

*Fifty-ninth Session
Dhaka, Bangladesh
22-25 August 2006*

SEA/RC59/15

30 June 2006

ALCOHOL CONSUMPTION CONTROL – POLICY OPTIONS IN SOUTH-EAST ASIA REGION

The attitudes and practices related to the use of alcohol in Member States of the Region have been undergoing substantial change possibly due to economic growth, increasing trade liberalization and globalization. This is particularly so during the last two decades. There is substantial evidence that consumption of alcohol both in urban and rural areas is rising, particularly among youth and young adults. Recognizing the increasing occurrence of public health problems caused by harmful use of drugs and alcohol among the people, the Regional Committee in 2001 adopted a resolution SEA/RC54/R2, urging Member States to enhance the development of national policies and programmes on Mental Health and Substance Abuse including Alcohol. Two policy documents were released by WHO in 2004 on the global evaluation of alcohol consumption patterns and national alcohol control policies that contained information from countries of the Region. In May in 2005, the Fifty-eighth World Health Assembly reviewed the global situation and adopted a resolution WHA58.26 which covered the public health problems caused by harmful use of alcohol. The resolution stated that "harmful use of alcohol" referred to "the public health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in anyway." The resolution also urged Member States to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol.

Alcohol control policies should be evidence-based. Although interventions are available the cost-effectiveness of each intervention should be considered before implementation.

This document is submitted to the Regional Committee to review and recommend to Member States for adoption and adaptation of various policy options for reducing public health problems caused by the harmful use of alcohol. It could also be used as a guide by Member States in reviewing and realigning national strategies, policies, programmes and plans of action for the prevention and control of the harmful use of alcohol.

CONTENTS

Introduction	1
Harm from alcohol use	1
Policy options	3
Effectiveness and Cost-effectiveness of interventions	4
Taxation and other price control measures	4
Regulating the physical availability of alcohol	5
Measures against drink-driving	5
Regulating alcohol production and distribution	6
Advertising restrictions	6
Promoting community action	7
Education and persuasion	7
Modifying the drinking context	8
Early intervention and treatment services	8
Establishing sustainable managerial mechanisms	9
Key players and their role	10
WHO initiatives	10
Proposed actions	11
Conclusion	11

Introduction

1. In 2002 WHO estimated in its World Health Report that there were about 2 billion people worldwide who consume alcoholic beverages, and 76.3 million suffered from alcohol use disorders. Globally, alcohol use causes 3.2% of all deaths (1.8 million deaths) and 4% of Disability-Adjusted Life Years (DALYs) (58.3 million). These proportions are much higher in males (5.6% deaths and 6.5% of DALYs) than females (0.6% deaths and 1.3% DALYs).

2. Recognizing the importance of the public health problems caused by harmful use of alcohol along with other substance abuse, the Regional Committee in September 2001 adopted a resolution – SEA/RC54/R2, urging Member States to further strengthen the development of national policies and programmes on mental health, drug and alcohol-related problems. The South-East Asia Regional Office (SEARO) organized a consultation on prevention of harm from alcohol abuse in Bali, Indonesia, in June 2002. The meeting reviewed national programmes on prevention and control of harmful use of alcohol, and identified four key strategic areas for Member States to implement. These strategic areas were: (a) promoting advocacy campaigns for reducing public health problems caused by alcohol use, (b) implementing primary prevention and health promotion focusing on young people and adolescents, (c) introducing early interventions by preventing people who start alcohol use from progressing to habitual users, and (d) implementing harm reduction measures.

3. In 2004 WHO released two documents on the global evaluation of alcohol consumption patterns and status of national alcohol control policies. The Fifty-eighth World Health Assembly in May 2005 reviewed the global situation and adopted a resolution (WHA58.26) on – public health problems caused by harmful use of alcohol. The resolution urged Member States to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol. The resolution also stated that harmful use of alcohol referred to the public health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in anyway.

