Globalization and Health

RESEARCH Open Access

Framing alcohol harm in the UN context – the importance of language

Øystein Bakke[1] and Sally Casswell[2*]

Abstract

Background Alcohol is a global health issue with a high level of controversy. After being absent from World Health Organization (WHO) global governing body discussions for about 20 years, alcohol re-entered the agenda in 2005. The expression 'harmful use of alcohol' became the compromise language after hard negotiations, an example of 'adopted language" that has remained for almost 20 years.

This article analyses the background and use of the expression 'harmful use of alcohol' in the context of WHO governing bodies, current challenges and implications for public health.

Methods The article is based on textual analysis of source documents from the time periods 2004–2010 and 2019–2022 and the authors' experience from involvement in the global alcohol policy scene for more than 20 years: WHO governing body records and other documents were analysed, as well as Member State and Non-State Actors' positions and contributions in consultations and statements in WHO governing body debates.

Results The introduction of the concept 'harmful use of alcohol' in WHO documents from 2005 onwards was a political compromise between approaches focussed either on 'alcohol abuse' or a wider concept of harm from alcohol consumption. It has permeated into national alcohol policy documents, academic literature about alcohol harm and UN documents, and been embraced by the alcohol industry. However, it has not prevented and some would argue that it has enabled development of normative statements from WHO that include recommendations for population wide interventions. The relatively new evidence of harm from alcohol at low levels and questioning of evidence suggesting a beneficial effect of moderate use of alcohol together with industry appropriation of 'harmful use' have led to increasing critique of the framing implied by 'harmful use of alcohol'.

Conclusions The language used in WHO documents holds political power in that it may influence the subsequent course of events. This is accentuated by the normative role of WHO in global health policy and the uptake of negotiated language beyond WHO documents. In the next five years it will be possible and valuable to examine in more detail the extent to which this power was made manifest and the need and possible ways to effect change.

Keywords WHO, Alcohol policy, Global health policy

Background

The public health approach to alcohol harm and ameliorating policies focuses on a wide spectrum of alcohol harm and regulatory measures, with total consumption, measured as Alcohol Per-capita Consumption (APC) of population level harms [1], a useful indicator. The public health focus is on promoting evidence-based effective alcohol policies to reduce heavy alcohol consumption and APC [2]. Due to increasing evidence of the links

*Correspondence:
Sally Casswell
s.casswell@massey.ac.nz
[1] FORUT, Oslo, Norway
[2] SHORE & Whariki Research Centre, College of Health, Massey University, Auckland, New Zealand

between alcohol and cancer, particularly breast cancer, the concept of 'no safe limits' is making its way into public health discourse [3, 4].

In contrast, the individualistic approach is characterised by education and treatment together with targeted interventions identified as the solution to reducing 'alcohol abuse' while supporting individual responsibility and moderate consumption [5]. This discourse focuses on possible beneficial health effects of alcohol, and is promoted by the alcohol industry, their front organisations, and some Member States. They also underline the importance of alcohol in trade (see Rinaldi et al. [6]).

These different framings of alcohol underscore the tension between commercial interests and public health in much of the alcohol policy debate at the national and international level.

At the international level the WHO is the United Nations (UN) specialised agency for health and the policy holder for alcohol. Decision making between Member States in WHO governing bodies, the Executive Board (EB) and the World Health Assembly (WHA) is generally consensus based and follows a regular pattern. Often informal consultations are undertaken before negotiations at the governing bodies. The decisions reached through these mainly political processes are important for the framing of global health challenges and their solutions. However, for some Member States other competing, often commercial, interests may influence their positions and trade-offs can result in weak language or shallow commitments [7]. Many actors try to influence the decisions of WHO's governing bodies, including civil society, professional organisations, and corporate actors who exercise considerable power via Member States' positions [8]. Once challenging negotiations reach a compromise, this language tends to be replicated in future negotiations [9] as 'agreed' or 'adopted' language.

WHO involvement in alcohol has moved in cycles with earlier activity peaks in the 1950s and from the late 70 s to the early 80 s [10]. In 1983 a resolution was passed at the WHA, focusing on alcohol consumption and alcohol related problems (S1).[1] However, the new energy in the alcohol field was dampened by the Reagan administration in the USA (1981–1989), who sought to 'depoliticize' intergovernmental institutions and received assurances that "WHO global health programs are in line with the principles of private enterprise" [10]. A WHO co-ordinated research project investigating trade in alcohol was brought to an abrupt end prior to completion, with many suspecting this was due to clandestine industry power at work [11, 12]. Following this there was little attention given to alcohol until the early 2000s.

