixed amount consumed; I think that finding this “limit” can be even more difficult.

Furthermore, this approach assumes that the person who has an AUD is aware of the problem and acts accordingly. But this clashes with reality. A significant percentage of people with AUD often deny that they have a problem with alcohol until the advanced stages of the problem.

Let us also not forget the case of domestic violence related to alcohol, in which there is a situation where the wives of people with AUD “tolerate” or “are afraid” to recognize/report these “problems” (including violence) for fear of retaliation.

7. “It means that whether or not someone has a drinking problem is not determined by fixed quantities of alcohol, or fixed timings, but instead is a matter of negotiation.”

Negotiation is a very valid social tool for interpersonal relationships, and I believe that we should all be trained in “negotiation” and apply what we learn in our daily lives.

I do not deny that negotiation cannot occur in many cases of alcohol consumption, but it seems to me that it would be more feasible in non-severe cases. I have serious doubts that negotiation can be applied in these cases.

But yes, it can be a strategy for “individual addressing” alcohol-related problems. As long as both parties are in equal conditions to “negotiate” .

8. “...now, someone’s ability to drive after drinking has been re-negotiated by society such that it is determined by their blood-alcohol level...”

This is completely true, this measure is being applied, but it was not due to a “social negotiation” between alcohol consumers and no-consumers, but rather an imposition from “the majority of society” . Society has imposed this limitation to protect third parties and the alcohol consumers themselves from the dangerous consequences of driving after consuming alcohol.

This was achieved despite the “resistance” of many alcohol consumers and the alcohol industry (which fiercely opposed the measure).

I can argue this with knowledge of the facts, given that in my country, Uruguay, the permitted level of alcohol is “ZERO” .

I also want to highlight that the solution here is simple: there is no level of alcohol that does not impair the ability to drive, there is an objective measure of the problem (level of alcohol detected) and this measure is applied by an “independent” third party. (the police or traffic inspectors).

I appreciate this type of contribution, because it can allow us to exchange opinions on a complex topic, and on which there is much to do.

Kind regards,

Eduardo

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Email: ebianco@nextgenu.org
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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Biancos research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and

former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco AT nextgenu.org

Alcohol Use Disorders (132) Alcohol consumption in different countries (4) Alcohol consumption in Uganda

8 March, 2024

Two weeks ago on HIFA we learned that Uganda has the highest alcohol consumption in Africa and the 7th highest in the world

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-96-role-alcohol-i...>

I asked: "Why does Uganda have such a high consumption?" It would be interesting to hear from HIFA members in Uganda. Meanwhile I found this report from Movendi International, a global NGO on alcohol issues.

'Uganda worryingly tops for being the African country with the highest alcohol intake, according to a World Health Organization (WHO) report. On average, each person in Uganda consumes 12.21 liters of alcohol per year. Men seem to be heavier users of alcohol compared to women. Movendi International had documented that alcohol is so widely accepted and easy to get in Uganda based on a past study, even though there are rules against it for minors. This leads to people thinking it is harmless to use alcohol not realizing the health problems it can cause. The report also sheds light on the global impact of heavy drinking, which causes millions of deaths and a ton of different diseases and injuries. While progress has been made in some places, Uganda still has work to do in meeting their goals for reducing alcohol-related risks and other health dangers.

'The World Health Statistics 2023 report shows staggering levels of alcohol use in Uganda. Per capita alcohol consumption is 12.21 liters of alcohol per year in Uganda...

'On average, men consume about 19.93 liters of pure alcohol annually, while women consume 4.88 liters...

'To address this catastrophic situation, WHO in collaboration with international partners, launched the SAFER initiative in 2018. SAFER is a World Health Organization initiative and technical package that can help governments reduce the harmful use of alcohol and related health, social and economic consequences...

'The easy access to alcohol challenge can be handled by policy makers through establishing an effective system for domestic taxation on alcohol that raises the final price of alcohol to reduce consumption, prevent initiation, and generate much-needed resources for the government.'

I read elsewhere that a quarter of advertising billboards near schools advertise alcoholic drinks. Nearly 4000 die annually from road traffic accidents due to alcohol. An alcohol expert is reported (controversially?) as saying that the alcohol industry should fund education about the risks of alcohol. <https://www.monitor.co.ug/uganda/news/national/uganda-places-fifth-on-al...>

For more information about SAFER, see Eduardo's message a few days ago: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-124-who-alcohol-a...>

Would HIFA members in Uganda like to comment? I note that Tanzania also has very high levels of consumption. What is driving this and how can it be addressed?

Do policymakers have the knowledge and tools they need to address alcohol use disorders in their country?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

Email: neil@hifa.org

Alcohol Use Disorders (133) SAFER Initiative (2)

8 March, 2024

Dear Joseph,

In a previous message you said: "governments are misguided in neglecting the fact that what they gain through taxation of alcohol, they lose by what it takes the health system to manage the poorer health of the population from alcohol misuse, accidents including road traffic accident and so on"

[<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-114-role-alcohol-...>]

This may be so, but the level of taxation is clearly important here. If governments have a policy of *high* taxation on alcohol, this will serve both to reduce per capita alcohol consumption while maintaining or even raising income for public services.

This is reflected in the "R" of SAFER:

'RAISE prices on alcohol through excise taxes and other pricing policies'

As an example, I sent a message about alcohol consumption in Uganda earlier today, which noted: 'The easy access to alcohol challenge can be handled by policy makers through establishing an effective system for domestic taxation on alcohol that raises the final price of alcohol to reduce consumption, prevent initiation, and generate much-needed resources for the government.' The implication is that Uganda should be charging more alcohol tax, with benefits to both public health and the public purse.

It would be interesting to know if there is a comparative analysis, country by country, of taxation policy versus per capita consumption.

How can public health professionals and policymakers be better empowered to deliver this and other measures of the SAFER initiative?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization.

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Alcohol Use Disorders (134) Compilation of messages 1-133

9 March, 2024

Dear HIFA colleagues,

We now enter our 6th and final week of the deep-dive into Alcohol Use Disorders, where I invite you to reflect on what has been discussed so far (and

what has not been discussed). In your view, what is the key learning in relation to the 5 questions we have explored:

1. Do people understand the health, socio-economic and environmental harms of alcohol? What matters to them? How can they be better informed? How to reduce stigma?
2. Do health workers have adequate knowledge to prevent and manage alcohol use disorders among their patients? What matters to them? How can they be better informed?
3. What is the role of the alcohol industry? What can be done to address misinformation from the alcohol industry?
4. Do public health professionals and policymakers have adequate knowledge to prevent and treat alcohol use disorders in their country? What are current national policies and what more can be done to fully implement those policies?
5. How can we define and measure alcohol use disorders?