4. In recent decades, the traditional societal values in the South-East Asia Region (SEAR), including discouraging alcohol consumption, are being gradually replaced by so-called modernistic values and lifestyles. This is accompanied by a rapid change in the way people think and live, resulting in different lifestyles and behaviours compared to yesteryears. Member States of the Region have become an emerging market with increased sales of alcohol. The adverse impact on public health is likely to be high in the context of an overall increase in consumption of alcohol.

5. This document is submitted to the Regional Committee to review and to recommend to Member States for adoption and adaptation of various policy options for reducing public health problems caused by harmful use of alcohol. It could also be used as a guide by Member States in reviewing and realigning national strategies, policies, programmes and plans of action for the prevention and control of harmful use of alcohol.

Harm from alcohol use

6. There is a spectrum of use among those who consume alcohol, which can range from one-time use, occasional use, regular use, hazardous use, harmful use (referred to as alcohol abuse by some experts in some countries) to dependence. The proportion of people

in different groups of this spectrum of consumption varies considerably among different societies, population groups and countries and there are differences even among individuals within each country. "Harmful use" of alcohol refers to a pattern of use which leads to adverse social, occupational, medical and public health consequences. The implication of "harmful use" is broader than high volume and frequent consumption, such as regular heavy drinking, habitual consumption, and occasional binge drinking, it includes other consumption pattern which also pose the implicit risks for the drinker themselves, those surrounding people and society, particular in long-term. These include consumption on light to moderate basis in inappropriate circumstances, consumption by high risk consumers (e.g. pregnant woman, etc), and regular non-binge drinking that cause accumulated undesired results, such as chronic diseases and poverty. The issue today is the innumerable problems associated with harmful use of alcohol, ranging from domestic and family violence to road traffic or other occupational accidents to physical or mental health damage. These problems in the absence of dependent use are grouped as "alcohol-related problems".

7. Most countries have a legal definition of an "alcoholic beverage" for the application of national laws mainly for taxation purposes. If the limit on alcohol content is set at higher level, some beverages with low level of alcohol content may not be subject to any regulations. For example, if the limit of alcohol by volume is set at a level by which low alcohol beer or wine is not considered as an alcoholic beverage, these would be left out of any sales or advertising restrictions. According to the Global Status Report on Alcohol Policy – 2004,¹ the range for the legal definition of alcoholic beverages across the world lies between 0.1 to 12.0% alcohol by volume with a mean of 1.95%. Regional analysis showed that the level ranged from any amount in Nepal to 5% in Bhutan.²

8. The risk of many adverse consequences of alcohol use increase with increasing quantities of alcohol consumed. This implies that risks increases even at the very low volume consumed. For example, research indicates that the risk and severity of road traffic crashes increases with the blood alcohol concentration (BAC). This suggests that driving under the influence of alcohol, even when the BAC is within the legal limit, has a higher risk, particularly among new and young drivers. With a BAC of 50mg% which is the legal limit in most countries to drive a vehicle, the risk for road traffic injuries is two-times higher than for drivers with no alcohol in the blood.

9. Even occasional use of alcohol can be a gateway to future high risk use, by increasing tolerance and familiarity of users to drinking and drinking environments, as well as addictive effects of alcohol itself.

10. Available evidence suggests that the protective effect from regular light alcohol consumption for Coronary Heart Disease (CHD) is not a valid risk reduction strategy at the population level. On the contrary, regular alcohol use is not, and cannot be recommended as a public health strategy for CHD protection. For most countries, the net effect of alcohol on CHD is negative,³ particularly in areas of lower mortality from cardiovascular diseases, such as developing countries.⁴ There are other more cost-effective interventions for prevention of CHD rather than regular light alcohol consumption (stop smoking, appropriate diet and physical activities). It should be noted that regular light consumption of alcohol predisposes to other adverse health and social consequences.

