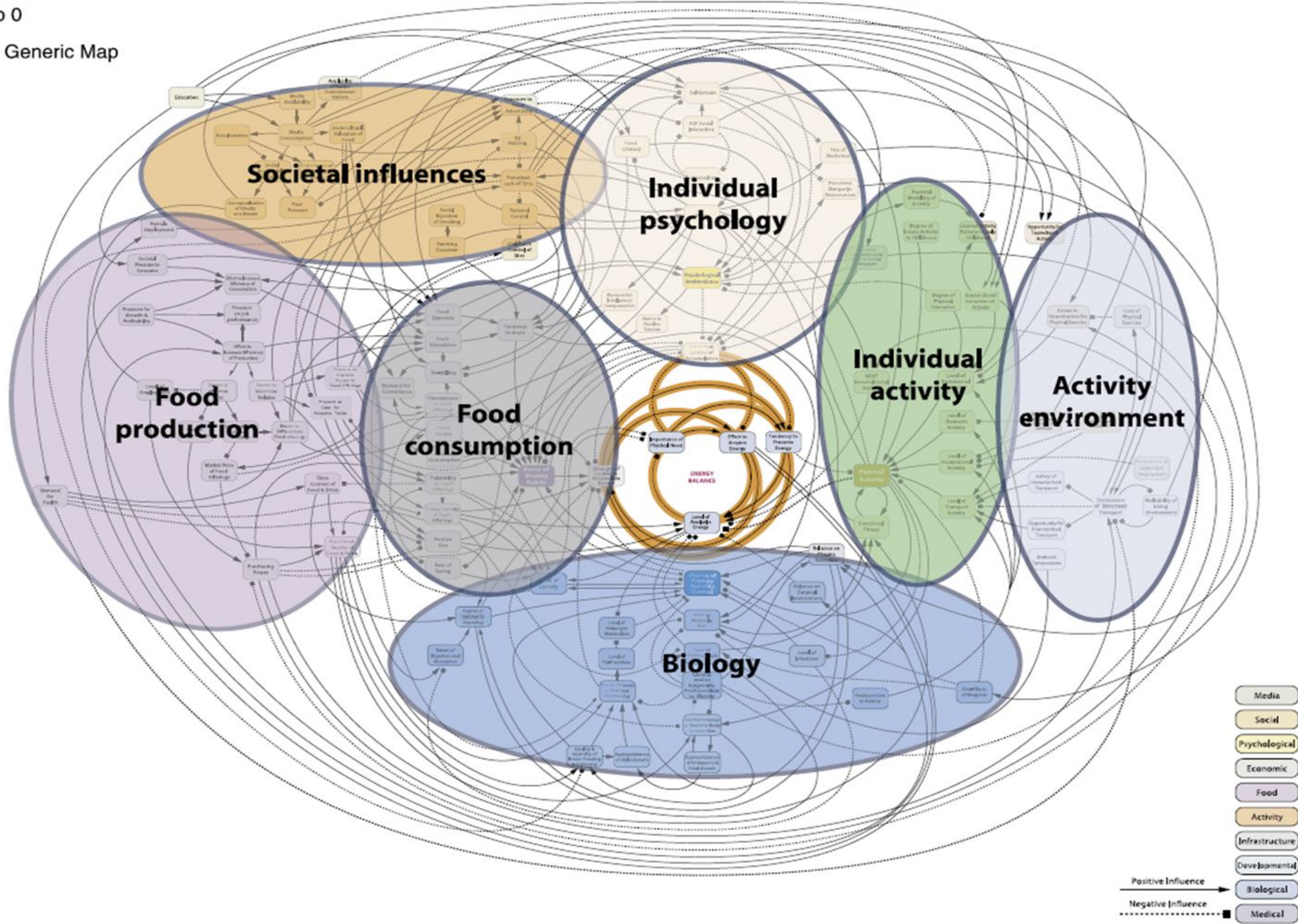
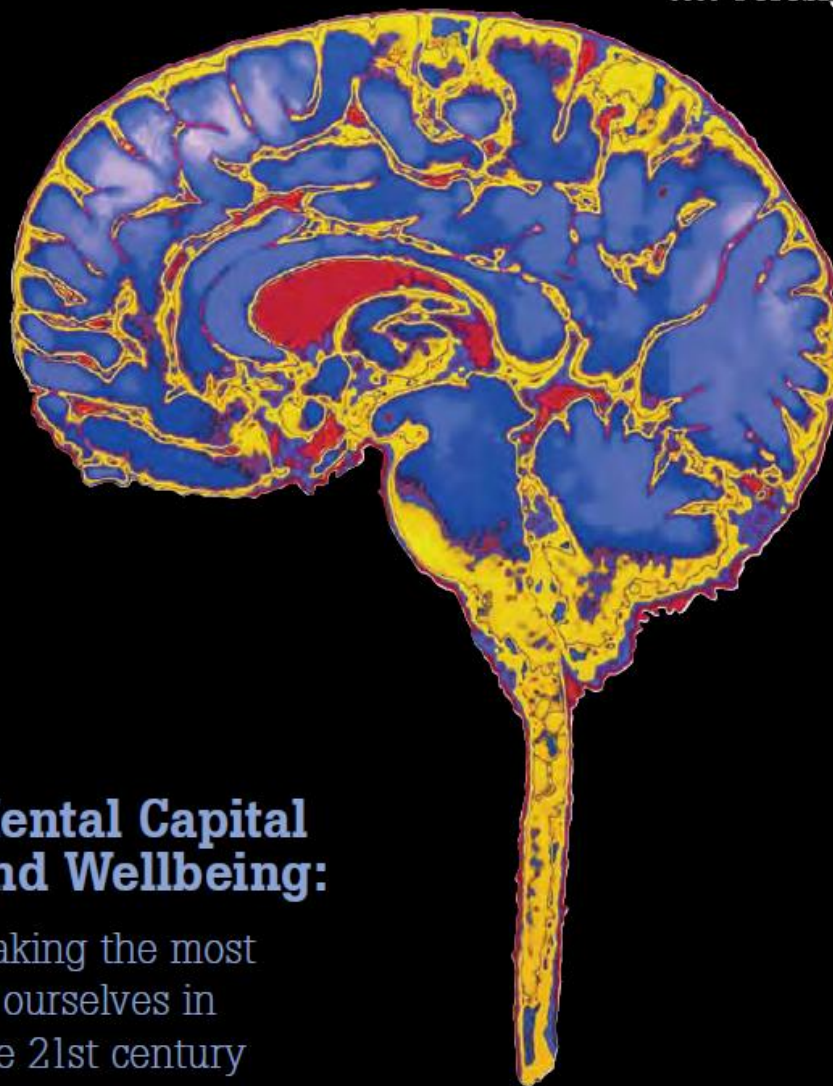
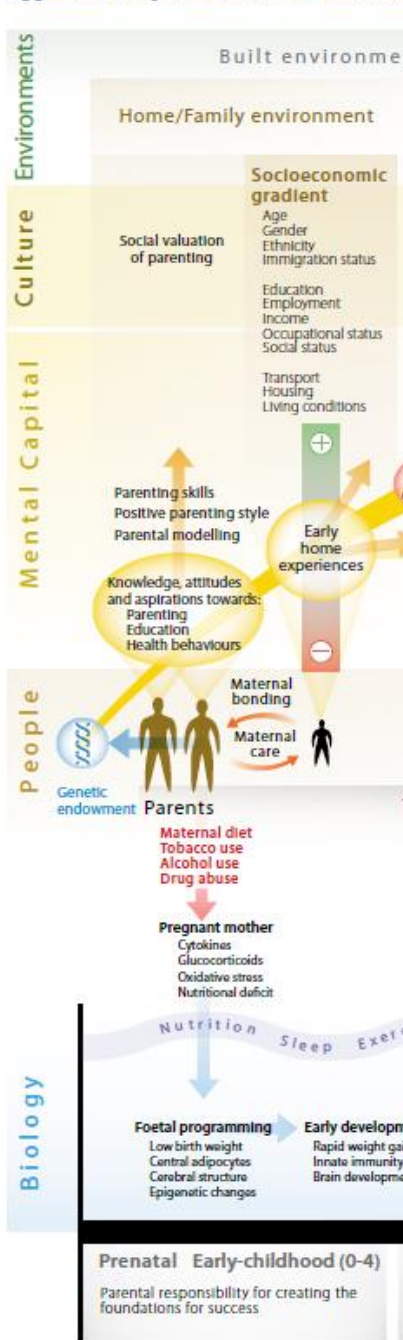


