World Health Organization
REGIONAL OFFICE FOR South-East Asia

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Contents

Abbreviations

AA	Alcoholic Anonymous
ADIC	Alcohol and Drug Information Centre – Sri Lanka
APC	Adult per capita consumption
AUD	Alcohol Use Disorders
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood alcohol concentration
BI	Brief intervention
BICMA	Bhutan Information Communication and Media Authority
CSO	Civil society organization
DALYs	Disability-adjusted Life Years
FISD	Foundation for Innovative Social Development – Sri Lanka
GDP	Gross Domestic Product
Global Strategy	WHO Global Strategy to Reduce Harmful Use of Alcohol
HED	Heavy episodic drinking
IMAP	Integrated Management of Alcohol Intervention Programme in the Health Care System – Thailand
LPA	Litre of pure alcohol
MDA	Minimum drinking age
MPA	Minimum purchasing age
NATA	National Authority on Tobacco and Alcohol – Sri Lanka
NCDs	Noncommunicable diseases
RBT	Random breath testing
RTI	Road traffic injuries
SEAR	WHO South-East Asia Region
StopDrink	Stop Drink Network – Thailand
ThaiHealth	Thai Health Promotion Foundation – Thailand
WHO	World Health Organization

Foreword

I am pleased to present the WHO SEARO publication on 'Alcohol policy situation in the WHO South-East Asia Region'. This report gives an insight to the progress of alcohol policy implementation in the Region, since the endorsement of the Global Strategy to Reduce the Harmful Use of Alcohol by the Sixty-third World Health Assembly in May 2010.

Globally, harmful use of alcohol causes 3.3 million deaths, and 5.1% of the global burden of disease is attributable to alcohol consumption. Alcohol-related harm impedes social and economic development particularly in low- and middle-income countries. Healthcare cost, property damage and loss of productivity and quality of life are burdens of harmful use of alcohol. The detrimental and far-reaching implications of harmful use of alcohol affect not only the drinker but also the family, the community and the country as a whole.

With grave concern, we observe a gradual but significant increase in alcohol consumption among the general population in the Region – particularly among adolescents, youth and females. The Region faces the burden of high prevalence of heavy episodic drinking, or binge drinking; also, the situation of unrecorded alcohol is a huge challenge for the Region. Implementation of effective strategies is hindered by the cultural diversity that leads to varied perception on alcohol consumption. Some Member States endorse absolute prohibition of alcohol consumption while for others, it is an integral part of the social culture; this paradox makes alcohol control a growing challenge to address.

Another significant connotation of the harmful use of alcohol for the Region is that with lower economic wealth, the morbidity and mortality risks are higher per litre of pure alcohol (LPA) consumed than in the higher-income countries.

A coordinated, multisectoral approach is required to address the complex issues of prevention of harm from alcohol use, and measures to protect people from the dangers of harmful use of alcohol.

This review of the alcohol policy implementation situation in Member States reflects on the existing situation and recommends appropriate measures from a regional perspective to reduce the harmful use of alcohol. WHO SEARO is committed to strengthen its actions and activities to prevent and reduce alcohol-related harm at all levels. A resolution on the South-East Asia Regional Action Plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol (2014–2025) was adopted in the Sixty-seventh Session of the Regional Committee Meeting. A Regional Action Plan to Implement the Global Strategy to Reduce the Harmful Use of Alcohol 2014–2025 was adopted by Member States in the Sixty-seventh Session of the WHO South-East Asia Regional Committee meeting and through this resolution, the Regional Action Plan to implement the Global Strategy to Reduce the Harmful use of Alcohol for WHO South-East Asia Region (2014–2025) was endorsed.

I believe that policy-makers and programme managers will find this document useful to reflect on the progress made by countries based on specific national strategies and action plans that need to be developed to reduce the harmful use of alcohol.

Dr Poonam Khetrapal Singh
Regional Director

Preface

Dr Thaksaphon Thamarangsi, Director, Noncommunicable Diseases and Environmental Health

This report on 'Alcohol Policy in the WHO South-East Asia Region' enumerates the progress made in alcohol policy development in WHO South-East Asia Region Member States since the endorsement of the Global Strategy to Reduce the harmful Use of Alcohol in 2010.

The World Health Organization and Health Promotion Policy Research Center (HPR), Thailand, the International Health Policy Program Foundation and the Social Pharmacy Research Unit, Mahasarakham University, Thailand, jointly developed this report. The purpose of this report is to review the situation of alcohol policy interventions in the WHO South-East Asia Region Member States, based on the Global Strategy to Reduce the Harmful Use of Alcohol.

Data presented in the report have been collected through the WHO country offices from the national counterparts. Evidence shows that the overall situation of policy implementation and intervention to address harms from alcohol in the WHO South-East Asia Region are far from adequate. The report aims to help policy-makers and programme managers identify the areas that need attention and to work towards effective implementation and enforcement of policies and legislations. The need for alcohol policy-specific infrastructures to support the alcohol policy process, including designated responsible agency, policy and strategy, and law and regulation, is also required at the country level.

The report is presented in three sections. Section 1 gives an insight to the alcohol consumption situation in the WHO South-East Asia Region and cites the alcohol-related problems that the Region is facing. Section 2 illustrates the policy situation in the 10 areas of national action identified in the Global Strategy to Reduce the Harmful Use of Alcohol and gives specific recommendations pertaining to these areas. Section 3 provides overall recommendations.

The overall recommendations provided in the document are as follows:

(1) To review the situation of alcohol policy and interventions in the 11 WHO SEA Region Member States, based on the Global Strategy to Reduce Harmful Use of Alcohol.

(2) To provide recommendations for the advancement of national and subnational alcohol policy process and the implementation of the South-East Asia Regional Strategy and Action Plan in line with the Global Strategy to Reduce Harmful Use of Alcohol in Member States of the WHO SEA Region.

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The preparation of this report is a collaborative effort of the Mental Health Unit of WHO-SEARO and Health Promotion Policy Research Center (HPR), Thailand; the International Health Policy Program Foundation and the Social Pharmacy Research Unit, Mahasarakham University, Thailand.

Data collection was conducted in collaboration with the eleven country Offices of WHO South-East Asia Region, and their support is much appreciated. The contribution in providing country data by the mental health focal points and their team in the ministries of health is gratefully acknowledged.

Executive summary

This report is based on secondary data analysis. Literatures were collected and screened from several sources, including World Health Organization (WHO) publications, academic journals, official documents and reports from related government organization websites, and also unpublished grey literature. The search was undertaken with the following keywords (in isolation and combination): alcohol, production, distribution, consumption, drinking, consequences (individual key words for various disorders were used), regulation, policy, intervention, programme and names of 11 WHO South-East Asia Region countries (Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste), Asia, the South-East Asia Region. Various databases like WHO website, PubMed, Google Scholar and others were searched using these key words. Newspaper articles and electronic media reports were accessed using the general Google search engine. Special efforts to examine current policies, programmes and interventions were made to obtain the most updated literature. Data have been analysed from both quantitative and qualitative perspectives. By researchers' limitation, the search is only for literatures and information in English.

This report used the 10 policy areas in the Global Strategy to Reduce Harmful Use of Alcohol as the structure backbone and major content. The conceptual framework for policy review and analysis covers policy contents (e.g. legal aspects, initiatives), policy implementation (e.g. scale of policy, responsible agencies and relevant stakeholders) and policy enforcement.

The report consists of three main sections:

(1) Alcohol-related situations in the South–East Asia Region

(2) Policy situation in 10 areas and recommendations:

- a) leadership, awareness and commitment;
- b) health services' response;
- c) community action;
- d) drink-driving policies and countermeasures;
- e) availability of alcohol;
- f) marketing of alcoholic beverages;
- g) pricing policies;
- h) reducing the negative consequences of drinking and alcohol intoxication;
- i) reducing the public health impact of illicit alcohol and informally produced alcohol;
- j) monitoring and surveillance.

Content for each area includes ideology of interventions, detail of existing interventions in countries (at national and subnational scales) as well as ongoing policy movement. Upon available data, researchers identify policy gaps and recommendations to strengthen alcohol policy process, all based on contexts and circumstances.

(3) Conclusion and discussion.

The last part provides an overview of the situation of alcohol policies implemented in the South-East Asia Region and recommendations.

Introduction

Alcohol consumption leads to many negative consequences on various dimensions – health, physical, mental, social and spiritual. Alcohol-related harm is not confined only to drinkers – their families, the surrounding people, communities and societies as a whole bear the burdens derived from the drinkers.[1] At the aggregate level, evidence shows that alcohol-related harm could impede human, social and economic development of societies due to, among others, health-care cost , property damage and loss of productivity and quality of life, particularly in low- and middle-income countries.

Alcohol consumption has been identified as an important behavioural risk factor for health and well-being. The harmful effects of alcohol led to an estimated 3.3 million global deaths in 2012 (5.9% of all global death, increased from 3.8% in 2004), including 634 539 deaths in the SEA Region.[2] It attributed to 5.1% of global burden of diseases, in term of total disability-adjusted life years (DALYs) in 2012 (increased from 4.6% in 2004), and 4.0% in the SEA Region.[3] Recognized as one of the big four major risk factors, alcohol use associates with many noncommunicable diseases (NCDs), which are the leading causes of global death, estimated at 35 million deaths or two thirds of all deaths, with four fifths of NCD mortality that occurs in low- and middle-income countries; alcohol-related NCDs include various types of cancers, cardiovascular diseases, chronic respiratory diseases and diabetes.[4]

The Global Strategy to Reduce Harmful Use of Alcohol, endorsed by the World Health Assembly in May 2010, is the major milestone of global movement to address alcohol consumption and related problems. The vision behind the Global Strategy is to improve health and social outcomes for individuals, families and communities, and reduce morbidity and mortality due to harmful use of alcohol and their ensuing consequences. It is envisaged that the Global Strategy will promote and support local, regional and global actions to prevent and reduce the harmful use of alcohol. The Global Strategy provides a portfolio of interventions that is to be considered by Member States to implement as part of the national policy as well as within a broader development framework.[5] Later, a target at a relative 10% reduction of harmful use of alcohol by 2025 was adopted as part of the global voluntary targets on NCDs prevention and control.[6]

In the WHO SEA Region, all Member States are low- and middle-income countries, with major demographic change and economic growth in recent times. There has been a gradual but significant increase in alcohol consumption among the general population in the Region – particularly among adolescents, youth and females in some Member States. The Region also faces quite a high prevalence of heavy episodic drinking (HED), or binge drinking, and a situation of unrecorded alcohol. With these changes, the magnitude and severity of alcohol-related problems in the SEA Region are prominent, particularly on NCDs, violence (including domestic violence) and road traffic injuries (RTI). It is also of concern that the SEA Region is an emerging market for the alcohol industry, which is progressively investing and aggressively marketing in the Region to recruit and maintain their consumers to gain long-term profit. This has resulted in a shift in consumption of beverage types from indigenous/traditional to modern beverages, such as wine and beer as well as from ritual use to lifestyle-related drinking.

Evidence shows that the overall situation of policy and intervention to address harms from alcohol in Member States of the South-East Asia Region are quite bleak. It presents the challenges of incomprehensiveness, inconsistency, and in many cases, outdated methods. Most importantly, existing policies and legislations often lack effective implementation and enforcement and do not take into account public health interests adequately. Most Member States in the SEA Region have no alcohol policy-specific infrastructures to support the alcohol policy process, including designated responsible agency, policy and strategy, law and regulation.

The Global Strategy to Reduce Harmful Use of Alcohol has not been well translated into action in the South-east Asia Region. It has become imperative and an urgent need to review the existing situation of implementation of the Global Strategy, which will help to formulate needed specific actions for implementation.

Objectives

(1) To review the situation of alcohol policy and interventions in the 11 WHO South-East Asia Region Member States, based on the Global Strategy to Reduce Harmful Use of Alcohol.

(2) To provide recommendations for the advancement of national and subnational alcohol policy process and the implementation of the South-East Asia Regional Strategy and Action Plan in line with the Global Strategy to Reduce Harmful Use of Alcohol in Member States of the WHO South-East Asia Region.

Methodology

This report is based on secondary data analysis. Literatures were collected and screened from several sources, including WHO publications, academic journals, official documents and reports from related government organization websites, and also unpublished grey literature. The search was undertaken with the following keywords (in isolation and combination): alcohol, production, distribution, consumption, drinking, consequences (individual key words for various disorders were used), regulation, policy, intervention, programme and names of 11 countries in the SEA Region (Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste), Asia, and the South-East Asia Region. Various databases like WHO website, PubMed, Google Scholar and others were searched using these key words. Newspaper articles and electronic media reports were accessed using the general Google search engine. Special efforts to examine current policies, programmes and interventions were made to obtain the most updated literature. Data have been analysed from both quantitative and qualitative perspectives. By researchers' limitation, the search is only for literature and information in the English language.

This report used the 10 policy areas in the Global Strategy to Reduce Harmful Use of Alcohol as the structure backbone and major content. The conceptual framework for policy review and analysis covers policy contents (e.g. legal aspects, initiatives), policy implementation (e.g. scale of policy, responsible agencies and relevant stakeholders) and policy enforcement.

The report consists of three main sections:

(1) Alcohol-related situations in South–East Asia Region

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- f) marketing of alcoholic beverages;
- g) pricing policies;
- h) reducing the negative consequences of drinking and alcohol intoxication;
- i) reducing the public health impact of illicit alcohol and informally produced alcohol;
- j) monitoring and surveillance.

Content for each area includes ideology of interventions, detail of existing interventions in countries (at national and subnational scales) as well as ongoing policy movement. Upon available data, researchers identify policy gaps and recommendations to strengthen alcohol policy process, all based on contexts and circumstances.

(3) Conclusion and discussion.

The last part provides an overview of the situation of alcohol policies implemented in the South-East Asia Region and recommendations.

Part 1: Alcohol-related situations in the WHO South-East Asia Region

This section summarizes and analyses the alcohol consumption situation, its determinants and alcohol-related health and social harms in the South-East Asia Region.

Alcohol consumption situation in the WHO South-East Asia Region

Average global adult per capita consumption (APC) in 2010 was estimated at 6.2 litres of pure alcohol (ethanol) consumed per person aged 15 years or older, which is equivalent to 13.5 grams of pure alcohol per day. A quarter of this consumption volume (24.8%) was classified as unrecorded alcohol consumption, i.e., homemade alcohol, illegally produced or sold outside the government controls and registrations. Of total recorded alcohol consumed worldwide, 50.1% was consumed in the form of distilled spirits. However, it should be noted that this high consumption volume was contributed from the minority of global population, as 62% of the adult population had not consumed alcohol in the past 12 months, whereas 16.0% of drinkers had drunk heavily.[2]

As a general observation, aggregated economic status of the society seems to have association to both consumption volume and drinker prevalence. High-income countries tend to have higher APC and higher prevalence of general drinkers and of heavy episodic drinkers among drinkers, compared to their lower-income counterparts. However, there are considerable variations of alcohol consumption across WHO regions, countries and even within countries.

The situation of alcohol consumption in SEAR is shown in *Table 1* and is as follows.

- **Prevalence of alcohol consumption:** The prevalence of alcohol consumption in the last 12 months is relatively low (13.5%) and varies from 1.9% to 29.7%. The highest prevalence was in Thailand (29.7%), followed by the Democratic People's Republic of Korea (21.1%), Sri Lanka (18.3%) and India (15.1%). Relatively less people in Bangladesh (1.9%) drink alcohol.
- **Consumption volume:** Adult per capita consumption rose from 2.2 in 2005 to 3.4 litres of ethanol in 2010, which was ranked, among WHO regions, as the second lowest consumption level and was about 3.2 times lower than the highest consumption volume (10.9 litres of ethanol) in the WHO European Region.
- **Drinking pattern:** Compared to other regions, it appears that the WHO South-East Asia Region has a relatively low prevalence of heavy episodic drinking (HED: defined as 60 or more grams of pure alcohol on, at least, one single occasion, at least, monthly) (12.4%); however, drinkers consume quite a high amount of alcohol per capita per year at 23.1 litres. The highest prevalence of HED was in Democratic People's Republic of Korea (4.3%), followed by Indonesia (2.4%) and India (1.6%).
- **Gender variation:** In all Member States of the SEA Region, the prevalence of alcohol consumption is much higher among males than females overall, especially in Bangladesh and India, where the proportion of male and female drinkers was about 17.5 times and 5.3 times, respectively.