¹ WHO Global Status Report: Alcohol Policy, Geneva, 2004

² WHO SEARO, Alcohol Control Policies in South-East Asia Region: Selected issues, New Delhi, 2006

³ Room R, Babor TF, Rehm J. Alcohol and public health. *Lancet* 2005;365:519-30

⁴ Murray CJL, Lopez AD. Quantifying the burden of disease and injury attributable to ten major risk factors. In: Murray CJL, Lopez AD, editors. *The Global Burden of Disease: A comprehensive assessment of mortality and disability from diseases injuries, and risk factors in 1990 and projected to 2020*. Cambridge: Harvard School of Public Health; 1996. p. 295-324

11. The effects of alcohol use by an individual are noticeable in all spheres (physical, psychological, social, and economical) of an individual's life. Since every person is part of a family, it has an impact on other members of the family. Further, the collective and long-term effects of alcohol use are felt in the society. Apart from 60 or so physical and mental disorders as identified in International Classification of Diseases (ICD-10), harmful use of alcohol could lead to violence, intentional and unintentional injury, road traffic injuries, family impact and unemployment.

12. WHO estimated in 2004 that the average Adult Per capita Consumption (APC) in 2001 was approximately 2 litres of pure alcohol, however, there is wide variation across different countries, ranging from less than 1 litre in Indonesia to 8.47 litre in Thailand. After adjusting for unrecorded consumption (illicit beverages as well as tax-evaded products) which account for 45–50% of total consumption, the average APC would be higher.

13. Given the poor socioeconomic status of many rural communities, a disproportionate amount of family income is spent on alcohol, leaving very little money for food, education, housing and health that could perpetuate poverty. According to economic studies, the cost of health and social consequences of alcohol use up to 6% of GDP significantly outweighs the benefit from alcohol consumption in terms of revenue generation in most countries.

14. Health care cost for treating people with alcohol-related conditions and illnesses are huge for individuals, families and even for Governments. The societal cost of alcohol consumption is implicit, such as productivity loss and loss of future earning due to premature death of the wage earner. Most of the social and economic burden is borne by the society, not the drinkers. The seeming gain from the existing alcohol policies which is the revenue from tax on alcohol ends up being spent to counter the effects of alcohol use.

Policy options

15. Increase in alcohol use in the Region imposes numerous challenges for policy makers, professionals and the civil society. The growing evidence of harmful effects on individuals, families and society as a whole has created a dilemma in the area of public health. As documented by WHO-SEARO,⁵ it is not just the people with alcohol dependence or the heavy drinkers who overwhelm the health services, but also the infrequent, or social consumers.

16. Research studies show that there are a wide range of policy options and interventions for reducing public health problems caused by harmful use of alcohol are available. These could be adapted and implemented in SEAR Member countries and included in national alcohol control policies.

Effectiveness and Cost-effectiveness of interventions

17. Research also shows that there is no single policy which is effective in controlling harm from alcohol use, rather it is a mix of policy options which are effective. A two-pronged strategy is desirable. This could include (a) a population-based approach, with legislative and managerial measures with concerted efforts for preventing harmful use and reducing overall consumption of alcohol, and (b) an individual risk reduction approach, aimed at high-risk settings and hazardous individual behaviors, especially targeting existing or potential consumers.

⁵ WHO SEARO: Public Health Problems Caused by Harmful Use of Alcohol in South-East Asia: Gaining Less or Losing More? New Delhi, 2006

18. Strategies and interventions to reduce alcohol-related harms are not equally effective. Furthermore, cost-effectiveness of interventions should be highly prioritized in alcohol policy framing process, particularly in poor resource setting in developing countries. Among policy options, ten best practices of alcohol policy, as in WHO report EB115/37, are 1) minimum legal purchasing age, 2) government monopoly of retail sales, 3) restriction on hours or days of sale, 4) outlet density restrictions, 5) alcohol taxes, 6) random breath test, 7) lower blood alcohol concentration limits, 8) administrative license suspension, 9) graduated licensing for novice drivers and 10) brief intervention for high-risk drinkers. Generally, interventions directed at the general population are more effective, but the two are complementary and not alternatives. Further, the most efficient public health response to the burden of alcohol use depends on the prevalence of hazardous alcohol use which is related to overall per capita consumption. Population-wide measures, such as taxation, are probably the most cost-effective response in populations with moderate or high levels of drinking (such as in developed countries). Whereas more targeted strategies such as brief physician advice, roadside random breath testing and advertising bans are likely to be most cost-effective in populations with lower rates of hazardous alcohol use such as South-East Asia.⁶

19. The following paragraphs present various policy options which are available along with the evidence for the effectiveness of each. Member countries can decide what is appropriate for their own situation and culture, then adapt these prior to implementation. The policy options proposed are based on evidence gathered from implementing various control measures in the Region and in western countries.

