Alcohol and Community Health in the SWPH Region

Awareness, Consumption and Policy Insights

Evaluation
Southwestern Public Health
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Contents

Summary

Alcohol can cause considerable harm to individuals, families and communities. It can contribute to physical (e.g. cancers and injuries) and mental health conditions and places a substantial financial burden on the health-care system. In the SWPH region, alcohol-related deaths and emergency visits remain high and have increased in recent years, particularly among women. Alcohol is a carcinogen linked to multiple cancers and hundreds of health conditions, with risks varying by age, sex and socioeconomic status. These harms disproportionately affect people with lower income or education, despite similar levels of consumption.

Many people in Canada and Ontario are not aware that alcohol causes cancer or what a standard drink is. The purpose of our evaluation was to examine the relationship between knowledge of alcohol-related harms and drinking behaviours and to measure the level of public support for alcohol policies among SWPH adults.

We used SurveyMonkey to administer a survey to a pool of available respondents. Descriptive statistics and cross-tabulations were used to summarize levels of understanding among respondents. A total of 136 respondents completed our survey. Compared with the overall SWPH population, the survey sample included a slightly higher proportion of female respondents and individuals with high school or less education.

Findings showed a modest association between awareness and low-risk drinking, but overall awareness was still limited. There was strong public support for alcohol policies, especially labelling, with most respondents favouring health warnings, standard drink information and restrictions on sales near sensitive locations.

Although our findings offer valuable insight, they should be interpreted with caution due to the survey's small sample size and demographic skew, which limit generalizability. Despite these limitations, the results align with broader research. We hope to use these findings to monitor our alcohol program indicators and guide local interventions, such as tailoring alcohol-related messages to key audiences and advocating for evidence-informed policies to reduce the harms of alcohol.

Alcohol and Community Health in the SWPH Region

Background

In 2019/2020, 60.3% of SWPH residents reported having at least one drink in the last week, a proportion similar to that of Ontario residents (58.3%). (1) While the Canadian Guidance on Alcohol and Health states that one to two drinks will likely avoid alcohol-related consequences at an individual level, the World Health Organization has made the statement that there is no safe level of alcohol consumption that does not affect health. (2,3)

The risks are well documented. Alcohol is a carcinogen that can cause cancer of the breast, colon, rectum, mouth and throat, liver, esophagus and larynx. [(2)] Further, the consumption of alcohol has been linked to 200 different disease and injury conditions, some of which are considered secondary harms that affect people other than those who consume alcohol themselves (e.g. Fetal Alcohol Spectrum Disorder, impaired driving crashes, child abuse and injuries). [(4,5)]

Alcohol caused 6,202 deaths, 60,902 hospitalizations (including day surgery) and 258,676 emergency room visits in Ontario in 2020. [(6,7)] In the Southwestern Public Health (SWPH) region, in an average year, alcohol was attributable to 76 deaths (2014-2018), 388 hospitalizations (2015-2019) and 3,707 emergency department visits (2015-2019) among people aged 15 and older. [(8)]

Between 2018 and 2021, the alcohol-related mortality rate (with and without drug involvement) increased in our region, while the provincial rate declined. By 2021, the SWPH rate had risen to 3.4 per 100,000, surpassing the Ontario rate of 2.5 per 100,000. During the same period, mortality among female residents rose steadily, nearly equaling the historically higher rate among males in 2021 (3.3 vs. 3.5 per 100,000). (1) Equally concerning, the proportion of

women who gave birth reporting any alcohol exposure during pregnancy increased from 2.8% in 2018 to 3.7% in 2022. (9)

According to the Canadian Guidance on Alcohol and Health, alcohol affects different demographic groups in distinct ways. For females, health risks increase more sharply than for males when alcohol consumption exceeds six standard drinks per week, largely due to biological factors such as hormones and body composition. Women also face heightened risks of male-perpetrated violence, including intimate partner and sexual violence, when alcohol is involved. Men, meanwhile, are more likely to be involved in injuries, violence and deaths related to alcohol, with risk increasing when drinking above two drinks on a single occasion. [2]

For youth and young adults, whose brains continue to develop until about age 25, alcohol can disrupt brain development and is a behavioural risk factor for injury, death and social harms. For older adults, slower liver function and interactions with medications or chronic conditions increase alcohol-related risks. (2)

Despite widespread effects, alcohol-related harms fall disproportionately on people with low socio-economic status, even though they consume similar or lower levels of alcohol than people with higher socio-economic status. This pattern is known as the alcohol harm paradox. [10,11]

Effective, evidence-based interventions to reduce alcohol-related harms have been well documented in Canada and internationally. The most cost-effective and impactful strategies are policy-based and include:

- Increasing taxes on alcoholic beverages,
- Restrictions on the physical availability of alcohol,
- Restrictions on alcohol advertising and marketing,
- Enforcing drunk driving countermeasures and
- Implementing screening, brief interventions, referral and treatment. [2,4,11,8,6,12]

Reducing alcohol use and related harms requires coordinated alcohol-control policies across all levels of government. As with tobacco control, increasing public support for alcohol policies depends on people understanding the health risks, especially the link between alcohol and cancer. Research shows that when people learn the about alcohol cancer risk, their support for policy measures (particularly pricing, which is the most effective population-level intervention) increases. [13]

However, most people in Ontario and Canada are unaware that alcohol causes cancer. [14,15,16] Many also do not understand what a “standard drink” is, which is essential for following the Canadian Guidance on Alcohol and Health and reducing consumption. (2,17,18)

These gaps highlight the need to assess local understanding of the link between alcohol and health, especially cancer, so we can design programming and messaging that aligns with our community’s knowledge and behaviours.