Table 1: Alcohol consumption situations in the 11 Member States of the SEA Region

		SEAR Member States										
		Bangladesh	Bhutan	Democratic Republic of Korea	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Thailand	Timor-Leste
Adult per capita consumption/APC (litre of ethanol per year)	Total	0.2	0.7	3.7	4.3	0.6	1.2	0.7	2.2	3.7	7.1	0.6
	Male (15+years)	0.3	1.2	7.4	8	1.1	2.3	1.4	4.4	7.3	13.8	1
	Female (15+years)	0	0.1	0.4	0.5	0.1	0.1	0	0.2	0.3	0.8	0.1
Recorded/unrecorded alcohol (litre of ethanol per year)	Recorded alcohol	0	0.4	3.2	2.2	0.1	0.7	0.1	0.2	2.2	6.4	0.1
	Unrecorded alcohol	0.2	0.3	0.5	2.2	0.5	0.5	0.6	2	1.5	0.7	0.5
	Share of unrecorded alcohol (%)	100	43	14	51	83	42	86	91	41	10	83
Drinking pattern	Per drinker consumption (litre of ethanol per year)	9	6.9	17.9	28.7	7.1	13.8	8.9	28.8	20.1	23.8	8
	Daily consumption volume (gram of ethanol)	17.6	14.9	38.5	62.7	15.9	28.8	18.4	61.8	43.6	51.9	16.8
Prevalence of current drinkers (%)	Total	1.9	10.3	21.1	15.1	8.1	9.0	7.9	7.6	18.3	29.7	7.1
	Male (15+years)	3.5	15.3	30.8	24.8	11.4	14	12.4	12.1	27.2	45.4	11
	Female (15+years)	0.2	4.2	12.1	4.8	4.8	3.9	3.8	3.6	9.9	14.9	3.1
Prevalence of heavy episodic drinker (HED) (%)	Total	0	0.7	4.3	1.6	2.4	0.4	0.1	0.4	0.4	1.1	0.1
	Male (15+years)	0.1	1.2	8.8	3.2	4.6	0.7	0.2	0.8	0.8	2.3	0.1
	Female (15+years)	0	0	0.1	0	0.2	0	0	0	0	0.1	0
Prevalence of heavy episodic drinker (HED) (%)	Total	0	0.2	0.2	1.6	0	0.2	0.2	0.2	0.2	0.2	0.2
	Young male (15–19 years)	0	0.3	0.3	3.1	0	0.3	0.2	0.3	0.3	0.4	0.3
	Young female (15–19 years)	0	0.1	0.1	0	0	0	0.1	0.1	0.1	0.1	0.1

Source: Analysed from WHO Global Status Report on Alcohol and Health 2014[2]

- **Unrecorded consumption:** Consumption of illicit or informally produced alcohol is clearly a specific problem in the Region. Unrecorded alcohol consumption makes up about 50% of total alcohol consumption in the Region (unrecorded alcohol – 1.6 litres; recorded alcohol 1.8 litres). In India, homemade spirits constitute the highest proportion of total alcohol consumed at 2.2 % of total alcohol volume.
- **Beverage types:** Distilled spirit is the most dominant beverage type in the Region. About 77.3% of total of recorded alcohol per capita is in the form of distilled spirits, followed by beer at about 22.3%.

Alcohol-related problems

Health consequences: Mortality and Morbidity

Alcohol use associates with more than 200 disease and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers and injuries. The latest causal relationships suggested by research are those between harmful use of alcohol and infectious diseases such as tuberculosis and HIV/AIDS.[2] Alcohol consumption also leads to many NCDs, including cardiovascular diseases and many cancers that attributed to a great proportion of global and regional burden of diseases.[4]

In term of total global burden of diseases and injury, alcohol attributed to 5.1% of total DALYs and 5.9% of all global deaths in 2012. The data on DALYs estimate per 100 000 in 2012 among SEAR countries by several diseases and injuries are shown in *Table 2*. The proportion of alcohol-attributable deaths relative to all deaths in the SEA Region was 4.6. The prevalence of alcohol use disorders in the SEA Region was 4.0% among males and 0.5 % among females.[4]

Alcohol poisoning

Alcohol poisoning, or toxic alcohol death, is an acute fatal poisoning from either ethanol or alcohol with contaminants. It is a common occurrence in many settings in the Region, particularly when taking into account large proportion of illicit or informally produced alcohol. Contamination of methanol and other toxic compounds, particularly in rural areas, has been referred to as a cause of the mass poisoning incidence.

In India, there are several news reports on number of mass deaths due to alcohol poisoning in rural areas across the country every year. The Emergency Management Research Institute (108 ambulance service), during 1 August 2007 – 31 July 2008 in Gujarat and Andhra Pradesh recorded 40 541 behavioural emergencies of which alcohol intoxication was the third most common emergency at 3%.[8] Another example is during an Indian cricket match, where, at least, 17 people died and 122 were hospitalized due to the consumption of toxic contaminated illegal alcohol brew.[9]

Table 2: Health consequences: Mortality and Morbidity

	Bhutan	Bangladesh	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Thailand	Timor-Leste	DPR-Korea
Alcohol use disorders (per 100 000 population)*											
Both sexes	127	1	3510	251	1	84	38	77	388	1	76
Female (15+years)	21	0	425	43	0	14	9	8	39	0	12
Male (15+years)	106	1	3085	208	1	71	29	69	348	1	65
Poisoning (per 100 000 population)*											
Both sexes	494	14	2195	158	0	37	93	6	10	1	42
Female	192	4	787	37	0	15	41	1	3	0	14
Male	302	9	1408	121	0	22	51	4	6	0	28
Liver cirrhosis (per 100 000 population)*											
Both sexes	704	5	7910	1708	0	557	132	112	336	2	201
Female	293	2	2428	379	0	93	56	13	79	1	55
Male	411	3	5482	1329	0	464	76	99	257	1	146
Liver cancer (per 100 000 population)*											
Both sexes	94	1	860	480	0	150	6	21	606	1	153
Female	38	0	328	123	0	43	2	7	170	1	40
Male	55	0	531	357	0	107	3	14	435	1	113

	Bhutan	Bangladesh	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Thailand	Timor-Leste	DPR-Korea
Road injuries (per 100 000 population)*											
Both sexes	1170	7	14413	2892	1	492	305	168	1221	17	180
Female	289	3	3311	826	0	178	106	41	272	5	58
Male	881	4	11102	2065	1	314	198	128	949	12	121
Interpersonal violence (per 100 000 population)*											
Both sexes	262	2	4039	254	1	471	45	91	260	3	80
Female	108	1	689	56	0	256	13	15	30	1	20
Male	155	1	3350	197	1	215	32	76	230	2	60

*Age-standardized disability-adjusted life-year (DALYs) estimates (all ages) per 100 000, estimates for the year 2012.

Source: WHO Department of Health Statistics and Information Systems (May 2014), Regional cause-specific DALYs estimates for the years 2000 and 2012.[7]

Road traffic accidents

The effects of alcohol impairment to vehicle drivers are magnified when combined with fatigue from driving. This explains why alcohol is considered a particular risk for commercial drivers, who spend long hours on the road and have legal responsibilities for the passengers or cargo they carry.[10] Alcohol is among the most important risk factors for road accidents in the Region. The road traffic fatality rate in the South-East Asia Region is at 18.5 deaths per 100 000 population, which is nearly two times higher than in high-income countries. About one third of all road traffic deaths in WHO South-East Asia Region countries that occur are among motorcyclists, 15% among car occupants, 12% among pedestrians and 4% among cyclists. Almost half of all countries worldwide lack data on alcohol-related road traffic deaths. The proportion of road traffic deaths involving alcohol is only available for Thailand at 26%.[10] However, these data are to be handled with caution, due to their potential underestimation and complex information system. The number of road traffic fatalities reported in 2010 and loss in terms of estimated proportion of Gross Domestic Product (GDP) is shown in *Table 3*.

Table 3: Reported road traffic fatalities 2010

	Both sex*	Male (%)	Female (%)	*Note	Estimated GDP lost due to road traffic crashes (%)	
Bhutan	79	71	29	Police records. Defined as died within 30 days of crash	–	
Bangladesh	2958	85	15	Police records. Defined as death caused by a road traffic crash (unlimited time period)	1.6	2003, Transport Research Lab UK
India	133 938	85	15	Police records. Defined as death caused by a road traffic crash (unlimited time period)	3	2009, 10th 5 year Plan, volume 2
Indonesia	31 234	78	22	Combined sources. Defined as died within 30 days of crash	2.9–3.1	2010, National Plan on Road Safety
Maldives	6	67	33	Police records. Defined as died within 30 days of crash	–	
Myanmar	2464	75	25	Police records. Defined as died within 30 days of crash	0.5	2008, Traffic Rules Enforcement Supervisory Committee
Nepal	1689	83	17	Police records. Defined as died within 35 days of crash	0.8	2011, World Health Survey, Final Report on Study of Healthcare Cost for Road Traffic Accidents

	Both sex*	Male (%)	Female (%)	*Note	Estimated GDP lost due to road traffic crashes (%)	
Sri Lanka	2483	81	19	Police records. Defined as died within 30 days of crash	–	
Thailand	13 766	79	21	Combined sources. Defined as death caused by a road traffic crash (unlimited time period)	3	2009, Traffic accidents costing in Thailand (Pichai Thausevauauoun)
Timor-Leste	76	79	21	Combined sources. Defined as died within 24 hours of crash	–	
DPR-Korea	–	–	–		–	

Source: WHO Global Status Report on Road Safety 2013[10].

Part 2: Policy situation in 10 areas and recommendations

Area 1: Leadership, awareness and commitment

Political leadership and commitment is critical and is the fundamental building block for development of national alcohol policy, strategy and plan, and for its implementation. Two indicators in the Global Survey on Alcohol and Health 2012 for the leadership, awareness and commitment area are development of national alcohol policies and presence of awareness-raising activities.[2]

Current situation

Addressing alcohol-related problems has recently gained public attention in many societies across the world. However, alcohol policy is still far from being in the top public agenda in many Member States of the WHO SEA Region. Sixty-six countries around the world have their written national alcohol policies in place.[1] Apart from three Muslim countries (Bangladesh, Indonesia and Maldives), where alcohol consumption is totally or almost totally banned according to religious principles, only Sri Lanka (with tobacco in the same law) and Thailand have an alcohol policy framework. It can be said that these two laws are the modern alcohol control legislations that have specific purposes to protect public health and safety. ITheyprovide more comprehensive contents and indicate the system or mechanism for implementation (*Box 1*). The National Authority on Tobacco and Alcohol (NATA) Act of Sri Lanka was endorsed in 2006 with more than 10 years of dedicated efforts. The Alcohol Beverage Control Act B.E.2551 of Thailand was adopted in 2008.

Box 1. Examples of comprehensive national alcohol control legislation in the SEA Region

The National Authority on Tobacco and Alcohol Act, No.27 of 2006, Sri Lanka (2006)[11]

This Act is for the establishment of the National Authority on Tobacco and Alcohol for the purpose of identifying the policy on protecting public health; for the elimination of tobacco and alcohol-related harm through the assessment and monitoring of the production, marketing and consumption of tobacco products and alcohol products; to make provision for discouraging persons especially children from smoking or consuming alcohol, by curtailing their access to tobacco products and alcohol products; and for matters connected therewith or incidental thereto.

Main components of this Act:

Part I covers

- Establishment of the National Authority on Tobacco and Alcohol
- Members of the Authority
- Powers and functions of the Authority
- Authorized Officer and its powers

Part II covers

- Prohibition of the manufacturing, sale and distributions of alcohol and tobacco
- Prohibition of alcohol and tobacco advertisements
- Prohibition of Sponsorships for any educational, cultural, social or sporting organization, activity or event
- Prohibition of smoking in public places

Alcohol Beverage Control Act B.E.2551 (2008), Thailand[12]

The reason for the promulgation of this Act is that it is recognized that alcohol beverages have caused health, family, accident and criminal problems, which affect the overall social and economic condition of the country. It is deemed expedient to stipulate measures for control of alcohol beverages as well as treatment or rehabilitation of alcoholics in order to reduce social and economic impacts and improve public health by making people realize the dangers of alcohol beverages and protect children and youth against easy access to alcohol beverages. It is, therefore, necessary to promulgate this Act.

The main components of this Act are as follows:

Chapter 1. National Alcohol Beverage Policy Committee

Chapter 2. Alcohol Beverage Policy Committee

Chapter 3. Office of Alcohol Beverage Policy Committee

Chapter 4. Control of Alcohol Beverage

- Regulation on alcohol packaging, labels and warning messages for alcohol manufacturers and importers
- Control of alcohol physical availability, including sale and distribution: including minimum purchasing age, time of sale and place of sale
- Drinking context modification: including prohibition of alcohol consumption in public places
- Advertising and marketing communication regulation: including control of illustration of trademark, logo and corporate brand

Chapter 5. Treatment or Rehabilitation of Alcoholics

Chapter 6. Competent Officials

Chapter 7. Penalties

All Member States of the SEA Region have their alcohol-related legislations, particularly control of alcohol supply chain, including production, distribution, taxation and licensing system in place. For example, the Hotel Regulations and the Sale and Distribution of Alcohol Act (B.S. 2023) and the Alcohol (First Amendment) Act (B.S.2056) in Nepal, and the Controlling and Monitoring of Alcoholic Beverages Supply, Distribution and Sale, regulation No. 20/2014 (11 April 2014) in Indonesia. It is also common that alcohol is integrated in the national drug or substance policy in many societies. For example, alcohol is categorized in Class B intoxicants as same as LSD, barbiturates, amphetamines, and methyl amphetamines under the Narcotics Control Act 1990[13] (also known as the Intoxicant Control Act, 1990) in Bangladesh. Likewise, the alcohol-related legislations that concern advertising and drink-driving exist in separate laws for different agencies, such as the Vehicle and Transport Regulation Act (B.S. 2049) of Nepal and the Road Safety Act of Bhutan 1999 for control of drink-driving and the National Broadcasting Act 1993 of Nepal and the Bhutan Information, Communication and Media Act 2006 for control of alcohol advertising. However, such regulation may not always be for the purpose to control alcohol-related problems. Further, having alcohol legislations in place may not reflect the effectiveness of implementation and enforcement. Implementation and law enforcement seems to be weak in the Region.

Another indicator of political commitment on addressing alcohol policy is having a comprehensive policy framework, strategy or plan. In Bhutan, the National Policy and Strategic Framework to Reduce Harmful Use of Alcohol (2013–2018) endorsed in 2013[14] has shown the efforts and commitment of the Royal Government of Bhutan in strengthening enforcement of the existing alcohol regulations and establishing the coordination mechanism for multisectoral actions responding to alcohol problems at the national level.

Recently, as results of the movement of NCD prevention and control at global and regional levels, addressing harmful use of alcohol was identified as a major behavioural risk factor in national NCD strategy/plan in many Member States. A 10% relative reduction of harmful alcohol use was declared as a global voluntary target in NCD prevention and control at global and regional levels. As suggested in the WHO Global Action Plan on Prevention and Control of NCDs, some Member States in the SEA Region have adopted such a target in their national context.

Despite the variety of alcohol-related harm, alcohol policy in many countries is still regarded as an initiative of health sector alone, and responsibilities in addressing such harm is considered to be the sole responsibility of the health sector. Addressing the alcohol problem, in fact, needs multisectoral collaboration at the policy level. Efforts of the health sector alone is unlikely to successfully advance the alcohol agenda towards national priority and to promote and facilitate multisectoral collaboration.

The 3-tier coordination and management mechanisms of the Thai Alcohol Beverage Control Act 2008 (*Box 2*) are examples of multisectoral function in addressing alcohol problems. The Prime Minister chairs the National Alcohol Policy Committee, and Committee members are from different ministries and several government departments, including the Ministry of Tourism and Sports, Social Development and Human Security, Interior, Justice, Education and Industry. Academic, professional bodies and civil society are also engaged as experts on the National Alcohol Consumption Control Committee and Provincial Alcohol Control Committee at the provincial level. Establishment of the office of the National Alcohol Consumption Control Committee, as the main responsible public agency, at the Ministry of Public Health, is key to the success of the recent alcohol policy movement in Thailand.

Box 2. Multisectoral function in 3-tier committees under the Alcohol Beverage Control Act 2008 in Thailand

3-tier committee	Chair	Committee Member
National Alcohol Policy Committee (NAPC)	Chair: Prime Minister Deputy Chair: 1. Minister of Public Health 2. Minister of Finance	Minister of Tourism and Sports, Social Development and Human Security, Interior, Justice, Education, Industry, Permanent Secretary to Office of PM Secretary: Permanent Secretary to MOPH Assistant secretaries: Director of Fiscal Policy Office
National Alcohol Consumption Control Committee (NACCC)	Chair: Minister of Public Health Deputy Chair: 1. MOPH Permanent Secretary 2. Minister of Finance 3. Minister of Interior	Permanent Secretary of the Office of Prime Minister, Tourism and Sports, Social Development and Human Security, Commerce, Justice, Culture, Education, Industry, Bangkok Metropolitan, Commissioner General of Royal Thai Police, Manager of ThaiHealth, Three representatives from civil society organizations, Three selected experts Secretary: The Director-General of the Disease Control Department
Provincial Alcohol Control Committee	Chair: Governor Deputy Chair: Deputy Governor	Provincial Police Commander, Chief Provincial Excise Department officer, Chief of Provincial Disaster Mitigation Office, Director of Educational Service Area Office, Provincial Public Relations Officer, Provincial Social Development and Human Security Officer, Director of Disease Control Office, Representatives of Local Administrative Offices, four selected experts Secretary: Provincial Chief Medical Officer

Likewise, in Sri Lanka, the Authority consists of senior officers of several government departments, including Health, Justice, Education, Media, Trade, Sports and Youth Affairs, and other national institutions, such as the National Dangerous Drugs Control Board, the Commissioner-General of Excise, the Inspector-General of Police. The functions of the Authority are many, including advising the government on the implementation of the National Policy on Tobacco and Alcohol. Similarly, in Nepal, a high-level health service facilitation and coordination committee for NCD prevention and control was recently set up. Alcohol was included in their agenda, and this body consists of representatives from various ministries, such as agriculture, finance, education, health and planning.

