

Community Action to Reduce Harm from Alcohol Use

*Report on Meeting of Experts
Bangkok, Thailand, 22–23 April 2009*



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1. Introduction

The Fifty-ninth session of the WHO Regional Committee for South-East Asia through a resolution (SEA/RC59/R8), requested the Regional Office to provide technical support to Member States in building and strengthening institutional capacity for developing information systems, policies, action plans, programmes, guidelines and monitoring and evaluation programmes on prevention of harm from alcohol use. Thus, governments of Member States have requested technical support from the Regional Office for South-East Asia (SEARO) to develop programmes related to harm from alcohol use.

Alcohol use and its related harm depends on the socio-cultural milieu in which it is used. Policies, legislation, enforcement, cultural norms, alcohol industry activities, the services available, level of empowerment of communities and individual perceptions are some of the factors that contribute to the initiation of use, maintenance and behaviours that lead to harm from alcohol use. This leads to many variations in behaviours, perception and programmes related to use of alcohol, not only between countries, but also within countries.

There is a large body of information related to alcohol use, policies and interventions that has been produced internationally. Though such information is useful, it should not be assumed that transplanting measures found to be successful elsewhere, under completely different circumstances, will be effective in this Region. Largely, such research and information is from countries and regions that are economically developed with advanced infrastructure and services. In such situations, harm related to alcohol use is considered mainly an issue of health. In this Region it is quite different. In addition to its health costs, alcohol is a significant contributor to poverty and impedes development.

Traditionally, information used for programme development has been mainly statistical data on the consumption rates and morbidity / mortality. Such data alone is quite insufficient to develop and implement effective programmes to reduce alcohol-related harm. Qualitative information

covering the context and patterns of use, the perceptions of communities, the diverse agencies involved (often with conflicting interest), the initiatives already in place, current capacities and gaps that need to be fulfilled are more important and urgent at this juncture. This is because alcohol-related programmes should not only be developed, strengthened and expedited, but also made relevant in the environments in which they will be implemented. Quantitative information relating to alcohol use is rare in most countries of the South-East Asia Region and relevant qualitative information is even more difficult to gather. It is in this context that assessment studies were undertaken in selected countries and data from other countries analyzed.

Many languages, religions, ethnicities, cultural norms, geographic regions, political ideologies and forms of government exist in countries of the WHO South-East Asia Region. This diversity leads to many variations in behaviour, perceptions and programmes related to use of alcohol, not only between countries, but also within countries. Traditional western models of prevention of alcohol use have not been very useful in countries of the Region due to the many special features associated with alcohol use.

The basis for the prevention of alcohol-related harm in the context of the South-East Asia Region should not only be disease prevention but reduction of poverty, disempowerment, violence - including domestic violence, prevention of injuries and improvement of well-being and social capital. Programmes should address local patterns of alcohol consumption, such as pay-day drinking, attitudes of some communities that consuming alcohol is a sign of "growing up" for boys, etc. Also that people usually consume large quantities of alcohol at one time (binge drinking) when they drink, unlike western patterns of consumption, such as one glass of wine every day. Another issue of concern is the consumption of alcohol among women which is currently quite low, but gradually increasing. Some communities do not traditionally use alcohol due to religious or other reasons. The success of these voluntary restrictions needs to be studied.

In addition, surveys, including community assessments and field observations show that illicit alcohol production and consumption is also of concern in the Region. The enforcement agencies are often overstretched by the limited resources available. Therefore, legislation and policy measures alone cannot fully address the reduction of harm related to alcohol use in the Region. Thus, community empowerment programmes

become important as a strategy to reduce harm from alcohol use in the community.

Initiatives to reduce harm from alcohol use in this Region have to take into account all the above factors. A “one-size-fits-all” solution to this problem does not exist in the context of this Region. Hence, care should be taken to ensure that interventions are tailored to the countries and communities being addressed. If this does not happen, the effectiveness and the efficiency of interventions are bound to suffer. It is imperative that the policy makers, programme planners in government and other agencies responsible for reducing alcohol-related harm at country level have relevant information to design and implement effective programmes.

2. Proceedings

The meeting was chaired by Dr Usaneya Perngparn, Head, Drug Dependence Research Centre, College of Public Health Sciences, Chulalongkorn University, Bangkok. Dr. Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse, WHO / SEARO presented the following specific objectives of the meeting: These were to:

- (1) Discuss the demographic and epidemiological characteristics, current knowledge of harm from alcohol use and on-going programmes in the proposed sites for intervention to reduce harm from alcohol use;
- (2) Discuss adaptation of interventions for community action across sites to reduce harm from alcohol use; and
- (3) Finalize an action plan for community action at the proposed sites to reduce harm from alcohol use.