After an absence of discussion from the World Health Organization (WHO) global governing bodies for about 20 years, alcohol re-entered the agenda in 2005 as 'public health problems caused by alcohol' (S2). However, through negotiations at the EB and WHA that year this framing was replaced by the expression 'harmful use of alcohol' (S3). It has remained the official language for almost 20 years – an example of adopted language.

This article analyses the background and use of the expression "harmful use of alcohol" in the context of WHO governing bodies, current challenges and implications for public health.

Methods

Data sources and methodology

We identified relevant research literature concerning the alcohol agenda in WHO. This literature [10, 13] revealed pivotal points in time when the alcohol terminology was discussed. Data sources for the textual analysis were: documents from WHO governing bodies, other official WHO documents, Member State and Non-State Actors' positions and contributions in consultations and statements in WHO governing body debates as transcribed in the official records. In addition we drew on both authors' experience from civil society involvement in the global alcohol policy scene for 20 years, including as observers in WHO governing body meetings. Recent literature on public health aspects of alcohol was included in the analysis.

We approached the topic by mapping WHO EB and WHA reports, resolutions, verbatim or summary records (see table with list of source documents). The first author used the meeting agendas of WHO EB and WHA during the crucial years (2004, 2005, 2007, 2008 and 2010) to identify the relevant WHO documents. These documents were drawn from the WHO website and the same author conducted keyword searches in WHO reports, resolutions and meeting records using the search terms "alcohol", "harmful" and "abuse".

Sections of the documents that included these terms were closely read in full by the first author to understand the context, discourse, narrative and the arguments used through a thematic analysis.

Since the Nordic countries, through Nordic cooperation at the ministerial level, were taking a leading role in pushing the alcohol agenda [10, 13], we searched for background information from the Nordic Council. Minutes from the meetings where this topic was discussed were obtained with kind assistance from the Nordic Council Archive. Early resolution drafts and other

[1] The notations S1, S2 and so on refer to the source documents analysed for this study. Full details of documents are provided in a table at the end of the article.

relevant documents not available on the WHO website were drawn from private collections of the authors.

The discussion about terminology reemerged during 2019–2022 in the WHO's process to develop the Global Alcohol Action Plan. Submissions in online consultations in relation to this process from member states, civil society, the private sector, and academia were downloaded from the WHO website and analysed in a similar manner, looking for references to harmful use or other framings. Finally, the WHO European region process to develop the Alcohol Framework was also identified as relevant for the objective of this study.

In the following, key terms used in the analysis are underlined to facilitate easy identification.

Results

In the introduction to the World Health Report, 2002, "Reducing Risks, Promoting Healthy Life" [14], alcohol is acknowledged as part of the "Risk transition" marketed globally by multinational companies, and is mentioned numerous times throughout the report, both together with tobacco (tobacco and alcohol) or as excessive alcohol use [14]. The WHO Director General Gro Harlem Brundtland mentioned alcohol in her opening speech at the WHA, also using the term excessive alcohol consumption. Among the concerns raised by Dr Brundtland, she noted that "Alcohol like tobacco and other risk factors, is widely marketed – particularly to young people" (S4).

The Nordic intervention

In 2003–2004, ministers of Health and Social affairs from several Nordic countries responded to a perceived threat to maintaining effective national and local alcohol policy measures due to the growth of globalisation and international trade (S5) [13]. They agreed to work towards promoting alcohol on the WHO agenda (S6, p.57). Based on this, preparations began between the ministries in Norway, Sweden, and Iceland. Mr David Gunnarson from Iceland was a member of the WHO Executive Board and this proved to be important [13]. In order get a joint Nordic initiative, Finland and Denmark were also included.

Building on the 2002 World Health Report [14] and the 2004 report from the WHO secretariat to the EB, "Health promotion and healthy lifestyles" (S2), the Nordic countries, together with several co-sponsoring Member States, tabled a resolution in the 2004 Executive Board meeting. While the WHO Secretariat's report used the language alcohol abuse (S2, paragraph 3) when introducing the resolution, the representative from Iceland, Mr David Gunnarsson, used the term harmful use of alcohol, which was also used in the draft resolution. This was the first recorded use of this language (S7, p. 60–61).

In 2024, therefore, different forms of language were being used. Although having introduced the concept of harmful use, the resolution initiated by the Nordic group, in line with normal procedures in WHO's governing bodies, asked for a report on alcohol issues from the WHO Secretariat. In this request the focus was specified as WHO's future work on alcohol consumption (S7, p. 62).

The WHO Secretariat started drafting the report for the 2005 governing body meetings, now using the title "Public health problems caused by alcohol". The first Nordic Council of Ministers' drafts for a resolution (December 2004–January 2005) also used the framing of the secretariat's report – "Public health problems caused by alcohol" (S8).

