Media centre

Alcohol

Fact sheet
Updated January 2015

Key facts [1]

- Worldwide, 3.3 million deaths every year result from harmful use of alcohol,[2] this represent 5.9 % of all deaths.
- The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions.
- Overall 5.1 % of the global burden of disease and injury is attributable to alcohol, as measured in disability- adjusted life years (DALYs).[3]
- Alcohol consumption causes death and disability relatively early in life. In the age group 20 – 39 years approximately 25 % of the total deaths are alcohol-attributable.
- There is a causal relationship between harmful use of alcohol and a range of mental and behavioural disorders, other noncommunicable conditions as well as injuries.
- The latest causal relationships have been established between harmful drinking and incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS.
- Beyond health consequences, the harmful use of alcohol brings significant social and economic losses to individuals and society at large.

Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. The harmful use of alcohol causes a large disease, social and economic burden in societies.

Alcohol impacts people and societies in many ways and it is determined by the volume of alcohol consumed, the pattern of drinking, and, on rare occasions, the quality of alcohol consumed. In 2012, about 3.3 million deaths, or 5.9 % of all global deaths, were attributable to alcohol consumption.

The harmful use of alcohol can also result in harm to other people, such

as family members, friends, co-workers and strangers. Moreover, the harmful use of alcohol results in a significant health, social and economic burden on society at large.

Alcohol consumption is a causal factor in more than 200 disease and injury conditions. Drinking alcohol is associated with a risk of developing health problems such as mental and behavioural disorders, including alcohol dependence, major noncommunicable diseases such as liver cirrhosis, some cancers and cardiovascular diseases, as well as injuries resulting from violence and road clashes and collisions.

A significant proportion of the disease burden attributable to alcohol consumption arises from unintentional and intentional injuries, including those due to road traffic crashes, violence, and suicides, and fatal alcohol-related injuries tend to occur in relatively younger age groups.

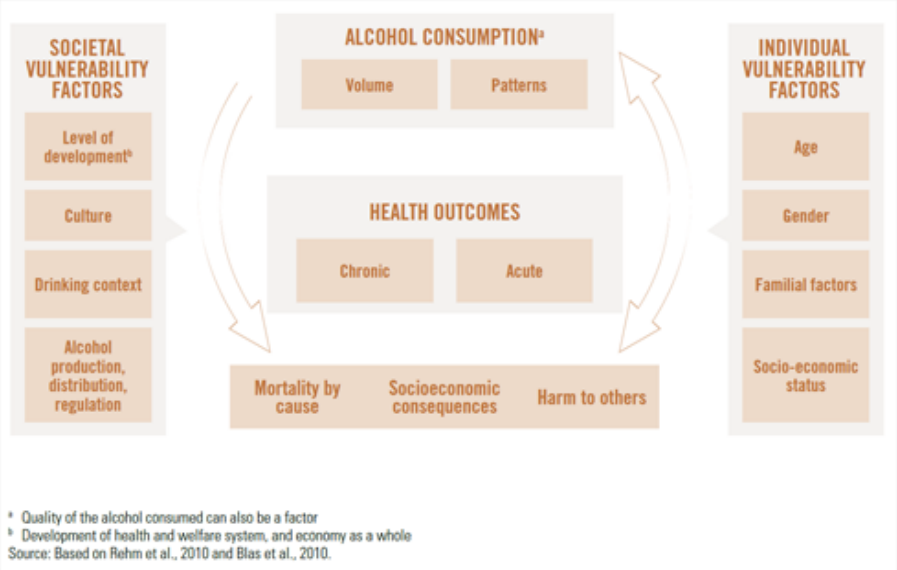
The latest causal relationships are those between harmful drinking and incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS. Alcohol consumption by an expectant mother may cause fetal alcohol syndrome and pre-term birth complications.

Factors affecting alcohol consumption and alcohol-related harm

A variety of factors have been identified at the individual and the societal level, which affect the levels and patterns of alcohol consumption and the magnitude of alcohol-related problems in populations.

