



Programme on reducing harm from ALCOHOL use in the community

"ALCOHOL CONTROL" SERIES, No. 7

Other titles in the "Alcohol Control" Series are:

- No.1. Burden and Socio-Economic Impact of Alcohol — The Bangalore Study
- No.2. Public Health Problems Caused by Harmful Use of Alcohol — Gaining Less or Losing More?
- No.3. Alcohol Control Policies in the South-East Asia Region —Selected Issues
- No.4. Alcohol Use and Abuse — What You Should Know
- No.5. Reducing Harm from Use of Alcohol – Community Responses
- No.6. Current Information on Use and Harm from Alcohol in the WHO South-East Asia Region

**Programme on reducing harm
from **ALCOHOL** use
in the community**



**World Health
Organization**

Regional Office for South-East Asia

WHO Library Cataloguing-in-Publication data

World Health Organization, Regional Office for South-East Asia
Programme on reducing harm from alcohol use in the community.
(Alcohol Control Series No. 7)

1. Alcoholism – prevention and control. 2. Alcohol-related Disorders
– prevention and control. 3. Alcohol Drinking – prevention and control.
4. Substance Abuse – prevention and control. 5. Community Mental
Health Services. 6. World Health Organization, Regional Office for South-
East Asia.

ISBN 978-92-9022-343-6

(NLM classification: WM 270)

© World Health Organization 2009

All rights reserved.

Requests for publications, or for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – can be obtained from Publishing and Sales, World Health Organization, Regional Office for South- East Asia, Indraprastha Estate, Mahatma Gandhi Marg, New Delhi 110 002, India (fax: +91 11 23370197; e-mail: publications@searo.who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Printed in India

For technical information, please contact:

Dr Vijay Chandra, Regional Adviser, Mental Health and Substance Abuse

Dr Sajeeva Ranaweera, Temporary International Professional, Mental Health and Substance Abuse

Department of Noncommunicable Diseases and Social Determinants of Health
World Health Organization
Regional Office for South-East Asia
New Delhi, India
Email: mhs@searo.who.int

- Paintings on pages 16, 35 and 45 are contributed to WHO complimentary by Yogeeta, an eminent artist.
- Paintings on pages 4, 8, 18, 23, 24 and 40 are part of WHO-sponsored global school contest on mental health for children.

Contents

Summary	iv
1. Introduction	1
2. Issues on alcohol use relevant to WHO South-East Asia Region	5
3. Information on alcohol use from India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand	7
3.1 Myanmar and Sri Lanka.....	7
3.2 Nepal	8
3.3 India, Indonesia and Thailand	9
3.4 Findings	10
4. Designing programmes to reduce harm from alcohol use through community action	25
4.1 Priority areas for action	25
4.2 Concept of community action to reduce harm from alcohol use	37
5. Implementation and evaluation of programmes to reduce harm from alcohol use in the community.....	41
5.1 Capacity building for adapting, implementing and managing interventions at local levels	41
5.2 Sites for pilot studies to reduce harm from alcohol use.....	42
5.3 Evaluation of programmes	43
5.4 Role envisaged for WHO/SEARO	44
References	46
Annexes	
1. Draft questionnaire with glossary.....	49
2. India	55
3. Indonesia	56
4. Myanmar.....	60
5. Nepal.....	68
6. Sri Lanka.....	74
7. Thailand.....	81

Summary

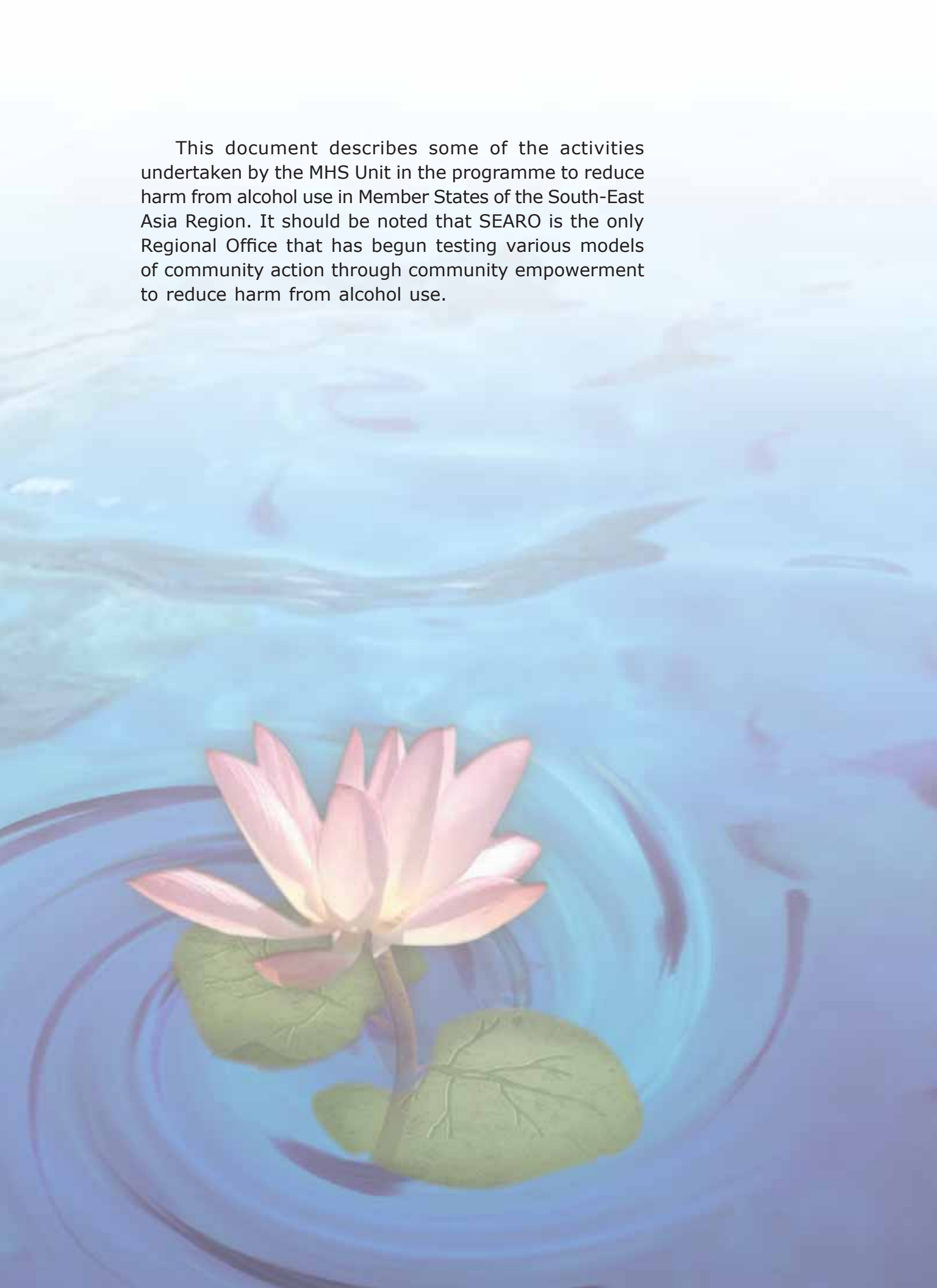
The WHO Regional Office for South-East Asia (SEARO) initiated a programme to acquire and synthesize information relevant to developing and implementing interventions on the use and harm from alcohol through community action in six Member States (India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand). 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 South-East Asia (SEA) Region, different contexts and circumstances of alcohol use exist among countries as well as within different population groups within countries. Thus, information on alcohol use and harm from use in different locations and population groups was obtained. Information 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 was collected.

Following the analysis of data, a meeting of experts identified the issues for addressing harm related to alcohol use through community empowerment projects. These include alcohol use among youth, violence and antisocial behaviour following alcohol use, use of alcohol at special occasions, and pay-day use.

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

This document describes some of the activities undertaken by the MHS Unit in the programme to reduce harm from alcohol use in Member States of the South-East Asia Region. It should be noted that SEARO is the only Regional Office that has begun testing various models of community action through community empowerment to reduce harm from alcohol use.



**protect
your
community**



1

Introduction

There is substantial evidence that alcohol use is a major determinant of ill-health and of economic and social disempowerment. Many governments worldwide, including the governments of Member States in the South-East Asia Region, consider harm from alcohol use in the community a serious issue which needs to be addressed, as evidenced by several World Health Assembly resolutions and resolutions¹ adopted by the WHO Regional Committee for South-East Asia (SEA/RC34/R2 and SEA/RC59/R8).

In 2006, the WHO Regional Committee for South-East Asia, through resolution SEA/RC59/R8, requested the Regional Office to support Member States in building and strengthening institutional capacities for developing information systems, policies, action plans, programmes, guidelines and monitoring/evaluation programmes on prevention of harm from alcohol use. Thus, governments of Member States have requested technical support from SEARO to develop programmes related to reducing harm from alcohol use.

Alcohol use and its related harm depend on the sociocultural milieu in which it is used. Policies, legislation, enforcement, cultural norms, alcohol industry activities, the medical and social services available, the level of empowerment of communities and individual perceptions

There is substantial evidence that alcohol use is a major determinant of ill-health and of economic and social disempowerment.

Alcohol use and its related harm depend on the socio-cultural milieu in which it is used.

Many governments worldwide, consider harm from alcohol use in the community a serious issue which needs addressing.

are some of the factors that contribute to the initiation of use, maintenance of use and behaviours that lead to harm from alcohol use. As a result, many variations in behaviours, perception and programmes related to use of alcohol can be observed, not only between countries, but also within countries.

There is a large body of internationally documented information related to alcohol use, policies and interventions. 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. Such research and information is largely 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 the situation is quite different. Alcohol is a significant contributor to poverty and impedes development, in addition to its adverse social, psychological and health impact.

Traditionally, information used for programme development in this area has been mainly statistical data related to the consumption rates and morbidity/mortality. But such data alone are quite insufficient to develop and implement effective programmes to reduce alcohol-related harm. Qualitative information covering the context and patterns of use, perceptions of communities, the diverse agencies involved (often with conflicting interests) is more important and urgent at this juncture. In addition, initiatives already in place, current capacities and gaps that need filling should be considered. This is because alcohol-related programmes should not only be developed, strengthened and expedited, but also made relevant to 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 analysed. The Mental Health and Substance Abuse Unit (MHS) 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 on the socioeconomic harm due to 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 developed and disseminated. Other resource material that has been developed, such as pamphlets which can be used in schools, have also been circulated².

The second step in the development of programmes to reduce harm from alcohol use was the compilation and analysis of community-based data on alcohol use from Member States. Community-based surveys on the use of and harm from alcohol use were conducted in Myanmar, Nepal and Sri Lanka. These sample survey data and information from national surveys in three other countries (India, Indonesia, and Thailand) were analysed.

The third step was to design programmes to reduce harm from alcohol use through community action. These programmes have been developed in consultation with experts from Member States where the programmes will be implemented and were based on the findings of data compiled from six countries.

The fourth step, which is currently in progress, will be the implementation and evaluation of the programmes to reduce harm from alcohol use in the community through community action.

This document describes some of the activities undertaken by the MHS Unit in the programme to reduce harm from alcohol use in Member States of the South-East Asia Region.

A faint, stylized illustration in the background of the right side of the page shows a person sitting at a table, possibly drinking from a bottle. The style is simple and artistic, with soft colors.

Alcohol is a significant contributor to poverty and impedes development. It also has an adverse social, psychological and health impact.

HEALTHY ADD



~~PEAK?
! ?
PRESSURE~~



A Period which can
make or break ur life

2

Issues on alcohol use relevant to WHO South-East Asia Region

There is a rich diversity of languages, religions, ethnicities, cultural norms, geography, political ideologies and forms of government in countries of the WHO South-East Asia Region. Traditional western models of prevention of harm from alcohol use have not been very useful in countries of the Region due to the many special features associated with alcohol use.

The emphasis 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, and other behaviours. It should also be remembered that people usually consume large quantities of alcohol at one time (binge drinking), unlike western patterns of consumption, such as habitual

Care should be taken to ensure that interventions are tailored to the needs of the countries and communities.

consumption of one glass of wine every day. Another issue of concern is the consumption of alcohol among women in the Region, which is currently quite low but gradually increasing. Although some communities advocate abstinence from use of alcohol for 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 are also of concern in the Region. Illicit alcohol is now included under the category of “unrecorded” alcohol in WHO programmes. The enforcement agencies responsible for curbing illicit alcohol are often overstretched by the limited resources available.

Legislation and policy measures alone cannot fully address the reduction of harm related to alcohol use in the Region. In this context, community empowerment programmes become important as a strategy.

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. Hence, care should be taken to ensure that interventions are individually tailored to the countries and communities concerned. 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.

3

Information on alcohol use from India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand

The objective of compiling and analysing community-based data on alcohol use was to document the current situation of use and harm from alcohol 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.

3.1 Myanmar and Sri Lanka

A protocol was developed by the MHS Unit for the assessment, which included a questionnaire, sampling frame and a format for reporting of findings. The questionnaire used to obtain these data is attached in Annex 1.

Myanmar and Sri Lanka implemented their programmes with a similar design. As per the objectives of the assessment in Myanmar and Sri Lanka, the questions



MA THIRI NANDA SHWE WAR
PHONE

and the sampling frame were designed to obtain specific information that would enable development of practical community-level interventions. For example, this survey did not try to ascertain the exact amount of alcohol consumed by each respondent. It 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 by making the users recall the amount consumed (often unreliable) and trying to calculate the amount of alcohol contained in the various types of beverages used in local communities. Also, when designing community-level interventions relevant to the context, they 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). 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 assessment. The corresponding figures for Southern Shan State and for Mon State were 1260 respondents and 1116, respectively.

