Contributing Authors

BHUTAN
MR TANDIN CHOGEY
Program Officer for Mental Health
Department of Public Health
Ministry of Health
Thimphu

MR TSHERING DORJI
District Health Officer
Mongar District

MR KARMA WANGCHUK
District Health Officer
Lhuentse District

INDIA
DR VIVEK BENEGAL
Professor of Mental Health
National Institute of Mental Health and Neuro Sciences
Bangalore

MS. ANITA CHOPRA
Scientist,
National Drug Dependence Treatment Centre
All India Institute of Medical Sciences
New Delhi

DR G. GURURAJ
Professor & Head
Department of Epidemiology
National Institute of Mental Health and Neuro Sciences
Bangalore

DR RAKESH LAL
Professor and Officer-in-Charge
National Drug Dependence Treatment Centre
All India Institute of Medical Sciences
New Delhi

DR GIRISH N RAO
Associate Professor
Department of Epidemiology
National Institute of Mental Health and Neuro Sciences
Bangalore

DR RAJAT RAY
Professor and Chief National Drug Dependence
Treatment Centre and
Head, WHO Collaborating Centre
All India Institute of Medical Sciences
New Delhi

SRI LANKA
DR SAJEEVA RANAWEERA
Epidemiologist and Director
Public Service Delivery and Social Welfare Evaluation
Presidential Secretariat
Colombo

MR PUBUDU SUMANASEKARA
Alcohol and Drug Information Centre
Colombo

THAILAND
DR CHITLADA AREESANTICHAI
Lecturer and Researcher
College of Public Health Sciences
Chulalongkorn University
Bangkok

DR USANEYA PERNGPARN
Drug Dependence Research Center
College of Public Health Sciences
Chulalongkorn University
Bangkok

DR THAKSAPHON THAMARANGSI
Center for Alcohol Studies
International Health Policy Programme
Ministry of Public Health
Bangkok

MS ORRATAI WALEEWONG
Specialist in Alcohol Policy
International Health Policy Programme
Ministry of Public Health
Bangkok
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Documented evidence suggests that fermented beverages existed at least as early as 10,000 BC. Ancient references to alcoholic beverages can be found in literature from China, Egypt, Greece, India, Iran, Italy, pre-Colombian America and sub-Saharan Africa. Use of alcohol has a place in the rituals of many cultures around the world, including in some South-East Asian communities. Throughout history, alcohol has been regulated through social control whereby its use is permitted, and abuse discouraged. But today, things have evolved.

South-East Asian societies are experiencing changing stages of growth and development due to macro- and micro-level influences. The impact of globalization, industrialization, migration and the media on the lives of people is palpable. The shift from agrarian to modern societies has led to psychological, cultural and social change. People are embracing new lifestyles, cultures and practices, leading to emerging problems such as the increased use and abuse of alcohol.

Traditionally, alcohol use has been considered a matter of personal choice, and harm from alcohol use seen as an issue to be addressed by the individual and the family. In recent years, awareness about harm from alcohol use has increased, not only with regard to the user but also harm to the family, the community and the entire nation.

Alcohol use results in approximately 2.5 million deaths each year, which is greater than the global number of deaths caused by HIV/AIDS, tuberculosis or violence. Approximately 4.5% of the global burden of disease and injury – more than 60 major types – is attributable to alcohol use. Alcohol consumption is the world’s third largest risk factor for disease and disability. In addition, it is also associated with many serious social issues, including gender-based violence, child neglect and abuse, and absenteeism at the workplace.

Harm from alcohol use has been clearly detailed in the “Alcohol Control Series” developed by experts from the South-East Asia Region of the World Health Organization.
In trying to reduce this harm, we are confronting a formidable enemy. There are an estimated 600 factories, 1582 distributors and thousands of retail outlets involved in alcohol production and retailing in the Region. Over four million people are involved in this industry.

We now realize that only a coordinated, multisectoral approach can address the complex issues of prevention of harm from alcohol use, and governments are increasingly taking measures to protect their citizens from the dangers of alcohol abuse.

The Sixty-third World Health Assembly in May 2010 endorsed the Global Strategy to Reduce the Harmful Use of Alcohol. This strategy, based on evidence and best practices, provides policy options taking into account diverse national, religious and cultural contexts. To be locally relevant, the strategy also considers the differences in Member States’ resources, capacities and capabilities. Similarly, at its Fifty-ninth session in 2009, the Regional Committee for South-East Asia requested the Regional Director to support Member States in building and strengthening institutional capacity to develop information systems, policies, action plans and programmes on the prevention of harm from alcohol use.

In response to these high-level resolutions, experts in the South-East Asia Region have carried out significant studies to show governments and communities that, with their participation, harm from alcohol use can be minimized. The impact evaluation of the community-based programmes in Bhutan, Sri Lanka and Thailand has shown very positive results. Other Member States may wish to analyse these pilot studies with a view to adapting them in their own countries.

I am confident that experts and governments working to promote the welfare of their communities by reducing harm from alcohol consumption will find this document useful.

Dr Samlee Plianbangchang
Regional Director
EXECUTIVE SUMMARY

Communities around the world have been consuming alcohol for centuries. Although alcohol use is acceptable in society, its abuse is strictly controlled by societal norms. More recently, alcohol use has shifted from its original ritualistic and symbolic purposes to recreational and excessive use in many parts of the world. Widespread alcohol use, leading to harm not only to the user but also to the family, the community and the entire nation is now recognized as a public health problem in many countries.

Globally, alcohol use results in approximately 2.5 million deaths each year. This figure is greater than the number of deaths caused by HIV/AIDS, tuberculosis or violence. Alcohol is a causal factor in more than 60 major types of diseases and injuries and a component cause in 200 others. Indeed, alcohol use represents approximately 4.5% of the global burden of disease and is the world’s third largest risk factor for disease and disability. It is also associated with many serious social issues, including gender-based violence, child neglect and abuse, absenteeism at the workplace and economic loss.

The formal alcohol industry, which has emerged during the last few decades, strives to increase alcohol consumption through many means, and uses vast resources to do so. It is estimated that in the South-East Asia Region of the World Health Organization, over 600 factories, 1582 distributors, thousands of retail outlets and over 4 million people are involved
in alcohol production, retail and other elements of the industry.

The community and policy-makers in the Region should be made aware of issues related to alcohol consumption such as increasing use by women and the youth, the earlier age of initiation, availability of illicit alcohol, and the targeting of markets in developing countries by multinational manufactures.

The global community has realized the harm from alcohol use and is taking measures to reduce it. In May 2010, the World Health Assembly, representing all 193 WHO Member States, approved resolution WHA63.13 endorsing the Global Strategy to Reduce the Harmful Use of Alcohol, which includes evidence-based measures to address use and consequent harm. Similarly, at its Fifty-ninth session in 2009, the Regional Committee for South-East Asia requested the Regional Director to support Member States in building and strengthening institutional capacity to develop information systems, policies, action plans and programmes on prevention of harm from alcohol use.

The experience of selected SEAR Member States in reducing harm from alcohol use through policy development and community action is documented in this book. In particular, the impact evaluation of community-based programmes in Bhutan, Sri Lanka and Thailand has shown very positive results.
1. INTRODUCTION

1.1 Historical note

The archaeological discovery of late Stone Age jugs has established the fact that fermented beverages existed at least as early as 10 000 BC. Ancient references to alcoholic beverages can be found in literature from China, Egypt, Greece, India, Iran, Italy, pre Colombian America and sub-Saharan Africa. The Babylonians as early as in 2700 BC worshipped a wine goddess and other wine deities. Use of alcohol has a place in the rituals of many cultures around the world. The Indian ayurvedic text describes the pleasurable and beneficial effects of alcohol if consumed in moderation but a poison if consumed in excess. Throughout history, alcohol use was regulated through social control whereby its use was permitted, but abuse discouraged.

South-East Asian societies are in transition through stages of growth and development due to macro- and micro-level influences. The impact of globalization, industrialization, migration and the media on the lives of people is palpable. The shift from agrarian to modern societies has affected them psychologically, culturally and socially. It has influenced every sphere of their lives. People are embracing new lifestyles, cultures and practices, which has given rise to new problems such as the increasing use and abuse of alcohol. Governments are now taking measures to protect their citizens from these changing global influences.

1.2 The alcohol industry

Historically food grains were converted into alcoholic beverages in small quantities for personal use in homes in some countries in the WHO South-East Asia (SEA) Region. However, the advent of commercial distillation in the mid 19th century led to an expansion of the alcohol industry and easy availability of large quantities of alcohol for purchase. This in time led to large-scale use of alcohol, which resulted in abuse and consequent harm.

The alcohol industry is huge in the SEA Region. Over 600 factories, 1582 distributors and thousands of retail outlets are estimated to be involved in alcohol production and retailing. Over 4 million people are involved in the industry1.
The fast pace of globalization of economies in the SEA Region has resulted in the local alcohol industry acquiring a new status due to recent tie-ups with more established transnational companies and brands. The mergers and acquisitions of businesses in the liberalized market economy have not only brought about ‘economies of scale’, but have also imparted a new vigour to a nascent industry on a global scale.

With many parts of the world reaching stable and saturated consumption, and with declining trends of alcohol consumption in the European Region and other traditional markets, lobbies are increasingly targeting new potential markets, especially in Asia. Operating through different media channels and using a wide variety of promotional strategies amid social and cultural forces of globalization, these changes are expected to result in a rise in the production, distribution and consumption of alcohol in the SEA Region.

The market for spirits and wines is observed to have increased in the last few decades, with variations across countries in the Region. In Thailand there was an 11-fold increase in beer production between 1970 and 1993, while in Sri Lanka the increase in beer and arrack production was approximately 50%. In India, the total annual estimated alcohol production has increased to more than double in a matter of two years: from 362 million litres in 1993–1994 to 789 million litres in 1995–1996. The Planning Commission of India (2003) noted in its 10th 5-year plan a steady increase in the production of alcohol (Annex 2 in this book). Alarmed at the rapidly increasing consumption of alcohol and the corresponding harm to the community, global bodies, civil society and other concerned stakeholders have responded appropriately. Examples of this response are evident in World Health Assembly resolution WHA61.4, and Regional Committee resolutions SEA/RC54/R2 and SEA/RC59/R8 among others.

The promotion and sale of alcohol depends on a number of prevalent practices and policy initiatives in each country. Some of these include taxation policies on alcoholic beverages,
wholesale and retail policies, the final market price, constraints imposed (or not imposed) on sale in terms of duration of sale hours, age restrictions, permissible legal sanctions for alcohol consumption and most importantly restrictions on promotional practices like the use of print and electronic media for advertising purposes.

Midanik and Room identified the existence of different perspectives regarding alcohol use in a community:

- governments – alcoholic beverages are a source of revenue
- market economist – alcoholic beverages are one more category of consumer products
- cultural anthropologist – it is a widely used medium of sociability with a diversity of symbolic meanings
- public health specialist – it is an agent of morbidity and mortality
- common man – it is a bottle or one more bottle.

These different perspectives drive the agenda and decide the context of promotion and sale of alcohol depending on the power play in society.

Alcohol use in Member States of the SEA Region presents diverse challenges to policy-makers, professionals and civil societies. The growing evidence of harmful effects coupled with inadequate information on effective interventions creates a dilemma in public health. The divergent perspectives of stakeholders have only added to the existing confusion resulting in ‘now-on-now-off’ public health policies.
2. SPECTRUM OF ALCOHOL USE IN THE SOUTH-EAST ASIA REGION

Despite widespread consumption, worldwide, a high percentage of people currently do not drink alcohol at all. Almost half of all men and two-thirds of women have not consumed alcohol in the past year. Abstention rates are low in high-income, high-consumption countries, and higher in North African and South Asian countries. Female abstention rates are very high in these countries.5

The SEA Region can be characterized as having a low but increasing level of alcohol drinking with a detrimental pattern, dominated by the consumption of spirits as well as a high degree of unrecorded alcohol consumption. The major problem in the Region is heavy episodic or “binge” drinking. With the influence of global economies and changing cultural norms, more and more young people are experimenting with alcohol at a very early age.

2.1 Practice of alcohol use

There is a spectrum of use among those who consume alcohol including dimensions such as frequency, volume, risk and harm. Thus, drinkers range from one-time users to daily users, from light to heavy users, from low- to high-risk drinkers, and from first sip to alcohol dependence. The proportion of people in different groups of this spectrum varies considerably among different societies, and even within each country.

The permissiveness of occasional use varies across societies and cultures. For example, in some communities serving alcohol to guests on joyous occasions and festivals is a common practice.

Numerous problems are associated with even occasional use of alcohol. These range from domestic and family violence, road or occupational accidents, to physical or mental trauma. These and other such problems in the absence of dependent use should be considered as “harm from alcohol use”. The recognition of “harm from alcohol use” is the first step in reducing this harm. An important point to note is that harm from alcohol use is linked to context and not quantity of use in one drinking episode.
Harmful use of alcohol refers to a pattern of use that leads to adverse social, occupational, medical and public health consequences. It is also a well-defined risk factor for noncommunicable diseases. This pattern of use is not necessarily a result of daily consumption of alcohol. Harmful use can also lead to a worsening medical or psychiatric illness. Interaction between alcohol and other medications can be severely deleterious. In contrast to harm from alcohol use, “harmful use” is generally linked to the quantity of alcohol used at any one time.

Hazardous drinking is a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. Included in this pattern of drinking can be either “binge drinking” (consumption of five or more drinks in one sitting or on one occasion) or pathological drinking (unable to stop drinking once started). Generally, hazardous use of alcohol is linked to the quantity consumed in one occasion but also use of alcohol in inappropriate circumstances, such as drink-driving or unprotected sex.

The conditions of alcohol dependence and hazardous use of alcohol are grouped as “alcohol use disorders”. The problems arising in the personal, family and social spheres of an alcohol-dependent person are well documented.

It is now being recognized that alcohol-related harm is not only associated with addiction but also with intoxication or other physiological processes triggered by alcohol use. Both volume and pattern(s) of drinking are thus more important than the addiction status of an alcohol user. The group at risk is the new user, especially the youth who, due to their relative inexperience in handling an alcoholic drink, are invariably subject to adverse consequences of alcohol use (e.g. road traffic injuries, fights, antisocial behaviour, unprotected sex).

In the SEA Region, WHO estimates that 80% of people are lifetime abstainers – 93% of which are women and 68% men. This rate of lifetime abstinence is second only to the WHO
The group at risk of harm is the new user, especially the youth.