To help with this, I have prepared a full compilation of our discussion so far (205 pages):

https://www.hifa.org/sites/default/files/publications_pdf/Alcohol_Use_Di...

I shall now work on an edited version (selected text organised under subheadings for each of the 5 questions and for other topics) and will get this to you asap.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (135) Alcohol industry and misinformation (18) DrinkAware has changed their advice to heavy drinkers (42 U/week)

10 March, 2024

Dear HIFA colleagues,

Further to our discussions on HIFA, in the past week DrinkAware HAS CHANGED THEIR ADVICE to people who drink 42 units per week (3X the recommended maximum). Questions remain about how many people were misled by previous advice, whether that advice was deliberate, and whether WHO's AUDIT test (currently used as the basis for the DrinkAware test) should continue to be used by anyone as an unsupervised self-evaluation tool.

BACKGROUND

On 22 February 2024 I reported on HIFA an apparent problem with DrinkAware, the UK's largest alcohol charity, funded by the alcohol industry.

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-79-role-alcohol-i...>

I took their Drinking Check. I posed as a man who drinks 42 units per week (3X the recommended maximum) and DrinkAware told me: "Great news! You are at lower risk of alcohol-related problems. This means you are at lower risk of serious diseases such as stroke, heart and liver disease, and seven types of cancer and may already be noticing the benefits of lower risk drinking such as deeper sleep, more energy and brighter moods."

There was no advice to reduce my consumption.

This test was repeated by other HIFA members in subsequent days, with the same results.

On 4 March 2024 we reported our findings to the World Health Organization.

CHANGE IN ADVICE

Today, 10 March 2024, I took the test again. As before I posed as a man who drinks 42 units per week. This time I got a different result:

"You are on the right track. You are at lower risk of alcohol-related problems... To keep your health risks low, the UK Chief Medical Officers advice is to drink no more than 14 units a week. If you are regularly drinking above 14 units per week there are tips and advice below about how to cut down."

INTERPRETATION

Prior to 4 March 2024, DrinkAware was encouraging many heavy drinkers (up to 42 units per week) to continue drinking as they are.

DrinkAware claims that its Drinking Check tool was used by 250,991 people in 2021, so it appears that potentially tens or even hundreds of thousands of people drinking 14-42 units per week may have been misinformed.

At some point between 4 March and 9 March, Drinkaware changed their Drinking Check tool so that heavy drinkers (up to 42 units per week) are now advised to cut down.

SHOULD WHO'S AUDIT TEST BE USED AS AN UNSUPERVISED SELF-EVALUATION TOOL?

Previous messages on HIFA have suggested that AUDIT should only be used as a clinical tool by health professionals, and not as an unsupervised self-evaluation tool. WHO's AUDIT manual notes: 'Care must be taken to tell patients why questions about alcohol use are being asked and to provide information they need to make appropriate responses. A decision must be made whether to administer the AUDIT orally or as a written, self-report questionnaire.'

https://iris.who.int/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6a-eng.pdf

NEXT STEPS

How many people were misled by previous advice, was that advice deliberate, and should WHO's AUDIT test (currently used as the basis for the DrinkAware test) continue to be made available as an unsupervised self-evaluation tool?

I invite HIFA members to suggest next steps. Are you a health journalist (or do you know a health journalist) who might be interested to look into this in more depth? Please pass this on and/or contact me: neil@hifa.org

Meanwhile I shall report this new finding to WHO.

I look forward to your comments and suggestions: hifa@hifaforums.org

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (136) Alcohol industry and misinformation (19) DrinkAware has changed their advice to heavy drinkers (2)

11 March, 2024

Hello Neil

This is a very good development, that HIFA discussion has uncovered the bad advice given to alcohol users by DrinkAware. And who knows how many such Organisations are giving similar bad advice, even now.

I believe you are right in wanting to take this further, at least to ensure that DrinkAware explicitly takes verifiable steps to make sure that its many fans are aware of the change in its advice.

Let's hope that some health journalist can take up the issue and give it even more publicity.

Well done HIFA!

Joseph Ana.

HIFA Profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety (CCGR&PS) with Headquarters in Calabar, Nigeria, established by HRI Global (former HRIWA). He is the Country Coordinator for PACK Nigeria (Practical Approach to Care Kit) which is specifically designed to improve clinical competence (improving accuracy of diagnosis and treatment) in primary health care. He is also a Member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health (2004-2008), Joseph Ana led the introduction of the evidence based, homegrown quality tool, the 12-Pillar Clinical Governance Programme (12-PCGP) in Nigeria, which also suitable for lower-, low-, and middle income countries (LLMIC) with similar weak health sector and system. To ensure sustainability of 12-PCGP, the 'Department of Clinical Governance, Servicom & e-health' was established in Cross River State Ministry of Health in 2007. His main interest is in 'Whole health sector and system strengthening in LLMICs'. He has written six books on the 12-Pillar Clinical Governance Programme, including the TOOLS manual for its Implementation, currently in its 2nd Edition. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Association's 'Award of Excellence' on three consecutive occasions for the innovation of 12-PCGP in Nigeria. He served as Chairman, Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He was Member,

National Tertiary Health Institutions Standards Committee (NTISC) of the Federal Ministry of Health, 2017-2022. He is the pioneer Secretary General/Trustee-Director of the Charity, NMF (Nigerian Medical Forum UK) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group; the HIFA working group on Community Health Workers, and the Working Group on HIFA-WHO Collaboration (<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>). Email: info AT hri-global.org and jneana AT yahoo.co.uk

Alcohol Use Disorders (137) Summary of our discussion so far

11 March, 2024

Dear HIFA colleagues,

Thank you all for your contributions to this rich discussion. We are now in our final week.

I invite you to reflect on anything that has been shared so far. To help with this, I have prepared what HIFA calls a 'long edit': an informal edit of our discussion up to 8 March 2023, with selected content organized under headings and subheadings:

https://www.hifa.org/sites/default/files/publications_pdf/Alcohol_Use_Di...

Please keep your contributions coming: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (138) Unanswered questions

11 March, 2024

Dear HIFA colleagues. Earlier I shared a link to an edited version of our discussion so far:

https://www.hifa.org/sites/default/files/publications_pdf/Alcohol_Use_Di...

This is 35 pages so many of you will not have time to read it. So I have prepared a list (below) of questions that have been raised in our discussion, and which are still (at least partly) unanswered. Here they are, organised under our five themes:

1. Do people understand the health, socio-economic and environmental harms of alcohol? What matters to them? How can they be better informed? How to reduce stigma?

