

# Development of Projects for Prevention of Harm from Alcohol Abuse

*Report of an Intercountry Consultation  
Bali, Indonesia, 25-27 June 2002*

WHO Project No.: ICP MNH 001



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## 1. INTRODUCTION

The attitudes and practices of alcohol use have been undergoing definitive changes in the countries of the South-East Asian Region, more so in the last two decades. The Global Status Report on Alcohol by the World Health Organization (1999) documents that alcohol consumption in the South-East Asia Region is rising. This trend of increasing consumption also needs to be seen in the context of falling consumption patterns in the European Region. It is believed that with the developed parts of the world reaching stable saturation or declining patterns of consumption, market forces are targeting the developing parts of the world such as Member Countries of SEAR. These forces, operating through the media and other promotional strategies, complement the social and cultural forces of globalization and will lead to an expected rise in the consumption of alcohol in the Asian region.

Alcohol abuse in the rural communities of SEAR Member Countries is a particularly serious problem. No reliable population-based data are available about consumption of alcohol in such rural communities. The pattern of drinking is usually binge drinking centred around pay day or on special occasions such as marriages and festivals. Alcohol consumption is frequently responsible for domestic violence and quarrels with neighbours. It also accounts for numerous accidents such as road accidents and falling down hills in mountainous communities. Also, given the poor socioeconomic status of most rural communities, disproportionate amounts of family income is spent on alcohol leaving very little money for food, education, housing and health. Thus a vicious cycle of poverty is perpetuated. Usually, locally-brewed or home-brewed alcohol is consumed. Sometimes this is contaminated with methanol or other toxic agents; thus, poisoning is frequently reported in rural areas.

Recognizing the importance of harm from alcohol abuse in the community, the WHO Regional Committee, in its 54<sup>th</sup> meeting in Yangon in September 2001, passed a resolution recommending WHO support to Member Countries in developing programmes and projects for prevention of harm from alcohol abuse. In response to this resolution, an Intercountry Consultation on Prevention of Harm from Alcohol Abuse was organized in Bali, Indonesia from 25-27 June 2002 to develop a strategy to address the

multi-faceted issues related to harm from alcohol abuse in the Region and to identify unique solutions to reduce the harm due to alcohol abuse in the community. Bali was selected as the venue of the consultation as alcohol consumption is said to be a part of the local way of life and its abuse is widespread in the community.

## **2. OBJECTIVES**

### **2.1 Overall Objective**

To develop projects for prevention of harm from alcohol abuse in the community.

### **2.2 Specific Objectives**

- (1) To discuss the patterns of alcohol use in the communities of Member Countries with particular emphasis on local patterns.
- (2) To share country experiences on successful and unsuccessful interventions to prevent harm from alcohol abuse.
- (3) To review draft strategy documents on prevention of harm from alcohol abuse in the community, which can be adapted by individual Member Countries.
- (4) To develop community-based projects for prevention of harm from alcohol abuse, and
- (5) To review indicators to assess success of strategy for reduction of harm from alcohol abuse.

## **3. OPENING SESSION**

Mr Georg Petersen, WHO Representative to Indonesia opened the meeting, and conveyed the greetings of the Regional Director, WHO, SEARO. He outlined alcohol problems and other issues involved with the abuse of alcohol and referred to the high social costs of alcohol abuse.

He added that the unseen impacts in this part of the world were perhaps more serious. These included the impact on people living in poverty and the

violence associated with alcohol abuse. This was specially significant with regard to domestic violence.

Mr Peterson concluded by appealing for innovative solutions and wishing the meeting success.

Dr Molin Yudiasa, Director of Health Services of the Province of Bali, officially declared the meeting open. He outlined the problems associated with alcohol in Bali. He also referred to the cultural and social roles that alcohol plays in the community.

Ms Nina Rehn, Technical Officer from the Dept of Substance Abuse of WHO Geneva spoke briefly on the global situation. She referred to the effect of promotion by the alcohol industry and the proportion of people's disposable income spent on alcohol.

She emphasized the need to focus on all levels of use, and the harm associated with each of these. It was not enough to focus on the few individuals who were most heavily dependent.

