Regional Conference of Parliamentarians
on Legislative and Policy Actions
for Promoting Health

Bali, Indonesia, 8-9 October 2007

POLICY OPTIONS FOR REDUCING HARM FROM ALCOHOL USE

World Health Organization
Regional Office for South-East Asia

PARLIAMENTARIANS CONFERENCE WORKING PAPER

Why control alcohol?

Many countries of the South-East Asia Region that had low levels of consumption of alcohol until recently are moving towards higher levels. The impact of globalization and rapid trade liberalization has accelerated this movement. It is well established that an increase in alcohol consumption by a community or a nation leads to an increase in alcohol-related health and social problems.

Individually, the negative effects of dependence on alcohol affects an individual's quality of life. In addition, use of alcohol has a significant adverse impact on families and communities, most notably in social and economic aspects. Use of alcohol which causes any kind of harm to an individual, family or community could be considered as harmful use of alcohol.

As such, there is a need to focus on the prevention and control of harmful use of alcohol in countries of the Region from the perspectives of both health promotion as well as socio-economic development.

What are the types of alcohol consumed in the Region?

Many types of alcoholic beverages are produced and consumed in the Region. Beer and whiskey, which are heavily marketed, are used widely. There are many other types of alcoholic beverages being used, which have a range of concentrations of alcohol, flavours and customs of use. Production and sale of these varieties occur legally as well as illegally. In some countries home production for self-consumption is seen.

Some examples of the types of alcohol used are as follows: Ara, distilled from locally produced rice, barley and maize, and home-made wines such as bangchung, sinchang and tongba are used in Bhutan. Toddy from coconut palm, rice beers such as handia and chhung, rice wines such as apong and jack fruit wine are used in parts of India. Distillates such as arrack and pahua and daru are also used in India. Brem, a rice wine, Tulak, a fermented sugar palm drink and distilled arak are used in parts of Indonesia. Jad and chang, made of rice and raski made of rice, millet or barley are some traditional alcohol beverages in Nepal. Toddy from coconut palm, arrack, and illegally distilled kasippu are used in Sri Lanka. Satoh, Ou and karuche are traditional alcohols in Thailand while lao-khao is a distilled rice alcohol (1).

What proportion of people consume alcohol?

The Demographic and Health Survey of Nepal found that 67% of the males between 15 and 60 years of age consumed alcohol (2). In Sri Lanka a nationally representative sample showed 53.1% of males and

6.4% women above 15 years old were current alcohol users. The majority of male drinkers began drinking between 10-24 years while for female drinkers it was between 20-34 years (3). In Thailand, according to the National Statistics Office, 56% of males and 10% of females consumed alcohol in 2004 (4). In India, surveys covering large proportions of the population show that around 20-30% of adult males and less than 5% of adult females use alcohol. Alcohol use is higher in poorer communities. The average age of initiation has reduced from 28 years during the 1980s to 20 years in recent years (5,6,7,8).

What role does alcohol play in society?

Though alcohol seems to have been present in many countries of the Region for a long period, religious and cultural rules covered who could drink and under what circumstances. Society did not support routine alcohol use. During the twentieth century distilled beverages with higher alcohol content gradually replaced traditional fermented beverages. Drinking has changed from ceremonial and occasional to being a part of everyday social life and entertainment.

Even at present, alcohol is as important as food in parts of the Region. Very little stigma is attached to its use. Serving alcohol to visitors is a custom in some societies. In some communities alcohol use is sanctioned and is the norm. Glaring differences in alcohol consumption are apparent within areas of the same country where such communities co-exist with others who do not sanction everyday alcohol use.

Due to economic development there is now a growing “middle class” in most countries. Most such populations perceive alcohol as a status symbol. Therefore social occasions such as weddings and other gatherings have become events where alcohol “must” be served and used. This is also becoming the norm in recreational activities. Concerts, sporting events and other occasions where large crowds of mostly young people gather are becoming open forums of alcohol use. Such changes in social behaviour do not occur by accident. Many mainstream mass-entertainment mediums such as television and cinema now depict alcohol use and its users in positive light.

Therefore, alcohol is fast becoming a norm of day-to-day living. Routine social activities are becoming associated with alcohol use. This increases the consumption of alcohol in a society, which in turn leads to increases in social, economic and health harms related to alcohol. Closely monitoring the marketing efforts of the alcohol industry may provide some insights as to how such behviours are made to be considered normal.

