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Doing well by doing good: An empirical evaluation of the alcohol industry's "Actions to Reduce Harmful Drinking"

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Abstract

Objectives: The aims of this study were to: 1) describe the alcohol industry actions across six

global geographic regions; 2) estimate the benefits accruing to the industry ("doing well"); and

3) estimate the public health impact of the actions ("doing good"). *Setting:* Actions from six

geographic UN regions. *Participants:* A web-based compendium of 3551 Corporate Social

Responsibility (CSR) initiatives, representing the efforts of the alcohol industry to reduce

harmful alcohol use, was issued in 2012. The compendium consisted of short descriptions of

each action, plus other information about the sponsorship, content and evaluation of the

activities. Public health professionals (N=19) rated a sample (N = 1046) of the actions using a

content rating procedure. *Outcome measures:* World Health Organization Global Strategy target

area, estimated population reach, risk of harm, advertising potential, policy impact potential, and

other aspects of the activity. *Results*: The industry actions were conducted disproportionately in

regions with high-income countries (Europe and North America), with lower proportions in

Latin America, Africa and Asia. Only 27% conformed to recommended WHO target areas for

global action to reduce the harmful use of alcohol. The overwhelming majority (96.8%) of

industry actions lacked scientific support (p <.01) and 11.0% had the potential for doing harm.

The benefits accruing to the industry ("doing well") included brand marketing and the use of

CSR to manage risk and achieve strategic goals. *Conclusion*: Alcohol industry CSR activities are

unlikely to reduce harmful alcohol use but they do provide commercial strategic advantage while

at the same time appearing to have a public health purpose. *Trial registration:* Non-applicable.

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Article Summary

Strengths and limitations of this study

- Use of a global database of industry activities that is likely to be comprehensive and representative of the alcohol industry's CSR activities.

- Only a 30% sample was selected from the IARD database. Different conclusions may have resulted with a larger sample.

- Unable to estimate the costs of the industry actions to determine whether they represented significant charitable contributions or were merely activities that in some cases would have been conducted anyway (e.g., staff training at breweries).

- Although all raters were initially trained to an acceptable level of reliability, we cannot rule out differential bias in the raters recruited from different regions.

Introduction

 Corporate social responsibility (CSR) refers to business practices that help companies manage their economic, social, and environmental impacts, and their relationships in key areas of influence, such as the marketplace, the supply chain, the community, and the public policy arena [1-2]. The notion that commercial enterprises can "do well" (e.g., improve their brand image, increase their profitability) by "doing good" (i.e., contribute to socially beneficial groups and causes) has motivated this rapidly expanding global movement [3-4]. While the motives behind CSR vary, they appear to be indirectly related to the financial performance of corporations (e.g., [5-6]). CSR has been described as one of the few remaining strategies for unhealthy commodity industries (e.g., tobacco, alcohol, gambling) to present their products in a positive light and thereby improve their reputations [7-8]. Evidence indicates that the tobacco industry used CSR activities to improve their image, deflect criticism, enable access to policy makers, and mitigate legal risks, thereby increasing profits [7, 9-11]. Despite a substantial amount of published research that has questioned the motives of the alcohol industry's CSR activities [12-15], little is known about the characteristics of these activities or their impact on public health [16].

 The alcohol industry has invested significant resources to promote CSR initiatives around the world. In what is perhaps the largest initiative of its kind, on October 9, 2012, eleven major global producers of alcoholic beverages and two major trade associations issued a set of "Producers' Commitments" to reduce harmful drinking (http://www.producerscommitments.org/default.aspx). To illustrate the industry's efforts to fulfill these commitments, an industry-sponsored database (initially posted at initiatives.global-actions.org, but subsequently removed) was created by the International Center for Alcohol Policies (ICAP) (now called the International Alliance for Responsible Drinking [IARD]). The

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database was an inventory of over 3,500 "industry actions" conducted in support of the World

Health Organization's (WHO) Global Strategy to Reduce the Harmful Use of Alcohol (Global

Strategy) [17]. The Global Strategy is a menu of ten evidence-based policy options that the

WHO Member States can use to achieve reductions in harmful alcohol use. Contributors to the

industry-supported database included multinational producers of beer, wine, and distilled spirits;

alcohol distributors and wholesalers; members of related industries, such as hotels, restaurants,

bars, and advertisers; and industry-affiliated social aspect and public relations organizations

(SAPROs).

Considering the significant contribution alcohol makes to global disease burden [17], this

study evaluated whether the Global Producers' actions reflect evidence-based approaches likely

to reduce alcohol harm, or whether they are mainly conducted as a form of "stakeholder

marketing" [18] designed to produce favorable public perceptions and less restrictive regulatory

environments. To answer this question, we conducted a systematic evaluation of a sample of the

industry actions using a content rating procedure designed to evaluate their public health

implications and commercial benefits.

The study had three aims: 1) to describe the global distribution of the industry actions

according to UN geographic regions and high and low resource areas; 2) to estimate the benefits

accruing to the industry in terms of marketing potential, impact on regulatory policy, and type of

CSR strategy; and 3) to evaluate the public health impact of the industry actions in terms of their

likely effectiveness and potential harm. We were particularly interested in the extent to which the

industry's actions conformed to options recommended by WHO and the evidence base that

informed the Global Strategy. This is the first comprehensive analysis of the 3,500 industry

actions posted on the ICAP/ IARD website. Analyses of the drinking and driving initiatives [19]

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and the marketing potential of the initiatives conducted in Latin America and the Caribbean [15]

have been published in prior reports.

Methods

From 2014 until 2016, 19 trained raters from Brazil, Argentina, the USA, the European

Union (EU) and Australia analyzed a sample of 1,046 industry actions. Data was exported from

the website's print view from August 2013 to August 2015 prior to the database being shut down

without explanation in April 2016. Actions were sorted by UN region and then alphabetically by

action title. Units were selected so that the sampling strata maintained the proportions of the

"target population," which in this case is the total number of industry actions (N=3,551). This

means that each stratum (UN geographic region) has the same sampling fraction. Using data

from two countries (US and UK) and one region (Latin America and the Caribbean) where all

industry actions were rated, we determined that a proportionate sample size of 30% provided an

accurate estimate of the actual distribution. The random sample generator function in SPSS was

used to select the 30% sample from each UN region and those labeled by IARD as

"international" or "global" (n = 1046).

Patient and Public Involvement: None

Descriptive Measures

An evidence benchmarking protocol was used to extract information on the sponsoring

organization, partners, year started, country, and industry-reported evaluation (if applicable) for

each industry action sampled from the database. Based on the short qualitative summaries of the

actions (mean words per action = 132) provided on the website, we assigned numeric codes for

the type of partners listed (e.g., government, Non-governmental organization (NGO), SAPRO,

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trade association, etc.) and for the type of evaluation reported by the industry (process

evaluation, uncontrolled outcome evaluation, controlled outcome evaluation, or does not meet

the minimum criteria). We used country names to define geographic regions following the

United Nations Statistics Division (UNSD) classification of world regions (e.g., Africa, Asia)

and sub-regions (e.g., Latin America and the Caribbean)

(https://unstats.un.org/unsd/methodology/m49/) and the World Bank database

(https://data.worldbank.org/country) to define country income-level.