Eastern Mediterranean Region. Worldwide, the lifetime abstinence rate is 45%, with 55% women and 35% men, respectively. However, this situation should not be considered as a justification for inaction. In countries of the South East Asia Region, the smaller percentage of the population that drinks is consuming alcohol at a hazardous pattern. Therefore, individual as well as social costs of alcohol are still high.\(^5\)

More than two-thirds of the total beverage consumption within the Region is in India, thus making it one of the alcohol hotspots in the global market.

To highlight the role of alcohol in health and social problems in a country or community, a summary measure is the “pattern of drinking score” that reflects how people drink instead of how much they drink. It reflects the alcohol-attributable burden of disease in a country, on a scale from 1 (least risky drinking pattern) to 5 (most risky drinking pattern). The higher the score, the higher the alcohol-attributable burden of disease for the country. It is based on different aspects of “heavy drinking” occasions, drinking with meals, and drinking in public places. Currently, examples of the pattern of drinking scores in the Region are India 3 (medium risk) and Thailand 3 (medium risk).\(^5\) Among the youth, alcohol use usually begins as ‘experimentation’, often initiated in peer groups. Unlike smoking, drinking alcohol does not take place during the actual time spent at school. However, school friends usually form the first group in which alcohol consumption is initiated. It may also occur within the family, at social gatherings on special occasions such as birthdays or marriages, where alcohol is served.
Some young people move from experimentation to regular consumption and others to harmful consumption of alcohol. The first occasion of “getting drunk” is an event of similar importance to that of initiation into alcohol consumption. The attitude of some communities in which alcohol consumption, particularly among young males, is condoned and accepted as a sign of “growing up” encourages young people to drink alcohol.9 Parents’ drinking10 habits and the attitude of the family to alcohol strongly affect children’s pattern of alcohol consumption. A study from Thailand reported that if any one or both of the parents drank alcohol, the children were respectively 1.7 or 2 times more likely to drink alcohol, compared with families in which neither parent consumed alcohol.11

Availability, advertising and legal restrictions on the supply of alcohol are known to influence drinking habits among young people. Marketing, particularly to the young, plays a critical role in the globalization of patterns of alcohol use. Even in countries where alcohol advertisements are banned, surrogate advertisements abound and compete with the fierce advertising by the cola companies. An example of the success of alcohol industry promotions is the finding that a significant number (27%) of Sri Lankan men expressed favourable attitudes towards the alcohol industry.12 Given that aggressive marketing strategies are used by these industries to promote their products among young people, scientifically designed epidemiological studies of alcohol use are essential to formulate effective prevention strategies.

The pattern of drinking alcohol in rural areas is usually binge drinking centred around ‘pay-day’ or special occasions such as marriages and festivals or during political elections.

2.2.1 Average adult per capita consumption
The recorded average Adult Per Capita Consumption (APC) in the SEA Region remained stable during the 1960s and 1970s but started to increase at the beginning of the 1980s. WHO estimated in 2004 that the average APC was approximately
two litres of pure alcohol, with wide variation across countries, ranging from less than one litre in Indonesia to 8.47 litres in Thailand. In 2005, the average APC in the SEA Region was estimated at 2.2 litres of recorded consumption and 1.52 litres of unrecorded consumption. However, levels of recorded and unrecorded consumption vary between countries, examples of which are given in Table 1. After adjusting for unrecorded consumption (including illicit beverages, home brewed and tax-evaded products which can account for 45–50% of total consumption, the average APC would be higher. It is pertinent to note that average APC may give a different representation if one considers the pattern of the entire population or only of those who consume alcohol. In a population where the large majority abstain, the amount consumed by those who drink alcohol can reach very high levels.

2.2.2 Unrecorded alcohol consumption
Many countries of the Region have illustrated how the often quoted average APC figures do not give the true picture of alcohol consumption. This is mainly because, parallel to the more expensive industrially produced beverages, which usually constitute the recorded consumption, most countries have local and cheap beverages, either legal or illegal, that are not computed in national or international statistics. Alcohol brought into the country by citizens and tourists and that which is smuggled, also contribute substantially to the total quantity of alcohol available in a country but not part of the official data.

As a proportion of total consumption, unrecorded alcohol consumption is estimated at four times the recorded consumption in India and Myanmar, and over ten times in Nepal, as Table 1 shows. Therefore, the actual average APC would be much higher than what is reported in several countries of the Region.

2.2.3 Beverage types
Attitudes towards and practices regarding alcohol use are undergoing significant change in the SEA Region, particularly
over the last decade. The characteristics of adult alcohol consumption are similar in some ways across the Region. The type of beverage most often consumed is spirit. A noticeable trend is the appearance of wines and beer in the spectrum of alcohol use, especially during the late 1980s and early 1990s in some countries. This corresponds to the immense socio-political and economic changes that these countries are undergoing. Benegal observes that even though it constitutes less than 5% of total alcohol consumption, 70% of beer sales are dominated by strong beers at strengths over 8% alcohol by volume. In the SEA Region, rural households consume more local brews.

Table 1. Recorded and unrecorded average adult per capita alcohol consumption in countries of the South-East Asia Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Recorded average adult per capita consumption, 2003–2005*</th>
<th>Unrecorded adult per capita consumption, 2005*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhutan</td>
<td>0.22</td>
<td>0.33</td>
</tr>
<tr>
<td>India</td>
<td>0.55</td>
<td>2.04</td>
</tr>
<tr>
<td>Myanmar</td>
<td>0.11</td>
<td>0.46</td>
</tr>
<tr>
<td>Nepal</td>
<td>0.20</td>
<td>2.21</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>0.35</td>
<td>0.44</td>
</tr>
<tr>
<td>Thailand</td>
<td>6.37</td>
<td>0.71</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>0.36</td>
<td>0.50</td>
</tr>
</tbody>
</table>

* (15+ years; in litres of pure alcohol)

Adapted from WHO Global Status Report on Alcohol and Health 2011.
2.2.4 Illicit brews

As a result of the triple process of centuries of colonization, decades of industrialization and recent globalization, along with liberal liquor control policies in individual countries, the illicit brewing industry has also seen its highs and lows. Most often, clandestine cottage industry preparations are made in unhygienic environments and the additives to the deadly mix enhance the hazard. In Sri Lanka, the most common form of alcohol used in the villages is the illicit brew kasippu. The reasons given for its popularity among villagers are the low cost and easy availability.15

<table>
<thead>
<tr>
<th>Country</th>
<th>Local brew</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Bangla Mad, Cholai, Tari</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Ara</td>
</tr>
<tr>
<td>India</td>
<td>Tari, Tharra, Fenni, Toddy Chaang, Raksi, Mahua</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Palm Wine</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Tin Lei Phyu</td>
</tr>
<tr>
<td>Nepal</td>
<td>Raksi, Tadi, Chayang, Tomb</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Toddy, Arrack, Kasippu</td>
</tr>
<tr>
<td>Thailand</td>
<td>Oou, Krachae, Namtanmao, Sa-tho</td>
</tr>
</tbody>
</table>

Toddy is obtained from the flowers of the coconut or palm tree. A white liquid, with a sweetish taste, oozes out of these flowers. When consumed fresh, this juice has no intoxicating effect. This liquid is collected and allowed to ferment. At times, yeast is added to hasten the process. The fermented juice has an alcohol content of approximately 5–10%.

Source: World Health Organization14
2.2.5 Hazardous consumption

Hazardous consumption of alcohol is a common but harmful pattern of consumption in the Region. A survey in Sri Lanka as part of a WHO international collaborative study, showed that 10.2% of current male drinkers are frequent heavy drinkers and 20% are infrequent heavy drinkers, with the highest proportion of frequent heavy drinkers being in the 30–44 year age group. Frequent heavy drinking was reported by 21.8% male respondents in this age group in a similar survey conducted in India, much higher than in the younger (12.5%) and older (14.1%) age groups.17

Illicit alcohol consumption and mass tragedies

There have been many instances of poisoning and deaths following the consumption of adulterated liquor. People of lower socioeconomic status sometimes consume illicit or home-brewed alcohol because of its low cost, despite its known hazards. Mass casualties as an aftermath of consuming toxic brews are not infrequent. At least 90 Bangladeshis died in 1998, including 70 in Gaibandha, after consuming illegal home-brewed alcohol. In the following year, in an incident of alcohol poisoning in the north-eastern town of Narsingdi, about 50 miles from the capital Dhaka, 96 people reportedly died and more than 100 were hospitalized.2 In 2009, India witnessed the greatest number of deaths (143 reported deaths) consequent to consumption of spurious liquor in the state of Gujarat (a state under prohibition).3 Such tragedies devastate entire families who lose their productive members. Casualties due to methyl alcohol poisoning frequently occur in India.16

The Bangalore study conducted between March 2004 and January 2005 reported that 41% of alcohol-users in the study population in the four areas under review engaged in binge drinking, one third of whom reported the frequency of this type of drinking to be less than monthly18. Nearly a quarter of the study population report to be pathological alcohol users in the last 12 months, i.e. they have not been able to stop drinking once started. It was observed that, of those who indulged in binge drinking on a monthly basis, nearly 50% across the four areas are also pathological drinkers.
2.2.6 Alcohol use and presumed health benefits
There is some evidence, mainly from developed countries, that regular use of small amounts of alcohol is associated with a lower risk of Coronary Heart Disease (CHD). However, daily light drinkers are rare in developing countries. Overall, alcohol consumption is associated with multiple health risks that, at the population level, clearly outweigh potential benefits. Therefore, daily alcohol use is not, and cannot be recommended as a public health strategy for CHD protection. For most countries, the net effect of alcohol on CHD is negative, particularly in areas of lower mortality from CHD such as developing countries. A recent report documented the lack of cardioprotective effects in India.

In the SEA Region, some communities believe that the daily consumption of small quantities of alcohol is beneficial for certain common ailments. Such beliefs mistakenly tend to perpetuate or encourage alcohol use as a health-promoting strategy.

2.2.7 Women – alcohol use and impact
Traditionally, women, like men, have also consumed alcohol. Studies from India, Sri Lanka, Thailand, and China have reported a significantly lower prevalence of alcohol use of around 5% in women, which is the same across different societies. Contrary to popular belief, alcohol use is not confined to tribal women, women of low and high socioeconomic status, and commercial sex workers.

In the national survey conducted in Thailand in 2007, although there was a substantial difference in the numbers who consumed alcohol (54% men and 10% women), the proportion of those who consumed alcohol on a daily basis was exactly the same (9.9% men and 9.9% women). Kumar reported that “of the 500 youth going to pubs in Bangalore city during the weekends, about 100 were girls (13 to 19 years)”.

Notions of undesirable moral values and negative images of women who consume alcohol seem to be the key reason...
for underreporting and also for low consumption, but not exactly abstinence from alcohol. In recent years, there is an increasing trend of alcohol consumption among young women, especially in urban areas. Among the high-income group, the number of young girls and women who have taken to drinking alcohol is high. Changing roles in society (entry of women into traditionally male dominated areas), economic and social emancipation, greater acceptability of social drinking, easy availability of alcohol, peer pressure, glamour and disappearing stereotypes about femininity are some of the factors that seem to have contributed to the increasing trend of alcohol use among women – a trend closely watched by the alcohol industry but of growing concern to health researchers and health policy-makers.

**Mistaken belief in benefit from alcohol (India)**

Jayamma always suffered from colds and coughs. When he found that she was sick all the time, her father started giving her alcohol in small quantities. He drank alcohol regularly, and believed that a little was good for health. This became a habit for her: she would drink it every day. As she grew older and was of marriageable age, her mother asked her to give up the habit for fear it would be difficult to find a partner. She did, and later got married and was happy. But her husband would drink alcohol every day. During her first pregnancy she once again fell sick with a cold and cough. Her husband gave her a little alcohol to drink. Since then she has again got into the habit of drinking alcohol daily.

**Mistaken belief in benefit from alcohol (Sri Lanka)**

One very common comment was that people regarded alcohol as a kind of medicine. The school teacher in the village in Vavuniya district commented that people drink kasippu for any ailment or illness. They say that if you have a headache, drink some kasippu and sleep, you will be OK. Several informants mentioned that people drink to get rid of body aches after the day’s work. Relief from mental problems was also commonly mentioned as a reason for alcohol use.
Alcohol use and young urban woman (India)

Check this scene out. You are at a party and having a blast. You, of course, are a woman. You have gone to the party with a friend. It is an evening you have looked forward to, when you know you will be able to let your hair down and relax. No stress, no spill-over of your responsibilities. Just some good fun — interesting food, some dancing and great company ... and then the first drink ... then comes the next drink. You are a little hesitant, but what the heck, you had the first and nothing happened. You are a big girl; you can handle it. And so goes the next one. And the third. When a Screwdriver or a gin or a Peach Schnapps replaces the Bloody Mary, you do not notice the difference and frankly don’t care. You are simply having a blast. Next morning, you have a hangover the size of hell. You suck lime, you peer blearily at the world, tsk-tsk sympathies away, but inside there’s a happy smile. You have proved a point to yourself and your friends. Whoever thought you were a behenji with no sophistication had finally seen the real you. And wow, were they impressed!

“Young urban women have taken to alcohol as a way of knocking down social barriers and gaining acceptance among peers. Coming equipped with a strong academic, professional or family background is no longer enough. Alcohol has become the unisex leveller, an equalizer that promises instant entry amongst favoured circles. This is true of girls and women who have come from smaller towns to make a name and fortune in bigger cities.”

Source: Ray, S. Why women get addicted to alcohol. The Tribune, 21 April 2002, Chandigarh, India

Two divergent patterns of drinking are noticed among women — the traditional pattern and an emerging pattern. The traditional pattern is seen among less educated women from rural settings and poorer sections of urban society where drinking is marked by “bingeing” and drinking to intoxication, use of cheaper, high alcohol-containing beverages (spirits, illicit and country liquor) generally at home, usually alone. Although they drink less frequently, their pattern is nearer the rural male pattern of drinking. Drinking to enhance positive experiences appears to be less of a motivation.

The emerging pattern is seen among urban women — younger, educated, earning more, spending more, drinking less on typical drinking occasions, less frequently, for shorter durations, more likely to be unmarried, without children and drinking in more social circumstances such as at restaurants,
Urban women and alcohol use (India)

Swati has lived in a number of cities during her growing-up years. Four years back when Swati finally landed a dream job at a top advertising agency in Mumbai, she was jubilant. A fat pay packet, rented digs, an instantly enriched lifestyle, weekend parties, pubs, discos, and hip colleagues. The booze was only incidental. “One day it was fun, a hard but very satisfying job, great partying friends, a super boyfriend and a good life. Initially, when my colleagues spoke of their high-flying contacts or related their personal success stories, I felt totally inadequate. Though my boyfriend was very supportive, I could sense his impatience at times. The only times I could really relax were at these parties. I no longer felt out of place and could really mix around with the crowd.”