Taxation and other price control measures

20. Generally, consumers respond to a price increase in alcoholic beverages. Data from developed countries suggests that the impact is more among price-sensitive consumers such as the youth rather than occasional drinkers. Heavy drinkers also respond to price change. Studies from some countries suggest that an increase in taxation on alcoholic beverages reduced the rates of alcohol-related traffic injuries and mortality, and incidents of alcohol-related violence in the community. Taxation on alcoholic beverages should raise its retail price to the level that can alter consumption decision, with an effective enforcement mechanism to prevent consumer's shifting towards cheaper illegal alcohol. With increasing income the impact of one time rise in price maybe neutralized. Thus the taxation system should be adjusted so that the price of alcohol beverages rise at or beyond the rate of inflation and purchasing power.

21. With rapid expansion of trade liberalization, taxation for alcohol products has been more rationalized (usually reduced) by treating them like any other commodity. Alcohol is a source of substantial revenue for governments. There are examples (e.g. from some states in India) that restrictions on the sale of alcohol have been removed because of loss of revenue. However, there is also evidence from a research project sponsored by WHO, conducted in Bangalore, India,⁵ that in the long-term the financial losses to the state are far greater than the immediate revenue. One option is to allocate part of the taxes generated from the sales of alcohol to support health promotion programmes. Thailand has adopted, under its Health Promotion Foundation Act, the use of additional 2% of "sin tax" on tobacco and alcohol and the proceeds are used for health promotion activities, including reducing alcohol consumption and related problems.

⁶ Chisholm D, Rehm J, Van Ommeren M, Monteiro M. Reduction in the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *Journal of Studies on Alcohol* 2004;65(6):782-93

Regulating the physical availability of alcohol

22. Various legislative measures have been/could be used for reducing alcohol consumption, and thereby the harm from its use, by limiting the physical availability of alcohol. There is evidence that limiting the availability of alcohol influences the rates of alcohol-related injuries and other problems.

- *Minimum legal purchasing or drinking age:* Setting a minimum legal age limit for purchase or drinking alcohol is a measure targeted at the youth by restricting their access to alcohol. Evidence suggests that consumption of alcohol is usually influenced by the age at which alcohol is legally available (on or off license) and increasing legal age for purchasing/drinking is one of the most effective interventions in reducing alcohol-related problems and the consumption of alcohol by minors. The minimum age limit in SEAR countries varies from 18 to 21 years, except India where it is 25 years. Globally, the age limit varies from 15 to 21 years. However, to achieve its goal, minimum purchasing/ drinking age laws need effective enforcement and surveillance mechanism.
- *Restrictions on sales:* There are a number of policy options to limit the sales of alcohol to consumers, such as (a) restricting the number, density and locations of sale outlets; (b) limiting hours and days of sale; and (c) imposing some other restrictions on sale.

Studies have shown that measures such as closing of sales outlets or restriction of sale at certain time of the day/specific days like religious days or paydays, restrictions on sale of high alcohol content beverages or rationing the amount of alcohol sold to an individual, could reduce social and health-related problems linked to alcohol use in the short- and long-term. Restriction on serving and selling alcohol (such as not serving already intoxicated customers) has shown to be effective only if enforced with server/seller liability. Prohibition of public drinking at specific settings such as educational institutions, public places (offices and factories), recreational settings (parks and beaches, cinema halls, sports stadiums) and fast-food restaurants could ensure a safe public environment and minimize or avoid injuries and loss of public property and productivity.

- *Total prohibition or ban on alcohol:* Worldwide experiences shows that total prohibition on the production, sales, and consumption of alcohol usually does not succeed, unless firmly rooted in the local culture or strong religious convictions of the majority of the population. Although there is some evidence that total prohibition of alcohol does reduce consumption and alcohol-related problems, it could also promote organized crime and corruption through cross-border smuggling and brewing of illicit liquor.