The alcohol industry reacted to this framing. Belgian brewing company InBev issued a position paper stating: "InBev strongly objects the Secretariate's Report's clear presumption that *all* alcohol use is bad. The report links health disorders and risk behaviour to alcohol *use* rather than alcohol *misuse*" (S9).

Other industry influence may have come from Denmark as the Nordic states sought to achieve a joint approach. Traditionally Denmark has been the more liberal country on alcohol policy in this group and is the home of the global alcohol corporation Carlsberg. During the preparations for the next debate on alcohol in the 2005 governing body meetings, it was deemed essential to get Denmark's cooperation to be part of the joint Nordic initiative to promote a resolution on alcohol. The term 'harmful use' offered a compromise that Denmark could accept [15].

Furthermore, the term 'harmful use' was introduced in the draft resolution while the Nordic diplomats were garnering support from other member states. Different countries had different preferences. For example, Thailand preferred 'alcohol consumption' whereas the USA wanted 'abuse' [15]. (In the previous year, at the WHA, the USA had succeeded in replacing alcohol consumption with alcohol abuse as a risk factor for Road Safety (S10, p. 94).)

115th EB, January 2005

After an intense period of informal consultation with Member States in Geneva, the Nordic countries introduced the proposed resolution with the title "Public health problems caused by harmful use of alcohol" at the EB in 2005. The resolution, drafted by the Nordic countries was co-sponsored by a much wider group of 49 countries, including some of the European wine producing countries like France and Italy. However, the co-sponsors did not include some countries with significant exports of alcohol products, such as the USA, Australia, and New Zealand (S11, p. 114). Mr Gunnarsson from

Iceland was now the Chair of the WHO EB. In introducing the draft resolution, he referred to "what had not been an easy discussion; alcohol meant different things in different cultures. Even the title of the resolution had proved controversial: some had favoured the formulation 'caused by use of alcohol', while others would have preferred 'caused by abuse of alcohol'. He concluded that "the text before the Board was a compromise between the many views expressed." (S11, p. 114–116 – underline added).

During the debate in the Executive Bord, the question of the name of the resolution was one of several related topics that attracted much discussion [16] (S11, p. 114–121), after which the resolution was adopted with some minor amendments, and forwarded to the World Health Assembly without a change to the name (S11, p121).

During the process some Member States voiced the belief that certain patterns of alcohol use might be beneficial to health, particularly for the heart. This was mentioned in the Secretariat's report (S2) and had been raised in some interventions in the EB in 2005: EB Board Member, Dr Montalvo from Ecuador said, "It should not be forgotten that alcohol consumption could also be beneficial", referring to statistics on brain haemorrhages; and EB Board Member, Dr Steiger (USA) noted, "Scientific evidence pointed to benefits from a moderate consumption of alcohol, and it was to be hoped that an appropriate balance could be struck enabling WHO to deal with harmful use without becoming involved in areas beyond its purview" (S11, p. 116–118).

The alcohol industry was very active when alcohol was being discussed, and industry representatives could be observed as observers and lobbyists in the corridor and public galleries at the WHO governing body meetings throughout the period from 2005 through 2010.

58TH WHA, May 2005

When the resolution came up for discussion at the WHA in 2005, the name of the Secretariat's report had changed to "WHA58/18 Public health problems caused by harmful use of alcohol", indicating their adherence to the consensus achieved at the EB (S12).

In the WHA debate, an early reference to research indicating risk from low levels of alcohol use was mentioned. New Zealand, for example, referred to a "balance between benefits and harms" but also pointed out that "current evidence suggested that for some non-communicable diseases such as breast cancer, the risk increased in proportion to consumption with no apparent safe lower limit" (S3, p. 291).

Hard negotiations followed, including on the term 'harmful use' and informal meetings were required, as recorded in the statements of the Chair in the committee debate (S3, p. 320). In the last session of the WHA debate, a new paragraph was inserted to meet the concerns of several countries from the Eastern Mediterranean Region (EMRO) that the term did not take into consideration the religious and cultural sensitivities of a considerable number of Member States. The text "emphasizing that use of the word 'harmful' in this resolution refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way" was sufficient to reach consensus on this matter. (S3, p. 327).

Illustrating their concern that adoption of the term harmful use might undermine alignment with population wide alcohol control policies, Thailand had proposed a footnote pointing to the 10 "best practices" outlined in the Secretariat's report, including the population wide alcohol policies that became known as the 'best buys' [17]. This was supported by many countries but opposed by, among others, the USA. Mr Hohman said he "did not endorse the amendments proposed to the draft resolution, including the Thai proposal on the inclusion of a footnote relating to best practices, which were not, in his government's view, evidence-based. Nevertheless, if a consensus emerged to accept that amendment, he would not go against it" (S3, p. 293) After informal negotiations the whole of the Group of Americas came out against that amendment (S3, p.322) and, in the interests of reaching consensus, Thailand withdrew its proposal (S3, p.328).