2.1 Presentation: Addressing harm from alcohol use in the South-East Asia Region – Dr Vijay Chandra

The two aspects of reducing harm from alcohol use - policy and interventions - were described. The policies are diverse in each country, and the interventions need to be different in each community as well. It was explained that the concept of “harmful use of alcohol” is quantity related while the concept of “reducing harm from alcohol use” is harm and

context related and does not depend on the quantity consumed alone. It was emphasized that the objective of the interventions is not the prohibition of alcohol, but addressing the public health concerns.

The issues unique to the Region such as pay-day use of alcohol, differences in consumption between males and females, home-based production and illegal alcohol were also described. It was mentioned that although there have been alcohol-demand-reduction projects in the Region, there was a need for designing and implementing programmes that were relevant and owned by the communities to empower them to take control and address the problems related to alcohol.

It was stated that the Mental Health and Substance Abuse Unit of the WHO Regional Office for South-East Asia has undertaken many activities related to reducing harm from alcohol use.

As a first step, several technical publications covering the socio-economic harm from alcohol in the Region; alcohol control policies in the Region; community responses to reduce harm from alcohol; and current research information related to alcohol have been produced and disseminated in the Region. Other resource material, for example, pamphlets which can be used in schools have also been developed and disseminated ¹.

The second step was a multisectoral symposium entitled “Reducing harm from alcohol use in the community” in which diverse aspects related to addressing alcohol-related harm were discussed from the perspective of different sectors including trade and economics, law and enforcement, media, education, health and the community. Reducing harm from alcohol use was also included in the agenda of the Regional Conference of Parliamentarians on legislative and policy actions for promoting health in the countries of the WHO South-East Asia Region.

¹. Burden and Socio-Economic Impact of Alcohol; The Bangalore Study
Public Health Problems caused by Harmful Use of Alcohol; Gaining Less or Losing More ?
Alcohol – Control Policies in the South-East Asia Region: Selected Issues
Alcohol – Use and Abuse – What YOU Should Know
Reducing Harm from Use of Alcohol – Community Responses
Current Information on Use and Harm from Alcohol in the South-East Asia Region
Facts on Alcohol Use and Abuse – Programme on Adolescent Mental Health

The next step in the sequence was the compilation and analysis of community-based data on alcohol use from the Member States. Community-based surveys on the use and harm from alcohol use were conducted in three countries (Myanmar, Nepal and Sri Lanka). These survey data and national data of three other countries (India, Indonesia, and Thailand) were analyzed.

The fourth step was designing programmes to reduce harm from alcohol use through community action. These programmes were designed in consultation with experts from Member States where the programmes will be implemented and were based on data compiled from six countries.

The next step which is currently in progress and for which this meeting was organized is the implementation and evaluation of the programmes to reduce harm from alcohol use in the community.

Discussion

During the discussion which followed the concept of community interventions was discussed by the participants. Differences between the medical model of treatment and community empowerment to address issues related to harm from alcohol were highlighted. It was pointed out that the community interventions which will be developed should go beyond improving treatment seeking and provision of service.

The participants also discussed the concerns related to the sustainability of community level changes observed in the longer term. Some of the experiences related to this issue were discussed by the participants from India and Sri Lanka. The issue of unrecorded or illegal alcohol was discussed in the context of harm to communities and the methods of addressing related harm. The point of making the interventions relevant to the culture and the context of the communities and making them relevant to community norms was discussed in detail.

The differences, advantages and disadvantages related to various levels of interventions were pointed out. It was stated that the medical model mainly targets individuals, while behavioural change requires group and community level efforts to change and sustain patterns of behaviour.

2.2 Concept of community interventions to address alcohol related harm – Dr. Sajeeva Ranaweera

When interventions are considered, one of the major areas that have been highlighted through community assessments is that factors, behaviour patterns and harm related to alcohol use are quite diverse, even within different population groups in the same geographic area. Therefore, programme design and management methods have to be modified and a more inclusive, decentralized approach is needed if lasting and effective interventions are to be implemented to prevent harm from alcohol use.

Community interventions should be carried out in two phases. The first phase should be a learning phase with the second being the intervention phase. It is advisable that the learning phase is satisfactorily completed prior to the intervention phase to avoid any confusion during implementation of interventions.

In any community action programme, several factors related to alcohol use need to be assessed and addressed. For example, the perceived effects of alcohol on alcohol users, the attractiveness of alcohol, the unfair “privileges” given to alcohol users (e.g. less social sanctions on rowdy behaviour and violence following alcohol use), use of alcohol in social events such as weddings and funerals, factors that increase consumption (e.g. advertising and media portrayals), availability of legal and illegal alcohol, the knowledge of relevant harm (e.g. economic harm to families). Therefore, such interventions should be developed in consultation with the community and should be owned by the community to ensure effectiveness and sustainability. One important aspect of community intervention is addressing the entire community until individuals begin to change. Changes seen in specific individuals should not be taken as indicators of success or failure of programmes.