Environmental factors include economic development, culture, availability of alcohol, and the comprehensiveness and levels of implementation and enforcement of alcohol policies. For a given level or pattern of drinking, vulnerabilities within a society are likely to have similar differential effects as those between societies. Although there is no single risk factor that is dominant, the more vulnerabilities a person has, the more likely the person is to develop alcohol-related problems as a result of alcohol consumption.

Conceptual causal model of alcohol consumption and health outcomes



The impact of alcohol consumption on chronic and acute health outcomes in populations is largely determined by 2 separate but related dimensions of drinking:

- the total volume of alcohol consumed, and
- the pattern of drinking.

The context of drinking plays an important role in occurrence of alcohol-related harm, particularly associated with health effects of alcohol intoxication, and, on rare occasions, also the quality of alcohol consumed. Alcohol consumption can have an impact not only on the incidence of diseases, injuries and other health conditions, but also on the course of disorders and their outcomes in individuals.

There are gender differences in alcohol-related mortality, morbidity, as well as levels and patterns of alcohol consumption. The percentage of alcohol-attributable deaths among men amount to 7.6 % of all global deaths compared to 4.0 % of all deaths among women. Total alcohol per capita consumption in 2010 among male and female drinkers worldwide was on average 21.2 litres for males and 8.9 litres of pure alcohol for females.

Ways to reduce the burden from harmful use of alcohol

The health, safety and socioeconomic problems attributable to alcohol can be effectively reduced and requires actions on the levels, patterns and contexts of alcohol consumption and the wider social determinants of health.

Countries have a responsibility for formulating, implementing, monitoring

and evaluating public policies to reduce the harmful use of alcohol. Substantial scientific knowledge exists for policy-makers on the effectiveness and cost–effectiveness of the following strategies:

- regulating the marketing of alcoholic beverages (in particular to younger people);
- regulating and restricting availability of alcohol;
- enacting appropriate drink-driving policies;
- reducing demand through taxation and pricing mechanisms;
- raising awareness of public health problems caused by harmful use of alcohol and ensuring support for effective alcohol policies;
- providing accessible and affordable treatment for people with alcohol-use disorders; and
- implementing screening and brief interventions programmes for hazardous and harmful drinking in health services.

WHO response

WHO aims to reduce the health burden caused by the harmful use of alcohol and, thereby, to save lives, prevent injuries and diseases and improve the well-being of individuals, communities and society at large.

WHO emphasizes the development, implementation and evaluation of cost-effective interventions for harmful use of alcohol as well as creating, compiling and disseminating scientific information on alcohol use and dependence, and related health and social consequences.

In 2010, the World Health Assembly approved a resolution endorsing a global strategy to reduce the harmful use of alcohol. The resolution urges countries to strengthen national responses to public health problems caused by the harmful use of alcohol.

The global strategy to reduce the harmful use of alcohol represents a collective commitment by WHO Member States to reduce the global burden of disease caused by harmful use of alcohol. The strategy includes evidence-based policies and interventions that can protect health and save lives if adopted, implemented and enforced. The strategy also contains a set of principles to guide the development and implementation of policies; it sets priority areas for global action, recommends target areas for national action and gives a strong mandate to WHO to strengthen action at all levels.

The policy options and interventions available for national action can be grouped into 10 recommended target areas, which are mutually supportive and complementary. The 10 areas are:

- leadership, awareness and commitment

- health services' response
- community action
- drink–driving policies and countermeasures
- availability of alcohol
- marketing of alcoholic beverages
- pricing policies
- reducing the negative consequences of drinking and alcohol intoxication
- reducing the public health impact of illicit alcohol and informally produced alcohol
- monitoring and surveillance.

The Global Information System on Alcohol and Health (GISAH) has been developed by WHO to dynamically present data on levels and patterns of alcohol consumption, alcohol-attributable health and social consequences and policy responses at all levels.

Successful implementation of the strategy will require action by countries, effective global governance and appropriate engagement of all relevant stakeholders. By effectively working together, the negative health and social consequences of alcohol can be reduced.

Footnotes

1. Based on the Global status report on alcohol and health 2014.
2. The Global strategy refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way. The concept of "harmful use of alcohol" in this context is different from "harmful use of alcohol" as a diagnostic category in the ICD-10 Classification of Mental and Behavioural Disorders (WHO, 1992).
3. The disability-adjusted life year (DALY) extends the concept of potential years of life lost due to premature death to include equivalent years of "healthy" life lost by virtue of being in states of poor health or disability.