The 2005 WHA resolution '58.26 Public health problems caused by harmful use of alcohol' was therefore a result of hard negotiations and carefully crafted compromises (S13).

The framing around alcohol continued to be contentious, as illustrated by the failure to reach consensus on a new resolution in 2007, when, among several obstacles, the Dominican Republic proposed changing harmful use to misuse (S14, p. 91). However, during protracted discussions in 2008 (S15, p. 62–70) and leading up to the adoption of the "Global strategy to reduce the harmful use of alcohol" in 2010, there were no further attempts to change the 'harmful use' language (S16, p. 118–126).

The 'harmful use of alcohol' language has become agreed UN language. It became the term used for one of the four common risk factors for NCDs in the UN High Level Meeting Political Declaration [18] in 2011, in target 3.5 of the Sustainable Development Goals (SDG) [19] and has remained the accepted term in many areas involving alcohol in the UN and WHO (e.g., S17, p. 13). The term has also permeated into other contexts (e.g., S18, S19), national alcohol policy documents (e.g., S20) and academic literature (e.g., [20]) about alcohol harm.

Implications and interpretations of the 'harmful use' language

The trem 'Harmful use of alcohol' is the same as a diagnosis in the International Classification of Diseases (ICD10), but in the context of the UN, it encompassed more than this narrow and limited part of the alcohol problem. The 2010 "Global strategy to reduce the harmful use of alcohol" [21] included a broad definition of the term 'harmful use': "the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes."

The use of the compromise term did not prevent, and some would argue enabled, WHO to develop normative statements in the *Global Alcohol Strategy*, which included recommendations for population wide interventions [21]. These were endorsed by the WHA. WHO later developed the 'best buys' set out in Appendix 3 of the NCD Global action plan [17] and led an initiative called SAFER, which recommends these effective alcohol policy measures, including alcohol taxation, regulating availability and banning or restricting alcohol advertising [22].

In line with the alcohol industry playbook the industry appropriated the 'harmful use' language, adding 'harmful drinking'. Harmful drinking was then counterposed to responsible drinking, the promotion of which was presented as a solution, for example in publications by the International Center on Alcohol Policy (ICAP) [23]. In their statements and communications, including in "industry commitments" issued by 13 of the world largest alcohol producers, the industry portrayed itself as a partner in reducing 'harmful use of alcohol' but reframed it by emphasising drinking patterns (rather than the APC indicator) and equating harmful use with 'alcohol abuse' or 'hazardous drinking' [6, 24].

Throughout the last 20 years two different stances have been taken towards the 'harmful use' language in the public health community. One is that it is easier to assume a broad definition of the concept rather than change the language, which was a result of a hard won consensus. This was the dominating view for many years. The other is that the 'harmful use' language is not helpful, puts the focus on the drinker not industry practices promoting alcohol products, has been coopted by the alcohol industry, and should be changed.

'Harmful use' was agreed at a time when 'good for the heart' was part of the discussion. However, over the following 20 years the earlier evidence for possible health benefits of moderate alcohol consumption has been challenged [25–27], and put into a more realistic perspective in terms of population impact [28]. Awareness has grown of evidence that increased risk of breast cancer begins at low levels of consumption, often referred to as 'no safe level' [29].

This, together with industry appropriation of 'harmful use' has provided increased impetus for a new challenge to the term. The alcohol policy civil society organisations were never happy about 'harmful use' (e.g., [30]) and when in 2019 and 2020, alcohol returned to the WHO governing bodies' agenda, although as a sub-item under NCDs, (S21, p. 32 and S22, p.38) it started a process that offered an opportunity to raise concerns about the language. In the WHO consultation on the implementation of the global strategy and the way forward in 2019, the 'harmful' language was challenged in seven NGO submissions. Movendi International pointed out the need for clear ways to communicate alcohol harms and that the "concept of 'harmful use of alcohol' is highly problematic and needs rethinking" (see [6, 31]). Several industry submissions took the opposite view, arguing for a sole focus on 'harmful use' and not on 'consumption per se' (e.g., S23, p. 32).

In 2020 WHO held an online consultation on a working document to develop a global alcohol action plan [32] (S24, S25). Compared to the previous consultation, the number of submissions rose considerably, both for civil society and private sector entities, and the framing question became even more articulated [33]. The industry maintained their focus on harmful or excessive use [34]. The need to change 'harmful use' was put forward in many civil society submissions. Some 36 organisations stated some variation of the need to change the way that alcohol use and harm is referred to throughout the document by moving away from references to the 'harmful use of alcohol', which incorrectly implies that there are 'safe levels' of alcohol use (S24, S25) [32]. However, as the mandate for the action plan was implementation of the "Global strategy to reduce the harmful use of alcohol", this was deemed not an opportune time to change agreed language; neither the Secretariat nor Member States endeavoured to change the agreed language.