Sounds like a “rags to riches “ story in a liberal woman’s magazine? Well, today Swati is on a slow and painful road to recovery after a long and tiring battle with alcoholism. Back in her parent’s home in Gurgaon, near Delhi, Swati still shudders at the memories.


Women may experience different alcohol-related problems to men. Physical problems are experienced earlier in female drinkers than males. In the Gender, Alcohol and Culture: an International Study (GENACIS) paper from India, it was seen that women users suffered equivalent physical health consequences to males at lower quantities and frequencies, and these occurred after a shorter duration of drinking than in men. Studies across the globe have shown that because of biological differences women are more susceptible to liver damage from alcohol use. Alcohol drinking during pregnancy can cause many health problems for both mother and child. Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term describing the range of effects that can occur in an
Women may experience different alcohol-related problems to men. Physical problems are experienced earlier in female drinkers than males.

Individual whose mother drank alcohol during pregnancy. These effects include physical, mental, behavioural and/or learning disabilities with possible lifelong implications. The most severe form of FASD, fetal alcohol syndrome (FAS), is characterized by abnormal facial features, growth deficiencies, and problems in the central nervous system. Furthermore, no level of alcohol consumption during pregnancy has been shown to be safe. Alcohol consumption, as in males, constitutes for females yet another node in a matrix of risk.

2.2.8 Changing faces and emerging trends
Historically, the use of alcohol and its consequences have been a universal phenomenon. The massive economic changes and urbanization process in the last decade of the 20th century has thrown up new challenges. Alcohol consumption patterns have changed, with the emergence of harmful drinking. More young men and women, usually from the upper social strata, consider drinking alcohol a status symbol. The numerous and varied problems related to alcohol use are often an underestimated burden.

It is difficult to arrive at one single composite indicator of alcohol consumption patterns and effects in every society. The real and complete socioeconomic burden and costs due to alcohol consumption in the community have to be examined from diverse aspects using data from multiple sources, both in a quantitative and qualitative manner. This makes it even more challenging. Despite many shortcomings, various approaches have been tried in order to document the quantum of alcohol-related problems in a community and the costs on society due to these problems.

With the growing awareness of alcohol-related problems in the SEA Region and the limited understanding of the socioeconomic impact of alcohol use in emerging societies, formulating future strategies has been complex and difficult. To estimate the socioeconomic burden of alcohol-related problems, the WHO Regional Office for South-East Asia (SEARO) sponsored a feasibility study to examine this problem.
The burden due to alcohol consumption has to be assessed both quantitatively and qualitatively in communities. The study was conducted in Bangalore, India, among 28,507 individuals drawn from 7,912 households in 4 communities (rural, town, slum and urban). It was the first major attempt of its kind to document the effects of alcohol in transitional communities, both among users and non-users of alcohol. The study examined the problem from different perspectives such as impact on the family, and the social, educational, occupational, psychological, legal and emotional impact on individuals and their households. Both quantitative and qualitative approaches were used. An attempt was made to cost the impact in individual areas. Although the findings are broad-based and cross-sectional in nature, they provide an indication of the costs of alcohol consumption and its consequent economic impact, not just on the individual, but also society in general.

Changes in alcohol consumption patterns in the SEA Region during last decade

- Emergence of wine and beer drinking
- Increase in drinking among women
- Early experimentation and decreasing age of initiation
- Spread of consumption from urban to rural areas and transitional towns
- More binge drinking
- Greater acceptability of drinking as a social norm
- Alcohol use linked to high-risk sexual behaviour.

Changing faces of alcohol consumption

“Grab a drink to be ‘in’ has become the mantra with Bangalore’s youth! Taking a closer look at them, one is reminded of a free society, which decides its ‘flavour of the month’ and sets the trend. It is another matter that these youngsters are advocating a rise in alcoholism, or are at least giving legitimacy to easy consumption of alcohol.”

Source: Vijaya Times, 11 September 2005, Bangalore, India.
The objective of compiling and analysing community-based data on alcohol use was to document the current situation of use and harm from use and to use these data to design intervention strategies to reduce harm from alcohol use in communities of Member States. Data from India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand were available. Other relevant data are referenced.

A protocol was developed by the Mental Health and Substance Abuse Unit, SEARO for the assessment, which included a questionnaire, sampling frame and a format for reporting of findings. The questionnaire used to obtain these data is given in Annex 1 of the Alcohol Control Series No. 7 entitled “Programme on Reducing Harm from Alcohol in the Community”.

Myanmar and Sri Lanka implemented their programmes with a similar design. As per the objectives of the assessment in both countries, the questions and the sampling frame were designed to obtain specific information that would enable development of practical community-level interventions. For example, the survey was designed to obtain a broad picture of consumption and the outcomes of consumption. This eliminated the problem of calculating the amount of alcohol used from user recall (often unreliable) and trying to calculate the amount of alcohol contained in the various types of beverage used in local communities. Also, community-level interventions relevant to the context should aim to reduce harm from use and not to change the amount of alcohol consumed. Each question in the survey instrument was carefully selected based on the known consumption patterns in the Region.

In Myanmar the survey was carried out in Yangon Division, Southern Shan state and Mon state (Annex 4 of Alcohol Control Series No. 7). In Yangon Division, 2586 persons aged 15 years and above who had consumed at least one alcohol-containing beverage in the last three months were interviewed for the
Reduction of harm from alcohol use

In Sri Lanka, the survey was carried out in all nine provinces of the country (Annex 6 of Alcohol Control Series No. 7). A total sample of 1800 persons aged 15–64 years who had consumed at least one alcohol-containing beverage in the past three months were interviewed.

In Nepal, the WHO STEPwise approach to surveillance (STEPS) for chronic disease risk factors was used. This is a joint programme of the Noncommunicable Diseases unit of SEARO and the Ministry of Health and Population of the Government of Nepal. A total of 4328 persons between 15–64 years were interviewed. (Annex 5 of Alcohol Control Series No. 7)

National surveys on alcohol use have been conducted by the respective governments in India, Indonesia and Thailand. The method of data collection varied in each country. These data were reviewed and are included in the analysis for this programme.

India

The data of the National Family Health Survey 3 (NFHS-3) was reviewed. This survey was implemented by the International Institute for Population Sciences, Mumbai, and covered all 29 states of India. It was carried out in 2005–2006 and the report published in September 2007.40 A total sample of 198 754 persons in the age group 15–49 years were assessed (Annex 2 of Alcohol Control Series No. 7).

Consequent to increased production and distribution, the sales of alcohol has increased significantly in Indian society.3 (Annex 2 in this book)

Indonesia

Data published by the National Institute for Health Research and Development in its report “Basic Health Research 2007: National Report” were reviewed. This was a cross-sectional
3.4 Findings

3.4.1 Magnitude of alcohol use

The NFHS-3 survey in India reported that the national average of alcohol use was 31.9% for men and 2.2% for women. “Alcohol use” was defined as any use. The magnitude of use varied from state to state, the highest being in Arunachal Pradesh and the lowest in Gujarat.

In Indonesia, it is estimated that overall, about 4.6% of the population aged 10 years and older had consumed an alcohol-containing beverage in the previous 12 months. However, in some districts, the magnitude of alcohol use was much higher than the national average (Gorontalo 12.3%, Sulawesi Utara 17.4% and Nusa Tenggara Timur 17.7%). In the Nepal study sample, 37.3% of those interviewed (aged 15–64) had consumed an alcohol-containing beverage in the previous 12 months. In Thailand, it was estimated that 28.4% of persons aged 12–65 years had consumed an alcohol-containing beverage in the 12 months prior to the survey. In Myanmar and Sri Lanka, the study design did not permit an estimate of the magnitude of alcohol use in the entire country, but attempted to obtain information on harm from alcohol use. In another study of a nationally representative sample in Sri Lanka, 53.1% of men and 6.4% of women above 15 years of age were current alcohol users.
This information suggests a pattern of widespread use of alcohol in some communities in Member States of the SEA Region. The harm from alcohol use is described below.

3.4.2 Types of alcohol consumed

Information on the types of alcohol used in various communities is available from India, Myanmar, Nepal, Sri Lanka and Thailand.

In the Bangalore study in India, whisky (46.4%) was the most common type of alcohol consumed followed by “arrack” which is a type of spirit brewed locally (33.9%).

In Myanmar, the most common type of alcohol consumed was country liquor (45.4%-73.3%). Only a small proportion of respondents consumed home-made liquor (2–9%). Illegal alcohol was consumed by approximately 20% of all respondents in Southern Shan state – more by women than by men, but in much smaller proportions at the other two sites. Approximately 15% of alcohol users consumed beer in Southern Shan and Mon states, but less than 9% in Yangon Division. In all survey sites, western-type spirits such as whisky were only consumed by a small proportion of the respondents.

In Nepal, the overwhelming majority of alcohol users (75.7%) consumed home-made alcohol. It should be noted that a very small percentage (5.3%) consumed illegally produced alcohol. Beer was consumed more commonly in urban than rural areas (17.3% versus 4.4%) whereas home-made alcohol was used more commonly in rural areas (78.9% versus 61.7%).

In Sri Lanka, the types of alcohol consumed most often by respondents were legal country liquor (approximately 42%), beer (30%) and illegal country liquor (around 20%). Home-brewed alcohol was used by only 6.6% of respondents.

In Thailand, beer was the most popular alcoholic beverage consumed, followed by white spirits, whisky, medicinal alcohol, home-made alcohol and wine.
These data are important as they suggest possible intervention strategies. For example, commercially produced alcohol (beer and whisky) may be amenable to policies such as increased taxation and reduced availability, while home-brewed and illegally produced alcohol could be controlled through action by local communities where they are produced and sold.

It should also be noted that the proportion of people in the community using illegal alcohol varies substantially, and that it is not necessarily the most common type of alcohol used in the SEA Region. Therefore, interventions aimed at users of illegal alcohol should only be given preference in areas where its use is significant. This is important even at the national policy formulation level because the alcohol industry often argues (strongly and without supporting evidence) that restrictions should not be placed on legal alcohol until illegal alcohol is eliminated.

3.4.3 Frequency of alcohol use

In India, as per the NFHS-3 survey the percentage of men who drink alcohol every day by age group was as follows: 3.4% (15–19 years); 7% (20–34 years); and 13.2% (35–49 years). The corresponding percentages for women were much lower.41

In all three sites surveyed in Myanmar, the percentage of daily or almost daily users varied between 25% and 28% of respondents. Others consumed alcohol either on special occasions only or infrequently.

In Nepal, 26.1% users were daily or almost daily users while the rest consumed alcohol on special occasions only or infrequently. A high proportion of respondents who consumed alcohol daily or almost daily consumed home-made alcohol (31.4%).

In Sri Lanka, 12.8% of respondents were daily or almost daily alcohol users while the rest consumed alcohol on special occasions only or infrequently.

In Thailand, the proportion of drinkers who consume alcohol every day or almost every day (regular users) has increased
3.4.4 Age distribution and initiation into alcohol use

In India, the age distribution of alcohol use is reported as follows:
- Men: 15–19 years: 11%, 20–34 years: 34.9%, 35–49 years: 39.1%
- Women: 15–19 years: 1.0%, 20–34 years: 2.1%, 35–49 years: 3.2%.

In Indonesia, the highest prevalence of alcohol use was in the 25–34 year-old age group (6.7%), followed by the 15–24 year-old age group (5.5%).

In all the three sites surveyed in Myanmar, the majority of users were in the 26–50 year-old age group; prevalence of alcohol use ranged from 65% in Mon state to over 75% in Yangon Division. Interestingly, in Yangon Division the percentage of alcohol users in the 15–25 year age group was the lowest (12%).

A disturbing finding from India is that the age of initiation of alcohol use has declined from a mean of 28 years to 20 years between the birth cohorts of 1920–30 and 1980–90.

from 19.5% in 1996 to 27.1% in 2011, i.e. a 39% increase in 15 years.

Figure 2. Age of starting to drink alcohol in Karnataka, India

In Nepal, the use of alcohol was uniformly distributed across all age groups in both genders, except for young women, in whom the use was lower.

In Sri Lanka, a breakdown by age showed that 28%, 26% and 20% of all users were within the 25–34, 35–44 and 45–54 year age groups, respectively. When people drink alcohol with friends, most commonly they drink legal country liquor and beer, whereas when they drink alone, they most commonly drink illegal or legal country liquor.

In Sri Lanka, the age of initiation into alcohol use varied between geographical areas as well as within different population groups in a given geographical area. Overall, around 5% admitted starting to use alcohol before the age of 15, although this becomes 20% among internally displaced persons (IDP) in the Central Province. Overall, 61% of male users started using alcohol between the ages of 15 and 24 years.

In Myanmar the age of initiation into alcohol use was more or less equally distributed in all the three areas of survey. The overwhelming majority of users (around 70%) started using alcohol between 16 and 25 years of age, whereas less than 10% started use before the age of 15. In Nepal, the age of initiation into alcohol use was similar between genders and age span. However, up to 17% of men and 10% of women initiated alcohol use early in life, between the ages of 15 and 24, and 5% users initiated the habit before 15 years of age.

3.4.5 Alcohol use by young persons

In India, among the male users between the ages of 15-49 years, 19% were aged 15–19. In Indonesia, the highest prevalence of use was in the 25–34 year age group (6.7%), followed by the 15–24 year age group (5.5%). Although these proportions appear small, they are important because of the large population of the country where, unlike many other countries, younger age groups consume more than the older groups.
In the Southern Shan state of Myanmar, 18% of current male users were between 15 and 25 years of age. The figure was 17% in Mon state.

Data from Nepal showed that 30.1% of regular users were young (15–24 years old). As much as 43.3% of the respondents in the 45–54 year age group were regular users. Daily or almost daily use was much more common in rural versus urban areas (29.4% versus 11.7%).

In Sri Lanka, the study showed that around 9% of users were aged 15–24 years. In another report, published in 2004, the prevalence of alcohol use was 21.2% and 3.3% among men and women, respectively, in a survey of 455 students aged 15–19 years in a southern district.12

In Thailand, surveys of high-school students in classes 7, 9 and 11 in four provinces in southern Thailand found that the proportions of students who had consumed alcohol in the previous 30 days were 19.3% (2002), 17.3% (2003) and 15.2% (2004),45 respectively for the three classes.

The above data make it imperative that alcohol use among young people be addressed as a priority. However, factors that promote alcohol use in this age group should be carefully determined and addressed so that sustainable results can be achieved.