Measures against drink-driving

23. Research indicates that the risk and severity of road traffic injuries increases with drink-driving. This suggests that driving under the influence of alcohol, even when the Blood Alcohol Concentration (BAC) is within the legal limit, has a higher risk particularly for new and young drivers.

24. Effective countermeasures include: (1) setting legal BAC at appropriate level, and if possible, lowering the legal BAC level; (2) active surveillance system for drink-driving; (3) swift punishment(s) including license suspension; and 4) measures for high-risk groups, such as setting a specific lower level of legal limit of BAC among new and young drivers and

commercial drivers (“zero tolerance”). It has been shown in research studies that regular and comprehensive Random Breath Testing (RBT) is more effective than setting fixed sobriety checkpoints.

Regulating alcohol production and distribution

25. Legislative control of production, marketing and sale of alcohol could take two positions from (a) *total control of production and/or sales (state monopoly)* on one side to (b) *absolutely no control (total liberalization)* on the other extreme. Studies of the effects of privatizing alcohol retail sale monopolies have shown that there was some increase in the levels of alcohol consumption and alcohol-related problems, due in part to the increase in number of outlets and hours of sales, that increased with privatization measures based on profit motives. From a public health perspective, it is the retail level which is important for controlling individual consumption while monopolization of production or wholesale distribution may facilitate revenue collection and effective control of the market.

26. Trade and Commerce sectors regard "alcohol" as a "commercial good" to be traded freely across countries like any other commodity. Investment in production and sale of alcohol is seen as a service or an investment within the arrangement of multilateral trade agreements. Therefore, concerted efforts are needed to create awareness at national and international levels that alcohol should be considered as special item that could lead to adverse social and health consequences that go beyond economic gains and free trade agreements. Furthermore, consideration should be given to the formulation of special initiatives for select items (including alcohol) of crucial public health importance.

Advertising restrictions

27. Alcohol advertising has the potential of promoting changes in attitudes and social values, including publicizing the desirability of social drinking to its viewers, which all encourage a higher consumption of alcohol and weaken the social climate towards effective alcohol control policy. In countries where advertising in the media is not totally banned, there is frequent portrayal of alcohol in media materials, particularly in magazines, newspapers and television, especially of internationally branded beverages. The mainstream of these portrayals suggests alcohol use as a harmless pursuit, showing solidarity, friendship and masculinity, while neglecting any negative consequences.

28. Studies in developed countries have shown that advertising can influence consumer choices, have a positive short-term impact on knowledge and awareness about alcohol, but it has proved difficult to measure the exact effects of advertising on demand for alcoholic beverages, in part because the effects are likely to be cumulative and long-term. Recent literature suggests that advertising and other marketing activities increase the overall demand and influence teenagers and young adults towards higher consumption and harmful drinking. Self regulation by the industry and mass media has been attempted by developing codes of advertising as a preferred alternative for legal advertising regulation. However, the effectiveness of voluntary codes is likely to be limited.

29. Even in places where alcohol advertising is banned, messages on alcohol use could be conveyed to existing or potential consumers in a variety of ways. These include: *surrogate advertising* – brand sharing of products including name and logos, advertising at the point of sales, and sponsorship of events particularly in teenager-friendly events such as sports, music and cultural events. Thus an effective monitoring system is needed.

Promoting community action

30. In recent decades, community-level efforts to control harmful use of alcohol in some countries were successful through enhanced partnerships and networks, involving public agencies and NGOs. Community action is not in itself a strategy, but rather a process of implementation of one or more policy interventions at the community level. Recognition of harm from use of alcohol within a community is an important step in organizing community-based efforts.

31. Various measures of community action include: (a) organizing awareness programmes to deal with harm from alcohol use within the community, (b) monitoring alcohol-related social and economic situations, (c) creating an atmosphere for social control of harm from alcohol use by formulating community sponsored rules and regulations, and d) supporting measures including community-based treatment and rehabilitation programmes.

32. There have been several reports on community-based alcohol control actions initiated by various women's groups using different strategies. One effective strategy has been restricting the availability of alcohol in specific communities or townships by direct intervention.

