4 ALCOHOL CONSUMPTION

In contrast to the declining trends in alcohol consumption in other Regions of WHO, the SEAR shows recent and continuing increase in consumption. Across South-East Asian countries one fourth to one third of the male population drink alcohol, while the proportion amongst the females is quite low (4–9%). Notwithstanding this, however, these countries are similar to other heavy drinking countries in terms of consumption per drinker: 13 to 14 litres of absolute alcohol per annum (WHO, 2004).

In contrast to the declining trends in alcohol consumption in other Regions of WHO, the SEAR shows recent and continuing increase in consumption.

The SEAR can thus be characterized as a Region with comparatively low (as compared to other Regions of the world), but increasing levels of drinking with a detrimental pattern, dominated by the consumption of spirits as well as a high degree of unrecorded consumption. A key problem area is heavy episodic or "binge" drinking. Based on the adult per capita consumption and available sample surveys, there are clear indications that alcohol consumption is escalating in these countries, possibly with a more rapid rate of increase in the near future. With the influence of the globalizing economies and changing cultural norms, more and more young people are experimenting with alcohol at a very early age.

4.1 Spectrum of Alcohol Use

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 varies considerably among different societies and there are differences even within each individual country.

Among those who consume alcohol, the spectrum of use can range from one-time use, occasional use, regular use, hazardous use to harmful use.

The permissiveness of occasional use varies across societies and cultures. For example, in some communities serving alcohol to guests on joyous occasions and festivals is a common practice. What is beginning to emerge are the numerous problems associated with even occasional use of alcohol. These range from domestic and family violence to road, or other occupational accidents to physical or mental health damage. These and other such problems in the absence of dependent use are grouped as "alcohol-related problems". The recognition and acceptance

Spectrum of alcohol use

Harmful use

A pattern of alcohol use that is causing damage to health. The damage may be physical (as in cases of hepatitis from prolonged use of alcohol) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Source: Adapted from WHO (2003b)

Hazardous use

Hazardous use is a pattern of alcohol consumption carrying with it a risk of harmful consequences to the drinker. The damage may be to health — physical or mental, or they may include social consequences to the drinker or others. In assessing the extent of risk, the pattern of use, as well as other factors such as family history, should be taken into account.

Source: Adapted from Babor and Higgins-Biddle (2001)

Dependence syndrome

A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated alcohol use and that typically include a strong desire, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

Source: Adapted from Benegal V et al. (2001)

Traditionally, any alcohol use pattern leading to social, occupational or medical impairment, is called harmful use of alcohol.

of the “alcohol-related problems” group as a “problem” is associated with the definition of a social drinker and general attitudes of the particular community or society towards alcohol use. This implies that certain communities may be more tolerant to excess alcohol consumption and ignore the ‘transient problems’ related to alcohol use, whereas other communities may be intolerant. For example, in certain communities, verbal abuse of the wife by her husband who is under the influence of alcohol is tolerated as a culturally accepted phenomenon.

“Harmful use” of alcohol refers to a pattern of use which leads to adverse social, occupational, medical and public health consequences. “Harmful use” is not necessarily a result of daily consumption of alcohol. Harm from alcohol use could also be due to drinking too much alcohol at one time. Other patterns of consumption, such as consumption of alcohol by pregnant women, would also qualify under the term “harmful use” in a broad sense.

Hazardous consumption of alcohol can be either "binge drinking" (consumption of five or more drinks in one sitting or on one occasion) or pathological drinking (unable to stop drinking once started). Heavy "binge drinking" can result in alcohol poisoning and subsequent death.

The conditions of dependence and harmful use of alcohol are grouped as "Alcohol Use Disorders". The problems in the personal, family and social sphere of the alcohol-dependent person are well-documented.

In addition to the health risks due to the toxicity of alcohol, intoxication stops one from thinking clearly and acting sensibly. It puts the person and also others at risk of harm from other adverse effects: for example, injury due to falls, risky behaviour or assault. It is for this reason that alcohol is closely associated with road crashes, fights and violence, coercive sexual activity and unprotected sex, domestic violence, perpetuation of poverty etc.