Taking into consideration these issues, community-based programmes on reducing harm from alcohol use are being implemented in this Region based on a participatory and constructionist, empowerment-based model.

The interventions incorporate the principles enunciated in the Ottawa² and Bangkok Charters³ for Health Promotion.

The full text of this paper is attached in Annex D.

2.3 Country Presentations: India

Presented by Prof Rajat Ray, Dr Dipesh Bhagabati, Professor Rakesh Lal, Dr Pratima Murthy

Findings on alcohol from the National Household Survey on Drug and Alcohol use (NHS)⁴, a Rapid Assessment Survey (RAS) in Uttar Pradesh, the Drug Abuse Monitoring System (DAMS) and Focused Thematic Studies (FTS) were highlighted and discussed. The overall current prevalence of use of alcohol by adult males was shown to be 21% in the NHS. This survey also estimated that there were 10.5 million dependent alcohol users in the country. The findings of the GENACIS study and a Ford Foundation study relating to issues of alcohol and women were also presented. The GENACIS study found that 5.8% of women and 33% of men used alcohol. The mean number of drinking occasions, the quantities consumed and the number of drinking occasions were lower in females compared to males. A significantly higher proportion of women used wine compared to men, while both sexes had similar proportions using beer. 20% of men and 19% of women used alcohol daily. The Ford Foundation study was an in-depth study in a slum in Bangalore. This study found a high level of alcohol consumption in the families with 49% of mothers and 31% of the sisters in the sample consuming alcohol. Many reported various problems related to alcohol. Findings of another study showing a strong association between alcohol use and violent injury was presented⁵.

The responses of the government to these findings on alcohol use and its harm were described. The response of the government is spearheaded

² Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, 21 November, 1986. WHO/HPR/95.1

³ Bangkok Charter for Health Promotion in a globalized world, 6th Global Conference on Health Promotion, August, 2005

⁴ Extent, pattern and trends of drug abuse in India, National Survey 2004, Ministry of Social Justice and Environment, Government of India and United Nations Office for Drugs and Crime

⁵ Benegal V. et al. Alcohol and Injury, Emergency Department Study in Bangalore India, National Institute of Mental Health and Neurosciences, India 2001

by the Ministry of Health & Family Welfare and the Ministry of Social Justice & Empowerment. The goals of the Ministry of Health and Family Welfare in this regard were listed as: dissemination of health education materials, developing better treatment strategies, community mobilization, workplace-based prevention, harm minimization and documentation.

The objectives of the proposed project to be conducted at five sites were given in detail and the activities identified. These included capacity strengthening and community mobilization. The proposed methods for evaluation which include mid-term and end-of-term evaluations against a baseline were described.

The sites selected and the demography of each site was discussed in detail. The sites selected in India are: Meerut (Uttar Pradesh), Moregaon (Assam), Mandsaur (Madhya Pradesh) and Bastar (Chhattisgarh). A proposal for a location in Karnataka will also be made through the National Institute of Mental Health and Substance Abuse (NIMHANS).

The rationale for the selection of the sites was discussed. Some of the reasons listed were the availability of capacity, the support of the district administrators and ongoing activities in these areas. In Moregaon, for example, the harm included use of rice to manufacture alcohol and neglect of agriculture. Of specific concern was the production of home brew by the tribal populations of these areas.

The initial work that had taken place was presented. Patterns of alcohol use and the data relating to those seeking help were outlined. The activities planned such as staff training and protocol development were outlined. The Rapid Situation Analysis (RSA) being carried out in Meerut was presented in detail. According to the current findings, it is a high alcohol use prevalence area. It is a relatively prosperous industrial area where the sugarcane industry is widespread. The workers were found to be frequent consumers of alcohol with daily use of alcohol is almost a norm. The number of alcohol retail outlets was increasing steadily. Unruly behaviour following use, safety of women and the relationship of alcohol use with crime were some of the issues highlighted through this survey.

2.4 Country Presentations: Sri Lanka

Presented by Dr. Sajeeva Ranaweera, Mr. Pubudu Sumanasekera

The technical aspects of the proposed project were presented. The locations, demography, methods of intervention and factors relating to sustainability were discussed. The project will be implemented in two districts of Sri Lanka. The catchment areas will contain approximately 1000 alcohol users. In one of the locations, the main occupations is sand mining and farming with most workers being daily wage earners. The other locations are a fishing community, a rural farming community and a plantation community. Plantation communities are different as they are very poor, with low levels of literacy and low, and with alcohol consumption relatively high.