- Are alcohol use disorders are the single most important [medical] cause of harm to others (accidents, violence, gender-based violence).

- Only 1 in 10 people in the UK are aware of the link between alcohol and cancer. What about other countries? What is being done to better inform people?

- What can be done to harmonise conflicting public health messages from different health professionals and different academic institutions, especially regarding the potential benefits of low alcohol consumption? - - How can the health community present a more united front and thereby restore trust and credibility among the general public?

- Do people have adequate access to reliable information about the causes, symptoms, and treatment options for alcohol addiction, in a language they can understand? What information is available for the individual with alcohol use disorder, their loved ones, and the general public?

- How can false beliefs about alcohol be better addressed, individually and collectively?

- There is wide consensus that the term alcoholism should be abandoned as it is stigmatising. Is it time for the National Institute on Alcohol Abuse and Alcoholism to be renamed as the National Institute on Alcohol Use Disorders.

- How can we, as a community, work towards destigmatizing alcohol use disorders and encourage a more informed and empathetic approach to addressing this challenge?

- What can be done to reduce social pressures (especially on young men) to drink large quantities of alcohol?

- What can be done to reduce stigma in some countries against people who do NOT drink?

2. Do health workers have adequate knowledge to prevent and manage alcohol use disorders among their patients? What matters to them? How can they be better informed?

- What guidance have HIFA members found to be helpful to identify and manage patients with Alcohol Use Disorders?

- What information is available about knowledge of alcohol use disorders among different health workers in different countries?

- It has been said that evidence-based alcohol care is easy. Is it?

- Brief advice is recognised as a mainstay of management, but has only been mentioned once in our discussion. How can all health workers be empowered to deliver brief advice?

- In some cultures alcohol use disorders are considered by health workers as a moral failing or due to poverty, rather than a medical disorder that can be treated. How can this be addressed?

3. What is the role of the alcohol industry? What can be done to address misinformation from the alcohol industry?

- The alcohol industry downplays the role of alcohol in cancer and other NCDs. How can this misinformation be better addressed?

- The alcohol industry is able to act in LLMICs in ways that are no longer possible in HICs. This could have devastating consequences on public health in LMICs as they face a huge and increasing non-communicable disease burden with very limited healthcare resources. How to address this?

- We found that DrinkAware provided misleading advice. Since we reported this to WHO, the advice has been changed. But questions remain: How many people have been exposed to this advice? Was it deliberate? And why is WHO's AUDIT test being used as the basis for DrinkAware's test when WHO itself says that it should only be administered in a clinical setting?

- Auditscreen.org gave similar misleading advice. Since we reported this to WHO, their advice has been changed. The above questions relating to DrinkAware are applicable also to Auditscreen.

4. Do public health professionals and policymakers have adequate knowledge to prevent and treat alcohol use disorders in their country? What are current national policies and what more can be done to fully implement those policies?

- WHO has a Global Alcohol Action Plan 2022-2030 but this is only available in pre-print. Is there a final version available?

- What does the Global Alcohol Action Plan 2022-2030 say about misinformation by the alcohol industry? I was unable to find anything on this

- HIFA members have shared observations about alcohol consumption in Ethiopia, Indonesia, Malawi, Nigeria, Uganda, UK, Uruguay, Zimbabwe. What about other countries?

5. How can we define and measure alcohol use disorders?

- Is there a universally agreed definition of Alcohol Use Disorders?

- How did WHO calculate there are 280 million people with Alcohol Use Disorders?

- Part of the world use DSM, while other parts of the world use ICD. These references have different terminology and definitions. Which reference is most useful to the practising health worker? Is there potential for DSM and ICD to bridge the gap between the two publications?

Please send your thoughts on any of the above to: hifa@hifaforums.org

With thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Alcohol Use Disorders (139) The problem of not recognizing the problem

12 March, 2024

Dear colleagues,

Today I want to reflect on one of the main barriers in Alcohol Use Disorder (AUD): denial.

When people don't know or can't admit that they have a problem, there is no way to find a solution.

According to SAMSHA's 2019 National Survey on Drug Use and Health, 21.6 million people in the US had substance use disorders (SUD), of which only 4.3% believed they had a problem that needed to be treated. (1)

In other words, the denial of the existence of the "problem" is a major "problem" in substance use disorders.

Denial is defined as "the refusal to admit the truth or reality of something." In psychology it is usually a defense mechanism to avoid facing a personal problem. (2)

Denial is common in people with alcohol use disorder, who tend to minimize the importance of their consumption, but it also extends to the environment of the person with AUD, whether family or friends.

There are several causes of this denial, among which the following stand out: the stigma associated with alcoholism and not being ready to stop drinking. (3)

Therefore, the first step in facing an alcohol use disorder (AUD) is to recognize and accept that alcohol has a negative impact on the person's life and, eventually, those around us.

Tools like the AUDIT and others are useful so that people with AUD can make it visible that they have a problem.

In most cases, someone who views alcohol as an important tool for managing their emotions and situations will continue to deny that they have an AUD until the problems become impossible to ignore.

Alcohol consumption can be problematic if it affects the person's health or puts life at risk due to traffic accidents or alcohol-related illnesses, or if it creates interpersonal difficulties with family and friends, if it impairs other activities such as work or study. (4)

Therefore, we should not wait for people to recognize that they have a problem with alcohol, because many times it may be too late.

Health professionals should apply available tools that make it easier for people with AUD to become aware of the problem and inform them that help is available to deal with it.

What do you think about it?

What is the situation in your country?

Kind regards,

Eduardo

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Alcohol Use Disorders (140) Unanswered questions (2)

Strategies to reduce alcohol consumption in minors

13 March, 2024

Dear colleagues,

Neil raised a series of unanswered questions that he identified during the course of the forum. [<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-138-unanswered-qu...>]

Among them is what can be done to reduce social pressures (especially on young people) to drink large quantities of alcohol?

With this communication I want to summarize the information available in this regard.

There is no single measure - a silver bullet - that can solve this complex social problem on its own.

Alcohol consumption, especially among adolescents, is one of the most difficult behaviors to change, fundamentally because alcohol consumption is deeply rooted in social culture. (1) It is difficult for young people to change their behavior regarding alcohol if there is no change in society in general.

The classic strategy, often promoted or supported by the alcohol industry, is to prioritize education at the school level. Research on effective interventions to reduce underage drinking (particularly through school-based programs) has increased substantially over the past few decades. While there is some positive data, researchers have concluded that these programs alone are unlikely to lead to sustained reductions in underage drinking. (2)

Reducing alcohol-related problems among young people necessarily requires comprehensive interventions, including public policies, that help change the general social and cultural environment in which they live and sustainably reduce the amount of total alcohol consumed by society.