Civil society organizations (CSOs) could play an outstanding role in addressing alcohol at community and national levels as well as advocacy for alcohol policy in Sri Lanka and Thailand In Thailand, the Stop Drink Network (StopDrink) , consisting of over 400 member organizations at the local level, has been successful in promoting alcohol-free community and alcohol-free cultural events or festivals. In Sri Lanka, Alcohol and Drug Information Centre (ADIC) plays the significant role in alcohol policy development and implementation, as well as a collaborative role among alcohol alliances in Sri Lanka.

Financing support on alcohol policy is vital for successes. Most countries support the development and enforcement of alcohol policy interventions through normal government budgets. Innovative financing for health promotion has been identified as a sustainable resource for alcohol policy movements. Thai Health Promotion Foundation (ThaiHealth), receiving a surplus of 2% from alcohol and tobacco excise taxation to fund health promotion activities, including alcohol and tobacco control, has been regarded as a best practice in supporting alcohol policy.

Recommendations

It is suggested that where the issuance of alcohol is not given sufficient awareness, then alcohol advocacy might be the entry step to enhance the alcohol problem as a national agenda. Public campaign or social mobilization to create public awareness and to promote collective responsibility might be introduced, along with public education for health literacy of populations. It is encouraged that Member States should aim for high-level political commitment and alcohol regulations and legislations as the ultimate goals as well as in setting up multisectoral collaboration platforms as an operation mechanism.

In the WHO South-East Asia Region, existing social capitals (such as religion, culture and community structure) could be conducive determinants for alcohol policy development and implementation. These are vital in facilitating social attitudes on alcohol drinking and alcohol problems and public support for alcohol policy interventions. Bringing new argument themes apart from health issues, such as alcohol as a barrier to human, social and economic development, could promote interest, engagement and appeal for policy-makers in low- and middle-income countries to alcohol policy.

Monitoring and evaluation mechanisms, including information management, are the unsung backbone of any effort to address alcohol problems. This information should include not only consumption situations, but also situations on policy need and implementation. Taking into account the high dynamics of alcohol consumption determinants, regular review of alcohol policy is recommended. Member States should also evaluate the availability, adequacy and sustainability of human, technical and financial resources. Building capacity at individual and institutional levels is important for effective and sustainable policy implementation. This includes strengthening health professionals to be the major front line workforce in addressing alcohol problems at all levels.

Sustainable success in addressing alcohol problems requires the institutionalization of alcohol policy, particularly by establishing an effective responsible agency for stakeholder coordination, resource mobilization, collective capacity-building and monitoring and evaluation of progress in addressing alcohol problems. Side-by-side empowering and promoting engagement of stakeholders at the community level is essential in materializing national alcohol policy to grass-root contexts. Effective mechanisms to promote collaboration across and engagement of public and civil society agencies, relevant to alcohol policy, are also keys to long-term success.

Area 2: Health services' response

Alcohol consumption has been identified as a component cause for more than 200 health conditions covered by the International Statistical Classification of Diseases and Related Health Problems (ICD) 10th Revision (ICD-10) disease and injury codes.[2] Of these health conditions, alcohol use disorders (AUDs) (also known as alcoholism or alcohol dependence syndrome), which are defined as being 100% attributable to alcohol, are the most significant followed by liver diseases (most prominently alcoholic liver cirrhosis), are relatively prevalent and are among the top 20 causes of death globally; alcohol-attributable liver disease is a major factor in global burden of disease.[15] Health services have a crucial role in providing prevention, early detection and treatment services at the individual level to those currently having alcohol-use disorders and other health conditions, as well as to those at risk. Screening and brief intervention with referral to treatment (SBIRT), also commonly known as Brief Intervention (BI), has been shown to be both effective and cost-effective in different settings, and for across-the-broad spectrum of alcohol problems. BI is devised as a tool to bridge the gap between primary prevention efforts and more intensive treatment for persons with serious AUD.[16] A standardized and validated screening instrument is recommended to conduct screening systematically. WHO has developed the Alcohol Use Disorders Identification Test (AUDIT) to

identify persons with hazardous and harmful alcohol consumption as the cause of the presenting illness as well as alcohol dependence and some specific consequences of harmful drinking.[17]

Another important potential contribution of health service sectors and health professionals, according to the Global Strategy, is taking the lead in informing societies about the public health and social consequences of harmful use of alcohol, supporting communities to take effective action to reduce the harmful use of alcohol and advocating effective societal responses as well as establishing a data system for monitoring any health consequences of alcohol consumption.

Policy situation

Although not clearly stated, health treatment services for patients with alcohol use disorder and alcohol-related health problems in most WHO South-East Asia Region Member States are provided by the public health-care sector. Many countries integrate these services with the general health service, while some designate mental health service agencies to be responsible for it. The private sector and CSOs, including faith-based and community agencies, are also providing these services in some Member States of the SEA Region.

In Thailand, many prevention and treatment programmes are carried out at all 10 mental health hospitals across the country as well as in general hospitals for each province. In Myanmar and Bangladesh, private hospitals play an important role in providing alcohol detoxification and rehabilitation services. Long-term residential rehabilitation centres supported by NGOs are more accessible than other settings in many countries especially in Nepal and India. The majority of services are usually set up under/with the treatment programme for illegal drug users, which in some countries are aligned with the National Narcotic Control policies. In Bhutan, the Treatment and Rehabilitation Centre for Drug and Alcohol Dependence (TRCDAD) was established in 2009 with support of the Bhutan Narcotic Control Agency (BNCA), United Nations Office on Drugs and Crime (UNODC) and several international development agencies to address the alcohol and drug problem among young people.[18] In Sri Lanka, there are four treatment and rehabilitation centres for drug and alcohol dependence established across the country with support from the National Dangerous Drug Control Board (NDDCB), the statutorily responsible state body for drug abuse management.[19] Traditional treatment for alcohol-related diseases at the National Traditional Medicine Hospital (NTMH) is a recognized alternative channel for Bhutanese patients.[20] Other social support activities and mutual help or self-help activities, such as Alcoholics Anonymous (AA), are in place partially.

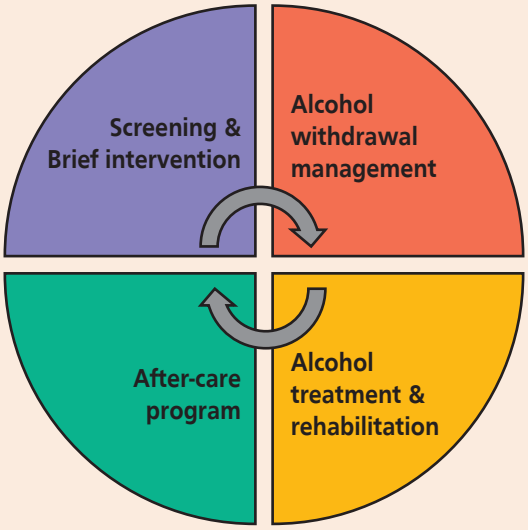
Taking into account the variety of health-related problems that stem from alcohol comprehensive care is vital for an effective health system response. For example, a narrow focus on mental health problems and addiction might limit the opportunity of health systems to address physical effects of alcohol, including gastrointestinal, cardiovascular diseases and cancer. Moreover, health systems may face a broad spectrum of alcohol-related problems from risky to relapse stages. Unfortunately, not every country has a comprehensive prevention and treatment programme on screening, detoxification, treatment, rehabilitation and after care. The model of Integrated Management of Alcohol Intervention Program in Health Care System (IMAP-Health) in Thailand was developed to be the standard screening and treatment protocols and standard guideline that is applicable for all levels of health-care settings as well as in communities in Thailand[21] (*Box 3*).

Availability of competent health workforces to provide screening and treatment services is a crucial issue for the WHO South-East Asia Region. Health-care workers are key to the success to health-care delivery services. An example of good practice is the initiative in India where doctors working in rural areas were trained to address and treat problems related to psychoactive drugs and alcohol. The initiative included initial and follow-up training and the BI approach was tested and found to be successful

in India.[22] Due to limited health resources, screening and brief intervention have not yet been initiated in most of South-East Asia Member States; only Bhutan and Myanmar reported routine implementation in primary care routinely.[23] In Thailand, there is an effort to set up routine screening in health services, especially for patients at risk and with alcohol problems, such as pregnant women and chronic disease patients; however, it is not yet fully implemented in all health-care settings.

The summary of health service alcohol (and drugs) in the Atlas on resources for the prevention and treatment of substance use disorders[23] are shown in Table 4.

Box 3. Model of Integrated Management of Alcohol Intervention Program in Health Care System (iMap-Health)[21]: An example of national guidelines on alcohol interventions in health services



The iMap-Health model comprises four strategies as follows:

(1) **alcohol screening and brief intervention** to classify drinkers and provide brief intervention to motivate them to reduce harm and stop or cut down their drinks,

(2) **alcohol withdrawal management or detoxification** to assess withdrawal risks and monitor alcohol withdrawal symptoms, especially in physically-ill patients,

(3) **alcohol treatment and rehabilitation** using psychosocial interventions and pharmacotherapy to help people with alcoholism stay sober or control their drinking behaviour, and

(4) **after-care programmes** to provide continuous support to identified drinkers and maintain their quality of life while living in communities.

Source: Integrated Management of Alcohol Intervention Program (IMAP) (2012).

Recommendations

As suggested by the Global strategy to Reduce the Harmful Use of Alcohol and the Global Mental Health Action plan 2013–2020,[24] enhancing availability, accessibility and affordability of the health delivery services for patients with AUD, especially for people of low socioeconomic status, would be prioritized in SEA Region Member States. Ensuring universal health coverage as a major determinant of success of the health sector response would be emphasized. Building capacity of healthcare personnel and social

Table 4. summary of health service alcohol (and drugs) in SEA Region Member States

.	Bhutan	Bangladesh	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Thailand	Timor-Leste	DPR-Korea
National epidemiological data collection system	No	No	No	Yes	Yes	No	No	Yes	Yes	No	n/a
Prevalence estimates for alcohol use disorders3 (12-month prevalence, %) (2004)											
Female (15+ years)	0.20	0.08	0.42	0.34	0.47	0.52	0.48	0.44	0.99	0.25	n/a
Male (15+ years)	1.53	0.61	3.47	1.95	3.74	1.62	3.80	4.34	10.18	1.94	n/a
Most important financing method for treatment services:	Social health insurance	Out-of-pocket payment	Tax-based funding	Out-of-pocket payment	-	Tax-based funding	NGOs	Tax-based funding	Tax-based funding	Free treatment service (with out-of-pocket contributions)	n/a
Of those receiving treatment for alcohol-use disorders, the percentage (%) treated:											
Public sector	-	3	50	-	-	25	20	68	95	-	n/a
Private sector	-	92	20	-	-	75	10	25	2	-	
Joint public-private sector venture	-	1	0	-	-	-	10	5	2	-	n/a
NGOs	-	6	30	-	-	-	60	2	1	-	n/a
Most commonly-used treatment setting for:	General health service	Mental health service	General health service	Primary health care, special treatment centre	-	General health service	Mental health service	Primary health care	General health service	Primary health care	n/a
Availability of treatment services (Yes/No) and estimated coverage* (%) of population: Alcohol use disorders											
Inpatient medical detoxification	<10	<10	50–90	<10	-	10–50	<10	50–90	10–50	-	n/a
Outpatient medical detoxification	<10	<10	50–90	-	-	10–50	<10	50–90	10–50	-	n/a

.	Bhutan	Bangladesh	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Thailand	Timor-Leste	DPR-Korea
Long-term residential rehabilitation	-	-	10–50	-	-	-	<10	<10	<10	-	n/a
Number of outpatient treatment slots for alcohol and drug use disorders (per week)	-	2400	-	10 500	-	-	-	-	80	0	n/a
Total number of beds for alcohol and drug use disorders (most recent year available)	4	2533	7520	1800	-	-	470	464	-	0	n/a
Implementation of alcohol screening/brief intervention in primary care	Yes, routinely	No	No	No	No	Yes, routinely	No	No	Yes, but rarely	No	n/a
Specialized treatment system for alcohol use disorders	Integrated with mental health care	Yes	Yes	-	-	Integrated with general health care, primary health care	Integrated with general health care	Yes	Yes	Yes	n/a
Pharmacotherapy used for treatment of alcohol withdrawal											
Benzodiazepine	Diazepam	Diazepam	Diazepam	Diazepam	-	Diazepam, Alprazolam	Chlordiazepoxide	Librium	yes	-	n/a
Chlorpromazine	-	-	-	Chlorpromazine	-	Chlorpromazine	Chlorpromazine	-	-	-	n/a
New anti-psychotics	Risperidone	Risperidone	-	-	-	Risperidone	-	-	-	-	
Other pharmacotherapy	Haloperidol	Haloperidol	-	-	-	Haloperidol	Olanzapine	Acamprosate (only in the private sector)	-	-	n/a

.	Bhutan	Bangladesh	India	Indonesia	Maldives	Myanmar	Nepal	Sri Lanka	Thailand	Timor-Leste	DPR-Korea
Three most important health professionals for treatment of persons with:											
Psychiatrists	✓	✓	✓	✓	-	✓	✓	-	-	-	n/a
General Practitioners	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	n/a
Primary Health Care Workers	✓	-	-	✓	-	-	-	✓	-	-	n/a
Social workers	-	✓	✓	-	-	-	-	-	✓	-	n/a
Psychiatric Nurses	-	-	-	-	-	-	✓	-	✓	-	n/a
General medical officers	-	-	-	-	-	✓	-	-	-	-	n/a
General physicians	-	-	-	-	-	-	-	✓	-	-	n/a
NGOs in the country focusing on alcohol	Yes	Yes	Yes	No	No	No	Yes	Yes*	Yes	No	n/a

Remark: * Sri Lanka; under the National Dangerous Drug Control Board (NDDCD) and NGOs, separated from mental health and general.

Source: World Health Organization, ATLAS on substance use (2010). Resources for the prevention and treatment of substance use disorders.

service workers, especially at primary care level, are also important as it is the forefront in the prevention, identification of those in need of help, referral and treatment, as well as the promotion of health in a broader context.

Screening and brief intervention for early identification of problem drinkers as the most effectiveness intervention to be introduced through integration with health prevention and promotion programmes at the community level; making alcohol treatment and management guidelines available at all health-care settings. Involvement of community or volunteer systems in the context of limited resources is also key to success.

Area 3: Community actions

Evidence shows that community-initiated actions empower the community and can bring collective outcomes in addressing alcohol-related harms at local level. Numbers of local communities in the South-East Asia Region have faced negative consequences from harmful use of alcohol. Government and nongovernment stakeholders need to support community actions, initiatives and interventions to tackle alcohol-related problems. These national, subnational and local level efforts can be a support from government sectors or nongovernment domestic and international development partners. It should be noted that community actions may also include local support for national/subnational alcohol policy, particularly the implementation, monitoring and surveillance of policy at grass-root levels.

National government support

Community action against alcohol is not new in the WHO South-East Asia Region. Many Member States have clear national policy in supporting community actions. Their support can be grouped into four broad approaches, including financial support, particularly earmarked funds, provision of technical tools, training programmes and community programmes and policies. India, Sri Lanka and Thailand provide support by implementing all approaches mentioned at the national level. Bangladesh and Myanmar have focused their support in capacity-building through training programmes, while Timor-Leste supports both training programmes and community programmes and policies (Table 5).

Providing technical tools, training programmes and community programmes and policies all require context-specific design for their content and implementation. This Report illustrates SEA Region Member States' highlight on community programmes and policies for vulnerable population groups, usually the so-called high-risk groups. Those programmes may either be alcohol-specific community action or supportive to local development policy in general, reckoning alcohol consumption as a barrier for development.