The factors promoting the use of alcohol in communities and the practical experiences related to addressing alcohol related violence, pay day use, reducing attractiveness of alcohol and interventions for younger age groups were described. Some of the factors that promote alcohol use in the communities have been found to be positive portrayals in media, positive images attached to users and the negative image attached to non-users, unfair social privileges provided to users following the use of alcohol and the lack of knowledge of the harm relevant to the communities and individuals.

The activities envisaged were listed and described. These include social mapping of the community, focus group discussions, community meetings, house visits etc. Factors improving sustainability of outcomes were presented. These include building capacity in communities to address harm from alcohol use, handing over the ownership of the initiative to the community at the inception of the project, introduction of enjoyable activities related to harm reduction into the daily life of the community and keeping contact with the community following conclusion of the project period. The results and outcomes of previous similar interventions were discussed, where major changes occurred in the attitudes related to alcohol, the sale of illegal alcohol and the levels of violence.

An overall framework for intervening in the communities was outlined. The methods of evaluation and the proposed outcomes in the community were presented. The types of indicators – the processes, outcome and the impact, as well as measuring behaviour change at community level were discussed. The theoretical basis for the interventions

derived from the social learning theory, and the concepts of social capital, participatory action and evaluation and health promotion were outlined. Measuring behaviour change using the example of violence related to alcohol use was described. The cognitive changes that should be looked for before behaviour changes occur were outlined. The continuum of behaviour change which should occur in this respect was presented.

Practical indicators of progress were discussed. It was stated that the community will play a key role in choosing indicators and carrying out evaluations. A detailed presentation was made on the evaluation process. This included the process and outcome indicators, methods of measurement and indicators relating to several aspects of addressing harm from alcohol such as anti-social behaviour and violence following alcohol use. The outcomes expected for interventions with young people were discussed. It was stated that the qualitative indicators will be given emphasis during the evaluation process. These topics are described in detail in the concept paper in Annex E.

As this was a pilot intervention and a learning-experience, it was stated that different approaches will be adopted in the four different locations of the two sites. For example, in one of the locations, only users will be approached for the initiation of community change. In another, specific groups – young people, women etc. will be targeted separately. Activities envisaged during the period up to December 2009, relating to each of the different sites were listed. These included establishing community links and identifying community resources through resource mapping; building rapport with the community; the baseline survey; selection and training community facilitators; building community interest to work on alcohol issues through participatory approaches; conducting monthly training/monitoring meetings; initiation of interventions related to youth; use on special occasions and anti-social behaviour following use; and evaluations (August and November 2009).

2.5 Country Presentation: Thailand

Presented by Dr Sawitri Assanangkornchai

The design and findings of the National Survey on alcohol⁶ was presented and discussed. This survey consisted of a multistage sample of 26,633 respondents aged 12-65 years from 11,348 households. The survey found 41% of males and 7.8% of females used alcohol in the preceding 30 days. National statistics for alcohol production in 2007 were presented – beer accounted for 69% of production (in litres) while white sprits accounted for 19.4% and imported alcohol accounted for 6.1%. The number of fatal accidents related to alcohol use was 12,492 which was down from over 14,000 in 2003. The economic loss due to harm from alcohol in 2006 was estimated to be 156,105.4 million Baht which was 2% of the Gross Domestic Product.

There have been many policy responses to alcohol-related harm in Thailand. Two per cent of the sales price of alcohol is collected as a designated tax and used for health promotion activities through the Thai Health Promotion Foundation. Direct advertising of alcohol products is not allowed. The minimum legal age for purchase of alcohol has been increased to 20 years from 18. There are restrictions with regard to hours of sale and consumption of alcohol is prohibited in several locations such as educational institutions, public parks and government institutions.

The demography of the sites selected for the community interventions was presented. One site is in the sub-district of Nongna of Pattananicom District, where the University has an ongoing project on brief interventions to address alcohol use. The people there are involved mainly in agriculture, chicken farming and animal food manufacture. The most significant harm related to alcohol in the location is poverty due to spending on alcohol. Therefore, interventions addressing this issue will be designed and implemented with community participation. The other site, Songkla, consists mainly of business people, academics and plantations.

⁶ National Household Survey on Estimation of Population of Alcohol Abuse 2007, Administrative Committee for Substance Abuse Research Network

The activities and the approaches that will be used in general for the community action programme were discussed. These include district-based interventions, promoting understanding of the national alcohol control policies, raising awareness of strategies used by the alcohol industry to increase alcohol use, development of partnerships with local government organizations and nongovernmental organizations, chambers of commerce etc., using the social sanction approaches among others.