In Sri Lanka, the survey was carried out in all nine provinces of the country (Annex 6). A total sample of 1800 persons aged 15 to 64 years who had consumed at least one alcohol-containing beverage in the past three months were interviewed.

3.2 Nepal

In Nepal, the STEPS sample was used. STEPS³ 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 and 64 years were interviewed (Annex 5).

3.3 India, Indonesia and Thailand

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 (NHFS-3) was used⁴. 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 was published in September 2007. A total sample of 198 754 persons in the age group of 15 to 49 were assessed (Annex 2).

Indonesia

Data published by the National Institute for Health Research and Development in its report, "Basic Health Research 2007: National Report"⁵ was reviewed. This was a cross-sectional descriptive survey covering all households in Indonesia. The total sample was 258 366 households and 987 205 household members were interviewed (Annex 3).

Thailand

Data from the National Household Survey on Estimation of Population of Alcohol Abuse 2007 was reviewed⁶. This survey used a multistage sampling approach through which 29 provinces were selected, with a final sample of 11 348 households surveyed (Annex 7).

WHO Regional Office for South-East Asia has undertaken many activities related to reducing harm from alcohol use.

A pattern of widespread use of alcohol has been observed in some communities in Member States of the South-East Asia Region.

Illicit alcohol production and consumption is also of concern in the Region.

3.4 Findings

Magnitude of alcohol use

The NHFS-3 survey in India reported that the national average of alcohol users 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 lowest in Gujarat.

In Indonesia, it is estimated that overall, about 4.6% of the population ten years of age and older had consumed an alcohol-containing beverage in the previous 12 months. However, in some districts, the magnitude of alcohol use is 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 (age group 15–64) had consumed an alcohol-containing beverage in the previous 12 months. In Thailand, it is estimated that 28.4% of persons aged 12 to 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 estimating the magnitude of use of alcohol in the entire country, but attempted to obtain information of harm from alcohol use. In another study of a nationally representative sample in Sri Lanka, 53.1% of males and 6.4% women above 15 years were current alcohol users⁷.

This information suggests a pattern of widespread use of alcohol in some communities in Member States of the South-East Asia Region. The harm from alcohol use is described below.

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 India⁸, whiskey (46.4%) was the most common type of alcohol consumed, followed by “arrack” which is a type spirit brewed locally (33.9%).


In Myanmar, the most common type of alcohol consumed in all three locations of the survey 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, but in much smaller proportions at the other two sites. However, in southern Shan State, a high proportion of female alcohol users consumed illegal liquor. Approximately 15% of alcohol users consume beer in southern Shan State and Mon State, but less than 9% in Yangon division. In all three survey sites, western-type spirits (such as whiskey) were 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%) consume illegally produced alcohol. Beer was consumed more commonly in urban areas 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, whiskey, medicinal alcohol, home-made alcohol and wine, in that order.

Any interventions aimed at users of illegal alcohol should be given preference only in areas where there is significant use of illicit alcohol.



These data are important as they suggest possible intervention strategies. For example, commercially produce alcohol (beer and whiskey) may be amenable to policies such as increased taxation, reduced availability, etc. But home-brewed and illegally produced alcohol could be controlled through action by local communities where it is produced and sold.

It should also be noted that the proportion of people in the community using illegal alcohol varies substantially, and it is not necessarily the most common type of alcohol used in the South-East Asia Region. Therefore, any intervention aimed at users of illegal alcohol should be given preference only in areas where there is significant use of illicit alcohol. 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.

Frequency of alcohol use

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

In all three sites surveyed in Myanmar, the proportion 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% of 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.

Information on the frequency of alcohol use is not available from the data under review from Indonesia and Thailand.

Age distribution and initiation of 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%).

In Nepal, use of alcohol was uniformly distributed across the age groups in both genders, except for young women, in whom 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 of alcohol use varied between geographical areas as well as within

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

different population groups within a given geographical area. Overall, around 5% admitted starting to use alcohol before the age of 15, but with a high of about 20% among the 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 of 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 of alcohol use was similar between the genders and age span. However, up to 17% of males and 10% of females initiated alcohol use early in life, between the ages of 15 and 24, and 5.1% of users initiated the habit before 15 years of age.

A disturbing finding reported from India is that the age of initiation of alcohol use habit has declined from a mean of 28 years to 20 years between the birth cohorts of 1920-30 and 1980-90⁹.

Alcohol use by young persons

In India, among male users 15-49 years old, 19% were aged 15-19 years¹⁰. In Indonesia, the highest prevalence of use was in the 25-34 year age group (6.7%), followed by those aged 15-24 years (5.5%)¹¹. Although these proportions appear small, they are important because of the large population of the country; and unlike many other countries, in Indonesia, younger age groups consume more than the older groups.

In the southern Shan State of Myanmar, 18% of current male users were between the ages of 15 and 25 years. The figure was 17% in Mon State.

Data from Nepal showed that 30.1% of daily or almost daily users were in the young age group (15-24 years). As much as 43.3% of the respondents in the

Alcohol use among young people should be addressed as a priority.

45–54-year age group were daily or almost daily users. Daily or almost daily use was much more common in rural areas (29.4% versus 11.7%).

In Sri Lanka, the current 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 males and females, respectively, in a survey of 455 students aged 15–19 years in a southern district¹².

In Thailand, surveys of high-school students in classes 7, 9 and 11 in four provinces in southern Thailand found that the proportions who had consumed alcohol in the past 30 days were 19.3%, 17.3% and 15.2% in 2002, 2003 and 2004,¹³ respectively, for the three classes.

The above data make it imperative that alcohol use among young people be addressed as a priority. However, this should be undertaken with care. Factors that promote alcohol use in this age group should be carefully determined and addressed so that sustainable results can be achieved. (This issue is discussed further in Section 4.)

Geographic locations and different population groups

In all the 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 larger.

Assumptions related to the various “subgroups” of populations being more prone to alcohol use need to be carefully considered. It is commonly believed that alcohol use is more common in rural and tribal areas and in some

Factors that promote alcohol use in the young age-group should be carefully determined and addressed for sustainable results to be achieved.

Intervention strategies appropriate to the culture of the community should be implemented.



communities, such as the plantation sector in Sri Lanka. Some communities believe that alcohol consumption by boys is a sign of “growing up”. Although the above assumptions about 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.

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

Use of alcohol on special occasions has been reported in 23%–33% of respondents in Myanmar and almost 14% of respondents in Nepal. In Sri Lanka, 37% of users admitted 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 use or harmful use, such as binge drinking.

Consumption of alcohol by people who receive relatively large sums of money periodically is common in the South-East Asia 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

Pay-day drinking is particularly deleterious as large parts of the earnings are squandered on alcohol.



AINDRILA DEY

needs, further contributing to poverty. It will also affect their family's health status and education of children.

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 amounts of alcohol consumed on any given occasion. Recall is also not accurate. It is also 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 such 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 impacts were reported by a small proportion of users ranging from 1.5% to 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 large in some of the sub-groups 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 those experiencing major effects felt them when using alcohol during special occasions. For example, in the Yangon Division of Myanmar, it was 15.8%, while in southern Shan State it was 24.5% and in Mon State it was 22.3%. In Nepal, 16.4% of men who used 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% of men and 61% of women could be classified as having a moderate to high risk for alcohol-related harm. This rate was highest among those in the 12–24 year age group.

Problems following alcohol use

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

A survey in Bangalore, India, showed that a disproportionately greater proportion of alcohol users compared to 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 work¹⁴. In a study of 658 admissions with injuries to an emergency unit of a general hospital in Bangalore, India, 30% of males and 4% of females had consumed alcohol prior to the injury. Injuries in 80% of men and 18% of women were probably linked to use of alcohol by self or others. Violent and deliberate injuries are significantly related to alcohol use and form the largest

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

Problems reported amongst alcohol users include marital problems, sexual problems, children having emotional and behavioural disorders, deliberate self-harm, and problems at the workplace.

segment of alcohol-related injuries¹⁵. 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/100ml¹⁶.

In Myanmar, 20%–40% of those 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 the burden of social and economic costs of alcohol use in the country.

The study in Sri Lanka also identified some problems linked to alcohol use. In Sri Lanka, 32% of all users surveyed encountered problems at least once due to alcohol use during the past three months. A majority of them (30.1% of 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 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 has consumed alcohol were more likely to be hospitalized and far more likely to be killed¹⁷. 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 the 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 Thailand¹⁸.

“Strong urge” to use alcohol, harmful pattern of use (binge drinking), addiction to alcohol (alcohol use disorder)

In India, the Household Survey on Drug and Alcohol published in 2004,¹⁹ based on data collected from March 2000 to November 2001, reported that 17%-26% of current alcohol users were dependent users. In terms of absolute numbers, this survey estimated that nationwide, there were 62.5 million persons who were “alcohol abusers” and 10.5 million who were “dependent users”. The Bangalore study in India found that 41% of the study population engaged in “binge drinking”, in which large quantities of alcohol are consumed at one time. Such a drinking pattern can lead to alcohol poisoning and serious social and medical problems (e.g. road traffic accidents).

One study reported that 41% of the population engaged in “binge drinking”, in which large quantities of alcohol are consumed at one time. Such a drinking pattern can lead to serious problems.

A significant proportion of those interviewed admitted they had a “strong urge” to use alcohol.

The surveys in Myanmar, Nepal and Sri Lanka tried to obtain an estimate of persons with alcohol use disorders. As the objective was not to identify the exact number of persons based on clinical criterion, 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 analysis was carried out by using the CAGE scale²⁰ for the identification of dependent users, 15% of male users could be classified as “dependent users”.

In Sri Lanka, 21.3% of the users said that they have a “strong urge” to drink alcohol daily, though only 12.8% used 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% users in rural areas, while 34% of users in the fisheries community in the same province surveyed 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 Estimation of Population of Alcohol Abuse 2007 classified 2 793 201 people (22.7%) as hazardous drinkers, 386 431 (3.1%) as harmful drinkers and 233 747 (1.9%) as alcohol-dependent using 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 of 25–44 years (32%) and 12–24 years (31%). Among women,

the highest prevalence was in the age group of 12–24 years (11.6%), and among them, 7411 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).

Summary

The data summarized above formed the basis for designing implementation strategies to reduce harm from alcohol use in the community through community action.



LOVE THYSELF

'COZ YOU HAVE
Every-thi



4

Designing programmes to reduce harm from alcohol use through community action

4.1 Priority areas for action

Interventions for young people

Traditionally, many prevention programmes have been targeted at this age group. But attempting to prevent alcohol use with a “harm from alcohol use” approach that emphasizes risks may be inappropriate or even counterproductive—actually increasing the attractiveness of alcohol use as a “dangerous but desirable” pursuit.

Prevention of use interventions should address all young people, irrespective of whether they use 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 use 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 the users in this age group.

Any activity designed for the young age-group should be interesting and informative, and appeal to their intellect.

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 making an effort to design and implement school-based programmes, careful consideration should be given to improving the effectiveness and efficiency of such programmes.

Another popular approach is media-based interventions. Alcohol use and users are often glamourized and promoted in media. Therefore, this approach also seems quite sensible initially. 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 depends 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 initiating and carrying out community interventions to prevent use of alcohol. These communities have low rates of initiation and consumption, according to observational surveys and focused group discussion studies. The groups are involved in designing and implementing community action in their respective communities. These young persons are aware of the factors that make alcohol use attractive and also are 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 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 of 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 strategies which are being used for the promotion of alcohol use and which may be used in the future.

Addressing the context of alcohol use: Use on special occasions

In the SEARO-sponsored surveys, it was seen that special occasions are the most important social context that promotes use of alcohol by young people specifically and all users in general. This is also the most important context of heavy use of alcohol.

In the South-East Asia Region, there are many “special” social occasions ranging from births, weddings, funerals, social and cultural festivals such as New Year and harvesting occasions, to 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 at such 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. The alcohol industry

**Special occasions
are the most
important social
context that
promote use of
alcohol.**

quite discretely uses such occasions to promote and glamourize alcohol use.

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 behaviours. Community leaders were of the opinion that one individual could not refuse to serve alcohol during a funeral as it was 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 an individual. Antisocial behaviour during funerals disappeared and funerals were observed with sanctity.

Addressing the alcoholization of social, religious and other events in a society is best achieved through community action.

Addressing the alcoholization of social, religious and other events in a 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.

Pay-day use of alcohol

A large number of current alcohol users consume alcohol on pay-day. There are several possible methods of intervening to reduce such use at the community and individual level.

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 non-using 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 seen after harvesting. As the contexts are entirely different, the same intervention will not work in both locations.

**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 in Sri Lanka. This has been a 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 by 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 displayed on pay-day, such as violence and injuries, which were common in these communities.

Practical and acceptable methods of addressing pay-day drinking should be developed in consultation with communities



Addressing social harm after alcohol use: Antisocial behaviour/violence and road traffic accidents

Violence, antisocial behaviour and accidents after alcohol use is common, and needs to be addressed on a priority basis. Many interventions have been initiated globally to address this issue. They range from law enforcement programmes to server training in bars to media campaigns to initiatives aimed at modifying social norms that promote antisocial behaviour following alcohol use. The last approach has been effective in this 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 those consuming alcohol are not in control of their behaviour following its use and are not fully aware of their surroundings, social commitments and etiquette. Though there is scientific evidence that consuming a large amount of alcohol will impair the coordination and judgment that are needed for skilled activities such as driving, there is no evidence supporting the belief that alcohol makes its users unaware of their social behaviours.

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 changing social

acceptance of such behaviour and encouraging the communities to respond to such behaviour differently than before, thereby leading to a reduction of antisocial behaviour. Cautious application of such interventions with appropriate adjustments in other settings should be attempted.