Dr Vijay Chandra, Regional Advisor, WHO/SEARO thanked all those who had contributed, with much enthusiasm, towards organizing the meeting, and outlined the objectives of the meeting. He said that the emphasis of the meeting would be on prevention of harm from alcohol abuse to individuals, rather than on issues related to the supply of alcohol. Attention also needed to be given to the unique problems of the Region related to alcohol consumption such as alcohol dependence in rural areas and illicit alcohol.

Dr L K Suryani was nominated Chairperson, Dr Tairjing Siriphanich as Co-chair and Dr Diyanath Samarasinghe as Rapporteur.

## **4. PROCEEDINGS**

### **4.1 Regional and global situation analysis**

Dr Vijay Chandra, Regional Adviser (H&B) SEARO provided the keynote address on 'Strategies for prevention of harm from alcohol abuse'.

He explained the range of harm caused by alcohol, the need to collect relevant data linked to interventions, and the need for testing multiple strategies. He briefly outlined suggestions for possible action.

Ms Nina Rehn, Technical Officer from the Dept of Substance Abuse, WHO/ Geneva introduced the 'Global Alcohol Database'. She outlined the sources of information and the major items of information available in it. Per capita consumption, usage data and control policies were examples of key areas covered.

Ms Rehn then introduced the WHO/HQ strategy and work plan for the years 2002-2003.

She concluded by presenting information on trends or changes in per capita consumption of alcohol, in different parts of the world. Increases were evident in Western Pacific and, to a smaller extent, in SEAR. The main domains in which changes needed to be monitored included patterns of drinking, drinking consequences and health consequences.

Dr Imam Mochny, Resource Person, WHO SEARO, made a presentation on the assessment of harm from alcohol through surveys. He gave an overview of the approaches to interventions and gave a summary of the methods for assessing the situation regarding alcohol abuse and related harm.

During the discussions on the three presentations, several important issues were raised:

- The relative neglect arising out of alcohol consumption problems compared to tobacco;
- The possibility of integration with life-skills projects of the Adolescent and Child Health Programme of WHO SEARO, to focus on young people;
- The need to look at supply side issues as well;
- The promotion and advertising of alcohol as a significant influence in increasing consumption;
- The relatively high proportion of illicit or locally produced alcohol skews the consumption data. In this Region, the amount of locally produced alcohol is relatively large – perhaps much larger than for other regions such as Europe;
- Alcohol not only takes away money from food and education in poor families, but also diverts foodgrains to the production of 'local' alcohol. The amount of grains diverted for alcohol production was significant enough to impact the grains available for nutritional needs;
- Reservations were expressed about the risks of recommending 'safe limits' for public consumption;

- Problems in implementation of control on alcohol because of governments being interested in revenue from alcohol; were presented, and
- Confusion caused by approaches advocating 'sensible drinking', 'abstinence', 'safe limits', 'temperance', 'prohibition', 'harm reduction' and 'moderate drinking'.

Dr Diyanath Samarasinghe, Resource Person for the consultation, expanded on the draft strategy for prevention of harm from alcohol abuse. He presented a conceptual framework on which to base community interventions to reduce alcohol-related problems.

## 4.2 Country Reports

Bhutan	Dr Bhakta Raj Giri
Indonesia	Dr Ralph B Kairupan, Dr Eka Viora, Professor Dr L.K. Suryani
Nepal	Dr N M Shrestha and Dr K D Upadhyay
Sri Lanka	Dr Neil Fernando
Thailand	Dr T Siriphanich

### ***Bhutan***

Consumption of alcohol is widely accepted in the Bhutanese society. Its use is culturally permitted. On almost every occasion, be it marriage, blessings, ceremony of rites of passage or offering to deities, alcohol has an important place in a Bhutanese home.

Distilled alcohol is locally produced in Bhutan, a huge amount of home-brewed alcohol is also made and consumed. Harm from alcohol abuse is a serious problem with cirrhosis of the liver being the third commonest cause of death in Bhutan. Home-brewing of alcohol is an important part of the local economy, with foodgrains being diverted to alcohol production.

The Royal Government of Bhutan has taken several measures related to prevention of harm from alcohol abuse. Several control and advocacy measures have been initiated.

## **Indonesia**

There were three presentations from Indonesia: Jakarta, Manado and Bali.

The Ministry of Health of the Government of Indonesia established a National Committee on Drug Abuse, handling the prevention, promotion, treatment and rehabilitation aspects related to drug abuse. This committee also covers alcohol abuse issues. All the activities are funded by the Ministry of Health through the Directorate-General of Community Health and Directorate-General of Medical Care.