3. Decisions and recommendations

It was decided that each country should develop a project proposal for implementation based on the discussions and presentations. The first phase of these projects will be completed by November 2009 and progress reported to SEARO to be documented for further action.

The following activities related to the community intervention projects were agreed upon:

- Identify sites for intervention
- Document harm, by using Focus Group Discussion (FGD) and key informants. Individual, family-related and community level harm should be ascertained and recorded. Four or five major alcohol-related harm in the community could then be selected for interventions.
- Assess harm (magnitude) by using ordinal scale measurement
- Design and initiate interventions addressing the needs of both users and non-users of alcohol. Identify target groups for intervention, assessment and outcomes to be measured.
- Progress report of the intervention should be submitted to SEARO by November 15, 2009. The second progress report should be submitted by April 1, 2010. The meeting on community action is anticipated to be held in December 2010.

Annex 1

List of participants

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Annex 2

Specific objectives

- (1) Discuss demographic and epidemiological characteristics, current knowledge of harm from alcohol use and on-going programmes in the proposed sites for intervention to reduce harm from alcohol use
- (2) Discuss adaptation of interventions for community action across sites to reduce harm from alcohol use.
- (3) Finalize an action plan for community action at the proposed sites to reduce harm from alcohol use.

Annex 3

Tentative agenda

- (1) Community action to reduce harm from alcohol use previously implemented by the experts.
- (2) Demographic and epidemiological characteristics of proposed sites for community action to reduce harm from alcohol use.
- (3) Current knowledge of harm from alcohol use in the proposed sites for community action.
- (4) Adaptation of interventions for community action across sites to reduce harm from alcohol use.
- (5) Finalization of action plan for community action at the proposed sites to reduce harm from alcohol use.

Annex 4

Programme

Day 1: 22 April 2009, Wednesday

- 0800 – 0900 Registration
- 0900 – 0930 Opening Session:
- Welcome Address by the Dean of the School of Public Health, Chulalongkorn University
 - Welcome Address by WR Thailand/Dr Vijay Chandra
- 0930 – 1015 Introduction of participants – Dr V. Chandra
Appointment of Office Bearers
Objectives and scope of the meeting – Dr V. Chandra
- 1030 – 1245 Presentation and discussion by sites of intervention in **India** – demographic and epidemiological characteristics, harm from alcohol use and ongoing programmes in the proposed site (45 minutes per site)
- 1245 – 1300 Brief discussion
- 1400 – 1530 Presentation and discussion by sites of intervention in **India** – demographic and epidemiological characteristics, harm from alcohol use and ongoing programmes in the proposed site (45 minutes per site)
- 1530 – 1615 Presentation and discussion by sites of intervention in **Sri Lanka** – demographic and epidemiological characteristics, harm from alcohol use and ongoing programmes in the proposed site (45 minutes per site)
- 1630 – 1715 Presentation and discussion by sites of intervention in **Sri Lanka** – demographic and epidemiological characteristics, harm from alcohol use and ongoing programmes in the proposed site (45 minutes per site)
- 1900 onwards Welcome reception

Day 2: 23 April 2009, Thursday

- 0900 – 1030 Presentation and discussion by sites of intervention in **Thailand** – demographic and epidemiological characteristics, harm from alcohol use and ongoing programmes in the proposed site (45 minutes per site)
- 1045 – 1200 Presentation and discussion by sites of intervention in **Thailand** – demographic and epidemiological characteristics, harm from alcohol use and ongoing programmes in the proposed site (45 minutes per site)
- 1200 – 1300 Open discussion on adaptation of interventions for community action across sites to reduce harm from alcohol use
- 1400 – 1630 Finalization of action plan for community action at the proposed sites to reduce harm from alcohol use
- 1630 – 1700 Conclusion and next steps

Annex 5

Concept of community interventions to reduce harm from alcohol use

Dr. Sajeeva Ranaweera

This document is based on a technical paper prepared for the Mental Health and Substance Abuse Unit, WHO Regional Office for South-East Asia entitled “Interventions to reduce alcohol-related harm in Member States of the South-East Asia Region through community empowerment” by the author.

1. Introduction

When interventions are considered, one of the major areas that have been highlighted through the community assessments is that factors, behaviour patterns and harm related to alcohol use are quite diverse, even within different population groups in the same geographic areas. Therefore, one should not fall into the trap of designing interventions for countries or geographic areas. Although this is what programme planners, designers and implementers are comfortable with, true behaviour changes will not be achieved using this model. Therefore, traditional programme design and management methods have to be modified and a more inclusive, decentralized approach is needed if lasting and effective interventions are to be implemented to prevent harm from alcohol use.