What are the unique features of alcohol use in the Region?

The countries of the WHO South-East Asia Region are blessed with diversity. A myriad of languages, religions, ethnicities, cultural norms, climates and weather conditions, geographic regions, political ideologies and forms of government flourish in this Region. This leads to many variations in behaviours, perception and contexts related to use of alcohol, not only between countries, but also within countries.

There is a large body of information international in scope, related to alcohol use, policies and interventions. Such information is quite useful in providing direction to alcohol control efforts in this Region. At the same time, it should not be assumed that directly transplanting measures found to be successful elsewhere, under completely different circumstances, will be appropriate in this Region. There are unique features related to alcohol use in this Region that should be taken into consideration.

Traditionally, alcohol is used by men. Consumption among women is quite low. Even among men there are significant proportions of life-time abstainers and current abstainers. Among users, frequent use of small quantities of alcohol is not the predominant pattern of use. The number of drinking occasions is fewer, but the amounts consumed at these occasions are large. Some studies also suggest that among users, the proportion of dependent users is larger compared to figures for other Regions. This is further elaborated in a later section.

Atypical drinking patterns such as pay-day drinking are quite common in many countries. Violence, including domestic violence, associated with alcohol is a serious concern. Advocates for the prevention of domestic violence argue that alcohol is a contributory factor in a large proportion of cases. This stems from the way that an alcohol user is perceived. In most rural areas behaviour patterns that are not usually tolerated are accepted following alcohol use. Violence and disorderly behaviour is one example.

Alcohol is a significant contributor to poverty and loss of income in addition to its health costs. Studies in countries such as India and Sri Lanka have shown that in economically disadvantaged sectors of society, a high proportion of income is spent on alcohol (6,9). This further impedes acquisition of basic necessities as well as nutrition, education and well-being of children and families, trapping them in poverty.

It has also been shown that children of households that use tobacco and alcohol were less likely to be immunized, more likely to have acute respiratory tract infections, more likely to be malnourished and more likely to die before their first birthday (10). Recent studies also show that such children are iron deficient, have inadequate social and emotional stimulation and are exposed to violence. They do not reach their optimum educational and economic potential. This perpetuates

the intergenerational cycle of poverty (11). Alcohol is a significant contributor to these dynamics.

Illicit and home-brewed alcohol is used widely in the Region. The types, alcohol concentrations, geographical spread and the names of such brews are quite diverse. The production and use of such alcohol is socially and culturally sanctioned in some communities. Due to such factors, as well as many other constraints, tackling it with enforcement alone has not been successful in most countries. Other interventions appropriate to the Region, including community intervention and community empowerment, are needed to address this issue.

What are the health and social impacts of alcohol?

The effects of alcohol cover a broad spectrum. It encroaches on the social sector, public order, health and economics. Alcohol is causally related to more that 60 medical conditions. Its use has been associated with diseases ranging from stroke, myocardial infarction, cirrhosis, depression and psychosis to cancers of the liver, oesophagus, mouth and oropharynx. It is also associated with motor vehicle accidents, drowning, falls, poisoning, homicide, suicide and self-inflicted injuries (12). Socially deviant behaviours such as staying away or running away from home, indulging in gambling and other addictive behaviours have been shown to be higher among alcohol users (6).

In countries of the Region where studies have been conducted, alcohol has been shown to be a major contributor to road accidents. In countries such as Thailand, road accidents are a leading cause of death with alcohol being a leading contributor to such accidents. For example, in a large prospective study which included on-scene, in-depth investigation and reconstruction of 969 collisions, alcohol proved to be the most outstanding causative factor (13). In a study in Bangalore, India, it was found that nearly 28% of traffic injuries were directly attributable to alcohol (14).

Alcohol use is considered a risk factor for high risk sexual behaviours (15). In India, a significant relationship has been established between alcohol and risky sexual behaviour leading to HIV/AIDS and other sexually transmitted diseases (5).

The prevalence of alcohol dependence (formerly known as “alcoholism”) is relatively high in countries in this Region from which information is available. Alcohol dependence in Thailand was 19.4% and 4.1% among the male and female adults respectively in 2001 (4). In a survey of both males and females in a town in Nepal, the prevalence of alcohol dependence was 25.8%. It peaked at 45-54 years (16). As these figures seem relatively high, further attention and research is needed on this issue.