Related links

Global status report on alcohol and health

Global strategy to reduce the harmful use of alcohol

Resources for the prevention and treatment of substance use

disorders

Global Information System on Alcohol and Health

WHO Mental Health Gap Action Programme

The global burden of disease

Global Health Risks (2009)

Management of substance abuse

Information sheet on opioid overdose

November 2014

Key facts

- Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues. Examples are morphine and heroin.
- Worldwide, an estimated 69 000 people die from opioid overdose each year.
- There are an estimated 15 million people who suffer from opioid dependence (i.e. an addiction to opioids). The majority of people dependent on opioids use illicitly cultivated and manufactured heroin, but an increasing proportion use prescription opioids.
- There are effective treatments for opioid dependence yet only 10% of people who need such treatment are receiving it.
- Due to their pharmacological effects, opioids in high doses can cause respiratory depression and death.
- The inexpensive medication naloxone can completely reverse the effects of opioid overdose and prevent deaths due to opioid overdose.

Opioids

Opioids are substances derived from the opium poppy, or synthetic analogues with similar effects. Examples are morphine, heroin, tramadol, oxycodone and methadone. Opioids have the potential to cause substance dependence that is characterized by a strong desire to take opioids, impaired control over opioid use, persistent opioid use despite harmful consequences, a higher priority given to opioid use than to other activities and obligations, increased tolerance, and a physical withdrawal reaction when opioids are discontinued. Dependence on prescription opioids includes iatrogenic dependence following the treatment of chronic pain, and dependence following the diversion and theft of prescription opioids from patients, medical facilities, pharmacies and the manufacturing and distrubution chains.

Opioid overdose

Due to their effect on the part of the brain which regulates breathing, opioids in high doses can cause respiratory depression and death. An opioid overdose can be identified by a combination of three signs and symptoms referred to as the “opioid overdose triad”. The symptoms of

the triad are:

- pinpoint pupils
- unconsciousness
- respiratory depression.

Combining opioids with alcohol and sedative medication increases the risk of respiratory depression and death, and combinations of opioids, alcohol and sedatives are often present in fatal drug overdoses.

Because of their capacity to cause respiratory depression, opioids are responsible for a high proportion of fatal drug overdoses around the world. The number of opioid overdoses has increased in recent years, in part due to the increased use of opioids in the management of chronic non-cancer pain[1]. In the United States of America alone in 2010, there were an estimated 16 651 deaths due to overdose on prescription opioids and 3036 due to overdose on heroin.

Risk factors for opioid overdose

People dependent on opioids are the group most likely to suffer an overdose. The incidence of fatal opioid overdose among opioid-dependent individuals is estimated at 0.65% per year. Non-fatal overdoses are several times more common than fatal opioid overdoses.

People at higher risk of opioid overdose

- people with opioid dependence, in particular following reduced tolerance (following detoxification, release from incarceration, cessation of treatment);
- people who inject opioids;
- people who use prescription opioids, in particular those taking higher doses;
- people who use opioids in combination with other sedating substances;
- people who use opioids and have medical conditions such as HIV, liver or lung disease or suffer from depression;
- household members of people in possession of opioids (including prescription opioids).

People likely to witness an opioid overdose

- people at risk of an opioid overdose, their friends and families;
- people whose work brings them into contact with people who overdose (health-care workers, police, emergency service workers, people providing accommodation to people who use drugs, peer education and outreach workers).

Risk factors for overdoses with prescribed opioids include a history of

substance use disorders, high prescribed dosage (over 100mg of morphine or equivalent daily), male gender, older age, multiple prescriptions including benzodiazepines, mental health conditions and lower socioeconomic status.

Emergency responses to opioid overdose

Death following opioid overdose is preventable if the person receives basic life support and the timely administration of the opioid antagonist naloxone. Naloxone, which is effectively an antidote to opioid overdose, will completely reverse the effects of an opioid overdose if administered in time. Naloxone is effective when delivered by intravenous, intramuscular, subcutaneous, and intranasal routes of administration. Naloxone has virtually no effect in people who have not taken opioids.