*„rozdźwięk między pięknymi słowami
wypowiadanymi podczas uroczystych celebracji
a czynami będącymi zaprzeczeniem tych słów
świadczy o głębokim kryzysie moralnym...”*

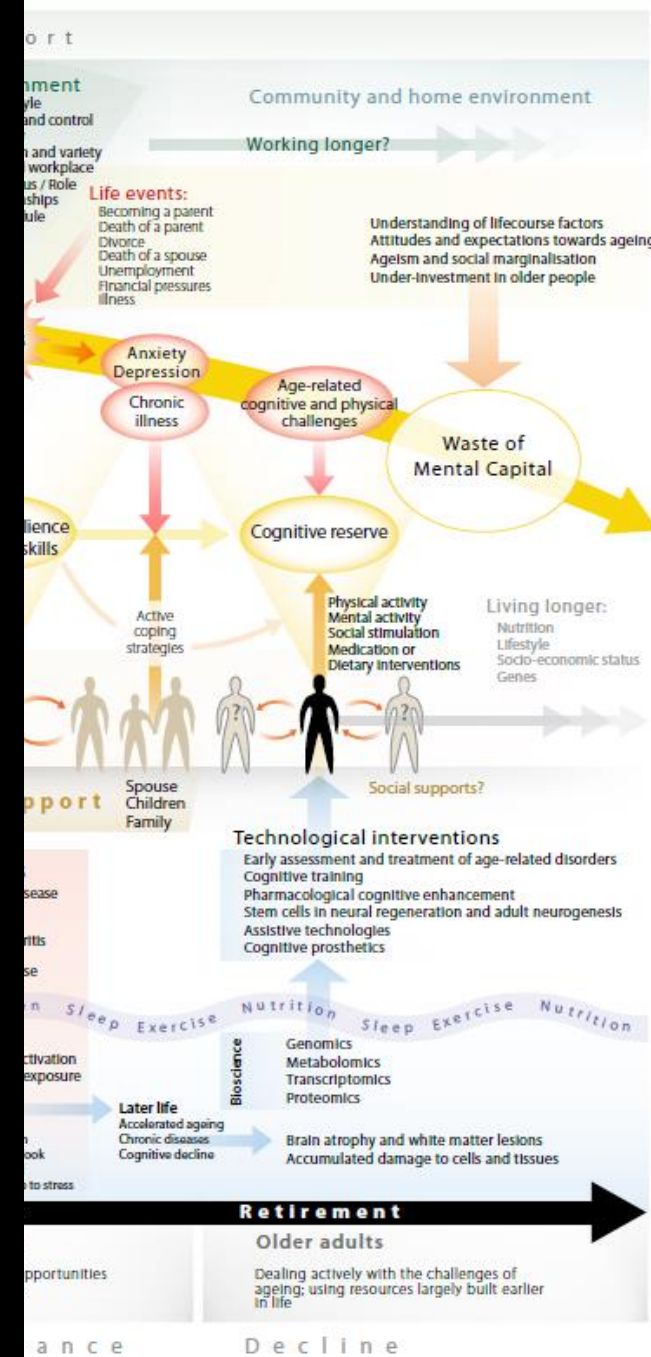




Mental Capital and Wellbeing:

Making the most of ourselves in the 21st century

EXECUTIVE SUMMARY





World Health Organization

W naszym zespole ponad 8 tysięcy profesjonalistów są wiodący na świecie eksperci zdrowia publicznego włączając lekarzy, epidemiologów, naukowców i menażerów.

Wspólnie koordynujemy światową reakcję na zagrożenia zdrowotne, promujemy życie w dobrostanie, zapobiegamy chorobom i rozszerzamy dostęp do opieki zdrowotnej.

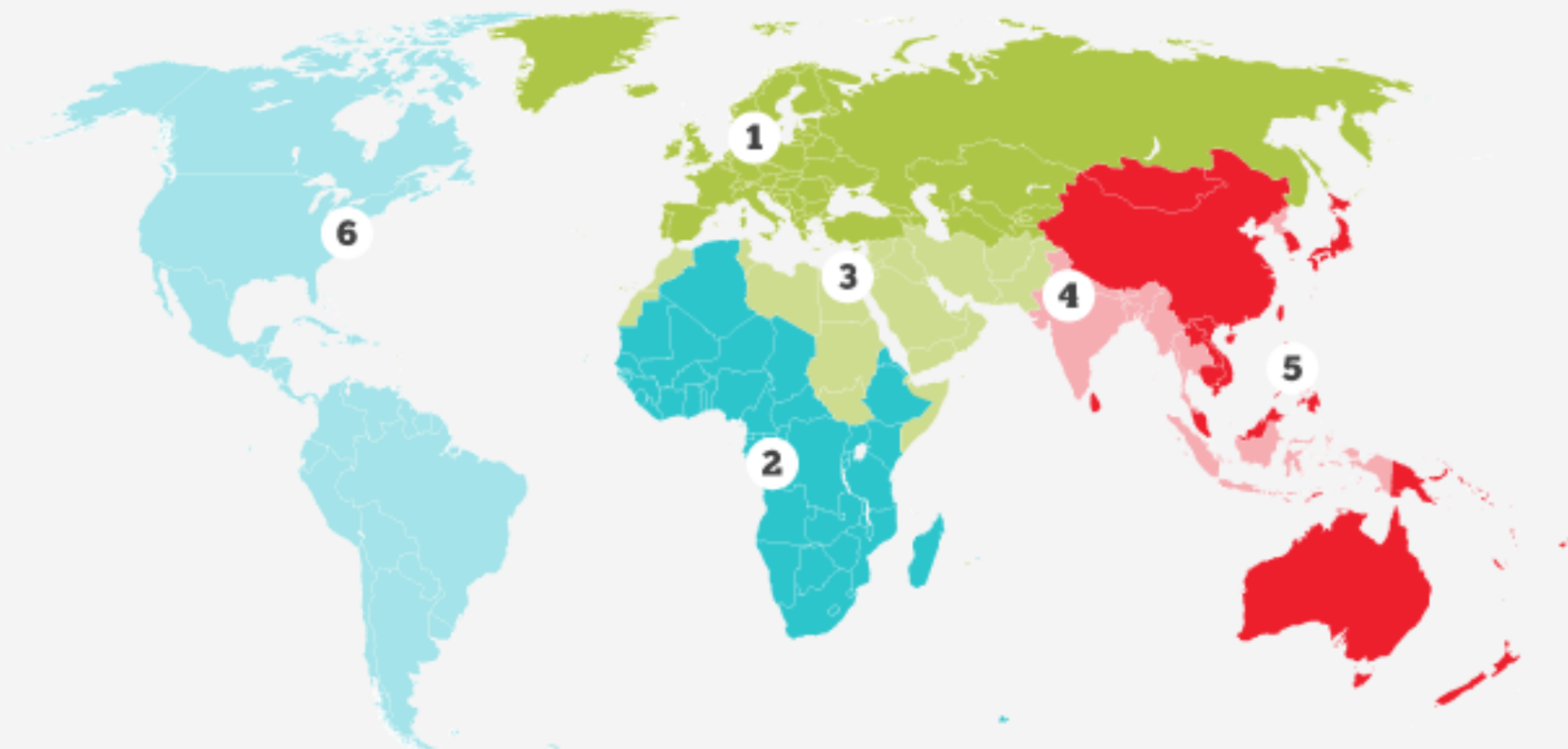
Przez przekazywanie narodom, ludziom i partnerom wiedzy naukowej na której mogą polegać dążymy do tego, aby dać każdemu równe szanse bezpiecznego i zdrowego życia.