Estimated Population Reach refers to the number of people in the target group that could

be served when an intervention is provided under real-world conditions. Coding options were

none, small, moderate and large. This variable is relative and was coded after raters were trained

using model scenarios. For example, if the action was implemented across the entire US, but

only reached 10,000 people, it was coded as small.

Measures of Industry Benefits ("Doing well")

Each industry action was coded for *marketing potential*. If the action involved giving

away promotional materials or marketed a specific product, it was coded as having "possible"

marketing potential. Actions that did not meet this criterion and all activities undertaken by trade

organizations or SAPROs were rated as having no marketing potential.

The *policy impact potential* of each action (i.e., whether the action had the potential to

impact national or local policy) was coded as "none" or "possible". We coded only activities

that had a clear political or policy impact as "possible".

The type of *Corporate Social Responsibility* was coded based on previously published

definitions [20]. Coding options were "none" – not having a social or environmental

responsibility interpretation or not reflecting positively on the company; "altruistic" –

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responsibilities that reflect giving back time or money to contribute solely to the wellbeing of a community or society at the possible expense of the business; "risk management" –legal or ethical obligations that are socially required; or "strategic" –aimed at achieving business goals while also promoting societal welfare. Coders were provided with examples and indicators for each type of CSR to minimize subjective bias.

Societal ("Doing good") Benefit Measures

Raters assessed whether the initiative fit into any of the ten WHO Global Strategy target areas. If a clear match was not possible, based on descriptions in the WHO [17] Global Strategy, the initiative was coded as either "not classifiable" because of insufficient information, or "not compatible with any of the ten categories."

Activity type was coded for each action in order to identify actions that had evidence of effectiveness [21]. Activities were coded according to a list of 67 interventions, campaigns, programs and policies that had been evaluated in prior research for effectiveness [21]. Actions that did not fit these activity types were coded as "other", which had 12 sub-codes. These included administrative changes by a particular company, online media campaigns, industry-sponsored research, conference sponsorships, information for parents, promotional events and activities unrelated to reducing the harmful use of alcohol, such as scholarships for students being trained in the hospitality industry.

Evidence of effectiveness was coded from the public health perspective [21-22] by assigning scores to each coded activity to estimate its potential for reducing alcohol related-harm: 0 = lack of effectiveness; 1 = limited effectiveness; 2 = moderate effectiveness; 3 = high degree of effectiveness; 9 = no studies have been undertaken or there is insufficient evidence on which to make a judgment.

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Harm potential was also assessed for each action. If an action was considered likely to pose a risk of harm based on current theory or evidence, harm potential was coded as "possible". Raters were instructed to code harm potential very conservatively, based on the available evidence.

Training of raters.

Nineteen health professionals, addiction scientists and graduate students from Latin America (9), USA (3), the EU (5) and Australia (2) analyzed the industry actions within their respective regions. After the raters were trained at regional sites using a standardized protocol, they each rated the same 35 randomly selected actions from the database and discussed discrepancies until consensus was achieved. A second round of another 35 randomly selected initiatives was then conducted. After achieving an acceptable level of inter-rater reliability (kappa >.50), the raters continued rating the remaining actions independently.

Statistical Analyses.

Data was analyzed using SPSS for Windows Version 24 (Armonk, NY: IBM Corp.). Omnibus χ^2 tests were used to determine significant differences in variables that were dichotomous (e.g., marketing potential) or categorical (e.g. sponsoring organizations) across UN geographic regions that conformed approximately to the WHO regions used for administrative and statistical purposes.

Significance was set at $p < 0.05$. To understand the meaning of a significant omnibus test, several logistic regressions were used. In each model, a single UN region was compared against the rest of the world for a specific dependent variable. For instance, the prevalence of industry actions that had marketing potential in Africa was compared against the prevalence of industry actions with marketing potential in all other UN regions combined. Statistical

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significance was determined using 95% confidence intervals (CIs) of the resultant odds ratios.

This method allowed for increased interpretability of the results, while limiting the impact of

Type I error, which would have been a serious concern had pairwise comparisons been

implemented. χ^2 tests and Spearman correlations were also used to determine whether population

reach was correlated with marketing potential and effectiveness.

Results

Table 1 presents descriptive information about the actions. More than half of the actions

were conducted in Europe (57.7%), and 76% were based in high-income countries. Less than 8%

of actions were conducted in lower-middle and low-income countries (LMIC). Despite the

claims of ICAP/ IARD that the actions were conducted "in support of" the Global Strategy [17],

most (65.7%) were initiated prior to the 2010 release of the Global Strategy, and some (10.4%)

prior to 2000, according to the dates provided in the listings.

<<INSERT TABLE 1 HERE>>

Doing well: Benefits accruing to the industry

The first three sections of Table 2 show the regional percentages, odds ratios and

confidence intervals of three benefits accruing to the alcohol industry. Overall, 26.5% of the

actions were rated as having a marketing potential, 15.2% had the potential to have a policy

impact and 18.0% were classified as having a "strategic" CSR function. The proportion of

actions that were considered to have one or more of these benefits was 46.0%.

<<INSERT TABLE 2 HERE>>

Activities coded as having a marketing potential included giving away branded

merchandise and adding a responsible drinking message to the product's commercial advertising

materials. There were significant differences in industry actions that contained marketing

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potential across UN regions (χ^2 = 47.44; df = 6; p <.01). Actions conducted in Latin America and Africa were significantly more likely to have marketing potential compared to actions conducted in all other regions (Table 2). Actions conducted in Oceania had a significantly lower likelihood of marketing potential.

We also evaluated the association between estimated population reach and marketing potential. Of the 277 actions with marketing potential, 44.4% had moderate to large population reach (χ^2 = 29.31; df = 1; p <.01). The Spearman correlation indicated a positive correlation, which was statistically significant (r_s(1046) = .158, p = <.01).

Fifteen percent (15.2%) of actions were found to have the potential to influence policies, for example, sponsoring of a traffic safety council or conducting workshops for policy makers (Table 2). Actions with policy potential differed significantly among regions (χ^2 = 26.58; df = 6; p <.01). Actions in Africa, Oceania and those conducted on an international scale were considered more likely to have a policy impact.

Regarding the type of CSR, the majority of sampled actions (77.4%) were coded as "risk management" (e.g., "responsible drinking message added to labels") while 18.0% were coded as strategic CSR (e.g., a conference promoting self-regulation of alcohol advertising) (Table 2). The number of actions categorized as having a strategic CSR approach was significantly different across regions (χ^2 = 36.15; df = 6; p <.01). A strategic CSR approach was more likely to be utilized on an international scale and in the African Region. Actions in North America were less likely to take a strategic CSR approach. Less than two percent (1.6%) of actions were coded as altruistic type CSR. Three percent of actions were coded as not fitting any CSR approach.

Doing good: Public health impact of the industry actions

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Table 3 shows the regional percentages, odds ratios and confidence intervals of industry

actions that were consistent with the WHO Global Strategy targets. Overall, only 27.1% were

considered classifiable into the WHO target areas, which was significantly different between UN

regions (χ^2 = 34.68; df = 6; p <.01). Actions in Africa and North America were more likely to

fall under one of the 10 Global Strategy target areas, although the majority of actions remained

inconsistent with the Global Strategy.

