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Unite for a Framework Convention for Alcohol Control



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In the 2012 UN Political Declaration, when describing the main contributors to the four most prominent non-communicable diseases, the term harmful use is only used to describe alcohol use. Such a term implies that alcohol use can be safe and beneficial. This assumption could be partly driven by the findings of conventional epidemiology studies indicating moderate drinkers have a lower risk of cardiovascular disease than non-drinkers. Such conclusions have been the topic of debate for several decades because moderate drinkers might have other characteristics that are cardioprotective, rather than alcohol itself (ie, confounding). Wood and colleagues¹ reported that limits for alcohol use should be much lower than currently recommended. Recommendations from some researchers and health-care professionals, together with the alcohol industry's aggressive and uncontrolled promotion to drink for cardiovascular health, have added to the increasing epidemic of alcohol use.

In a prospective cohort study in *The Lancet*, Iona Millwood and colleagues² showed that, at least for stroke, the apparently protective effects of moderate alcohol consumption were largely non-causal using mendelian randomisation, which is the optimal non-experimental design to minimise confounding. These findings, consistent with previous mendelian randomisation studies,^{3,4} were based on a large Chinese sample using robust genetic analyses with verification of pleiotropy in women who had low alcohol consumption. Although randomised trials would yield the most definitive answer, the MACH15 trial (NCT03169530) of moderate drinking

was terminated because of potential pro-industry bias. Considering that this study by Millwood and colleagues² and a previous analysis¹ cast doubts about the net protective effects of moderate drinking and the 2016 Global Burden of Disease Study⁵ showed harms at all levels of alcohol use, further trials would be unethical.

Conventional epidemiology studies have successfully shown the harms of smoking and supported tobacco control with the WHO Framework Convention on Tobacco Control (FCTC) before mendelian randomisation was feasible. However, conventional epidemiology results on the cardioprotective effect of alcohol, albeit confounded, will likely appear repeatedly,⁶ generate confusion, and might be exploited by the alcohol industry to enable market expansion.

Conventional epidemiology studies always lag behind the development of an epidemic of harmful exposure over several decades. Thus, the absolute and relative risks of the harms, such as smoking and drinking, will continuously be underestimated, and new harms caused by these factors will continue to be identified.⁷ These problems will apply to conventional epidemiology studies not only on alcohol use but also on tobacco use, unhealthy diet, physical inactivity, and obesity.⁷ The direct implication is that the burden of diseases attributable to these factors will also be underestimated. Future conventional epidemiology studies of alcohol consumption and abstinence need to analyse the time-varying nature of alcohol use throughout the life course, with long-term follow-up to capture the cumulative effect of prolonged alcohol use and use trajectories.⁷

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Triangulating evidence from different study designs is needed.^{8,9} Randomised trials on quitting alcohol at different levels will be ethical, informative, and warranted.

Braillon⁸ proposed the term moderate alcohol use should be replaced with low risk of drinking, where appropriate, to show that there is a health risk associated with drinking at any level. We further advocate that the term harmful use should no longer be used.

The WHO voluntary global non-communicable diseases target for 2025 of a 10% reduction in harmful alcohol use (which is ill-defined) is unachievable with current approaches. Alcohol control is complex and stronger policies are required. The alcohol industry is thriving and should be regulated in a similar way to the tobacco industry.^{10,11} Since the WHO FCTC has been successful, we advocate for a Framework Convention for Alcohol Control (FCAC)^{10,11} and urge WHO to start the process as soon as possible. We also propose a stage of alcohol epidemic model (SAEM) with reference to the stage of tobacco epidemic model and the stage of obesity epidemic model.¹² At present, alcohol use is increasing in all countries. The SAEM forewarns that alcohol-attributable diseases will continue to increase, even when alcohol prevalence has reached the peak (ie, 0% increase) and begins to decline. The lag between the peak of alcohol prevalence and alcohol-induced diseases, which could be several decades, might confuse policy makers, and be used by the alcohol industry and related interests to argue against more stringent control measures by claiming that moderate drinkers should not be deprived of the supposed health benefits. We need to

learn from tobacco control and unite to advocate for a FCAC.

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Local trends in immunisation coverage across Africa

Immunisation coverage across Africa has greatly increased over the past few decades, with corresponding reductions in disease mortality and morbidity.¹ Future increases in coverage are anticipated to return large health benefits,² but coverage rates in many countries across the continent are far from national targets, with many rates stagnating or falling.^{3,4} This incomplete coverage across Africa is still a major contributor to child mortality and morbidity.⁵

Although national and first-level administrative estimates of routine coverage are assessed annually,⁴ they conceal heterogeneities in coverage at fine spatial scales, precluding a comprehensive quantitative assessment of local barriers to vaccination and their potential effect on disease burdens. From an African public health perspective, more local assessments of coverage can help to identify areas with vaccine delivery system weakness and help to support more



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