WHO is an organization of 194 Member States. The Member States elect the Director-General, who leads the organization in achieving its global health goals.

Dr Hans Kluge is the WHO Regional Director for Europe. His term began on 1 February 2020, following his nomination by the WHO Regional Committee for Europe and appointment by the WHO Executive Board.

ŚWIATOWA ORGANIZACJA ZDROWIA

OBSZAR FUNKCJONOWANIA I SIEDZIBY POSZCZEGÓLNYCH BIUR REGIONALNYCH



- 1** Biuro Regionalne na Europę
siedziba: Kopenhaga (Dania)
- 2** Biuro Regionalne na Afrykę
siedziba: Brazzaville (Kongo)
- 3** Biuro Regionalne na Wschodni Rejon Śródziemnomorski
siedziba: Kair (Egipt)
- 4** Biuro Regionalne na Azję Południową i Wschodnią
siedziba: New Delhi (Indie)
- 5** Biuro Regionalne na Zachodni Pacyfik
siedziba: Manila (Filipiny)
- 6** Biuro Regionalne na Ameryki
siedziba: Waszyngton (USA)

Agenda na rzecz zrównoważonego rozwoju do roku 2030, przyjęta przez wszystkie państwa członkowskie Organizacji Narodów Zjednoczonych w 2015 r., stanowi wspólny plan na rzecz pokoju i dobrobytu dla ludzi i planety, teraz i w przyszłości. W jego sercu znajdują się 17 Celów Zrównoważonego Rozwoju (SDG)



UNITED NATIONS



TIMES OF CRISIS,
TIMES OF CHANGE
SCIENCE FOR ACCELERATING
TRANSFORMATIONS
TO SUSTAINABLE
DEVELOPMENT



GLOBAL SUSTAINABLE
DEVELOPMENT REPORT 2023

Nine Targets for 2025



stworzenia łatwego
dostępu do 80%
przystępnych cenowo



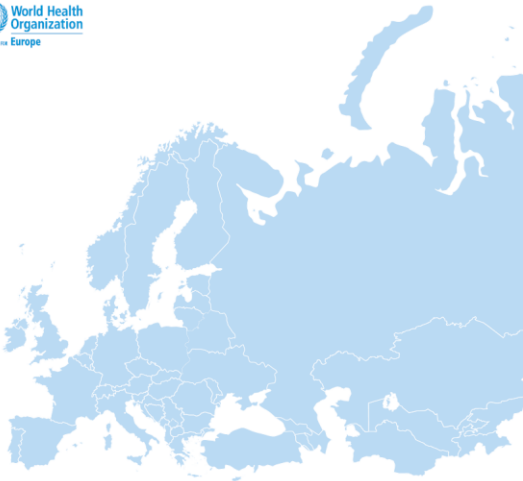
Skuteczne

zmniejszenia o 25%
występowania
przypadków



World Health Organization

zmniejszenia o 10% picia alkoholu w sposób szkodliwy



MAKING THE WHO EUROPEAN REGION

SAFER

DEVELOPMENTS IN ALCOHOL CONTROL POLICIES, 2010–2019

The SAFER action package

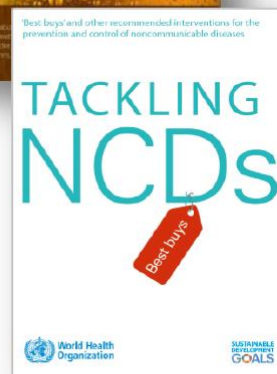
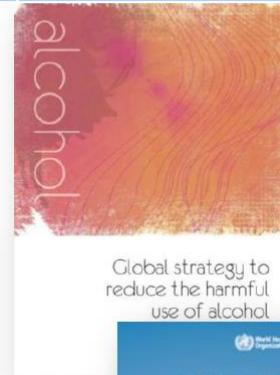
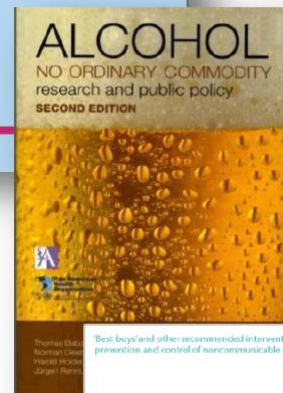
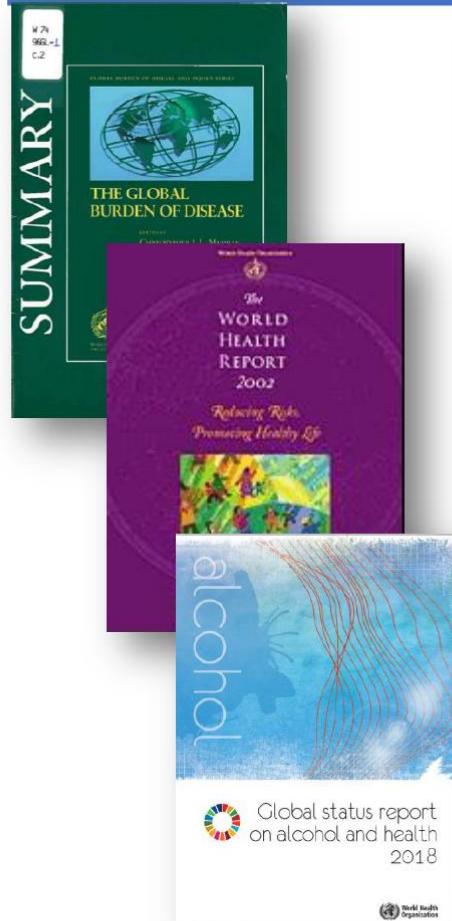
- S** Strengthen restrictions on alcohol availability
- A** Advance and enforce drink–driving countermeasures
- F** Facilitate access to screening, brief interventions and treatment
- E** Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion
- R** Raise prices on alcohol through excise taxes and pricing policies

The problem

The solutions

The decisions

The actions





Overwhelming evidence indicates that industry producing and selling unhealthy commodities have defeated, delayed, or weakened public policies' design, implementation, and evaluation worldwide. Strategies used include interference in policy development, litigation, coalition-building through front groups and misusing knowledge or propagating misinformation. There are irreconcilable differences between governments' goals, which include protecting and promoting people's health and well-being and the goals of economic operators, which are to pursue private profit maximisation through increased alcohol consumption. Corporate social responsibility initiatives, narratives related to individual choices, moderate and responsible drinking and the co-option of public health researchers and universities to collaborate with alcohol industry-funded organisations may undermine the effectiveness of alcohol control policies. Evidence points to opportunities to reduce conflicts of interest, including using evidence to inform the development of alcohol control policies, disclosure of research funding and implementing national and regional policies that capitalise on opportunities presented through trade law and negotiations.