Earmarked fund, also called fund from dedicated tax, is an innovative approach to support specific programmes, alcohol and beyond. For example, India has implemented its earmarked fund from tobacco excise tax for welfare scheme for bidi workers, which include areas on health, education, housing and recreation.[25] Another example is earmarked fund for health promotion activities in community in Sri Lanka and Thailand.[26,27] One example of health promotion activities in Thailand is area-based selected community programmes to quit drinking and reducing domestic violence against women and children.[28]

Nongovernment stakeholders also play an active role in supporting community action to reduce harmful use of alcohol. Nongovernment stakeholders may refer to domestic and international CSO as well as community-based international organizations. By nature, those organizations may be alcohol-specific (issue-based), area-based as well as development agencies-relevant to alcohol consumption.

Table 5: National government support for community action to reduce harmful use of alcohol in the South-East Asia Region

Member States	National Government support	National government's approaches			
		earmarked funds	technical tools	training programmes	community programmes and policies
Bangladesh	✓	–	–	✓	–
Bhutan	n/a	–	–	–	–
India	✓	✓	✓	✓	✓
Indonesia	–	–	–	–	–
Maldives	n/a	–	–	–	–
Myanmar	✓	–	–	✓	–
Nepal	–	–	–	–	–
Sri Lanka	✓	✓	✓	✓	✓
Thailand	✓	✓	✓	✓	✓
Timor-Leste	✓	–	–	✓	✓

Source: WHO 2012 Global Information System on Alcohol and Health survey.

Remark: community programmes and policies refer to community programmes and policies for subgroups at particular risk, n/a (no data available).

Issue-based community actions

Alcohol-related community actions could be primarily based on many issues, from health, well-being, economic, gender and general community development. In another word, alcohol-related problems at the community level can be addressed by both alcohol policy interventions, which specifically focus on alcohol problem, and interventions that address other alcohol-related issues, including poverty, health promotion, NCDs, welfare, social wellbeing, education, social order, social safety and domestic violence.

Sri Lanka and Thailand are among those with active issue-based community interventions to tackling negative consequences of alcohol in place. Sri Lanka addresses alcohol at the community level through integration with tobacco and drug abuse.[1] These community-based interventions have highlighted comprehensive programmes on controlling consumption of these products. Key examples of community programmes in Bhutan, India and Thailand are briefly described below.

Awareness raising on alcohol-related harms

Many community actions in Sri Lanka and Thailand are public campaigns to raise awareness on alcohol-related harms. In Sri Lanka,[1] communities run programmes to address antisocial behaviour and violence influenced from alcohol consumption, which could lead to fruitful result in the reduction of domestic violence incidence. Social marketing activities, for several alcohol-related issues, have been conducted at the community level in Thailand.[29] Among many, the most successful campaigns include promotion of alcohol-free events (e.g. alcohol-free Buddhist lent) and alcohol-free day, also as another supportive mechanism in promoting alcohol availability control in community settings.

Alcohol rehabilitation and prevention of substance abuse

A successful programme in addressing antisocial behaviour and domestic violence influenced by alcohol in India has been shown in this area. For example, community-centred rehabilitation, pioneered by the T.T.Ranganathan Clinical Research Foundation's "TTK Hospital" in Chennai, successfully organized community-based camps for those with alcohol dependence and their families. This programme also suggested that quality care at the community level can be achieved at lower cost with minimal investment in infrastructure.[30] This is along the same line with findings from Thailand. Stop Drink Network[31] (StopDrink), a Thai CSO, has run community-based 'peer help' to support drinkers who want to quit or reduce their drinking in various settings across Thailand. Moreover, Foundation for Innovative Social Development[32] (FISD), a Sri Lankan nongovernmental organization, has implemented comprehensive community-based programmes on prevention of alcohol, tobacco and drugs.

Alcohol and health promotion

Sri Lanka and Thailand have focused on implementing health promotion activities at the community level, which recognize alcohol use as a major health risk. Therefore, alcohol-control activities have been integrated as components of health promotion programmes. In Sri Lanka, the Alcohol and Drug Information Centre[33] (ADIC) has organized many community programmes for alcohol and tobacco control in several geographical areas. StopDrink has implemented numbers of alcohol-control community programmes in Thailand; some communities have run both alcohol and tobacco control.

Alcohol and domestic violence

Domestic violence has been recognized as a clear negative consequence from alcohol use at the community level. Community actions to reduce alcohol-related domestic violence have been introduced in Sri Lanka and Thailand. Several programmes are run by ADIC and FISD to address both harm from alcohol consumption and address domestic violence influenced from alcohol on a comprehensive basis. Community activities promoting quit drinking and reducing domestic violence against women and children have been operated in several areas in Thailand, run by StopDrink and its partner agencies.

Alcohol and young people

Underage drinking is one of the key concerns in alcohol policy in most societies. To deter drinking initiation is an effective approach to prevent alcohol-related harm among this high-risk population. SEA Region Member States, including India, Sri Lanka, Thailand and Timor-Leste, have made concerted efforts in supporting prevention of alcohol-related harms for young people, especially a support for community actions. However, with limited data available, this Report reviewed activities for underage group in Sri Lanka and Thailand.

Numbers of school programmes have been conducted for raising awareness on harms from alcohol, tobacco and drugs in Sri Lanka. Those programmes have been supported by ADIC with collaboration with public agencies like the Ministry of Education. Facilitated by StopDrink, a number of communities and youth groups in Thailand have implemented programmes and activities on alcohol-free events and areas that focus on area-based social and cultural events, which are popular among youngsters. Activities to promote voluntary collaboration from alcohol retail outlets to comply with minimum purchasing age (MPA) regulation have also been organized in many areas in Thailand. Both Member States also have in place programmes to raise literacy on alcohol industry marketing strategy among young people.

Alcohol, well-being and lifestyle

Sri Lanka and Thailand have conducted community actions linking alcohol, well-being and lifestyle. Addressing alcohol use on Pay day[30] has been implemented in communities in the Central and Sabaragamuwa Province in Sri Lanka. This programme aims at raising awareness among drinkers on alcohol expenditure on pay day, using family demand as leverages, and also minimizing alcohol outlet in the community to reduce an easy access to alcohol. This intervention was successful in reducing alcohol-related violence and injuries.

Facilitated by ThaiHealth, happy workplace, referred to 'Happy8' conceptual framework,[34] was a concept that focuses on work life balance for employees, consisting of 8 pillars. This concept consists of 3 areas (people, family and society) and these 8 pillars; the objective of the happy workplace programme is to improve the mental and physical health of employees. In practice, companies and organizations may not solely focus on only alcohol control activities, but as a part of broader framework. Currently, several private sector companies and organizations, both domestic and transnational, have adopted this concept into action. Similar to Sri Lanka's pay-day practices, Thai's community programmes – supported by StopDrink – have focused on household accounts, with an aim to promote household saving by reducing alcohol expenditure.

Development of community-level alcohol policy

The key example of development of local alcohol policy can be found in Thailand. Civil society groups have played an active role in supporting the launch of local alcohol policies.[28] Such policies include promotion of alcohol-free zone and/or alcohol-free events, especially nationwide cultural events (Songkran Festival/ Thai New Year), Loi Krathong Festival and other local cultural events as well as traditional ceremonies (e.g. funerals, weddings). These local policies have been implemented at various levels, ranging from village, subdistrict to provincial levels.

Implementation gap and recommendation

Although many community actions have been implemented in order to help reduce the harmful use of alcohol, evidence on effectiveness of those programmes is limited. In addition, long-term support for alcohol-control community actions was not clearly announced by SEA Region Member States.

- It is crucial to identify gaps and priorities for communities, with participation of civil society groups, in order to contextualize their community action.
- Community action should be part of a comprehensive programme, with other public health and socioeconomic issues. It is highly important to strengthen existing effective activities and to increase participation in order to sustain collective outcomes from those community actions.
- Long-term capacity-building is needed to strengthen capacity of community members, community-based organizations and local authorities to address alcohol-related consequences in their areas.
- Strategic support from government and other stakeholders is required to ensure collective outcomes from community action. Financial support and its phasing out also requires a participatory planning between funders, supporters and relevant stakeholders.
- Knowledge and experience sharing within country and among SEA Region Member States could expedite the upscaling process.

Table 6: Community action for alcohol control, categorized by issues

Issue-based community actions	Awareness on alcohol-related harms	Alcohol rehabilitation and prevention of substance abuse	Alcohol and health promotion	Alcohol and domestic violence	Alcohol and young people	Alcohol and well-being and lifestyle	Development of community-level policy
Bangladesh	–	–	–	–	–	–	–
Bhutan	–	–	–	–	–	–	–
India	–	Community-centred rehabilitation (Southern India)*	–	–	–	–	–
Indonesia	–	–	–	–	–	–	–
Maldives	–	–	–	–	–	–	–
Myanmar	–	–	–	–	–	–	–
Nepal	Few international nongovernment organizations help facilitating community actions in reducing alcohol consumption in community. Those activities are not only about to reduce harmful use of alcohol but also to help other problems in communities.						
Sri Lanka	Addressing antisocial behaviour and violence influenced from alcohol**	Programmes or activities for Prevention of Alcohol, tobacco and drug	Alcohol and tobacco	Several programmes run by ADIC and FISD	Knowing alcohol industry marketing strategy and other school programmes	Pay-day use*	–
Thailand	Social marketing (e.g. alcohol-free events/zone, domestic violence, underage drinking, NCDs)	Community support to taking care of drinkers after rehabilitation	Alcohol and tobacco	Quit drinking and reducing domestic violence against woman and children	Alcohol-free events/areas, Minimum Purchasing Age, Knowing alcohol industry marketing strategy	Happy workplace, alcohol and family spending	Local policy on alcohol-free areas/ events
Timor-Leste	–	–	–	–	–	–	–

Source: * Reducing harm from alcohol use: Good practices, World Health Organization Regional Office for South-East Asia (2012).
** Programme on reducing harm from alcohol use in the communities: Alcohol control series No. 7, World Health Organization Regional Office for South-East Asia (2009).

Area 4: Drink-driving control and countermeasures

Driving under the influence of alcohol is one of the major risk factors of road traffic accidents. Alcohol-related traffic injuries cause huge health and social burdens to many Member States. Impacts from drink-driving are not limited to drinking drivers only, but also to passengers, other drivers, pedestrians, family and the society as a whole. Drink-driving control has been recognized as a key policy tool to reduce both alcohol-related problems and RTI. Drink-driving countermeasures consist of both legislative and non-legislative approaches, such as public awareness raising. Both approaches should be conducted on a complementary basis, not alternative to each other.

The fundamental parts of drink-driving countermeasures are the three legal frameworks. The first legal framework is on how to define the behaviour of driving under the influence of alcohol. For most modern societies, the Blood Alcohol Concentration (BAC) has been the gold standard. The second framework is how to set the surveillance mechanism to screen for any drink-driver on the road; random breath testing (RBT) was identified as the best practice in promoting visibility of law enforcement. Setting up sobriety checkpoints at certain fixed geographical points is a less effective alternative to RBT. And third, countries also need a legal framework on penalty and further obligations for drink-driving offenders. For example, repeated offenders may be banned from driving in long term and subject to compulsory alcohol treatment.

Member States of the South-East Asia Region have enforced drink-driving countermeasures in a variety of details in their legislations.

Box 4. Definition of BAC limit, Sobriety checkpoints and Random breath testing by WHO

BAC is defined as the legal maximum blood alcohol concentration (measured as mass per volume) allowed while driving a vehicle, in a country. The BAC limits for the general population, young/novice drivers and professional/commercial drivers respectively are indicated.

Sobriety checkpoint means checkpoints or roadblocks established by the police on public roadways to control drink-driving.

Random breath testing (RBT) is defined as a test given by the police to drivers randomly chosen to measure the amount of alcohol that drivers have. It means that any driver can be stopped by the police at any time to test the breath for alcohol consumption.

Legal Blood Alcohol Concentration

The aim of maximum legal BAC is to limit the amount of alcohol intake for individuals who drive a vehicle. Level of BAC correctly reflects the driving ability, and thus risk of injuries. Most Member States endorsed national 'blanket' BAC limit in various scales, measured on the basis of mass per volume, to be applied for general drivers without a special lower limit for high-risk drivers, such as young people and professional drivers.

The BAC limit is set as 'zero tolerance' for the general population in Bangladesh, Indonesia and Maldives, also due to the total prohibition of alcohol in the cultural context. For other Member States, given the most widely used internationally is 0.05% (equivalent to 50 mg/dl), the limit has been set in a range of 0.03–0.08% for the general population. The relatively strict BAC limit 0.03% is implemented in India. Thailand and Timor-Leste have enforced the BAC limit of 0.05%. The relatively less strict are the legal limits in Myanmar (0.07%), Bhutan and Sri Lanka (0.080%). It is interesting to note that most

Member States endorse a single BAC limit for both general population and young people. Only Myanmar addresses the mandate of zero tolerance especially assigned for young drivers. Moreover, India, Sri Lanka and Timor-Leste have implemented only one level of BAC limit for the general population, young people and professional drivers. In addition, Bhutan, Myanmar and Thailand endorse zero tolerance for professional drivers. More detail is shown in Table 7.

BAC Enforcement

Like many other policies, drink-driving law enforcement in SEA Region Member States is very challenging. Based on self-report on categorizing BAC enforcement into three groups, Bangladesh and Indonesia both enforce zero tolerance, have perceived poor enforcement on their mandate. No data are available on enforcement from Maldives, which also implemented zero tolerance for its citizens. Expert opinions from Myanmar and Timor-Leste have indicted poor enforcement, while Thailand has perceived their poor enforcement on BAC limit by both empirical information and expert opinions.

India and have considered their enforcement for BAC limit as moderate. India has enforced relatively strict BAC limits, and its performance is perceived by both empirical information and expert opinions. Meanwhile, Bhutan has perceived its performance on legal BAC limit as a good one. At a glance, it seems that enforcement level may necessarily relate to the level of legal BAC limit in countries.

Table 7: BAC limits in SEA Region Member States (unit: %)

Member States	General drivers	Young drivers	Professional drivers
Bangladesh	Zero tolerance	Zero tolerance	Zero tolerance
Bhutan	0.08	0.08	0.08
India	0.03	0.03	0.03
Indonesia	Zero tolerance	Zero tolerance	Zero tolerance
Maldives	Total ban	Total ban	Total ban
Myanmar	0.07	Zero tolerance	Zero tolerance
Nepal	-	-	-
Sri Lanka	0.08	0.08	0.08
Thailand	0.05	0.05	Zero tolerance
Timor-Leste	0.05	0.05	0.05

Remark:
1) Nepal had no mandatory BAC limit.
2) There are no data available for Democratic People's Republic of Korea.
Source: Global status report on alcohol and health 2014.

Sobriety checkpoints and random breath testing

Sobriety checkpoints refer to checkpoints or roadblocks established by the police on certain public roadways to control for driving under the influence of alcohol. Although most Member States have set a legal BAC limit, a few Member States (Nepal, Thailand and Timor-Leste) have implemented sobriety checkpoints. In Thailand, responsible agencies, such as Royal Thai Police and Ministry of Interior, seem to limit their implementation attention on long holidays, with high transportation volume by increasing number of sobriety checkpoints.

RBT is a BAC test that is randomly chosen by law enforcing officers, such as the police. Theoretically, RBT is randomly applied across location and time to promote the equal chance of being screened. It is not implemented as a fixed point as are sobriety checkpoints. RBT implies that any driver can be stopped by the police at any time to test the breath for alcohol consumption. It is noted that Nepal and Timor-Leste have implemented both RBT and sobriety checkpoints. However, Bhutan, India, Myanmar and Sri Lanka have endorsed only RBT.

Drink-driving penalty

Penalty and punishment to drink-driving offenders could be given in different ways. In some settings, offenders are subject to drink-driving violation as a basic penalty, and also subject to additional penalty, based on any further damage to health and property.

- *Fines and penalty point:* All Member States that implement legal BAC limit set fines as penalty; Nepal, though it had no legal BAC limit, has also applied fine as a penalty for drink-driving. Penalty point system has been set, together with fines, as a step-wise penalty approach for violating BAC limit in Bangladesh, Nepal and Timor-Leste.
- *Community/public service*: Nepal and Thailand have implemented community/public service for individuals for drink-driving.
- *Short-term detention and vehicle impounded:* For BAC offenders, short-term detention has been set as a penalty that focuses on a punishment for an individual, while vehicle impoundment relates to temporarily confining a vehicle from an individual. Few Member States have implemented short-term detention, including India, Nepal, Sri Lanka and Thailand. Only Timor-Leste set vehicle impoundment as one of its penalty approaches.
- *Mandatory treatment and mandatory education and counselling*: Treatment and/or counselling for repeated drink-drivers seem to be less popular in the Region. Bhutan mandates treatment and education and counselling as penalty for violating legal BAC limit. Interestingly, Nepal, given that it had no legal BAC limit, has implemented mandatory education and counselling as a penalty for drink-driving.
- *Driving license suspension and revocation*: In some settings, driving license suspension and/or revocation could be seen as a more serious penalty for a drink-driver. Most Member States that implemented legal BAC limit have mandated driving license suspension for those who violate the BAC limit, including Bhutan, India, Myanmar, Nepal and Timor-Leste. Member States that set zero tolerance have no enforcement on driving license suspension for drink-driving. However, Bangladesh, where zero tolerance has been set, has enforced driving license revocation. Bhutan, where less strict BAC limit of 0.08% has been implemented, has applied both driving license suspension and driving license revocation.
- *Imprisonment*: Imprisonment is seen as the most serious legal punishment for those offenders. It has been set as a legal penalty for several Member States, including Bangladesh (zero tolerance), Bhutan (0.08 %), India (0.03 %), Myanmar (0.07 %) and Nepal (no legal BAC limit).