Alcohol-containing beverages (commercial products) are relatively expensive and usually purchased in bottles from stores or in pubs or discotheques. In some provinces, there are homemade alcohol-containing beverages, known as "Tuak" in North Sumatra, "Brem" in Bali, and "Cap Tikus" in North Sulawesi.

Drinking alcohol-containing beverages is a common habit in some provinces (e.g., North Sumatra, Central Kalimantan, Bali, North Sulawesi, Maluku [Ambon], Central Sulawesi [Poso], and Papua). Many people in these provinces can be classified as moderate drinkers, and some of them are alcohol abusers. This habit is commonly seen in the recreational facilities (discotheques, pubs), or during cultural festivals/events.

## **Nepal**

Alcohol is generally produced, consumed and accepted as a social norm in Nepal by some ethnic groups. Overall alcohol use is increasing in the country, but national data on alcohol production and abuse are not available, as there are no records of locally brewed alcohol. Alcohol abuse is mainly a problem in males.

Two research projects were presented:

- (1) To assess the possibility of integrating the psychoactive substance abuse problems into primary health care, and to know the current situation of substance abuse problems in the community. A key informant survey was carried out in 1996 in a rural community covering 40,000 population. 215 key informants were interviewed. The findings were:
  - Age of starting alcohol use 15 to 20 years in 80 percent population;
  - Home-brewed alcohol is used by more than 90% of rural alcohol users;

- Millet, maize, rice and sugar are used for home brewing of alcohol;
- Alcoholic drinks are easily available from early morning till late at night;
- Relaxation, enjoyment and habit are the three most common causes of consuming alcohol;
- Domestic violence towards spouse and children and public offences are two common social problems.

The key informants made the following six recommendations to reduce alcohol abuse in the community.

- Promote social awareness on harmful affects of alcohol abuse;
- Strong law enforcements;
- Stop production and sale of home brewed alcohol;
- Ban alcohol;
- Activate local women's groups, and
- Increase tax on alcohol.

(2) Another study of alcohol use in Kathmandu metropolitan city (Shrestha et al 2001) showed:

- 31% of general population aged 12 years and above used alcohol (22% men and 9% women)
- Prevalence of alcohol dependence in general population is 5.5%
- Prevalence of alcohol dependence among alcohol users 17.7% (male:female ratio 5.6:1)

Based on these two studies, several activities have been conducted and action taken. Nepal does not have a National Alcohol Policy, but it has a National Drug Control Policy since 1996. This policy mainly concentrates on illicit drugs. However, this policy also states that there is a need to focus on licit drugs such as nicotine, alcohol and some medicinal substances with regard to regularization, prevention and control.

Provision has been made in the legislation regarding production, import, sale and consumption of alcoholic beverages in the country, but in practice

they are not functional. In the last 4–5 years, local women’s group known as the “Mothers’ Group “ took initiatives to ban alcohol brewing as well as use in the villages, but was not successful. However, this initiative has been partially successful in reducing alcohol abuse as reported by the print media.

Local administration in some districts have decided to ban alcohol use and declared the areas as dry, and selling and drinking as illegal, but this has not been successful. Also, advertisement of alcoholic drinks in the electronic media has been banned in Nepal since the last two years. There is also a plan to ban advertisements in the print media in the future.

### ***Sri Lanka***

Types of alcoholic beverages consumed in Sri Lanka include distilled liquor, locally-brewed liquor (toddy and arrack) and unlawfully manufactured local liquor. Illicit liquor production is a lucrative business and is like a “cottage industry”.

Surveys have shown that about 67% of families had at least one member consuming alcohol and tobacco. 43% of urban shanty dwellers and 60% of estate workers consume alcohol. The poor spent as much as 30% of income on alcohol.

There is increasing recognition of medical morbidity, psychological harm and social problems related to alcohol abuse. Youth drinking is an emerging problem.

### ***Thailand***

Problems related to alcohol abuse are rapidly emerging. Production of distilled liquor is increasing. It is estimated that about 30% of adults over 15 years of age consume alcohol, of which 85% are males. Road traffic accidents related to drunken driving are a serious problem. A nationwide campaign against drunken driving has been launched. Alcohol is also related with family violence and quarrels with neighbours.