**World Health
Organization**

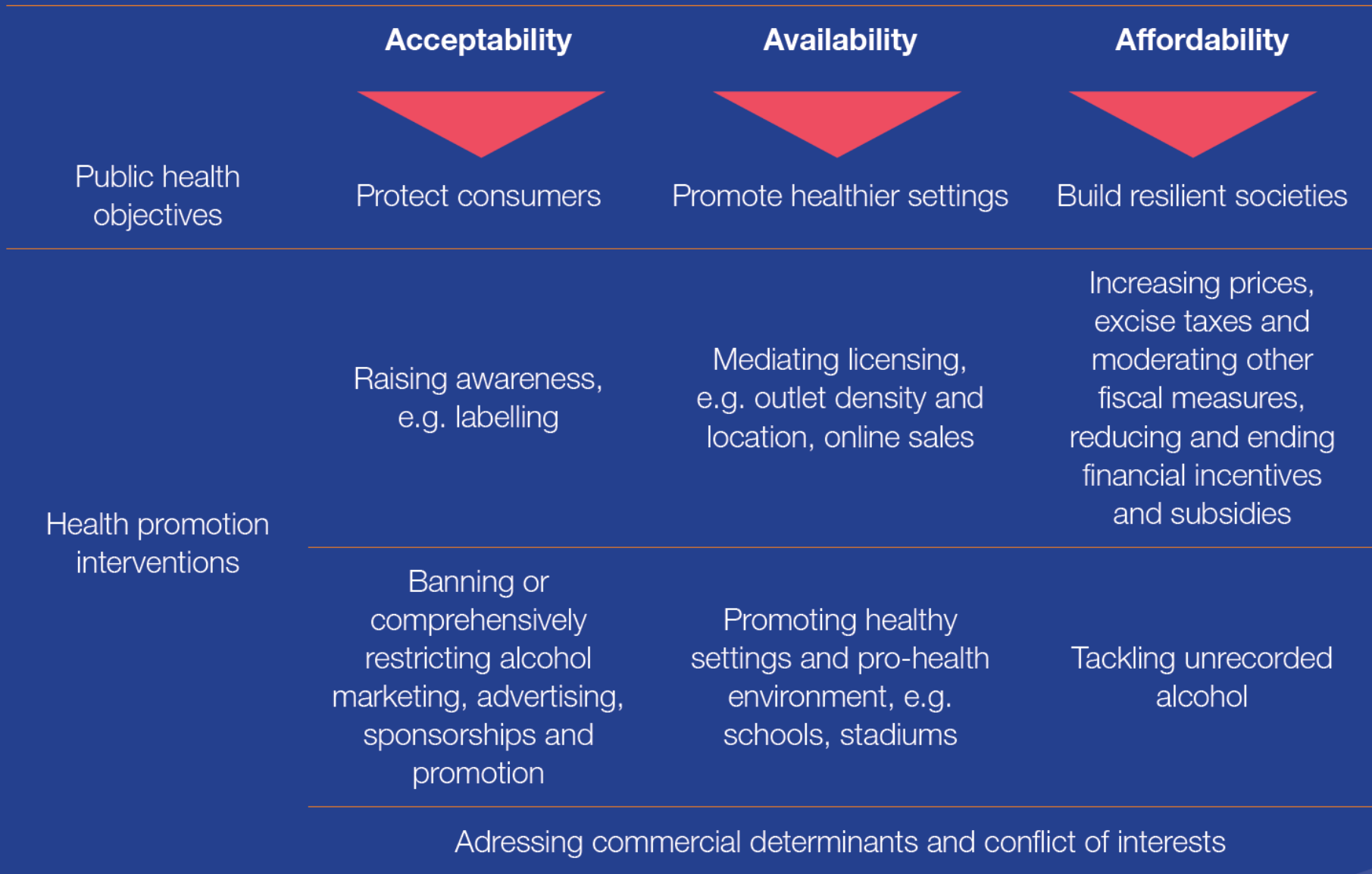
European Region

Addressing and managing conflicts of interest in alcohol control policies

Snapshot series on alcohol control policies and practice

Brief 3, 3 September 2021

Determinants driving the consumption of alcohol



Addressing and managing conflicts of interest in alcohol control policies

Snapshot series on alcohol control policies and practice

Brief 3, 9 September 2021

“There was a massive level of lobbying from the industry during this time. Almost a hundred representations were made to government over the course of a single year. In fact, this particular piece of legislation has been described as the most contested in the history of the state”

Sheila Gilheany, Alcohol Action Ireland at the webinar Addressing and managing conflicts of interest in alcohol control policies

There is a need for strong leadership at government level to ensure that public health concerns remain the focus of any alcohol policy. One proposal to achieve that is the suggestion of a dedicated Alcohol Office to lead on alcohol policy and provide insight across government departments on the impact of alcohol in areas ranging from the night-time economy to agriculture.



Addressing and managing
conflicts of interest in
alcohol control policies

Snapshot series on alcohol control policies and practice

Brief 3, 3 September 2021

Takeaway messages

1

There are irreconcilable differences between public health and economic interests.

2

Industries producing and selling unhealthy commodities have defeated, delayed or weakened the design, implementation and evaluation of public policies worldwide.

3

Evidence shows that protecting policy development from conflicts of interest is essential to decrease the burden of disease.

4

There is no robust evidence that corporate social responsibility reduces alcohol consumption.

5

International frameworks and coalitions help in managing conflicts of interest and advance alcohol control policies.

6

The current research practices to disclose conflicts of interest are insufficient to ensure transparency and unbiased science.

7

Adopting procedures to identify and limit interactions with the alcohol industry prevents interferences and ensure transparency during the development of public health policies.

8

Civil society can improve the recognition of and anticipate the industry practices.



Addressing and managing conflicts of interest in alcohol control policies

Snapshot series on alcohol control policies and practice

Brief 3, 9 September 2021



Health warning labels on alcoholic beverages:

opportunities for informed
and healthier choices

Snapshot series on alcohol control policies and practice

Brief 4, 8 November 2021



Digital marketing of alcoholic beverages

what has changed?

Snapshot series on alcohol control policies and practice

Brief 6, 9 December 2021



A PUBLIC HEALTH PERSPECTIVE ON ALCOHOL ESTABLISHMENTS: **LICENSING, DENSITY AND LOCATIONS**

BRIEF ③, NOVEMBER 2022

SNAPSHOT SERIES ON
ALCOHOL CONTROL
POLICIES AND PRACTICE

Box 1. Policy options for restricting the physical availability of alcohol

Restricting the availability of alcohol is a highly cost-effective intervention for low- and middle-income countries. It requires the capacity for implementing and enforcing regulations and the need to address unrecorded alcohol production and consumption (133, 138-141).

Policy-makers can opt for a combination of the following measures:

- ▶ Establishing a state monopoly on import, production, wholesales, distribution, retail sales and export.
- ▶ Licensing for import, production, wholesales, distribution, retail sales and exports.
- ▶ Restricting hours of alcohol sale on weekdays and weekends.
- ▶ Forbidding the location of alcohol establishments in proximity of health facilities, educational institutions, government offices, military and police buildings.
- ▶ Prohibiting alcohol consumption in public places, e.g. public transport, parks and streets, beauty salons, movie theatres, sporting events, workplaces, educational institutions, health facilities, and houses of worship.
- ▶ Banning the consumption of alcohol in specific circumstances, e.g. operating machinery, driving.
- ▶ Banning the sale of alcohol at specific events, e.g. national holidays, election days, and religious celebrations.
- ▶ Prohibiting the sale of alcohol via automatic vending machines, sachets, through taps, peddling (hand baskets, portable trays), and from stands in the street.
- ▶ Banning remote ordering of alcohol through a virtual outlet by mail, phone call or text message, computer or the use of mobile applications.
- ▶ Restricting the days of alcohol sale on weekdays and weekends.
- ▶ Banning procuring alcohol to minors.
- ▶ Prohibiting serving alcohol intoxicated patrons.
- ▶ Reducing the density of alcohol establishments.
- ▶ Restricting the delivery of alcoholic beverages ordered remotely to those regulated.
- ▶ Preventing illegal, informal, smuggled and home-made production, distribution and sale of alcoholic beverages.
- ▶ Restricting the alcohol content or quantity of alcohol per unit, e.g. setting a minimum or maximum of alcohol content per unit or beverage or setting a minimum or maximum quantity per pack.
- ▶ Banning certain products, e.g. energy drinks containing alcohol or low alcoholic beverages.
- ▶ Strengthening enforcement systems, e.g. active surveillance, complaint system and applying penalties for violations, e.g. fines on alcohol establishments, consumers and patrons, suspension or removal of license to operate, requiring employees to take training.