Successful intervention programmes for addressing antisocial behaviour/violence following alcohol use in Sri Lanka

Antisocial behaviour following alcohol use is common in some communities in Sri Lanka. Through incremental interventions to reduce the acceptance of such behaviour, the levels of antisocial behaviour and violence have been demonstrably reduced. Changes in community behaviour occur when the concept of unfair privileges attached to alcohol use is clearly understood by the community. Communities then begin to react to antisocial behaviour following alcohol use, in the same way that they would react were the same behaviour displayed but without the preceding consumption of alcohol (e.g. the harassing of women in public with or without involvement of alcohol would be strongly disapproved). Reduction of violence, including domestic violence, has also been seen in rural communities in the Central and Southern Provinces of Sri Lanka where these interventions have been implemented. A plantation hospital in Sabaragamuwa Province reported more than an 80% reduction of admissions with violent injuries within one year of the commencement of the intervention.

There are many examples of successful interventions to reduce alcohol-related road traffic injuries. Research has shown that there are many factors that influence

the success of such programmes²¹. 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 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”).

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

“Suraksha Sanchar” (Safer Travel) was launched in Bangalore during 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. The 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 those tested positive, 35% were above the legally permissible limits of 30 mg/100 ml when checked on a breath analyser.

The second phase of the project to be implemented next year will utilize 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 work²².

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 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 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.

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 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 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. With a “health” argument, the alcohol industry is saying that their “unhealthy product” is better than an even more “unhealthy product” (illicit liquor).

Therefore, a significant finding of these surveys is that caution should be exercised when national policies and community interventions are developed. Programmes should be developed and implemented if illegal (unrecorded) alcohol use is widespread and a major cause of harm to the community.

Programmes should be developed and implemented if illegal alcohol use is widespread and a major cause of harm to the community.

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


Several initiatives to address availability of alcohol in villages have been spearheaded by women in India. There are several examples from Kerala, Madhya Pradesh, 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. However, the sustainability of such programmes may be limited. But 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 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.

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 such services and interventions are provided in inappropriate places, the effort and the resources will not be optimally used.

YOGEEETA

An abstract painting featuring a dense, textured composition of warm, earthy tones including ochre, terracotta, and muted browns. Overlaid on these colors are numerous expressive, white brushstrokes of varying lengths and directions, creating a sense of movement and depth. The overall effect is one of organic complexity and layered visual information.

A successful intervention programme for harmful use of alcohol in India

Community-centered 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 to identify such persons which include 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. At these camps 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 showed 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.

4.2 Concept of community action to reduce harm from alcohol use

Introduction

When interventions are considered, one of the major areas that has been highlighted through community assessments is that the contributing 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 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.

Components of community action

In any community action programme, several factors related to alcohol need to be assessed and addressed. These include, for example, the perceived effects of alcohol on alcohol users, the attractiveness of alcohol, the unfair “privileges” given to alcohol users (e.g. fewer 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, interventions should be developed in consultation with

Interventions should be developed in consultation with the community and should be owned by the community to ensure effectiveness and sustainability.

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 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.

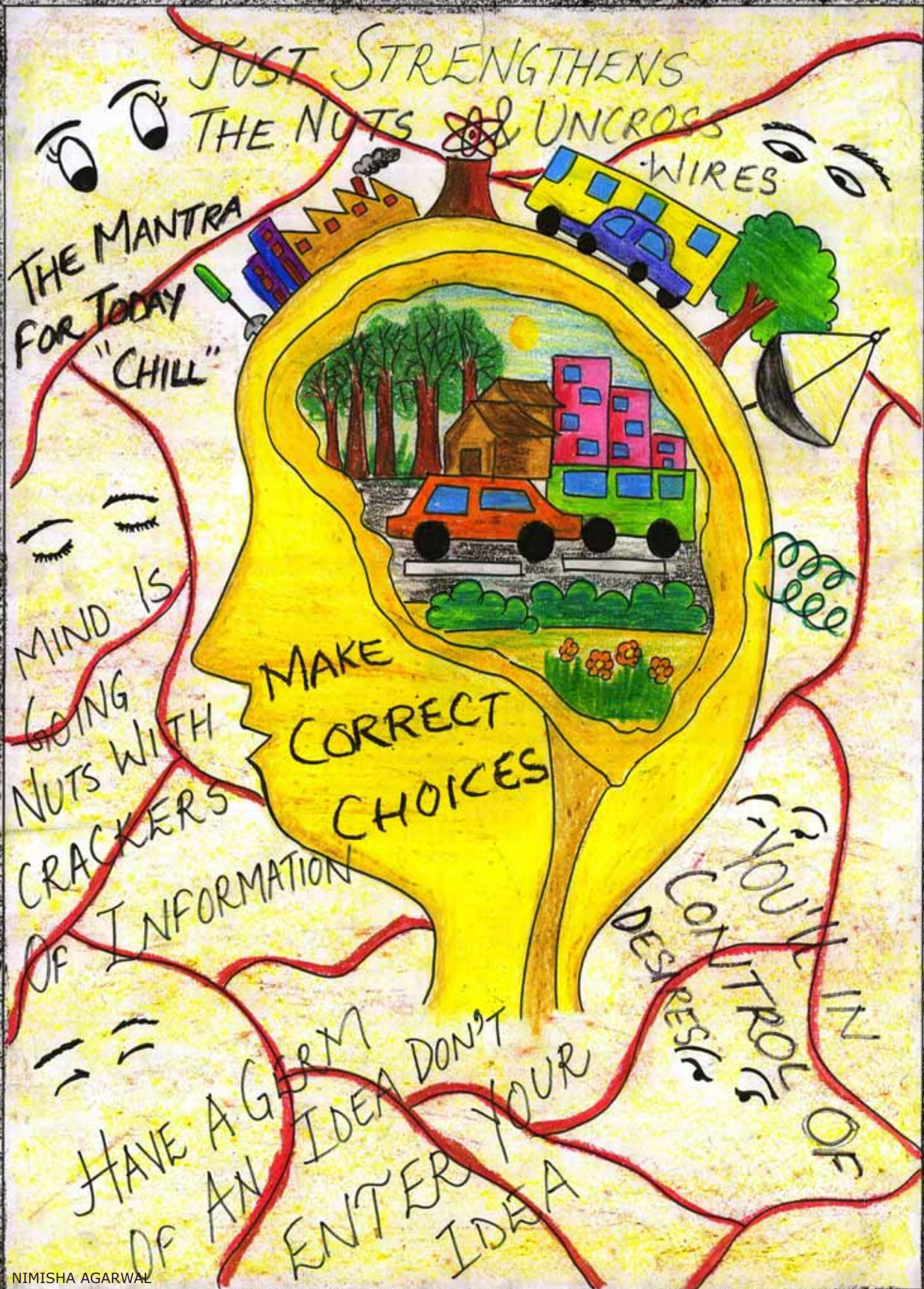
Taking into consideration these issues, community-based programmes on reducing harm from alcohol use are being implemented in this Region based on a participatory, constructive, empowerment-based model. The interventions incorporate the principles enunciated in the Ottawa²³ and Bangkok Charters²⁴ for Health Promotion.

Summary

The programmes in each country and within each community should be adapted to meet the socio-cultural requirements of the community. The important factor is community acceptance and participation. It is only when the community takes ownership of the programme that it will be successful and sustainable.

Outline of principles of the community action programme to reduce harm from alcohol use





5

Implementation and evaluation of programmes to reduce harm from alcohol use in the community

5.1 Capacity building for adapting, implementing and managing interventions at local levels

A major area of emphasis should be building capacity to address issues related to alcohol use at the community level. Although national-level policies, legislation and plans of action are important, ultimately most of these have to be converted into community action for widespread and sustained impact. There are extremely committed public health networks that reach out to the family level in most countries of the South-East Asia Region. Also, in many countries, committed community-based organizations (CBOs) are active, working on many issues related to community development. The capacity of such organizations to effectively address alcohol-related issues will contribute substantially to promoting community action to reduce harm from alcohol use.

A major area of emphasis should be building capacity to address issues related to alcohol use at the community level.

Capacity building must be approached as a long-term and sustained set of activities based on sound knowledge of the existing capacity and the requirement of each country and population group.

As stated earlier, if country-level centralized planning and programming is to be successful, action has to be implemented effectively at the community level.

5.2 Sites for pilot studies to reduce harm from alcohol use

In an intercountry meeting of experts familiar with the concept of community action to reduce harm from alcohol use held in Bangkok from 22 to 23 April 2009, the following sites were selected for developing and testing a programme to reduce harm from alcohol use:

India: Meerut (Uttar Pradesh), Morigaon (Assam), Mandsaur (Madhya Pradesh) and Bastar (Chhattisgarh).

Sri Lanka: Two locations, one each from Kalutara and Galle districts, covering communities with a total of at least 1000 alcohol users.

Thailand: One district in each of two provinces Lop Buri Province (central region) and Songkhla Province (southern region).

Each site will initially conduct an assessment of use and harm from alcohol in the community. Based on the findings of the assessment, specific intervention strategies will be developed in consultation with the community. SEARO's experience as described in this document can form the basis of discussions and development of interventions.

A timeframe of 18 months is planned, with a review at 6 months and then a final review at 18 months. If

the programmes are effective in reducing harm from alcohol use in the community, these will be discussed with governments of Member States in the Region for adaptation and implementation.

5.3 Evaluation of programmes

The main aim of evaluating community interventions is to ascertain if the community is moving in the right direction—in this case, in addressing the determinants of alcohol use and harm from alcohol use. It should be understood that community and group behavioural changes occur within a spectrum, and any particular behaviour can move either way within this spectrum during a given period of time. As stated earlier, changes in individuals are not good examples of successes or failures of community-based behavioural change interventions.

It is well established that community-level behavioural change requires long periods of interventions, often years. Therefore, the evaluation carried out should be able to measure subtle changes which occur in the early phases, indicating the direction of the changes.

Measures used in the earlier phases need to be sensitive to the type of change that can be expected within the timeframe. 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 thought at the planning stage. An appropriate and significant amount of resources should be allocated for evaluation as it is one of the cornerstones of successful interventions.

The main aim of evaluating community interventions is ascertaining if the community is addressing the determinants of alcohol use and harm from alcohol use.

The methods of evaluation and the suitable indicators should be given adequate thought at the planning stage.

Detecting early changes is best carried out by members of the community themselves using less formal methods.

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 to evaluate the programme. Determining the actual “cognitive” and group 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 in the SEARO document on this subject²⁵.

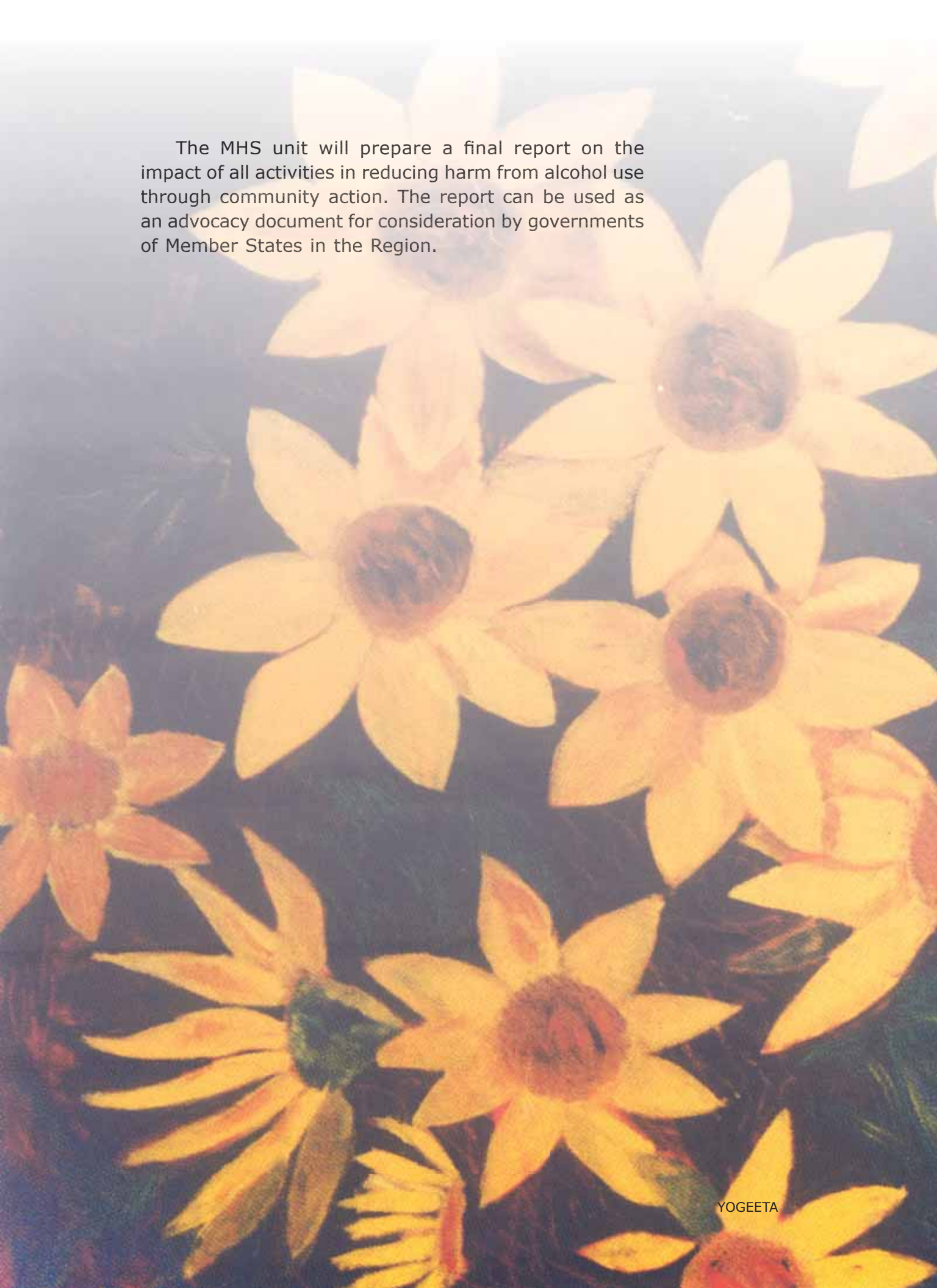
In practice, the development process and outcome measurements should involve the community as a whole. Detection of early changes is best carried out by members of the community themselves using less formal methods. The community should be encouraged to develop their own indicators to measure change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

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.