<<INSERT TABLE 3 NEAR HERE>>

Figure 1 compares the proportions classified into the 10 WHO Global Strategy areas by

the public health raters with those classified by the industry and reported on the ICAP and IARD

websites. The table shows substantial discrepancies between the proportions assigned to three

key areas: leadership (22.3% IARD vs 3.0% public health raters), drinking and driving initiatives

(28.7% vs 14.1%) and reducing negative consequences (27.4% vs. 3.6%). The main reason for

these discrepancies was that the public health raters, using WHO definitions of the target areas,

were not able to classify 72.9% of the actions into any of the 10 categories, either because they

clearly did not fit the definitions (39.3%) or they were too vague (33.6%).

<<INSERT FIGURE 1- NEAR HERE>>

In addition to the ratings based on the broad WHO categories, separate ratings were

conducted to classify the specific type of activity and to estimate its potential effectiveness.

Table 4 shows how the actions were classified according to activity type and evidence for

effectiveness. The majority of actions (75.9%) were coded "other" activity types which have not

been evaluated in the literature. Each activity code was assigned an effectiveness score based on

expert consensus ratings [21-22]. Since there were only 33 actions coded as limited, moderate or

high effectiveness, these three categories were collapsed. There were considerably more

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ineffective actions or actions of unknown effectiveness (96.8%) compared to effective actions

overall (p <.01). Nearly half of the actions (46.8%) were activities that have not been evaluated

in the research. Over twenty percent (21.0%) were activities that were not relevant to public

health (i.e. funding of SAPROs). Twenty-nine percent of the actions have been evaluated in the

alcohol literature [21] and have been found not to be effective; 1.3% were found to have limited

effectiveness. Only 1.8% of total activities sampled had evidence of moderate to high

effectiveness (e.g., minimum legal alcohol purchase age).

Another part of the content ratings focused on the potential of the action (e.g., using the

Grand Prix racing event to launch an awareness campaign) to cause harm. Eleven percent of

actions were found to have the potential to cause harm from a public health perspective, which

was significantly different across regions ($\chi^2 = 32.98$; df = 6; p <.01). Actions that had a

potential for harm were most likely to occur in LAC and Oceania and were least likely to occur

in North America (Table 3).

<<INSERT TABLE 4 HERE>>

Discussion

The present analysis of CSR activities conducted by alcohol industry bodies ostensibly in

support of the WHO's Global Strategy adopted a perspective that contrasted public health

interests with the commercial interests of the alcohol industry. Our initial review of the data

posted on the industry-reporting database suggested that the industry actions were compiled

without consideration of the public scrutiny they might be subjected to. For example, most of the

actions had start dates before the WHO Global Strategy was issued, raising questions about the

screening process used and the aims of the database. In addition, the entire inventory of industry

actions was removed without explanation as our study was underway, suggesting that IARD did

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not want to have its compendium of industry CSR initiatives subjected to careful scrutiny. Within this context, the analyses we conducted provide insights into the motivations of the alcohol industry in their approach to public health initiatives promoted by WHO to reduce the harmful use of alcohol.

While the actions were found to be conducted disproportionately in HICs of Europe and North America, actions in Africa and LAC were found to be significantly associated with an increased likelihood for marketing potential. This is consistent with research suggesting that competitive industries that depend on marketing to sell their products are more likely to include product marketing in their CSR activities [3], and that the large producers are targeting developing countries [23-24]. The positive association found between marketing potential and population reach provides further indication that industry segments may be using the industry actions for marketing purposes.

Regarding the benefits accruing to the alcohol industry ("doing well"), our analyses show that the industry's CSR activities tend overwhelmingly to be oriented toward risk management and achieving strategic goals. Research suggests that industry-funded educational campaigns lead to positive views of that industry [25]. As Bond, Daube, & Chikritzhs [26] note, alcohol industry documents further demonstrate the public relations benefit of 'responsibility' messages and education campaigns.

Although alcohol industry bodies promoted the online inventory as a reflection of their commitments to the WHO 2010 Global Strategy, 72.9% of the industry actions we evaluated were scored as not conforming to the WHO recommended target categories. Some activities (e.g., a brewery's 60th anniversary celebration) seemed to contradict the intent of the Global Strategy and were seemingly inconsistent with the stated purpose of the alcohol industry actions.

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There were also major differences between the industry's classification of their own actions and those conducted by the expert raters. Whereas IARD classified most (75%) of the actions under the areas of leadership, drinking-driving countermeasures, and reducing negative consequences, the raters found that almost one-third were too vague to classify and another 38% did not fit any of the WHO categories. As an industry-funded SAPRO, ICAP/ IARD had a clear conflict of interest that could have biased their interpretation of the actions, as had been demonstrated in prior analyses of their international activities [27-28].

Estimates of the public health benefits showed that the overwhelming majority (96.8%) of industry actions lacked scientific support of their effectiveness in reducing harmful drinking and a small percentage (11.0%) had the potential for doing harm. These findings suggest that either the alcohol industry lacks the expertise to contribute constructively to the WHO Global Strategy, or they are using their CSR activities primarily for strategic commercial purposes, such as the dilution or avoidance of regulatory policies that would limit alcohol availability or raise its costs.

One strength of this study is its use of a global database of industry activities that is likely to be comprehensive and representative of the alcohol industry's CSR activities. Our analysis indicates that those activities contribute minimally to the public health efforts of the World Health Organization. This research also had some methodological limitations. Because of resource limitations, we evaluated only a sample from the IARD database. Different conclusions may have resulted with a larger sample. In addition, we were not able to estimate the costs of the industry actions to determine whether they represented significant charitable contributions or were merely activities that in some cases would have been conducted anyway (e.g., staff training

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at breweries). Although all raters were initially trained to an acceptable level of reliability, we

cannot rule out differential bias in the raters recruited from different regions.

Conclusion

      This analysis was conducted on activities compiled and promoted by the industry,

ostensibly in support of the WHO Global Strategy to Reduce the Harmful Use of Alcohol. It

represents a comprehensive inventory of the CSR activities conducted by a broad spectrum of the

alcohol industry, ranging from global producers to small, independent retailers and includes trade

associations and industry funded social aspects organizations. As such, it provides a window into

the CSR activities considered by the alcohol industry to have relevance to their response to the

WHO Global Strategy. The magnitude and global scope of these initiatives speaks to the ability

of the alcohol industry to mobilize its diverse commercial components in pursuit of a common

cause, much like the tobacco industry did before them. The Guidelines on Implementation of

Articles 5 and 13 of the WHO Framework Convention on Tobacco Control propose a ban on all

contributions from tobacco companies to any other entity for "socially responsible" causes as

"the aim, effect, or likely effect…is to promote…[the] product or use, either directly or

indirectly" [29]. Our analysis suggests that a similar ban would be appropriate for the alcohol

industry. This caveat was reiterated by then WHO Director General Margaret Chan in her

statement that alcohol companies should have "no role in the formulation of alcohol policies,

which must be protected from distortion by commercial or vested interests" [30]. More recently,

one transnational alcohol producer, AB InBev, pledged to spend one billion USD to reduce the

harmful use of alcohol worldwide by 10%. Far from confirming industry claims that they can

"do well" by "doing good," the findings of the present study suggest that the public health

benefits of their CSR activities are likely to be minimal, whereas the public relations benefits can

be substantial.

Abbreviations

CSR - Corporate Social Responsibility

ICAP - International Center for Alcohol Policies

IARD - International Alliance for Responsible Drinking

LMIC - Lower-middle and low-income countries

SAPRO - Social Aspect and Public Relations Organization

WHO - World Health Organization

UNSD - United Nations Statistics Division

Patient consent/involvement: Not applicable, no human subjects or patients involved. The

raters were co-investigators or research assistants or students, not the subject of the research.