What is the economic impact of alcohol?

There are many economic harms from alcohol, some obvious and some not. Spending on alcohol is known to lead to many secondary problems in families, including loss of work and therefore income, malnutrition and lack of basic facilities. All such secondary impacts lead to further problems. For example, there is little or no information on the economic costs of alcohol-related road traffic accidents in the Region. The cost to law enforcement agencies in handing problems related to alcohol is difficult to quantify. Therefore, precise quantification of the economic impact is not possible, although there have been many attempts. Due to the constraints involved, such studies may underestimate the costs.

Studies have shown that spending on alcohol for social occasions is a major factor in obtaining loans and becoming tied to loan payments for longer periods – a loss of income not apparent at first glance (9). A recent study estimated that Rs. 244 billion was spent yearly in India to manage the consequences of alcohol use. This study also found that alcohol users were significantly more likely to be involved in gambling, borrow money, pawn their belongings and miss work (6).

The International Labour Organization has estimated that in many workplaces, 20 to 25% of accidents involve intoxicated people injuring themselves and innocent victims. It also states that on-the-job supplies of drugs and alcohol account for 15 to 30 per cent of all accidents at work (17). This is a major impediment to productivity. In Bhutan, it is felt that as much as 50% of the grain harvests of households may be used to brew alcohol. In certain areas homemade alcohol is the only source of cash income to farmers (18). This may have a major impact on the food consumtion.

How can harm from alcohol be addressed?

Though many policy-makers may consider alcohol a major revenue-earner, decision-makers have to strike a balance between the revenue generated from alcohol and its social and economic costs.

Reducing harm from alcohol may seem an intractable problem, but there are many policy options that have been proven to be successful. Empirical evidence from various policy studies and evidence-based research studies show that in almost every country of the Region, a wide range of policy measures are in place for reducing public health problems caused by alcohol. These measures become effective when incorporated and implemented in a coordinated fashion under the purview of a comprehensive national alcohol policy.

The most effective policies to reduce harm from alcohol are based on

the following principle: *Measures that reduce the adult per-capita alcohol consumption of a population reduce harm from alcohol.*

The harm from alcohol to a given population (community, district, province, state or country) depends on the per-capita alcohol consumption of that population. This is the amount of pure alcohol consumed by the population (usually measured in litres), divided by the number of adult individuals (both users and non-users) in the population. The amount of pure alcohol is used to correct for the differences in the concentration of alcohol in different types of alcohol consumed. For example, a litre of whiskey has more alcohol than a litre of beer.

When the adult per-capita consumption of alcohol increases, the harm (both health and social) increases. When it decreases, the harm decreases. Therefore, government should adopt measures that reduce the adult per-capita consumption. It is important to note that the harms depend on the quantity of alcohol consumed, not on the status of the alcohol – legal or illegal.

One of the unique features in the South-East Asia Region is the large proportion non-users (abstainers) in almost all populations. If alcohol use spreads to traditional non using populations such as women, adult per-capita consumption can increase rapidly.

It must be conceded that in most countries of the Region, illegal or home-brewed alcohol is a serious concern, and is only partially covered by measures taken to control the legal market. But in general, the existence of such a non-formal market does not justify postponement or inaction to control the formal market. The legal market is often quite substantial and therefore contributes substantially to the social and health costs of alcohol. The illicit market should be tackled in parallel.

The alcohol industry may try to argue that controls placed on the legal market of alcohol will only help the illegal market. At a country or state level, it should not be an either / or situation. Both types of alcohol contribute to the harm and therefore consumption of both should be reduced. The alcohol industry may also argue that controls should only be placed on those who use alcohol excessively. But as evidence suggests, the harms from alcohol to a society occur from all levels of use, not only from those drinking to excess.

What policy options can be used to reduce alcohol related harm?

Taxation: Generally, increased prices reduce consumption. Such reductions occur more among price-sensitive consumers that include youth and heavy drinkers.

Some countries have allocated part of the taxes generated from sale of

alcohol to support health promotion, including community empowerment, sports and recreation activities. Under its health promotion act, Thailand has adopted a tax on tobacco and alcohol, the proceeds of which are used for health promotion activities, including reducing alcohol consumption and related problems. Nepal has a similar fund (12,20,21,22).