Purpose

The purpose of this evaluation was to understand, within constraints of time and budget, the extent to which adults in the SWPH region are aware of the link between alcohol and health harms, especially cancer, and whether these perceptions relate to their own alcohol consumption. We also sought to measure public support for alcohol-related policies.

We will use findings from this evaluation to inform our 2027 Alcohol Plan reporting indicator and to guide the development of targeted public education on alcohol-related risks, as well as to support education and policy development. Given that policy interventions are among the most effective ways to reduce alcohol consumption and related harms, understanding which policies the public supports can help inform discussions with local decision-makers and identify opportunities to advance evidence-informed alcohol policy.

Evaluation Questions

The evaluation questions for this project were as follows:

- To what extent does knowing that alcohol causes harm impact alcohol consumption?
- What percentage of the population (19-99 years of age) supports alcohol policies?

Study Design

We used a descriptive research study design, as our purpose is to understand our sample's perception of alcohol and its link to harms, especially cancer and whether these perceptions relate to their alcohol consumption. We conducted a survey and used a form of non-probability sampling (e.g. convenience sampling) to achieve our purpose. We used a pool of respondents from SurveyMonkey to form our survey sample.

Data Collection

We used SurveyMonkey to administer a survey to a pool of available respondents on the platform. We understood that this format was not necessarily representative of our population characteristics; however, we felt it was the most feasible option for collecting this type of information at this time.

Survey questions revolved around participants' knowledge of alcohol harms, standard drinks and an understanding of their alcohol consumption behaviour. We also collected demographic data, including age, gender, education and income. SurveyMonkey provided us with the age and gender of each respondent who consented to the survey, while we asked questions about education and income in our survey.

Data Analysis

Survey data from SurveyMonkey was exported into an Excel spreadsheet. Descriptive statistics (e.g., frequency counts, percentages) were used to summarize levels of understanding among respondents. Data was also analyzed using cross-tabulations to understand how knowledge variables relate to demographic and alcohol consumption variables.

We aimed to achieve a sample size of at least 89 respondents, which corresponds to an estimated margin of error of approximately ±10% at a 95% confidence level. While this margin of error is higher than the ideal ±5%, we considered it acceptable for our context, because of our study's purpose to identify broad trends. Therefore, we believed it was acceptable for

estimates to be less precise. Given geographical and resource constraints, recruiting a larger sample was not feasible at this time.

Recruitment Strategy

The inclusion criteria for this survey included people who fit the following criteria:

- lived in Oxford or Elgin counties (St. Thomas included)
- were 19-99 years old
- were a part of SurveyMonkey's panel of representatives who voluntarily joined their program to take surveys

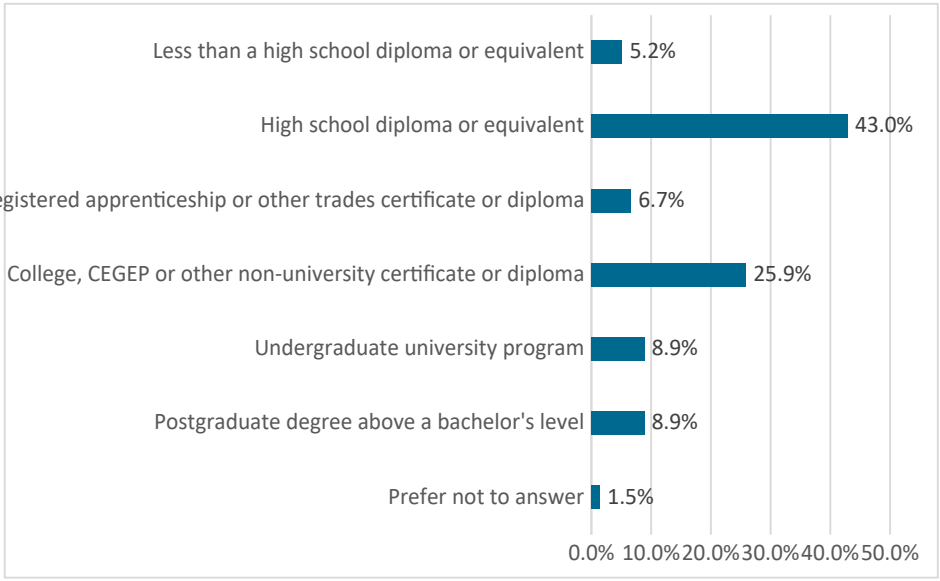
We distributed the survey to SurveyMonkey's survey panel audience. We limited the panel to people who were 19-99 years and lived in Elgin and Oxford Counties (using their Counties and Division filtering options). These criteria enabled us to send the survey to a maximum of 130 participants. The ideal sample for this survey was 384 people. However, given that this survey was exploratory and the maximum number of participants SurveyMonkey would enable us to distribute this survey to was up to 130 people, we acknowledged the limitations of our sample size.