Availability of data and materials:

The industry action summaries are no longer available from the IARD website. Copies can be

requested from the authors. The data coded from these summaries, which were used in the

current study, are available from the authors upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Figure Legend

Figure 1. Percent of industry actions classified by IARD and by health professionals according to WHO Global Strategy target areas

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Table 1. Characteristics of Industry Actions to Reduce Harmful Drinking online compendium (n = 1046).

	n (%)
Region[a]	
Africa	69 (6.6)
Asia	63 (6.0)
Europe	604 (57.7)
Latin America	67 (6.4)
North America	163 (15.6)
Oceania	40 (3.8)
International	40 (3.8)
Country Income level[b]	
High	797 (76.2)
Upper-middle	127 (12.1)
Lower-middle	59 (5.6)
Low	22 (2.1)
Multiple	41 (3.9)
Year started[c]	
1990-1999	105 (10.4)
2000-2009	559 (55.3)
2010-2014	346 (34.2)
Estimated Population reach	
None	218 (20.8)
Small	499 (47.7)
Moderate	218 (20.8
Large	111 (10.6)
Sponsor	
Producer	537 (51.3)
SAPRO	306 (29.3)
Trade Association	182 (17.4)
Other	21 (2.0)
Partner	
None reported	509 (48.7)
Governmental	64 (6.1)
NGO/ University	92 (8.8)
SAPRO/ Trade Assoc.	55 (5.3)
Commercial	65 (6.2)
Multiple partner types	170 (16.3)
'Non specified collaborator'/ Other	91 (8.7)
Industry-reported Evaluation	
None reported	688 (65.7)
Does not meet min. criteria	92 (8.8)
Process	217 (20.7)
Outcome	49 (4.7)

[a] Regions according to UN classifications.
[b] According to World Bank classifications
[c] N=1010 because of missing data

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Table 2. Percentages, Odds ratios and 95% CIs by region for marketing potential, potential policy impact and strategic CSR.

Region[a]	Marketing Potential			Policy Impact			Strategic CSR Actions		
	%	OR[b]	95% CI	%	OR[b]	95% CI	%	OR[b]	95% CI
Africa (n = 69)	43.5	3.08	1.24, 7.64	29.0	2.46	1.41, 4.26	33.3	2.45	1.45, 4.16
Asia (n = 63)	15.9	0.50	0.25, 1.00	6.9	1.19	0.60, 2.34	20.6	1.77	0.87, 3.61
Europe (n = 604)	24.0	0.74	0.56, 0.97	13.9	0.79	0.56, 1.10	15.2	0.64	0.47, 0.89
LAC (n = 69)	53.7	4.65	1.87, 11.56	7.5	0.43	0.17, 1.09	22.4	1.34	0.73, 2.44
North America (n = 163)	27.0	1.03	0.70, 1.50	10.4	0.6	0.35, 1.03	11.0	0.52	0.31, 0.87
Oceania (n = 40)	10.0	0.29	0.10, 0.84	27.5	2.19	1.07, 4.98	27.5	1.77	0.87, 3.61
International (n = 40)	33.3	0.68	0.31, 1.50	27.5	2.19	1.07, 4.98	40.0	3.22	1.67, 6.19
Totals (n=1046)	26.5	.	.	15.2	.	.	18.0	.	.

[a]Regions based on UN classifications; [b]UN region compared to the rest of the world

Table 3. Percentage, odds ratios and 95% CIs of actions rated as meeting WHO Global Strategy target areas and actions with potential for harm, by region (n = 1046)

Region[a]	WHO Global Strategy target area met			Potential for harm		
	%	OR[b]	95% CI	%	OR[b]	95% CI
Africa (n = 69)	39.1	1.81	1.09, 2.99	7.2	0.61	0.24, 1.56
Asia (n = 63)	23.8	0.83	0.45, 1.51	15.9	1.57	0.77, 3.19
Europe (n = 604)	24.8	0.76	0.58, 1.01	9.6	0.71	0.48, 1.05
LAC (n = 69)	32.8	1.34	0.79, 2.28	25.4	3.05	1.69, 5.50
North America (n = 163)	38.7	1.89	1.38, 2.69	6.1	0.48	0.24, 0.94
Oceania (n = 40)	7.5	0.21	0.06, 0.68	27.5	3.29	1.59, 6.78
International (n = 40)	10.0	0.21	0.06, 0.68	10.0	0.89	0.31, 2.56

[a]Regions based on UN classifications; [b]UN region compared to the rest of the world

Table 4. Activity type by level of effectiveness (n = 1046)

		Evidence of effectiveness	
Activity Type *(example)*	N	None/ Unknown	Limited-Moderate
Availability *(MLPA, different availability by strength)*	7	0.0	0.7
Environment *(RBS training)*	49	4.0	0.7
Drink-Driving *(designated driver campaigns, safe rides)*	49	4.6	0.1
Brief Intervention and Treatment	5	0.0	0.5
Marketing *(self regulation codes)*	67	6.2	0.2
Education and Persuasion	75	6.1	1.1
'Other' *(activities with no evaluation research)*	794	75.9	0.0
Total	1046	96.8%	3.2%

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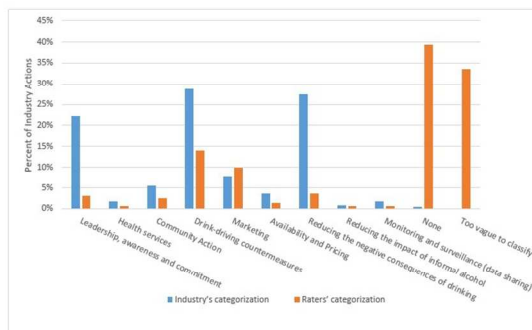43
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Figure 1. Percent of industry actions classified by IARD and by health professionals according to WHO Global Strategy target areas

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Is the alcohol industry doing well by "doing good"? Findings from a content analysis of the alcohol industry's Actions to Reduce Harmful Drinking

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Is the alcohol industry doing well by "doing good"? Findings from a content analysis of the alcohol industry's Actions to Reduce Harmful Drinking

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Abstract

Objectives: The aims of this study were to: 1) describe alcohol industry Corporate Social

Responsibility (CSR) actions conducted across six global geographic regions; 2) identify the

benefits accruing to the industry ("doing well"); and 3) estimate the public health impact of the

actions ("doing good"). *Setting:* Actions from six global geographic regions. *Participants:* A

web-based compendium of 3551 industry actions, representing the efforts of the alcohol industry

to reduce harmful alcohol use, was issued in 2012. The compendium consisted of short

descriptions of each action, plus other information about the sponsorship, content and evaluation

of the activities. Public health professionals (N = 19) rated a sample (N = 1046) of the actions

using a content rating procedure. *Outcome measures:* World Health Organization Global

Strategy target area, estimated population reach, risk of harm, advertising potential, policy

impact potential, and other aspects of the activity. *Results*: The industry actions were conducted

disproportionately in regions with high-income countries (Europe and North America), with

lower proportions in Latin America, Africa and Asia. Only 27% conformed to recommended

WHO target areas for global action to reduce the harmful use of alcohol. The overwhelming

majority (96.8%) of industry actions lacked scientific support (p <.01) and 11.0% had the

potential for doing harm. The benefits accruing to the industry ("doing well") included brand

marketing and the use of CSR to manage risk and achieve strategic goals. *Conclusion*: Alcohol

industry CSR activities are unlikely to reduce harmful alcohol use but they do provide

commercial strategic advantage while at the same time appearing to have a public health

purpose. *Trial registration:* Non-applicable.