During the Sixty-third Session of the World Health Assembly in Geneva in May 2010, WHO's 193 Member States reached a historic consensus on a global strategy to reduce the harmful use of alcohol through adopted resolution WHA63. 13. The resolution adopted and the strategy endorsed provide guidance to both Member States and the WHO Secretariat on ways to reduce the harmful use of alcohol. (3)

It contains ten areas of policy options and interventions in which governments can intervene to reduce the harmful use of alcohol. (4)

1. Leadership, awareness and commitment.
2. Response of health services.
3. Community action.
4. Policies and measures against driving under the influence of alcohol.
5. Availability of alcohol.
6. Marketing of alcoholic beverages.

7. Pricing policies.

8. Mitigation of the negative consequences of alcohol consumption and alcohol intoxication.

9. Reduction of the public health impact of illicit alcohol and informally produced alcohol.

10. Monitoring and surveillance.

Sphere 1. Leadership, awareness and commitment. For actions to be sustainable, strong leadership and solid political will and commitment are needed, expressed through the adoption of comprehensive and intersectoral national policies, evidence-based, sufficiently funded and free of conflicts of interest.

Policies must be accompanied by a concrete action plan and supported by effective and sustainable implementation and evaluation mechanisms, and the timely participation of civil society.

Sphere 2. Health services response. Health services are essential to address individual-level harm among people with alcohol use disorders and other alcohol-induced health problems. These should offer prevention and treatment interventions to individuals and families who are at risk of, or already have, alcohol use disorders and associated conditions. The health service response must be strengthened and sufficiently funded to match the magnitude of the public health problems caused by the harmful use of alcohol.

Sphere 3. Community action. Governments and other stakeholders can support communities and build their capacity to use theoretical and practical knowledge to adopt effective approaches to prevent and reduce alcohol use and modify collective behavior, and then impact individual behavior.

Policy options and interventions in this area include, among others: support for rapid assessments to identify gaps and priority areas of action in community-level interventions; promoting greater recognition of alcohol-related harms at the local level and promoting appropriate effective and cost-effective responses; strengthening the capacity of local authorities to promote and coordinate concerted community actions; capacity building at the community level for regulatory enforcement; mobilization of communities to prevent the sale of alcohol to minors; provision of care and support to affected people and their families; community programs and policies for subpopulations at particular risk, such as youth and others

Sphere 4. Policies and measures against driving under the influence of alcohol. Driving under the influence of alcohol seriously affects judgment, coordination

and other motor functions. This is a major public health problem that affects the drinker and, in many cases, innocent parties. Policy options and interventions in this area include, among others, implementing and enforcing an upper limit for blood alcohol concentration; increased checkpoints and random breath testing; administrative suspension of driving license; progressive permit for new drivers with zero tolerance for alcohol while driving.

Sphere 5. Alcohol availability. Public health strategies aimed at regulating the commercial or public availability of alcohol through laws, policies and programs are an important means of reducing the overall level of alcohol use, especially by vulnerable or high-risk groups. Reducing the commercial and public availability of alcohol can in turn influence the social availability of alcohol and thus contribute to changing social and cultural norms.

Policy options and interventions in this area include the implementation of an appropriate system to regulate the production, wholesale and service of alcoholic beverages and to impose limits on the distribution of alcohol and the operation of alcohol outlets, through the application of the following measures (5): introduction of a retail marketing authorization system or state monopolies aimed at public health; regulation of the number and location of alcohol point of sales, whether or not located on premises; regulation of the days and hours of operation of retail outlets; regulation of retail sales in certain locations or during special events; establishing an appropriate minimum age for purchasing or consuming alcoholic beverages; adoption of policies to prevent sales to intoxicated persons and those under the legal minimum age, and consideration of the possibility of implementing mechanisms to hold sellers and waiters accountable in accordance with national legislation; formulation of policies regarding the consumption of alcohol in public places and in official activities and functions of public bodies; adoption of policies aimed at reducing and eliminating the availability of alcoholic beverages produced, sold and distributed informally or illicitly.

Sphere 6. Marketing of alcoholic beverages. Reducing the impact of marketing, especially among young people and adolescents, is an important objective if the use of alcohol is to be reduced. Alcohol is marketed through increasingly sophisticated advertising and promotion techniques, including sponsorship of sporting and cultural events. It is very difficult to target marketing to young adult consumers without simultaneously exposing those under the legal drinking age.

Policy options and interventions in this area include:

(a) regulatory frameworks, preferably of a legislative nature, through: regulation of the content and magnitude of marketing (direct and indirect) in all media; regulation of sponsorship activities; restriction or prohibition of

promotions; regulation of new forms of alcohol marketing, such as social media;

(b) development by public bodies or independent bodies of effective monitoring systems for the marketing of alcohol products;

(c) establishment of effective administrative and deterrent regimes regarding violations of marketing restrictions.

Sphere 7. Pricing policies. Pricing policies are one of the most effective interventions to reduce the consumption of alcoholic beverages (especially by minors), and stop the progression towards the ingestion of large quantities of alcohol and/or episodes of binge drinking.

It is estimated that increasing the price of alcohol by 10% would reduce overall alcohol consumption by an average of around 7% across all types of drinks. The more the price of alcohol increases, the more alcohol consumption and related harms could potentially be reduced. (6)

The existence of a significant illicit market for alcohol can undermine these policies, so changes in taxation must be accompanied by activities aimed at subjecting illicit and informal markets to effective public control.

Increasing taxes may also encounter resistance from consumer groups and economic operators.

Policy options and interventions in this area include: a specific national tax regime on alcohol, accompanied by effective enforcement measures; periodic review of prices based on inflation and income; prohibition or restriction of any direct or indirect form of promotional prices, discount sales, prices below cost and single prices that give the right to unlimited drinking; setting minimum prices for alcohol, where applicable; reduction or interruption of subsidies for economic operators in the alcohol sector.