33. A large proportion of the formal and non-formal sectors' labour forces are affected by harmful use of alcohol. The impact on the work force includes absenteeism, work accidents, unemployment and poor productivity. Although it is not mandatory for an employer to provide counseling and treatment for alcohol-related problems, more and more employers are beginning to view harmful use of alcohol as a social problem and its control as a corporate responsibility.

Education and persuasion

Mass media campaigns

34. Mass media has been used both by the alcohol industry to promote its products and by governments to control harm from alcohol use. While mass media is a popular means for attempting to control harm from alcohol use, evidence suggests that complementary and reciprocal community actions pursued in conjunction are more effective than media campaigns alone. In addition mass media campaigns are expensive and could be countered by aggressive, well-funded alcohol industry advertisements. Ingredients of an effective mass media campaign are: well defined target group, undertaking formative research, pre-test campaign materials, messages which build on existing knowledge, messages which satisfy existing needs and motives, addressing knowledge and beliefs which impede adoption of messages, guaranteed media plan for exposure and long-term commitment for a campaign.

Educating school children

35. Traditionally, schools promote sporting activities and religious values, but more recently, schools have started educating students on skills which they need to deal with stressful life events, e.g. stress management and handling peer-pressure. This strategy is termed as "Life-skills education". Part of these skills is to stay away from habits such as smoking and drinking alcohol. Such programmes include getting students to talk openly about the subject of alcohol use, their attitudes, and environmental pressures on them to drink alcohol and giving them information on the harmful effects of alcohol. These programmes can go a long way in preventing the initiation of alcohol use, particularly its harmful use.

Modifying the drinking context

Provision of alternative recreational facilities

36. In many instances, the avenue for entertainment or recreation for adolescents and blue-collar workers are taverns/public bars/restaurants, where alcohol is liberally served together with food and other entertainment such as music, TV, karaoke, dancing or billiards. Thus, initiatives in many countries especially by city development authorities, to provide and encourage alternate recreational places, and also organize leisure activities which involve less or no drinking of alcohol could be helpful in reducing alcohol-related problems. Job-creation and skill development programmes could also be useful for adolescents, particularly those from the low socio-economic strata where jobs are scarce and alcohol consumption rampant.

Public nuisance and the responsibility while intoxicated

37. A person charged for an offence can, and generally pleads not guilty with the excuse of being under the influence of alcohol. The lawful position of self-inflicted intoxication has been controversial. It seems that in principle, legislation in most countries makes judgment for intoxicated persons as if they were sober.

Early intervention and treatment services

Role of the family

38. Harmful consumption of alcohol by even one member of the family can adversely affect the whole family. In the strong social network prevalent in Member States, the role of the family becomes crucial. Family members have a significant role in prevention of alcohol-related problems, especially the role of parents in encouraging abstention, promoting alcohol-free activities, conveying appropriate messages with regard to consumption and problems and monitoring any negative situation.

39. The first step is recognizing when alcohol consumption is reaching harmful levels and facilitating interventions aimed at reducing alcohol use. For persons with alcohol-use disorders, the next step is to obtain appropriate professional help. Family support to the person is needed not only to seek treatment, but to persist with the treatment, which is sometimes unpleasant. Rehabilitation, which includes a return to normal family responsibility and a position of respect within the family, is essential. Careful observation to prevent a relapse into abuse of alcohol is very important. Often, friends play a major role in perpetuating practices relating to alcohol use. The family also has a crucial role to play in keeping its members away from the influence of such friends or relatives who could draw the person back into harmful use again. Parents should set a good example to their children in alcohol use.

Expanding the role of the health sector from recipient to proactive agents

40. The traditional role of the health sector is to provide treatment and rehabilitation services for alcohol abusers and treating medical complications for physical and mental disorders (e.g. liver and other gastro-intestinal diseases, mental disorders, etc.). In addition, an important role of the health sector, which includes primary care physicians, nurses, other professionals and community health workers, could be in screening and early identification of people who abuse alcohol followed by brief interventions, particularly at primary health care level. This is particularly important considering that there is a WHO-developed technology using the AUDIT (Alcohol Use Disorder Identification Test) to screen for harmful alcohol consumption.