Results

Demographics

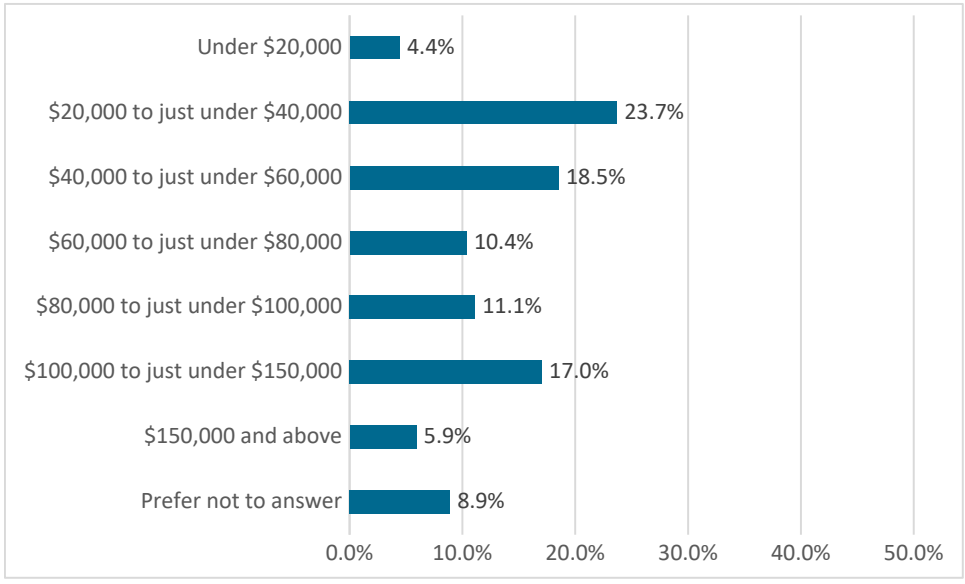
A total of 136 respondents completed our survey. Demographic characteristics are shown in Figures 1-3. Most respondents reported either a high school diploma or equivalent (43.0%) or a college, CEGEP, or other non-university certificate or diploma (25.9%) as their highest level of education (Figure 1). Compared with the overall SWPH population, the survey sample included a slightly higher proportion of individuals with a high school diploma or less education.

Figure 1: Distribution of survey respondents by highest education level



Household income varied, with the largest group of respondents reporting between $20,000 and just under $40,000 a year (23.7%) (Figure 2). In contrast, income levels in the SWPH region tend to fall into higher categories.

Figure 2: Distribution of survey respondents by household income



This survey had a higher proportion of female respondents in comparison to the general SWPH population. Female respondents accounted for 59.3% of the sample, whereas male respondents accounted for 40.7% (Figure 3). The two most common age groups among survey respondents were 45–60 year olds (31.1%) and those aged 60 years and older (31.1%) (Figure 4). The SWPH region has a broader age distribution overall, including younger age groups.

Given the under-representation of certain demographic groups in the sample, subgroup analyses should be interpreted with caution.

Figure 3: Distribution of survey respondents by gender

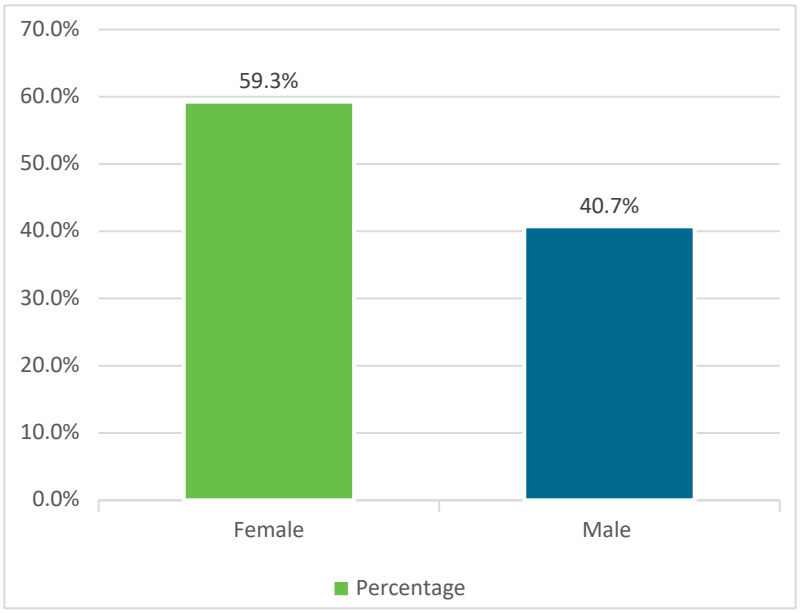
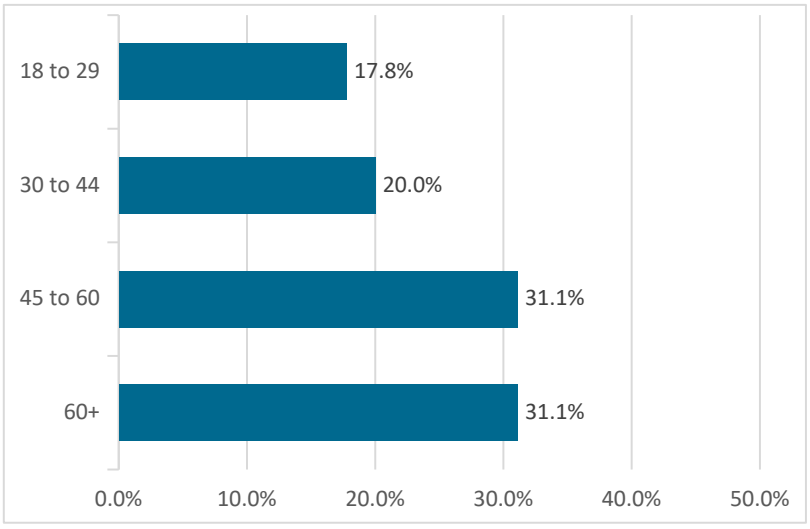