Sphere 8. Mitigation of the negative consequences of alcohol consumption and alcohol intoxication. It includes policy options and interventions that focus directly on reducing the harm caused by alcohol intoxication and alcohol consumption. Including:

(a) regulating the context of alcohol consumption to minimize violence and disruptive behaviors, including the use of plastic or shatterproof glass containers to serve alcohol and the management of alcohol problems at large scale public events;

(b) demand compliance with laws that prevent the serving of alcohol to the point of intoxication of the drinker and legal responsibility for the consequences of the resulting damages;

(c) adoption of management policies in relation to the responsible serving of alcoholic beverages on premises and training of staff in relevant sectors on how best to avoid situations of drunk and aggressive drinkers, and to identify and treat such persons;

(d) reduction of the alcoholic content of different types of beverages;

Sphere 9. Reducing the public health impact of illicit alcohol and informally produced alcohol

The consumption of illicitly or informally produced alcohol can hamper the ability of governments to intervene in the alcohol problem by taxing and controlling the marketing of alcohol.

To achieve this, good scientific, technical and institutional capacity must be available to plan and apply appropriate national, regional and international measures. Good knowledge of the market and a correct understanding of the composition and production of informal or illicit alcohol are also important, as well as an adequate legislative framework and measures for its effective enforcement.

The increased revenue from the alcohol tax can be, in part, used to combat illicit trade.

Sphere 10. Monitoring and surveillance. Monitoring and surveillance measures are required at the local, national, and international levels to monitor the magnitude and trends of alcohol-related harms, strengthen advocacy activities, formulate policies, and evaluate the impact of interventions.

For practical purposes of understanding and implementation, priority measures to reduce alcohol consumption and alcohol-related problems have been summarized in the SAFER Strategy: (7)

Strengthen restrictions on alcohol availability. Enacting and enforcing restrictions on commercial or public availability of alcohol through laws, policies, and programmes are important ways to reduce harmful use of alcohol. Such strategies provide essential measures to prevent easy access to alcohol by young people and other vulnerable and high-risk groups.

Advance and enforce drink driving countermeasures. Road users who are impaired by alcohol have a significantly higher risk of being involved in a crash. Enacting and enforcing strong drink-driving laws and low blood alcohol concentration limits via sobriety checkpoints and random breath testing will help to turn the tide.

Facilitate access to screening, brief interventions and treatment. Health professionals have an important role in helping people to reduce or stop their drinking to reduce health risks, and health services have to provide effective interventions for those in need of help and their families.

Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion. Bans and comprehensive restrictions on alcohol advertising, sponsorship and promotion are impactful and cost-effective measures. Enacting and enforcing bans or comprehensive restrictions on exposure to them in the digital world will bring public health benefits and help protect children, adolescents and abstainers from the pressure to start consuming alcohol.

Raise prices on alcohol through excise taxes and pricing policies

Alcohol taxation and pricing policies are among the most effective and cost-effective alcohol control measures. An increase in excise taxes on alcoholic beverages is a proven measure to reduce harmful use of alcohol and it provides governments revenue to offset the economic costs of harmful use of alcohol.

I hope this material can be useful to you.

Kind regards,

Eduardo

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Alcohol Use Disorders (141) Alcohol consumption in different countries (5) Alcohol consumption in Portugal and Sweden

13 March, 2024

Hello everyone,

I haven't had the opportunity to introduce myself earlier. My name is Ana Rita Oliveira, I am Portuguese, and I have a Bachelor's and a Master's degree in Pharmacy. Currently, I am pursuing a second Master's degree in Public Health in Sweden, and I would like to share some information regarding alcohol use in Portugal and the contrasting attitudes towards alcohol culture when comparing Portugal and Sweden.

Among countries in the European Union, Portugal has the highest percentage of the population (around 20%) consuming alcoholic beverages daily. According to GISAH - WHO Global Information System on Alcohol and Health, in 2016, the alcohol consumption per person over 15 years of age in Portugal was 12 liters of pure alcohol annually, roughly equivalent to 4.6 liters of beer per week. In 2018, Portugal was shown to have the highest wine consumption in the world, with an average consumption of 62 liters per inhabitant per year, and the prevalence of alcohol dependence increased from 3% in 2012 to 4.2% in 2022, according to the Portuguese Society of Alcoology.

In Portugal, many still believe that alcohol, especially wine, is good for health, but often overlook the risks. This raises concerns about how cultural beliefs can overshadow health considerations.

In contrast, in Sweden, there's a notable emphasis on responsible alcohol consumption and a strong awareness of the risks associated with excessive drinking. The Swedish government has implemented strict regulations, such as high taxes and limited availability through state-owned alcohol retailers (Systembolaget), to mitigate alcohol-related harm. The per capita consumption was about 8.8 liters of pure alcohol per person (15+ years) in 2022, and youth drinking has been declining for two decades in Sweden. Despite this progress, the majority of young people in Sweden still consume alcohol, which can lead to dire consequences.

In conclusion, while Sweden demonstrates more promising outcomes in managing alcohol consumption, there remains a need for changing action in both countries. From my perspective, it's important that both Portugal and Sweden prioritize initiatives to raise awareness, enforce regulations, and foster healthier attitudes towards alcohol to safeguard public health.

Kind Regards,

Ana Rita

HIFA profile: Ana Rita Primo Ferreira Oliveira é mestranda em Saúde Pública na Universidade de Lund, Suécia. Licenciada em Farmácia e Mestre em Farmacoterapia e Farmacoepidemiologia (BPharm, MPharm) e Medical Information Specialist. anaritaprimoliveira@gmail.com

Alcohol Use Disorders (142) Unanswered questions (3)

13 March, 2024

Dear Neil,

Thanks to the HIFA forum discussions on Alcohol Use Disorder (AUD) which enables to learn about interesting experiences and research from our HIFA colleagues in various countries.

I would like to add the inclusion of community participation in policies to address adolescents and children education early.

1. Do people understand the health, socio-economic and environmental harms of alcohol? What matters to them? How can they be better informed? How to reduce stigma?

- Awareness on healthy lifestyle today has come a long way which has also created an interest in adolescents. As per the UNESCO publication 'Globally, on average, about one in four 13-15 year olds report having used alcohol during the last 12 months - twice as many as used tobacco'.

- Alcohol Use Disorder (AUD) in past and even today is seen more of a stigma

(compared to smoking) and delay in seeking health care service support.

- Infographics (posters) should be freely (without cost) available on AUD for community engagement particularly in LMICs.

- There are several challenges with AUD such as:

Alcohol is not so easy to acquire; it is drunk privately (not on the streets such as smoking); social drinking is recently getting more acceptability as a social, modern and economic lifestyle status; its costs varies from very cheap to very expensive

2. Do health workers have adequate knowledge to prevent and manage alcohol use disorders among their patients? What matters to them? How can they be better informed?

- All health facilities should be encouraged to establish a program with 'trained staff' on AUD in order to help not only patients but also their staff.