4.2 Prevalence of Alcohol Use

4.2.1 India

The United Nations Office on Drugs and Crime and the Ministry of Social Justice and Empowerment, Government of India, have recently reported the extent, pattern and trends of drug abuse in India, including alcohol abuse (Ray, 2004). Triangulating the different methodologies the study has attempted to provide a realistic picture of the extent, pattern and trends of drug abuse in the country. By a country-wide two-stage stratified random sample, based on probability proportional to size, the National Household Survey reported the current one-month-period use for alcohol to be 21.4%. Of the total alcohol-users, 17%, were classified as dependent users based on ICD 10. Applying the prevalence estimates to the population figures of India for 2001, it was estimated that there are 62.5 million alcohol-users (62.5/1000 population) and 10.6 million dependent users in India (Ray, 2004).

The National Household Survey in India reported the current one-month-period use for alcohol to be 21.4%. It estimated that, of the 62.5 million alcohol-users in India, 10.6 million are dependent users.

Gururaj et al. (2004a), observe that "in accordance with the growing consumption of alcohol all over the country, the hospital admission rates due to adverse effects of alcohol consumption are also increasing." Several studies indicate that nearly 20–30% of hospital admissions are due to alcohol-related problems (direct or indirect).

Several recent studies from the National Institute of Mental Health and Neurosciences, (NIMHANS), Bangalore, have estimated the

prevalence of alcohol use at the household level and at the individual level. Gururaj et al. (2006), observed in a population-based study in Bangalore that 36% of the households in rural areas and 34% in semi-rural or transitional towns had at least one alcohol-user in the 15 to 60 year age group (hereafter referred to as the Bangalore study). In another study on health behaviour surveillance, it was observed that the prevalence rate of habitual alcohol use among the 15 to 55 year olds was 90/1000 population. The group interaction revealed the magnitude of the problem to be much larger. The group of men opined that nearly 60% among the youth consume alcohol and it was felt that its use was starting at a younger age than before (Gururaj, 2004b).

Alcohol-related psychiatric problems have been documented in psychiatric morbidity surveys in general populations and also in specific populations. The prevalence of alcohol abuse has varied between 13/1000 to 14/1000 (Gururaj, 2004a). A WHO sponsored study on unrecorded consumption of alcohol of 15 000 households throughout the state of Karnataka, estimated the prevalence of alcohol use as 30% of all adult males in the state and about 1% of all adult females (Benegal, 2003). The head-of-household survey undertaken by Mohan D et al. (1992), in Delhi reported that 26% of residents in urban slums were substance abusers, the majority involving alcohol. Specific population surveys of alcohol use have been carried out amongst school students, industrial workers, medical personnel, etc. and rates ranging between10–66% have been reported (Gururaj, 2005a). Anand et al. (2000), estimating the burden due to alcohol use considered it as 'numero uno' amongst all non-communicable disorders.

4.2.2 Sri Lanka

Perera B et al., found in their study of 1565 adults, that 23% of men were alcohol-users.

Perera B et al., found in their study of 1565 adults, that 23% of men and 0.9% of women were alcohol-users. Fernando N observes that surveys in Sri Lanka have found that 67% of the families had at least one member consuming alcohol and tobacco (WHO, 2002). Amongst the 15 to19 year-old students in a southern district of Sri Lanka, the current prevalence of alcohol consumption was reported to be 21.2% among men and 3.3% among women (WHO, 2004). Apart from strokes, heart disease and cancer, lifestyle diseases such as drugs, alcohol, sexually transmitted diseases, and suicide are said to be amongst the top six causes of death, both among the rich and poor alike (Gunawardene, 1999). Dissanayake and Navaratne (1999) report that 24% of male deaths are related to alcohol.