Access to naloxone is generally limited to health professionals. In many countries there is still limited availability of naloxone even in medical settings, including ambulances. At least one country, Italy, has already made naloxone available in pharmacies without prescription.

Since most overdoses are witnessed by a friend or family member, if a friend or family member had access to naloxone, he or she may be able to reverse the effects of opioid overdose, while waiting for medical care to arrive. While naloxone administered by bystanders is a potentially life-saving emergency interim response to opioid overdose, it should not be seen as a replacement for comprehensive medical care.

In recent years, a number of programmes around the world have shown that providing naloxone to people likely to witness an opioid overdose, in combination with training on the use of naloxone and on the resuscitation of people having an opioid overdose, could substantially reduce the deaths resulting from opioid overdose.

A recent survey in the United States found that the distribution of approximately 50 000 naloxone kits through local opioid overdose prevention programmes had resulted in more than 10 000 uses to reverse overdoses.

A number of countries and jurisdictions have started to adopt this approach. A policy of providing naloxone to people at risk of opioid overdose as well as to people likely to witness an opioid overdose has been in place in Scotland since 2011, and in a number of jurisdictions in the United States. Ireland has also announced this as a national policy. An evaluation of the impact of the policy in Scotland, which included people leaving prison as a target population, found that the proportion of opioid overdoses occurring within four weeks of leaving prison had

halved since the introduction of naloxone.

Prevention of opioid overdose

Beyond approaches to reducing drug use in general in the community, specific measures to prevent opioid overdose include:

- increasing the availability of opioid dependence treatment, including for those dependent on prescription opioids;
- reducing irrational or inappropriate opioid prescribing;
- monitoring opioid prescribing and dispensing;
- limiting inappropriate over-the-counter sales of opioids.

The gap between recommendations and practice is significant. Only 42% of countries provide access to effective treatment options for opioid dependence and less than 10% of people worldwide in need of such treatment are receiving it.

WHO recommendations

WHO recommends that naloxone be made available to people likely to witness an opioid overdose, as well as training in the management of opioid overdose.

WHO recommends the use of a range of treatment options for opioid dependence which include psychosocial support, opioid maintenance treatments such as methadone and buprenorphine, supported detoxification and treatment with opioid antagonists such a naltrexone. WHO supports countries to introduce such treatment programmes where they do not exist.

WHO supports countries in monitoring trends in drug use and related harm, to better understand when opioid dependence and opioid overdose is occurring. WHO supports countries to use medicines rationally, including medicines under international control such as strong opioids, to ensure the optimal of availability for medical purposes and minimization of their misuse and non-medical use.

WHO recommends a stepped approach to the use of opioids in the management of cancer pain in adults – the WHO Cancer Pain Ladder, which recommends the initial use of non-opioids, then weak opioids, then strong opioids as pain increases. In the management of persisting pain in children, WHO recommends that weak opioids not be used, due to the variable metabolism of codeine in children. When prescribing opioids, WHO recommends measures to reduce the risk of misuse and diversion of opioids, including careful patient selection, and supervision of dosing

where necessary.

Footnotes

[1] Pharmaceutical opioids, in particular strong opioids of the type that are typically involved in opioid overdoses, have been restricted in the past to the management of acute pain and cancer pain, such as is recommended in the WHO Cancer Pain Ladder. There has been a trend in the last 10 years to use opioids in the management of chronic non-cancer pain, such as back pain.

Publications

- Community management of opioid overdose
  Guidelines
- Opioid overdose: preventing and reducing opioid overdose mortality
- More publications on opioid overdose

Related links

- Substance abuse overview

Management of substance abuse

Public health problems caused by harmful use of alcohol

A 2005 World Health Assembly resolution calls on WHO to intensify international collaboration in reducing public health problems caused by the harmful use of alcohol.

The hazardous and harmful use of alcohol has now become one of the most important risks to health: it is the leading risk factor in developing countries with low mortality rates and ranks third in developed countries, according to the World Health Report 2002.

While alcohol use is deeply embedded in many societies, recent years have seen changes in drinking patterns across the globe: rates of consumption, drinking to excess among the general population and heavy episodic drinking among young people are on the rise in many countries.