- Medical, Nursing and Allied Health Sciences should be encouraged to get 'formal training' (tools, online courses) on AUD during their medical school curriculum.

- Basic Training course (tools) on AUD should be developed to encourage more patient participation during their hospital stay or in outpatient clinics and community engagement for dissemination.

- AUD for TV screening should be included along with what is shown normally on immunisations, maternal and children health, while patients are waiting at the out-patient clinic.

- Health care workers should have access to updated evidence-based information (social media, scientific platforms etc.) on AUD.

3. What is the role of the alcohol industry? What can be done to address misinformation from the alcohol industry?

- It is important to engage the alcohol industry and communities in order to bring policy change through evidence-based information (e.g. every cigarette packet has a warning message in bold, this change took several years).

4. Do public health professionals and policymakers have adequate knowledge to prevent and treat alcohol use disorders in their country? What are current national policies and what more can be done to fully implement those policies?

- Most of the countries have either national guidelines or policies for alcohol use disorders. (Ref. UNESCO booklet¹⁰ in collaboration with UNODC and WHO: Good policy and practice in health education. Education sector responses to the use

of alcohol, tobacco and drugs. 2017).

- However, these are not implemented at the grassroots level involving the communities.

- The education sector with its varied actors can be mobilised as a solid ecosystem to bring a change in the early adolescent period. AUD should be included in the education curriculum particularly in 'the primary school children'.

- School systems can reach a very wide audience in the community for policy changes.

- During adolescence the brain is at a crucial stage of developing and studies have shown that repeated alcohol use can have long lasting serious neurological consequences. (ref. 2015).

- Emphasis on 'awareness programs for adolescents' can make a difference.

A long-term follow-up study showed that school children who were provided with either 'universal web-based prevention for all students' or 'preventive interventions for high risk students' or provided a 'combination of both these interventions' could benefit with long-lasting effects of reduction of risky and harmful drinking until their adulthood in comparison to those children provided with only 'health education as usual'. (ref. Journal of the American Academy of Child and Adolescent Psychiatry April 2022)

- Of the WHO's four priority areas for global action, three areas align to HIFA's vision:

public health advocacy and partnership; technical support and capacity building
; production and dissemination of knowledge

5. How can we define and measure alcohol use disorders?

The National Institute on Alcohol Abuse and Alcoholism:

- defines binge drinking as a pattern of drinking that brings a person's blood alcohol concentration, or BAC, to 0.08 grams per deciliter or above.

- This typically happens when men consume five or more drinks, and when women consume four or more drinks, in about two hours.

Best wishes

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<http://www.gfmer.ch/surgery/cancer.htm>

www.gfmer.ch/surgery/cancer.htm

Senior Advisor, Global Action, International Society of Geriatric Oncology (SIOG), Switzerland. Permanent Committees - SIOG <https://siog.org/about-us/governance/leadership/permanent-committees/>

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Currently she works as the Director, Global Health New Challenges program, Geneva Foundation for Medical Education and Research, Geneva, Switzerland; Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China; Senior Advisor, Global Action, International Society of Geriatric Oncology, Switzerland; Member of the WHO-HIFA Working Group on Essential Health Services and COVID-19; and HIFA mHEALTH-INNOVATE Working Group.

Alcohol Use Disorders (143) Unanswered questions (4)

How can all healthcare workers be empowered to provide brief advice?

13 March, 2024

Dear Neil,

In response to your request to address some questions not (properly) answered in the Forum, I would like to provide information on the following point:

How can all healthcare workers be empowered to provide brief advice?

What is an alcohol brief intervention?

“Brief interventions are those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it.”

Face-to-face alcohol brief interventions (ABIs) are heterogeneous interventions that include “short conversations aiming in a non-confrontational way to motivate individuals to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm” .

ABIs have historically included the use of a screening questionnaire to assess an individual’s consumption level and risk of alcohol problems, and the provision of personalized feedback to those identified as being in need of support .

Evidence supports the use of widespread screening for alcohol problems in primary care so as to identify people who may benefit from an intervention at the earliest opportunity.

Some large-scale programmes (such as in Scotland, United Kingdom) have chosen to take a very broad targeted approach in primary care, in which practitioners were provided with a long list of potential presenting conditions and issues for which screening was recommended.

Although this approach potentially missed some patients, it was felt to make it easier for practitioners to feel comfortable raising the issue of alcohol and to take a patient-centered approach.

ABIs also include interventions delivered electronically, such as through mobile phone applications and websites. These interventions may be accessed independently by patients, accessed following a recommendation from a professional, used with guidance or together with advice from, for example, a primary care professional.

There is evidence from several systematic reviews that electronically delivered interventions are also effective in reducing alcohol consumption by a small but significant amount.

Digitally delivered screening and brief interventions may cost less to establish and implement per patient and have the potential to reach a wider population, but they might not be accessed by those less motivated to change.

Brief interventions are known in research literature and practice by many different names and acronyms.

The most common terms in the international research literature are screening and brief intervention (SBI) and, in the United States of America, screening, brief intervention and referral to treatment (SBIRT). In the United Kingdom, identification and brief advice (IBA) is the most common term. There is little consensus about specific differences between the different terms, and the content or delivery of an intervention cannot necessarily be identified by the acronym by which it is described.

The term brief intervention is, therefore, best seen as an umbrella term encompassing a wide range of interventions that fit within the broad definitions given above. Most types of brief intervention draw (or have drawn) to a greater or lesser extent on two key concepts: stages of change and motivational interviewing.

We are using the term ABI, meaning an alcohol brief intervention which includes screening, and SBI, meaning screening and brief intervention.

Types of brief intervention

Brief interventions vary in several ways:

- length: from five minutes to several sessions of an hour or more
- tone: advice-giving versus guiding
- based (or not) on MI
- based (or not) on stages of change
- focused on different severities of alcohol problem (hazardous/harmful/dependent drinking).

Brief Advice ----- Brief Intervention ----- Extended BI or brief MI

Screening. Screening Screening

Feedback Listen and motivate. MI- Based counselling

Advice 1+ sessions 1+ sessions

1 session (5-15 min) (20-30 min)

(< 5 min)

Although they may be known under different names and acronyms, they are all brief interventions.

While the length of brief interventions does not dictate the content or style, they are best viewed as a continuum.

Regarding where HCW can reach further information:

1. WHO alcohol brief intervention training manual for primary care

https://www.drugsandalcohol.ie/28029/1/WHO_Alcohol-training-manual-final...

This manual provides information to plan training and support for primary care practitioners to confidently deliver SBI for alcohol problems to their patients. The manual outlines the background and evidence base for SBI, and gives practical advice on establishing an implementation programme as well as detailed educational materials to develop the knowledge and skills of participants in organized training sessions.