Figure 4: Distribution of survey respondents by age group



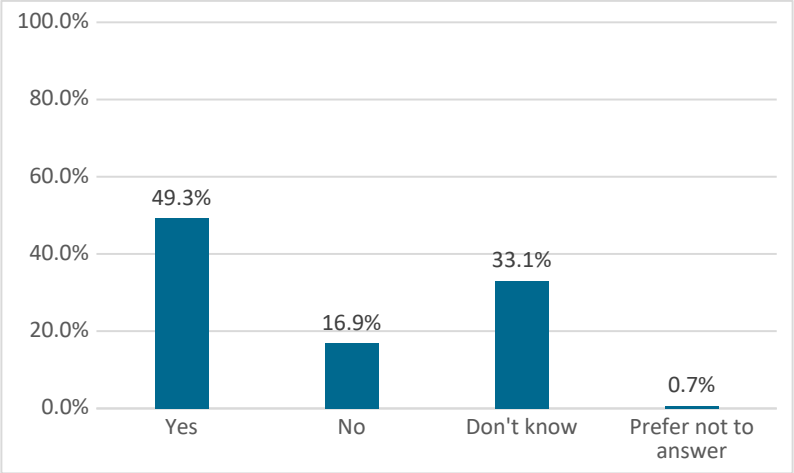
Awareness of Alcohol Harms and Cancer Risk

Awareness that alcohol can cause harm was high among survey respondents. Overall, 97.1% of respondents reported that they knew or believed that alcohol can cause harm, such as stroke, impaired driving and high blood pressure.

These high levels of awareness were consistent across demographic groups. Recognition of alcohol-related harms exceeded 90% across all age groups, genders, household income levels and education levels. Notably, all respondents aged 60 years and older reported that alcohol can cause harm. Awareness was slightly higher among females (98.8%) compared to males (94.5%), though awareness remained high in both groups.

Awareness that alcohol can cause cancer was substantially lower than awareness of general alcohol-related harms. Overall, about half of the respondents (49.3%) reported that they believed alcohol can cause cancer. In contrast, nearly one-third of respondents (33.1%) indicated that they did not know whether or not alcohol can cause cancer (Figure 5).

Figure 5: Proportion of people who know or believe that alcohol can cause cancer



A recognition of the link between alcohol and cancer increased with age. Respondents aged 18 –29 were the least likely to be aware that alcohol can cause cancer (41.7%), while awareness was higher among those aged 45–60 (52.4%) and those aged 60 and above (50%). Males reported slightly higher awareness than females (50.9% vs. 47.5%), though females were more likely to indicate uncertainty (“don’t know”: 36.3% vs. 29.1%).

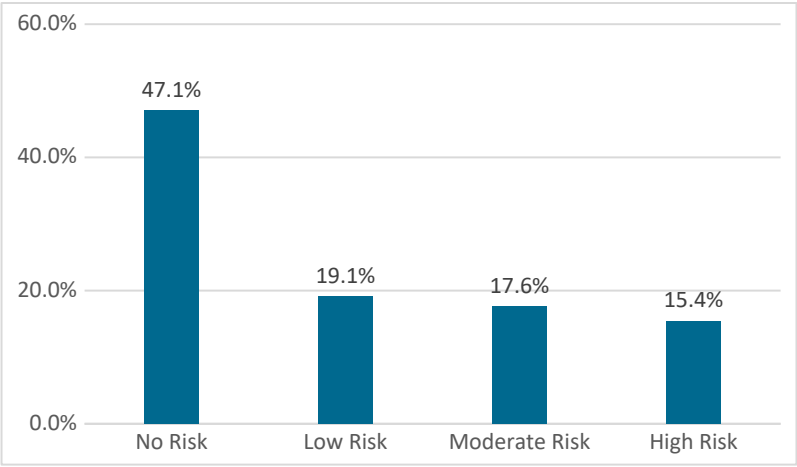
Respondents with an undergraduate university degree showed the highest awareness (n=10, 83.3%), with the majority recognizing the risk. In contrast, those with less than a high school education were far less aware (n=3, 42.9%). Many were unsure or believed that alcohol does not cause cancer. Responses by people with other education levels fell in between, with awareness generally rising with higher educational attainment.

Respondents in mid and higher income brackets were more likely to be aware that alcohol can cause cancer. The income group ($40,000 to just under $60,000) showed lower awareness (44%). Some mid-income groups also showed higher uncertainty.

Alcohol Consumption Risk Categories and Heavy Drinking

Survey respondents were classified according to their self-reported level of alcohol consumption in the past week based on Canadian drinking guidelines. Almost half of respondents (47.1%) reported no alcohol consumption in the past week (no-risk), while 19.1% drank 1–2 drinks in the past week, placing them in the low-risk category. Smaller proportions of respondents fell into the moderate-risk category (17.6%, 3-6 drinks per week) and the high-risk category (15.4%, 7 or more drinks per week) (Figure 6). Heavy drinking (defined as consuming five or more drinks on a single occasion for men, or four or more drinks for women) was reported by 11.8% of respondents.

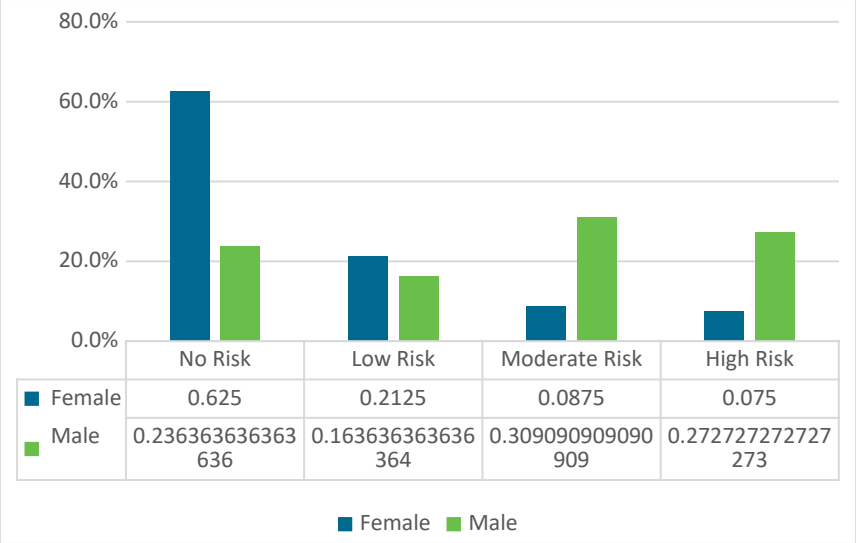
Figure 6: Proportion of survey respondents by alcohol consumption risk categories