Fig. 4 Policy options to regulate the physical availability of alcohol across the supply chain

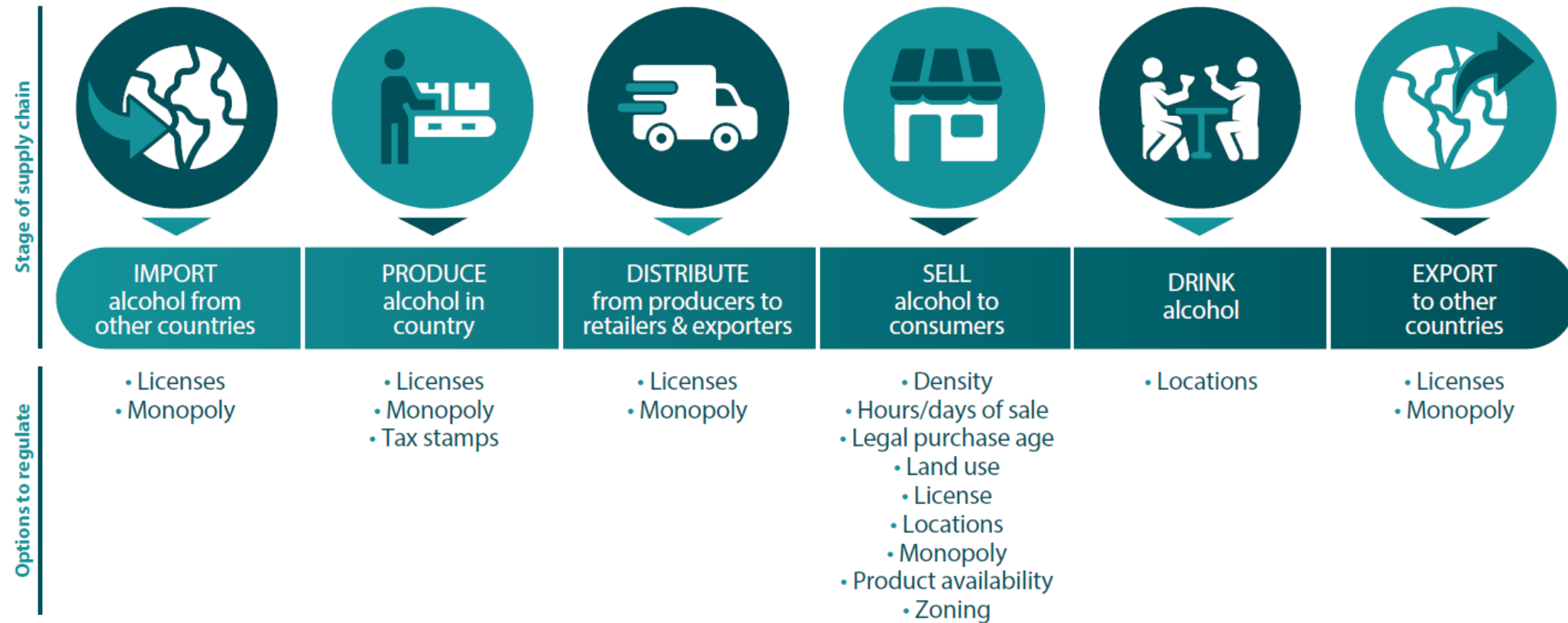


Fig. 8 Implications of population changes in the estimation of alcohol outlet density

The premise

- ▶ **Scenario A.** Consider a fictional region with an alcohol outlet density threshold of one establishment for every 1500 people.
- ▶ **Scenario B.** Consider is an influx of people who move into the region, causing the density to decrease to one establishment for every 2500 people even though there were no changes in the number of licenses.
- ▶ **Scenario C.** Consider a scenario where enough people left the region to cause the ratio to increase to one establishment for every 900 people. Also in this case, there were no changes in the number of licenses.

Scenario A. One establishment every for 1500 people



Scenario B. Population increases so there is one establishment every for 2500 people



Scenario C. Population decreases so there is one establishment for every 900 people



 100 people

 100 people who moved into the region

 100 people who moved away from the region

 1 establishment

Conclusions

In these scenarios, the alcohol policies did not change, but the ratio of establishments to people rose and fell, according to the movement of the population. Liquor licensing boards in jurisdictions that use population-based indicators should be prepared to grant new licenses and cancel existing licenses based on population movements to maintain optimal levels of density.

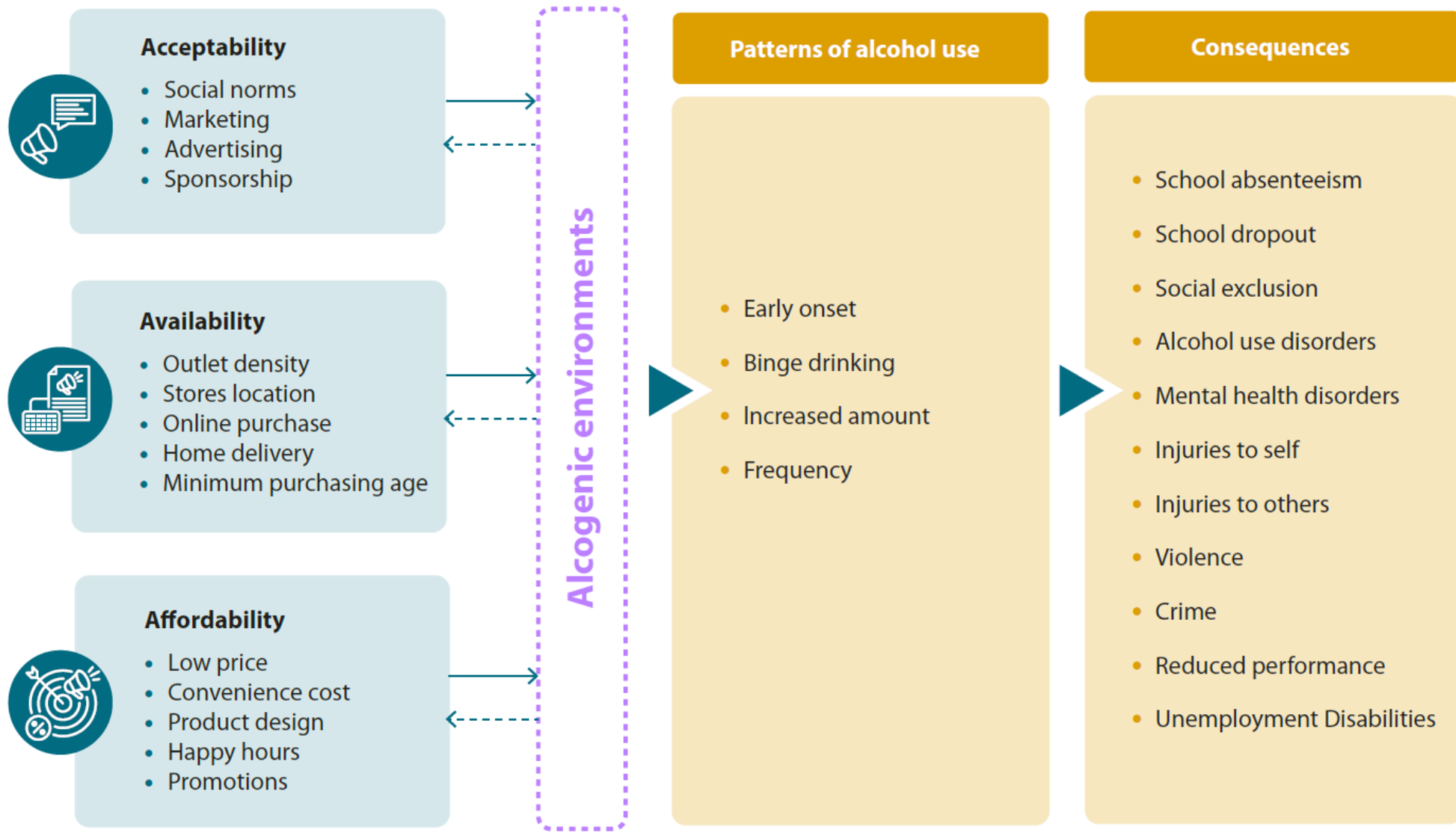
A PUBLIC HEALTH
PERSPECTIVE ON ALCOHOL
ESTABLISHMENTS:
**LICENSING, DENSITY
AND LOCATIONS**