Table 8: Summary of policy and interventions, compared to policy options suggested by the Global strategy

	Policy options and interventions suggested by the Global strategy	Enforcement by Member States	Remark
(a)	introducing and enforcing an upper limit for blood alcohol concentration, with a reduced limit for professional drivers and young or novice drivers	Bhutan, Thailand	The BAC limit for professional drivers is set to zero, which is lower than the limit set for general population
		Myanmar	The BAC limit is set to zero for both professional drivers and young people
(b)	promoting sobriety checkpoints and random breath-testing	Nepal, Thailand, Timor-Leste	For sobriety checkpoints
		Bhutan, India, Myanmar, Nepal, Sri Lanka	For RBT
(c)	administrative suspension of driving licenses	Bhutan, India, Myanmar, Nepal, Timor-Leste	–
(d)	graduated licensing for novice drivers with zero tolerance for drink-driving	None	–
(e)	using an ignition interlock, in specific contexts where affordable, to reduce drink-driving incidents	None	–
(f)	mandatory driver-education, counselling and, as appropriate, treatment programmes	Bhutan, Nepal	Bhutan has implemented mandatory driver-education, counselling and treatment programmes
(g)	encouraging provision of alternative transportation, including public transport until after the closing time of drinking places	None	–
(h)	conducting public awareness and information campaigns in support of policy and in order to increase the general deterrence effect	Bangladesh, India, Myanmar, Nepal,	–
(i)	running carefully-planned, high-intensity, well-executed mass media campaigns targeted at specific situations, such as holiday seasons, or audiences such as young people	Thailand	In recent years, Thailand has many mass media and TV advertising for awareness raising on drink-driving for long holidays/public holidays

Recommendations

- Review and consider setting and/or lowering BAC limit, in particular to set a special low BAC for high-risk drivers, including young and professional/public drivers.
- Strengthen BAC law implementation, including building capacity of implementing officers and setting up the multisectoral mechanisms to facilitate the engagement of civil society and community groups to promote law enforcement.
- Conduct public campaigns to promote conducive social norm, enforcement visibility and accountability of relevant sectors in addressing drink-driving, as a complement to legislation and law enforcement.

Area 5: Availability of alcohol

Restrictions on availability of alcohol is one of the most effective measures to addressing alcohol-related problems.[1] These restrictions focus mostly on physical availability of commercial alcohol, which has an impact on both volume and pattern of alcohol consumption in a society as well as on magnitude and pattern of alcohol-related harm. Physical availability of alcoholic beverages could be controlled through many means, including control on supply chain (producers, distributors, sellers, products), condition of sales (time and place) and on purchasers. Therefore, legal definitions of alcohol beverages, of alcohol production, distribution and sales, and of alcohol consumption are all important to physical availability of control policy.

Although there is relatively limited evidence on effectiveness and enforcement of this intervention group in SEAR, most Member States, at least, have enacted some legislation to control physical availability of alcohol, in particular MPA and restrictions on alcohol sales.

Minimum purchasing age

The age limit for purchasing alcohol from both on- and off-premise outlets is defined as the minimum legal age at which a person can buy alcoholic beverages in any commercial setting. The aim of this measure is to reduce physical availability of alcohol for young people, seen as a target population. First, it is important to note that MPA is not necessarily the same age limit as minimum drinking age (MDA). MDA is set to put more focus on the age limit that people can drink alcohol and to prohibit any individuals to give alcohol to young people, as a reflection of social availability of alcohol. Second, MPA and MDA can vary by beverage types (between wine, beer and distilled spirit) and alcohol outlet settings (between on- and off-premises).

Box 5. Definition of age limit by WHO

Age limit for on-premise alcohol service and off-premise alcohol sales: The legal age limit for on-premise service of alcoholic beverages is defined as the age at which a person can be served alcoholic beverages on premises in a country, i.e. alcoholic beverages cannot be served to a person under this age.

The legal age limit for off-premise sales of alcoholic beverages is defined as the age at which a person can be sold alcoholic beverages off premises in a country, i.e. alcoholic beverages cannot be sold to a person under this age.

Most Member States have implemented national laws on age limits, while India has addressed this intervention at the state level. Member States with total prohibition of alcohol sales/consumption,

including Bangladesh and Maldives, may not need any additional age limit regulation, as it is regarding alcohol and not practice. Among those with MPA, legal limits, for both on- and off-premise outlets, the range is between 18 and 21 years old for national legislation and between 18 and 25 years old for subnational mandate. Meanwhile, Timor-Leste has no law on age limit for alcohol sale to minors. Indonesia has endorsed an age limit only for off-premise sales. Most Member States have set the same legal age limit for both MPA and MDA. However, Thailand has regulated legal age by a different legislation. Its legal purchasing age is 20 years old, implemented under the 2008 Alcohol Beverage Control Act, whereas the legal drinking year is 18 years, enacted under the Child Protection Act, 2003.

Table 9: Legal age for on- and off-premise alcohol sales in the South-East Asia Region

	On-premise sales		Off-premise sales	
National law	Total ban	Maldives	Total ban	Maldives
	18	Bhutan, Myanmar, Nepal	18	Bhutan, Myanmar, Nepal
	20	Thailand	20	Thailand
	21	Sri Lanka	21	Indonesia, Sri Lanka
Subnational law	Total ban	India (Gujarat)		
	18	India (Himachal Pradesh, Rajasthan, Andaman and Nichobar, Sikkim, Puducherry, Daman and Diu)		
	20	–		
	21	India (Andhra Pradesh, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Goa, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Meghalaya, Orissa, Tamil Nadu, Uttarakhand, Uttar Pradesh, West Bengal, Tripura, Dadra and Nagar Haveil)		
	25	India (Haryana, Maharashtra, Punjab, Chandigarh, Delhi)		

Source: 1) Global Status Report 2014, 2) Alcohol Marketing and Regulatory Policy Environment in India (2013), Public Health Foundation of India, 3) What Works in Alcohol Policy? Evidence from Rural India, Ajay Mahal (2000).

Note:
(1) For India, legal minimum drinking age refers to purchasing and drinking alcohol.
(2) No data available for Democratic People's Republic of Korea.

Restriction on alcohol sale and consumption

Existing regulations can be categorized into legislation on alcohol-sale systems (sale monopoly and licensing) and a conditional prohibition on alcohol sale at on- and off-premise commercial settings (hours, days, locations, density, specific events and intoxicated persons) as well as restrictions on alcohol use in public places.

Regulations on alcohol-sale systems

Alcohol-sale monopoly

Currently, few SEAR Member States has enforced alcohol-sale monopoly. Bangladesh and Nepal enact alcohol retail-sale monopoly for beer, wine and spirits. Indonesia has regulated its retail-sale monopoly on wine and spirits, which is supervised by several ministries, including the Ministry of Finance, Ministry of Commerce, Ministry of Industry and the National Agency of Drug and Food.

Alcohol retail-sale licensing

Alcohol outlet licensing is a popular policy, but it may not always be for the purpose of controlling alcohol-related problems. Most Member States have national legislation on retail alcohol-sale licensing in place, whereas India has implemented at the subnational level, which focuses on sale prohibition, control on hours and location of sales. Given that Maldives set a total ban on alcohol production and consumption for its citizen, no licensing system is needed. In addition, Indonesia has implemented retail-sale licensing regulation for wine and spirits but not for beer. A brief overview of retail-sale monopoly and licensing are summarized as shown in *Table 10*.

Table 10: Alcohol retail-sale monopoly and licensing in the South-East Asia Region

Member States	Retail-sale monopoly			Retail-sale licensing		
	Beer	Wine	Spirits	Beer	Wine	Spirits
Bangladesh	✓	✓	✓	✓	✓	✓
Bhutan	–	–	–	✓	✓	✓
India	–	–	–	Subnational	Subnational	Subnational
Indonesia	–	✓	✓	–	✓	✓
Maldives	Ban	Ban	Ban	Ban	Ban	Ban
Myanmar	–	–	–	✓	✓	✓
Nepal	✓	✓	✓	✓	✓	✓
Sri Lanka	–	–	–	✓	✓	✓
Thailand	–	–	–	✓	✓	✓
Timor-Leste	–	–	–	✓	✓	✓

Source: WHO 2012 Global Information System on Alcohol and Health survey.

Prohibition of alcohol sale at on- and off-premises

Hours of alcohol sale

Half of the South-East Asia Member States have hours of sale restriction on alcohol sale in place in both on- and off-premise commercial settings. However, restriction on selling hours only in on-premise alcohol outlets has been implemented in Myanmar. Those regulations covered all beverage types: beer, wine and spirits. A brief summary of hour of sale restriction is shown in *Table 11*.

Day of alcohol sale

Restriction on days of alcohol sale has been mandated in several Member States, including Bangladesh, Bhutan, India, Sri Lanka and Thailand. This regulation has been implemented in both on- and off-premise alcohol outlets for beer, wine and spirits. A brief overview on restriction of days of alcohol sale is illustrated in *Table 11*.

The forms of regulations on day of sales are varied in the Region. For instance, prohibition of alcohol sales on key religious days has been enforced in Thailand. In addition, another important example of day restriction – dry days – has been applied in Bhutan and India. Tuesday[35] is set as a dry day in Bhutan, which refers to restriction on the off-license sale of beer, wine and spirits. India has implemented 'dry days' both at national and subnational levels. There is a nation-wide mandatory dry day[36] in India in which

Mahatma Gandhi's birthday – 2 October – is set as another restriction on day of alcohol sale. Furthermore, some Indian States have initiated other dry days, which is usually set for one day in the week, whereas others – Andaman and Nicobar Islands – have set payday as a dry day. Moreover, the Government of Delhi has set major religious festivals and national holidays as dry days; therefore, alcohol is not available for general public on those 21 days in a year.

Alcohol outlet locations

Most Member States have regulated national restrictions on alcohol sale, for both on- and off-premise settings. Timor-Leste has set no legal measure for controlling both on- and off-premise alcohol-sale locations. Nepal has focused its restriction on on-premise settings, while Myanmar has set its national mandate for controlling alcohol sale at off-premise locations. *Table 11* below shows recent regulation for controlling alcohol-sale locations of South-East Asia Member States.

It is important to note that legal restriction for controlling locations of alcohol outlets in some Member States might be closely related to restriction on alcohol use in public settings. For example, a number of Indian States have set their subnational legislations not to issue licenses if a premise is located close to an educational institution, place of worship, main bus stand, crematorium, burial ground, socioeconomically backward colony, labour colony, market place or established habitat.[37] In another example, in addition to the alcohol-sale license under the 1950 Liquor Act, Thailand is currently in the process of launching a mandate not to give an alcohol-sale license if the premise is located within a 300-metre radius of undergraduate institutions.[38]

Alcohol outlet density

Control on alcohol outlet density is an effective means of addressing alcohol availability at the macroeconomic level. However, only a few SEA Region Member States, including Bangladesh, India and Sri Lanka, have regulated density of alcohol sale at both on- and off-premise locations. Moreover, Bhutan has also set its mandates for both on- and off-premise alcohol-sale settings with the exception of sale of spirits at on-premise locations. In addition, Myanmar has implemented density control for only on-premise alcohol-sale outlets. A brief review on alcohol-sale density control policy is shown in *Table 12* below.

Control on specific events

Bangladesh, Bhutan, Myanmar and Sri Lanka have controlled alcohol sale, for both on- and off-premise settings, during specific events. India and Nepal have focused their regulation on controlling on-premise alcohol sale during specific events. Although there is no national legislation, Thailand has voluntarily implemented various campaign actions on alcohol-free festive events or alcohol-free zones[28] in several provinces. Key examples of those activities include alcohol-free Songkran (Thai New Year, a nationwide traditional event), alcohol-free boat racing festival (local festival) and alcohol-free funerals (cultural and traditional lifestyle). Some Member States have imposed a ban on alcohol sale on other specific days, which may not be for alcohol control, such as the ban of alcohol sale on political election day in Thailand primarily for social order objective. *Table 12* below displays brief information on alcohol-sale control during specific events.

Sale to intoxicated persons

Not many Member States have implemented a control regulation for selling alcohol to intoxicated persons in general. However, their regulations cover alcohol-sale prohibition, all types of alcoholic beverages, to intoxicated drinkers at on-premise locations. A summary on national policy to control alcohol sale to intoxicated persons is shown in *Table 12* below.

Table 11: Legal restriction on alcohol sale (hours, days, locations) in the South–East Asia Region

Member States	Hours						Day						Locations					
	On-premise			Off-premise			On-premise			Off-premise			On-premise			Off-premise		
	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits
Bangladesh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bhutan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
India	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Indonesia	✓	✓	✓	✓	✓	✓	–	–	–	–	–	–	✓	✓	✓	✓	✓	✓
Maldives	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Myanmar	✓	✓	✓	–	–	–	–	–	–	–	–	–	✓	✓	✓	–	–	–
Nepal	–	–	–	n/a	n/a	n/a	–	–	–	n/a	n/a	n/a	–	–	–	n/a	n/a	n/a
Sri Lanka	–	–	–	–	–	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Thailand	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Timor-Leste	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

Source: WHO 2012 Global Information System on Alcohol and Health survey.
Remark: n/a (no data available).

Table 12: Legal restriction on alcohol sale (density, specific events, intoxicated persons, petrol stations) in the South–East Asia Region

Member States	Density						Specific events						Intoxicated persons			Petrol stations		
	On-premise			Off-premise			On-premise			Off-premise			On-premise			Off-premise		
	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits
Bangladesh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bhutan		✓	No	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	✓	✓	✓
India		✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	–	–	–	✓	✓	✓
Indonesia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Maldives	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Myanmar		✓	✓	–	–	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–
Nepal	–	–	–	n/a	n/a	n/a	✓	✓	✓	n/a	n/a	n/a	✓	✓	✓	n/a	n/a	n/a
Sri Lanka	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	✓	✓	✓
Thailand	–	–	–	–	–	–	–	–	–	–	–	–	✓	✓	✓	✓	✓	✓
Timor-Leste	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

Source: WHO 2012 Global Information System on Alcohol and Health survey.
Remark: n/a (no data available).

Sale at petrol stations

Half of the Member States have paid attention to controlling alcohol sale at petrol stations. To limit availability of alcohol for drinkers in transportation settings will help preventing negative consequences from alcohol consumption of drivers, passengers and pedestrians, all contributing to overall RTI. A brief summary of prohibition of alcohol sale at petrol stations is shown in *Table 12* below.

Restrictions on alcohol consumption in public places

Restriction of alcohol use in public places is seen as an approach to promote public order and safety, and to help control acute societal problems from alcohol, such as public nuisance and violence assault. Alcohol-free settings can be broadly categorized into 3 groups, including workplace settings, public facility areas, and areas for social, cultural and leisure events.

There are various levels of restrictions mandated by Member States, ranging from highly strict ban on alcohol use or partial statutory restriction to, relatively less restriction, voluntary or self-regulated as well as no restriction at all. These variations are within Member States themselves, given a variety of places and contexts, and also different across Member States (Table 13).

Bangladesh, Indonesia and Maldives have set strong restrictions on alcohol use in public settings, including health-care establishments, educational buildings, government offices, public transport settings, public parks, streets, sporting events, leisure events such as concerts, workplaces as well as places of worship. India and Sri Lanka have also regulated a strict prohibition by banning alcohol use in almost all public places, mentioned earlier, except implementing a partial statutory restriction at leisure events.

It can be observed that most Member States have set prohibition of alcohol use in public buildings and office settings, regardless of whether those utilized public areas are owned by both government and nongovernment/private agencies. However, restriction rules on alcohol use are varied across public facility areas (e.g. public transportation settings, parks, streets, etc.). Banning alcohol use in public transport settings is popular in Member States of the SEA Region. Total ban on alcohol use in public transport settings has been implemented in Bangladesh, India, Indonesia, Maldives, Sri Lanka and Timor-Leste, while a partial statutory restriction has been regulated in Myanmar, Nepal and Thailand. Furthermore, as in other public buildings and office settings, the workplace has been banned for alcohol use in most Member States. Voluntary or self-regulated alcohol use at the workplace has been implemented in Bhutan and Timor-Leste; however, Thailand has no legislation on restriction on alcohol use at the workplace.