Alcohol consumption patterns varied across education and income groups, but there was no clear trend. No-risk drinking (0 drinks in the past 7 days) was most common (ranging between 37% and 57% for various education levels and between 27% and 67% across various income groups). Heavy drinking on a single occasion was reported by a smaller proportion of respondents (between 5% and 33% by education and 7% and 17% by income).

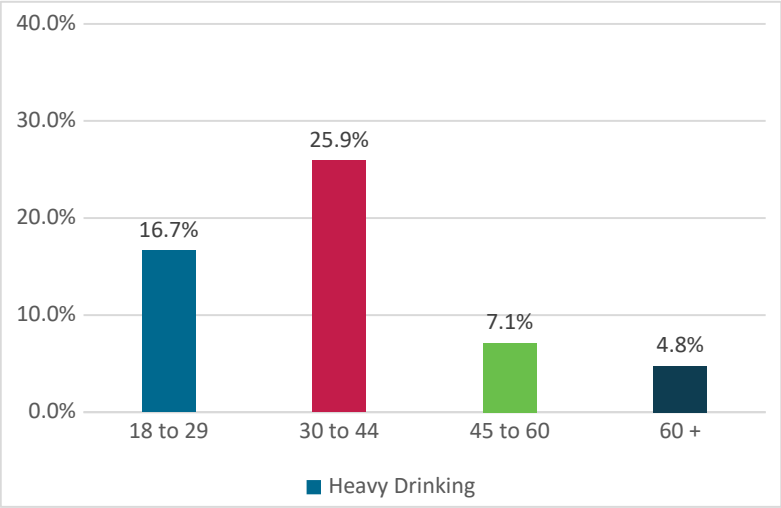
In contrast, bigger differences were observed by gender and age. Females were more likely to report no-risk drinking than males (62.5% vs. 23.6%), while males were more likely to fall into moderate (8.8% vs. 30.9%) and high-risk categories (7.5% vs. 27.3%) (Figure 7).

Figure 7: Proportion of alcohol consumption risk categories by gender



No-risk drinking was highest among adults aged 45-60 (57.1%) and lower among younger adults aged 18-29 (41.7%) and 30-44 (44.4%). High-risk drinking was most common among adults aged 30-44 (29.6%). Overall, while many respondents reported no or low-risk drinking, higher risk and heavy drinking were more common among men (27.3% and 20%) and adults aged 30-44 (29.6% and 25.9%) (Figure 8).

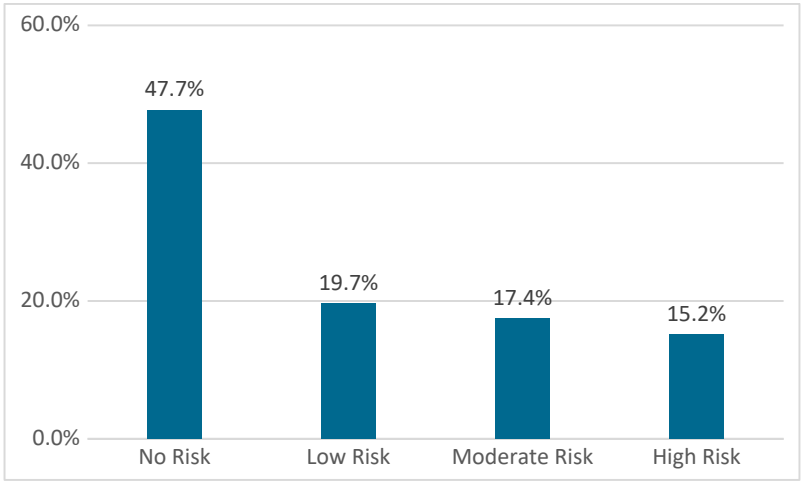
Figure 8: Proportion of heavy drinking by age group



Awareness of Alcohol Harms and Cancer Risk by Alcohol Consumption Risk Categories

Awareness that alcohol causes harm was highest among respondents who were categorized as no-risk (47.7%) compared to respondents who were categorized as low (19.7%), moderate (17.4%) and high-risk (15.2%). As the risk level of drinking increased, awareness of harm decreased (Figure 9).

Figure 9: Proportion of awareness of alcohol harms by alcohol consumption categories



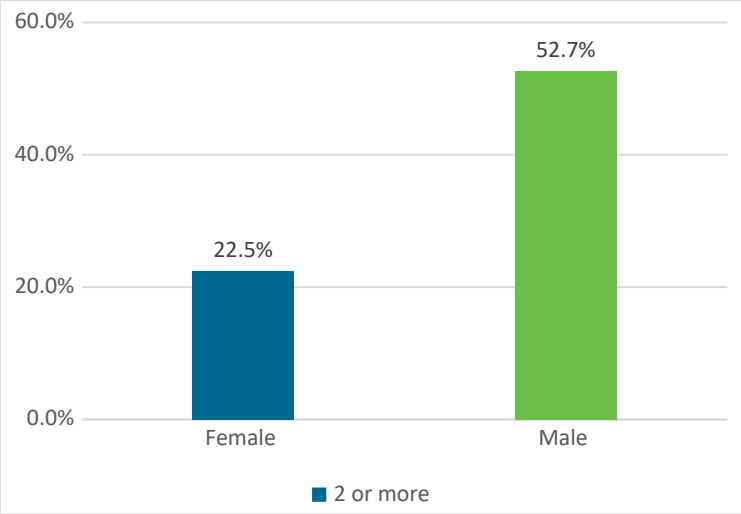
Similarly, awareness that alcohol can cause cancer was highest among respondents who were categorized as no-risk (46.3%), in comparison to respondents who were categorized as low (16.4%), moderate (19.4%) and high-risk (17.9%).