BRIEF ©, NOVEMBER 2022

SNAPSHOT SERIES ON
ALCOHOL CONTROL
POLICIES AND PRACTICE



Fig. 1. Alcogetic environments and potential effects on young people



Source: adapted from Martineau et al. (52).

A HEALTH PROMOTION
APPROACH FOR
REDUCING YOUTH
EXPOSURE TO ALCOGENIC
ENVIRONMENTS



BRIEF

SNAPSHOT SERIES ON
ALCOHOL CONTROL
POLICIES AND PRACTICE



Takeaway messages

1

The environment in which young people live, learn and play significantly affect their decisions about whether to consume alcohol. Environmental factors have been described as the main risk factors driving alcohol consumption and related harm among young people.

2

Alcogenic environments promote the normalization of alcohol consumption, leading to adverse effects on brain development, decreased educational attainment, low mental well-being, increased risk for social problems such as violence and crime, earlier development of liver cirrhosis, higher likelihood of binge drinking, increased risk of alcohol use disorders, earlier onset and greater of alcohol consumption throughout the lifespan.

4

Policy-relevant research should be conducted to understand further what approaches are effective in reducing the effects of alcogenic environments, including conducting evaluations on existing policy choices.

5

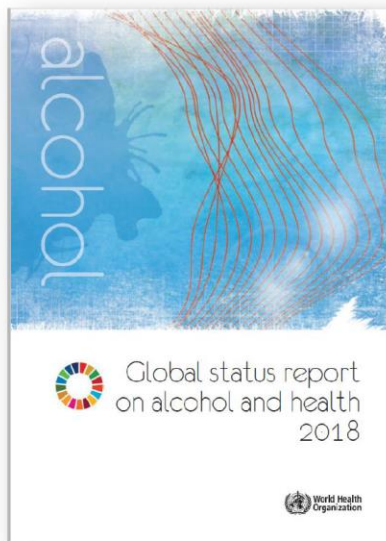
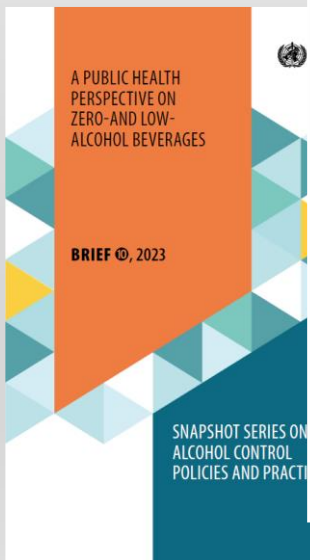
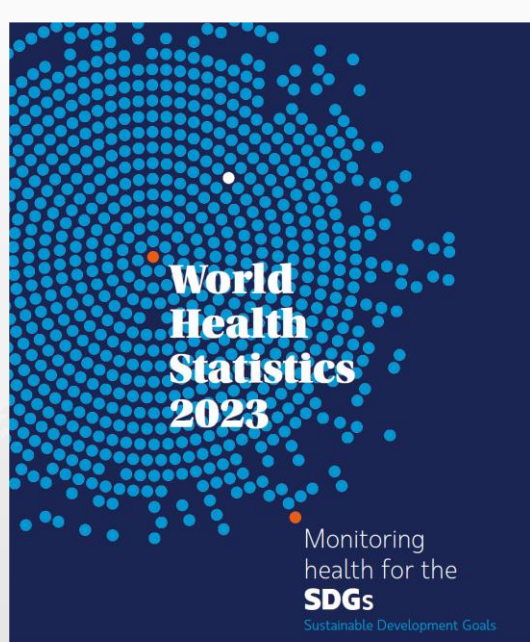
Interventions that focus on single settings, such as those solely targeting schools or families rather than the whole environment, provide inconclusive evidence about their effectiveness in decreasing the harm derived from consuming alcohol.

6

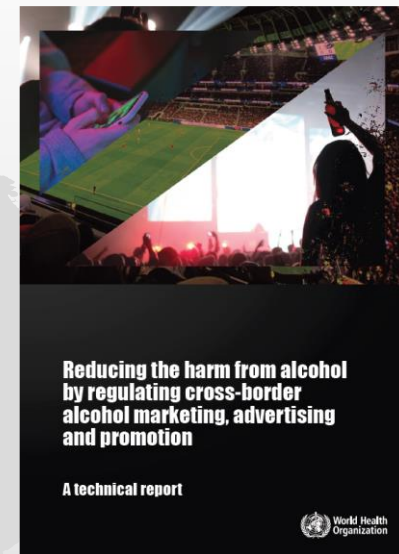
Multipronged interventions that tackle the acceptability, availability and affordability driving alcohol consumption are most effective in reducing young people's exposure to alcogenic environments.

7

Partnerships among many stakeholders ensure widespread advocacy, design, implementation and enforcement of initiatives that address upstream the causes of the harm caused by alcohol consumption.



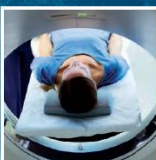
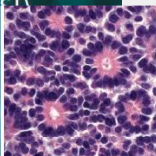
Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders



ASSIST

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

Manual for use in primary care



World Cancer Report

Cancer research for cancer prevention

Edited by CHRISTOPHER P. WILD, ELISABETE WEIDERPASS, and BERNARD W. STEWART



WHO alcohol brief intervention training manual for primary care



WHO HEALTH EVIDENCE NETWORK SYNTHESIS REPORT 68

What is the current alcohol labelling practice in the WHO European Region and what are barriers and facilitators to development and implementation of alcohol labelling policy?

Eva Jané-Llopis | Daša Kokole | Maria Neufeld | Omer Syed Muhammad Hasan | Jürgen Rehm