3.4.6 Geographic locations and different population groups

In all countries for which data are available, there were no significant differences in the proportion of users living in urban and rural areas. However, since rural populations are larger than urban populations, the absolute numbers of persons using alcohol in rural areas will be much larger. Also, since poverty is more common in rural and tribal areas, the harm from alcohol use in these areas will be greater.

Assumptions related to the various “subgroups” of populations more prone to alcohol use need to be carefully considered. It is
commonly believed that alcohol use is more frequent in rural and tribal areas and in communities such as the plantation sector in India and Sri Lanka. Some communities believe that alcohol consumption by boys is a sign of “growing up”. Although these assumptions on the prevalence of alcohol use in various groups and communities may be true in some cases, they should be based on evidence so that interventions are appropriate for the culture.

### 3.4.7 Use of alcohol on special occasions and on “pay day”

Use of alcohol on special occasions was reported by 23–33% of respondents in Myanmar and almost 14% of respondents in Nepal. In Sri Lanka, 37% of users admitted to consuming alcohol mainly on special occasions. This is a very important finding for interventions, and indicates the “alcoholization” of cultural and other special occasions. Infrequent users—those who drink less than once a week or those who drink alcohol only on special occasions—are an important group as they would be amenable to programmes to prevent their alcohol-use behaviours from progressing to daily or harmful use, such as binge drinking.

Consumption of alcohol by people who receive relatively large sums of money periodically is common in the SEA Region. This is because in many survey areas, individuals were not in formal employment. For example, farmers or fishermen earn money periodically (not daily). Around half the alcohol users in Myanmar indulged in “pay-day drinking”. In Nepal, those who indulged in pay-day drinking most commonly consumed home-made alcohol (72.1% of male respondents). In Sri Lanka, a quarter of all users reported drinking when paid.

Pay-day drinking is particularly deleterious as large parts of the earnings are squandered on alcohol. Workers may be robbed while drunk, often get into fights and are injured, and may be forced to take loans for essential needs, further contributing to poverty. It will also affect their family’s health status and the education of children.
3.4.8 Immediate effects of alcohol use

This section of the survey was designed as a proxy to estimate the amount of alcohol consumed on a given drinking occasion. In most countries of the Region, there are many types of alcoholic beverages with varying levels of alcohol content. Also, the receptacles used to consume alcohol vary in size and form. This makes it difficult to estimate the amount of alcohol consumed on any given occasion.46 Recall is also not accurate, and it is known that alcohol users usually underestimate their consumption. Further, more than one type of alcohol could be consumed in one drinking session.

Therefore, it was decided to use the effects felt after consumption as a measure of the quantity of consumption in the surveys conducted in Myanmar, Nepal and Sri Lanka. It should be noted that perceptions of effects are subjective and may be influenced by the surroundings and the context of use. However, it is safe to assume that when major effects such as drowsiness, vomiting and loss of consciousness are experienced, the quantity of alcohol consumed is large.

In Myanmar, major effects were reported by a small number of users, ranging from 1.5–6% in all three locations. In Nepal, 6.4% of all users admitted having major effects following use. In Sri Lanka, 5% of users said that they usually encountered major effects following alcohol use. Approximately 20% felt less severe effects and the rest had no effects or encountered only minor discomfort. Although overall, the number of those reporting major effects appears to be low, it was quite high in some of the subgroups surveyed. For example, in the agricultural population in Uva Province of Sri Lanka, it was 22%; in the resettled tsunami-affected population in the Southern Province, it was 12%; and among IDPs in the armed conflict area in the Northern Province, it was 10%.

In all three countries, a sizable proportion of individuals experiencing major effects from alcohol felt them during special occasions. For example, this was 15.8% in the Yangon Division of Myanmar, 24.5% in Southern Shan state and 22.9% in Mon State.
In Nepal, 16.4% of men who drank alcohol stated that they felt major effects on special occasions. Thus, alcohol use on special occasions is an area needing intervention on a priority basis.

In Thailand, the drinking intensity (average amount of alcohol consumed on the day of drinking) was high, at 88.91 grams per drinking day in men and 51.99 grams in women. These levels of intake could be considered as moderate- to high-risk levels for alcohol-related harm (more than 60 grams per day in men and more than 40 grams for women). Using these levels, 63% men and 61% women could be classified as having a moderate to high risk for alcohol-related harm. This rate was highest among youth in the 12–24 year age group.

3.4.9 Problems following alcohol use
Immediate and medium-term harm related to alcohol use was significant in all countries.

The Study in Bangalore, India, showed that a disproportionately greater number of alcohol users compared with non-users (7.8% versus 1.6%) suffered from intentional or unintentional injuries during the preceding 12 months. They also had problems at home and at work. In a study aimed at identifying alcohol-related road traffic injuries in 12 major hospitals in Bangalore city, it was found that nearly 28% of traffic injuries were directly attributable to alcohol. The roadside survey showed that the percentage of drivers under the influence of alcohol varied from 11% as detected by police testing drivers on suspicion to 40% by random checking. Among those who tested positive, 35% were above the legally permissible limit of 30mg/100ml.

In Myanmar, 20–40% of persons surveyed reported problems following alcohol use. Around 12–14% of users reported they were involved in fights and violence, while 5–13% reported being involved in accidents, including domestic accidents. These data suggest a burden of social and economic costs from alcohol use in the country.
In Thailand, it has been shown that alcohol is the most important factor in road traffic accidents.

The study in Sri Lanka also identified some problems linked to alcohol use. Of all users surveyed, 32% encountered problems at least once due to alcohol use during the previous three months. A majority of these (30.1% men) were involved in violent incidents following alcohol use. Nearly 25% of male alcohol users have had accidents after alcohol use. Of those who said they had problems associated with alcohol use, 28% mentioned problems other than those listed in the questionnaire. These were effects like marital problems, sexual problems, children having emotional and behavioural disorders, deliberate self-harm, and problems at the workplace such as being less productive and absenteeism. The distribution of self-reported harm also differed according to the population group and the geographical area. For example, in the Central Province plantation sector, 97% of those surveyed reported problems following alcohol consumption.

In Thailand, in a large prospective study covering on-scene, in-depth investigation and reconstruction of 969 collisions involving 1082 motorcycle riders, alcohol proved to be the most important causative factor. Alcohol-related accidents were more frequent on weekends and particularly at night. Drunk drivers were more likely to be involved in a single-vehicle accident, violate traffic control signals, and be in non-intersection collisions. They were more likely to be inattentive to the driving task just before they crashed, and to be the primary or sole cause of the accident. Drivers who had consumed alcohol were more likely to be hospitalized and far more likely to be killed. Also in Thailand, users within the age group of 12–24 years had higher rates of problems in social relationships, drinking-related fights, financial problems and problems related to work, study and employment than did people in older age groups. In a study of autopsies at Chiang Mai University, Thailand, the blood alcohol concentrations in accident deaths were very high, with 67 (81.7%) having blood alcohol concentrations of more than 50 mg, and only 15 (18.3%) with less than 50 mg. The authors concluded that alcohol was one of the most common factors linked with unnatural death in Thailand.
3.4.10  “Strong urge” to use alcohol, harmful pattern of use (binge drinking), addiction to alcohol (alcohol use disorders)

In India, the Household Survey on Drug and Alcohol published in 2004,\textsuperscript{50} based on data collected from March 2000 to November 2001, reported that 17-26% of alcohol users were dependent users. In terms of absolute numbers, this survey estimated that nationwide, there were 62.5 million “alcohol abusers” and 10.5 million “dependent users”. The Bangalore study in India found that 41% of the study population engaged in binge drinking, during which large quantities of alcohol were consumed. Such a drinking pattern can lead to alcohol poisoning and other serious medical and social problems, e.g. road traffic accidents.

The surveys in Myanmar, Nepal and Sri Lanka tried to estimate the number of persons with alcohol use disorders. As the objective was not to identify the exact number of persons based on clinical criteria, a question was included as to whether the respondent had a “strong urge” to use alcohol. This may be a crude indicator of the possible number of persons who are alcohol-dependent.

In Myanmar, the proportion of alcohol drinkers who admitted that they had a strong urge to consume alcohol ranged from 19% to 24% in the three sites surveyed.

In Nepal, 27.3\% of all users stated that they had a strong urge to use alcohol. When the data were analysed using the CAGE scale,\textsuperscript{51} 15\% of male users could be classified as “dependent users”.

In Sri Lanka, 21.3\% of users said that they had a strong urge to drink alcohol daily, although only 12.8\% actually imbibed alcohol daily. Among these persons, 45\% used illegal alcohol most often and 31\% used legal country liquor. There were wide variations in the results, even within specific population groups in a single geographical area. For example, in the North-Western Province, 9\% of users in rural areas and 34\% of users in the fisheries community in the same province reported a strong urge to use alcohol daily. In the IDP population in the Northern Province it was as high as 51\%.
In Thailand, the National Household Survey on Substance and Alcohol Use 2007 classified 2.793 million people (22.7%) as hazardous drinkers, 386,431 (3.1%) as harmful drinkers and 233,747 (1.9%) as alcohol-dependent, using the Alcohol Use Disorders Identification Test (AUDIT) criteria. The prevalence of alcohol use disorders was about three times higher in men than in women. The highest prevalence was in the age groups 25–44 years (32%) and 12–24 years (31%). Among women, the highest prevalence was in the age group 12–24 years (11.6%), and among them, 7,411 women could be classified as having severe alcohol use disorder or alcohol dependence. People in Bangkok had the highest prevalence of alcohol use disorders (38.4% in men and 10.7% in women), followed by people in the north (37.2% in men and 7.4% in women).

In conclusion, the data summarized above formed the basis for designing implementation strategies to reduce harm from alcohol use in the community through community action.
4. Harm From Alcohol Use In The South-East Asia Region

Alcohol-related harm is unrelated to addiction status. It is related to pattern of drinking.

The effects of alcohol use by an individual are widespread and noticeable in all spheres (physical, psychological, social and economical) of his or her life. Since every person is part of a family, these effects impact on other family members as well. Further, the collective and long-term effects are felt by all sectors of the immediate society, particularly by the health sector. Several non-health sectors like the law, judiciary, police, welfare and transport also experience the impact of alcohol use in a significant way.

4.1 Morbidity and mortality

Alcohol consumption and problems related to alcohol vary widely around the world, but alcohol-related morbidity and mortality remain significant in most countries. Alcohol use results in approximately 2.5 million deaths each year, more than deaths caused by HIV/AIDS, violence or tuberculosis. Alcohol is a causal factor in more than 60 major types of disease and injuries and a component cause in 200 others. Indeed, approximately 4.5% of the global burden of disease and injury is attributable to alcohol use. Alcohol consumption is the world’s third largest risk factor for disease and disability, and associated with many serious social issues, including violence, child neglect and abuse, and absenteeism at the workplace.

The impact of harm from alcohol use

Findings from a study of alcohol-dependent persons in Bangalore, India
- Individuals spent more on alcohol than they earned
- Most people took loans to support their habit
- An average 12.2 working days per year were lost
- 18.1% lost their jobs in one year
- 59.4% of families were supported by income from other family members
- 9.7% sent children under 15 years of age to work to supplement family income.

Source: Benegal and Velayudan (2000).
In Thailand, alcohol consumption is the second most significant health risk factor, with 8.1% of overall disability adjusted life years (DALYs) in 2004.\textsuperscript{53}

In the Bangalore study, the overall impact of alcohol consumption has been measured by comparing users and non-users with respect to eight components: health, injury and its effects (both unintentional and intentional including abuse of spouse, children, and siblings), social, occupational, economic, emotional and psychological, legal and help-seeking areas. In addition, every reported event was qualified by further enquiries to link its occurrence to alcohol use in self or in others. Thus the study not only focused on obtaining the frequency of occurrence of alcohol-related events, but also on the attributable proportion of this particular event to alcohol use. Table 3 shows that numerous facets of an individual’s life are affected by the use of alcohol, although the proportion of each facet varies.
### Table 3. Psychosocial harm from alcohol use: the Bangalore study

Frequency of health or related events among users and reported proportion attributed to alcohol

<table>
<thead>
<tr>
<th>Event</th>
<th>Occurrence of event among users (%)</th>
<th>Event attributable to alcohol use in self (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health problems</td>
<td>33</td>
<td>40</td>
</tr>
<tr>
<td>Unintentional injury</td>
<td>8</td>
<td>38</td>
</tr>
<tr>
<td><strong>INTENTIONAL INJURY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0.3</td>
<td>33</td>
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<tr>
<td>Shoving, grabbing, pushing</td>
<td>42</td>
<td>93</td>
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<tr>
<td>Hitting/threatening injury</td>
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<td>48</td>
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<tr>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td><strong>ABUSE</strong></td>
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<tr>
<td>Mild-moderate spouse abuse</td>
<td>76</td>
<td>82</td>
</tr>
<tr>
<td>Moderate-severe spouse abuse</td>
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<td>Severe spouse abuse</td>
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<tr>
<td>Parent abuse</td>
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<td>83</td>
</tr>
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<td>66</td>
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<td>Friend/neighbour abuse</td>
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<tr>
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<td>44</td>
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<tr>
<td>Got abused</td>
<td>23</td>
<td>39</td>
</tr>
<tr>
<td>Got beaten</td>
<td>0.3</td>
<td>55</td>
</tr>
<tr>
<td><strong>SOCIAL ISSUES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stayed away from home</td>
<td>21</td>
<td>77</td>
</tr>
<tr>
<td>Ran away from home</td>
<td>1</td>
<td>83</td>
</tr>
<tr>
<td>Family members felt bad</td>
<td>52</td>
<td>99</td>
</tr>
<tr>
<td>Others felt bad</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td><strong>OCCUPATIONAL ISSUES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to be on time</td>
<td>25</td>
<td>84</td>
</tr>
<tr>
<td>Missed going to school or work</td>
<td>34</td>
<td>72</td>
</tr>
<tr>
<td>Decreasing ability to work</td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td>Disciplinary action taken</td>
<td>1</td>
<td>94</td>
</tr>
<tr>
<td>Losing pay</td>
<td>17</td>
<td>74</td>
</tr>
<tr>
<td>Borrowing money</td>
<td>37</td>
<td>34</td>
</tr>
<tr>
<td>Losing a job</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td>General household economy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always difficult</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>Sometimes difficult</td>
<td>79</td>
<td>53</td>
</tr>
<tr>
<td><strong>Psychological</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all happy</td>
<td>8</td>
<td>48</td>
</tr>
<tr>
<td>Not enjoying normal day-to-day work</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Constantly under stress/strain</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Lost sleep</td>
<td>30</td>
<td>53</td>
</tr>
<tr>
<td>Sad for unnecessary things</td>
<td>14</td>
<td>59</td>
</tr>
<tr>
<td>Not able to take day-to-day decisions</td>
<td>12</td>
<td>67</td>
</tr>
<tr>
<td>Difficulty in sex</td>
<td>23</td>
<td>89</td>
</tr>
<tr>
<td><strong>LEGAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police complaint</td>
<td>1</td>
<td>47</td>
</tr>
<tr>
<td>Paid penalty</td>
<td>0.4</td>
<td>71</td>
</tr>
<tr>
<td>Stayed in police station</td>
<td>0.3</td>
<td>82</td>
</tr>
</tbody>
</table>

Events in bold text are reported to be linked to alcohol use by more than 50% of users. Due to multiple positive events reported by the same individual, event-specific responses have to be analysed.
4.3 Economic harm

Alcohol imposes a high economic cost on society. Monetizing the economic impact of alcohol use should include both direct and indirect costs and tangible and intangible costs. Direct costs include medical costs – acute, long-term and lost earnings due to death and disability. Indirect costs include loss of work, school time and savings, loans taken, cost to the employer/society, low self esteem, social costs of postponed events and lost productivity, vehicle and property damage and legal costs. The calculation of the monetary impact of these elements depends on the availability of nationally representative data from different sources like hospitals, the transport department, the police department, legal services, repair and insurance costs. It is difficult to put a precise monetary value on the intangible costs of alcohol use like death, pain, suffering and bereavement, just as it is difficult to estimate the monetary value in efforts to reduce this pain and suffering.