There is a variety of regulations for controlling alcohol use in public areas – such as parks and streets – across Member States. Ranging from the most restrict regulation, total prohibition on alcohol use at parks and streets has been ruled in Bangladesh, India, Indonesia, Maldives and Sri Lanka. Moreover, there has been a partial statutory restriction implemented for such settings in Nepal and Thailand. However, the relatively less restriction by voluntary or self-regulation on alcohol use in parks and streets has been set in Myanmar and Timor-Leste. In addition, Bhutan has no regulation to restrict alcohol use in public transport settings and parks and streets.

Member States did not necessarily apply the same regulation on prohibition of alcohol use in areas for social, cultural and leisure events. Alcohol use has been banned at sporting events in many Member States (Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka); a partial statutory restriction in such events has been regulated in Bhutan. A voluntary or self-regulated restriction on alcohol use at sporting events has been set in Myanmar and Timor-Leste. Interestingly, Thailand has no legal restriction on alcohol use in sporting events.

Table 13: Restrictions on alcohol use in public places in the South-East Asia Region

	Building or office settings				Public facility areas		Areas for social, cultural and leisure events		
	Health-care establishments	Educational building	Government offices	Workplaces	Public transport	Parks, streets, etc.	Sporting events	Leisure events (concerts etc.)	Places of worship
Bangladesh	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Bhutan	Ban	Ban	Ban	Voluntary/self-regulated	No restriction	No restriction	Partial statutory restriction	No restriction	No restriction
India	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Partial statutory restriction	Ban
Indonesia	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Maldives	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Myanmar	Ban	Ban	Ban	Ban	Partial statutory restriction	Voluntary/self-regulated	Voluntary/self-regulated	No restriction	Ban
Nepal	Ban	Ban	Ban	Ban	Partial statutory restriction	Partial statutory restriction	Ban	Partial statutory restriction	Ban
Sri Lanka	Ban	Ban	Ban	Ban	Ban	Ban	Ban	Partial statutory restriction	Ban
Thailand	Ban	Ban	Ban	No restriction	Partial statutory restriction	Partial statutory restriction	No restriction	No restriction	Ban
Timor-Leste	Ban	Ban	Ban	Voluntary/self-regulated	Ban	Voluntary/self-regulated	Voluntary/self-regulated	Voluntary/self-regulated	Voluntary /self-regulated

Source: WHO 2012 Global Information System on Alcohol and Health survey.

Some Member States have set the same rule to regulate alcohol use in both sporting events and leisure events, such as during concerts. The highly restricted rule on total ban during both events has been applied in Bangladesh, Indonesia and Maldives. Voluntary or self-regulated use of alcohol during both events, much less restriction, has been set in Timor-Leste. In addition, Thailand set no mandate on prohibition of alcohol use during both events. However, a few other Member States have banned alcohol use during sporting events but set a partial statutory restriction for leisure events (India, Nepal and Sri Lanka). It is interesting to note that both Bhutan and Myanmar have no legal restriction on alcohol use during leisure events.

Most Member States ban alcohol use in places of worship and religious places, Timor-Leste, however, has set it voluntary and on self-regulated rules; and Bhutan has no legal restriction.

Implementation gap

Although the number of control regulations enacted by Member States covered various dimensions of alcohol availability, there is limited evidence on strength of implementation of those controls. Weak enforcement is a common manifest in SEA Region Member States. Moreover, levels of implementation that are defined vary across Member States. It is important to note that surveillance and monitoring system, specifically for controlling alcohol availability, is required to promote implementation of such regulations.

In addition, there are not only legal measures and public sectors that help to address the implementation of availability control. In some local settings, other stakeholders, especially civil society groups, together with government authorities, have also helped in promoting law compliance. Collaboration among stakeholders – whether health and non-health sectors or government agencies and CSOs – is active in a few Member States; however, it can be of relatively less priority among others.

Recommendations

- Reviewing and strengthening existing regulations: It is essential that SEA Region Member States have their gap identified, both in content of existing regulations and in the implementation process. Context-specific analysis should also be made. Those gap and context-specific analysis will be important inputs for improving and strengthening existing regulations.
- Establishing effective enforcement mechanisms: Once gaps in the implementation process have been analysed, Member States can further develop enforcement mechanisms, which can strengthen existing mechanisms or new ones. A decent starting point can be a study on building up enforcement mechanisms for a selected regulation.
- Building up information on monitoring law enforcement: An effective implementation for controlling alcohol availability should be regularly evaluated. However, it is highly important that Member States have set a national/subnational surveillance and monitoring system for this dimension. A good start can be developing a set of existing information on law compliance and/or penalty cases.
- Empowering multisectoral collaboration: It is crucial to promote collaboration among stakeholders, including health and non-health sectors as well as government and nongovernment agencies. Empowering roles of civil society groups and communities will help in supporting law enforcement and in monitoring of its violation at local and/or specific settings. It is important to note that effective outcomes can be ensured from collaboration that is free of conflict of interest.

Area 6: Marketing of alcoholic beverages

Alcohol marketing is vital for the alcohol industry to create, maintain and enhance demand for alcoholic beverages to current and future drinkers. Evidence confirms that alcohol marketing has a clear effect on those with intentions to drink[39] and intention to purchase, [40] as well as on drinking initiation among youth.[41] Apart from effects at the individual level, it also has an impact on social values around alcohol, including promoting the collective 'alcohol normalization' attitude, seeing alcohol consumption as an ordinary element of everyday life, which may affect adversely social acceptability of more restrictive alcohol policies and practice.[42] Marketing goes beyond just advertisement and promotion, but covers all direct and indirect communications on the products, producers and alcohol consumption in general. Definition of alcohol marketing, in the Global Strategy, refers to any form of commercial communication or message that is designed to increase, or has the effect of increasing, the recognition, appeal and/or consumption of particular products and services,[5] which is not limited to advertising using traditional media outlets such as television, radio and print, but communicating through new media opportunities, including internet and social media as well as exploiting promotional activities, such as product design, distribution and pricing promotion. Additionally, sport and music marketing, including sponsorship, has been an important marketing strategy for promoting positive attitude towards alcohol consumption and consumer loyalty to the brands in recent periods.[1]

Thus, as evidence suggests, restriction on alcohol marketing is a significant approach to reducing exposure to alcohol advertising and promotion in order to prevent new drinkers and to reduce alcohol volume consumption among current drinkers, thus preventing further alcohol-related harm in the short and long term. It is identified as one of the affordable, feasible and high cost-effective interventions to address behavioural risk factors of NCDs or the 'Best-Buys' interventions.[4]

Policy situation

Marketing restrictions in the WHO South-East Asia Region Member States range from no restrictions to partial bans to total bans. Total or near-total bans on alcohol advertising with legally binding laws were implemented in three countries (Bangladesh , Indonesia and Maldives), where alcohol consumption by residents is literally prohibited, based on cultural norms. Advertising of alcoholic beverages is totally banned in any mass media in Indonesia as stated in Article 58 of Regulation on Food Labelling and Advertisement 1999.[43]

Sri Lanka has in place fairly comprehensive bans on alcohol advertisement, together with regulation on tobacco advertisement, under Section 35 of the NATA since 2006.[11] This law provides a broad definition of alcohol advertisement referring to any distinctive writing, still or moving picture, sign, symbol or colours or other visual image or any audible message or any combination of the aforesaid that promotes or is intended to promote drinking and purchasing of alcoholic products. Presenting registered trademarks, brand names, manufacturer names of alcohol producers on any package containing alcohol product is also prohibited as well as displaying a notice identifying availability of alcohol for sale and their prices at the point of sale, advertising alcohol in a book, magazine or newspapers, through internet, any television or radio programme and film, and publishing any alcohol-related information claiming benefit to the public. In addition, sponsorship from alcohol and tobacco producers, defined in Section 36 of the NATA as using brand name or trademark of, or any symbol associated with alcohol products, or the manufacturer name, whether directly and indirectly, in connection with the promotion of any educational, cultural, social or sporting organization, activity or event is not allowed; in such a manner as indicated or acknowledged, that any financial or other assistance has been given by, or on behalf of, the manufacturer, importer or distributor of alcohol products towards such organization, activity or event, is also not allowed.

Alcohol advertising in Thailand is mainly regulated by the Alcoholic Beverage Control Act 2008.[12] Under section 32 of the law, alcoholic beverages shall not be advertised in a manner that directly or indirectly claims benefits or promotes its consumption, and may not show the product or its packaging, and all advertisements must also be accompanied with other sub-regulations, such as the Ministerial Regulation and the Notifications on contents, times, places and conditions of the advertisement. For example, the display of symbols and names of alcohol companies can be shown only at the end of TV advertising and shall not be presented exceeding 5% of the total advertising time, and the size should not exceed 5% of the whole advertising area for printed media.[44] Alcohol advertisement must present warning messages lasting, at least, two seconds for video advertisements and occupying at least one third of the advertisement area for print media.[45] For monitoring and detecting marketing infringement, Thailand uses the active surveillance by the government as well as a hotline. Penalties for violations of marketing restrictions range from warnings to imprisonment in the most severe cases; however, the most common mode of enforcement is through fines imposed on offending parties.

In India, advertising control policies vary according to States. Out of 30 States, prohibition on alcohol advertising, promotion and sponsorship is in place in 15 states, where ban on surrogate advertising clearly declared in two States, including Delhi and Himachal Pradesh, and ban of advertising at the point of sale implemented in four States.[37] The voluntary advertisement codes as provided in the Cable Television Network Rules, 1994[46], notified in 2008, under the Cable Television Network (Regulation) Act 1995 of the Ministry of Information and Broadcasting, The Government of India clearly stated that promotion of direct or indirect production, sale or consumption of cigarettes, tobacco products, wine, alcohol, liquor or other intoxicants is not allowed. The Rules were amended later in 2009 with the aim to tackle increased surrogate advertising of surrogate non-alcoholic products having the same brand name as alcoholic products (such as audio cassettes, drinking water, soda, juices) to allow advertising the shared brand names only in certain conditions as follows: (i) the story board or visual of the advertisement must depict only the product being advertised and not the prohibited products in any form or manner; (ii) the advertisement must not make any direct or indirect reference to prohibited products; (iii) the advertisement must not contain any nuances or phrases promoting prohibited products; (iv) the advertisement must not use particular colours and layout or presentations associated with prohibited products; and (v) the advertisement must not use situations typical for promotion of prohibited products when advertising the other products.[47] The Advertising Standard Council of India (ASCI), a voluntary self-regulatory body, has also through its Code laid down basic guidelines prohibiting Surrogate Advertising with its own monitoring system, the National Advertising Monitoring Service.[48] However, this code is applicable for only television and other cable services.

The Health Ministry of Nepal, with the cooperation of WHO, issued the decree to ban alcohol advertisement in the 'electronic media', including radio, television and private-owned FM radio channels since February 1999.[49] In December 1999, further additional legislation was proposed to ban alcohol and tobacco advertising in all media, including print media and public display. This was opposed by the industry, and was not put in place. Alcohol advertising continues to be seen on foreign satellite channels, newspaper and billboards. Outdoor advertising may have to comply with local administration rules, but is not totally restricted however.[50]

Bhutan has a strong and clear total ban policy on alcohol advertisements, which is responsible by the Bhutan Information Communication and Media Authority (BICMA), an autonomous agency under the Bhutan Information, Communication and Media Act 2006. The law well covers a broad range of media channels, including TV, radio, cable TV, published, billboard, films, internet and performances. However, there is no given definition of advertising and promotion in the Act. Additionally, there are also non-legal binding interventions to control the practice of mass media operators, such as Filming Guidelines and

Table 14: Policy situation on alcohol marketing for SEA Region Member States

Legally binding regulation on alcohol marketing	Maldives	Bangladesh	Indonesia	Sri Lanka	Bhutan	Thailand	Myanmar	India	Nepal	Timor-Leste	DPR Korea
Ban of alcohol advertising	–	–	–	–	–	–	–	–	–	–	–
National TV	✓	✓	✓	✓	✓	✓*	✓	✓	✓	–	–
Private TV	✓	✓	✓	✓	✓	✓	–	–	–	–	–
National radio	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–
Local radio	✓	✓	✓	✓	✓	–	–	–	–	–	–
Print media	✓	✓	✓	✓	✓	–	–	–	–	–	–
Billboard	✓	✓	✓	✓	✓	–	–	–	–	–	–
Point of sale	✓	✓	✓	✓	✓	–	–	–	–	–	–
Cinema	✓	✓	✓	✓	✓	–	–	–	–	–	–
Internet	✓	✓	✓	✓	✓	–	–	–	–	–	–
Social media	✓	✓	✓	✓	✓	–	–	–	–	–	–
Ban of product placement	✓	✓	✓	✓	–	–	–	–	–	–	–
Ban of sale promotion	✓	✓	✓	✓	–	–	–	–	–	–	–
Ban of alcohol sponsorship	✓	✓	✓	✓	–	–	–	–	–	–	–

Remark: *national television, private television, national radio, local radio, print, billboards, point of sale, cinema, Internet and social media.

Code of Practice, and Journalist Code of Ethics[51]. BICMA is also responsible to monitor the regulation compliance and penalization.

In Myanmar, advertising and sponsorship of all types of alcohol are completely banned on National TV and radio programmes as well as local radio programmes. Partial restriction is legal for advertising in printed materials, newspapers and magazines and on cinema.[35] Ban of alcohol advertisement in all print media is also suggested by the 16 Guideline published in 2012.[52] Alcohol industry sponsorship is a partial legal restriction in sporting events and youth events. There is no restriction on sales promotion of alcohol, especially at the points of sales.[35]

To the authors' knowledge, there is no alcohol adverting legislative control in Democratic People's Republic of Korea and Timor-Leste.

Recommendations

WHO's Global Strategy[5] recommends that countries establish regulatory or co-regulatory frameworks for alcohol marketing, preferably with a statutory basis, to regulate the content and level of exposure of direct or indirect marketing, sponsorship, promotions in connection with activities targeting young people and new forms of alcohol marketing techniques such as social media. Such frameworks should ideally incorporate all forms of new and emerging media as well as existing media and other promotional channels.

Most of existing policies in SEAR countries have covered conventional mass media, such as TV and radio. It is recommended to expand the coverage to other types of media, including integrated marketing, such as high-technology media, viral marketing, including through mobile phone, music and sport sponsorship, marketing at point of sale, price promotion, cross-border advertisement, indirect advertisement, including surrogate advertisement or advertisement of product sharing name, logo and brand with alcoholic beverages. The regulation should be comprehensive to address sport and music marketing, which are increasingly important to the Region, taking into account their effectiveness to reach the industry targeted group – the young population. This includes the alcohol product/brand placement within mass-captured national and regional films, and sponsorship in popular sports in the Region, such as cricket.

For countries having no legislative marketing control measures, it is suggested not to establish degree on self-regulation by alcohol marketers or media agencies as the main and single mechanism, but as complimentary approach to regulative mechanism in the form of their decisions to refrain from pursuing new marketing opportunities in order to keep to the spirit of protecting vulnerable populations from exposure to their marketing.

Furthermore, an effective and comprehensive monitoring and surveillance system by public agencies, or independent bodies, such as Watch Dog Group, should be set up to enhance the effectiveness of policies. It is needed to keep an eye on advertising that crosses national borders, for instance, via television or the internet that will be a major challenge in enforcing the regulations.

Area 7: Alcohol taxation and pricing policy

Rationale of alcohol taxation and pricing policy

One of the fundamental economic laws is that quantity demanded of a product is related inversely to its price. When other factors are held constant, such as income and price of other goods, a rise in alcoholic beverage price leads to less alcohol consumption volume, and thus less alcohol-related harm, and vice

versa. Price increases reduce alcohol-related harm caused by alcohol, through both collective volume and also through altered drinking patterns in many drinker groups. There is evidence that alcohol price has an impact on younger and heavier drinkers. Price increase also associates with the reduction of both consumption and frequency of heavy drinking episode. Furthermore, policies that increase alcohol prices could delay the drinking initiation, slow young people's progression towards drinking larger amounts and reduce heavy drinking among them.