4.2.3 Thailand

Studying the prevalence of hazardous/harmful consumption of alcohol in a southern Thai community, Assanangkornchai S et al. (2003), in a cross-sectional survey observed that the age-adjusted prevalence of hazardous/harmful drinkers was 10% (27% in males and 1% in females). The "Bangkok metropolis survey" undertaken by Chulalonkorn University found that drug and substance-use disorders (11.2%), and alcohol use disorders (18.4%), were the commonest problems. Amongst migrant workers, the extent of alcohol use was found to be 24.5% (Howteerakul, 2005). In a KAP survey in Thailand, harmful use of alcohol was the second most common problem. The lifetime use of beer, hard liquor and wines were 35%, 26% and 23% respectively (WHO, 2003a). Amongst those seeking care for chronic disorders through a mobile unit (Swaddiwudhipong, 1999), 70% of men were current alcohol-users as compared to 39% of women.

According to the "Bangkok metropolis survey", by Chulalonkorn University, drug and substance use disorders, and alcohol use disorders, were the commonest problems.

4.2.4 Nepal

Jhingan (2003) reported the extent of alcohol dependence to be 25.8% as assessed by a CAGE questionnaire in the city of Dharan. Shrestha et al., have observed that the prevalence of alcohol use in Kathmandu metropolitan city was 31% among the general population aged more than 12 years (22% men and 9% women) while alcohol dependence was 5.5%. Nearly 18% of the alcohol-users were dependant users (WHO, 2002).

Jhingan (2003) reported the extent of alcohol dependence in Nepal to be 25.8%.

Other SEAR Member States: Such data on consumption are not available from other SEAR Member States.

4.3 Abstinence

Lifetime abstinence rates among men range from 44% in Thailand to almost 90% in Indonesia; among women the range is between 73% in Nepal and nearly 100% in Bangladesh (WHO, 2004). Despite the high reported rates of abstinence, it is vital to consider the detrimental effects of alcohol consumption by those who do not abstain and their impact on the abstainers. Commenting on the belief about India being a traditionally 'dry' or 'abstaining' culture, Benegal (2005), traces this construct to be of relatively recent origin, led by the process of *sankritisation* of the emerging urban Indian middle class who were a collective part of the 19th century rapid industrialization, as also the result of the nationalist movement which championed the cause of prohibition as a reaction to the perceived colonial imposition of the alcohol problem in the country. The inter-country consultation of four countries (Indonesia, Sri Lanka,

Despite the high reported rates of abstinence, the detrimental effects of alcohol consumption by regular users and their impact on the abstainers is significant.

Thailand, Nepal) of the SEAR in 2002 (WHO, 2002) felt that in these communities consumption of locally brewed alcohol is a tradition and a way of life. In that context, abstention may be reported only with respect to alcohol that is purchased.

4.4 Drinking Patterns

It is now being recognized that alcohol-related harm is unrelated to addiction but is related to pattern(s) of drinking.

It is now being recognized that alcohol-related harm is unrelated to addiction but is related to intoxication or other physiological processes triggered by alcohol use (Rehm, 2003). The pattern(s) of drinking is thus more important rather than the addiction status of an alcohol-user. The group at risk is the new user, especially the youth, who, due to their relative inexperience in handling an alcoholic drink, get invariably drawn into adverse consequences of alcohol use (eg. road traffic injuries, fights, anti-social behaviour).

To highlight the role of alcohol in health and social problems in a country or community, a summary measure is the average drinking pattern. The estimated average drinking pattern is in the range of 1 to 4. Currently, in the Region the average drinking pattern ranges between 2.5* (Thailand) and 3* (India) (WHO, 2004).

Among the youth, alcohol use usually begins as 'experimentation' often initiated in peer groups. Unlike smoking though, drinking does not take place during the actual time spent at school. School friends usually form the first group in which alcohol consumption is initiated. It may also occur within the family, at social gatherings on special occasions such as birthdays or marriages, where alcohol is served.