The National Sample Survey Office (NSSO) of India conducts nationwide household consumer expenditure surveys at regular intervals. These surveys are conducted through interviews of a representative sample of households selected randomly to cover the entire geographical area of the country. The 66th round survey (July 2009 to June 2010) collected information from 100,794 households in 74,28 villages and 5,263 urban blocks spread over the entire country. Among sample households, over a month period 14% of rural households and 7.7% of urban households reported consuming alcohol in the past month. The percentage of average monthly expenditure per person on alcohol for rural and urban areas was 0.7% and 0.5% respectively.

In Thailand, alcohol consumption was shown to be linked to poverty at individual and collective levels. Thai households with alcohol drinker(s) spent 6–8% of total income on alcohol. In addition, expenses of Thai household on alcohol increased more than the increase in total income. Drinkers from lower socioeconomic strata, generally consumed alcohol in more harmful ways, and, have more difficulties dealing with alcohol-related harms. The total social cost of alcohol-related problems...
in Thailand in 2006 was estimated to be 1.5 trillion Baht, equivalent to 1.97% of GDP. This is around two times higher than the state revenue generated from alcohol production in the same year.

The Bangalore study in India, also attempted to estimate the expenses related to alcohol use (Table 4) compared to the revenue collected by the Government from sale of alcohol.

<table>
<thead>
<tr>
<th>SI No</th>
<th>Particulars</th>
<th>Frequency b</th>
<th>Total amount (per year in Rs)</th>
<th>Average amount per person (per year in Rs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. HEALTH-RELATED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Physical problem</td>
<td>327</td>
<td>394,770</td>
<td>1,207</td>
</tr>
<tr>
<td>2</td>
<td>Unintentional injury</td>
<td>194</td>
<td>147,608</td>
<td>761</td>
</tr>
<tr>
<td>3</td>
<td>Intentional injury ¹</td>
<td>64</td>
<td>19,355</td>
<td>302</td>
</tr>
<tr>
<td>4</td>
<td>Psychological aspects</td>
<td>4</td>
<td>735</td>
<td>184</td>
</tr>
<tr>
<td>B. WORK-RELATED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Loss of pay due to absence from work</td>
<td>395</td>
<td>102,485</td>
<td>260</td>
</tr>
<tr>
<td>6</td>
<td>Borrowed money at workplace</td>
<td>411</td>
<td>65,205</td>
<td>159</td>
</tr>
<tr>
<td>C. SOCIAL ASPECTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Debts</td>
<td>1,195</td>
<td>1,820,060</td>
<td>1,508</td>
</tr>
<tr>
<td>8</td>
<td>Pawned goods/ articles</td>
<td>383</td>
<td>3,710,150</td>
<td>9,664</td>
</tr>
<tr>
<td>9</td>
<td>Lost money</td>
<td>34</td>
<td>26,720</td>
<td>79</td>
</tr>
<tr>
<td>10</td>
<td>Gambling</td>
<td>56</td>
<td>205,150</td>
<td>3,663</td>
</tr>
<tr>
<td>11</td>
<td>Damage to property</td>
<td>31</td>
<td>14,700</td>
<td>474</td>
</tr>
<tr>
<td>D. AMOUNT SPENT ON DRINKING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Only to purchase alcohol</td>
<td>3,256³</td>
<td>12,487,210</td>
<td>3,835</td>
</tr>
<tr>
<td>13</td>
<td>Costs per event of drinking⁴</td>
<td>3,256³</td>
<td>15,100,572</td>
<td>4,637</td>
</tr>
<tr>
<td>E. TOTAL OUT OF POCKET EXPENSE INCURRED BY ALCOHOL-USERS IN THE STUDY SAMPLE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cost of consequence of alcohol use (A + B + C)</td>
<td>1,665</td>
<td>6,506,938</td>
<td>3,908</td>
<td></td>
</tr>
<tr>
<td>Total cost of the drinking event (D)</td>
<td>32,56³</td>
<td>15,100,572</td>
<td>4,638</td>
<td></td>
</tr>
<tr>
<td>Total of A + B + C + D⁵</td>
<td>3,256³</td>
<td>21,607,510</td>
<td>6,626⁶</td>
<td></td>
</tr>
</tbody>
</table>

a  Mean values have been considered for calculation purposes and occasional extreme costs spent by one or very few individuals have been excluded.
b  Frequency is the number of respondents who reported the consequence and also attributed the occurrence of the event to the use of alcohol in either self or others.
1  Includes attempted suicide, spousal injury, parental abuse, workplace injury, sibling abuse, friend abuse, child abuse, experienced violence (because of small numbers these have been clubbed together).
2  Cost categories of not being able to be on time, decreased ability to work, expenses for being under the influence of alcohol while at work did not have any representation.
3  The individuals with extreme costs have been excluded from computation.
4  Includes the money spent on refreshments and travel, etc.
5  The total expense has been computed by adding the individual costs and finding the mean for the entire study user population of 3256.

Source: Bangalore study.¹⁸
It is estimated that the Indian Government spends nearly Rs 244 billion (US $ 5.23 billion US$ 1 = 46.61 Rs, January 2001) every year to manage the consequences of alcohol use, which is more than its total earning from excise duties Rs 216 billion (US $ 4.63 billion). If all costs are comprehensively examined and calculated for all events, the economic impact would be much higher than the conservative estimates noted above. In the final analysis, the Indian society is losing more than it is reportedly gaining.
5. Reducing Harm From Alcohol Use

5.1 Initiatives of the WHO South-East Asia Region

SEARO activities focus around six broad areas:
1) Advocacy with governments
2) Intercountry workshops
3) Support for development of alcohol policy
4) Support for community action to reduce harm from alcohol use
5) Development of advocacy documents
6) Technical support to Member States on implementation of the draft Global Strategy to Reduce Harmful Use of Alcohol.

1) Advocacy with governments
To address and create awareness of the critical need to reduce harm from alcohol use, SEARO has been active in advocacy at the highest level of government. Discussions led to the following high-level actions:
• Resolution approved in the Fifty-fourth session of the Regional Committee, Yangon, Myanmar, 3–6 September 2001 (SEA/RC54/R2).
• Resolution approved in the Fifty–ninth Session of the Regional Committee, held in Dhaka from 22–25 August 2006 (SEA/RC59/R8)
• Follow-up discussions at the Sixty-first session (New Delhi, September 2008) and the Sixty-second session (Kathmandu, September 2009) of the Regional Committee.

2) Intercountry workshops
SEARO has hosted several intercountry workshops to discuss the issue of harm from alcohol in the community and how this can be taken forward by Member States, as follows:
• Symposium on Reducing Harm from Alcohol Use in the Community, Bali, Indonesia, 4–6 October 2007.
• Possibility of Developing a Framework Convention on Control of Harm from Alcohol Use, Intercountry Consultation, SEARO, New Delhi, 5–6 January 2009.
• Intercountry workshop to discuss the draft Global Strategy to Reduce Harmful Use of Alcohol, Nonthaburi, Thailand 24–26 February 2009.
• Community Action to Reduce Harm from Alcohol Use – Meeting of Experts, Bangkok, Thailand, 22–23 April 2009.
• Mobilize the Global Alcohol Strategy in Regional Context, Global Alcohol Policy Conference, Nonthaburi, Thailand, 13–15 February 2012.

In these workshops, experts from Member States discussed issues of relevance to their countries, and through exchange of ideas with other experts from the Region, developed and adapted solutions to suit local needs and cultures.

3) Support for development of alcohol policy
Two Member States in the Region (Sri Lanka and Thailand) have developed and implemented alcohol control measures. SEARO received a request from Bhutan to provide technical assistance for development of an alcohol control policy. A team of Thai experts went to Bhutan in July 2011 and developed recommendations for the National Strategic Framework for Reducing Harmful Use of Alcohol. As and when other requests are received, SEARO will respond appropriately.

4) Support for community action to reduce harm from alcohol use
The Regional Office has initiated a programme to acquire and synthesize information relevant to developing and implementing interventions on the use and harm from alcohol use through community action in six Member States (India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand). Community-based surveys were conducted in Myanmar, Nepal and Sri Lanka by country experts with technical support from SEARO. Data from India, Indonesia and Thailand were obtained from national surveys conducted in these countries.

Within the Region, different contexts and circumstances of alcohol use exist in countries as well as within different population groups in countries. Thus, information on alcohol use and harm from use in different locations and population
groups was obtained. Information collected related to the types of alcohol, frequency and contexts of use, age of initiation, quantity of use and social and other problems related to use.

Development and implementation of pilot interventions have commenced in five sites in India (Uttar Pradesh, Assam, Madhya Pradesh, Chhattisgarh and Karnataka), two sites in Sri Lanka (Galle and Matara districts) and two sites in Thailand (Pattananicom district and Songkia). Each site will design its own community action programme based on the factors identified, the cultural background and the requirements of the community.

5) Development of advocacy documents
SEARO, in consultation with experts within the Region, has developed many information materials that create awareness in the community and among policy-makers to document the harm from alcohol and what can be done to reduce such harm. These include:

• Burden and Socio-economic Impact of Alcohol – The Bangalore Study (Alcohol Control Series -1)
• Public Health Problems Caused by Harmful Use of Alcohol – Gaining Less or Losing More? (Alcohol Control Series -2)
• Alcohol Control Policies in the South-East Asia Region – Selected Issues (Alcohol Control Series -3)
• Alcohol Use and Abuse – What You Should Know (Alcohol Control Series -4)
• Reducing Harm from Use of Alcohol – Community Responses (Alcohol Control Series -5)
• Current Information on Use and Harm from Alcohol in the WHO South-East Asia Region (Alcohol Control Series -6)
• Programme on Reducing Harm from Alcohol Use in the Community (Alcohol Control Series -7)
• Facts on Alcohol Use and Abuse – Programme on Adolescent Mental Health
Strategies to Address Alcohol Problems (Author Diyanath Samarasinghe, Sri Lanka)
Interactive Audiovisual on Alcohol Use and Abuse.

6) Technical support to Member States on implementation of the Global Strategy to Reduce Harmful Use of Alcohol
The Sixty-third session of the World Health Assembly in 2010 reached an historical consensus on a global strategy to reduce the harmful use of alcohol by adopting resolution WHA63.13. This resolution and endorsed strategy give guidance to Member States on ways to reduce the harmful use of alcohol. SEARO is providing technical assistance as requested by Member States in the Region to implement components of this strategy. Other related resolutions to reduce the harmful use of alcohol are SEA/RC59/R8 (2006), WHA58.26 (2005) and WHA61.4 (2008).

5.2 Policies for control of alcohol use: global and national

There is a wide range of alcohol control policy options. It is evident from research that measures are available that can significantly reduce alcohol-related problems and the resulting harm. However, there is clearly no single policy measure that is able to combat and reduce all alcohol-related problems. Rather, it is more effective to incorporate a range of measures in a comprehensive alcohol control strategy. It is the policy “mix” or finding the right balance that is the key in reducing the overall public health burden of alcohol consumption.

The goal of a comprehensive, effective and sustainable alcohol control policy can only be attained by ensuring the active and committed involvement of all relevant stakeholders. Alcohol control strategies need a high degree of public awareness and support in order to be implemented successfully. Without sufficient popular support, the enforcement and maintenance of any restriction is jeopardized, and resistance and circumvention are likely to develop. Multiple agencies – for example, ministries of industry, revenue, agriculture, customs department, transport, law enforcement departments, medical associations and nongovernmental organizations – should lobby for a clear formulation and effective implementation of a rational, integrated and comprehensive alcohol control policy.
5.2.1 Global policies

- **Global strategy**

The Global Strategy to Reduce the Harmful Use of Alcohol was endorsed by the Sixty-third World Health Assembly in May 2010 (Resolution WHA63.13). The consensus reached on the global strategy is the outcome of close collaboration between WHO Member States and the WHO Secretariat. The process that led to the development of the global strategy included consultations with stakeholders such as nongovernmental organizations and economic operators. The global strategy and resolution WHA63.13 build on several WHO global and regional strategic initiatives and represents the commitment by WHO Member States to sustained action at all levels.

The strategy contains a set of principles that should guide the development and implementation of policies at all levels. It sets priority areas for global action and recommends target areas for: national action; leadership, awareness and commitment; health services’ response; community action; drink-driving policies and counter-measures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance.

Successful implementation of the strategy requires concerted action by countries, effective global governance and appropriate engagement of all relevant stakeholders. To this end, WHO will promote the integration of strategies to reduce the harmful use of alcohol and work on global development and in related investment decisions.

- **Global Information System on Alcohol and Health**

The Global Information System on Alcohol and Health (GISAH) is a user-friendly and comprehensive Internet-based platform to display information on alcohol and health, with regional interfaces, including the South-East Asia Regional Information System on Alcohol and Health. It provides a reference source of information for global epidemiological
surveillance of alcohol consumption, alcohol-related harm and alcohol policies. The data in GISAH contain indicators to assess the alcohol situation in WHO Member States as they relate to public health. They are arranged in categories, as follows: levels of consumption; patterns of consumption; harms and consequences; economic aspects; alcohol control policies; and resources for prevention, research and treatment. The GISAH is the portal to the Global Alcohol Database (GAD) which WHO has been building since 1997 through the compilation of information from published and grey literature, government documents, national statistics, national and global surveys, the industry, intergovernmental organizations, and data collection through the WHO Global Survey on Alcohol and Health. Currently, GISAH encompasses more than 200 alcohol-related indicators in 225 countries and territories. Over time, indicators will be updated, improved and new ones added.