As evidence indicates that raising taxes and prices of alcoholic beverages is effective and cost-effective in reducing alcohol consumption and its related harm, taxation and pricing policy is one of ten target strategies recommended for WHO Member States to implement for the prevention and control of the harmful use of alcohol.[5] The price of alcoholic beverages could be altered by many means. In general, the excise tax system is the most significant mechanism to manipulate price and thus control alcohol-related harm. Given that demand for alcohol is usually found to be inelastic to price, increasing alcohol taxes not only reduces alcohol consumption and related harm but also increases government revenues at the same time. On the opposite direction, natural experiments in countries obligated to economic treaties that result in decreases in alcohol taxes and prices have led to the increase in alcohol sales and consumption in such societies. However, cross-border issues, including cross-border consumption and trade, cannot be solved by just lowering alcohol taxes.[1,53]

Situation of alcohol taxation and pricing policy in Member States in the South-East Asia Region

Variety of alcohol taxation and pricing policy among South-East Asia Region Member States can be easily observed, mainly due to differences in economy and cultural context, in particular alcohol production and sale systems. Apart from industrialized beverages, countries could also apply taxation policies to those traditional beverages that are rampant in the Region. Moreover, unrecorded alcoholic beverages, all untaxed by nature, could play a significant role in taxation policy. *Table 15* shows common traditional/indigenous alcoholic beverages in the SEA Region.

Based on data available in the WHO Global Information System on Alcohol and Health (GISAH) website[55] and Global Status Report on Alcohol and Health 2014,[2] 10 out of 11 SEAR Member States reported that they had excise taxes on alcoholic beverages. These 10 Member States levy excise taxes on three main beverage categories: spirits, wine and beer, with the exception of Bhutan, which collects excise taxes only from spirits and wine. Traditional beverages are also taxed; for example, in Thailand, they are taxed in the category of wine.

Table 15: Traditional/indigenous alcoholic beverages in the SEA Region

Member State	Traditional beverages
Bangladesh	Bangla Mad, Cholai Tari
Bhutan	Ara
India	Tari, Tharra, Fenni, Toddy Chaang, Raksi, Mahua
Myanmar	Tin Lei Phyu
Nepal	Raksi, Tadi, Cayang, Tomb
Sri Lanka	Toddy, Arrack, Kasippu
Thailand	Oou, Krachae, Namtanmao, Sa-tho

Source: WHO Regional Office for South-East Asia (2012).[54]

Recently, there was a study reporting excise taxation in four South-East Asia countries where three (Indonesia, Myanmar and Thailand) are also SEA Region Member States. The four countries use both a single and combination taxation system based on a specific tax rate and ad valorem tax rate. *Table 16* displays all types of beverages to be bought to a standard litre of pure alcohol rate. The specific rates are standardized to Thai Baht equivalent.[56]

From eight Member States providing data on other pricing measures, two (25%) had other pricing measures, including supporting non-alcoholic beverages at a lower price (Bangladesh), ban on below-cost selling (Bangladesh) and ban on volume discounts (Bangladesh and Thailand).

Five Member States provided data on tax incidence as a percentage of excise tax relative to retail price. The tax burden on alcoholic beverage prices varied from 4% (Myanmar) to 50% (Thailand) for beer, from 4% (Myanmar) to 50% (Thailand) for wine and from 4% (Myanmar) to 72% (Nepal) for spirits. Myanmar had the lowest tax burden, whereas Thailand had the highest, except for spirits in Nepal. When comparing the excise tax per price of 1 litre pure alcohol, the tax burden on alcohol price ranged from 3.3% in Nepal to 22.2% in Thailand.

To reflect real price of alcohol, excise taxes should be adjusted for inflation and other economic situations. Among nine Member States that responded to this issue, three Member States reported adjusting excise taxes for inflation but they did only for beer and wine. Most Member States collected taxes using the excise stamp method. Value added tax in these Member States varied from 5% in Myanmar to 20% in Sri Lanka.

Table 16: Alcohol excise duties in four SEA Region Member States

Member State	Taxation system	Beer tax	Wine tax	Spirits tax
Indonesia	Single taxation (Specific rate)	740 THB/LPA	1047 THB/LPA (local) 1392 THB/LPA (import)	815 THB/LPA (local) 1415 THB/LPA (import)
Malaysia	Combination system (Specific and Ad valorem rates)	1525 THB/LPA + 15%	987 THB/LPA + 15%	308 THB/LPA + 15%
Myanmar	Single taxation (Specific rate)	50%	50%	50% (rural) 60% (local) 200% (import)
Thailand	Combination system (Specific or Ad valorem rate, which provides greater tax amount)	100 THB/LPA or 60%	100 THB/LPA or 60%	400 THB/LPA or 50% (special spirits) 300 THB/LPA or 50% (mixed spirits) 120 THB/LPA or 50% (local white)

Source: Preece (2012).[56]
Note: THB – Thai Baht equivalent, LPA – litre of pure alcohol, % – percentage of declared beverage prices.

For price of alcoholic beverages in the market of nine Member States reported to WHO GISAH, beer prices had a narrow range between US$ 0.62 in India and US$ 1.95 in Bangladesh for the 500-ml most popular beer. Prices of local (750-ml most popular) spirits had substantial difference between Member States, ranging from US$ 0.46 in Bhutan to US$ 26.64 in Myanmar (*Table 17*).

However, the price of alcoholic beverages in Member States should be interpreted relative to the buying power in such societies. In previous alcohol reports, a ratio of the price between beer and colas is used as an indicator to compare relative alcohol price across countries. In SEA Region Member States, the beer-cola ratio ranges from 2 to 4.[35] This illustrates that one can buy 2 to 4 colas for the same price as one beer. The price of spirits relative to beer in some Member States is low, indicating that people can easily commercially access an alcohol product even if it has high alcohol content.

Table 17: Average prices of alcoholic beverages in SEA Region Member States

Member State	Year	Prices for alcoholic beverages (average, US$)			
		500 mls most popular beer	750 mls table wine	750 mls most popular imported spirits	750 mls most popular local spirits
Bangladesh	2012	1.95	14.59	48.85	18.33
Bhutan	2012	0.72	13.83	22.9	0.46
Democratic People's Republic of Korea	2012	*n/a*	*n/a*	*n/a*	*n/a*
India	2012	0.62	7.21	72.13	5.41
Indonesia	2012	1.94	30.56	111.25	*n/a*
Maldives	2012	*n/a*	*n/a*	*n/a*	*n/a*
Myanmar	2012	1.18	1.37	7.4	21.64
Nepal	2012	1.89	6.43	29.28	8.36
Sri Lanka	2012	1.2	11.21	14.2	9.72
Thailand	2012	1.08	8.48	9.5	3.77
Timor-Leste	2012	1.92	69.12	1.88	1.5

Source: WHO GISAH website.[55]
Note: n/a (no data available).

Strength in taxation enforcement, in particular in addressing untaxed and unrecorded alcohol, is crucial in effectiveness of alcohol taxation. Smuggling, consumption across border, informal trade and counterfeit alcoholic beverages are among major concerns in the development of alcohol taxation policy. The minimum price is a newly introduced concept to address availability of too-cheap beverages, including through price promotion marketing of the industry. Countries could apply the minimum pricing concept as minimum pricing regulation itself or through taxation design. The effectiveness of such a concept in the Region is yet to be explored.

Implementation gap

Data of WHO South-East Asia Region Member States available in WHO GISAH and WHO global status report on alcohol and health there are also other online sources of data.. The SEA Region Member States levied excise taxes on alcoholic beverages on the basis of different taxation systems; for example, specific

tax rate in Indonesia and Myanmar and mixed tax rate in Malaysia and Thailand. The price of alcoholic beverages in Member States is different across countries. The gap of alcohol taxation and pricing policy can be identified as follows:

- There is no Member State using alcohol taxation as a tool to reduce alcohol consumption and its related harm.
- Some Member States do not tax some kinds of alcoholic beverages such as beer or low-alcohol content products.
- Prices of alcoholic beverages in Member States are low.
- Apart from alcohol taxation, there are few pricing measures implemented in Member States. The lacking measures are minimum pricing, ban on below-cost selling, ban on volume discounts and incentive for producing non-alcoholic beverages at a lower price.

Recommendations

Member States should develop an action plan to implement and/or strengthen the alcohol taxation and pricing policy as recommended here:

- To ensure that taxes set the price of alcohol at a level that reduces alcohol-related harm.
- To ensure that alcohol prices are raised to account for changing in inflation, income and the prices of other commodities.
- To set a minimum price per unit of alcohol as a policy option to reduce the availability of low- and cut-priced alcohol.
- To prevent lowering taxes on alcohol to offset cross-border trade or an illicit market in alcohol, can bring the risk of extra alcohol-related harm.
- To prevent and control illicit alcohol products, which will reduce the effect of alcohol taxation and pricing policy.
- To set a mechanism to protect national alcohol policy from the threat of international trade or international agreements.

Area 8: Reducing the negative consequences of drinking and alcohol intoxication

The key objective of this intervention group is to manage environments around alcohol consumption and provide information to consumers to make drinking safer. The policy options and interventions suggested by the Global Strategy include regulating drinking context, enforcing laws against serving to intoxicated customers and legal liability of alcohol-related harms, responsible serving, reducing the alcohol concentration in different beverage categories, providing necessary care or shelter for severely intoxicated persons as well as providing consumer information and health warning labels.

Interventions in this target area seem not to be popular in the Region; the Global status report on alcohol and health shows that only health warning labels and provision of consumer information were in place in a few SEA Region Member States. It may be implied that Member States might set relatively less priority in addressing interventions to reduce the negative consequences of drinking alcohol intoxication.

There is limited evidence on the effectiveness of health warning labels and consumer information, both on alcohol advertisement and containers. It can be seen as a long-term decision not only to provide information to current consumer based on consumer right, but also as information for drinkers-to-be and to shape social norms around alcohol consumption.

Health warning labels

Few Member States have mandated health warning labels at national levels. India, Indonesia and Thailand have implemented health warning labels on both alcohol advertisement and containers/bottles. Furthermore, Thailand has made an effort in advancing national legislation on pictorial health warning in alcoholic beverage containers.

Most messages in health warning labels on alcohol advertisement are health-oriented warning information. However, a few mandatory messages could also relate to social consequences from alcohol consumption, including violence and crime as warning for social well-being and social order. In addition, legal warning messages in alcohol containers/bottles cover warning information on alcohol sale to specific group of population and drink-driving.

Examples of warning messages mandatorily provided in product labels are listed below.

- Alcohol advertisement
  - Health-related warning: 'It may harm your health' (Indonesia), 'Liquor consumption could lead to cancer' (Thailand), 'Liquor consumption could lead to sexual impotency' (Thailand), 'Liquor consumption could lead to disability and death' (Thailand).
  - Violence and crime-related warning: 'Liquor consumption could lead to quarrel and crime' (Thailand).
  - Social well-being and social order: 'Liquor consumption could harm family and society' (Thailand).
- Alcohol containers/packages/bottles
  - Alcohol sale to a specific group of population: 'Alcohol sale to minors under 18 years of age is prohibited' (Thailand), 'Minors under 18 years of age should not drink alcohol' (Thailand), 'Forbidden for under 21 years old and pregnant women' (Indonesia).
  - Drink-driving: 'Drinking alcohol deter driving ability' (Thailand).

Information on product containers

Legal requirements regarding label information on alcohol product containers can be broadly categorized as labels that display information about nutrition (i.e. calories, additives, vitamins and micro elements), number of standard drink and alcohol content. A few Member States have enforced those legislations.

Consumer information regarding labels of alcohol containers that display nutrition was made a legal mandate in Bangladesh, Indonesia and Sri Lanka. As for legislation on displaying the number of standard drink, it was implemented in Sri Lanka and Thailand. Moreover, a legal requirement to display alcohol content (% of ethanol by volume) on labels of alcohol containers has been mandated in Bangladesh, India, Indonesia, Sri Lanka and Thailand. In addition, there are some community initiatives regarding consumer information in Nepal.

Implementation gap

Analysis of implementation gap on policy to reduce the negative consequences of drinking and alcohol intoxication is summarized in *Table 18* below.

Table 18: Analysis of implementation gap on policy to reduce the negative consequences of drinking and alcohol intoxication

	Policy options and interventions suggested by the Global strategy	Enforcement by Member States	Remark
(a)	regulating the drinking context in order to minimize violence and disruptive behaviour, including serving alcohol in plastic containers or shatter-proof glass and management of alcohol-related issues at large-scale public events	None	–
(b)	enforcing laws against serving to intoxicated persons and legal liability for consequences of harm resulting from intoxication caused by alcohol serving	None	–
(c)	enacting management policies relating to responsible serving of beverage on premises and training staff in relevant sectors in how better to prevent, identify and manage intoxicated and aggressive drinkers	None	–
(d)	reducing the alcoholic strength inside different beverage categories	None	–
(e)	providing necessary care or shelter for severely intoxicated people	None	–
(f)	providing consumer information about, and labelling alcoholic beverages to indicate, the harm related to alcohol		
	Health warning labels On alcohol advertising	India, Indonesia, Thailand	Most messages are health-oriented information. Thailand has those warning messages that cover issues in health, crime, and social well-being
	On drinking containers	India, Indonesia, Thailand	Most warning messages are indicating a prohibition of selling alcohol to minors
	Label on containers Consumer information(2012)	Indonesia, Sri Lanka	–
	Number of standard alcoholic drinks displayed on containers	Sri Lanka, Thailand	–
	Alcohol content displayed on containers	India, Indonesia, Sri Lanka, Thailand	–

Recommendations

Implementing warning messages and informing consumers about harmful effects of alcohol can be an effective tool for achieving two main policy outcomes such as reducing the negative consequences and public awareness on harmful use of alcohol. Although there may be relatively less evidence on their effectiveness compared with other interventions, policy efforts should be considered crucial by Member States to invest in launching legislation health warning labels and consumer information.

Member States should not only make an effort to enact such interventions, but also to integrate initiative in the broad alcohol policy framework, as suggested below.

- Prohibition of serving alcohol to intoxicated persons and the legal liability of alcohol sellers can be a policy option to deal with consequences of harm resulting from intoxication caused by the serving of alcohol in some specific settings. These efforts may enact together with availability control legislations.
- Provision of necessary care or shelter for severely intoxicated people can be a policy option to help reduce harm from intoxicated drivers in some settings. However, it may be a burdensome activity to government agencies.

Area 9: Reducing the public health impact of unrecorded alcohol

Rationale of the strategy

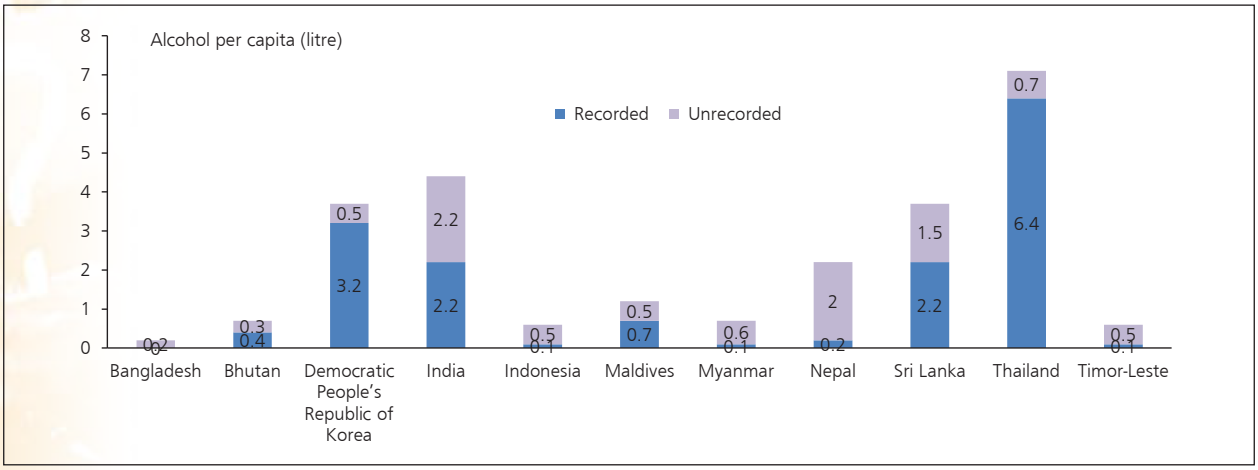
Unrecorded alcohol is defined as consumed alcoholic beverages that are not registered and/or controlled through national and subnational systems, in particular taxation mechanisms. These include home-made, illegally produced or smuggled alcohol products as well as surrogate alcohol that is not officially intended for human consumption (mouthwash, perfumes, eau-de-colognes and alcohol for industrial use). Unrecorded alcohol could lead to many negative health consequences due to a higher ethanol content and contamination with toxic substances, including methanol and lead, for which many poisoning outbreaks and fatalities have occurred and possibly also from some higher alcohols, which have been attributed to higher rates of alcoholic liver disease.[53]

Illegally traded alcohol can bring an additional health risk due to either contamination during the unfettered production and trading process or to a lower cost than legal alcohol leading to higher consumption. Hence, strategies to reduce unrecorded alcohol are vital to reduce unrecorded alcohol consumption and prevent the public health impact of unrecorded alcohol. However, little is known about the scale of unrecorded alcohol in the South-East Asia Region.