Health problems associated with alcohol consumption have reached alarming levels, and alcohol use contributes to a wide range of diseases, health conditions and high-risk behaviours, from mental disorders and road traffic injuries, to liver diseases and unsafe sexual behaviour.

Through this WHA resolution, WHO's Secretariat is requested to address a number of areas related to the issue of harmful use of alcohol, including: gathering and sharing scientific information on alcohol consumption and related public health problems; preparing research and policy initiatives and recommendations for effective policies and interventions; providing support to Member States in monitoring alcohol-related harm and implementing effective strategies and promoting identification and management of alcohol-use disorders in primary health care.

The World Health Assembly takes note that the word 'harmful' in this resolution refers only to the public health effects of alcohol use and does not intend to prejudice the religious beliefs or cultural norms of any Member State.

Read all relevant resolutions in here

WORLD HEALTH ASSEMBLY RESOLUTION

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WHA58.26 - Public health problems caused by harmful use of alcohol

English
pdf, 24kb

French
pdf, 26kb

Spanish
pdf, 26kb

Arabic
pdf, 33kb

Chinese
pdf, 690kb

Russian
pdf, 122kb

REPORT BY THE SECRETARIAT TO THE WORLD HEALTH ASSEMBLY

Report by the Secretariat to the 61st World Health Assembly - Strategies to reduce the harmful use of alcohol: A61/13

A61/13 Strategies to reduce the harmful use of alcohol

Report by the Secretariat to the 60th World Health Assembly - Evidence-based strategies and interventions to reduce alcohol-related harm: A60/14 and A60/14 Add.1

A60/14 Evidence-based strategies and interventions to reduce alcohol-related harm

A60/14 Add.1 Global assessment of public-health problems caused by harmful use of alcohol (Addendum)

Report by the Secretariat to the 58th World Health Assembly - Public health problems caused by harmful use of alcohol: A58/18

A58/18 Public health problems caused by harmful use of alcohol

EXECUTIVE BOARD RESOLUTION

EB122.R2 - Strategies to reduce the harmful use of alcohol

English [pdf 74kb]

REPORT BY THE SECRETARIAT TO THE EXECUTIVE BOARD

Report by the Secretariat to the Executive Board 121st Session - the Second Report of the WHO Expert Committee on Problems Related to Alcohol Consumption: EB121/10

Report by the Secretariat to the Executive Board 121st Session on the Second Report of the WHO Expert Committee on Problems Related to Alcohol Consumption

Report by the Secretariat to the Executive Board 120th Session - Implementation of resolutions: progress reports: EB120/35

EB120/35 Implementation of resolutions: progress report on public-health problems caused by harmful use of alcohol

ACTIVITIES FOLLOWING THE WHA RESOLUTION

Open informal consultation on alcohol production and distribution data (19-20 February 2008)

WHO Expert Committee on Problems Related to Alcohol Consumption (10-13 October 2006)

Meeting with stakeholders on health problems related to alcohol consumption (9 October 2006)

WHO is seeking views and opinions of stakeholders on health problems related to alcohol consumption (deadline 15 September 2006)

Meeting with representatives of nongovernmental organizations and professional associations (24-25 April 2006)

Open consultations with representatives of alcohol industry, agricultural and trade sectors (8 March 2006)

INITIATIVES IN THE WHO REGIONS

WHO Regional Office for Africa

AFR/RC57/14: Harmful use of alcohol in the WHO African Region

AFR/RC58/3: Actions to reduce the Harmful Use of Alcohol

WHO Regional Office for the Americas:

Brasilia declaration on alcohol public policies
pdf, 69kb

WHO Regional Office for Europe:

Framework for alcohol policy in the WHO European Region

WHO Regional Office for the Eastern Mediterranean

Resolution (2006): Public health problems of alcohol consumption in the Region

Technical paper: Public health problems of alcohol consumption in the Region

WHO Regional Office for South-East Asia

Resolution (2006): Alcohol, consumption control - Policy options

Endorsed document: Alcohol Consumption Control - Policy Options in the South-East Asia Region

WHO Regional Office for the Western Pacific

Regional Strategy to reduce alcohol-related harm

RELATED LINKS

Global Information System on Alcohol and Health

European alcohol information system

Media centre

WHO calls on governments to do more to prevent alcohol-related deaths and diseases

News release

12 MAY 2014 | GENEVA - Worldwide, 3.3 million deaths in 2012 were due to harmful use of alcohol, says a new report launched by WHO today. Alcohol consumption can not only lead to dependence but also increases people's risk of developing more than 200 diseases including liver cirrhosis and some cancers. In addition, harmful drinking can lead to violence and injuries.