5.2.2 Policies in Member States of the SEA Region

Bhutan

1. Parliamentary action

Bhutan is recognized as the country of Gross National Happiness (GNH) around the world. However, the abundant availability of alcohol is not in line with the philosophy of GNH. Thus the parliament approved the petition “Restriction on alcohol” on the fifth day of the fourth month of the iron female rabbit year corresponding to 6 June 2011. The salient features of this policy (see also Section 5.4) are:

• Reducing the number of alcohol manufacturing industries and new establishments/industries.
• Reviewing existing regulations and formulating harmonized rules across the country.
• Reducing the import of alcohol.
• Increasing tax and bar licence fees.
• Decentralizing authority to local government for stringent rules regarding issuance of licences and strict monitoring at the community level.
• The relevant ministries, religious bodies and media working together to educate and raise awareness on the ill-effects of alcohol.

In Bhutan the petition “Restriction on alcohol” has been approved by the parliament in June 2011
2. National level action
A draft national policy and strategic framework to reduce the harmful use of alcohol in Bhutan has been developed with the technical assistance of a WHO consultant working closely with national experts. The final draft is being prepared by a core group of Bhutanese experts consisting of key stakeholders. The salient features of the policy are:

- “Harm minimization”, a term used to refer to policies and programmes aimed at reducing alcohol-related harm for individuals and communities.
- Public policy and interventions to prevent and reduce alcohol-related harm are guided and formulated by public health interests and clearly set goals based on best available evidence.
- Policies are equitable and sensitive to national, religious and cultural contexts.
- All involved stakeholders are responsible for acting in ways that do not undermine the implementation of policy and interventions to prevent and reduce harmful use of alcohol.
- Protection of populations at high risk of alcohol-attributable harm and those exposed to the effects of harmful drinking by others are an integral part of policies addressing the harmful use of alcohol.
- Individuals and families affected by the harmful use of alcohol have access to affordable and effective prevention and care services.
- Children, teenagers and adults who choose not to drink alcoholic beverages have the right to be supported in their non-drinking behaviour and protected from pressures to drink.
- Policy and interventions to prevent and reduce alcohol-related harm encompass all alcoholic beverages and surrogate alcohol.
- Balanced approach that adopts concurrent supply reduction, demand reduction and harm reduction strategies with emphasis on integrating alcohol related law enforcement and crime prevention into all health and other strategies aimed at reducing alcohol related harm.
An evidenced-based practice where all supply reduction, demand reduction and harm reduction strategies are formulated on scientific evidence following rigorous research and evaluation, including assessment of the cost-effectiveness of interventions.

3. Dzongkhag-level (district) action
- All gewogs (blocks) should implement the strategies of reducing harmful use of alcohol.
- The bar owners in all gewogs should strictly follow existing rules and regulations issued by the Department of Trade and Industry for sale of alcohol, such as separation of the alcohol sales section from general merchandise in shops and hours of sale.
- The Regional Trade Office should support implementation of activities related to reducing harmful use of alcohol.

Penalties for violating the gewog policies
- If anyone is found selling alcohol outside the official regulations, Geog will issue a warning.
- If anyone is found illegally selling alcohol a second time, the committee members will cut off the rural water supply system and electricity and public services for the offender.
- If anyone repeats the offence for a third time the Geog administration will hand over the person to the Dzongkhag Authority.

4. Community-level actions
The community identifies specific harms from alcohol use and develops their own unique solutions to reduce them.

In India a National Policy on Prevention of Alcoholism and Substance Abuse and Rehabilitation is being developed

India
Article 47 of the Constitution of India directs the state to move to ban “intoxicating drugs injurious to health”. Some states have sustained prohibition for a long time (e.g. Gujarat, Manipur, Mizoram and Nagaland) while others have moved back and forth (Andra Pradesh, Haryana). The National Health Policy (2002) does not mention control of alcohol/drug use and no single national policy for alcohol/drug treatment exists.
Currently a draft National Policy on Prevention of Alcoholism and Substance Abuse and Rehabilitation is being developed under the auspices of the Ministry of Social Justice and Empowerment of the Government of India.

**Sri Lanka**

Sri Lanka has been active in alcohol control. The government has implemented a comprehensive package of legislation and administrative measures with the aim of reducing per capita consumption of alcohol, in order to minimize alcohol-related harms. This legislation totally bans all forms of direct and indirect advertising and promotion of alcohol products, including all sponsorships by the alcohol industry. Sale of alcohol to persons below the age of 21 is prohibited and sale through vending machines is banned. All alcohol sale points require licensing. Free distribution of alcohol products is prohibited. Alcohol sale is not permitted on many religious holidays. Consumption of alcohol openly in public places is not permitted. There are severe penalties for drunk driving. The major agencies entrusted with this work are the National Authority on Tobacco and Alcohol, Department of Excise, the Police and the Ministry of Health.

Many of the above measures were included in the National Authority on Tobacco and Alcohol Act in 2006. It is an independent multisectoral government agency operating under the Ministry of Health. However, it is governed by a Board that consists of members from many sectors relevant to alcohol control. These are high-ranking members from the government ministries and agencies such as education, excise, police, justice, media, trade and commerce and sports. This agency has the responsibility of implementing the legislative measures of the above Act as well as carrying out other measures to reduce harm from alcohol in Sri Lanka. Some examples are media and health promotion work, policy and other research, advising on taxation, evaluation of policy implementation, collating information on health, economic and other harm from alcohol use and liaison with the non-government sector on alcohol control.
In addition to the government response, there is a vibrant non-government sector that carries out initiatives to reduce harm from alcohol at community level. These activities are carried out independently, and more often as joint activities with government agencies and personnel working at grass-roots level.

Thailand

Thailand has a continuous effort of addressing alcohol-related problems, in particular the development of the Alcohol Beverage Control Act B.E. 2551 (2008) which provided the structure for alcohol problem prevention and control at national and provincial levels. This Act contains the regulations on marketing, physical availability of alcohol and drinking venues. Another major law in Thailand, the Liquor Act B.E. 2493 (1950) contains regulation on taxation and outlet licences. Compared with other countries, Thailand has many alcohol policy interventions, with an increasing recognition among the general population of harm from alcohol. Major limitations are, however, the strength of policy content and consistency of implementation. Considering the situation of alcohol consumption and consequences in Thailand, therefore, the Thai alcohol policy is far from effective.

The Thai Health Promotion Foundation (ThaiHealth) is a statutory public organization working within the government. Uniquely, it receives a dedicated budget through a direct and specific process—an earmarked 2% of tobacco and alcohol excise taxes. Established by the Health Promotion Foundation Act BE 2544 (2001), ThaiHealth was designed to provide financial support for health promotion activities, particularly in areas hard to reach by conventional bureaucratic systems. Since alcohol consumption is a major health risk factor, ThaiHealth developed its Alcohol Consumption Control Programme with the primary purpose of reducing consumption and harm. ThaiHealth has supported many initiatives aimed to tackle alcohol-related harms in Thai society, at both national and local levels.
5.3 
Priority areas for action to reduce harm from alcohol use

5.3.1 Interventions for young people
Traditionally, many prevention programmes have targeted this age group. However, the approach to prevent “harm from alcohol use” by emphasizing the risks may be inappropriate or even counterproductive, as it actually increases the attractiveness of alcohol as “dangerous but desirable”.

Prevention of alcohol use
Interventions should address all young people, irrespective of whether they drink alcohol or not. Factors that promote alcohol use in this age group should be carefully determined and addressed.

Most users in this age group are infrequent users and many drink alcohol only on special occasions. Therefore, traditional approaches that address more regular alcohol users need to be modified accordingly. Carefully tailored interventions are needed that specifically target this age group.

One of the most popular interventions in this age group has been school-based programmes. Such programmes are popular with programme planners, teachers, parents and policy-makers for a variety of reasons. But when evaluations of such programmes are carried out, many of them are shown to be ineffective, or even counter-productive. Therefore, before designing and implementing school-based programmes, careful consideration should be given to improving their effectiveness and efficiency.

Another popular approach is media-based interventions to counter alcohol industry propaganda. Both alcohol use and users are often glamorized and promoted in the media. Therefore, the approach to counter it, initially seemed sensible. But, unless careful consideration is given to the content, frequency of the message and other factors, the impact of such interventions could be mediocre at best, and counterproductive at worst.
Successful intervention programmes to reduce harm from alcohol use among young people in Sri Lanka

The success and sustainability of activities aimed at young people depend on involving this group in community action. For example, in communities in the north-western and the eastern provinces of Sri Lanka, groups of young people are active in designing and implementing interventions to prevent use of alcohol in their respective communities. These communities have low rates of initiation and consumption, according to observational surveys and focus group discussion studies. These young persons are aware of the factors that make alcohol use attractive and are also motivated to empower others to address these factors.

Any activity designed for this age group should be interesting and informative, and appeal to their intellect. In particular, community and school interventions that have an effective and sustained impact are those that:

• demonstrate how alcohol and its use are made attractive through formal and informal means, promotions, social contexts and beliefs;
• empower young persons to understand how they are being specifically targeted through the media to initiate and continue use of alcohol;
• encourage youth to sensitize and empower others in the same age group; and
• motivate youth to devise and engage in appropriate activities to minimize the impact of alcohol use, contexts, promotions and media portrayals.

5.3.2 Addressing the context of alcohol use: special occasions

In SEARO-sponsored surveys, it was seen that special occasions are the most important social context that promotes the use of alcohol, by young people specifically and all users in general. This is also the most important context of heavy alcohol consumption.
In the SEA Region, there are many “special” social occasions ranging from births, weddings, funerals and social and cultural festivals such as the New Year and harvesting occasions, religious festivals and other events (e.g. sporting events). When alcohol becomes or is made to become a central theme at these events, alcohol use, initiation and heavy use become the norm. These occasions can also be a showcase for alcohol use by increasing its attractiveness and associating it with fun, and normalizing its use for younger age groups in particular. The alcohol industry discretely uses such occasions to promote and glamorize alcohol use.

Addressing the alcoholization of social, religious and other events in society is best achieved through community action. Interventions designed and implemented locally and relevant to the locations and population groups are more likely to succeed in this regard than centralized interventions such as media campaigns.

### 5.3.3 “Pay-day” use of alcohol

A large number of current alcohol users consume alcohol on “pay-day” (see also Section 3.4.7). There are several possible...

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**A successful intervention programme for reducing harm from alcohol use during special occasions in Thailand**

A community in northern Thailand decided that alcohol use during funerals led to a lot of antisocial behaviour. Community leaders felt that serving alcohol during a funeral was seen as a longstanding tradition, and not serving alcohol may be interpreted by the community as a sign of disrespect for the departed soul. Thus, the community decided that as a general policy, in future, serving alcohol during funerals would be prohibited. This ban was successfully implemented as it was a policy developed and implemented by the community, not by an individual. Antisocial behaviour during funerals disappeared and funerals were observed with sanctity.

*Source: Programme on Reducing Harm from Alcohol Use in the Community. Alcohol Control Series No. 7. World Health Organization Regional Office for South-East Asia, 2009*
methods of intervening to reduce such use at the community and individual levels.

One possibility is directly depositing the pay in a bank. This may not be practical or feasible in many areas in the Region such as rural and remote areas. Another way may be to hand over the pay to the abstinent spouse or child of the payee. Other practical and acceptable methods of addressing this issue should be developed in consultation with communities, as the range and context of pay-day use of alcohol has to be taken into account when designing interventions. For example, in an urban area, office workers may indulge in such use following receipt of the monthly pay. In rural areas this phenomenon may be observed after harvesting. As the contexts are entirely different, the same intervention will not work in any two locations.

5.3.4 Addressing social harm following alcohol use: antisocial behaviour, violence and road traffic accidents

Violence, antisocial behaviour and accidents following alcohol use are common and need to be addressed on a priority basis. Many interventions have been initiated globally to address

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**Successful intervention programmes to reduce harm from pay-day use of alcohol in Sri Lanka**

Pay-day use of alcohol is common in many plantation communities in Sri Lanka. Such use has been significantly reduced in communities in the Central and Sabaragamuwa Provinces. This has been the result of several parallel interventions in these communities including discussions and efforts to make users aware of the actual amount of money spent on pay day; pressure from wives and children on users; and minimizing sales points, preventing easy access to alcohol on pay day. Interventions were also successful in reducing antisocial behaviour on pay day, such as violence and injuries, which were common in these communities.

*Source: Programme on Reducing Harm from Alcohol Use in the Community. Alcohol Control Series No. 7. World Health*
this issue. They range from law enforcement programmes, “server training” in bars, media campaigns to initiatives aimed at modifying social norms that promote antisocial behaviour following alcohol use. The last approach has been effective in the SEA Region. This approach is based on reducing and eliminating unfair social privileges attached to alcohol use. It addresses the behaviour of groups and individuals who intentionally use prevailing social norms and privileges (such as being excused from gender-based violence or behaving irrationally) accorded to alcohol users, to indulge in antisocial behaviour. Participatory approaches with entire communities have shown success.

In many parts of the Region, there is a widespread belief that following the consumption of alcohol, users are not in control of their behaviour and are not fully aware of their surroundings, social commitments and etiquette. Although there is scientific evidence that consuming a large amount of alcohol will impair the coordination and judgement needed for skilled activities such as driving, there is no evidence supporting the belief that alcohol makes its users unaware of their social behaviour.

Encouraging outcomes have been shown in interventions carried out in Sri Lanka to address the social norms related to alcohol use that promote violence, including domestic violence and antisocial behaviour. These interventions aim at changing social acceptance of such behaviour and encouraging communities to respond to such behaviour differently, thereby leading to a reduction in antisocial behaviour. A cautious application of such interventions with appropriate adjustments in other settings should be attempted.
There are many examples of successful interventions to reduce alcohol-related road traffic injuries. Research has shown that many factors influence the success of such programmes. Effective counter-measures include:

1. setting the legal blood alcohol concentration (BAC) at an appropriate level and, if possible, lowering the legal BAC level;
2. having an active surveillance system for drunk driving;
3. swift and high probability of punishment(s) including licence suspension; and
4. measures for high-risk groups, such as setting a specific, lower legal BAC among new and young drivers and commercial drivers (“zero tolerance”).
It is well established that excessive BAC causes unconsciousness. But at such high levels, neuro-muscular coordination is so impaired that it is hardly possible for people in such a condition to indulge in violence or targeted antisocial behaviour. In fact, what social and anthropological research have shown that in different cultures, users of alcohol behave very differently after consuming it. Some people turn quiet and pensive, and others antisocial. The behaviour is mostly governed by the social and cultural norms that apply to the setting and the situation rather than any chemical effect of alcohol itself.