Article Summary

Article focus

- This paper describes alcohol industry corporate social responsibility (CSR) actions across six global geographic regions, estimating the benefits accruing to the industry ("doing well") and the public health impact of the actions ("doing good").

Strengths and limitations of this study

- Use of a global database of industry activities that is likely to be comprehensive and representative of the alcohol industry's CSR activities.

- A 30% sample was selected from the International Alliance for Responsible Drinking (IARD) database. Different conclusions may have resulted with a larger sample.

- Unable to determine whether the industry actions represented significant charitable contributions or were merely activities that in some cases would have been conducted anyway (e.g., those required by law).

- Although all raters were initially trained to an acceptable level of reliability, we cannot rule out differential bias in the raters recruited from different regions.

Introduction

      Corporate social responsibility (CSR) refers to business practices that help companies manage their economic, social, and environmental impacts, and their relationships in key areas of influence, such as the marketplace, the supply chain, the community, and the public policy arena [1-2]. The notion that commercial enterprises can "do well" (e.g., improve their brand image, increase their profitability) by "doing good" (i.e., contribute to socially beneficial groups and causes) has motivated this rapidly expanding global movement [3-4]. While the motives behind CSR vary, they appear to be indirectly related to the financial performance of corporations (e.g., [5-6]). CSR has been described as one of the few remaining strategies for unhealthy commodity industries (e.g., tobacco, alcohol, gambling) to present their products in a positive light and thereby improve their reputations [7-8]. Evidence indicates that the tobacco industry used CSR activities to improve their image, deflect criticism, enable access to policy makers, and mitigate legal risks, thereby increasing profits [7, 9-11]. Despite a substantial amount of published research that has questioned the motives of the alcohol industry's CSR activities [12-15], little is known about the characteristics of these activities or their impact on public health [16].

      The alcohol industry has invested significant resources to promote CSR initiatives around the world. In what is perhaps the largest initiative of its kind, on October 9, 2012, eleven major global producers of alcoholic beverages and two major trade associations issued a set of "Producers' Commitments" to reduce harmful drinking (http://www.producerscommitments.org/default.aspx). To illustrate the industry's efforts to fulfill these commitments, an industry-sponsored database (initially posted at initiatives.global-actions.org, but subsequently removed) was created by the International Center for Alcohol Policies (ICAP) (now called the International Alliance for Responsible Drinking [IARD]). The

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database was an inventory of over 3,500 industry actions conducted in support of the World Health Organization's (WHO) Global strategy to reduce the harmful use of alcohol (Global strategy) [17]. The Global strategy is a menu of ten evidence-based policy options that the WHO Member States can use to achieve reductions in harmful alcohol use. Contributors to the industry-supported database included multinational producers of beer, wine, and distilled spirits; alcohol distributors and wholesalers; members of related industries, such as hotels, restaurants, bars, and advertisers; and industry-affiliated social aspect and public relations organizations (SAPROs).

The present study had three aims: 1) to describe the global distribution of the industry actions according to geographic regions and high and low resource areas; 2) to estimate the benefits accruing to the industry in terms of marketing potential, impact on regulatory policy, and type of CSR strategy; and 3) to evaluate the public health impact of the industry actions in terms of their likely effectiveness and potential harm. We were particularly interested in the extent to which the industry's actions conformed to options recommended by WHO and the evidence base that informed the Global strategy. This is the first comprehensive analysis of the 3,500 industry actions posted on the ICAP/ IARD website. Analyses of the drinking and driving initiatives [18] and the marketing potential of the initiatives conducted in Latin America and the Caribbean [15] have been published in prior reports.

Considering the significant contribution alcohol makes to global disease burden [17], this study evaluated whether the Global Producers' actions reflect evidence-based approaches likely to reduce alcohol harm, or whether they are mainly conducted as a form of "stakeholder marketing" [19] designed to produce favorable public perceptions and less restrictive regulatory environments. To answer this question, we conducted a systematic evaluation of a sample of the

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industry actions using a content rating procedure designed to evaluate their public health

implications and commercial benefits.

Methods

From 2014 until 2016, 19 trained raters from Brazil, Argentina, the USA, the European

Union (EU) and Australia analyzed a sample of 1,046 industry actions. Data was exported from

the website's print view from August 2013 to August 2015 prior to the database being shut down

without explanation in April 2016. Actions were sorted by region according to the geoscheme

created by the United Nations Statistics Division (UNSD), and then alphabetically by action title.

Units were selected so that the sampling strata maintained the proportions of the "target

population," which in this case is the total number of industry actions (N = 3,551). This means

that each stratum (UNSD geographic region) has the same sampling fraction. Using data from

two countries (US and UK) and one region (Latin America and the Caribbean) where all industry

actions were rated, we determined that a proportionate sample size of 30% provided an accurate

estimate of the actual distribution. The random sample generator function in SPSS Windows

Version 24 was used to select the 30% sample from each UN region and those labeled by IARD

as "international" or "global" (n = 1046).

Patient and Public Involvement: None

Descriptive Measures

An evidence benchmarking protocol was used to extract information on the sponsoring

organization, partners, year started, country, and industry-reported evaluation (if applicable) for

each industry action sampled from the database. Based on the short qualitative summaries of the

actions (mean words per action = 132) provided on the website, we assigned numeric codes for

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the type of partners listed (e.g., government, Non-governmental organization (NGO), SAPRO,

trade association, etc.) and for the type of evaluation reported by the industry (process

evaluation, uncontrolled outcome evaluation, controlled outcome evaluation, or does not meet

the minimum criteria). We used country names to define geographic regions following the

UNSD classification of geographic regions (e.g., Africa, Asia) and sub-regions (e.g., Latin

America and the Caribbean) (https://unstats.un.org/unsd/methodology/m49/) and the World Bank

database (https://data.worldbank.org/country) to define country income-level.

Estimated Population Reach refers to the number of people in the target group that could

be served when an intervention is provided under real-world conditions. Coding options were

none, small, moderate and large. This variable is relative and was coded after raters were trained

using model scenarios. For example, if the action was implemented across the entire US, but

only reached 10,000 people, it was coded as small.

In addition to these descriptive characteristics of the industry actions, we also coded

whether the activity was likely to produce benefits to the alcohol industry, and the ways in which

society in general would benefit (or be harmed). These variables and their operational definitions

are described in Table 1.

<<INSERT TABLE 1 NEAR HERE>>

Measures of Industry Benefits ("Doing well")

Each industry action was coded for *marketing potential*. If the action involved giving

away promotional materials or marketed a specific product, it was coded as having "possible"

marketing potential. Actions that did not meet this criterion and all activities undertaken by trade

organizations or SAPROs were rated as having no marketing potential.

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The *policy impact potential* of each action (i.e., whether the action had the potential to impact national or local policy) was coded as "none" or "possible". We coded only activities that had a clear political or policy impact as "possible".