The change in Europe

In 2022 a major change occurred within the WHO family when the European Regional Committee adopted a new European Framework that did not use the 'harmful use' language (S26). In several consultations and formal processes, including with Member States and Civil Society, there were strong sentiments voiced that 'harmful use of alcohol' was not helpful, the meaning was unclear, it did not reflect the emerging evidence of no risk-free use in relation to cancer, and should not be used in the new framework. The European Framework that was unanimously adopted by the 53 Member States from that

region only uses the term 'harmful use' when referring to other WHO documents; instead, the Framework recommends a "comprehensive approach" to have "the greatest impact in reducing alcohol consumption and alcohol-attributable harms" (S26). However, this Framework was not adopted without complications. In the Regional Committee meeting itself some wine and beer producing Member States delegations wanted to include 'harmful use' throughout the text whereas Slovenia, Estonia, Finland, Belgium and other EU countries did not want to open the Framework as presented by the Secretariat. It was argued that the technical competence of WHO should be respected. The compromise negotiated and proposed by the EU Member States was acceptable to all; to include 'harmful use' in a sentence about "harmful use of alcohol as an important risk factor" in the preamble of the Decision (S27) without changing the Framework.

Limitations

In-depth interviews with a range stakeholders were not carried out and could have provided more information, for example, on the efforts of NGOs in this space and the role, if any, of the framing harmful use in enhancing support or diminishing opposition to the 'best buys' of alcohol policy.

Discussion – way forward

In the "Action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority" [35], 'harmful use' is used within the definition given by the 2010 Global strategy. The Global Action Plan does however vary the vocabulary through the text and talks for instance about the "negative impact of alcohol consumption".

The dates of the action plan imply Member States will give WHO a renewed mandate to work on alcohol after 2030. This juncture may reopen discussions about WHO's work on alcohol, including the framing used and challenges to a focus on the most effective alcohol control policies. In the 2005 EB, the representative from Canada commented that "putting the resolution as it stood into practice could only be beneficial in the immediate term, and in the longer term, as consensus grew, the language of the text could be reviewed" (S11, p. 118–119). Some Member States and civil society might use the 2030 opportunity to build on the European majority position that 'harmful use' is not helpful and argue for a change in the language. Others may argue that continuing with a compromise framing may support the focus on effective population-wide strategies.

It will be relevant to monitor the progression in the framing of 'no safe level', and if and how this framing challenges 'harmful use of alcohol'. How the commercial interests respond to any expansion of the framing of 'no safe level' will be relevant to the development of the policy debate in the lead up to 2030.

Conclusions

The initial adoption of the 'harmful use' language and the recent challenge from the WHO European region illustrates typical processes within the global discourse of the UN agencies. It reflects the belief by all the parties involved that such agreed/adopted language holds power. This is accentuated by the normative role of WHO in global health policy and the uptake of negotiated language beyond WHO documents. In the next five years it will be possible and valuable to examine in more detail the extent to which this power was made manifest and the need and possible ways to effect change.

Source documents

ID	Document
S1	WHA36.12 Alcohol consumption and alcohol-related problems: development of national policies and programmes. 1983 https://iris.who.int/bitstream/handle/10665/160567/WHA36_R12_eng.pdf?sequence=1&isAllowed=y
S2	EB115/37 Public health problems caused by alcohol. Report by the Secretariat. 23 December 2004. https://apps.who.int/gb/ebwha/pdf_files/EB115/B115_37-en.pdf
S3	WHA58/2005/REC3-en Fifty-Eighth World Health Assembly. Geneva, 16–25 May 2005. Summary Records of Committees. Reports Of Committees. 2005. https://apps.who.int/gb/ebwha/pdf_files/WHA58-REC3/A58_REC3-en.pdf
S4	WHA55/3; Brundtland GH. Address by Dr Gro Harlem Brundtland, Director-General. Fifty-Fifth World Health Assembly, Geneva, 13 May2002 https://iris.who.int/bitstream/handle/10665/78456/ea553.pdf?
S5	Nordic Council of Ministers Declaration from the Nordic council of Ministers, Ministers of Social Affairs and Health, Regarding Alcohol Policy, 29 October 2004, Journal no. 43001.15.002/04
S6	Norwegian Parliament With Paper Stortingsmelding nr 48; 2003–2004; Nordisk samarbeid https://www.regjeringen.no/contentassets/4bd076b16adc48dcb26f6fdc0b8636cc/no/pdfs/stm200320040048000dddpdfs.pdf