41. Evidence suggests that type of service for treatment of alcohol use disorders makes little difference in long-term outcomes⁷, and more sophisticated and high-cost services are not demonstrably more effective^{8,9}. Overall, brief intervention, particularly at primary health care level, is the most cost-effective among screening and treatment measures¹⁰.

Establishing sustainable managerial mechanisms

Cooperation between stakeholders

42. There are varied opinions on prevention and control of harmful use of alcohol. Many public agencies and sectoral ministries, e.g. interior or home affairs, civil and criminal courts, industries, budget and revenue, agriculture, customs and other law enforcement agencies, medical associations, alcohol manufacturers, as well as consumers, civil society, and other NGOs are lobbying for their own point of view. This often creates confusion and conflict of interest as well as duplication, rather than a synergistic effort for working together with a clear formulation and effective implementation of national alcohol policy. Coordination and cooperation between various public agencies, civil society and private enterprises is essential, if it is conducted on commercial interest-free basis.

Establishment of a national alcohol control authority or similar agency

43. Alcohol and health issues related to it should be accorded high national priority. In doing so, there is a need to have an authoritative body, commission or committee, responsible for developing and updating a national public health oriented alcohol control policy and programmes. This body could represent the highest level of government administration (such as Council of Ministers, Parliamentary Committee or the Parliament). There should be adequate funding and secretariat support from the government. Financial support for such an establishment could be through earmarked taxes or a special allocation.

Monitoring and evaluation

44. There is a need for countries to work together in collaboration with WHO and interested alliances to monitor national and regional situation on alcohol consumption and related problems including social cost of alcohol consumption, as well as develop a comprehensive set of indicators for the purpose of monitoring and evaluation of various alcohol control policy options and strategies for reducing public health problems caused by alcohol. WHO has already developed an international guide for Member States and other stakeholders for monitoring alcohol consumption and related harm.¹¹

45. The potential for adaptation and use of such indicators depends upon the availability of information and the existence of national programmes. The data from other sectors and sources such as industry, customs, trade and commerce, revenue, police, transport, and national surveys, can be used in mutually consistent and supportive ways to create a valuable national information source. There is a need to have a national information clearing house for alcohol-related information.

⁷ Timko, C., et al., Long-term outcomes of alcohol use disorders: comparing untreated individuals with those in Alcoholics Anonymous and formal treatment. *Journal of studies on alcohol*, 2000. 61: p. 529-38.

⁸ Holder, H., et al., The cost effectiveness of treatment for alcoholism: a first approximation. *Journal of studies on alcohol*, 1991. 52(6): p. 517-40.

⁹ Finney, J.W., A.C. Hahn, and R.H. Moos, The effectiveness of inpatient and outpatient treatment for alcohol abuse: the need to focus on mediators and moderators of setting effects. *Addiction*, 1996. 91: p. 1773-96

¹⁰ Babor, T.F., et al., *Alcohol: No ordinary Commodity*. 2003, New York: Oxford University Press.

¹¹ WHO, *International Guide for Monitoring alcohol consumption and related harm (WHO/MSD/MSB/00.4)* 2002

Promoting national and regional networks/centres

46. National and regional networks of public health, economic and social institutions, public policy faculties and experts should address issues related to non-communicable diseases and their risk factors including alcohol. This would generate evidence-based information which would strengthen the planning, implementation, monitoring and evaluation processes, and in the adoption of policies and strategies for reducing public health problems from harmful use of alcohol.

Key players and their role

47. Most Member countries have some form of an alcohol control policy, although it may not be an exclusive formal policy dealing with alcohol. Most of these are sectoral actions indicating the commitment for preventing and reducing alcohol-related problems.