5.4 Role envisaged for WHO/SEARO

The MHS unit in the Regional Office will provide technical documentation to all participating sites. In addition, the MHS unit will be available to help resolve technical problems, based on experience at other sites.

All sites will be requested to provide progress reports every two months to MHS unit, so that progress at all sites can be monitored. A review meeting of all principal investigators is envisaged by SEARO in December 2009.



The MHS unit will prepare a final report on the impact of all activities in reducing harm from alcohol use through community action. The report can be used as an advocacy document for consideration by governments of Member States in the Region.

References

1. World Health Organization. *Alcohol and drug abuse*. World Health Assembly resolutions WHA 32.40, WHA 36.12, WHA 36.12, WHA 42.20, WHA 55.10, WHA 57.10, WHA 57.16, WHA 58.26 and WHA 61.4. Geneva; WHO.
2.
 - World Health Organization, Regional Office for South- East Asia. *Burden and socio-economic Impact of alcohol; the Bangalore Study*. (Alcohol Control Series 1). New Delhi: WHO-SEARO, 2006.
 - World Health Organization, Regional Office for South-East Asia. *Public health problems caused by harmful use of alcohol; gaining Less or Losing More?* . (Alcohol Control Series 2). New Delhi: WHO-SEARO, 2006.
 - World Health Organization, Regional Office for South-East Asia. *Alcohol – control policies in the South-East Asia Region: selected Issues*. (Alcohol Control Series 3). New Delhi: WHO-SEARO, 2006.
 - World Health Organization, Regional Office for South-East Asia. *Alcohol use and abuse – what you should know*. (Alcohol Control Series 4]. New Delhi: WHO-SEARO, 2006.
 - World Health Organization, Regional Office for South-East Asia. *Reducing harm from use of alcohol – community responses*. (Alcohol Control Series 5). New Delhi: WHO-SEARO, 2006.
 - World Health Organization, Regional Office for South-East Asia. *Current information on use and Harm from Alcohol in the South-East Asia Region*. (Alcohol Control Series 6). New Delhi: WHO-SEARO, 2006.
 - World Health Organization, Regional Office for South-East Asia. *Facts on Alcohol Use and Abuse – Programme on Adolescent Mental Health*.
3. World Health Organization. *STEPwise approach to chronic disease risk factor surveillance*. Geneva: WHO. (<http://www.who.int/chp/steps/riskfactor/en/> - accessed 03 August 2009).
4. *Questionnaires*. NHFS 3 <http://www.nfhsindia.org/ques.html> - accessed 04 August 2009).
5. National Institute for Health Research and Development: *Basic health research 2007: national report*. Jakarta: NIHRD, Ministry of Health, 2008.

6. Administrative Committee for Substance Abuse Research Network (ACSAN) of the Office of Narcotics Control Board (ONCB), Ministry of Justice, Thailand. National Household Survey on Estimation of Population of Alcohol Abuse 2007. Supported by the Centre for Alcohol Study, Office of Health Promotion Foundation.
7. Hettige S, Paranagama D. Gender and alcohol in Sri Lanka. In: *Alcohol, gender and drinking problems – perspectives from low and middle income countries*. World Health Organization, 2005
8. World Health Organization, Regional Office for South-East Asia. *Burden and socio-economic Impact of alcohol; the Bangalore Study*. (Alcohol Control Series 1). New Delhi: WHO-SEARO, 2006.
9. Benegal V. National experiences, India: alcohol and public health. *Addiction*. 2005; 100: 1051-1056.
10. NFHS3. National Family Health Survey, India. (<http://www.nfhsindia.org/nfhs3.htm> I- accessed 04 August 2009).
11. National Report. National Institute for Health Research and Development. *Basic Health Research 2007*. Jakarta: Ministry of Health, 2008.
12. Perera B, Torabi MR. Preliminary study of smoking and alcohol use among students in southern Sri Lanka. *Psychol Rep*. 2004 Jun; 94(3 Pt 1): 856-8.
13. Assanangkornchai S, Pattanasattayawong U, Samangsri N, Mukthong A. Substance use among high-school students in southern Thailand: trends over 3 years (2002-2004). *Drug Alcohol Depend*. 2007 Jan 12;86(2-3):167-74.
14. World Health Organization, Regional Office for South-East Asia. *Burden and socio-economic Impact of alcohol; the Bangalore Study*. (Alcohol Control Series 1). New Delhi: WHO-SEARO, 2006.
15. Benegal V, Gururaj G, Murthy P. *Project Report on a WHO Multi-Centre Collaborative Project on establishing and monitoring alcohol's involvement in casualties. 2000–01*. Bangalore: National Institute of Mental Health and Neurosciences Bangalore, 2002.
16. Gururaj G, Benegal V. *Driving under the influence of alcohol and road traffic injuries in Bangalore*. Bangalore: National Institute of Mental Health and Neurosciences Bangalore, 2002.

17. Kasantikul V, Ouellet JV, Smith T, Sirathranont J, Panichabhongse V. The role of alcohol in Thailand motorcycle crashes. *Accid Anal Prev*. 2005 Mar; 37(2): 357-66.
18. Narongchai S, Narongchai P. The prevalence of detectable blood alcohol concentration among unnatural deaths in northern Thailand. *Journal of the Med Association of Thailand*. 2006 Jun; 89(6): 809-13.
19. *The extent, pattern and trends of drug abuse in India: National survey 2004*. New Delhi: UNODC Regional Office for South Asia. (http://www.unodc.org/india/india_national_survey2004.html - accessed 04 August 2009).
20. CAGE questionnaire: http://en.wikipedia.org/wiki/CAGE_questionnaire. (downloaded 18 May 2009).
21. Elder RW et al. Effectiveness of sobriety checkpoints for reducing alcohol-involved crashes. *Traffic Injury Prevention*, 2002, 3: 266-274.
22. *Project report. "Driving under the influence of alcohol and road traffic injuries in Bangalore*. (Gururaj G and Benegal V - Project Coordinators). Bangalore: National Institute of Mental Health and Neuro Sciences. (<http://www.nimhans.kar.nic.in/deaddiction/lit/BATFReport.pdf> - accessed 04 August 2009).
23. *Health promotion: Ottawa charter: first International Conference on Health Promotion, Ottawa, 21 November, 1986*. Geneva: World Health Organization, 1986. WHO/HPR/95.1. http://whqlibdoc.who.int/hq/1995/WHO_HPR_HEP_95.1.pdf - accessed 04 August 2009).
24. *The Bangkok charter for health promotion in a globalized world: 6th Global Conference on Health Promotion, August, 2005*. http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf - accessed 04 August 2009).
25. World Health Organization, Regional Office for South-East Asia. *Reducing harm from use of alcohol – community responses*. (Alcohol Control Series 5). New Delhi: WHO-SEARO, 2006.

Annex 1

Draft questionnaire with glossary used in Myanmar and Sri Lanka

Rapid situational assessment of alcohol use in Myanmar and Sri Lanka

Study No	
Interviewer	

House address	
Head of household	

Area	Urban	Rural
------	-------	-------

Members of household over 15 years

No	Name (optional)	Present	Responded	Age	Sex	Alcohol use*
		Y/N	Y/N		M/F	Y/N

* Have you used alcohol during the last three months?

Complete separate questionnaire for each user

Questionnaire

1. What type of alcohol do you use?	Beer	Western liquor	Country Legal liquor	Illegal Country liquor	Home brew	Other
1.1 What type of alcohol do you use most commonly? *	Beer	Western liquor	Country Legal liquor	Illegal Country liquor	Home brew	Other

* Select only one response

2. How often do you consume alcohol?	Sp. Occ	1-4/ m	2-4 / w	Daily or almost daily
---	---------	--------	---------	-----------------------

3. What happens usually when you take alcohol?	Nothing or minor effects	Discomfort – headache, nausea, indigestion	Major effects- drowsiness, vomiting, LOC, medical Rx
---	--------------------------	--	--

4. How often do you drink until you suffer from major effects?	Never	Sp. Occ	1-3/m	2-4/w	Daily or almost daily
---	-------	---------	-------	-------	-----------------------

5. At what age (approximately) did you first consume alcohol?	
--	--

5.1 In what situation did you use it?	Sp. Occ	With friends	Alone	other
--	---------	--------------	-------	-------

5.2 What type of alcohol did you use when you first consumed?	Beer	Western liquor	Country Legal liquor	Illegal Country liquor	Home brew	Other
--	------	----------------	----------------------	------------------------	-----------	-------

6. Do you usually drink on pay day?	Y	N
--	---	---

6.1 Are you paid	Daily	Weekly	Monthly
-------------------------	-------	--------	---------

6.2 How do you get your pay	Cash to hand	Bank deposit
------------------------------------	--------------	--------------

7. Do you have a strong urge to need to drink every day?	Y	N
---	---	---

8. Have you had any of the following associated with alcohol use during last three months?

Fights / violence	Accidents or injuries (domestic or otherwise)	Law and order problems	Medical illness	Obtaining loans for daily needs	Others – passing out, money stolen etc
-------------------	---	------------------------	-----------------	---------------------------------	--

9. What do you think should be done to reduce your consumption of alcohol?

Glossary

Have you used alcohol during the last three months?

The period of three months is used to ensure that the recall is accurate. The one year or lifetime prevalence is not used. In the context of this study, which aims to gather the current picture for designing future interventions, the three-month prevalence is more valid.

The ages will be analyzed in three groups – 15-25 years, 26-50 years and 50+ years. This classification will be an approximation of the young (15-25 years), those likely to have family responsibilities (26-50 years), and later life (50+years).

1. What type of alcohol do you use?	Beer	Western liquor	Country Legal liquor	Illegal Country liquor	Home brew	Other
1.1 What type of alcohol do you use most commonly? *	Beer	Western liquor	Country Legal liquor	Illegal Country liquor	Home brew	Other

* Select only one response

Question 1 is to ascertain the use of different types of alcohol in the community. Beer and western liquor (whiskey, wine) are used throughout the Region. But locally produced alcohol (both legal and illegal) is used as widely. It is understood that the contents of alcohol may differ only slightly among “western” and “country” alcohol products. These are separated as there may be differences in their use within countries and communities. In some countries, home-brewed alcohol is also in common use. The type of alcohol used most commonly (in other words, more frequently) will be considered during the analysis of various other parameters in the questions below. This is required because it is well understood that alcohol users use different types of alcohol even within one drinking occasion. Therefore, analysis becomes complicated if question 1.1 is not used.

2. How often do you consume alcohol?	Sp. Occ	1-4/ m	2-4 / w	Daily or almost daily
---	---------	--------	---------	-----------------------

This will help identify target groups of users for interventions. Special occasions are any family, community or national occasions, except pay-day. Pay-day alcohol use is assessed separately. Special occasions are emphasized because qualitative information available from the Region shows that many special occasions such as weddings, festivals etc. have become drinking occasions. Therefore, it is important to assess it from the point of view of intervention design. Daily use is not separated as the intention is to obtain information on occasional to frequent use of alcohol.

3. What happens usually when you take alcohol?	Nothing or minor effects	Discomfort – headache, nausea, indigestion	Major effects- drowsiness, vomiting, LOC, medical Rx
---	--------------------------	--	--

Usually, the quantity of alcohol used per drinking occasion is obtained from the respondents. In the context of this Region it is difficult as the measures, the recall and the different concentrations of various types of alcohol will confound such information. A further complication is that persons may consume more than one type of alcohol per drinking occasion. The quantity consumed is usually used to assess potential harm. This question is designed to ascertain the effect, and therefore, indirectly, the approximate quantity – mild, moderate and heavy use.

4. How often do you drink until you suffer from major effects?	Never	Sp. Occ	1-3/m	2-4/w	Daily or almost daily
---	-------	---------	-------	-------	-----------------------

This aims to identify heavy drinking. The term “binge drinking” is not used as it has specific definitions. The number of drinks consumed is not considered for reasons given under the previous question.

5.1 In what situation did you use it?		Sp. Occ		With friends		Alone	other
5.2 What type of alcohol did you use when you first consumed?	Beer	Western liquor	Country Legal liquor	Illegal Country liquor	Home brew	Other	

Though the lifetime prevalence of alcohol use is not assessed in the questionnaire, the age of initiation, the type of alcohol used and the circumstances of initiation has many implications for policy and programme planning. The term "special occasion" is described under question 2. The age itself can be approximate, as it is understood that accurate recall for such a question may be difficult.

6. Do you usually drink on pay day?				Y	N
6.1 Are you paid		Daily	Weekly	Monthly	
6.2 How do you get your pay		Cash to hand	Bank deposit		

Using alcohol on pay days seems to be widespread in some communities. This will be analyzed for all those who get their salaries weekly or monthly. In addition, how they get their salary may be an important factor. Those whose salaries go to the banks may not be used to pay-day drinking or drink less. Information on this will be important when designing interventions.

7. Do you have a strong urge to need to drink every day?	Y	N
---	---	---

Alcohol dependence is difficult to assess reliably in a community survey such as this. Although screening instruments such as CAGE or Brief MAST have been used in community studies they are not used in this study, as the aim is not to identify alcohol dependents. This question based on a functional and subjective feeling, will give an idea of the scale of the problem, though the sensitivity and specificity of such a question may be contentious.