Drinking Two or More Standard Drinks in One Session

Overall, about one-third of respondents (34.6%) reported consuming two or more drinks on a single occasion, while the majority (65.4%) consumed fewer than two drinks. Patterns were relatively similar across education and household income groups, with no large differences between groups.

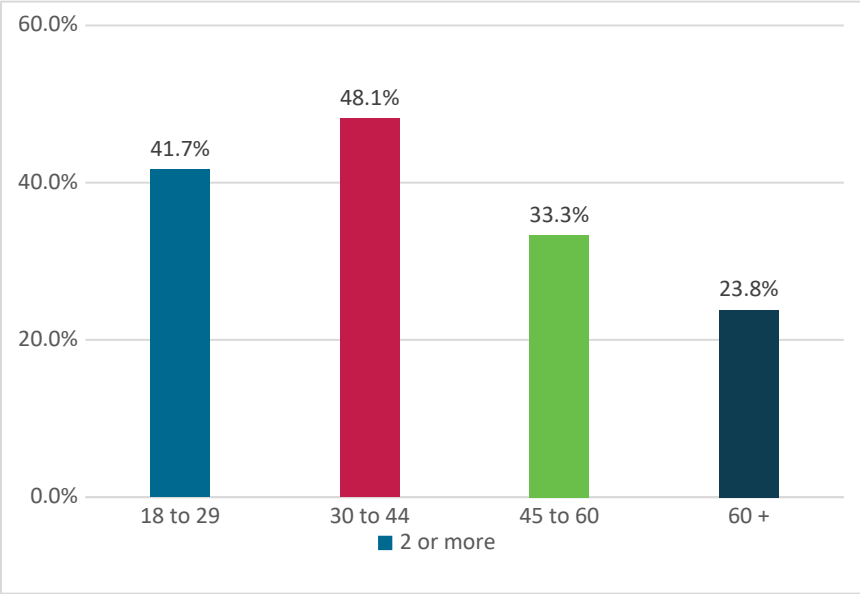
Males were more than twice as likely as females to consume two or more drinks in a single session (53.7% vs. 22.5%) (Figure 10).

Figure 10: Proportion of drinking two or more standard drinks by gender



Younger adults were more likely to drink two or more drinks (41.7%), with nearly half of those aged 30–44 reporting this behaviour (48.1%), compared with older adults aged 60+ (23.8%), among whom two or more drinks on one occasion was less common (Figure 11).

Figure 11: Proportion of drinking two or more standard drinks by age group



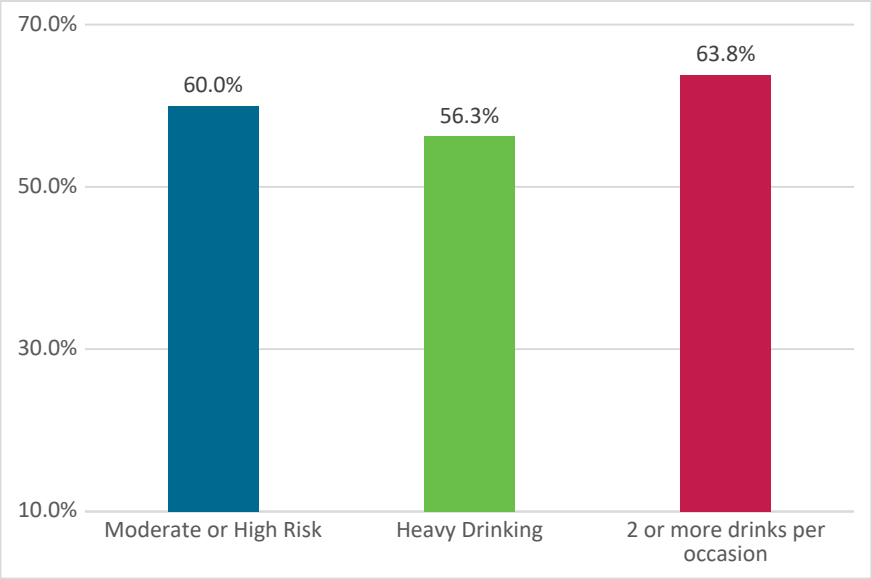
Among respondents who consumed two or more drinks on a single occasion (n=47), 84% were in the moderate or high-risk drinking categories and only about one-third were aware that alcohol could cause harm (34.1%) or cancer (37.3%).

Awareness of Alcohol-Related Messaging

Overall, about 59.6% of respondents reported that they had seen alcohol-related educational messages, while 39% had not and a very small proportion (1.5%) did not know. Among those who had seen educational messages (n=23), just over half (51.1%) were unsure whether alcohol can cause cancer.

Respondents in moderate or high-risk drinking categories, those reporting heavy drinking and those consuming two or more drinks on a single occasion, were more likely to have seen alcohol-related educational messages (60%, 56.3%and 63.8%, respectively) (Figure 12).