Source documents

ID	Document
S7	EB113-2004-Rec-2; Executive Board; 113th Session 2004; Summary Records; https://iris.who.int/bitstream/handle/10665/259571/EB113-2004-REC-2-eng.pdf?sequence=1&isAllowed=y
S8	Draft resolution proposal EB115 Jan-Rev16 2005. Public health problems caused by alcohol
S9	InBev. InBev position paper to WHO Secretariat Report 'Public Health Problems caused by Alcohol'. undated
S10	WHA57-2004-REC-3-eng.pdf; Fifty-Seventh World Health Assembly; 2004; Summary Records Of Committees; Reports Of Committees; https://iris.who.int/bitstream/handle/10665/260147/WHA57-2004-REC-3-eng.pdf?sequence=1
S11	EB115_REC2; Executive Board 115th Session; 2005; Summary Records https://apps.who.int/gb/ebwha/pdf_files/EB115/B115_REC2-en.pdf
S12	A58/18 Public health problems caused by harmful use of alcohol; Report by the Secretariat https://apps.who.int/gb/ebwha/pdf_files/WHA58/A58_18-en.pdf
S13	WHA58/18 Public health problems caused by harmful use of alcohol. 2005 https://apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_26-en.pdf
S14	WHA60/2007/REC/3; Sixtieth World Health Assembly; 2007; Summary Records of Committees; Reports of Committees https://iris.who.int/bitstream/handle/10665/22640/A60_REC3-en.pdf?sequence=1&isAllowed=y
S15	WHA61/2008/REC/3; Sixty-First World Health Assembly; 2008; Summary Records of Committees; Reports of Committees https://iris.who.int/bitstream/handle/10665/23571/A61_REC3-en.pdf?sequence=1&isAllowed=y
S16	WHA63/2010/REC/3; Sixty-Third World Health Assembly; 2010; Summary Records of Committees; Reports of Committees https://iris.who.int/bitstream/handle/10665/3107/WHA63_REC3-en.pdf?sequence=1&isAllowed=y
S17	WHA74/2021/Rec/1; Seventy-Fourth World Health Assembly; 2021; Resolutions and Decisions; Annexes https://apps.who.int/gb/ebwha/pdf_files/WHA74-REC1/A74_REC1-en.pdf
S18	OECD (2021), Preventing Harmful Alcohol Use, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/https://doi.org/10.1787/6e4b4ffb-en
S19	Europe's Beating Cancer Plan Communication from the commission to the European Parliament and the Council
S20	Royal Government of Bhutan; The National Policy and Strategic Framework to Reduce Harmful Use of Alcohol (2013–2018). (Obtained from Movendi International) https://movendi.ngo/wp-content/uploads/2016/01/Final-NPSF.pdf
S21	EB144/2019/REC/1; Executive Board 144th Session; 2019; Resolutions and Decisions; Annexes https://apps.who.int/gb/ebwha/pdf_files/EB144-REC1/B144_REC1-en.pdf#page=50
S22	EB146/2020/REC/1; Executive Board 146th Session; 2020; Resolutions and Decisions; Annexes https://apps.who.int/gb/ebwha/pdf_files/EB146-REC1/B146_REC1-en.pdf
S23	WHO web based Consultation on a discussion paper dated 21 October 2019; Submissions from private sector entities (downloaded version)
S24	Development of an action plan (2022–2030) to effectively implement the WHO Global strategy to reduce the harmful use of alcohol; Received Submissions from a Web-Based Consultation on The Working Doucment; Volume I https://cdn.who.int/media/docs/default-source/alcohol/alcohol-action-plan/volume-i-received-submission-to-the-working-document.pdf?sfvrsn=6529388c_13
S25	Development of an action plan (2022–2030) to effectively implement the WHO Global strategy to reduce the harmful use of alcohol; Received Submissions from a Web-Based Consultation on The Working Doucment; Volume II https://cdn.who.int/media/docs/default-source/alcohol/alcohol-action-plan/volume-ii-received-submission-to-the-working-document.pdf?sfvrsn=e32bae87_14 Both Volum I and Volum II are available here: https://www.who.int/news-room/articles-detail/global-action-plan-to-reduce-the-harmful-use-of-alcohol#cms

Source documents

ID	Document
S26	EUR/RC72/12 Provisional agenda item 10; European framework for action on alcohol 2022–2025; 2022 https://iris.who.int/bitstream/handle/10665/361662/72wd12e-Alcohol-220604.pdf
S27	EUR/RC72(4); European framework for action on alcohol 2022–2025; Decision; Regional Committee for Europe; 2022 https://iris.who.int/bitstream/handle/10665/363076/72ds04e-Alcohol-220781.pdf?sequence=1&isAllowed=y

Acknowledgements
The authors wish to thank Bernt Bull, David Gunnarsson, Turid Kongsvik and Maik Dünnbier for their contributions.