Evidence reveals that alcohol-drinking is being initiated at comparatively younger ages. Data from Karnataka, India showed a drop from a mean of 28 years (1920–30 borns) to 20 years (those born between 1980–90).

There is now evidence that drinking alcohol is being initiated at progressively younger ages. There has been a significant lowering of the age at initiation of drinking in India. Data from Karnataka showed a drop from a mean of 28 years to 20 years between the birth cohorts of 1920–30 and 1980–90 (Benegal, 2005). Some young people move from experimentation to regular consumption and some to harmful consumption of alcohol. The first occasion of "getting drunk" is an event of similar importance to that of initiation into alcohol consumption. Parents' drinking habits and the attitude of the family to alcohol strongly affect children's pattern of alcohol consumption. The attitude of some

* *To highlight the role of alcohol in health and social problems in a country or community a summary measure is the average drinking pattern. The estimated average drinking pattern is in the range of 1 to 4 (4 being the most detrimental pattern, based on the number of heavy drinking occasions, drinking outside meals, high levels of fiesta drinking and drinking in public places and 1 being least detrimental pattern, least heavy drinking occasions, drinking with meals, low levels of fiesta drinking and least drinking in public places).*

communities in which alcohol consumption, particularly among young males, is condoned and accepted as a sign of "growing up" encourages young people to drink alcohol because their uncivilized behaviour is excused. About two fifths of the youth respondents in the Thailand survey approved of consuming one or two drinks several times a week and about one fourth of the respondents opined that regular drinking entails no or slight risk (WHO, 2003a).

The pattern of drinking in rural areas is usually "binge drinking" centred around pay-day or special occasions, such as, marriages and festivals. Another special occasion in democratic India is during the elections.

Availability, advertising and legal restrictions on the supply of alcohol are known to influence drinking habits among young people. Marketing, particularly to the young, plays a critical role in the globalization of patterns of alcohol use. Even in countries where alcohol advertisements are banned, surrogate advertisements abound and compete with the fierce advertisement of the cola companies. An example of the success of alcohol industry promotions is the finding that a significant proportion (27%) of Sri Lankan men expressed favourable attitudes towards the alcohol industry (Perera, 2004). Given that aggressive marketing strategies are used by these industries to promote their products among young people, scientifically designed epidemiological studies of alcohol use are essential to formulate effective prevention strategies.

Drinking on Special Occasions (Sri Lanka)

In a Tamil village in Vavuniya district, drinking alcohol is an integral part of all special occasions to such an extent, that even non-drinkers are socially influenced into drinking. Some people, especially new settlers, run into debt by buying alcohol for such occasions. One special occasion that seems to include heavy alcohol consumption is the Sinhala and Tamil New Year. In Mihintale village we were told that during the months of February and March money circulation in the village is good. Therefore they celebrate New Year in a grand manner. Whatever they save during the year is spent on New Year. A large part of their savings is spent on alcohol. Some more is spent on gambling which takes place only during this part of the year. Alcohol seems to be an unquestionable part of the celebrations.

Source: Forut Report (2004)

Drinking on Special Occasions in India

Caught! Lorries carrying liquor for votes

Express News Service

Bangalore, Dec 24: Excise officials have confiscated two lorryloads of seconds liquor allegedly belonging to a powerful

ALCO-HAUL: Bangalore division excise officials have confiscated over 10,500 litres of liquor and over 1,500 litres of arrack being smuggled into the villages for the second phase of the panchayat polls held on Friday. The estimated value of the liquor is around Rs 50.4 lakh, officials said. Officials have seized 13 vehicles and arrested nine persons who are now in judicial custody.

Source: Indian Express newspaper, Bangalore edition dated 25 December 2005

4.4.1 Average Adult Per capita Consumption

The recorded Adult Per capita Consumption (APC) in the Region remained stable during the 60s and 70s. Beginning with 1980s, it has shown an increase. WHO estimated in 2004 that the average 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.