The report also finds that harmful use of alcohol makes people more susceptible to infectious diseases such as tuberculosis and pneumonia.

The "Global status report on alcohol and health 2014" provides country profiles for alcohol consumption in the 194 WHO Member States, the impact on public health and policy responses.

"More needs to be done to protect populations from the negative health consequences of alcohol consumption," says Dr Oleg Chestnov, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health. "The report clearly shows that there is no room for complacency when it comes to reducing the harmful use of alcohol."

Some countries are already strengthening measures to protect people. These include increasing taxes on alcohol, limiting the availability of alcohol by raising the age limit, and regulating the marketing of alcoholic beverages.

Report highlights

The report also highlights the need for action by countries including:

- national leadership to develop policies to reduce harmful use of alcohol (66 WHO Member States had written national alcohol policies in 2012);

- national awareness-raising activities (nearly 140 countries reported at least one such activity in the past three years);
- health services to deliver prevention and treatment services, in particular increasing prevention, treatment and care for patients and their families, and supporting initiatives for screening and brief interventions.

In addition the report shows the need for communities to be engaged in reducing harmful use of alcohol.

On average every person in the world aged 15 years or older drinks 6.2 litres of pure alcohol per year. But as less than half the population (38.3%) actually drinks alcohol, this means that those who do drink consume on average 17 litres of pure alcohol annually.

The report also points to the fact that a higher percentage of deaths among men than among women are from alcohol-related causes - 7.6% of men's deaths and 4% of women's deaths – though there is evidence that women may be more vulnerable to some alcohol-related health conditions compared to men. In addition, the authors note that there is concern over the steady increase in alcohol use among women.

"We found that worldwide about 16% of drinkers engage in heavy episodic drinking - often referred to as 'binge-drinking' - which is the most harmful to health," explains Dr Shekhar Saxena, Director for Mental Health and Substance Abuse at WHO. "Lower-income groups are more affected by the social and health consequences of alcohol. They often lack quality health care and are less protected by functional family or community networks."

Globally, Europe is the region with the highest consumption of alcohol per capita, with some of its countries having particularly high consumption rates. Trend analysis shows that the consumption level is stable over the last 5 years in the region, as well as in Africa and the Americas, though increases have been reported in the South-East Asia and the Western Pacific regions.

Through a global network, WHO is supporting countries in their development and implementation of policies to reduce the harmful use of alcohol. The need for intensified action was endorsed in the landmark 2011 United Nations General Assembly meeting, which identified alcohol as one of four common risk factors* contributing to the non-communicable diseases (NCDs) epidemic.