8. Have you had any of the following associated with alcohol use during last three months?

Fights / violence	Accidents or injuries (domestic or otherwise)	Law and order problems	Medical illness	Obtaining loans for daily needs	Others – passing out, money stolen etc
-------------------	---	------------------------	-----------------	---------------------------------	--

This will give an overall view of the acute harm caused by alcohol use. One user may have more than one such problem during the last three months. The law and order problems may be disorderly behaviour, drunken driving, violent conduct etc, associated with alcohol use.

9. What do you think should be done to reduce your consumption of alcohol?

This is an open-ended question that will allow users to assess their use and think of ways to reduce it, in addition to providing qualitative information, from the perspective of the user. This question should be post-coded, as the types of answers we would receive cannot be predicted.

Vignettes / stories or descriptive case studies under each question can be included as such information will provide more depth for the final report.

Annex 2

India

The most recent data on Alcohol Use in India can be obtained from the findings of the National Family Health Survey (NFHS-3). The study was carried out by the International Institute for Population Sciences, Mumbai in 2005-2006 and the report was published in September 2007. The highlights are as follows:

- Total sample size: 198,754 persons between the ages of 15-49 (M = 74,369, F = 124,385)
- Percentage of men who drink alcohol (defined as any use) was:
- Men who drink alcohol across all ages was (31.9%-National)
- Women who drink alcohol across all ages (2.2% National)
- Age wise break up of alcohol users for men: 15-19 yrs: 11%, 20-34 yrs: 34.9%, 35-49 yrs: 39.1%
- Percentage of men who drink almost every day: 15-19 yrs: 3.4%, 20-34 yrs: 7.0%, 35-49 yrs: 13.2%
- Percentage of alcohol use among men varies across states, highest being Arunachal Pradesh; (61.1%) and lowest being Gujarat (16.0%)
- Age wise break up of alcohol users for women: 15-19 yrs: 1.0%, 20-34 yrs: 2.1%, 35-49 yrs: 3.2%
- Percentage of women who drink almost every day: 15-19 yrs: 6.8%, 20-34 yrs: 13.6%, 35-49 yrs: 18.1%

For detailed information on this subject visit
<http://www.iipsindia.org>
<http://www.mohfw.nic.in>

Annex 3

Indonesia

National Institute for Health Research and Development (2008): *Basic Health Research 2007: National Report*. NIHRD, Ministry of Health, Republic of Indonesia.

Riskesdas 2007 is a cross sectional descriptive survey. The population is all households in Indonesia. Sampling of household and members of the household is identical to susenas 2007 (Social and Economic Survey 2007 done by Central Bureau of Statistics).

A total sample of 258,366 households and 987,205 household members have been collected. For biomedical measurements there were 36,357 samples collected.

The limitations of Riskesdas 2007 on the aspects of non-random error consists of development of new districts, census block that are unreachable, households that could not be found, difference in data collecting time, estimation at the level of district could not be applied to all indicators, and biomedical data that are representative only for urban census block.

Five provinces, Papua, Papua Barat, Maluku, Maluku Utara and NTT, were surveyed in August - September 2008, while the other 28 provinces had been completed in 2007.

Research questions of Riskesdas 2007:

- (1) What is the status of health and determinants of health at the national, province and district/ municipality level?
- (2) How is the relationship between poverty and health
- (3) Is there any specific health problems?

Goals of Riskesdas 2007:

To provide basic data on health and determinants of health status at the level of household and individual that comprises of:

- (1) Nutritional status
- (2) Access and utility of health service
- (3) Environment sanitation
- (4) Food consumption
- (5) Communicable, non-communicable diseases and history of inherited illness
- (6) Health service response
- (7) Knowledge, attitude and behavior
- (8) Disability
- (9) Mental health
- (10) Immunisation and growth monitoring
- (11) Infant health
- (12) Measurements of anthropometry, blood pressure, waist and upper arm circumference
- (13) Biomedical measurements
- (14) Visual examination
- (15) Dental examination
- (16) Verbal autopsy on the cause of death
- (17) Mortality

**Prevalence of alcohol use in the last 12 months
and last 1 month by province, basic health
research (Riskesdas) 2007, Indonesia**

Province	Consumption in the last 12 months *	Consumption in the last 1 month *
NAD	1,5	0,4
Sumatera Utara	6,1	4,4
Sumatera Barat	1,5	0,7
Riau	3,4	1,3
Jambi	2,7	1,7
Sumatera Selatan	2,9	2,1
Bengkulu	2,8	1,8
Lampung	2,2	1,4
Bangka Belitung	4,4	2,5
Kepulauan Riau	5,9	3,7
DKI Jakarta	4,0	2,7
Jawa Barat	2,6	1,3
Jawa Tengah	2,2	1,1
DI Yogyakarta	3,2	1,7
Jawa Timur	1,9	1,0
Banten	1,6	0,9
Bali	6,4	4,6
Nusa Tenggara Barat	2,0	1,2
Nusa Tenggara Timur	17,7	13,5
Kalimantan Barat	8,8	4,8
Kalimantan Tengah	6,5	3,5
Kalimantan Selatan	1,2	0,5
Kalimantan Timur	3,4	1,7
Sulawesi Utara	17,4	14,9
Sulawesi Tengah	8,9	6,4
Sulawesi Selatan	5,9	3,9
Sulawesi Tenggara	7,7	5,8
Gorontalo	12,3	10,7
Sulawesi Barat	4,0	2,6
Maluku	8,2	5,0
Maluku Utara	7,4	4,4
Papua Barat	8,1	4,9
Papua	6,7	4,4
Indonesia	4,6	3,0

* per 100 population, 10 years of age and older

Prevalence of alcohol use in the last 12 months and last 1 month by respondents' characteristics in Indonesia, Basic Health Research (Riskesdas) 2007, Indonesia

Respondents' Characteristics	Ever consume in the last 12 months *	Still consume in the last 1 month *
Age groups (Years)		
10-14	0,7	0,3
15-24	5,5	3,5
25-34	6,7	4,3
35-44	5,5	3,7
45-54	4,8	3,3
55-64	3,6	2,4
65-74	2,6	1,7
75+	1,5	0,9
Gender		
Male	8,8	5,8
Female	0,7	0,4
Education		
No school	3,1	2,1
Not graduated from Elementary School	3,8	2,5
Elementary School	4,5	3,0
Junior High School	5,5	3,5
Senior High School	6,0	3,8
University	3,9	2,4
Type of area		
Urban	3,9	2,5
Rural	5,1	3,3
Household expenditure per capita		
Quintile-1	4,4	2,9
Quintile-2	4,7	3,0
Quintile-3	4,6	3,0
Quintile-4	4,7	3,0
Quintile-5	4,7	3,0

* per 100 population, 10 years of age and older

Annex 4

Myanmar

The assessment of alcohol use was carried out in three sites in Myanmar (Southern Shan State, Yangon division and Mon State). Data were tabulated using a similar format for all three sites (available in detailed project report). One relevant table pertaining to one issue is reproduced below. Significant differences at other sites are noted below the table.

1. Current use of alcohol

1.1: Current use of alcohol * by age and sex in the study sample. Mon State

Age group (years)	Male	Female	Total
15-25	183 (16.6)	2 (15.4)	185 (16.6)
26-50	715 (64.8)	7 (53.9)	722 (64.7)
50+	205 (18.6)	4 (30.8)	209 (18.7)
Total	1,103 (100.0)	13 (100.0)	1,116 (100.0)

* Consumed alcohol containing beverage in the last 3 months

Comment: The highest proportion of alcohol users was in the age group 25 to 50 years at all three sites.

1.2: Current use of alcohol by type of alcohol used most often by sex. Southern Shan State

Type of alcohol	Male	Female	Total
Beer	199 (16.6)	6 (10.2)	205 (16.3)
Western type spirits	119 (9.9)	5 (8.5)	124 (9.8)
Country-liquor	553 (46.0)	19 (32.2)	572 (45.4)
Illegal liquor	224 (18.7)	24 (40.7)	248 (19.7)
Home made	70 (5.8)	3 (5.1)	73 (5.8)
Others	36 (3.0)	2 (3.4)	38 (3.0)
Total	1,201 (100.0)	59 (100.0)	1,260 (100.0)

Comment: The type of alcohol used most often was country liquor. In Southern Shan State, a large number of respondents, particularly females, also consumed illegal liquor (40.7%), the proportions were much lower at the other two sites.

1.3: Current use of alcohol by age and type of alcohol used most often. Southern Shan State

Type of alcohol	15-25	26-50	50+	Total
Beer	83 (35.5)	99 (11.7)	23 (13.1)	205 (16.3)
Western type spirits	19 (8.1)	85 (10.0)	20 (11.4)	124 (9.8)
Country-liquor	96 (41.0)	401 (47.2)	75 (42.6)	572 (45.4)
Illegal liquor	24 (10.3)	178 (20.9)	46 (26.1)	248 (19.7)
Home made	8 (3.4)	53 (6.2)	12 (6.8)	73 (5.8)
others	4 (1.7)	34 (4.0)	0 (0.0)	38 (3.0)
Total	234 (100.0)	850 (100.0)	176 (100.0)	1,260 (100.0)

Comment: Country liquor was the most common type of alcohol consumed by all age groups in all three sites.

2. Frequency of alcohol use

2.1: Frequency of alcohol use by sex. Mon State

Frequency of use	Male	Female	Total
On special occasion only	371 (33.6)	5 (38.5)	376 (33.7)
1-3 times a month	265 (24.0)	4 (30.8)	269 (24.1)
2-4 times a week	154 (14.0)	1 (7.7)	155 (13.9)
Daily/almost daily	313 (28.4)	3 (23.1)	316 (28.3)
Total	1,103 (100.0)	13 (100.0)	1,116 (100.0)

Comment: A majority of alcohol users consumed alcohol either on special occasions only or infrequently (1-3 times per month) at all three sites.

2.2: Frequency of alcohol use by age. Yangon Division

Frequency of use	15-25	26-50	50+	Total
On special occasion only	141 (44.9)	557 (28.6)	91 (28.2)	789 (30.5)
1-3 times a month	92 (29.3)	541 (27.8)	82 (25.4)	715 (27.7)
2-4 times a week	45 (14.3)	292 (15.0)	44 (13.6)	381 (14.7)
daily almost daily	36 (11.5)	559 (28.7)	106 (32.8)	701 (27.1)
Total	314 (100.0)	1,949 (100.0)	323 (100.0)	2,586 (100.0)

Comment: The proportion of people consuming alcohol daily or almost daily was highest in the older age groups at all three sites.

2.3: Frequency of alcohol use by type of alcohol used most often. Mon State

Type of alcohol	Sp. occasions	1-3 times a month	2-4 times a week	Daily or almost daily	Total
Beer	113 (30.1)	26 (9.7)	13 (8.4)	13 (4.1)	165 (14.8)
Western type spirits	18 (4.8)	17 (6.3)	10 (6.5)	5 (1.6)	50 (4.5)
Country-liquor	134 (35.6)	173 (64.3)	115 (74.2)	228 (72.2)	650 (58.2)
Illegal	12 (3.2)	13 (4.8)	1 (0.7)	10 (3.2)	36 (3.2)
Home made	71 (18.9)	5 (1.9)	3 (1.9)	19 (6.0)	98 (8.8)
others	28 (7.5)	35 (13.0)	13 (8.4)	41 (13.0)	117 (10.5)
Total	376 (100.0)	269 (100.0)	155 (100.0)	316 (100.0)	1,116 (100.0)

Comment: In Southern Shan State, beer was consumed most often on special occasions (42%). In Yangon division, the most commonly used alcohol on special occasions was country liquor (54.4%), while in Mon State, both country liquor and beer were commonly used. Country liquor is also commonly used in all three sites.

3. Age of initiation of alcohol use

3.1: Age of initiation of alcohol use by sex. Yangon Division

Age group (years)	Male		Female		Total	
	n	%	n	%	n	%
15 or before	210	8.1	1	16.7	211	8.2
16-25	1,985	76.9	2	33.3	1987	76.8
25+	385	14.9	3	50.0	388	15.0
Total	2580	100.0	6	100.0	2586	100.0

Comment: A majority of users began consuming alcohol between the ages of 16 and 25 years at all three sites.

4. Pay-day drinking

4.1: Pay-day drinking by type of alcohol used most often by sex. Yangon Division

Type of alcohol	Male		Female		Total	
Beer	147	(10.0)	0	(0.0)	147	(10.0)
Western type spirits	129	(8.8)	0	(0.0)	129	(8.8)
Country liquor	1,129	(76.7)	2	(100.0)	1,131	(76.7)
Illegal	42	(2.9)	0	(0.0)	42	(2.9)
Home made	21	(1.4)	0	(0.0)	21	(1.4)
others	4	(0.3)	0	(0.0)	4	(0.3)
Total	1,472	(100.0)	2	(100.0)	1,474	(100.0)

(Among 2586 responders, 1474 or 57% stated that they use alcohol on pay-day)

Comment: In Southern Shan State, more residents of rural areas drank alcohol whenever they had cash (pay-day) whereas at the other two sites, pay-day drinking was more of an urban phenomenon. Country liquor was most commonly used at all three sites on pay-day.

5. Impact of alcohol use

5.1: Impact of alcohol use by age. Mon State

Impact of use	15-25	26-50	50+	Total
Nothing/minor	140 (75.7)	513 (71.1)	142 (67.9)	795 (71.2)
Discomfort	34 (18.4)	168 (23.3)	54 (25.8)	256 (22.9)
Major	11 (6.0)	41 (5.7)	13 (6.2)	65 (5.8)
Total	185 (100.0)	722 (100.0)	209 (100.0)	1,116 (100.0)

Comment: A small proportion of alcohol users at all three sites suffered major adverse consequences.