It is pertinent to note that APC may give a misleading representation, if one considers the pattern only of those who consume alcohol. With a large majority of abstainer population (women and children), the amount consumed by those who drink alcohol can reach very high levels.

In many countries of the Region, the often quoted per capita consumption figures do not give a true picture because local and cheap beverages, either legal or illegal, are not computed into national statistics.

4.4.2 Unrecorded consumption

Many countries of the Region have illustrated how the often quoted per capita consumption figures do not give the true picture of consumption. This is mainly because parallel with the western and more expensive beverages, which usually constitute the recorded consumption, in most countries there exist local and cheap beverages, either legal or illegal, that are not computed into national statistics. Alcohol brought into the country by citizens and tourists and which is smuggled also contributes substantially to the total quantity of alcohol available in a country. Thus, a substantial amount of alcohol consumed is unrecorded, i.e., not part of the official data. Unrecorded consumption includes a wide range of local beverages and home brews.

As a proportion of total consumption, unrecorded alcohol consumption is estimated to be nearly half in India and nearly three fourths in Sri Lanka. Therefore, at least for India and other countries in the Region like Myanmar and Sri Lanka, the actual APC would be much higher than what is reported.

Estimated volume of unrecorded consumption of alcohol per capita for 15+ population in the SEAR		
Country	Unrecorded consumption (in litres of pure alcohol)	Unrecorded consumption as % of total consumption
Thailand	2.0	19
India	1.7	50
Myanmar	0.4	52
Sri Lanka	0.5	73

Source: Adapted from WHO (2004)

4.4.3 Beverage types

The attitudes towards and practices regarding alcohol use have been undergoing significant changes in the countries of the SEAR, particularly in the last decade. The characteristics of adult alcohol consumption are similar in some ways across the Region. The type of beverage consumed

In the SEAR, rural households consume more of local brews.

Common local brews in the SEAR	
Country	Local brews
Bangladesh	*Bangla Mad, Cholai, Tari*
Bhutan	*Ara*
India	*Arrack, Desi Sharab, Tari, Tharra, Fenni, Toddy*
Indonesia	*Palm Wine*
Myanmar	*Tin Lei Phyu*
Nepal	*Raksi, Tadi, Chayang, Tomb*
Sri Lanka	*Toddy, Arrack, Kasippu*
Thailand	*Oou, Krachae, Namtanmao, Sartha, Waark*

Arrack is a distilled beverage, obtained from paddy or wheat. Jaggery, sugar or sugarcane is added to either of these two cereals and boiled with water. This is allowed to ferment, after which it is distilled. This beverage contains about 50–60% of alcohol.

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

Source: WHO (2003)

most often is spirit. A noticeable trend is the appearance of wines and beer in the spectrum of alcohol use, especially during the late eighties and early nineties, in some countries (WHO, 2004). This corresponds to the immense socio-political and economic changes that these countries are undergoing. The last two years have seen a steady (20%) growth in wine sales in India. Commenting on the consumption of beer in India, Benegal V observes that even though it constitutes less than 5% of total alcohol consumption, 70% of beer sales are dominated by strong beers at strengths over 8% v/v (Benegal, 2005). In the SEAR, rural households consume more of local brews.

4.4.4 Illicit brews

As a result of the triple processes of centuries of colonization, decades of industrialization and the recent globalization along with liberal liquor control policies in individual countries, the illicit brewing industry has also seen its highs and lows. Most often the clandestine cottage industry preparations are made in unhygienic environments; the additives to the deadly mix enhance the hazard.

Hazardous Illicit Brewing (Rural Area Outside Bangalore, India)

A variety of *kalla bhatti* that the research team was able to procure, came in a 180 ml. bottle. The place of manufacture was a shed in the village itself. The raw materials used were jaggery, wood apple, waste fruit and *nau-sadar* (sal ammoniac). Other additives consisted of shells of batteries. Unconfirmed reports by consumers described other additives such as rubber slippers, lizards and other decomposing matter being added.