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Related links

Global status report on alcohol and health 2014

Fact sheet on alcohol

Portal on alcohol and health

Health topic on alcohol

SEARCH RESULTS

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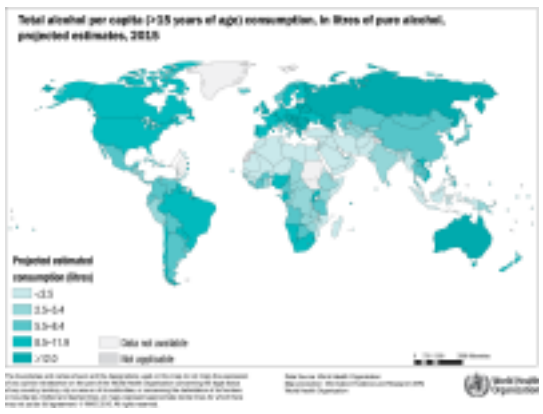
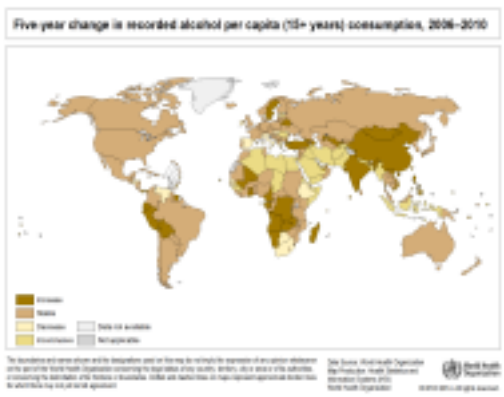
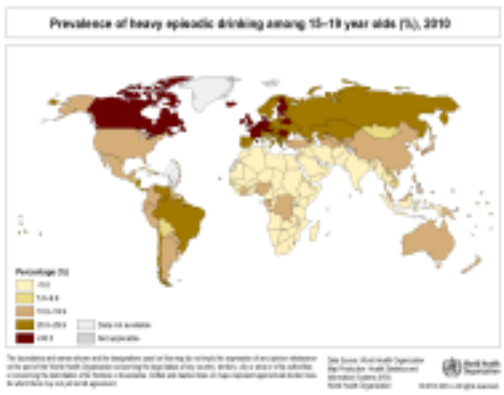


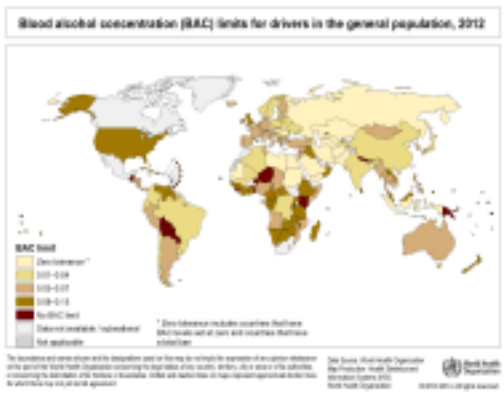
World : Total alcohol per capita (>15 years of age) consumption, in litres of pure alcohol, projected estimates, 2015
Date : 12/Jul/2016
Source : World Health Organization, World Health Statistics 2016
Topic : Alcohol and health
Keywords : Alcohol per capita consumption, World Health Statistics 2016
View map



World : Five-year change in recorded alcohol per capita (15+ years) consumption, 2006-2010
Date : 12/May/2014
Source : World Health Organization
Topic : Alcohol and health
Keywords : Alcohol adult per capita consumption, gisah
View map

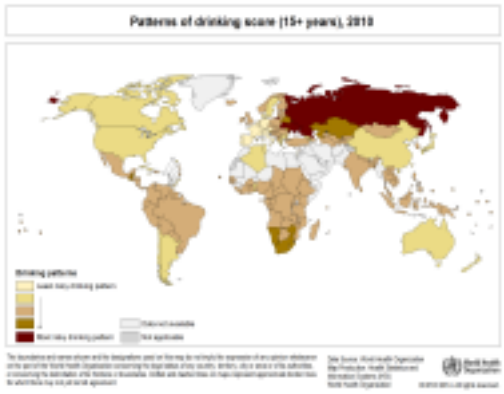


World : Heavy episodic drinking amont 15-19 year olds (%), 2010
Date : 12/May/2014
Source : World Health Organization
Topic : Alcohol and health
Keywords : Alcohol adult per capita consumption, gisah
View map



World : Legal Blood Alcohol Concentration (BAC) limits for drivers in the general population, 2012
Date : 12/May/2014
Source : World Health Organization
Topic : Alcohol and health
Keywords : Legal Blood Alcohol Concentration (BAC) limit, GISAH
View map

World : Patterns of drinking score (15+ years), 2010
Date : 12/May/2014



Source : World Health Organization

Topic : Alcohol and health

Keywords : Patterns of drinking score, GISAH

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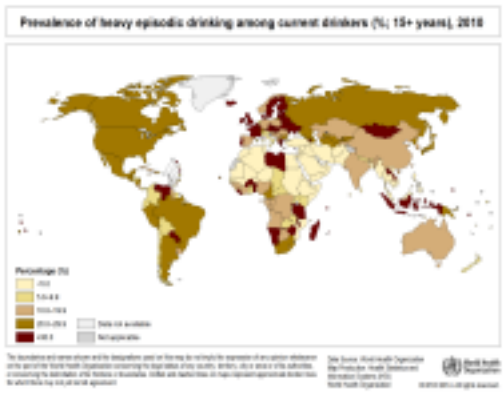