2. New NIAAA Resource Helps Healthcare Professionals Provide Better Alcohol-Related Care

<https://niaaa.scienceblog.com/415/new-niaaa-resource-helps-healthcare-pr...>

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has released The Healthcare Professional's Core Resource on Alcohol (HPCR) to help healthcare professionals provide evidence-based care for people who drink alcohol.

Created with busy clinicians in mind, the HPCR provides concise, thorough information designed to help them integrate alcohol care into their practice. Healthcare professionals can earn free continuing education (CME/CE) credits for completing HPCR articles.

Here you are some videos showing how to perform an Alcohol Brief Intervention:

<https://www.ccsa.ca/brief-intervention-establishing-rapport-discuss-alco...>

<https://www.youtube.com/watch?v=b-ilxvHZJDC>

<https://www.youtube.com/watch?v=PaSKcfTmFEk>

I hope this information can be useful to you.

Kind regards,

Eduardo

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HIFA profile: Eduardo Bianco is a medical doctor and Cardiologist, Certified Tobacco Cessation Expert with a Masters in Prevention and Treatment of Addictive Disorders. Currently, he is Chair of the World Heart Federation Tobacco Expert Group. Dr. Bianco's research examines tobacco control and cessation, and he is a prominent member of several organizations that address tobacco control in Latin America. Dr. Bianco has worked for 25 years in Uruguay and Latin America to promote and train in smoking cessation treatment and tobacco control policies. He is also the former Regional Coordinator for the Americas of the Framework Convention Alliance and former Technical Director of the MOH Center for International Cooperation for Tobacco. ebianco@nextgenu.org

Alcohol Use Disorders (144) Public meeting on the relationship between alcohol consumption & health

14 March, 2024

Join @NASEM_Health 3/28 for a public meeting on the relationship between alcohol consumption & health, including #Cancer, #NeurocognitiveDevelopment, and all-cause mortality. Members of the public will also have an opportunity to comment. Register now: <https://ow.ly/tNTf50QQuie>

Esha Ray Cahudhuri

Calgary, Canada

HIFA profile: Esha Ray Chaudhuri is an Equity Analyst, in Canada. Professional interests: Equity Issues in Health and Health Care with particular focus on interface of Local and Global contexts. She is affiliated to Patients for Patient Safety Canada-Healthcare Excellence Canada, and is a member of the GLL4QUHC at WHO.

[*Note from HIFA moderator (NPW): From the website: 'A National Academies of Sciences, Engineering, and Medicine committee will hold a meeting to undertake a review of the current scientific evidence on the relationship between alcohol consumption and health outcomes. As part of this meeting, the committee will invite speakers to present on related topics to its Statement of

Task such as neurocognitive development, cancer, all-cause mortality, and considerations for alcohol consumption measurement and patterns. During the meeting, members of the public will be able to provide comments. The committee will produce a report that summarizes the evidence in conclusion statements that will be graded to indicate the strength of the evidence, but it will not include dietary statements, recommendations, or advice.']

Alcohol Use Disorders (145) Harm to others from Alcohol

14 March, 2024

Dear colleagues,

Among the unanswered questions, Neil asked us the following one:

Are alcohol use disorders the single most important [medical] cause of harm to others (accidents, violence, gender-based violence).

At the moment, there appears to be not enough data to answer this question, because we should first estimate the “harm to others” caused by alcohol consumption (not just AUDs) and then compare it to other causes of harm to “others.”

The initial problem is the estimation of “harm to others” caused by alcohol.

Although this issue has been recognized for decades, until recently, no methodologies had been proposed to evaluate it.

The issue of harm to others from alcohol emerged in 1995, with the European Charter on Alcohol, which marked a shift towards a more comprehensive approach to harm caused by alcohol, and included harm to others as well as insisting on the obligation of governments to protect their citizens against it.

In 1996, the WHO took one of the fundamental principles of that charter: “Everyone has the right to a family, community and work life protected from accidents, violence and other negative consequences of alcohol consumption.”

In 2005, when the WHO European Region Alcohol Policy Framework was developed, it included among its guiding principles:

“Each Member State has not only the right but also the obligation to provide a high level of protection to its citizens against alcohol-related harm, particularly with regard to harm caused by the alcohol consumption of others and vulnerable groups.” like when they were children.”

In 2010, this perspective was further strengthened by the 2010 WHO Global Strategy to Reduce the Harmful Use of Alcohol which included the principle that

the protection of those exposed to the effects of harmful alcohol use by others should be a priority. integral part of alcohol control policies.

To refer to this issue, several terms were coined: "alcohol harm to others" and related terms such as "negative externalities," "collateral damage," and the "second-hand effects" of alcohol consumption.

As I said above, the problem with this topic is "quantification," since "alcohol harm to others" is broad in scope.

This can be about INDIVIDUALS: family members, other people who have a regular relationship with the drinker (friends, co-workers, neighbors), but also unknown people, as is the case of accidents due to driving under the influence of alcohol.

They can also be COLLECTIVE, and affect the physical and social environment, either at the level of:

- Neighborhood: can make a locality less attractive due to noise levels, nuisance and litter, which are often related to places where people gather to drink in the street
- An entire region or society can be negatively affected by alcohol. This is easier to see in small societies, such as in some indigenous societies with high alcohol consumption.
- A large nation: in the 1950s, at the height of alcohol consumption levels in France, the term "alcoholization" was coined to describe the adverse effects of high levels of consumption on society as a whole .

The study of harm to others can be approached from various points of view:

- an economic perspective, through studies of the "cost of illness". Given limitations in data availability, this perspective has focused on the costs to the government of institutional responses, rather than focusing on the costs to the family or others in direct contact with the drinker. Some of the ways in which alcohol burdens societies include: decreased work productivity, absenteeism, increased morbidity and mortality, increased pressure on health and social security systems, and finally, harm to the national and family economy.
- Another perspective relates to the number of cases recorded by social response systems that address current social problems (social welfare agencies, housing and family support, police and judicial systems, health systems and agencies: such as ambulance services and emergency services, hospitals, mental health and alcoholism treatment services, and primary care professionals). These records are a primary source of data on the social and health problems of a society.
- A third perspective is the drinker's point of view. While drinkers often recognize the harm or problems they cause others through their alcohol use,

sometimes they are not even aware of how their behavior has caused harm to others.

- A fourth perspective is the perspective of the other. A person who, whether known to the drinker or not, is negatively affected by another person's consumption of alcohol.