The type of *Corporate Social Responsibility* was coded based on previously published definitions [20]. Coding options were "none" – not having a social or environmental responsibility interpretation or not reflecting positively on the company; "altruistic" – responsibilities that reflect giving back time or money to contribute solely to the wellbeing of a community or society at the possible expense of the business; "risk management" –legal or ethical obligations that are socially required; or "strategic" –aimed at achieving business goals while also promoting societal welfare. Coders were provided with examples and indicators for each type of CSR to minimize subjective bias.

Societal Benefit Measures ("Doing good")

Raters assessed whether the initiative fit into any of the ten WHO Global strategy target areas. If a clear match was not possible, based on descriptions in the WHO [17] Global strategy, the initiative was coded as either "not classifiable" because of insufficient information, or "not compatible with any of the ten categories."

Activity type was coded for each action in order to identify actions that had evidence of effectiveness [21]. Activities were coded according to a list of 67 interventions, campaigns, programs and policies that had been evaluated in prior research for effectiveness [21]. Actions that did not fit these activity types were coded as "other", which had 12 sub-codes. These included administrative changes by a particular company, online media campaigns, industry-sponsored research, conference sponsorships, information for parents, promotional events and

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activities unrelated to reducing the harmful use of alcohol, such as scholarships for students being trained in the hospitality industry.

Evidence of effectiveness was coded from the public health perspective [21-22] by assigning scores to each coded activity to estimate its potential for reducing alcohol related-harm: 0 = lack of effectiveness; 1 = limited effectiveness; 2 = moderate effectiveness; 3 = high degree of effectiveness; 9 = no studies have been undertaken or there is insufficient evidence on which to make a judgment.

Harm potential was also assessed for each action. If an action was considered likely to pose a risk of harm based on current theory or evidence, harm potential was coded as "possible". Raters were instructed to code harm potential very conservatively, based on the available evidence.

Training of raters.

Nineteen public health professionals with expertise in alcohol control policy from Latin America (9), USA (3), the EU (5) and Australia (2) analyzed the industry actions within their respective regions. A rater training workshop was conducted by the protocol authors with each regional team prior to the start of the global project to ensure consistency. After the raters were trained at regional sites using a standardized protocol, they each rated the same 35 randomly selected actions from the database, compared their ratings to the ratings of the protocol authors, and discussed discrepancies with experts until consensus was achieved. A second round of another 35 randomly selected initiatives was then conducted. After achieving an acceptable level of inter-rater reliability (kappa >.60), the raters continued rating the remaining actions independently.

Statistical Analyses.

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Data was analyzed using SPSS for Windows Version 24 (Armonk, NY: IBM Corp.).

Omnibus χ^2 tests were used to determine significant differences in variables that were

dichotomous (e.g., marketing potential) or categorical (e.g. sponsoring organizations) across UN

geographic regions that conformed approximately to the WHO regions used for administrative

and statistical purposes.

Significance was set at $p < 0.05$. To understand the meaning of a significant omnibus

test, several logistic regressions were used. In each model, a single UN region was compared

against the rest of the world for a specific dependent variable. For instance, the prevalence of

industry actions that had marketing potential in Africa was compared against the prevalence of

industry actions with marketing potential in all other UN regions combined. Statistical

significance was determined using 95% confidence intervals (CIs) of the resultant odds ratios.

This method allowed for increased interpretability of the results, while limiting the impact of

Type I error, which would have been a serious concern had pairwise comparisons been

implemented. χ^2 tests and Spearman correlations were also used to determine whether population

reach was correlated with marketing potential and effectiveness.

Results

Table 2 presents descriptive information about the actions. More than half of the actions

were conducted in Europe (57.7%), and 76% were based in high-income countries. Less than 8%

of actions were conducted in lower-middle and low-income countries (LMIC). Despite the

claims of ICAP/ IARD that the actions were conducted "in support of" the Global strategy [17],

most (65.7%) were initiated prior to the 2010 release of the Global strategy, and some (10.4%)

prior to 2000, according to the dates provided in the listings.

<<INSERT TABLE 2 HERE>>

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Doing well: Benefits accruing to the industry

The first three sections of Table 3 show the regional percentages, odds ratios and confidence intervals of three benefits accruing to the alcohol industry. Overall, 26.5% of the actions were rated as having a marketing potential, 15.2% had the potential to have a policy impact and 18.0% were classified as having a "strategic" CSR function. The proportion of actions that were considered to have one or more of these benefits was 46.0%.

<<INSERT TABLE 3 HERE>>

Activities coded as having a marketing potential included giving away branded merchandise and adding a responsible drinking message to the product's commercial advertising materials. There were significant differences in industry actions that contained marketing potential across UN regions ($\chi^2 = 47.44$; df = 6; p <.01). Actions conducted in Latin America and Africa were significantly more likely to have marketing potential compared to actions conducted in all other regions (Table 3). Actions conducted in Oceania had a significantly lower likelihood of marketing potential.

We also evaluated the association between estimated population reach and marketing potential. Of the 277 actions with marketing potential, 44.4% had moderate to large population reach ($\chi^2 = 29.31$; df = 1; p <.01). The Spearman correlation indicated a positive correlation, which was statistically significant ($r_s(1046) = .158$, p = <.01).

Fifteen percent (15.2%) of actions were found to have the potential to influence policies, for example, sponsoring of a traffic safety council or conducting workshops for policy makers (Table 3). Actions with policy potential differed significantly among regions ($\chi^2 = 26.58$; df = 6; p <.01). Actions in Africa, Oceania and those conducted on an international scale were considered more likely to have a policy impact.

Regarding the type of CSR, the majority of sampled actions (77.4%) were coded as "risk management" (e.g., "responsible drinking message added to labels") while 18.0% were coded as strategic CSR (e.g., a conference promoting self-regulation of alcohol advertising) (Table 3). The number of actions categorized as having a strategic CSR approach was significantly different across regions (χ^2 = 36.15; df = 6; p <.01). A strategic CSR approach was more likely to be utilized on an international scale and in the African Region. Actions in North America were less likely to take a strategic CSR approach. Less than two percent (1.6%) of actions were coded as altruistic type CSR. Three percent of actions were coded as not fitting any CSR approach.

Doing good: Public health impact of the industry actions

Table 4 shows the regional percentages, odds ratios and confidence intervals of industry actions that were consistent with the WHO Global strategy targets. Overall, only 27.1% were considered classifiable into the WHO target areas, which was significantly different between UN regions (χ^2 = 34.68; df = 6; p <.01). Actions in Africa and North America were more likely to fall under one of the 10 Global strategy target areas, although the majority of actions remained inconsistent with the Global strategy.

<<INSERT TABLE 4 NEAR HERE>>

Figure 1 compares the proportions classified into the 10 WHO Global strategy areas by the public health raters with those classified by the industry and reported on the ICAP and IARD websites. The table shows substantial discrepancies between the proportions assigned to three key areas: leadership (22.3% IARD vs 3.0% public health raters), drinking and driving initiatives (28.7% vs 14.1%) and reducing negative consequences (27.4% vs. 3.6%). The main reason for these discrepancies was that the public health raters, using WHO definitions of the target areas,

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were not able to classify 72.9% of the actions into any of the 10 categories, either because they clearly did not fit the definitions (39.3%) or they were too vague (33.6%).