### ***NGO reports***

Presentations were also made by two representatives from non-governmental organizations. These were Ms Sudha Mani from TTK Ranganathan Clinical Research Foundaton, India and Mr Sampath de Saram from Alcohol and Drug Information Centre, Sri Lanka.

The community-based approach was the key ingredient in the alcohol rehabilitation efforts of TTK. The work consisted of engaging a community in the process of responding to its alcohol problems and working with them about what needs to be done. TTK was increasingly taking the role of technical expert and facilitator, while the communities themselves provided all the material resources.

After initial preparation and engagement, the community took on the task of organizing a 'camp' for rehabilitation of alcohol dependent persons. This helped to mobilize the entire community in the effort to deal with its alcohol problem. Details of how a treatment camp is organized and the follow up and results achieved were described.

In the presentation by ADIC, the mobilization of communities to implement a preventive approach to alcohol problems was described. The process included helping the community to recognize the real damage done to it because of alcohol abuse and the factors that promoted its use. This included those influences that made young people see alcohol in a positive and attractive light.

The community then learns how to overturn these promotive influences. Results were not only in terms of reduced initiation by young people but also influenced current users to reduce or stop their alcohol consumption.

Some common themes could be seen in the approaches of the two NGOs. Both appeared to be driven by an enthusiastic and committed spirit. They were able to achieve measurable, documented success in the projects. Results were presented by both agencies encompassing indicators beyond just the number of people who consumed alcohol, did not consume alcohol and stopped drinking alcohol.

The areas of focus of activities of the two organizations were quite different. ADIC concentrated on primary preventive work, while TTK focused on therapeutic interventions for those who were dependent on alcohol. But they both worked through community involvement. Rather than setting up their own representatives, they generally chose to work through existing community agencies. The other common feature was that they worked over an extended period.

During the discussion much interest was evinced about the approaches of these two organizations. Nearly all participants expressed surprise at the

results shown and wanted an explanation of the methodologies used. The group was keen to see how the community approach could be integrated into other activities.

#### 4.4 Alcohol and Culture

A presentation on 'Alcohol and culture' was made by Dr I Mochny.

Dr Mochny explained the connections between alcohol use and culture giving examples from different countries of the Region. He set out a model which showed the interactions between the different contributors to the genesis and maintenance of alcohol problems. He outlined the importance of a bio-psychosocial model and stressed the features of biological factors such as nutrition and other dietary habits. The influence of culture could be well illustrated using the influences that operated in Bali itself.

#### 4.5 Alcohol Situation in Bali

Prof L K Suryani presented not only the situation in Bali, but also the details of interventions carried out with substance users.

The situation of alcohol use and abuse was becoming a problem in Bali. The tourist trade contributed to the increasing problem of alcohol use and abuse. Other drugs were also being introduced through the same route. Alcohol abuse was becoming increasingly connected to sexual abuse of children and even with incest.

The traditional alcohol beverage in Bali is *tuak* (palm wine, containing 4-4.5% alcohol). Groups of people drink *tuak* in every *banjar* all over Bali. They drink *tuak* twice a day, in the afternoon and in the evening. Alcohol is consumed everywhere including in street corners, bazaars, group activities when they make *ogoh-ogoh* or kites. A community survey in a Balinese village in 1990 showed that approximately 40 per cent of the population consumed alcohol, predominantly locally-produced palm wine, and about 2.7 per cent of this population consumed alcohol regularly.

The responses from the community to address harm from alcohol abuse were encouraging. Interventions which were based on returning to traditional values, meditation and religious practice were showing good results at the community level. However, the state funded residential rehabilitation service for drug users were at risk of closing down due to lack of support.

The contribution of 'spiritual' elements in successful alcohol interventions was also discussed.

## **5. FIELD VISIT**

The group went for a field visit to study the alcohol situation in the community and how communities respond to this situation.

The field study included a visit to a treatment and rehabilitation centre for alcohol and drug users which is run by the University of Bali. Participants were able to learn about the different treatment modalities used in the centre.

The group next visited a Hindu temple located in a forest, where there was an exposition of the role of meditation in the traditional Balinese style and a discussion on how medication can be used to calm the mind and treat various psychological problems.