Traditionally, programmes for prevention of harm from alcohol use consisted of information dissemination which emphasized the harm of alcohol use. Evaluation of media campaigns and IEC material related to substance use show that the knowledge of harm that may occur because of a given behaviour does not change that behaviour, unless the harm is immediate and catastrophic. This is because human behaviour is influenced by many other factors than knowledge alone.

Many types of interventions aimed at reducing alcohol-related harm have been implemented globally and regionally by governments, nongovernmental organizations and international agencies. Many of these

are advocacy programmes, media campaigns, school-based educational programmes or campaigns aimed at detoxification. Comprehensive community interventions that address the determinants of alcohol use with the aim of reducing alcohol-related harm within communities have been rare. Several community-oriented programmes that have been published deal mainly with dependent users. Most of these programmes were clinically oriented in the sense that they targeted hazardous or dependent users with the objective of treatment.

Alcohol use and its related harm depend on the socio-cultural milieu in which it is used. Policies, legislation, enforcement, cultural norms, alcohol industry activities, services available, level of empowerment of communities and individual perceptions are some of the factors that contribute to the initiation and continuation of use and behaviours that lead to harm from alcohol..

What may seem obvious and necessary to those of us who plan and develop programmes may not be what is required and is practical at the community setting. Hence, community interventions should be carried out in two phases. The first phase should be a learning phase and the second will be the intervention phase. It has to be ensured that the learning phase has been satisfactorily completed prior to the intervention phase to avoid any confusion during implementation of interventions.

2. Components of community interventions

Human behaviour does not occur in a vacuum. For example, the behaviour of a person within a community will be governed by many factors such as cultural beliefs, social pressures, economic considerations, etc. Alcohol use-related behaviour is no different. In such an intervention, each community should be considered a unique setting. The extent of the problem, the physical, environmental and cultural milieu of the village, individual beliefs and behaviours and other factors relevant to subsequent interventions should be identified first. Unless this learning phase takes place, the interventions will have to be developed in a vacuum.

In any such community intervention several factors related to alcohol need to be assessed and addressed (e.g. the perceived effects of alcohol on alcohol users, the attractiveness of alcohol, the unfair “privileges” given to alcohol users (e.g. less social sanctions on rowdy behaviour and violence

following alcohol use), use of alcohol in social events such as weddings and funerals, factors that increase consumption (e.g. advertising and media portrayals), availability of legal and illegal alcohol, the knowledge of relevant harm (e.g. economic harm to families). Therefore, such interventions should be developed in consultation with the community and should be owned by the community to ensure effectiveness and sustainability.

Taking into consideration these issues, the community-based alcohol harm prevention programmes being implemented in this Region should be based on a participatory and constructionist, empowerment-based model. The interventions should incorporate the principles enunciated in the Ottawa and Bangkok Charters for Health Promotion. Concepts of promotion of health and well-being such as improvement of social capital and resilience, community mobilization and community ownership should be built into the intervention model.

The WHO Regional Office for South-East Asia has developed a manual for a comprehensive community intervention (*Reducing Harm from Use of Alcohol: Community Responses*, Diyanath Samarasinghe, WHO/SEARO, 2006) taking into account the context of this Region and the factors discussed above. It has been field tested and has shown to be effective. In addition, the principles outlined for developing interventions for low-income countries in the Second Report of the WHO Expert Committee on Problems Related to Alcohol Consumption (World Health Organization, 2007), should also be taken into account and incorporated.

3. Concepts and theoretical frameworks

Many theoretical frameworks related to group behaviour changes and concepts have been used successfully for intervening on health behaviours. Some of the concepts that have been put into practical use successfully are the concepts of social capital, participatory action and evaluation and the concept on empowerment. Briefly, institutions, networks, norms, reciprocity and social trust that shape the quality and quantity of social interactions and facilitate collective action, coordination and mutual benefit are determinants of social capital. It has been shown that social cohesion is critical for societies to prosper economically and their development to be sustainable.

The Bangkok Charter on Health Promotion (2005), outlines many concepts related to health promotion through community action and empowerment. It recommends making the promotion of health a key focus of communities and civil society. It further states: “communities and civil society often lead in initiating, shaping and undertaking health promotion. They need to have the rights, resources and opportunities to enable their contributions to be amplified and sustained. In less developed communities, support for capacity building is particularly important”.