<<INSERT FIGURE 1- NEAR HERE>>

In addition to the ratings based on the broad WHO categories, separate ratings were conducted to classify the specific type of activity and to estimate its potential effectiveness. Table 5 shows how the actions were classified according to activity type and evidence for effectiveness. The majority of actions (75.9%) were coded "other" activity types which have not been evaluated in the literature. Activities coded here include posters, leaflets and websites, industry-sponsored conferences, funding of SAPRPOs, and updates to producer employee handbooks. Each activity code was assigned an effectiveness score based on expert consensus ratings [21-22]. Since there were only 33 actions coded as limited, moderate or high effectiveness, these three categories were collapsed. There were considerably more ineffective actions or actions of unknown effectiveness (96.8%) compared to effective actions overall (p <.01). Nearly half of the actions (46.8%) were activities that have not been evaluated in the research. Over twenty percent (21.0%) were activities that were not relevant to public health (i.e. funding of SAPROs). Twenty-nine percent of the actions have been evaluated in the alcohol literature [21] and have been found not to be effective; 1.3% were found to have limited effectiveness. Only 1.8% of total activities sampled had evidence of moderate to high effectiveness (e.g., minimum legal alcohol purchase age).

Another part of the content ratings focused on the potential of the action to cause harm (e.g., using the Grand Prix racing event to launch an awareness campaign). Eleven percent of actions were found to have the potential to cause harm from a public health perspective, which was significantly different across regions (χ^2 = 32.98; df = 6; p <.01). Actions that had a

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potential for harm were most likely to occur in LAC and Oceania and were least likely to occur

in North America (Table 4).

<<INSERT TABLE 5 HERE>>

Discussion

The present analysis of CSR activities conducted by alcohol industry bodies ostensibly in

support of the WHO's Global strategy adopted a perspective that contrasted public health

interests with the commercial interests of the alcohol industry. While the actions were found to

be conducted disproportionately in HICs of Europe and North America, actions in Africa and

LAC were found to be significantly associated with an increased likelihood for marketing

potential. This is consistent with research suggesting that competitive industries that depend on

marketing to sell their products are more likely to include product marketing in their CSR

activities [3], and that the large producers are targeting developing countries [23-24]. The

positive association found between marketing potential and population reach provides further

indication that industry segments may be using the industry actions for marketing purposes.

Regarding the benefits accruing to the alcohol industry ("doing well"), our analyses show

that the industry's CSR activities tend overwhelmingly to be oriented toward risk management

and achieving strategic goals. Research suggests that industry-funded educational campaigns

lead to positive views of that industry [25]. As Bond, Daube, & Chikritzhs [26] note, alcohol

industry documents further demonstrate the public relations benefit of 'responsibility' messages

and education campaigns.

Although alcohol industry bodies promoted the online inventory as a reflection of their

commitments to the WHO 2010 Global strategy, 72.9% of the industry actions we evaluated

were scored as not conforming to the WHO recommended target categories. Some activities

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(e.g., a brewery's 60th anniversary celebration) seemed to contradict the intent of the Global

strategy and were seemingly inconsistent with the stated purpose of the alcohol industry actions.

There were also major differences between the industry's classification of their own actions and

those conducted by the expert raters. Whereas IARD classified most (75%) of the actions under

the areas of leadership, drinking-driving countermeasures, and reducing negative consequences,

the raters found that almost one-third were too vague to classify and another 38% did not fit any

of the WHO categories. As an industry-funded SAPRO, ICAP/ IARD had a clear conflict of

interest that could have biased their interpretation of the actions, as had been demonstrated in

prior analyses of their international activities [27-28]. Of note, most of the actions had start dates

before the WHO Global strategy was issued, raising questions about the screening process used

and the aims of the database.

Estimates of the public health benefits and harms showed that the overwhelming majority

(96.8%) of industry actions lacked scientific support of their effectiveness in reducing harmful

drinking and a small percentage (11.0%) had the potential for doing harm. The Guidelines on

Implementation of Articles 5 and 13 of the WHO Framework Convention on Tobacco Control

propose a ban on all contributions from tobacco companies to any other entity for "socially

responsible" causes as "the aim, effect, or likely effect…is to promote…[the] product or use,

either directly or indirectly" [29]. Our analysis suggests that a similar ban would be appropriate

for the alcohol industry. This caveat was reiterated by then WHO Director General Margaret

Chan in her statement that alcohol companies should have "no role in the formulation of alcohol

policies, which must be protected from distortion by commercial or vested interests" [30].

One strength of this study is its use of a global database of industry activities that is likely to be comprehensive and representative of the alcohol industry's CSR activities. Our analysis indicates that those activities contribute minimally to the public health efforts of the World Health Organization. This research also had some methodological limitations. Because of resource limitations, we evaluated only a sample from the IARD database. Different conclusions may have resulted with a larger sample. In addition, we were not able to estimate the costs to the industry of the actions conducted to determine whether they represented significant charitable contributions or were merely activities that in some cases would have been conducted anyway (e.g., staff training at breweries or actions which are already required by law). Although raters were all trained to an acceptable level of reliability, we cannot rule out differential bias in the raters recruited from different regions.

Conclusion

This analysis provides a window into the CSR activities considered by the alcohol industry to have relevance to their response to the WHO Global strategy. The magnitude and global scope of these initiatives speaks to the ability of the alcohol industry to mobilize its diverse commercial components in pursuit of a common cause, much like the tobacco industry did before them. Far from confirming industry claims that they can "do well" by "doing good," the findings of the present study suggest that the public health benefits of their CSR activities are likely to be minimal, whereas the public relations benefits can be substantial.

Abbreviations

CI - Confidence Interval

CSR - Corporate Social Responsibility

ICAP - International Center for Alcohol Policies

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IARD - International Alliance for Responsible Drinking

LMIC - Lower-middle and low-income countries

SAPRO - Social Aspect and Public Relations Organization

WHO - World Health Organization

UN - United Nations

UNSD - United Nations Statistics Division

Patient consent/involvement: Not applicable, no human subjects or patients involved. The

raters were co-investigators or research assistants or students, not the subject of the research.

Data sharing statement:

The industry action summaries are no longer available from the IARD website. Copies can be

requested from the authors. The data coded from these summaries, which were used in the

current study, are available from the authors upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Contributors

TFB contributed to the design of the study, recruitment of personnel, planning of statistical

analyses, and drafting of the manuscript. KR contributed to the design of the study, accessed the

raw data, supervised the coding procedures, conducted the statistical analyses, trained coders,

and helped to draft the manuscript. KB supervised the coding of EU data and helped to draft the

manuscript. JN contributed to the design of the study, conducted some of the statistical analyses,

and helped to draft the manuscript. MC and RIP recruited and supervised LAC raters, conducted

ratings, assisted with the statistical analyses, and contributed to the drafting of the manuscript.

DP supervised LAC raters, conducted ratings, assisted with the statistical analyses, and

contributed to the design of the study. IP contributed to the design of the study, obtained funding

for the LAC data collection and analyses, conducted ratings and contributed to the drafting of the

manuscript. All authors read, edited and approved the final manuscript.

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Figure Legend

Figure 1. Percent of industry actions classified by IARD and by health professionals according to WHO Global Strategy target areas

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Table 1. Measurement domains, variables measured and coding options used in content analysis of alcohol industry CSR activities.