The next destination was a traditional Hindu temple where representatives of the Ministry of Culture and the Head Priest described in detail the role of alcohol in religious rituals. It was pointed out that alcohol is served to evil spirits so that they can become good spirits. This is a traditional belief in Bali and is practised for the appeasement of spirits. In the discussion it was brought out that the common man has misinterpreted the offering of alcohol to appease evil spirits. Somehow, the impression has been created that alcohol is offered to "Gods", and what is offered to the Gods is clearly "holy" and thus desirable for humans to consume.

The role of religion in discouraging alcohol use and its possible role in helping those with problems were discussed at length with the priest of the temple. The participants were able to see how religion had been integrated successfully into the community responses to reduce alcohol-related problems in Bali.

## **6. COUNTRY-SPECIFIC PROJECTS**

There was then a discussion in small groups to develop plans for implementing community initiatives on prevention of harm from alcohol abuse. The countries presented their initial plans.

## **6.1 Bhutan**

Bhutan proposed a project on reduction of harm from alcohol abuse through community action. The project would be implemented at the village level by the basic health unit. Initially, an assessment of baseline indicators would be made, following which there would be intervention at the community level followed by a re-evaluation after 11 months. Specific objectives and expected outcomes were presented.

## **6.2 Indonesia**

Delegates from Indonesia developed the outline of three projects. One project to be implemented in North Jakarta aimed at developing a model for a community-based strategy for the prevention of harm from alcohol abuse. An initial assessment of the magnitude of alcohol use and abuse and the sociocultural determinants of alcohol abuse among harbour workers would be done. Community education and the capacity of primary health care workers would be enhanced hopefully, leading to reduction of harm from alcohol abuse. Specific process and outcome indicators were discussed.

Another project was proposed to be implemented in Manado, North Sulawesi, Indonesia, where alcohol abuse is a major problem among the youth. The project aims to develop community-based action for prevention of harm from alcohol abuse. The initial phase of the project aims at assessing the sociocultural determinants of alcohol abuse. Based on the findings of this assessment, specific intervention programmes would be developed.

Problems related to alcohol abuse are very serious in Bali. The project in Bali will use two strategies, one aimed at school-age children using teachers and counsellors and the second at community education on harm from alcohol abuse. A population-based study in nine areas was proposed.

## **6.3 Sri Lanka**

A project on developing methodology for “self-learning” for community volunteers in the prevention of harm from alcohol is to be developed.

## **6.4 Thailand**

Thailand proposed to use ‘reduction of road traffic accidents’ as an entry for community activities into prevention of harm from alcohol abuse.

The proposals were at a preliminary stage. The group added suggestions and amendments. The proposals are to be developed further depending upon the possibilities of finding funds for implementation.

## 7. RECOMMENDATIONS

- (1) The Regional Office should continue to strengthen capacity in Member Countries to develop and implement context specific community intervention projects to reduce alcohol-related harm.
- (2) Country projects developed during this consultation should be considered for technical and financial support by WHO.
- (3) Success stories related to reducing alcohol-related harm through community empowerment in the Region should be sought for and disseminated.
- (4) Four areas of work on prevention of harm from alcohol abuse were identified:
  - Advocacy
  - Primary prevention
  - Early intervention
  - Harm reduction

### **(a) Advocacy**

Alcohol abuse is often considered a “personal issue”. However, harm related to alcohol abuse affects not only the individual, but the family, the community, the society and the country at large. All strata of society need to be made aware of the harm from alcohol abuse. Unique local situations such as, home brewed liquor, country liquor, pay day drinking, binge drinking, and adolescent drinking should be addressed.

Advocacy efforts should be initiated aimed at making government and nongovernment organizations currently involved in other community-level activities to also become involved in initiatives to reduce alcohol-related harm.

### **(b) Primary prevention**

Using the lifeskills approach, provide information and education to adolescents regarding harm from alcohol abuse. There appears to be a prevalent myth

amongst adolescents that “beer is not alcohol”. This needs to be dispelled. Hopefully, the self-empowerment will prevent children from initiating the alcohol use habit. Activities should be addressed both to in school and out of school children. Great emphasis should be placed on rural alcoholism.

**(c) *Early intervention***

These projects should aim at preventing people who start the alcohol use habit in peer groups or in parties as “fun” from becoming chronic users. The programme strategy should be self-empowerment. Programmes particularly addressed to patterns of drinking in rural areas should be developed.