Clinical trial number
Not applicable.

Authors' contributions
Conceptualization: OB and SC; Data curation: OB; Investigation: OB; Methodology: OB and SC; Project administration: OB; Writing – original draft: OB and SC; Writing – review & editing: SC.

Funding
None.

Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
Massey University allows researchers to follow a peer review process for research projects they consider to pose a low risk. Following that process, the research presented in this paper was judged to be low risk and consequently it has not been reviewed by one of the university's Human Ethics Committees.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Received: 25 November 2024 Accepted: 11 April 2025
Published online: 24 April 2025

References

1. Rehm J, Crépault JF, Wettlaufer A, Manthey J, Shield K. What is the best indicator of the harmful use of alcohol? A narrative review. Drug Alcohol Rev. 2020;39:624–31. https://doi.org/10.1111/dar.13053.
2. Babor TF, Casswell S, Graham K, Huckle T, Livingston M, Osterberg E, et al. Alcohol: No Ordinary Commodity. 3rd ed. Oxford: Oxford University Press; 2023.
3. Anderson BO, Berdzuli N, Ilbawi A, Kestel D, Kluge HP, Krech R, et al. Health and cancer risks associated with low levels of alcohol consumption. Lancet Public Health. 2023;8:e6–7. https://doi.org/10.1016/S2468-2667(22)00317-6.
4. World Health Organization. No level of alcohol consumption is safe for our health. News release. 2023. https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health. Accessed 1 Apr 2025.
5. Mialon M, McCambridge J. Alcohol industry corporate social responsibility initiatives and harmful drinking: a systematic review. Eur J Public Health. 2018;28:664–73. https://doi.org/10.1093/eurpub/cky065.
6. Rinaldi C, van Schalkwyk MC, Egan M, Petticrew M. A Framing Analysis of Consultation Submissions on the WHO Global Strategy to Reduce the Harmful Use of Alcohol: Values and Interests. Int J Health Policy and Manage. 2022;11:1550–61. https://doi.org/10.34172/ijhpm.2021.68.
7. Buse K, Mialon M, Jones A. Thinking Politically About UN Political Declarations: A Recipe for Healthier Commitments-Free of Commercial Interests Comment on "Competing Frames in Global Health Governance: An Analysis of Stakeholder Influence on the Political Declaration on Noncommunicable Diseases." Int J Health Policy Manage. 2022;11:1208–11. https://doi.org/10.34172/ijhpm.2021.92.
8. Pingeot L. Corporate influence in the Post-2015 process. Working Paper. Aachen: Brot für die Welt; 2014. https://www.dawnnet.org/sites/default/files/articles/corporate_influence_in_the_post-2015_process_web.pdf .
9. Irwin R, Smith R. Rituals of global health: Negotiating the World Health Assembly. Glob Public Health. 2019;14:161–74. https://doi.org/10.1080/17441692.2018.1504104.
10. Room R. Alcohol and the World Health Organization: The ups and downs of two decades. Nordisk Alkohol- og Narkotikatidsskrift [English supplement]. 2005;22:146–62. https://doi.org/10.1177/145507250502201S03.
11. Wodak AD. News and views. Australian Drug Alcohol Rev. 1987;6:237–9. https://doi.org/10.1080/09595238780000651.
12. Cavanagh J, Clairmont FF. Alcoholic Beverages; Dimensions of corporate power. New York, NY: St. Martin's Press; 1985.
13. Bull B. The Nordic countries and the WHO Resolution on Alcohol at the 58th World Health Assembly, May 2005. Nordisk Alkohol- og Narkotikatidsskrift [English supplement]. 2005;22:163–6. https://doi.org/10.1177/145507250502201S19.
14. World Health Organization. The World Health Report 2002: Reducing Risks. Geneva: Promoting Healthy Life; 2002.
15. Gunnarson D. Alþjóðaheilbrigðismál Ísland til áhrifa (Iceland to influence international health matters). Reykjavík: Verkfræðubgafélag Ísland; 2016.
16. Room R. Negotiating the place of alcohol in public health: the arguments at the interface. Addiction. 2005;100:1396–7.
17. World Health Organization. Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva, 2013. https://iris.who.int/bitstream/handle/10665/94384/9789241506236_eng.pdf.
18. United Nations General Assembly. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases. 2011 16 September. A/66/L.1. https://digitallibrary.un.org/record/710899?ln=en&v=pdf.
19. United Nations. Sustainable Development Goals. 2015. http://www.un.org/sustainabledevelopment/sustainable-development-goals/. Accessed 14 Jun 2016.
20. Ferreira-Borges C, Parry CDH, Babor TF. Harmful Use of Alcohol: A Shadow over Sub-Saharan Africa in Need of Workable Solutions. Int J Environ Res Public Health. 2017;14:346. https://doi.org/10.3390/ijerph14040346.
21. World Health Organization. Global strategy to reduce the harmful use of alcohol. WHO. Geneva, 2010. https://iris.who.int/bitstream/handle/10665/44395/9789241599931_eng.pdf.
22. World Health Organization. SAFER Initiative. 2018. https://www.who.int/initiatives/SAFER. Accessed 10 Nov 2024.
23. Madden M, Bartlett A, McCambridge J. Constructing public–private partnerships to undermine the public interest: critical discourse analysis of Working Together published by the International Alliance for Responsible Drinking. Global Health. 2023;19:103. https://doi.org/10.1186/s12992-023-01000-0.
24. Babor T, Brown K, Jernigan D, Mbona N, Hastings G, Laranjeira R, et al. Statement of Concern: The international public health community responds to the global alcohol producers' attempts to implement the WHO global strategy on the harmful use of alcohol. Global Alcohol Policy Alliance. 2013. https://globalgapa.org/our-work/updates/statement-of-concern/.