5.2: Major impact of alcohol use by frequency of use and sex. Southern Shan State

Frequency of use	Male	Female	Total
No heavy use	563 (46.9)	39 (66.1)	602 (47.8)
special occasions	299 (24.9)	10 (17.0)	309 (24.5)
1-3 times a month	170 (14.2)	5 (8.5)	175 (13.9)
1-3 times a week	66 (5.5)	1 (1.7)	67 (5.3)
daily almost daily	103 (8.6)	4 (6.8)	107 (8.5)
Total	1,201 (100.0)	59 (100.0)	1,260 (100.0)

Comment: Most of the respondents suffering major effects of alcohol consumed alcohol on special occasions. This suggests a pattern of drinking too much alcohol on such occasions.

5.3: Major impact of alcohol use by age Southern Shan State

Age group (years)	Male	Female	Total
15-25	104 (16.3)	3 (15.0)	107 (16.3)
26-50	456 (71.5)	14 (70.0)	470 (71.4)
50+	78 (12.2)	3 (15.0)	81 (12.3)
Total	638 (100.0)	20 (100.0)	658 (100.0)

Comment: A majority of respondents suffering major impact of alcohol use were in the age group of 26-50 years at all three sites.

6. Problems related to alcohol use

6.1: Problems related to alcohol use by sex. Mon State

Problem	Male	Female	Total
Fights/ violence	159 (14.4)	2 (15.4)	161 (14.4)
Accidents (including domestic)	96 (8.7)	0 (0.0)	96 (8.6)
Law and order	6 (0.5)	0 (0.0)	6 (0.5)
Medical treatment	99 (9.0)	2 (15.4)	101 (9.1)
Loans	24 (2.2)	0 (0.0)	24 (2.2)
Theft	11 (1.0)	0 (0.0)	11 (1.0)
Total	390 (35.4)	4 (30.8)	394 (35.3)

The total responders were 1116. The percentage shown in the total column was positive responders of each type of problems with the denominator of 1116. Thus the total percentage in the total row does not add up to 100 because multiple responses were allowed.

Comment: The most common types of problems encountered after alcohol use were fights/violence and accidents (including domestic accidents).

7. “Strong urge to drink alcohol”

7.1: “Strong urge to drink alcohol” by age.
Yangon division

Age group (years)	Male	Female	Total
15-25	63 (12.8)	0 (0)	63 (12.7)
26-50	371 (75.1)	2 (66.7)	373 (75.1)
50+	60 (12.2)	1 (33.3)	61 (12.3)
Total	494 (100.0)	3 (100.0)	497 (100.0)

Comment: A vast majority of those who had a strong urge to drink alcohol were males and in the age group of 26-50 years at all three sites.

Annex 5

Nepal

A cross-sectional survey of individuals in the age-group 15 - 64 years from 15 districts representing five developmental and three ecological regions was carried out over a period of three months. Trained health supervisors and health workers from government and non-government departments conducted the field work.

A multistage stratified sampling strategy was adopted to select the number of subjects required for the survey. A total of 4400 individuals were targeted but 4328 were covered in the entire survey. A response rate of 98.4% was achieved (98.3% for men and 98.4% for women).

1. Demographic information of the study population

1.1: Distribution of study population by age and sex

Age group (years)	Male		Female		Total	
	n	%	n	%	n	%
15-24	488	25.6	545	22.5	1033	23.9
25-34	385	20.2	594	24.5	979	22.6
35-44	390	20.5	553	22.8	943	21.8
45-54	323	16.9	447	18.5	770	17.8
55-64	321	16.8	282	11.6	603	13.9
15-64	1907	44.1	2421	55.9	4328	100.0

1.2: Distribution of study population by area of residence and sex

Area	Male		Female		Total	
	n	%	n	%	n	%
Urban	978	51.3	1244	51.4	2173	50.2
Rural	929	48.7	1177	48.6	2155	49.8
Total	1907	44.1	2421	55.9	4328	100.0

2. Current use of alcohol

2.1: Current use of alcohol * by age and sex

Age group (years)	Male		Female		Total	
	n	%	n	%	n	%
15-24	152	31.1	43	13.9	195	26.6
25-34	206	53.5	108	21.7	314	37.5
35-44	214	54.9	120	30.1	334	45.4
45-54	154	47.7	101	37.1	255	47.9
55-64	149	46.4	62	20.8	211	46.5
15-64	875	45.9	434	22.7	1309	37.3

*Consumed alcohol containing beverage in last 12 months.

2.2: Current use of alcohol by type of alcohol used most often by sex

Type of alcohol	Male		Female		Total	
	n	%	n	%	n	%
Beer	139	8.9	29	1.5	168	6.8
Imported Alcohol	41	1.7	6	0.2	47	1.2
Legally produced Alcohol	112	10.8	16	1.1	128	8.0
Illegally produced alcohol	70	6.4	20	2.6	90	5.3
Home made alcohol	494	70.2	314	89.3	808	75.7
Other	19	2.1	49	5.3	68	3.0
Total	875		434		1309	

2.3: Current use of alcohol by area of residence

Area	Male		Female		Total	
	n	%	n	%	n	%
Urban	492	51.0	232	32.0	724	37.5
Rural	383	50.3	202	23.1	585	37.2
Total	875		434		1309	

2.4: Current use of alcohol by type of alcohol used most often by area of residence

Type of alcohol	Urban		Rural		Total	
	n	%	n	%	n	%
Beer	128	17.3	40	4.4	168	6.8
Imported Alcohol	36	2.7	11	0.9	47	1.2
Legally produced Alcohol	80	8.3	48	7.9	128	8.0
Illegally produced alcohol	40	6.6	50	5.0	90	5.3
Home made alcohol	401	61.7	407	78.9	808	75.7
Other	39	3.3	29	3.0	68	3.0
Total	724		585		1309	37.3

3. Frequency of alcohol use

3.1: Frequency of alcohol use by sex

Frequency of use	Male		Female		Total	
	n	%	n	%	n	%
Non user	1032	49.6	1987	77.3	3019	62.7
On special occasions only	139	13.1	155	16.0	294	13.9
Sometimes	300	29.6	179	48.6	479	35.1
1 – 3 times a month	112	9.2	32	8.2	144	8.9
1 – 4 times a week	124	14.2	21	11	145	13.3
5-6 times a week	32	2.6	9	2.9	41	2.7
Daily or almost daily	168	31.3	38	13.3	206	26.1
Total	1907		2421		4328	

3.2: Frequency of alcohol use by age

Frequency of use	15-24		25-34		35-44		45-54		55-64		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Non user	838	73.4	665	62.5	609	54.6	515	52.1	392	53.5	3019	62.7
On special occasions only	70	18.0	85	13.3	68	12.5	45	6.1	26	20.1	294	13.9
Sometimes	95	46.7	119	39.1	119	36.6	72	21.0	74	22.8	479	35.1
1 – 3 times a month	15	2.3	39	15.4	39	6.3	26	6.3	25	19.8	144	8.9
1 – 4 times a week	4	2.2	35	20.5	44	18.5	41	18.2	21	8.4	145	13.3
5-6 times a week	2	0.7	9	2.9	9	3.7	12	5.0	9	1.3	41	2.7
Daily or almost daily	9	30.1	27	8.7	55	22.5	59	43.3	56	27.6	206	26.1
Total	1033		979		943		770		603		4328	

3.3: Frequency of alcohol use by area of residence

Frequency of use	Urban		Rural		Total	
	n	%	n	%	n	%
Non user	1431	62.5	1588	62.8	3019	62.7
On special occasions only	234	35.4	60	9.0	294	13.9
Sometimes	216	26.9	263	37.0	479	35.1
1 – 3 times a month	84	11.4	60	8.4	144	8.9
1 – 4 times a week	96	11.7	49	13.6	145	13.3
5-6 times a week	18	2.9	23	2.6	41	2.7
Daily or almost daily	76	11.7	130	29.4	206	26.1
Total	2155		2173		4328	

3.4: Frequency of alcohol use by type of alcohol used most often

Type of alcohol	Special Occasions		Some-times		1-3 times a month		1-4 times a week		5-6 times a week		Daily		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Beer	72	32.2	66	54.7	16	10.0	10	2.0	3	1.0	1	0.1	168	6.8
Imported Alcohol	8	6.7	19	54.0	8	8.6	10	26.9	1	0.8	1	3.0	47	1.2
Legally produced Alcohol	20	12.6	47	42.2	30	23.1	19	14.8	1	0.8	11	6.6	128	8.0
Illegally produced alcohol	9	13.3	32	36.1	13	17.7	13	9.2	5	8.1	18	15.6	90	5.3
Home made alcohol	153	11.9	300	33.1	72	6.8	90	14.6	28	2.2	165	31.4	808	75.7
Other	32	30.4	15	14.3	5	6.6	3	3.7	3	14.2	10	30.8	68	3.0
Total	294	13.9	479	35.1	144	8.9	145	13.3	41	2.7	206	26.1	1309	

4. Age of Initiation

4.1: Mean age of initiation of alcohol use by sex

Age group (years)	Male			Female			Total		
	n	Mean	%	n	Mean	%	n	Mean	%
15-24	143	16.6	17.1	41	16.4	10.3	184	16.6	14.8
25-34	193	18.6	23.1	100	18.4	25.0	293	18.5	23.7
35-44	207	20.9	24.7	115	19.9	28.7	322	20.5	26.2
45-54	147	19.2	17.7	91	22.0	22.7	238	20.2	19.3
55-64	145	24.1	17.4	53	25.1	13.3	198	24.3	16.0
Total	835	19.4	100.0	400	19.6	100.0	1235	19.5	100.0

5. Pay-day drinking

5.1: Pay-day drinking by type of alcohol used most often

Type of alcohol	Male		Female		Total	
	n	%	n	%	n	%
Beer	14	8.6	0	—	14	8.6
Imported Alcohol	1	0.3	0	—	1	0.3
Legally produced Alcohol	16	13.3	0	—	16	13.2
Illegally produced alcohol	15	5.7	0	—	15	5.7
Home made alcohol	84	72.1	5	100.0	89	72.3
Other	0	—	0	—	0	—
Total	130		5		135	

6. Impact of use

6.1: Impact of alcohol use by sex

Impact	Male		Female		Total	
	n	%	n	%	n	%
Nothing / minor	737	68.6	405	95.4	1142	76.4
Discomfort	121	22.5	28	4.3	149	17.2
Major	17	8.9	1	0.3	18	6.4
Total	875		434		1309	

7. “Strong urge to drink alcohol”

7.1: “Strong urge to drink alcohol by age”

Age group (years)	Male		Female		Total	
	n	%	n	%	n	%
15-24	6	36.8	2	2.9	8	29.5
25-34	22	16.2	5	3.1	27	12.6
35-44	39	26.4	10	14.0	49	22.4
45-54	42	53.7	12	26.4	54	43.2
55-64	38	29.9	5	19.9	43	29.0
15-64	147	32.4	34	12.9	181	27.3

8. Alcohol Dependency

8.1: Alcohol dependency by age and sex (According to CAGE Scale : Yes \geq 2)

Age group (years)	Male		Female		Total	
	n	%	n	%	n	%
15-24	13	14.8	5	3.5	18	9.4
25-34	41	13.9	7	1.2	48	8.3
35-44	59	17.0	2	0.4	61	8.4
45-54	40	12.7	6	2.2	46	7.3
55-64	34	16.4	4	1.1	38	10.4
Total	187	14.9	24	2.0	211	8.8

Annex 6

Sri Lanka

1. Current use of alcohol

1.1: Current use of alcohol * by age and sex in the study sample.

Age group (years)	Female	Male	Total
15-24	17 (10.8)	141 (89.2)	158 (100)
25-34	35 (6.9)	471 (93.1)	506 (100)
35-44	19 (4.1)	448 (95.9)	467 (100)
45-54	19 (5.2)	349 (94.8)	368 (100)
55-64	17 (8.5)	182 (91.5)	199 (100)
65-74	13 (15.5)	71 (84.5)	84 (100)
75 and above	3 (16.7)	15 (83.3)	18 (100)
Total	123 (6.8)	1677 (93.2)	1800 (100)

* Consumed alcohol containing beverage in the last 3 months

1.2: Current use of alcohol by type of alcohol most often used by sex

Type of alcohol	Female	Male	Total
Beer	60 (48.8)	474 (28.3)	534 (29.7)
Western liquor	4 (3.3)	35 (2.1)	39 (2.2)
Country legal liquor	27 (22.0)	726 (43.3)	753 (41.8)
Illegal country liquor	14 (11.4)	341 (20.3)	355 (19.7)
Home brew	18 (14.6)	101 (6.0)	119 (6.6)
Total	123 (100)	1677 (100)	1800 (100)

1.3: Current use of alcohol users by age and type of alcohol used most often

Age group (years)	Type of alcohol					Total
	Beer	Western liquor	Country legal liquor	Illegal country liquor	Home brew	
15-24	83 (52.5)	4 (2.5)	49 (31.0)	12 (7.6)	10 (6.3)	158 (100)
25-34	243 (48.0)	11 (2.2)	189 (37.4)	49 (9.7)	14 (2.8)	506 (100)
35-44	111 (23.8)	13 (2.8)	210 (45.0)	99 (21.2)	34 (7.3)	467 (100)
45-54	49 (13.3)	7 (1.9)	169 (45.9)	117 (31.8)	26 (7.1)	368 (100)
55-64	26 (13.1)	2 (1.0)	87 (43.7)	60 (30.2)	24 (12.1)	199 (100)
65-74	17 (20.2)	2 (2.4)	39 (46.4)	17 (20.2)	9 (10.7)	84 (100)
75and above	5 (27.8)	0 (.0)	10 (55.6)	1 (5.6)	2 (11.1)	18 (100)
Total	534 (29.7)	39 (2.2)	753 (41.8)	355 (19.7)	119 (6.6)	1800 (100)