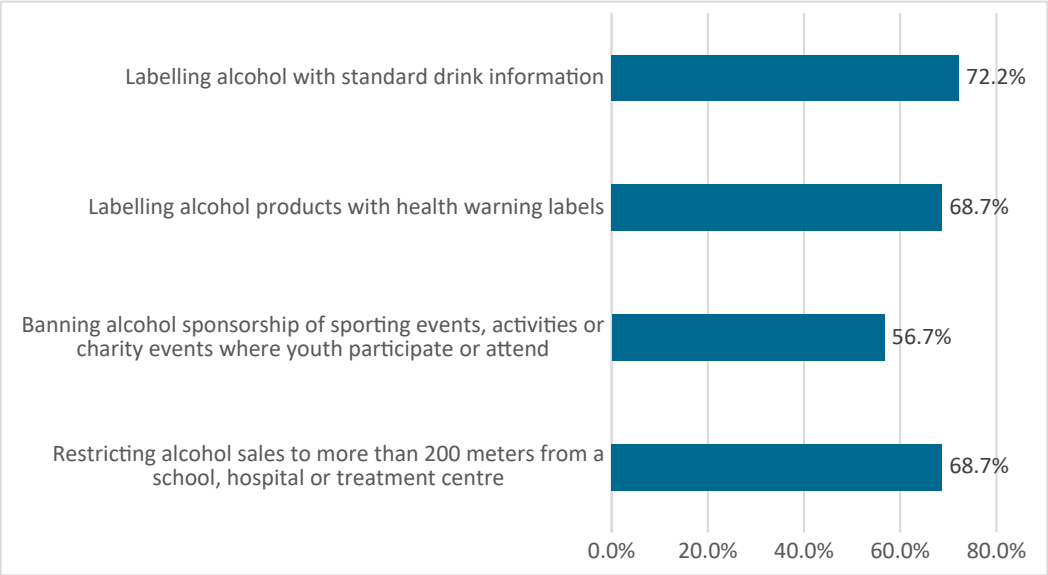
Figure 12: Proportion of awareness of alcohol-related health messages among high-risk and heavy drinkers



Support for Alcohol Policies

Most respondents expressed support for policies aimed at reducing alcohol-related harm. Around 68.7% supported restricting alcohol sales near schools, hospitals, or treatment centers, and a similar proportion (68.7%) supported labelling alcohol products with health warning labels. Support was slightly higher for labelling alcohol with standard drink information (72.2%). Just over half of respondents (56.7%) supported banning alcohol sponsorship of sporting or charity events where youth participate or attend (Figure 13).

Figure 13: Proportion of support for alcohol policies



Discussion

The survey results highlight key patterns in alcohol consumption, awareness and public support for policies. Most respondents reported no or low-risk drinking, yet about one-third consumed alcohol at moderate or high-risk levels. Consuming two or more drinks on a single occasion was common, particularly among men and adults aged 30–44. These proportions are generally consistent with SWPH estimates from 2019/2020, which reported 67% of residents drinking at no or low risk and 33% at moderate to high risk. (1) Any differences between the two sources should be interpreted cautiously, as our survey's small, non-representative sample limits direct comparability.

Awareness of alcohol-related harm was high, with nearly all respondents recognizing general risks, but fewer than half (49.3%) were aware of the link between alcohol and cancer. This is consistent with Ontario and Canadian estimates (28% and 57%). (15,16,19,20)

Our findings suggest a modest relationship between awareness of harms and low-risk alcohol consumption. For example, awareness that alcohol causes harm, including cancer, was highest among respondents who were in the no-risk category (general harm 47.7%; cancer 46.3%),

compared with those in low, moderate or high-risk groups. However, even in this lowest-risk group, only about half were aware, indicating that overall awareness remains limited.

About 60% of respondents reported seeing alcohol-related educational messages, compared to 81% in a national study (16), suggesting room to strengthen local alcohol-related messaging. Notably, even among those who had seen such messages (59.6%), just over half (51.1%) were still unsure whether alcohol can cause cancer. This gap has implications for local alcohol policy as evidence suggests a meaningful difference between awareness that alcohol causes cancer and belief that alcohol causes cancer, with belief being more strongly associated with support for pricing, marketing and availability policies. (14,13,19) Increasing the frequency and clarity of local messaging may improve both awareness and belief that alcohol causes cancer. (19) Because people must see a message multiple times to internalize it, increasing the frequency of alcohol-related health messaging can improve awareness and belief. (19,21) Encouragingly, our findings indicate that people who drink moderate amounts or more were most likely to have seen these messages, suggesting that current efforts are reaching key target populations.

Awareness, however, varied by sociodemographic factors. Respondents with higher education were most aware that alcohol causes cancer (83.3%), while awareness was much lower among respondents with less than a high school education (42.9%). Awareness also increased with income. These findings suggest directing educational efforts toward residents with lower income and education levels to reduce disparities in knowledge.

There was moderate to strong support for alcohol policies, especially product labelling. In our survey, 68.7% favoured health warning labels and 72.2% supported the inclusion of standard drink information. Support for restricting sales near schools, hospitals and treatment centers was similarly high (68.7%), while there was slightly lower support for limiting alcohol sponsorship of youth-focused events (56.7%). These findings align with national research showing broad support for labelling policies such as standard drink information (62%), health risk guidance (60%) and warning labels (55%). (16) Given the influence of public opinion on policy decisions, continued monitoring and message-framing research can guide local advocacy.

Although our findings provide important insights, they should be interpreted with caution. The survey’s small sample size (n=136) and demographic skew (older, more female participants and differences in education and income compared with the SWPH population) limit generalizability.