The process of manufacture is as follows: It starts with 20 litres of water in a large earthen pot. Into this, 10 kg jaggery, 5 kg wood apple and other fruits, as well as pieces of a certain thorn tree are added. Also added are 3 old battery shells and two pieces of *nau-sadar* ground into powder. The ingredients are thoroughly mixed and allowed to ferment for 5 to 6 days after which it is boiled for three hours. The mixture is then distilled by passing through a water cooled pipe, to allow the distillate to collect through a funnel into another pot. The process of distillation takes around 6 to 7 hours. The distilled liquid is then put in bottles, capped and kept for at least three days, after which it is sold. The liquor is light coffee brown in colour and of watery consistency. The manufacturers say that the liquor can be stored for up to three months. Two to three batches of 20 litres each are made in a day. The approximate cost of manufacture

(continued...)

Hazardous Illicit Brewing (continued...)

is INR 150 per 20 litres and the manufacturers say they make a profit of around INR 50 for every 20 litres. The consumer pays about INR 200 per quarter bottle (180 ml.). Consumers reported that the *kalla bhatti* was more potent and fiery than other licit country liquor and made them more inebriated and violent.

Informants recalled that while many years back, the manufacture was restricted to families belonging to a traditional caste of brewers, in recent times the business had been taken over by non-specific networks with considerable muscle power and alleged contacts with the powers that be.

Source: Benegal V et al. (2003)

Illicit alcohol consumption and mass tragedies

There have been many instances of poisoning and deaths following the consumption of adulterated liquor. People of the lower socio-economic status sometimes consume illicit or home-brewed alcohol because of its low cost, despite its known hazards. Mass casualties as an aftermath of consuming toxic brews are not infrequent. At least 90 Bangladeshis died in 1998, including 70 in Gaibandha, after consuming illegal home-brewed alcohol. In the following year, there was an incident of alcohol poisoning in the north-eastern town of Narsingdi, about 50 miles from the capital Dhaka, where 96 people reportedly died and more than 100 were hospitalized as a result of drinking illegal home-made liquor (WHO, 2004). Such tragedies devastate entire families who lose productive members of their family.

There have been many instances of poisoning and deaths following consumption of adulterated liquor.

Illicit Alcohol Consumption (Sri Lanka)

The most common form of alcohol used in all the villages studied is the illicit brew *kasippu*. The reasons given for its popularity among villagers are mainly that legal *arrack* costs more and that *kasippu* is more easily available.

Several informants said that if there is no liquor at a wedding, the participation will be poor, and that there are people who do not go to a wedding if alcohol is not being served. If there is no liquor, the value of the gift, which is normally money, will be reduced. If 200 people are invited they bring about 50 bottles of *arrack*. It costs around 14,000 rupees. If the family is poor, they would serve *kasippu* instead of *arrack*.

Source: Forut Report (2004)

Media reported illicit alcohol tragedies in India, 2003–05		
Place, Year	Deaths or cases	Remarks
Villupuram, Tamil Nadu, 2005	5 deaths	–
Nelamangala, Bangalore, 2005	21 deaths	Fake government emblems on the sachets
Hoskote, Bangalore, 2005	10 deaths	–
Rewari, Uttar Pradesh, 2005	8 deaths	–
Bikaner, Rajasthan, 2005	5 deaths	Nearly 36 suspected to have died
Kolayat, 2005	21 deaths	–
Menambedu, Tamil Nadu, 2005	13 deaths	Intoxicants worth INR 170 000 and 15 175 litres illicit liquor seized
Lucknow, Uttar Pradesh, 2005	7 deaths, 15 ill	–
Cuddalore, near Chennai, Tamil Nadu, 2004	46 deaths	120 treated, 29 lost their vision; 33 deaths in neighbouring villages in the previous month
Diwosas, Bareilly district, 2004	14 deaths	–
Thrissur, Kerala, 2004	3 deaths	–
Unnao, Uttar Pradesh, 2004	9 deaths	–
Mumbai, 2004	99 deaths, 100 hospitalized	1110 litres illicit liquor seized
Tangra, West Bengal, 2004	35 deaths	–
Koopana, Kerala, 2004	7 deaths, 30 ill	–
Hisar, Haryana, 2003	6 deaths , 12 ill	–
Dharwad, Karnataka, 2003	6 deaths	–
Tiruvallur, Tamil Nadu, 2003	13 deaths, 92 males ill	–