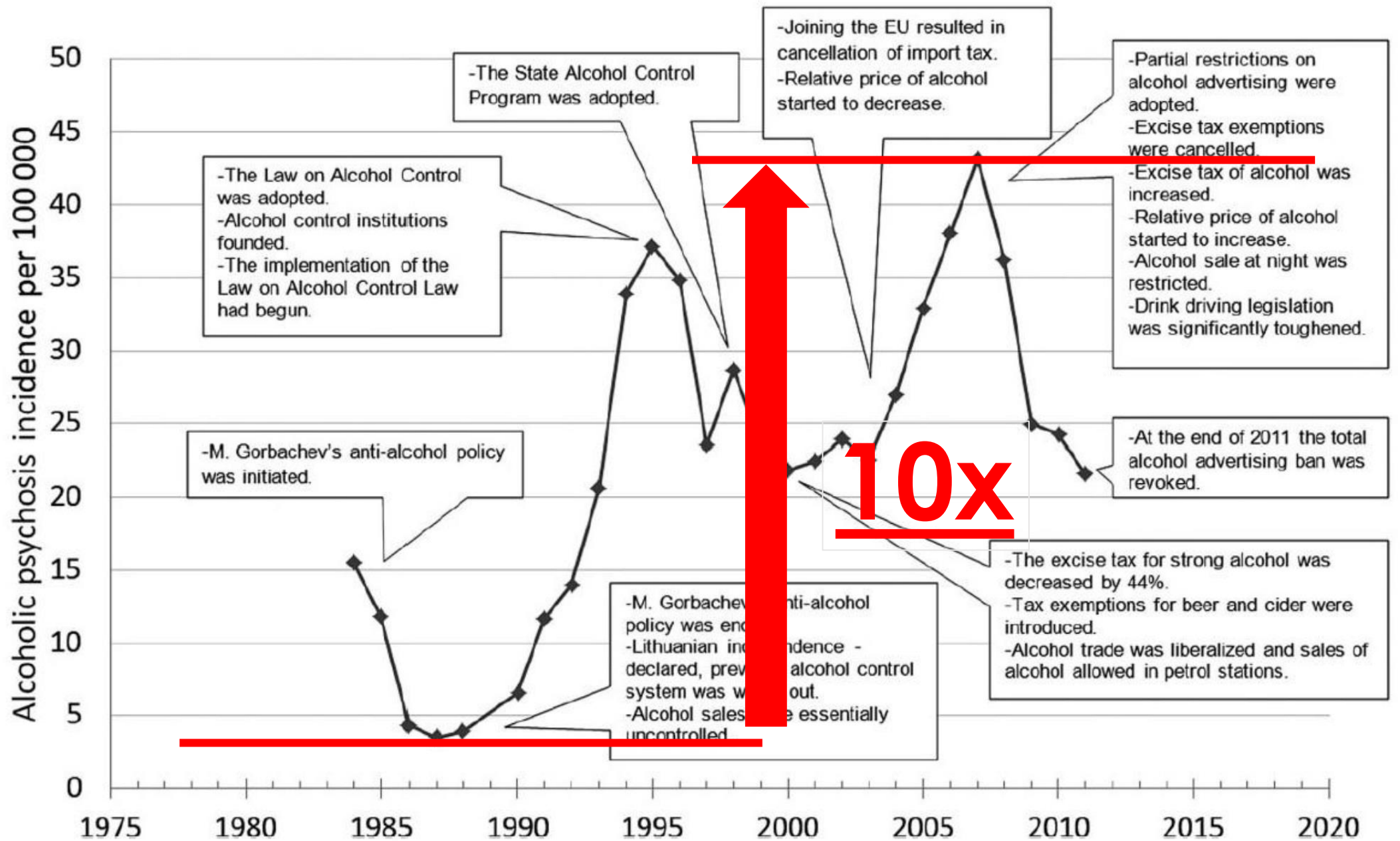


Figure 1 Reflection of alcohol control policy measures on alcoholic psychosis incidence in Lithuania (1984–2011). (Source:WHO HFA-DB)

PORÓWNANIE RYZYKA I KOSZTÓW

	<u>nikotyna</u>	<u>alkohol</u>
Potencjał uzależniający	<u>ekstremalnie wysoki</u>	
Ryzyko dla używającego	<u>ekstremalnie wysokie</u>	
Ryzyko dla osób trzecich	wysokie	<u>wyższe</u>
Liczba osób włączonych w ryzyko	wysoka	<u>znacznie większa</u>
Koszty ekonomiczne i społeczne	wysokie	<u>wyższe</u>
Atrakcyjność dla osób młodych i dzieci	wysoka	<u>wyższa</u>
Akceptacja społeczna	zmniejszająca się	<u>wysoka</u>
Ograniczenia prawne	znaczące	Mniejsze!!!



DOBRE PRAWO SKUTECZNIE EGZEKWOWANE

POLITYKA PAŃSTWA!!!

SUKCES??????

WIEDZA NAUKOWA

WSPÓŁPRACA INTERESARIUSZY

INFORMACJA I PROFILAKTYKA

SYSTEM LECZENIA UZALEŻNIEŃ

WHO Europe

Kraj	POLSKA	Liczba zyskanych lat życia w zdrowiu na 1 milion ludności rocznie	Koszty w skali roku (w EURO, 2005)		Koszt uzyskania 1 roku życia w zdrowiu (w EURO, 2005)
Ludność	38.165.400		Całkowite	Na osobę	
PKB na mieszkańca brutto (w euro, 2005)	6.352				
Kurs wymiany waluty (2005)	0,25				
Opodatkowanie aktualne		1.618	2.501.967	0,07	41
Opodatkowanie podwyższone (Aktualne + 25%)		1.822	2.998.916	0,08	43
<u>Opodatkowanie podwyższone</u>		1.822	2.998.916	0,08	39
<u>Zmniejszony dostęp do alkoholu</u>		1.822	2.998.916	0,08	499
<u>Wszystostronny zakaz reklamy</u>		1.822	2.998.916	0,08	378
Krótką interwencją w porady		1.822	2.998.916	0,08	745
Badania kierowców alko		1.822	2.998.916	0,08	2.871
Scenariusz realizowany		1.822	2.998.916	0,08	453
Kombinacja 1: Podwyższone		1.822	2.998.916	0,08	334
Komb 2: Podwyższone		1.822	2.998.916	0,08	138
Komb 3: Podwyższone		1.822	2.998.916	0,08	317
Komb 4: Podwyż. opod		1.822	2.998.916	0,08	324
Komb 5: Podwyż. opod dostęp.		4.375	57.790.415	1,51	346
Kombinacja 6: Podwyż. opodat. + zakaz reklamy + krótka porada + zmniejszony dostęp + RBT		4.605	82.962.624	2,17	472

Alcohol Policy
 Cost-effectiveness
 Briefing Notes
 for
 22 European Countries

Table 1. Increased risk of diseases and injuries for females based on average weekly alcohol use (standard drinks per week)

Disease or injury	1	2	3	4	5	6	7	14	21	35
Tuberculosis	3.7%	7.5%	11.4%	15.5%	19.7%	24.1%	26.3%	62.4%	105.2%	233.3%
Lower respiratory infections	1.0%	1.9%	2.9%	3.9%	4.9%	5.9%	6.4%	13.7%	21.0%	37.6%
Oral cavity and pharynx cancer	5.1%	10.3%	15.8%	21.6%	27.6%	33.8%	37.0%	89.4%	152.3%	338.4%
Oesophagus cancer	2.7%	5.4%	8.2%	11.1%	14.1%	17.2%	18.7%	42.7%	69.1%	139.3%
Colorectal cancer	1.4%	2.7%	4.1%	5.6%	7.0%	8.5%	9.2%	20.0%	31.1%	57.4%
Liver cancer	0.8%	1.6%	2.4%	3.2%	4.0%	4.8%	5.2%	11.2%	17.0%	30.1%
Breast cancer	1.8%	3.7%	5.6%	7.6%	9.5%	11.6%	12.6%	27.9%	44.0%	84.2%
Larynx cancer	3.0%	6.0%	9.1%	12.3%	15.5%	18.8%	20.5%	46.3%	73.8%	143.5%
Pancreatitis	-5.3%	-10.3%	-15.0%	-19.2%	-22.7%	-25.5%	-26.7%	-20.8%	14.8%	173.9%
Diabetes Mellitus	-15.2%	-19.9%	-23.0%	-25.2%	-26.9%	-28.3%	-28.9%	-33.5%	-34.6%	-32.7%
Liver cirrhosis	61.5%	94.3%	124.3%	153.3%	182.1%	211.0%	225.5%	444.7%	685.5%	1337.2%
Atrial fibrillation and flutter	1.3%	2.6%	3.9%	5.3%	6.6%	8.0%	8.7%	18.9%	29.2%	53.7%
Hypertension	1.2%	2.4%	3.6%	4.8%	6.0%	7.1%	7.7%	16.1%	24.8%	45.2%
Ischemic heart disease	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	4.0%	4.0%	15.0%
Ischemic stroke	-10.0%	-10.0%	-10.0%	-10.0%	-10.0%	-8.0%	-8.0%	8.0%	8.0%	14.0%
Intracerebral hemorrhage	-8.0%	-8.0%	-8.0%	-8.0%	-8.0%	-1.0%	-1.0%	25.0%	25.0%	67.0%
Subarachnoid haemorrhage	21.0%	21.0%	21.0%	21.0%	21.0%	11.0%	11.0%	39.0%	39.0%	82.0%
Epilepsy	3.1%	5.7%	8.3%	11.0%	13.8%	16.6%	18.0%	40.2%	64.5%	129.2%
Road injuries	1.9%	3.9%	5.9%	8.0%	10.1%	12.2%	13.3%	29.6%	46.8%	90.2%
Other unintentional injuries	1.6%	3.2%	4.8%	6.4%	8.1%	9.8%	10.6%	23.3%	36.5%	68.3%
Intentional injuries	5.1%	10.5%	16.1%	22.1%	28.3%	34.9%	38.3%	96.1%	171.2%	431.9%