Furthermore, to measure the harm that alcohol consumption causes to others, there are three big questions to consider:

A) that agencies tend to deal mainly with the most serious cases, leaving aside less serious events.

B) the variety of systems and types of institutions involved in the social response, ranging from government departments, subnational levels and even international organizations; there being no type of coordination between the different levels, so the damage to others is difficult to evaluate.

C) that many of these systems focus on evaluating the individual case and remedying the harm, but do not usually record whether another person's alcohol consumption was a factor in the harm.

At a 2009 WHO meeting in Stockholm, "an international collaborative research initiative on alcohol, health and development" was launched, which included harm to others.

Based on this study, in 2019 the WHO published: Harm to others from drinking: patterns in nine societies, accessible at:

<https://iris.who.int/bitstream/handle/10665/329393/9789241515368-eng.pdf...>

From this publication we have extracted the information for this communication.

The WHO publication constitutes a first look at patterns of harm caused by others' alcohol consumption in nine societies.

The data from the publication provide insight into the extent and distribution of harm at the interpersonal level in the general adult population.

It states that:

- The damage that alcohol consumption causes to others is usually large.

- Two studies have estimated that they are of the same order or greater magnitude than the adverse effects for the drinker. (Nutt, King et al. 2010) (Laslett et al. 2010: 177).

- Harm could be attributed to alcohol consumption by a friend, family member,

or acquaintance of the respondent (a known drinker) or a stranger, or both.

- harm to children caused by alcohol consumption by parents and other adults was considered,

- Harm can occur in a variety of contexts: at home; in a traffic accident; in an attack by one group of drinkers on another in a bar or on the street; or as property damage caused by a group of street drinkers at night.

In interpreting the different patterns of responses in the various societies represented, it is considered that the differences may partly reflect cultural differences regarding drinking.

Some consistent patterns identified were the followings:

- Harm caused by strangers was considerably more common than that caused by known drinkers in the three richest societies, which in turn have the highest levels of urbanization (Australia, New Zealand and Chile), but were also significant in Thailand.

- More tangible damages were more common in Thailand and Chile

- Thailand, Sri Lanka and India show the highest rates of harm caused by known drinkers.

- India, Thailand and Australia show high rates of harm from alcohol consumption by anyone, whether known or unknown to the respondent.

- Younger age was the only demographic factor that was consistently associated with greater harm to others from alcohol consumption in almost all countries studied.

There were differences between societies in gender, educational level, and geographic location of alcohol-related harms.

- In four countries, higher education was associated with more harm, and only in India was a lower level of education linked to harm.

- In four countries, people in non-rural regions suffered more harm than those in rural regions. While in Vietnam the opposite happened.

- A common finding was that respondents' alcohol consumption and risky drinking were associated with harm caused by others' alcohol consumption. Respondents who drink are more exposed to harm from others' alcohol consumption.

- Although men tend to be heavier drinkers than women in all countries, a similar or higher percentage of women were observed to experience some harm caused by others' alcohol consumption.

- The highest rates of harm caused by known drinkers were reported in Thailand, India and Sri Lanka, which are among the four lowest countries in per capita consumption and in the proportion of adults who drink alcohol. In these societies, drinking appears to be less socially acceptable, and the harms caused by drinking often appear in intimate relationships, when they "come home."

I hope this information can be useful.

Kind regards,

Eduardo

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Alcohol Use Disorders (146) How can we define and

19 March, 2024

Dear Richard Velleman,

Re: <https://www.hifa.org/dgroups-rss/alcohol-use-disorders-125-how-can-we-de...>

Thank you for confirming that there are multiple definitions of alcohol use disorders 'because different organisations DO focus on different issues - for

example, some may focus on physical health and harms to health, others may focus on social problems, some on criminal justice consequences, etc'.

Your own perspective - "Someone has an alcohol problem if their drinking causes them or anyone else a problem" - is persuasive. Indeed it cannot logically be refuted. This defines an 'alcohol problem' but how would you define 'alcohol use disorders'? In the same way?

You mention WebMD's definition - 'Alcohol use disorder (AUD) is a chronic illness in which you can't stop or control your drinking even though it's hurting your social life, your job, or your health' - as reflecting an outdated binary conceptualisation. But I find this definition also is persuasive, and adequately embraces (nearly) everyone who has, in your definition, 'an alcohol problem'.

You give the amusing example of a person who has one pint of beer and this becomes a relationship problem because the spouse is a teetotaler. Whether this is 'alcohol use disorder' depends on the context. If the person cannot 'control' their one pint a week while knowing that it is causing a problem in the relationship, then at a stretch this could be an alcohol use disorder. It sounds more likely that the problem is related to spousal intolerance and/or a deeper problem in the relationship.

"It means that whether or not someone has a drinking problem is not determined by fixed quantities of alcohol, or fixed timings, but instead is a matter of negotiation by the individual with him or herself, family, friends, work place, and society as a whole."

Very often, people may be drinking more than is healthy for them, predisposing them to cancers and other chronic illnesses later in life. But not so much as to be even recognised as an problem by themselves or others. I would see this situation being 'covered' adequately by the WebMD definition. The person cannot fully control their drinking (it has become a habit) and it is hurting their (long-term) health.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based

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Alcohol Use Disorders (147) How can we define and measure alcohol use disorders? (8)

19 March, 2024

Eduardo wrote: "I agree that different countries have different definitions regarding the unit of alcohol and the amount of alcohol in different drinks. That is part of the problem. Isn't it time for a global discussion on this matter (and others)? Something similar to the WHO- FCTC. [Framework Convention on Tobacco Control] Probably very difficult, but it could be tried."

This issue was presumably explored and debated in the WHO Global Alcohol Action Plan 2022-2030 (which curiously seems to be available only as a pre-print).

Among the agreed actions for the WHO Secretariat: Action 6: Review, update and disseminate WHO nomenclature and definitions of alcohol-related terms, particularly in the area of alcohol policy and monitoring.

The WHO Global Alcohol Action Plan states: 'In the International Classification of Diseases, 11th revision (ICD-11) (Geneva: World Health Organization; 2019), the "hazardous alcohol use" is defined as a "pattern of alcohol use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals".' It does not mention the DSM definition. The term 'alcohol use disorders' is mentioned once and not defined.

One of the many unanswered questions from our discussion is how WHO's number of 280 million people with alcohol use disorders was calculated.

<https://www.hifa.org/dgroups-rss/alcohol-use-disorders-138-unanswered-qu...>

<https://www.who.int/news/item/21-09-2018-harmful-use-of-alcohol-kills-mo...>

Best wishes, Neil (HIFA coordinator)