- WHO needs to work closely with each Member country to provide technical assistance to develop an effective, integrated and comprehensive national alcohol control policy.
- The local community (especially elected officials and senior administrators) are crucial for taking effective action, especially promoting awareness and legislative control, which are vital for public health.
- Health care professionals and public health institutions are not only responsible for the provision of public education and case management, but also in helping the implementation of effective policy responses and also in mobilizing and lobbying for a change in society.
- Various organized civil society groups at local, national, international level, including their networks should work together and can also play an advocacy role as well as function as a monitoring watchdog to provide vital checks and balances by highlighting best practices or policies to reduce public health problems caused by alcohol use.
- The alcohol industry, trade and commerce and associated businesses also have the primary responsibility in ensuring that their practices in production, sales and marketing of their products meet the highest possible standard of business ethics and fully comply with established rules and regulations.

WHO initiatives

48. The Regional Office has recently documented regional experience in a publication entitled "Public health problems caused by harmful use of alcohol in South-East Asia Region: Gaining Less or Losing More?" This document reviews the currently available information on the supply, demand and use of alcohol in the population. Some suggestions are also provided on what can be done to prevent harm from alcohol use in the community. It supplements the WHO Global Report on Alcohol by adding region-specific information.

49. Another document – "Alcohol Control Policies in the South-East Asia Region: Selected Issues" has been developed. It is intended to inform policy makers about the status of existing alcohol control policies in the Region and to provide a baseline for monitoring progress in prevention of harm from alcohol use. It could also serve as an advocacy tool for identifying existing gaps and raising awareness about the need for additional alcohol control policies.

50. A comprehensive study on the “Burden and Socio-Economic Impact of Alcohol Use – The Bangalore Study”, has been carried out by interviewing almost 29,000 individuals from rural, town, slum and urban areas in Bangalore, India, in 2005 showed the distinct effects and impacts of alcohol use among the studied population.

51. A self-learning material for community volunteers on prevention of harm from alcohol use entitled: “Reducing Harm from Use of Alcohol – Community Responses”, has been developed and tested. It contains simple instructions which can be used by a motivated community activist to initiate programmes within his/her community for prevention of harm from alcohol use.

52. A life skill-based programme on adolescent mental health promotion has been developed, consisting of eight modules on different aspects of relevance to adolescents. It also includes one module on prevention of harm from alcohol use. All these modules have been successfully tested in India, Indonesia and Thailand.

53. An advocacy material for adolescents entitled, “Facts on alcohol use and abuse: What you should know”, provides adolescents with brief and clear information on harm from alcohol use and abuse. This document has been extensively tested in India. The information is based on extensive feed back received from adolescents. They are currently being implemented in Bhutan and India.

54. Interactive CD-based material for adolescents on prevention of harm from alcohol is being prepared. A software development company in India will convert some of the materials developed by WHO into an interactive programme on prevention of harm from alcohol use.

Proposed actions

55. Member countries should consider appropriate participation of stakeholders not having any conflict of interest in order to develop of comprehensive national alcohol control policies, action plans and programmes for reducing public health problems cause by alcohol use.

56. There is also a need to establish and/or strengthen appropriate national and, where needed, sub national mechanism(s) for effective planning, implementation, monitoring and evaluation of national programmes with adequate institutional capacity and funding.

57. WHO should support Member States, in building and strengthening institutional capacities for developing; information systems, policies, action plans, programmes, guidelines and monitoring/ evaluation of the programmes.

58. WHO should pursue appropriate partnership mechanism to facilitate stakeholders' consultations and forums at national, intercountry and regional levels for effective planning, implementation, monitoring and evaluation of national programme, with adequate funding.

Conclusion

59. Many countries of the Region which had low levels of consumption of alcohol until recently are moving towards higher levels of consumption, particularly among the youth and young adults. The impact of increasing incomes, globalization and rapid trade liberalization has accelerated this movement. It is well established that an increase in alcohol consumption by a community or a nation could lead to a higher proportion of persons with alcohol-related health and social problems, which is a public health issue. Harmful use of alcohol has a significantly adverse impact on the lives of affected persons, their families and communities, most notably in social, economic and health aspects. The social impact and

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

60. The history of measures for alcohol control and scientific evidence also point to the need for pragmatic policy options and interventions rather than extreme positions like total prohibition. A public health approach that takes into account the trends of alcohol use is more likely to be effective.