2. Frequency of alcohol use

2.1: Frequency of alcohol use by sex

Frequency of use	Female	Male	Total
Less than once a month	92 (74.8)	702 (41.9)	794 (44.1)
1-4 times per month	7 (5.7)	521 (31.1)	528 (29.3)
2-4 times per week	13 (10.6)	235 (14.0)	248 (13.8)
Daily / almost daily	11 (8.9)	219 (13.1)	230 (12.8)
Total	123 (100)	1677 (100)	1800 (100)

2.2: Frequency of alcohol use by age

Age group (years)	Frequency of use				Total	
	Less than once a month	1-4 times per month	2-4 times per week	Daily / almost daily	n	%
15-24	96	38	18	6	158	8.8
25-34	286	140	51	29	506	28.1
35-44	197	145	64	61	467	25.9
45-54	113	111	68	76	368	20.4
55-64	61	68	32	38	199	11.1
65-74	30	22	13	19	84	4.7
75 and above	11	4	2	1	18	1.0
Total	794	528	248	230	1800	100.0

2.3: Situation of alcohol use by type of alcohol used most often

Type of alcohol	Situation of using alcohol			Total
	Special occasions	With friends	Alone	
Beer	321 (48.3)	167 (26.6)	46 (9.1)	534 (29.7)
Western liquor	21 (3.2)	13 (2.1)	5 (1.0)	39 (2.2)
Country legal liquor	264 (39.7)	296 (47.1)	193 (38.1)	753 (41.8)
Illegal country liquor	32 (4.8)	117 (18.8)	205 (40.5)	355 (19.7)
Home brew	27 (4.1)	34 (5.6)	57 (11.2)	119 (6.6)
Total	665 (100) [36.9]	629 (100) [34.9]	506 (100) [28.1]	1800 (100) [100]

3. Age of initiation of alcohol use

3.1: Age of initiation of alcohol use by sex

Age group (years)	Female		Male		Total	
	n	%	n	%	n	%
<15	6	4.9	87	5.1	93	5.1
15-24	64	52.1	1023	61.1	1087	60.4
25 or above	53	43.0	567	33.8	620	34.5
Total	123	100.0	1677	100.0	1800	100.0

4. Pay-day drinking

4.1: Pay-day drinking by age

Age group (years)	Drinking on pay-day			Total
	Yes	No	Not applicable	
15-24	33 (20.9)	89 (56.3)	36 (22.8)	158 (100)
25-34	100 (19.8)	363 (71.7)	43 (8.5)	506 (100)
35-44	126 (27.0)	292 (62.5)	49 (10.5)	467 (100)
45-54	135 (36.7)	190 (51.6)	43 (11.7)	368 (100)
55-64	60 (30.2)	101 (50.8)	38 (19.1)	199 (100)
65-74	18 (21.4)	32 (38.1)	34 (40.5)	84 (100)
75 and above	2 (11.1)	7 (38.9)	9 (50.0)	18 (100)
Total	474 (26.3)	1074 (59.7)	252 (14.0)	1800 (100)

4.2: Pay-day drinking by type of alcohol used most often

Type of alcohol	Drinking on pay-day			Total
	Yes	No	Not applicable	
Beer	64 (13.5)	382 (35.6)	88 (34.9)	534 (29.7)
Western liquor	5 (1.1)	30 (2.8)	4 (1.6)	39 (2.2)
Country legal liquor	191 (40.3)	475 (44.2)	87 (34.5)	753 (41.8)
Illegal country liquor	183 (38.6)	133 (12.4)	39 (15.5)	355 (19.7)
Home brew	31 (6.5)	54 (5.0)	34 (13.5)	119 (6.6)
Total	474 (100)	1074 (100)	252 (100)	1800 (100)

5. Impact of alcohol use

5.1: Impact of alcohol use by sex

Impact	Female	Male	Total
Nothing or minor effects	104 (84.6)	1239 (73.9)	1343 (74.6)
Discomfort, head ache, nausea,	15 (12.2)	349 (20.8)	364 (20.2)
Major effects	4 (3.3)	89 (5.3)	93 (5.2)
Total	123 (100)	1677 (100)	1800 (100)

5.2: Impact of alcohol use by age

Age group (years)	Impact			Total
	Nothing or minor effects	Discomfort, head ache, nausea,	Major effects	
15-24	102 (64.6)	50 (31.6)	6 (3.8)	158 (100)
25-34	358 (70.8)	124 (24.5)	24 (4.7)	506 (100)
35-44	367 (78.6)	77 (16.5)	23 (4.9)	467 (100)
45-54	270 (73.4)	75 (20.4)	23 (6.3)	368 (100)
55-64	157 (78.9)	29 (14.6)	13 (6.5)	199 (100)
65-74	72 (85.7)	8 (9.5)	4 (4.8)	84 (100)
75 and above	17 (94.4)	1 (5.6)	0 (0)	18 (100)
Total	1343 (74.6)	364 (20.2)	93 (5.2)	1800 (100)

6. Problems related to alcohol use

6.1: Distribution of 804 episodes of problems related to alcohol use among the 572 alcohol users * by sex

Problems	Female	Male	Total episodes
Encounter violence	1 (3.1)	163 (30.1)	164
Meet with accidents	2 (6.3)	137 (25.4)	139
Problems related to law & order	1 (3.1)	66 (12.2)	67
Physical and mental disease	2 (6.3)	81 (15.0)	83
Obtained loans	1 (3.1)	86 (15.9)	87
Money was stolen by thieves	0 (0)	54 (10.0)	54
Unconscious	1 (3.1)	48 (8.8)	49
Other effects	24 (75.0)	137 (25.4)	161
Episodes	32 (100)	772 (100)	804

* 32 female and 540 male alcohol users; multiple responses permitted

7. "Strong urge to drink alcohol"

7.1: "Strong urge to drink alcohol" by province and characteristics of the area of residence

Province	Characteristic of area	Strong urge to drink		Total
		Yes	No	
Western	Urban	11	89	100
	Resettled-tsunami	7	93	100
Central	IDP-land slide	9	91	100
	Plantation	14	86	100
Southern	Resettled-tsunami	12	88	100
	Fishing	34	66	100
Sabaragamua	Rural	21	79	100
	Plantation	44	56	100
Uva	High suicide rate	44	56	100
	Agriculture	9	91	100
North Western	Rural	9	91	100
	Fishing	34	66	100
North Central	Agriculture	8	92	100
	High suicide rate	11	89	100
Eastern	Rural	19	81	100
	Agriculture	14	86	100
Northern	Rural	32	68	100
	IDP – war	51	49	100
Total		383 (21.3)	1417 (78.7)	1800 (100.0)

Annex 7


Thailand

1. Patterns of alcohol consumption

It was estimated that 29,418,170 people of 12-65 years (63%) in Thailand were abstainers (about eight million men (41%) and more than 20 million women (80%)). Most of these abstainers were in the age group of 12-25 years (about 3 million men or 67%). About 3,659,367 people (7.8%) were ex-drinkers who had stopped drinking for more than one year.

There were about 13,235,354 people (28.4%) who had drunk alcohol in the 12 month-period of the survey and 10,543,496 (22.7%) had done so in the past 30 days. This group who had done so in the past 30 days could be considered to be current drinkers (about 8.5 million men (41%) and 2 million women (7.8%)). Among these current drinkers, more than half had also drunk alcohol in the seven days prior to interview. Furthermore, 6,757,720 people (14.5%) reported they sometimes binge drank at some points in the past 12 months before the survey. Binge drinking was defined here as drinking more than six cans or three bottles of beer, or more than five glasses or half a thin bottle of whiskey, or more than five glasses or half a bottle of wine on one occasion. The majority of the binge drinkers were men, less than one million women did so.

People in the southern region had the highest rate of abstention, compared to other regions. About 56% of men in the south never drank alcohol in their lifetime. The prevalence of current drinking, ex-drinking and binge drinking were highest in Bangkok. Among other regions, the rate of current drinking was similarly high in men in north and northeast regions but the rate in women was highest in the north.



Beer was the most popular beverage for both men and women, followed by white spirits, whiskey, medicinal alcohol, homemade alcohol and wine, respectively. The numbers of current beer drinkers and white spirits drinkers were about eight million men and five million women. The rates of lifetime and current drinking were higher in men for almost all kinds of beverages, except for fruit cocktails (alcopops), wine, and ready-to-drink (RTD) alcohol, the rates of which were higher in women than in men. About four million men (40%) agreed that they ever drank illegal homemade alcohol and 1.1-1.8 million (9-15%) ever drank duty-free imported whiskey, beer and wine. Categorizing by age group, fruit cocktails and RTD seemed to be the beverages of preference for teenagers and young adults (12-24 years). Beer drinking was common for all age groups. People in late adulthood (45-65 years) ever drank white spirits, homemade alcohol, illegal alcohol, Chinese whiskey and medicinal alcohol more than those in the younger age groups. Furthermore, the rates of whiskey, brandy and wine were highest among the middle age group (25-44 years).

The average daily consumption was 34.38 grams for men and 12.98 grams for women. Men in the 25-44 year age group drank the highest amount per day while those in the 45-65 year age group drank the lowest amount per day. In contrast, Women in the 45-65 year-age group drank higher amounts of alcohol per day than women in the younger age groups. The drinking intensity (average amount of alcohol consumed only on the day of drinking) was very 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% of men and 61% of women could be classified as having moderate to high risk for alcohol-related harm. This rate was highest among people in the teenage and young adult age group (12-24 years).

2. Prevalence of Alcohol-use disorders

About 2,793,201 people (22.7%) could be classified by the Alcohol Use Disorders Identification Test (AUDIT) as hazardous drinkers, 386,431 (3.1%) as harmful drinkers and 233,747 (1.9%) as alcohol dependents. The prevalence of alcohol use disorders was about three times higher in men than in women. The highest prevalence was in the age groups of 25-44 years (32%) and 12-24 years (31%). Among women, the highest prevalence was in the age group of 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).

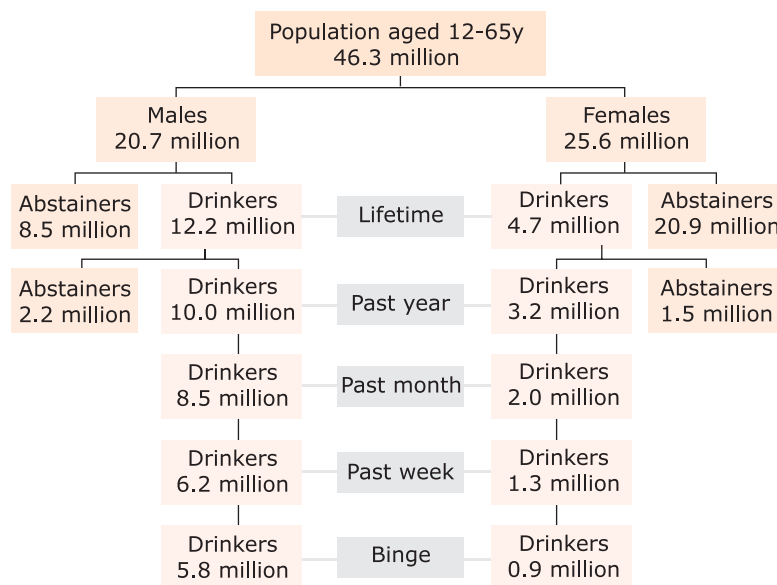
3. Alcohol-related problems and consequences

Men had higher rates of alcohol-related problems and consequences than did women. The top three problems with highest endorsement rates in men were feeling guilty or remorse after drinking (15.7%), financial problems (15.3%), and health problems (13.5%). Among women, they were health problems (9.6%) and guilt or remorse after drinking (9.0%). The problems with lowest affirmative responses were loss of employment (1.8% in men and 0.3% in women) and legal problems (1.8% in men and 0.6% in women). Comparing age groups, people in 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 the older age groups. In addition, 18.3% of men had 1-2 problems and 19.2% had at least three problems.

Looking at the association between alcohol use disorders and alcohol-related problems, a dose-response

relationship was found. Those with alcohol dependence had higher rates of having at least three problems than did harmful drinkers, who in sequence had higher rates than did hazardous drinkers, who also had higher rates than at risk drinkers.