### 5.3.5 Illicit (unrecorded) alcohol

The use of illicit (unrecorded) alcohol seems to be common in some communities. The problem related to obtaining accurate information regarding illegal alcohol is its illegality and lack of social acceptance. Even among regular alcohol users, those

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**Successful intervention programme on preventing alcohol-related road traffic accidents in India**

“Suraksha sanchar” (safer travel) was launched in Bangalore in 1999 with the active participation of the Bangalore Agenda Task Force, the Bangalore City Police, the National Institute of Mental Health and Neurosciences, the Global Road Safety Programme, nongovernmental organizations and citizens of Bangalore. “Reduction of drinking and driving” is the first major programme under this project. A roadside survey revealed that the proportion of drivers under the influence of alcohol varied from 11% as detected by the older methodology (police testing drivers selectively on suspicion) to 40% as detected by the newer methodology of random checking. Among individuals who tested positive, 35% were above the legally permissible limit of 30 mg/100 ml when checked on a breath analyser.

The second phase of the project to be implemented next year will use the information generated from these surveys to inform the public about the health, social, enforcement and legal aspects of drinking through the media and focused work.

*Source: Programme on Reducing Harm from Alcohol Use in the Community. Alcohol Control Series No. 7. World Health Organization Regional Office for South-East Asia, 2009*
who use illegal alcohol are viewed unfavourably. As a result, it is likely that some users falsely deny using illegal alcohol and also intentionally underreport its use. Despite this, it seems that the amount of illegal alcohol in use is far below the estimates provided by the alcohol industry with the aim of moderating effective control policies that may reduce legal alcohol consumption. Using its “health” argument, the alcohol industry purports that their “unhealthy product” is better than an even more “unhealthy product” (illicit liquor). Therefore, a significant finding of national surveys is that caution should be exercised when national policies and community interventions

Successful intervention programmes to reduce harm from illicit alcohol and reduce its availability in India and Sri Lanka

Several initiatives to address the availability of alcohol in villages have been spearheaded by women in India. There are several examples from Kerala, Madhya Pradesh, Haryana and Andhra Pradesh where agitations, protests and other campaigns by women significantly reduced the number of alcohol selling points. Some campaigns have even led to changes in local policy. For example, the protests in Dubagunta village, Andhra Pradesh, and in Monody village in Kerala, resulted in control of the illicit liquor trade. Although the sustainability of such programmes may be limited, this illustrates that community action can have a significant effect on implementation of alcohol policies. There have also been many cases of community action to reduce the sale of illicit alcohol in the North-Central Province in Sri Lanka. External facilitators, who were trained government community workers, initiated these activities within the communities, after which communities took ownership and continued the programme. The interventions ranged from community members cordially discussing the issue with those who produce and sell alcohol in the villages to “naming and shaming”, imposition of social sanctions and cooperation with enforcement agencies. In many villages, all such sales points were closed. It was seen that if the community became active, the local enforcement agencies and politicians could not ignore the issue. The outcomes were maintained while the social pressure was in place. In many cases the producers and sellers, who were perhaps the more enterprising groups in villages, moved into other, legal businesses. These initiatives dispelled the widely held belief that the issue of illegal alcohol could only be addressed through enforcement.

Source: Programme on Reducing Harm from Alcohol Use in the Community. Alcohol Control Series No. 7. World Health Organization Regional Office for South-East Asia, 2009
are developed. Programmes should be developed and implemented if illegal (unrecorded) alcohol use is widespread and a major cause of harm to the community.

5.3.6 Services for frequent users and referral services

Medical and social services and interventions for daily or almost daily users should concentrate on specific geographic areas and population groups that have a high number of such users. Assessments have shown that the numbers and percentages of such users vary widely even within the same geographical area. For example, in Myanmar, such users were concentrated only in urban locations of two of the three main geographic areas surveyed. Therefore, if services and interventions are provided in inappropriate places, the effort and resources will not be optimally used.
A successful intervention programme for harmful users of alcohol in India

Community-centred rehabilitation of alcohol users has been implemented successfully in southern India. This approach was pioneered by the T.T. Ranganathan Clinical Research Foundation’s “TTK Hospital” in Chennai, a nongovernmental organization. It involves both the community and service providers conducting community-based camps for those in need of services. The alcohol-dependent persons living in one specific area are identified using multiple sources, including teachers, doctors, health workers, clergymen, relatives, community leaders and recovering alcohol users. Next, the client and the family are motivated to attend the treatment camp, where medical support and other necessary services are made available. Typically, a client spends 15 days in such a camp. Family members and local communities also spend time in the camps. Monthly follow-ups are carried out. Awareness programmes are also conducted in the community. This approach has shown that quality care can be provided at low cost with minimal infrastructure. As help is available at their doorstep, people are willing to accept it. Here, the therapy and treatment procedures are made relevant even to illiterate villagers, and hence are appealing. As the entire community gets involved in the process, the incidence of problem drinking decreases over time.

Source: Programme on Reducing Harm from Alcohol Use in the Community. Alcohol Control Series No.7. World Health Organization Regional Office for South-East Asia, 2009.

The National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi, India.

Clinical Care: The NDDTC at AIIMS serves as a treatment and referral centre for persons with alcohol use disorders. This care is provided in three settings: community clinic, outpatient and inpatient departments. In addition to NDDTC, which serves mainly north India, the Ministry of Health supports four other regional resource centres with active intervention programmes. There are also multiple centres in various states of India, as well as rehabilitation centres funded by the Ministry of Social Justice and Empowerment of the Government of India.

Capacity building of doctors: The NDDTC trains doctors working in district/civil hospitals on management of substance
use disorders (with focus on alcohol). It is expected that in a span of four years, about 500 doctors in the country (i.e. about 1 doctor each from the 500 district hospitals of the county) will be trained in providing basic clinical care to people suffering from substance/alcohol use disorders.

Enhancing community-based care at the district level:
• Training of doctors on management of substance use disorders
• Training of nurses and paramedical staff on early identification and management of substance use disorders
• Sensitizing and equipping district stakeholders so that service provision can begin using the existing health-care infrastructure.

Addressing the problem of alcohol use at workplace settings: The Indian Oil Refinery in Digboi, Assam, has a sizable alcohol use problem among employees as well as others living in the township. The NDDTC has been assisting the hospital operated by the refinery management in: setting up a substance use treatment unit; training doctors; and training paramedical staff.

Using e-health for providing care for problem of alcohol use: This is a multi-country project (Belarus, Brazil, India and Mexico) funded by WHO headquarters, Geneva. Under this project a web portal is being developed (alcoholwebindia.in) that will provide information and data to various types of audiences: the general public, professionals, policy-makers and, most importantly, alcohol users themselves. The highlight of the portal will be an online assessment and intervention module, thus obviating the need to visit a health professional.

Promoting screening and brief interventions: The NDDTC has been actively involved in promoting the use of screening and the “Brief Intervention” technique. The centre is one of the sites that have adapted the WHO Alcohol Use Disorder Identification Test (AUDIT) and the WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Recently, Alcoholwebindia.in is a web portal which provides information to reduce harm from alcohol use
the Centre conducted a training of trainers programme on using ASSIST and the Brief Intervention technique. More training programmes are proposed.

Network of De-addiction Services: The feasibility of building a referral network and system in the treatment for alcohol and drug abuse by strengthening, collaboration and integration of a network of organizations working in the three sectors (government, non-governmental and private sector) has been carried out. Treatment seeker profile in all the three sectors showed that alcohol as the most commonly used substance. Monitoring of treatment seekers for a period of three months showed that 63.1% in government; 83.3% in nongovernment and 83.0 in private sector had sought treatment for alcohol use.67

Community-based projects to reduce harm from alcohol should take the “whole population approach” to ensure that users other than heavy users, as well as non-users, are brought under the purview of the interventions. All levels of user have different roles to play in addressing alcohol-related harm in the communities. It is considered that projecting alcohol as a common risk factor for noncommunicable diseases will cast a wider net, and make it easier to talk about in communities; as a medical problem it will be less stigmatizing. In addition, de-glamorizing the use and users of alcohol could be a potent approach to curb the harmful use of alcohol at the community level. The success of community interventions depends on community ownership in developing and implementing activities, and thus community concerns should be taken into account when initiating community behaviour change interventions.

India
A community-based programme for prevention and management of substance use was carried out on the request of a thermal power plant as part of its Corporate Social Responsibility initiative. The organization used has adopted a cluster of villages that voiced and shared concern about the drug/alcohol use related problems in the community. Two
villages with a reportedly high prevalence of alcohol use and problems associated with the use/abuse were identified. The programme implemented by the NDDTC carried out awareness campaigns through street plays, the distribution of information material and stake holder meetings with community members, women and youth groups.

**Bhutan**

Alcohol is a leading cause of morbidity and mortality in Bhutan. It is also the leading cause of domestic violence, divorce and road traffic accidents. Approximately 20% of food grains in the country are used to brew alcohol, sometimes leading to shortage of food in homes.

In Bhutan, alcohol has been widely used since time immemorial. But its consumption is thought to have increased significantly in recent times. It is served during social, religious and traditional functions in the country. Home brewed alcohol is an important beverage in rural Bhutan. Both sexes, including children, drink alcohol though men are heavier drinkers.

Two types of alcohol are produced in the country: home-brewed and industrial varieties. The production of home-brewed alcohol is restricted to domestic and religious use, although it is thought that this constitutes a major source of alcohol use in Bhutan. There has been a significant increase in the availability of the industrial variety in recent years due to increased local production and import from other countries.

**Pilot project**

A pilot project was implemented in Mongar and Lhuentse dzongkhags (districts), which lie in the eastern part of Bhutan. In Mongar dzongkhag, the project was implemented in three gewogs (blocks): Chaskhar, Ngatsang and Shermuung. In Lhuentse dzongkhag it was implemented in two gewogs: Jarey and Metsho.

The project was carried out over one year from March 2011, and was evaluated in March 2012.
The objectives of the project were:
• to reduce alcohol-related deaths, sickness and injuries by the end of the project;
• to reduce alcohol-related violence;
• to improve the economic conditions of people by reducing avenues of brewing alcohol and its use in the community;
• to help in the self-realization on the part of alcohol users about the harmful effects of excessive alcohol use; and
• to provide detoxification treatment and rehabilitation for all chronic drinkers in a gewog.

Mongar and Lhuentse dzongkhags were selected for the pilot study because people in the eastern part of Bhutan drink more than in other parts of the country; alcohol is consumed daily and has become a part of their food in the eastern culture. According to the Bhutan Health Ministry Information System (BHMIS) report 2011, the morbidity figures due to alcohol in Mongar and Lhuentse dzongkhags were 138 and 8 respectively, and for mortality they were 20 and 1 respectively, both being higher than other dzongkhags. In addition, most grains are used for brewing alcohol. People indulge in drinking and cannot work to earn adequate income for the family. Thus the level of poverty in the dzongkhags is high. Alcohol consumption and its related problems were reported by the community leaders in the two dzongkhags, and the dzongkhag and gewog administrations realized the harm from alcohol and were fully committed to take action to reduce the harmful use of alcohol.

**Methods of implementation**

• **Clearance from the government**
  The Ministry of Health, Royal Government of Bhutan recommended that the pilot programme be implemented in Mongar and Lhuentse dzongkhags.
• **Focus group discussion in the community**
  Meetings were held with community members in each of the five gewogs where pilot projects were to be conducted. The community members accepted the fact that alcohol use causes significant harm. They also identified specific types of harm from alcohol use, as well as unique solutions to reduce such harm.
• **Development of facilitators’ guide**
  The mental health programme of SEARO developed a facilitator’s guide for training community members on reducing harm from alcohol use with the technical support of a psychiatrist and medical officers from the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), Thinpu, a lecturer from the Royal Institute of Health Sciences (RIHS) and other senior health workers. The main contents of the guide book are:
  1. Basic facts on alcohol
  2. How, when and why people start drinking alcohol
  3. Myths and facts about the benefits of alcohol drinking
  4. Effect of high-risk drinking at individual level
  5. Alcohol control regulation of Bhutan
  6. Prevention of alcohol-related harms
  7. Alcohol harm-reduction strategies in the community
  8. Monthly reporting format.

  The guide was distributed to health workers of the basic health units at pilot project sites.

• **Training of community leaders**
  Before starting the community action, health workers conducted a training session for the community members in their respective gewogs using the facilitator’s guide.

**Activities implemented**

• Awareness on harm from alcohol use raised for the public, schools, civil servants, religious groups, voluntary health workers and non-formal education (NFE) learners in the gewog.

• Core groups formed at gewog and chiwog level (this group led the community-based programme to reduce harm from alcohol use).

• Trade rules on operating procedures to all bar owners.

• Consultation held with the public, religious groups and bar owners in the gewog to discuss the replacement of alcohol with alternative offerings (tea, milk and eggs, etc.) during farm works, baby shower and religious ceremonies.
• Rules and regulations formulated by the community with details of commitments on reducing the use of alcohol.
• Penalties for defaulters agreed upon.
• Monthly review meetings held among core group members. After a year, evaluation of the project revealed that community initiatives to reduce harm from alcohol use had been successful (Figure 3).

Figure 3. Selected outcomes of the pilot project to reduce harm from alcohol use

The subjective outcomes reported by community and village leaders (gups and tshogpas) were as follows:
• In general there was a drastic reduction in alcohol consumption and improvement in terms of livelihood.
• People could now pay their electricity bills regularly.
• People could work and produce vegetables, and thus earn more.
• People were able to concentrate on the main aspects of ceremonies, e.g. funerals and annual religious ceremonies, rather than on alcohol.
• As more food grains became available, people did not have to ask neighbours for food.
• More time was available to work and complete the work on time.
• Visitors such as civil servants coming on home leave were more aware of the district policy and did not bring or demand alcohol.
• Alcohol was completely forbidden during funerals as per the orders of the Lama and Dzongda.
• At the recently held dzongkhag assembly, the other gewogs also committed themselves to replicate similar community action in reducing harm from alcohol use.

Key factors to success
Commitment, support and hard work were central to the success of the project. The government (District Governor and local government), the District Health Officer and primary health workers, school teachers, as well as WHO supported the project contributing to its success.