World : Prevalence of heavy episodic drinking among current drinkers (%; 15+ years), 2010

Date : 12/May/2014

Source : World Health Organization

Topic : Alcohol and health

Keywords : Icohol adult per capita consumption, gisah

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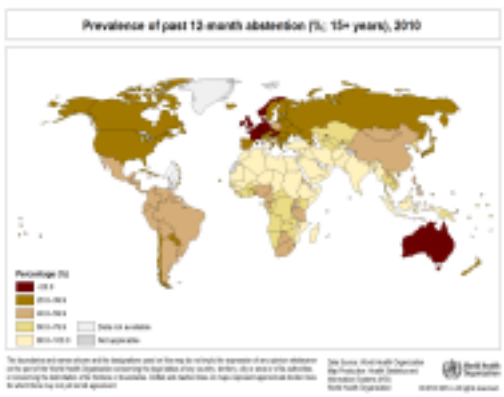

World : Prevalence of pst 12-month abstention (%; 15+ years), 2010

Date : 12/May/2014

Source : World Health Organization

Topic : Alcohol and health

Keywords : Alcohol, consumption patterns, abstainers, gisah

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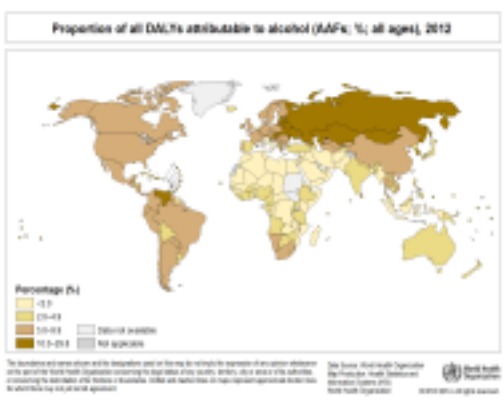

World : Proportion of all DALYs attributable to alcohol (AAFs, %; all ages), 2012

Date : 12/May/2014

Source : World Health Organization

Topic : Alcohol and health

Keywords : Proportion of alcohol-attributable DALYs

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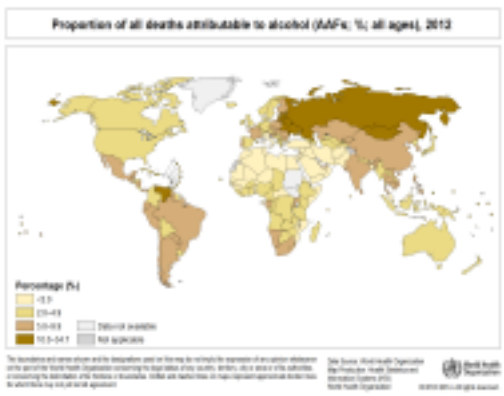

World : Proportion of all deaths attributed to alcohol (AAFs, %; all ages), 2012

Date : 12/May/2014

Source : World Health Organization

Topic : Alcohol and health

Keywords : Proportion of alcohol-attributable deaths

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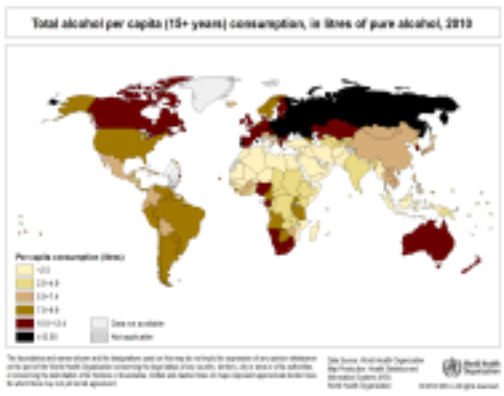

World : Total alcohol per capita (15+ years) consumption, in litres of pure alcohol, 2010

Date : 12/May/2014

Source : World Health Organization

Topic : Alcohol and health

Keywords : Alcohol adult per capita consumption, gisah

View map