**(d) *Harm reduction***

Any use of alcohol which interferes with one’s daily life can be considered “harmful”, e.g. road traffic accident after a bout of drinking, family violence after drinking on pay-day etc. Projects to address harm reduction from alcohol abuse should be developed.

## **8. CONCLUSION**

In the closing session, there was an agreement that at least one project should be implemented in each country. The need to combine ‘prevention’ with interventions directed at all levels of alcohol users was strongly emphasized. The fact that education or raising awareness alone were not enough was agreed. These need to be supplemented with community initiatives to reduce the attractiveness of alcohol, for instance.

The global context and the role of WHO headquarters too was briefly discussed. It was also noted that the Regional Committee for South-East Asia had specifically directed that alcohol issues should be addressed.

Dr Vijay Chandra expressed his thanks to the Government of Indonesia and the authorities in Bali for the excellent arrangements and hospitality along with the support of the WHO Representative and staff in Indonesia. He also thanked all the participants and others involved in making the meeting successful. He emphasized the need to ensure that all the planned projects were completed successfully. The results from these projects will reflect the efforts undertaken at the workshop.

## **Annex 1**

### **BACKGROUND PAPER ON PREVENTION OF HARM FROM ALCOHOL ABUSE**

Dr Vijay Chandra, Regional Adviser – Health And Behaviour

#### **Introduction**

Harm from alcohol abuse can affect not only the individual who abuses alcohol, but also his or her family, the community and the entire society in which they live. Harm from alcohol abuse is a major public health problem in the Member Countries of the South-East Asia Region, particularly considering the harmful affects of alcohol abuse to poor and impoverished rural communities.

Besides the adverse effects of alcohol abuse amongst the poor, there are many other unique features about alcohol abuse in the Region, such as, binge drinking or pay-day drinking in which large amounts of alcohol are consumed at one time on pay day, thereby squandering the entire salary on alcohol. Also important is the consumption of illicit locally brewed liquor, which is often poisonous, and the low cost and easy availability in rural areas makes it attractive for people to consume it. Besides, this illicit liquor is outside the purview of government control and taxation. In some communities, alcohol abuse even amongst children and adolescents is condoned as being “a part of the culture”. Since it is not ostracized by society, those among the youth who cannot control their consumption easily become prey to serious adverse effects of alcohol abuse.

There are two distinct patterns of alcohol consumption: the rural pattern as described above and an urban pattern which resembles the western styles of alcohol consumption. During this workshop, attention will be paid only to rural alcohol abuse as the magnitude and impact of abuse in the community is substantially greater.

#### **Control of the supply of alcohol**

One strategy, which has been used in the control of alcohol, is influencing the supply of alcohol. Various strategies have been successfully used, such as,

raising taxation, banning advertisement, limiting the distribution points for liquor, limiting the sale of liquor on pay days, not permitting sale of liquor to minors etc.

Although, limiting the supply of alcohol is an effective strategy, it is most applicable to urban areas, where it is easier for government enforcement mechanisms to be implemented.

Various governments have tried enforcing total prohibition on the sale of alcohol. Although claimed to be successful, the reality is that alcohol continues to be made available in such areas through the black market. This leads to increased corruption, but not necessarily reduced consumption.

### **What is harm from alcohol abuse?**

Harm from alcohol abuse may be simplistically described as consumption of alcohol, which leads to any form of harm regardless of the quantity consumed. E.g. consumption of even a small quantity of alcohol, which leads to a motor vehicle accident, should be included in the category of "harm from alcohol abuse".

Thus, "harm" may be defined as any adverse impact on the person, their family or the community. Examples of harm could include motor vehicle accidents under the influence of alcohol, family violence, particularly violence against women, increasing poverty and insolvency and indebtedness, no money for essential activities such as health, education and housing, inability to work or accidents at the work place. Also the numerous medical illnesses associated with alcohol abuse such as illnesses of the liver and pancreas are due to harm from alcohol abuse.

At the same time, it is not only the individual, but his/her family is also equally affected. In a broader context, even the neighbours and the community is affected by activities such as violence, road traffic accidents, crime and corruption, all related to alcohol.