2007 Thailand National Household Survey



Drinking status by sex and age group: N (%)

Question No.		Male			Total
		12-24	25-44	45-65	
Lifetime abstainer	1.1 (0)	3,153,556 (66.7)	2,632,329 (32.3)	2,681,943 (33.9)	8,467,829 (40.8)
Current (in 7 days) drinker	3 (1)	824,644 (17.5)	2,986,480 (36.7)	2,384,106 (30.2)	6,195,230 (29.8)
Current (in 30 days) drinker	3 (1,2)	1,159,921 (24.6)	4,116,607 (50.6)	3,267,305 (41.3)	8,543,833 (41.1)
Past year drinkers	3 (1,2,3)	1,430,782 (30.3)	4,743,786 (58.3)	3,845,487 (48.6)	10,020,055 (48.2)
Former drinker	3 (4)	120,814 (2.6)	726,163 (8.9)	1,353,640 (17.1)	2,200,616 (10.6)
Past year Binge drinker	13 (>0)	926,555 (19.6)	2,956,938 (36.3)	1,885,725 (23.9)	5,769,218 (27.8)
Age gr		Female			Total
		12-24	25-44	45-65	
Lifetime abstainer	1.1 (0)	4,854,875 (86.5)	8,248,928 (77.9)	7,846,540 (82.2)	20,950,342 (81.3)
Current (in 7 days) drinker	3 (1)	128,133 (2.3)	670,827 (6.3)	507,512 (5.3)	1,306,473 (5.1)
Current (in 30 days) drinker	3 (1,2)	257,643 (4.6)	1,015,815 (9.6)	726,206 (7.6)	1,999,664 (7.8)
Past year drinkers	3 (1,2,3)	544,047 (9.7)	1,632,885 (15.4)	1,038,367 (10.9)	3,215,299 (12.5)
Former drinker	3 (4)	174,413 (3.1)	665,350 (6.3)	618,988 (6.5)	1,458,751 (5.7)
Past year Binge drinker	13 (>0)	178,435 (3.2)	519,145 (4.9)	290,922 (3.0)	988,502 (3.8)

People with Alcohol Use Disorders

Number X1000, Percentage

Male	12-24Y		25-44Y		45-65Y		Total	
Hazardous drinking	397.6	27.8	1,434.2	30.2	954.5	24.8	2,786.3	27.8
Harmful drinking	50.2	3.5	200.9	4.2	135.2	3.5	386.4	3.9
Alcohol dependence	36.2	2.5	129.2	2.7	68.3	1.8	233.7	2.3
Total	484.0	33.8	1,764.3	37.1	1,158.0	30.1	3,406.4	34.0

Female	12-24Y		25-44Y		45-65Y		Total	
Hazardous drinking	69.2	12.8	129.8	8.0	106.5	10.3	305.5	9.5
Harmful drinking	9.8	1.8	16.7	1.0	14.8	1.4	41.3	1.3
Alcohol dependence	7.4	1.4	11.9	0.7	7.6	0.7	26.9	0.8
Total	86.4	16.0	158.4	9.7	128.9	12.4	373.7	11.6

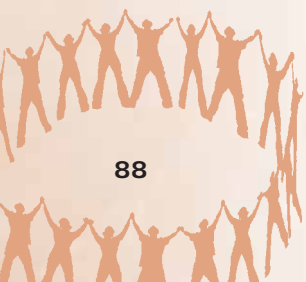
ACSAN

Prevalence of Alcohol-related problems



1. Drinking status by sex and age group: N (%)

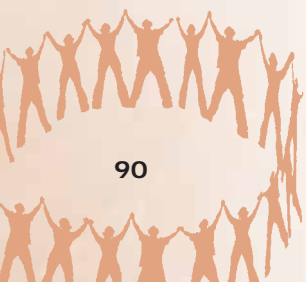
Question No.		Male			Total
		12-24	25-44	45-65	
Lifetime abstainer	1.1 (0)	3,153,556 (66.7)	2,632,329 (32.3)	2,681,943 (33.9)	8,467,829 (40.8)
Current (in 7 days) drinker	3 (1)	824,644 (17.5)	2,986,480 (36.7)	2,384,106 (30.2)	6,195,230 (29.8)
Current (in 30 days) drinker	3 (1,2)	1,159,921 (24.6)	4,116,607 (50.6)	3,267,305 (41.3)	8,543,833 (41.1)
Past year drinkers	3 (1,2,3)	1,430,782 (30.3)	4,743,786 (58.3)	3,845,487 (48.6)	10,020,055 (48.2)
Former drinker	3 (4)	120,814 (2.6)	726,163 (8.9)	1,353,640 (17.1)	2,200,616 (10.6)
Past year Binge drinker	13 (>0)	926,555 (19.6)	2,956,938 (36.3)	1,885,725 (23.9)	5,769,218 (27.8)
Age gr		Female			Total
		12-24	25-44	45-65	
Lifetime abstainer	1.1 (0)	4,854,875 (86.5)	8,248,928 (77.9)	7,846,540 (82.2)	20,950,342 (81.3)
Current (in 7 days) drinker	3 (1)	128,133 (2.3)	670,827 (6.3)	507,512 (5.3)	1,306,473 (5.1)
Current (in 30 days) drinker	3 (1,2)	257,643 (4.6)	1,015,815 (9.6)	726,206 (7.6)	1,999,664 (7.8)
Past year drinkers	3 (1,2,3)	544,047 (9.7)	1,632,885 (15.4)	1,038,367 (10.9)	3,215,299 (12.5)
Former drinker	3 (4)	174,413 (3.1)	665,350 (6.3)	618,988 (6.5)	1,458,751 (5.7)
Past year Binge drinker	13 (>0)	178,435 (3.2)	519,145 (4.9)	290,922 (3.0)	988,502 (3.8)



2. Drinking status by demographic data: N (%)

	Lifetime abstainer	Male				
		Current-7d drinker	Current-30 drinker	Past year drinker	Former drinker	Binge
Area: Municipality	1,730,766 (20.4)	1,133,918 (18.3)	1,680,044 (19.7)	1,987,677 (19.8)	407,008 (18.5)	1,178,340 (20.4)
Non-municipality	6,245,548 (73.8)	4,329,773 (69.9)	5,970,041 (69.9)	6,934,648 (69.2)	1,560,273 (70.9)	3,919,591 (67.9)
Bangkok	491,514 (5.8)	731,538 (11.8)	893,747 (10.5)	1,097,729 (11.0)	233,336 (10.6)	671,287 (11.6)
Ethnic: Thai	8,451,823 (99.8)	6,159,210 (99.4)	8,501,455 (99.5)	9,975,622 (99.6)	2,195,501 (99.8)	5,748,406 (99.6)
Non Thai	7,522 (.1)	30,209 (.5)	35,663 (.4)	35,663 (.4)	1,690 (.1)	18,768 (.3)
Religion: Buddhism	7,446,160 (87.9)	5,859,328 (94.6)	8,087,474 (94.7)	9,494,290 (94.8)	2,024,882 (92.0)	5,442,782 (94.3)
Islam	762,131 (9.0)	23,428 (.4)	25,286 (.3)	31,861 (.3)	33,761 (1.5)	24,079 (.4)
Christian	85,210 (1.0)	76,658 (1.2)	114,180 (1.3)	144,071 (1.4)	30,229 (1.4)	77,445 (1.3)
Other	2,851 (.0)					
Education: 1 ^o school	3,628,104 (42.8)	3,130,597 (50.5)	4,338,233 (50.8)	5,021,717 (50.1)	1,249,026 (56.8)	970,610 (52.0)
2 ^o school	2,999,517 (35.4)	1,660,672 (26.8)	2,201,780 (25.8)	2,572,574 (25.7)	466,078 (21.2)	439,448 (23.6)
Vocational college	633,986 (7.5)	520,091 (8.4)	759,639 (8.9)	889,299 (8.9)	154,158 (7.0)	170,520 (9.1)
University or higher	834,487 (9.9)	622,776 (10.1)	866,752 (10.1)	1,113,286 (11.1)	206,059 (9.4)	157,235 (8.4)
No education	295,287 (3.5)	160,475 (2.6)	249,515 (2.9)	283,596 (2.8)	75,124 (3.4)	110,805 (5.9)
Marital status: single	3,620,247 (42.8)	1,397,577 (22.6)	1,884,210 (22.1)	2,263,547 (22.6)	261,581 (11.9)	1,499,975 (26.0)
Married	4,553,042 (53.8)	4,435,710 (71.6)	6,134,316 (71.8)	7,170,238 (71.6)	1,758,703 (79.9)	3,927,857 (68.1)
Widowed/ separated/ divorced	252,778 (3.0)	342,511 (5.5)	492,724 (5.8)	539,355 (5.4)	170,159 (7.7)	320,896 (5.6)

	Female					
	Lifetime abstainer	Current-7d drinker	Current-30 drinker	Past year drinker	Former drinker	Binge
Occupation: Unemployed	300,376 (3.5)	254,898 (4.1)	323,329 (3.8)	357,620 (3.6)	130,284 (5.9)	222,282 (3.9)
Professional/ Executive	70,259 (.8)	32,122 (.5)	58,715 (.7)	70,435 (.7)	24,470 (1.1)	44,005 (.8)
Skilled	2,981,184 (35.2)	2,905,806 (46.9)	4,003,745 (46.9)	4,630,016 (46.2)	1,113,110 (50.6)	2,445,736 (42.4)
Clerical/ Office worker	910,733 (10.8)	989,556 (16.0)	1,386,071 (16.2)	1,649,998 (16.5)	298,585 (13.6)	1,043,232 (18.1)
Unskilled	1,546,473 (18.3)	1,673,955 (27.0)	2,280,924 (26.7)	2,644,784 (26.4)	511,019 (23.2)	1,611,847 (27.9)
Retired	74,998 (.9)	30,326 (.5)	37,125 (.4)	61,007 (.6)	32,194 (1.5)	27,859 (.5)
Home maker	37,446 (.4)	23,222 (.4)	49,791 (.6)	67,959 (.7)	21,125 (1.0)	31,793 (.6)
Student	2,540,681 (30.0)	276,604 (4.5)	395,391 (4.6)	524,550 (5.2)	69,830 (3.2)	336,427 (5.8)



2. Drinking status by demographic data: N (%)

	Lifetime abstainer	Female				
		Current-7d drinker	Current-30 drinker	Past year drinker	Former drinker	Binge
Area: Municipality	4,112,305 (19.6)	325,326 (24.9)	495,849 (24.8)	682,062 (21.2)	342,153 (23.5)	207,797 (21.0)
Non-municipality	15,329,006 (73.2)	752,678 (57.6)	1,160,232 (58.0)	1,915,192 (59.6)	825,099 (56.6)	597,105 (60.4)
Bangkok	1,509,032 (7.2)	228,469 (17.5)	343,583 (17.2)	618,046 (19.2)	291,500 (20.0)	183,600 (18.6)
Ethnic: Thai	20,885,746 (99.7)	1,305,843 (100.0)	1,999,034 (100.0)	3,214,670 (100.0)	1,454,034 (99.7)	988,502 (100.0)
Non Thai	42,276 (.2)	630 (.0)	630 (.0)	630 (.0)		
Religion: Buddhism	18,903,692 (90.2)	1,244,665 (95.3)	1,915,923 (95.8)	3,024,291 (94.1)	1,372,834 (94.1)	923,349 (93.4)
Islam	925,158 (4.4)	5,461 (.4)	8,300 (.4)	12,355 (.4)	11,724 (.8)	5,816 (.6)
Christian	276,315 (1.3)	21,863 (1.7)	27,586 (1.4)	100,647 (3.1)	28,163 (1.9)	21,398 (2.2)
Other	9,305 (.0)					
Education: 1 ^o school	11,278,232 (53.8)	721,798 (55.2)	1,061,921 (53.1)	1,650,721 (51.3)	701,123 (48.1)	577,615 (57.3)
2 ^o school	5,161,647 (24.6)	243,490 (18.6)	406,260 (20.3)	696,792 (21.7)	332,124 (22.8)	194,646 (19.3)
Vocational college	1,235,455 (5.9)	72,411 (5.5)	127,694 (6.4)	208,388 (6.5)	121,815 (8.4)	61,018 (6.1)
University/ higher	2,188,712 (10.4)	166,925 (12.8)	265,853 (13.3)	473,292 (14.7)	201,029 (13.8)	90,341 (9.0)
No education	944,899 (4.5)	87,043 (6.7)	116,693 (5.8)	154,435 (4.8)	88,763 (6.1)	78,304 (7.8)
Marital status: single	5,455,851 (26.0)	225,072 (17.2)	406,519 (20.3)	710,261 (22.1)	243,201 (16.7)	228,681 (23.1)
Married	13,181,960 (62.9)	874,146 (66.9)	1,318,097 (65.9)	2,092,367 (65.1)	923,373 (63.3)	614,925 (62.2)
Widowed/separated/divorced	2,207,524 (10.5)	202,108 (15.5)	267,979 (13.4)	403,002 (12.5)	280,349 (19.2)	144,056 (14.6)

	Female					
	Lifetime abstainer	Current-7d drinker	Current-30 drinker	Past year drinker	Former drinker	Binge
Occupation: Unemployed	946,917 (4.5)	57,865 (4.4)	82,803 (4.1)	126,104 (3.9)	127,189 (8.7)	43,444 (4.4)
Professional/Executive	221,064 (1.1)	8,086 (.6)	12,244 (.6)	49,451 (1.5)	18,320 (1.3)	8,444 (.9)
Skilled	7,765,015 (37.1)	471,455 (36.1)	680,328 (34.0)	1,101,406 (34.3)	404,880 (27.8)	298,823 (30.2)
Clerical/Office worker	1,858,355 (8.9)	177,288 (13.6)	277,663 (13.9)	443,997 (13.8)	232,030 (15.9)	125,998 (12.7)
Unskilled	4,779,554 (22.8)	394,719 (30.2)	592,237 (29.6)	840,768 (26.1)	398,330 (27.3)	295,779 (29.9)
Retired	74,551 (.4)	2,898 (.2)	8,902 (.4)	12,756 (.4)	6,990 (.5)	3,071 (.3)
Home maker	1,958,455 (9.3)	130,797 (10.0)	195,567 (9.8)	326,211 (10.1)	209,473 (14.4)	108,559 (11.0)
Student	3,313,087 (15.8)	61,172 (4.7)	147,726 (7.4)	312,413 (9.7)	54,560 (3.7)	104,383 (10.6)

The WHO Regional Office for South-East Asia (SEARO) initiated a programme to acquire and synthesize information relevant to developing and implementing interventions on the use and harm from alcohol 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 South-East Asia (SEA) Region, different contexts and circumstances of alcohol use exist among countries as well as within different population groups within countries. Thus, information on alcohol use and harm from use in different locations and population groups was obtained. Information 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 was collected.

Following the analysis of data, a meeting of experts identified the issues for addressing harm related to alcohol use through community empowerment projects were identified. These include alcohol use among youth, violence and antisocial behaviour following alcohol use, use of alcohol at special occasions, and pay-day use.

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

This document describes some of the activities undertaken by MHS Unit in the programme to reduce harm from alcohol use in Member States of the South-East Asia Region. It should be noted that SEARO is the only Regional Office that has begun testing various models of community action through community empowerment to reduce harm from alcohol use.



**World Health
Organization**

Regional Office for South-East Asia
World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India
Website: www.searo.who.int

ISBN 978 92 9022 343 6