25. Chikritzhs T, Stockwell T, Naimi T, Andreasson S, Dangardt F, Liang W. Has the leaning tower of presumed health benefits from "moderate" alcohol use finally collapsed? Addiction. 2015;110:726–7. https://doi.org/10.1111/add.12828.
26. Stockwell T, Zhao J, Clay J, Levesque C, Sanger N, Sherk A, et al. Why Do Only Some Cohort Studies Find Health Benefits From Low-Volume Alcohol Use? A Systematic Review and Meta-Analysis of Study Characteristics That May Bias Mortality Risk Estimates. J Stud Alcohol Drug. 2024;85:441–52. https://doi.org/10.15288/jsad.23-00283.
27. Millwood IY, Walters RG, Mei XW, Guo Y, Yang L, Bian Z, et al. Conventional and genetic evidence on alcohol and vascular disease aetiology: a prospective study of 500 000 men and women in China. Lancet. 2019;393:1831–42. https://doi.org/10.1016/S0140-6736(18)31772-0.
28. Yoon SJ, Jung JG, Lee S, Kim JS, Ahn SK, Shin ES, et al. The protective effect of alcohol consumption on the incidence of cardiovascular diseases: is it real? A systematic review and meta-analysis of studies conducted in community settings. BMC Public Health. 2020;20:90. https://doi.org/10.1186/s12889-019-7820-z.
29. Griswold MG, Fullman N, Hawley C, Arian N, Zimsen SRM, Tymeson HD, et al. Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet. 2018;392:1015–35. https://doi.org/10.1016/S0140-6736(18)31310-2.
30. Rajasuriya M. 4 Reasons WHO Should Quit the Concept of 'Harmful Use of Alcohol'. Movendi International. 2021. https://movendi.ngo/blog/2021/09/10/4-reasons-who-should-quit-the-concept-of-harmful-use-of-alcohol/. Accessed 21 Nov 2024.
31. Leung J. Summary of web-based consultation on the implementation of the WHO global strategy to reduce the harmful use of alcohol since its endorsement, and the way forward. GAPA, 2020. https://globalgapa.org/our-work/updates/summary-of-submissions-to-who-consultation-on-global-alcohol-strategy-implementation/.
32. World Health Organization. Developing a Global action plan to reduce the harmful use of alcohol – 2020 Web based consultation on a working document. 2020. https://www.who.int/news-room/articles-detail/global-action-plan-to-reduce-the-harmful-use-of-alcohol#cms. Accessed 10 Nov 2024.
33. Leung J. Summary of 2020 web-based consultation on the WHO working document – Appendix GAPA, 2021. https://globalgapa.org/our-work/updates/summary-of-2020-web-based-consultation-on-the-who-working-document/.
34. Dwyer R, Room R, O'Brien P, Cook M, D G. Alcohol industry submissions to the WHO 2020 Consultation on the development of an Alcohol Action Plan: A content and thematic analysis. La Trobe University/FARE, 2022, 2022. Report for the Foundation for Alcohol Research and Education [FARE]. https://fare.org.au/wp-content/uploads/Report-Alcohol-industry-submissions-to-the-WHO-2020-Consultation-on-the-development-of-an-Alcohol-Action-Plan-A-content-and-thematic-analysis.pdf.
35. World Health Organization. Global alcohol action plan 2022–2030. Geneva, 2024, June 20. https://iris.who.int/bitstream/handle/10665/376939/9789240090101-eng.pdf?sequence=1.

Publisher's Note