### **Assessment of harm from alcohol abuse**

Since harm from alcohol abuse is variable, assessment of harm must be done almost on an individual basis, depending on how the individual, their family or community is harmed.

Qualitative information on the harmful effects of alcohol abuse could be used as indicators of the success of intervention programmes if measured before and after an intervention.

Indicators of harm should address the harm to individuals, the family, the community and the country. Such indicators could include indicators of well being, both social and physical.

### **Strategies for prevention of harm from alcohol abuse**

- Multiple strategies will need to be developed, some of which may be appropriate in one community and others in another community. Even within one community multiple strategies may have to be used. For example, one person may respond to counselling from a doctor, another from his family and yet another from a priest.
- Primary prevention, i.e. preventing people from initiating the use/abuse of alcohol. This strategy is probably best used amongst adolescents and a life skills approach may be most appropriate.
- Community-based action must be considered. It is only when the entire community gets involved, that harm from alcohol abuse can be controlled.
- Detoxification centre although essential, have a limited role to play on making an impact on the problem on community-wide basis.
- Total abstinence from consumption of even very small quantities of alcohol such as, one glass of wine or beer is rarely successful or needed. It is more the harm from consumption of large quantities of alcohol which needs to be addressed.
- Strategies for control often address western liquor made within the country, but rarely address illicit and rural alcohol consumption.
- Many control programmes treat alcohol consumption as a law and order problem which rarely reduces harm or rehabilitates the patient.
- Since harm from alcohol is variable and affects people in different ways, strategies will have to be customized for individuals or at most for small groups.

- Society's attitude towards alcohol use will need to be modified. Violence in the family under the influence of alcohol is often condoned by the community as being an adverse effect of alcohol, rather than the intentional behaviour of the person.
- Individual introspection on harm from alcohol abuse, i.e., an individual must be convinced that he/she is being harmed from consumption of alcohol.

## **Annex 2**

### **AGENDA**

#### **Tuesday, 25 June 2002**

- (1) Inauguration and introduction
- (2) Presentation on SEARO proposal to address the issue of prevention of harm from alcohol abuse.
- (3) Presentation and discussion on situation of alcohol use and abuse in Bali.
- (4) Presentation and discussion of the situation of alcohol abuse in Member Countries.

#### **Wednesday, 26 June 2002**

- (1) Presentation and discussion on draft strategy for prevention of harm from alcohol abuse in the community.
- (2) Field visit to see patterns of abuse and their management in the community.

#### **Thursday, 27 June 2002**

- (1) Small working groups for modification and adaptation of draft SEARO strategy by Member Countries.
- (2) Plans for pilot testing of adapted strategy for prevention of harm from alcohol abuse in the community by four Member Countries.
- (3) Conclusion

## Annex 3

### PROGRAMME

#### Tuesday, 25 June 2002

0830-0900 hrs	Registration
0900-1000 hrs	Inauguration
1030-1100 hrs	SEARO proposal on strategies for prevention of harm from alcohol abuse: Dr Vijay Chandra
1100-1130 hrs	Global alcohol data base: Ms Nina Rehn, WHO/HQ
1130-1200 hrs	Assessment of harm from alcohol through surveys: Dr Imam Mochny
1300-1430 hrs	Country situation on alcohol abuse: BHU, INO, NEP, SRL, THA
1430-1500 hrs	NGO presentation : ADIC, Sri Lanka and TTK Chennai
1530-1700 hrs	Presentation and discussion on draft strategy for prevention of harm from alcohol abuse: Dr Diyanath Samarasinghe

#### Wednesday, 26 June 2002

0830-0930 hrs	Discussion on draft strategy for prevention of harm from alcohol abuse in the community.
0930-0945 hrs	Cultural aspects of alcohol abuse in Asia Dr. Imam Mochny
0945-1000 hrs	Situation of alcohol abuse in Bali
1000-1600 hrs	Field visit
1600-1800 hrs	Small working groups for modification and adaptation of SEARO strategy.

#### Thursday, 27 June 2002

0830-0930 hrs	Small working groups for modification and adaptation of SEARO strategy
0930-1030 hrs	Presentations from working groups for modifications and adaptation of SEARO strategy.
1030-1130 hrs	Discussion on future plans
1130-1200 hrs	Conclusion
1300-1600 hrs	Pending issues for discussion

## Annex 4

### LIST OF PARTICIPANTS

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