Despite these limitations, the results align with current research showing low awareness that alcohol is a carcinogen and strong support for alcohol-policy measures, particularly labelling policies. The survey still offers valuable baseline information for monitoring the Alcohol program indicators and guiding future local interventions, such as tailoring messaging to key audiences and advocating for evidence-informed policies to reduce alcohol-related harm.

Conclusion

The majority of people in Ontario and Canada do not know that alcohol causes cancer and do not understand the term “standard drink”. Evidence has shown that as people start to understand the link between alcohol and cancer (among other harms), their support for alcohol policy starts to increase.

Limited research exists on local awareness of alcohol-related harms, so the purpose of our evaluation was to understand the extent to which adults living in the SWPH region were aware of the link between alcohol and health harms, especially cancer, how these perceptions related to alcohol consumption and the level of public support for alcohol-related policies.

Although our findings should be interpreted with caution, the findings align with research showing low awareness that alcohol is a carcinogen and strong support for alcohol-policy measures, particularly labelling policies. Despite limitations, the survey provides valuable baseline information to monitor program indicators, tailor future messaging to priority audiences and support advocacy for evidence-informed policies aimed at reducing alcohol-related harm.

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References

1. Santos J. Adult substance use and harms in the SWPH region: alcohol. Woodstock: Southwestern Public Health; 2024.
2. Paradis C, Butt P, Shield K, Poole N, Wells S, Naimi T, et al. Canada's Guidance on Alcohol and Health: Final Report. Ottawa, ON: Canadian Centre on Substance Use and Addiction; 2023.
3. World Health Organization. News release: no level of alcohol consumption is safe for our health. [Online].; 2023 [cited 2026 April 8. Available from: https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health.
4. World Health Organization. Alcohol. [Online].; 2022 [cited 2023 April 28. Available from: https://www.who.int/news-room/fact-sheets/detail/alcohol.
5. Babor T, Casswell S, Graham K, Huckle T, Liningston M, Osterber E, et al. Alcohol: no ordinary commodity research and public policy. 3rd ed. Oxford: Oxford University Press; 2023.
6. Naimi T, Stockwell T, Giesbrecht N, Wettlaufer A, Vallance K, Farrell-Low A, et al. Canadian alcohol policy evaluation (CAPE) 3.0 Project. Victoria: University of Victoria, Canadian Institute for Substance Use Research; 2023.
7. Canadian Substance Use Costs and Harms. CSUCH visualization tool. [Online].; 2023 [cited 2024 02 29. Available from: https://csuch.ca/explore-the-data/.
8. Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of health conditions attributable to smoking and alcohol by public health unit in Ontario. Toronto:; 2023.
9. Better Outcomes Registry Network. Children's Hospital of Eastern Ontario (CHEO); 2018- June 2023.
10. Bloomfield K. Understanding the alcohol-harm paradox: what next? The Lancet: Public Health. 2020 June; 5(6).
11. Canadian Institute for Health Information. Alcohol harm in Canada: examining hospitalizations entirely caused by alcohol and strategies to reduce alcohol harm. Ottawa:, CIHI; 2017.

12. Myran D, Chen J, Giesbrecht N, Rees V. The association between alcohol access and alcohol-attributable emergency department visits in Ontario, Canada. Addiction. 2019 July 1183-1191; 114(7).
13. Weerasinghe A, Schoueri-Mychasiw N, Vallance K, Stockwell T, Hammond D, McGavock J, et al. Improving knowledge that alcohol can cause cancer is associated with consumer support for alcohol policies: findings from a real-world alcohol labelling study. International Journal of Environmental Research and Public Health. 2020 January; 17(2).
14. Hobin E, Shokar S, Vallance K, Hammond D, McGavock J, Greenfield T, et al. Communicating risks to drinkers: testing alcohol labels with a cancer warning and national drinking guidelines in Canada. Canadian Journal of Public Health. 2020 October; 111(5): p. 716-725.
15. Leger. Canada's guidance on alcohol and health: conducted by Leger for the Canadian Centre on Substance Use and Addiction. Montreal: Canadian Centre on Substance Use and Addiction; 2023. Report No.: Project number 83197-005.
16. Health Canada. Public awareness of alcohol-related harms survey 2023 [web summary]. Health Infobase. [Online].; 2024 [cited 2025 August 7. Available from: https://health-infobase.canada.ca/alcohol-related-harms-survey/
17. Wettlaufer A. Can a label help me drink in moderation? a review of the evidence on standard drink labelling. Substance Use and Misuse. 2017; 53(4).
18. Cochrane Canada Update of Canada’s Low-Risk Alcohol Drinking. Update of Canada's low-risk alcohol drinking guidelines: summary of the evidence on understanding and response to alcohol consumption guidelines. Summary of Evidence. Ottawa: Canadian Centre on Substance Use and Addiction; 2021.
19. Weerasinghe A, Forbes S, Hobin E. Does believing alcohol causes cancer moderate the relationship between consumer awareness of the alcohol-cancer link and support for alcohol policies? findings from a Canadian cross-sectional study. Drug and Alcohol Review. 2025 October.
20. Canadian Cancer Society IPSOS Poll. 2022 Polling topics. ; February 2022.
21. Hornik R. Exposure: theory and evidence about all the ways it matters. Social Marketing Quarterly. 2002; 8(3): p. 31-37.
22. Statistics Canada. Canadian Community Health Survey. ; 2015-2020.

23. Fitzgerald N, Angus K, Howell R, et al.. Changing public perceptions of alcohol, alcohol harms and alcohol policies: a multi-methods study to develop novel framing approaches. Addiction. 2024 November; 1(14).

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