Challenges faced
It is difficult to generalize the project’s findings since it was not implemented in the whole dzongkhag. A major challenge was that alcohol use has been rooted in the culture and traditions of the community for generations. Local people have strong beliefs in the myths about the benefits of drinking alcohol. Breaking these beliefs and convincing people that alcohol use is a root cause of suffering was also a challenge. Local people were not well informed about the Bhutan Alcohol Act 1995, which is why drinking age limits were not known, leading to early exposure to drinking alcohol in the community. It was also difficult to convince chronic alcoholics to quit alcohol. Pressure to use alcohol from seniors and guests from other dzongkhags (family members who are visiting) needed to be overcome.

Impediments included the absence of an authorization letter from the Trade Ministry to take action against shops that violate the trade rules, and the fact that the programme did not target traditional healers and religious leaders. In addition, the momentum in implementing the pilot study was disturbed due
to local government elections. Finally, budgetary constraints were a limiting factor.

Lessons learnt
Although it is difficult to overcome religious reluctance owing to the local culture and tradition of using alcohol, most people stopped drinking alcohol after the project, and changes were noticed in the behaviour of visitors and guests. The following additional lessons were learnt:

• Include religious groups during project implementation.
• Train health workers on the adverse effects of alcohol.
• Ensure stronger support from the dzongkhag authority.
• Implement the project in all gewogs.
• Include past alcoholics in the core committee as this proved helpful in convincing others.
• Project activities can be replicated to other dzongkhag.

Recommendations
• The pilot project on community initiatives to reduce harmful use of alcohol was successful in two pilot districts, and should therefore be replicated in the remaining gewogs in the dzongkhag and then to whole of the country in a phased manner.
• The pilot project districts are advised to continue project activities with the available resources and initiatives within the communities themselves until some financial assistance is formally provided through the national strategic framework on reducing harm from alcohol use.
• The possibility of diverting 5% of the total revenue generated from the alcohol sales tax for health promotion should be explored.
• The Mental Health Programme should provide appropriate information, education and communication (IEC) materials and audiovisual equipment to the local community at the earliest.
• Relevant authorities should put in place measures to reduce access to alcohol through limited annual quota system to bars and restaurants and take measures to limit alcohol imports.
• Success stories should be formally presented at national and international forums to give political and financial support for scaling-up the project.

Conclusion
The pilot project was successfully implemented and has had a positive impact. It is through such pilot projects that community empowerment can be effective to bring about changes in attitude, behaviour and practice. Such changes will enable people to make healthy choices. Also such approaches and best practices can be replicated to other gewogs and dzongkhags in the future.

Sri Lanka
A community-based programme to reduce harm from alcohol use was conducted in three selected locations of Thelikada village. The specific objectives of the programme were:
• to empower communities to understand and quantify the harm from alcohol use specific to their community;
• to motivate communities to address the harm from alcohol use through community action;
• to identify specific determinants to be addressed to reduce the harm from alcohol use; and
• to build capacity within communities to effectively address the determinants that promote alcohol use.

Baseline information
Among the 1005 families living in the village, 585 are “Samurdhi” beneficiaries, the National Programme introduced by the Government of Sri Lanka in 1994 to alleviate poverty. Some villagers are employed in the government sector and others are self-employed farmers and labourers. The number of unemployed youth is 350.

Large number of governmental and nongovernmental organizations and societies are active in the village such as “Samurdhi” Society, Farmers’ Society, Village Development Society, “SANASA” Society, Sports Club, Youth Club, Children’s Club, Health Society and Adults’ Society.
Villagers mentioned that their major problems were basic facilities (32 families do not have a permanent residence, 40 have no sanitary facilities, 77 lack basic infrastructure). They also noted the need for better transportation facilities, and proper road and irrigation facilities for farming and library services. Some said they wanted to reduce alcohol-related problems.

Members of 565 families seem to be drinking alcohol in the village, and most males above the age of 16 are consuming alcohol. The young people and adults use drugs at the ferries.

The basic flow of the project concept

- Entry to the community and conduct survey
- Motivate the community members and make them understand the changes that can take place
- Develop interventions jointly with the community and initiate community action
- Sustain the interest of the community to continue action
- Evaluate the project periodically by the community
- Modify approaches according to the evaluation findings in consultation with the community
Topics for focus group discussion
Community members were sensitized to critical issues related to alcohol use, particularly to deal with: (i) the attractiveness of alcohol use; (ii) unfair privileges attached to alcohol use; (iii) understanding the real harm from alcohol use; (iv) alcoholization of social and cultural events; (v) the image of a user and non-user, and (vi) how to formulate and implement village-level policies.

Impact evaluation
• Existing organizations and structures integrated alcohol prevention into their main agenda items and collective efforts were started.
• Married women achieved positive response from their husbands to reduce the consumption of alcohol.
• Factors that increase the attractiveness of alcohol use were addressed by the community:
  • media and other promotions
  • antisocial behaviour including violence
  • “pay-day” use
  • use of alcohol on special occasions.
• Serving of alcohol at weddings was completely stopped.

Challenges
Entry into the community with the agreement of the majority was the first challenge. Other issues encountered were: the ability to address issues of concern to the community; reaching consensus between anti- and pro-alcohol groups; integrating alcohol prevention measures into every activity of civil society; and promoting multisectoral collaboration (health, economy, community development, sports, art and culture).

Thailand
A programme to reduce harm from alcohol use was conducted in two villages in Pattana Nikom district, Lop-Buri Province, Thailand. This province has a high rate of alcohol use. There are 522 households in Lop-Buri, of which 116 volunteered to take part in the study, whose family members included current consumers of alcohol.
A baseline data survey and three meetings in the community were conducted. The Abbot, community leaders, District Officer and his staff, General Hospital Director and community health personnel and villagers participated. Money boxes were distributed, in which the money saved from reducing or abstaining from alcohol use was deposited. These families were also given a form to record the amount of money deposited. Those who saved the most were given prizes by the District Officer. A total saving of about 60 000 bahts were made over six months. At the end of the intervention period it was found that harm from alcohol use such as accidents, quarrelling and fighting in the family, and economic problems had reduced among hazardous as well as low-risk drinkers.

The success of this pilot project was due to the participation of community leaders. The participation of other sectors such as the district hospital that provided medical services and monthly check-ups to the villagers during the intervention period also contributed to the success.

**Challenges**

Short duration of the project and the participants’ work schedules made it difficult to arrange the group meetings and provide individual advice to participants.
Impact indicators

- Amount of money saved per month by the households participating in the project.
- Reduced number of accidents, quarrelling and fighting in the families.

Another ongoing project in Thailand to reduce harm from alcohol uses the strategy of integrated social marketing, with multi components, community involvement and media support about making religious or cultural festivals and events alcohol-free, e.g. the Buddhist Lent which is celebrated from mid July to mid October. The first campaign was launched in 2003 and still continues every year. Strategic messages are broadcast through public media ("air war" approach) and educational and persuasion activities conducted at ground level ("ground war" approach). The success of these programmes has led to declaring the first day of each Lent period as the “National No Alcohol Day” since 2008. The organizers of the programme
have also started to conduct similar “alcohol free” campaigns during other cultural and community events (alcohol-free boat racing) and promote the alcohol control policy at the local and national levels.

Successful projects in Thailand to reduce harm from alcohol have used the strategy of integrated social marketing campaign, with multiple component, community-involvement and media support to make religious or cultural festivals or events alcohol free. The Alcohol Free Buddhist Lent Period Campaign celebrated from mid-July to mid-October was first launched in 2003 and still exists today. The campaign aims to promote the abstaining or reduction of alcohol use during the Lent period by advocating through broadcasting of strategic messages through public media (“air war approach”) and conducting educational and persuasion activities at ground level (“ground war approach”). The success of these programmes has led to declaring the first day of each Lent period as the “National No Alcohol Day” since 2008. Similar alcohol free campaigns are being attempted in other cultural and community activities such as Alcohol Free Boat Racing.

**Impact indicators**
- Among alcohol users, 30.9% stopped and 22.3% reduced intake of alcohol for the entire duration of the three-month Lent period.
- A substantial amount of money was saved by the family (4711 bahts for those who stopped using alcohol and 3076 bahts for those who reduced alcohol use).
- The alcohol market shrunk nationally.

**Recommendations**
The projects conducted in Thailand highlight the following factors as being responsible for the success of programmes on reducing harm from alcohol use:

- The community members should be made aware of their important role in addressing local alcohol-related problems.
• Support is needed from the community in making cultural events alcohol-free.

• Support is needed for establishing an alcohol use policy at local level and for enhanced national alcohol policy enforcement.

• Lessons learnt on addressing alcohol-related problems at local level should be synthesized and disseminated, and knowledge-sharing among localities and institutions promoted.
6. CONCLUSION

Countries of the South-East Asia Region, which until recently had low levels of alcohol consumption, are now moving towards high levels of alcohol use. The impact of a global cultural mix seems to have accelerated this movement. It is well established that an increase in alcohol consumption by a community or a nation leads to a higher proportion of persons with problem use (abuse/harmful use) and addiction (dependence), which is a public health issue.

The harmful use of alcohol has a significantly adverse impact on the lives of affected persons, their families and communities, most notably in the social, economic and health domains. The substantial social impact and burden on the nation calls for a focus on prevention of harm from alcohol use, from the perspectives of both health promotion as well as social development.

Recognition of the consequences of alcohol use on physical and mental health, as well as on social life, is a necessary step for initiating appropriate action. The facts and figures available from countries of the Region, although not exhaustive or complete, provide an adequate basis for such recognition.

The strategies that have been shown to reduce harm from alcohol use are:

- Early identification of harm from alcohol use, not only in health settings but also in the social sector, through further studies pertaining to different aspects of possible impact of alcohol consumption on public health;
- Sensitization and mobilization of the community and legislative representatives on evidence-based strategies and interventions to reduce alcohol-related harm; and
- Development and implementation of effective policies and interventions to address public health problems caused by harmful use of alcohol.

Although some research has been initiated, more active and vigorous research on the epidemiological trends, consequences of alcohol use, related sociocultural mechanisms and effective
treatment and prevention strategies, needs to be carried out. This will generate information that can be useful for the countries and the Region. At the same time, there is a need to understand and modify some of the myths related to alcohol use.

Alcohol use must be recognized as having significant potential to adversely impact on health and development. The global history of measures for alcohol control and the scientific evidence points to the need for pragmatic solutions rather than extreme positions like total prohibition. A public health approach that takes into account the trends of alcohol use is likely to be more effective.
The Regional Committee,
Recalling World Health Assembly resolutions WHA32.40; WHA36.12, WHA42.20, WHA55.10, WHA57.10, WHA57.16, WHA58.26 and its own resolutions SEA/RC54/R2 on public health problems caused by alcohol use,

Recognizing that the adult per capita alcohol consumption in the South-East Asia Region has almost doubled in the last decade and that the patterns, context and overall level of alcohol consumption has a negative impact on health and cause serious social and economic consequences to the population, especially the poor,

Appreciating the continued efforts of Member States in adopting and implementing comprehensive national alcohol control policies and effective strategies for reducing public health problems caused by alcohol use,

Having considered the document SEA/RC59/15 which highlights various policy options to reduce public health problems caused by alcohol use, through concerted efforts by the government, public agencies, civil society and the private sector having no conflict of interest,

Noting the consequences of certain trade agreements that facilitate the free flow of and investment in alcohol, which boosts the consumption and negative impact of alcohol in the Region, and

Noting the unique characteristics of regional/national alcohol consumption and related problems e.g. linkage of alcohol to poverty, payday drinking, indigenous alcoholic beverages, which require context-specific policy and interventions,

1. ENDORSES the document Alcohol Consumption Control - Policy Options in South-East Asia Region (SEA/RC59/15) along the lines and amendments made by Members, to help reduce public health problems caused by alcohol use as a minimum framework for alcohol control policy and providing strategic guidance to Member States;
2. **URGES Member States**:  
   (a) to establish/strengthen institutional capacity, through multi-sectoral partnership, in order to generate information on consumption of alcohol and related problems based on socioeconomic strata, alcohol marketing strategies, commercial aspects and revenue generated from alcohol, to be used for policy, planning, monitoring and evaluation;  
   (b) to encourage appropriate participation of stakeholders having no conflict of interest, to develop comprehensive national alcohol control policies, action plans and programmes for reducing public health problems caused by alcohol use, based on the Regional Policy Options as a minimum framework;  
   (c) to assess the potential impact of certain trade agreements on alcohol consumption and related problems so that effective policy interventions could be formulated, and  
   (d) to establish/strengthen appropriate mechanism(s) for effective planning, implementation, monitoring and evaluation of national programmes, with adequate institutional capacity and funding, and  

3. **REQUESTS the Regional Director**:  
   (a) to support Member States in building and strengthening institutional capacities for developing: information systems, policies, action plans, programmes, guidelines and monitoring/evaluation of programmes on prevention of harm from alcohol use;  
   (b) to hold a biennial regional forum of key partners from Member States and other international partners to share progress, experiences and lessons on alcohol control programmes, and  
   (c) to report on the progress on the implementation of the Alcohol Consumption Control - Policy Options to the sixty-first session of the Regional Committee in 2008.
Annex 2:

Alcohol production in India

While precise estimates of production are not available, data from the United Nations Food and Agriculture Organization (FAO) reveal a 175% increase over a 15 year period (1990-1992 to 2005-2007) in alcohol production in India. In the same period, production increased from 3 kg/person/year to 4 kg/person/year (Consumption units as provided by FAO for respective year). In the post liberalization period (1990-1992 to 1995-1997), the increase in production was remarkable (nearly 150%). Exports increased by 18% during the decade 1995 to 2005. Imports during the 1990s were limited and in 2005-2007 were nearly 12 million kg/year (FAO, 2010).

Sale of alcohol

Consequent to increased production and distribution, the sale of alcohol has increased significantly in Indian society (Figures A2.1-3). Data available from the International Wine and Spirits Record (IWSR, 2010), reveal that the sale of alcohol increased nearly 3 times from 72 000 litre cases in 2000 to 200 million litre cases by 2009. Two distinct patterns can be seen from this increase: while sales of beer and spirits increased (a compounded growth rate of 12.1% during 2000-2009), the growth of white spirits like vodka increased four-fold in nearly 10 years. Alcohol import increased three-fold (557 000 to 1 646 000 litre cases).

Figure A2.1. Changing pattern of alcohol sales in India, 2000-2009

![Figure A2.1. Changing pattern of alcohol sales in India, 2000-2009](source: International Wine and Spirits Record, 2010.)
Figure A2.2. Changing pattern of sales of beer and dark spirits, 2000 – 2009


Figure A2.3. Changing sales pattern of white spirits, 2000 – 2009

7. References


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