Dark red > 50%; light red 20% to 50%; yellow 10% to < 20%; green < -10%

Table 2. Increased risk of diseases and injuries for males based on average weekly alcohol use (standard drinks per week)

Disease or injury	1	2	3	4	5	6	7	14	21	35
Tuberculosis	3.7%	7.5%	11.4%	15.5%	19.7%	24.1%	26.3%	62.4%	105.2%	233.3%
Lower respiratory infections	1.0%	1.9%	2.9%	3.9%	4.9%	5.9%	6.4%	13.7%	21.0%	37.6%
Oral cavity and pharynx cancer	5.1%	10.3%	15.8%	21.6%	27.6%	33.8%	37.0%	89.4%	152.3%	338.4%
Oesophagus cancer	2.7%	5.4%	8.2%	11.1%	14.1%	17.2%	18.7%	42.7%	69.1%	139.3%
Colorectal cancer	1.4%	2.7%	4.1%	5.6%	7.0%	8.5%	9.2%	20.0%	31.1%	57.4%
Liver cancer	0.8%	1.6%	2.4%	3.2%	4.0%	4.8%	5.2%	11.2%	17.0%	30.1%
Breast cancer	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Larynx cancer	3.0%	6.0%	9.1%	12.3%	15.5%	18.8%	20.5%	46.3%	73.8%	143.5%
Pancreatitis	3.5%	7.2%	11.0%	14.9%	18.9%	23.1%	25.3%	59.7%	100.1%	219.7%
Diabetes Mellitus	0.0%	0.0%	0.1%	0.1%	0.2%	0.2%	0.3%	1.1%	2.4%	5.9%
Liver cirrhosis	6.2%	12.4%	18.8%	25.6%	32.9%	40.5%	44.5%	113.6%	207.1%	553.0%
Atrial fibrillation and flutter	1.3%	2.6%	3.9%	5.3%	6.6%	8.0%	8.7%	18.9%	29.2%	53.7%
Hypertension	2.8%	5.7%	8.7%	11.8%	15.0%	16.6%	17.4%	29.3%	35.9%	47.2%
Ischemic heart disease	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	4.0%	4.0%	15.0%
Ischemic stroke	-8.0%	-8.0%	-8.0%	-8.0%	-8.0%	-8.0%	-8.0%	8.0%	8.0%	14.0%
Intracerebral hemorrhage	-8.0%	-8.0%	-8.0%	-8.0%	-8.0%	-1.0%	-1.0%	25.0%	25.0%	67.0%
Subarachnoid haemorrhage	21.0%	21.0%	21.0%	21.0%	21.0%	11.0%	11.0%	39.0%	39.0%	82.0%
Epilepsy	3.1%	5.7%	8.3%	11.0%	13.8%	16.6%	18.0%	40.2%	64.5%	129.2%
Road injuries	3.0%	6.1%	9.2%	12.5%	15.9%	19.3%	21.1%	48.8%	80.2%	168.0%
Other unintentional injuries	1.6%	3.2%	4.8%	6.4%	8.1%	9.8%	10.6%	23.3%	36.5%	68.3%
Intentional injuries	5.1%	10.5%	16.1%	22.1%	28.3%	34.9%	38.3%	96.1%	171.2%	431.9%














Dark red > 50%; light red 20% to 50%; yellow 10% to < 20%; green < -10%

Canada's Guidance on Alcohol and Health: Final Report

January 2023

Alcohol consumption per week

Drinking alcohol has negative consequences. The more alcohol you drink per week, the more the consequences add up.

0 drinks per week Not drinking has benefits, such as better health, and better sleep.	No risk	0 	During pregnancy, none is the only safe option. 	
1 to 2 standard drinks per week You will likely avoid alcohol-related consequences for yourself and others.	Low risk	1  2 		A standard drink means:  Beer 341 ml (12 oz) of beer 5% alcohol or  Cooler, cider, ready-to-drink 341 ml (12 oz) of drinks 5% alcohol or  Wine 142 ml (5 oz) of wine 12% alcohol or  Spirits (whisky, vodka, gin, etc.) 43 ml (1.5 oz) of spirits 40% alcohol
3 to 6 standard drinks per week Your risk of developing several different types of cancer, including breast and colon cancer, increases.	Moderate risk	3  4  5  6 		
7 or more standard drinks per week Your risk of heart disease or stroke increases.	Increasingly high risk	7  8  + 		
Each additional standard drink Radically increases the risk of these alcohol-related consequences.				

Notes on a Standard Drink

In Canada, a standard drink is 17.05 millilitres or 13.45 grams of pure alcohol, which is the equivalent of:

- A bottle of beer (12 oz., 341 ml, 5% alcohol)
- A bottle of cider (12 oz., 341 ml, 5% alcohol)
- A glass of wine (5 oz., 142 ml, 12% alcohol)
- A shot glass of spirits (1.5 oz., 43 ml, 40% alcohol)

Źródło: Puls Medycyny:

WHO: potrzebne nowe ograniczenia w reklamie alkoholu

Zmniejszenie szkód powodowanych przez alkohol – poprzez uregulowanie transgranicznego marketingu, reklamy i promocji alkoholu jest pierwszym wnioskiem z raportu WHO, który szczegółowo opisuje sposób, w jaki alkohol jest obecnie sprzedawany ponad granicami państw – często za pomocą środków cyfrowych – i w wielu przypadkach niezależnie od otoczenia społecznego, gospodarczego czy kulturowego.

Na całym świecie około 3 milionów ludzi umiera każdego roku w wyniku spożycia alkoholu – jedna na 10 sekund – co stanowi około 5 proc. wszystkich zgonów. Aż 13,5 proc. wszystkich zgonów wśród osób w wieku 20-39 lat jest związanych z alkoholem

Jedną z grup najbardziej narażonych na intensywną promocję alkoholu są kobiety - trzy czwarte alkoholu wypijanego na świecie jest spożywane przez mężczyzn, a co za tym idzie często dystrybutorzy alkoholu postrzegają rynek kobiet jako rozwojowy.

W raporcie WHO czytamy, że ponad 70 proc. wydatków na media czołowych sprzedawców alkoholu z siedzibą w USA w 2019 r. pochodziło z promocji, lokowania produktu i reklam online w mediach społecznościowych.

Prawie połowa państw nie ma regulacji dotyczących marketingu alkoholu w Internecie (48 proc.) i mediach społecznościowych (47 proc.)



Alcohol

NO!



**Unhealthy
food**

NO!

**Smoking
Vaping**



NO!

**Unlimited
screen time**

WHO, komunikat z 25 listopada 2023 roku.