Source: Compiled from media reports in daily newspapers

4.4.5 Hazardous consumption

Hazardous consumption of alcohol is a common pattern of consumption in the Region. This consumption pattern is particularly harmful.

A recent survey in Sri Lanka as part of the WHO Gender Alcohol and Culture: an International Study (WHO, 2003), shows that 10.2% of current male drinkers are frequent heavy drinkers and 20% are infrequent heavy drinkers, with the highest proportion of frequent heavy drinking being in the 30 to 44 year-age group (WHO, 2004). Frequent heavy drinking was reported by 21.8% of male respondents in this age group in a similar survey in India, much higher than in the younger (12.5%) and older (14.1%) age groups (Benegal, 2005).

The Bangalore study reports that 41% of the alcohol-users in the study population in the four study areas engaged in "binge drinking", with one third of them reporting the frequency of this type of drinking to be less than monthly (Gururaj, 2006). Nearly one fourth of the study population report to be pathological alcohol-users, i.e. they have not been able to stop drinking once started in the last 12 months. It was observed that of those who indulged in "binge drinking" on a monthly basis, nearly 50% across the four areas are also pathological drinkers.

4.4.6 Changing faces and emerging trends

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

It is difficult to arrive at one single composite indicator of alcohol consumption pattern and its effect in every society. The real and complete socio-economic burden and costs due to alcohol consumption in the community have to be examined from diverse aspects using data from multiple sources, both in a quantitative and qualitative manner. This makes it even more challenging. Despite many shortcomings, various approaches have been tried in order to document the quantum of alcohol-related problems in a community and also the costs on society due to these problems (For a fuller understanding of the issues concerned please refer to the document by Single E et al. 1996).

With the growing awareness of alcohol-related problems in the SEAR and the limited understanding of socio-economic impact of alcohol use in

Recent changes in alcohol consumption patterns

- Emergence of wine and beer drinking
- Increase in drinking among women
- Early experimentation and deceasing age of initiation
- Shift in consumption from urban to rural areas and transitional towns
- More "binge" drinking
- Greater acceptability of drinking as an accepted social norm
- Alcohol use along with high-risk sexual behaviour

Changing Faces of Alcohol Consumption

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

Source: *Vijaya Times*, Sept 11, 2005

With the growing awareness of alcohol-related problems in the SEAR and the limited understanding of the socio-economic impact of alcohol use in these societies, formulating future strategies has been complex and difficult.

these emerging societies, formulating future strategies has been complex and difficult. To estimate the socio-economic burden of alcohol-related problems, WHO Regional Office for South-East Asia (SEARO) sponsored a feasibility study to examine this problem in communities. The study was conducted in Bangalore, India, among 28 507 individuals drawn from 7912 household from 4 communities (rural, town, slum and urban). It has been the first major attempt of its kind to document the effects of alcohol in transitional communities both among users and non-users of alcohol. The study examined the problem in different dimensions of health, family impact, social, educational, occupational, psychological, legal and emotional impact on individuals and their households. Both quantitative and qualitative approaches were used. An attempt was made to cost the impact in individual areas. Though the findings are broad-based and cross-sectional in nature, it provides an indication of the costs of alcohol consumption and its consequent economic impact on not just the individual, but also society in general. The findings are reported in a separate document (Burden and Socio-economic Impact of Alcohol Use — The Bangalore Study: Alcohol Control Series No. 1).