An important behaviour-related theory that has been successfully applied to change community level behaviour is Bandura’s Social Learning Theory. Among other concepts it introduces the concept of Reciprocal Determinism which states that the environment largely controls or sets limit on the behaviour manifested. Attempts to positively influence changing the environment variables result in the modification of behaviour. (Bandura, A. Social learning theory. Englewood Cliffs, NJ., 1977)

4. Outlines of principles of community empowerment



5. Evaluation

The process and theory of evaluating health promotion interventions have been debated and published extensively. Although there are many reports and publications related to community interventions on health and other matters, there is no agreed “gold standard” for evaluation.

In practical terms, the nearest to a gold standard will be the qualitative measurement by individuals and the community itself, although this is subjective and not comparable.

The main aim of evaluating community interventions is ascertaining if the community is moving in the right direction, in this case, in addressing the determinants of alcohol use and harm. It should be understood that community and group behaviour changes occur within a spectrum and any particular behaviour can move either way within this spectrum during a given period of time.

As is well established, community-level behaviour change requires long periods of interventions, often years and the evaluation carried out should be able measure subtle changes. Those measures used in the earlier phases need to be sensitive to the type of change that can be expected within the time frame. Therefore, measurements carried out as an ongoing process during this intervention serve a different purpose to scientific studies. Standardized, validated questionnaires and standard techniques of gathering data may be inappropriate to detect such subtle, early changes.

Such evaluations should be built into any community intervention effort aiming to change behaviour. The methods of evaluation and the suitable indicators should be given adequate attention at the planning stage. An appropriate and significant amount of resources should be allocated to evaluation as it is one of the cornerstones successful interventions.

There should be several levels of evaluation, in addition to the standard process indicators that measure the implementation of interventions. The background processes involving initiating change, and the process of intervening, should be one set of measures. Determining the actual “cognitive” and behavioural changes that will be taking place requires other types of measures. The expected outcomes identified during the planning phase should be measured separately. Other micro-level measures should also be used during field visits to assess the situation.

Some practical examples of indicators that can be measured are outlined later in this document.

In practice, the development process and outcome measurements should involve the community as a whole. Detecting early changes are best carried out by members of the community themselves using less formal methods. The community is encouraged to develop their own indicators to measure change - this helps them in planning interventions as well.

Qualitative techniques based on observations and interviews with key persons should be the main methods of evaluation. It should be an ongoing process and the key is to look for changes over time rather than absolute measures.

6. Specific examples of interventions to reduce harm from alcohol use in communities

6.1 *Interventions for young people*

Traditionally, many prevention programmes have been targeted at this age-group. Attempting to prevent alcohol use in this age group with the “harm-from-alcohol-use” approach may be inappropriate or even counter-productive – actually increasing the attractiveness of alcohol use as a “dangerous” pursuit. Prevention of use interventions should address the whole age-group, irrespective of whether they use alcohol or not. Factors that promote alcohol use in this age-group should be carefully determined and addressed. Carefully tailored interventions are needed specifically targeting the users in this age-group. Most users in this age-group are infrequent users and many use alcohol only on special occasions. Therefore, traditional approaches which address more regular alcohol users need to be modified accordingly.

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 such programmes have shown to be ineffective, or even counter-productive. Therefore, before a headlong rush is made to design and implement school-based programmes, based on the findings of this analysis, careful

consideration should be given to improving the effectiveness and efficiency of such programmes.

Another popular approach is media-based interventions. After all, alcohol use and users are glamorized and promoted in most media in the Region. Therefore this approach too seems quite sensible at first glance. But, once again, unless careful consideration is given to the content, frequency and other factors, the impact of such interventions could be mediocre at best, and counter-productive at worst.

Some characteristics of community and school interventions that will have an effective and sustained impact on youth are those that:

- Demonstrate how alcohol and its use is made attractive through formal and informal means, promotions, individuals, social contexts and beliefs.
- Empower those in young age-groups to understand how they are being specifically targeted through the media to initiate and continue use of alcohol.
- Encourage them to sensitize and empower others in the same age-groups.
- Motivate them to devise and engage in appropriate activities to minimize the impact of such customs, contexts, promotions and media portrayals.
- Enable them to identify new types of strategies and promotions that may be used in the future, without external guidance.

6.2 Addressing the context of alcohol use: special occasions

In the South-East Asia Region, there are many “special” social occasions ranging from births, weddings, deaths, social and cultural festivals such as the new year and harvesting occasions, and many religious festivals. These are in addition to other more western-oriented occasions such as birthdays, concerts and games. When alcohol becomes or is made to become a central theme at these events, alcohol use, initiation and heavy use at these occasions becomes a norm. These occasions also become a showcase for alcohol use, by increasing its attractiveness and associating it with fun, and normalizing its use to younger age groups in particular. It is no secret that

the alcohol industry too uses such occasions to promote and glamorize alcohol use in several countries of the Region.