Measurement Domain	Variable Name	What is measured	Coding options
Industry Benefit Measures ("Doing well")	Marketing/ advertising potential	Whether the action has the potential to promote a specific brand or product.	None; possible
	Policy impact potential	Whether the action has the potential to impact national or local policy	None; possible
	CSR type	Likely operational impact rather than presumed motivation of industry actor	None, strategic, risk management, altruistic
Societal Benefit Measures ("Doing good")	WHO Global strategy target area	Whether the action covers one of the 10 target areas recommended by the WHO Global strategy	0 = Not consistent with any Global Strategy area 1-10 = consistent with one of the 10 Global strategy areas 11 = too vague to classify
	Activity type	Whether the action fit a list of 67 interventions, campaigns, programs and policies that have been evaluated in prior	Chose one of 78 activity types, of which 66 have been evaluated and 12 'other' which had not been

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		research for effectiveness	subjected to research
	Evidence of effectiveness	Estimate its potential for reducing alcohol related harm based on the scientific literature	The 78 activity types were coded as follows: 0 = Evidence indicates a lack of effectiveness 1= Evidence for limited effectiveness 2= Evidence for moderate effectiveness 3= Evidence of a high degree of effectiveness 9 = No studies have been undertaken or there is insufficient evidence upon which to make a judgment
	Risk of harm potential	Whether the action had the potential to cause harm or damage based on available evidence	None; possible

Table 2. Characteristics of Industry Actions to Reduce Harmful Drinking online compendium (n = 1046).

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	n (%)
Region[a]	
Africa	69 (6.6)
Asia	63 (6.0)
Europe	604 (57.7)
Latin America	67 (6.4)
North America	163 (15.6)
Oceania	40 (3.8)
International	40 (3.8)
Country Income level[b]	
High	797 (76.2)
Upper-middle	127 (12.1)
Lower-middle	59 (5.6)
Low	22 (2.1)
Multiple	41 (3.9)
Year started[c]	
1990-1999	105 (10.4)
2000-2009	559 (55.3)
2010-2014	346 (34.2)
Estimated Population reach	
None	218 (20.8)
Small	499 (47.7)
Moderate	218 (20.8
Large	111 (10.6)
Sponsor	
Producer	537 (51.3)
SAPRO	306 (29.3)
Trade Association	182 (17.4)
Other	21 (2.0)
Partner	
None reported	509 (48.7)
Governmental	64 (6.1)
NGO/ University	92 (8.8)
SAPRO/ Trade Assoc.	55 (5.3)
Commercial	65 (6.2)
Multiple partner types	170 (16.3)
'Non specified collaborator'/ Other	91 (8.7)
Industry-reported Evaluation	
None reported	688 (65.7)
Does not meet min. criteria	92 (8.8)
Process	217 (20.7)
Outcome	49 (4.7)

[a] Regions according to UNSD classifications.
[b] According to World Bank classifications
[c] N=1010 because of missing data

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Table 3. Percentages, Odds ratios and 95% CIs by region for marketing potential, potential policy impact and strategic CSR.

Region[a]	Marketing Potential			Policy Impact			Strategic CSR Actions		
	%	OR[b]	95% CI	%	OR[b]	95% CI	%	OR[b]	95% CI
Africa (n = 69)	43.5	3.08	1.24, 7.64	29.0	2.46	1.41, 4.26	33.3	2.45	1.45, 4.16
Asia (n = 63)	15.9	0.50	0.25, 1.00	6.9	1.19	0.60, 2.34	20.6	1.77	0.87, 3.61
Europe (n = 604)	24.0	0.74	0.56, 0.97	13.9	0.79	0.56, 1.10	15.2	0.64	0.47, 0.89
LAC (n = 69)	53.7	4.65	1.87, 11.56	7.5	0.43	0.17, 1.09	22.4	1.34	0.73, 2.44
North America (n = 163)	27.0	1.03	0.70, 1.50	10.4	0.6	0.35, 1.03	11.0	0.52	0.31, 0.87
Oceania (n = 40)	10.0	0.29	0.10, 0.84	27.5	2.19	1.07, 4.98	27.5	1.77	0.87, 3.61
International (n = 40)	33.3	0.68	0.31, 1.50	27.5	2.19	1.07, 4.98	40.0	3.22	1.67, 6.19
Totals (n=1046)	26.5	.	.	15.2	.	.	18.0	.	.

[a]Regions based on UNSD classifications; [b]UN region compared to the rest of the world

Table 4. Percentage, odds ratios and 95% CIs of actions rated as meeting WHO Global Strategy target areas and actions with potential for harm, by region (n = 1046)

Region[a]	WHO Global Strategy target area met			Potential for harm		
	%	OR[b]	95% CI	%	OR[b]	95% CI
Africa (n = 69)	39.1	1.81	1.09, 2.99	7.2	0.61	0.24, 1.56
Asia (n = 63)	23.8	0.83	0.45, 1.51	15.9	1.57	0.77, 3.19
Europe (n = 604)	24.8	0.76	0.58, 1.01	9.6	0.71	0.48, 1.05
LAC (n = 69)	32.8	1.34	0.79, 2.28	25.4	3.05	1.69, 5.50
North America (n = 163)	38.7	1.89	1.38, 2.69	6.1	0.48	0.24, 0.94
Oceania (n = 40)	7.5	0.21	0.06, 0.68	27.5	3.29	1.59, 6.78
International (n = 40)	10.0	0.21	0.06, 0.68	10.0	0.89	0.31, 2.56

[a]Regions based on UNSD classifications; [b]UN region compared to the rest of the world

Table 5. Activity type by level of effectiveness (n = 1046)

Activity Type (example)	N	Evidence of effectiveness	
		None/ Unknown	Limited- Moderate
Availability (MLPA, different availability by strength)	7	0.0	0.7
Environment (RBS training)	49	4.0	0.7
Drink-Driving (designated driver campaigns, safe rides)	49	4.6	0.1
Brief Intervention and Treatment	5	0.0	0.5
Marketing (self regulation codes)	67	6.2	0.2
Education and Persuasion	75	6.1	1.1
'Other' (newsletters, industry-sponsored conferences,)	794	75.9	0.0

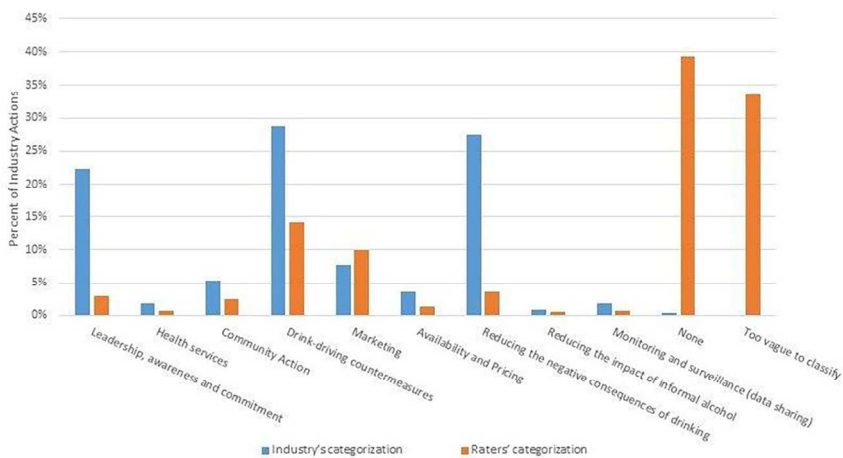|	Total	1046	96.8%	3.2%

Figure 1. Percent of industry actions classified by IARD and by health professionals according to WHO Global Strategy target areas

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