Restriction of advertising and promotions:

Alcohol advertising has the potential to promote changes in attitudes and social values, including publicizing the desirability of social drinking to its viewers, which encourages increased consumption. It may also weaken social demand for effective alcohol control measures. Studies have shown that advertising can influence consumer choices and have a positive impact on knowledge and awareness about alcohol. This may lead to increase in consumption (12,19,21,22).

Restricting availability and accessibility:

Restrictions on the places of sale, hours of sale and age limits for consumption are some restrictions that have been shown to reduce consumption.

Prohibition of the sale of alcohol has also been tried as a mode of restricting availability and accessibility. There are many levels of prohibition. Age limits and limits on places and times of sales are also within the spectrum of prohibition. Total prohibition of alcohol production, sale and use has been implemented in various countries at various times. Such blanket prohibitions tend to decrease consumption and alcohol-related health and social harms. In some instances criminality and other considerations have necessitated reversing this policy. Usually such total prohibition has been successful in societies where there is a strong cultural or religious sentiment against alcohol use.

Government alcohol monopolies have a lesser profit motive than the private sector. Therefore, they are considered to be relatively less harmful to populations. Privatization of state monopolies has resulted in increased alcohol consumption. Therefore maintaining government monopoly on alcohol is also effective in keeping the adult per-capita consumption of alcohol at lower levels, and therefore harms from alcohol as well (12,19, 20,21,22).

Health promotion / community action:

The most successful campaigns are those aimed at changing the social climate and attitudes rather than those aimed at individual attitudinal change. For example, changing the environment around the user and increasing popular support for alcohol policy measures

are more effective in changing attitudes and behaviours of individuals than directly trying to persuade individuals (19).

Drunk-driving countermeasures:

Driving under the influence of alcohol, even when the Blood Alcohol Concentration (BAC) is within the legal limit, has a higher risk, particularly for new and young drivers. Setting a BAC limit and strict implementation is effective in reducing alcohol-related accidents. This is an important area for action in this Region were current efforts can be strengthened (12,19,20,21,22).

Provision of appropriate services for users:

Brief outpatient interventions aimed at changing the attitude and behaviour around drinking are as effective as longer, more intensive treatments. Such interventions are quite inexpensive and needs less training. Primary health care and workplace settings can be used for such interventions. For hazardous or harmful use, screening and brief interventions are quite effective (12,19,20,22).

What policy options have limited or no effectiveness?

In reducing alcohol-related harm, many popular and often-used initiatives are actually of limited value. Some examples:

- School programmes based on health harms of alcohol and promoting refusal skills.
- Provision and encouragement of alternate activities.
- Provision of health information related to alcohol through mass media or other means.
- Server training, increasing safety of taverns.

Legislative and policy action for reducing harm from alcohol use

Need for a comprehensive national policy on alcohol

Reducing harm from alcohol requires action through many sectors. Finance, trade, health, education, justice and enforcement are some examples. Each sector has a role to play in reducing alcohol-related harm. Unless this is handled in an orderly and coordinated manner, the effectiveness of the initiatives is lessened. Therefore a clear national policy on alcohol is an essential first step in reducing alcohol-related harm in a sustainable manner. Such a policy should encompass the areas that should be addressed by each sector and ideally the responsible agencies.The overarching objective of such a policy should be protection

of health and well-being. It should also address cooperation between stakeholders, which include the government and civil society.

Setting up an implementing agency in the government

Due to the cross-cutting nature of the issues related to alcohol, an apex agency should be given the responsibility of overseeing and monitoring the implementation of the policy. One such example is the National Authority on Tobacco and Alcohol established in Sri Lanka. It is essential that such an agency be multisectoral, with expertise in as many sectors related to alcohol as possible. This body should be responsible to the highest level of government administration so that it can exercise effective coordination among various concerned sectors to plan and implement the national policy. Such an authoritative autonomous body, free of influence from the alcohol industry, will have the flexibility to address all major issues related to harm associated with alcohol.

Establishing a monitoring and evaluation mechanism in the government

Surveillance, monitoring and evaluation of the issues related to alcohol constitute the third most important area. This function could be carried out by existing mechanisms – the census / statistics departments, existing health indictor surveillance system, organizations involved in economic surveillance (e.g. central banks) or through a dedicated agency. The World Health Organization has already developed an international guide for Member Countries and other stakeholders for monitoring alcohol consumption and related harm.

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