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

An outline for a model for intervention in this respect is as follows:

- First, the facilitators study and understand the contexts in which use on special occasions occurs, social norms that make it happen and the perceptions and attitudes of the community related to such behaviour.
- During this process, the community members should also begin to understand their own views on using alcohol on special occasions and the ramifications and the costs to their community.
- Next,
 - Discussions initiated among community members on the subject
 - Suggestions of possible interventions are made
 - Community tests ways of reducing use of alcohol on special occasions
 - This is discussed regularly in the community to maintain momentum.

6.3 *Antisocial behaviour and violence*

Many interventions have been initiated globally to address this issue. They range from law enforcement programmes, server training and media campaigns to initiatives aimed at modifying social norms that promote anti-social behaviour following alcohol use. The last approach has shown an impact in this Region, and therefore needs serious consideration of being incorporated in different countries. This approach is based on reducing and eliminating unfair social privileges attached to alcohol. It addresses the

conduct of groups and individuals who intentionally use prevailing social norms and privileges accorded to alcohol users, to indulge in anti-social behaviour. Participatory approaches with entire communities have shown success in this respect.

In many parts of the Region, there is a widespread belief that those consuming alcohol are not in control of their behaviour following its use and are not fully aware of their surroundings and circumstances. Though there is scientific evidence that consuming a large amount of alcohol will impair coordination and judgment that are needed for skilled activities such as driving, there is scant evidence supporting the thesis that alcohol makes its users unaware of what they do on social occasions.

It is well established that excessive blood alcohol concentrations cause unconsciousness. But, at such high levels, neuro-muscular coordination is so impaired that it is hardly possible for them to indulge in violence or targeted anti-social behaviour. In fact, what social and anthropological research has shown is that in different cultures, users of alcohol behave very differently after consuming alcohol. In some, they turn quiet and pensive, and in some anti-social. 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.

Encouraging outcomes have been shown in interventions carried out in Sri Lanka, which address the social norms related to alcohol use that promote violence, including domestic violence and anti-social behaviour. These interventions aim at changes in social acceptance of such behaviour and make the communities respond to such behaviour differently than before. Reduction in anti-social behaviour following such interventions has been reported in several settings. Cautious application of such interventions with appropriate adjustments in other settings in the Region may be appropriate on an experimental or pilot basis.

6.4 *Factors to be taken into consideration when planning interventions*

The objective should not be to stop one individual or a whole community from stop using alcohol. Such well-intentioned programmes either do not get going (due to community resistance) or are doomed to fail disappointing the implementers and the community and re-enforcing the widespread belief that “nothing can be done”. The interventions should be aimed at

those with any level of alcohol consumption as well as non-users and should attempt to address harm.

The interventions should be developed within the individually unique contexts of each target community and owned by them. Scope should be provided for the communities and the facilitators to develop and test specific interventions. This is because behavioural interventions that work in one setting seldom have the same impact in different settings.

Behaviour change takes time. A project period of one year may not yield apparent and significant behaviour changes, but the direction that the interventions are taking the community into will be clear.

In implementing the interventions, patience, persistence and the ability and the enthusiasm to learn from the communities are the most important characteristics needed in the project team.

7. Sustainability

Many factors determine the sustainability of results of community action. The most important of them is to involve the community from the planning stages of the interventions and create ownership from day one. The community members should be actively involved in determining the problems and deciding on the priorities and timeframes. They should be actively involved in evaluation. The outcomes and the expected impacts should be discussed and decided with the communities.

During the intervention period foci within the community (both individuals and groups) should be identified and targeted specifically for capacity building. These foci should be chosen according to the contexts of each community and their personal / group characteristics.

The factors that will block progress and impede sustainability should be discussed clearly with the community during the period of intervention. This will provide the community a picture of what is likely to happen once outside support is phased out and enable them to prepare and to take action to prevent the reversal of results achieved during the intervention phase.

Remote engagement by the intervention team (through letters, phone calls etc.) and occasional visits to the community after the intervention period is over will also improve sustainability.

Bibliography

- (1) Reducing harm from use of alcohol: Community responses, Diyanath Samarasinghe. Alcohol Control Series No. 5. WHO Regional Office for South-East Asia

This meeting of experts was convened to develop community-level programmes to address harm related to alcohol use. Experts from India, Sri Lanka and Thailand participated. The delegates were experts in community action to reduce harm from alcohol use through community empowerment. Theoretical and practical aspects of implementing such interventions were presented and discussed. Proposals for the implementation of specific projects in selected communities were presented and modified to improve the quality of the outcomes. These initiatives are now being implemented. The summaries of presentations made and a paper on concepts of community intervention are included in this document.



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