Situation in WHO SEA Region Member States

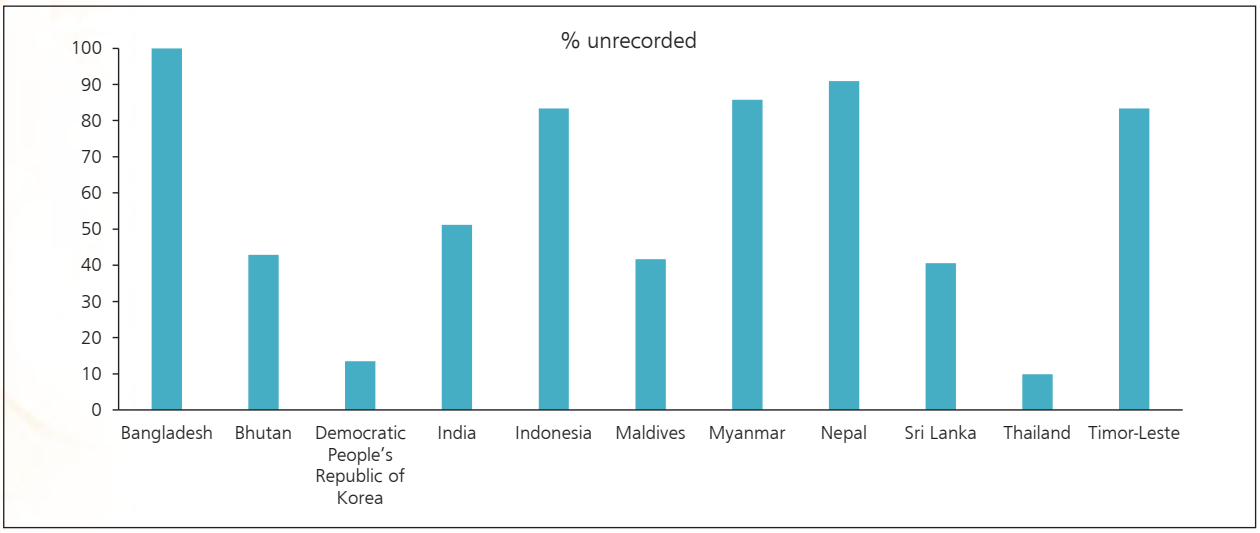
In 2014, the Global Status Report on Alcohol and Health showed that the majority of alcohol consumed in SEA Region Member States is in the form of unrecorded alcohol. It is estimated that the proportion of unrecorded alcohol in total consumption is more than 80% in Bangladesh, Indonesia, Nepal and Timor-Leste.[2] In some countries, the most common form of alcohol used in villages or rural communities is illict/traditional beverage, for example, the illicit brew kasippu in Sri Lanka. Illicit alcohol is the choice of villagers due to its low cost and ease of access.[35]

Figure 1: Total alcohol consumption in WHO SEA Region Member States (Unit: Alcohol per capita (litre))



Source: WHO (2014).[2]

Figure 2: Proportion of unrecorded alcohol consumption in WHO SEA Region Member States



Source: WHO (2014).[2]

The 2012 report on Reducing Harm from Alcohol Use: Good Practice in SEAR Member States documents mass tragedies due to illicit alcohol consumption. There have been many instances of poisoning and deaths following the consumption of adulterated liquor. In the Region, people in low socioeconomic status sometimes drink illicit or home-brewed alcohol because of its low cost, despite its known hazards. Mass causalities and the aftermath of consuming toxic brews are not infrequent. It is reported that at least 90 Bangladeshis died in 1998, including 70 in Gaibandha, after consuming illegal home-made products. In the following year, 90 people died and more than 100 were hospitalized because of consuming illicit alcohol in Narsingdi. In 2009, 143 Indians died after consuming spurious liquor in the state of Gujarat.[54] Recently, a British woman died after reportedly drinking poisoned alcohol during a trek in the Indonesian jungle.[57]

On the other hand, in some communities, people who consume illegal alcohol are viewed unfavourably. As a result, it is likely that some users falsely deny using illegal alcohol and also intentionally underreport its use. Despite this, it seems that the amount of illegal alcohol in use is far below the

estimates provided by the alcohol industry with the aim of moderating effective control policies that may reduce legal alcohol consumption.

However, there are case studies of successful intervention programmes in India and Sri Lanka to reduce harm from illicit alcohol through public campaigns and control of its availability. There are several examples from Kerala, Madhya Pradesh Haryana and Andhra Pradesh where agitations, protests and other campaigns by women significantly reduced the number of alcohol selling points. Some campaigns have even led to changes in local policy; for instance, the protests in Dubagunta village, Andhra Pradesh and in Monody village in Kerala resulted in control of the illicit liquor trade. There have also been many cases of community action to reduce the sale of illicit alcohol in the North-Central Province in Sri Lanka.[54]

Implementation gap

High social concern has been given to unrecorded and illicit alcohol on its additional harmful effect, through their toxic contaminants, higher alcohol content and lower prices. These determinants could easily lead to poisoning, intoxication and negative health impacts. There is a limited number of studies reporting public health impact of unrecorded alcohol. Moreover, there is no exact scale of unrecorded alcohol, both moonshine and smuggled alcohol.

Recommendations

To effectively implement the strategy to reduce public health impact of unrecorded alcohol, there are recommendations for Member States of the South-East Asia Region.

- To obtain better estimates of the size of the unrecorded market, including smuggled products.
- To identify scope and scale of the potential health risk from unrecorded alcohol.
- To strengthen legal measures and develop community intervention programmes to reduce the sale and availability of illicit alcohol.

Area 10: Monitoring and surveillance systems of harmful use of alcohol

Monitoring and surveillance of the alcohol situation, magnitude of alcohol-related harm as well as national and subnational response are crucial for all stages of the alcohol policy process, from policy agenda-setting, formulation, implementation to evaluation. The lack of comprehensive and up-to-date information on national and local alcohol consumption situation and magnitude of alcohol-related harm limits the opportunity for Member States to advance alcohol policy as well as fit it to country context and situations. Among those Member States with alcohol policy in place, the lack of information on its implementation curbs the ability to strengthen and sharpen policy enforcement.

To support policy process at the national level, Member States need to strengthen the monitoring and surveillance system on a comprehensive basis, including addressing the availability of evidence, regularity of surveillance data, data quality and validity, and coverage of data among key population groups, especially vulnerable population groups.

In-demand alcohol-related information consists of three data sets: alcohol consumption, alcohol-related harm and alcohol policy. Member States might consider developing these three datasets in a stepwise basis. The first and most-commonly used data are on alcohol consumption situations in general and among population groups of concerns. Specific attention needs to be paid on the quality of consumption data. Then, if Member States already have good quality of consumption data, they should

aim at ensuring availability of valid data on alcohol-related harm and alcohol policy. Meanwhile, surveys are not the only source of data. Many useful alcohol-related data can be archived from registry data, such as hospital and police records as well as industry, production and taxation sources.

Policy situation

The most urgent need for Member States of the South-East Asia Region is to promote the availability and validity of basic information on alcohol consumption patterns. Most Member States have had national surveys, providing fundamental information on alcohol consumption, including prevalence of drinking, frequency and volume of alcohol consumption. This information on alcohol is collected either through an alcohol-specific survey or, more commonly, a part of broader multi-risk surveys, such as the NCD STEP survey. These two options should not be regarded as an alternative to each other, but as more synergistic. While alcohol-specific surveys could provide more in-depth information, they often come with costly investment for the macro scale. On the other hand, multiple risk surveys could provide basic data on the aggregated situation, particularly on the co-existence of multiple risks, but quality and accuracy of data are often overlooked in such big survey settings. Apart from availability of evidence, population coverage of a key population is crucial in the formulation of an effective policy, particularly on local and targeted interventions. In the SEA Region, general adult drinking consumption is primarily reported, but vulnerable groups like consumption among adolescents, women and some particular ethic groups are often neglected.

Second and third data components, alcohol-related harm and alcohol policy are scarcer in the Region. Few countries like India, Sri Lanka and Thailand have included monitoring on alcohol-related problems that deal with health and social harm. Moreover, only Thailand provided regular monitoring of alcohol-related harm. To implement an effective alcohol control policy, comprehensive evidence should have been promoted. Most countries have not made efforts to produce effective evidence.

Significantly, the surveys conducted in many Member States, including Bhutan, Bangladesh, Indonesia, Maldives, Myanmar, Nepal and Timor-Leste contain only a few questions on drinking prevalence and basic drinking patterns, neglecting a broad view of alcohol consumption patterns, alcohol-related harm and policy response. This is largely due to the nature of viewing alcohol as a minor component within other areas such as NCDs, demographic and health surveys. For example, the STEPS surveys primarily focused on NCD risk factors and included a few items on patterns of alcohol consumption. The Demographic and Health Survey in Indonesia and Sri Lanka also integrated patterns of alcohol use and age onset of drinking. These multi-risk surveys generally are limited in reporting accurate and valid data to be utilized in the alcohol policy process. To make it operationally feasible, some surveys ask only about drinker status, average volume consumed per occasion and drinking frequency, which could hardly provide the real consumption situation at the individual and collective level.[58]

Regularity of surveillance and monitoring is fundamental in any effort to strengthen implementation and enforcement of an alcohol control policy. In the SEA Region, promoting regularity of monitoring the alcohol consumption situation, alcohol-related harm and policy progress is neglected in most countries.

To promote availability and validity of information and its translation to policy, Member States might have to consider establishing and strengthening comprehensive mechanisms and institutions to be responsible for alcohol-related information. The lack of alcohol-related data is partly because most Member States do not have clear designated agencies on tackling alcohol-related problems. Health agencies, particularly ministries of health and their subdivisions are responsible for monitoring alcohol-related situations in some Member States. Meanwhile, some Member States assign this task to academic

institutions, such as universities. And more common, the responsibility of alcohol policy monitoring and surveillance is fragmented and allocated to many agencies.

However, development of national and subnational targets and indicators on alcohol is in much better shape particularly after adoption of the Global and Regional Voluntary Targets in NCD Prevention and Controls in 2013, where there was a unanimous agreement on a 10% relative reduction of harmful use of alcohol.[59,60] Later, the Region agreed to use the APC (unit of litre of ethanol per adult population per year) as the indicator. Since then, the issues of monitoring agencies and regularity of reports have been discussed and planned.

Capacity and resource mobilization are important in strengthening the monitoring and surveillance system. Limited resources can diminish national organization and network capacity to work strategically. In most countries in the Region, resources are fragmented, and thus countries have to rely on support from international organizations in some Member States.

Recommendation

- Develop an alcohol policy monitoring and surveillance strategy, preferably as part of the comprehensive national strategy to address alcohol-related harm.
- Set up national and/or subnational target(s) and indicator(s) on alcohol policy, relevant to the general population and population groups of concern, as appropriate, preferably in line with the already committed targets on NCD prevention and control.
- Promote comprehensive evidence, including alcohol consumption situation, alcohol-related harm and policy responses.
- Strengthen existing national surveys that include alcohol as a component to be more comprehensive.
- Promote collaboration and capacity-building between responsible agencies and other partners in generating and translating evidence to policy and practice.
- Strengthen collective capacity and resource mobilization on alcohol policy monitoring and surveillance.

PART 3:
Conclusion and recommendation

This report reaffirms the urgent need to strengthen the national response to alcohol-related problems in most countries in the South-East Asia Region. This is regardless of the prevalence and explicitness of alcohol use in societies. In some low-drinking prevalence and low-average consumption volume settings, those who drink alcohol consumed in harmful ways are no different from drinkers in high-prevalence societies. Alcohol use is culturally embedded in many societies. Meanwhile, unrecorded alcohol consumption is rampant, sharing over half of total ethanol consumption in the Region, including the use of many indigenous, traditional and illegal alcoholic beverages.

In most societies, alcohol use has been of public concern, particularly among vulnerable population groups, including youth and young adults. The Region has witnessed the sharp increase in alcohol use, especially among those population groups with conventionally low drinking. Economic growth, demographic change and modernization all make the Region one of the alcohol emerging markets to the alcohol industry. The impact of the alcohol problem on the achievement of human, social and economic development has been broadly recognized in the Region. Alcohol consumption leads to many negative consequences on all dimensions of health; physical, mental, social and spiritual; acute and chronic. The extent of alcohol-related harm is not confined only to drinkers. Their family, surrounding people, community and society as a whole together bear great burdens derived from drinkers. Alcohol is associated with a wide range of social problems; for instance, increased burden of health-care cost, property damage and loss of productivity. Among young drinkers, alcohol consumption is a gateway to other problems and undesirable behaviours.

The **WHO Global Strategy to Reduce Harmful Use of Alcohol** provides a list of possible policy options in 10 areas. It reflects political commitment to address alcohol problems as the first alcohol policy initiative at the global level. The Global Strategy, however, does not earmark cost-effective and effective interventions. Meanwhile, advances in technical knowledge, which could differentiate effective public policy interventions from those that are ineffective, have not been fully translated into practice. Among many policy normative movements, the WHO Global Status Report on Noncommunicable Diseases lists three 'Best Buy' population-wide interventions, including taxation, marketing regulations and physical availability control. This report analyses the situation of alcohol policy according to the 10 areas of the Global Strategy.

Despite the high magnitude and variety of alcohol-related problems and high public concern, there are many system weaknesses in the Region, stemming from drawbacks in alcohol policy content, implementation, information system, coordination mechanism, resources and alcohol policy governance.

First, effective alcohol policy interventions are not very popular among Member States of the SEA Region. The lack of comprehensive alcohol policy framework and weak policy content are common manifests in the Region. Outdated and poor coverage legal frameworks and definitions of alcohol, determinants and related behaviours are a few examples.

Weakness in policy implementation, particularly law enforcement, could hamper the theoretical effectiveness of alcohol policy in Member States of the SEA Region. Despite their illegal status, smuggling and untaxed alcoholic beverages, sale of alcohol to underage minors and drink-driving offenders are commonly found.

Information system on alcohol and alcohol policy holds the potential to be the backbone of alcohol policy development. Low availability and validity of alcohol-related information could largely hamper the collective effort to address alcohol-related problems. However, an effective information system needs continuous long-term investment. Multisectoral coordination mechanisms and a designated public agency for alcohol policy development as well as monitoring and evaluation are subjects for urgent attention.

Overarching recommendations to SEA Region Member States:

(1) Establish a working group/committee to review situations and policy, and system gaps in addressing alcohol-related problems.

(2) Set up national and subnational targets for alcohol policy.

(3) Strengthen a comprehensive alcohol policy framework to address alcohol-related problems, with particular focus on effective and cost-effective interventions.

(4) Overhaul the national information system, including research and surveillance for alcohol consumption and related harm, and promote the translation of knowledge into policy process.

Overarching recommendations to WHO Regional Office for the SEA R.

(1) Strengthen the implementation of the Regional Action Plan for Reducing the Harmful Use of Alcohol, especially to provide technical support and build capacity of Member States.

(2) Continue to support capacity strengthening and international collaboration mechanisms, including network of experts and national counterparts..

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Annex

Monitoring and surveillance among South-East Asia Member States

Countries	Survey	Year*	Responsible agencies	Funders	Sample size(n)**	Variables	Level of survey	Note
Bhutan	Bhutan Living Standard Survey[61]	2003, 2007, 2012	National Statistics Bureau	National Statistics Bureau, Bhutan and Asian Development Bank	8968 households with a total of 39 825 persons	Alcohol expenditure, volume and beverage types	National level	
	Gross National Surveys[62]	2007, 2010	Centre for Bhutan Studies (CBS) and GNH Research and National Statistics Bureau (NSB)	The Royal Government of Bhutan, International Development Research Centre (IDRC)	7142, including all age groups	Onset of drinking, frequency of drinking and heavy drinking	National level	
	STEPS[63]	2004, 2007	Ministry of Public Health, Bhutan	WHO	2484 individual, aged 25–75 years	Frequency and volume	Subnational level	
Bangladesh	Noncommunicable Disease Risk Factor Survey Bangladesh 2010[64]	2010	Ministry of Health and Family Welfare, Bangladesh Society of Medicine, WHO and Directorate General of Health Services	Ministry of Health and Family Welfare	9275 respondents, aged 25 years or above	Frequency, volume and binge drinking	National level	Survey is included diet, tobacco, physical activity, obesity, blood pressure and diabetes mellitus
India	National Survey on Extent, Pattern and Trends of Drug Abuse in India[65]	2001	United Nations Office on Drug and Crimes and Ministry of Social Justice and Empowerment	United Nations Office on Drug and Crimes and Ministry of Social Justice and Empowerment	40 697 males, aged 12–60 years	Prevalence and alcohol dependence	National level	
	Alcohol consumption in India: a cross-sectional study[66]	1997	Department of Psychiatry and Drug Dependence Treatment Centre and all India Institute of Medical Sciences	Ministry of Health	32 019, aged 15 years or above	Frequency, Quantity, heavy drinkers and alcohol-related problems, including health and social harms	Subnational level	

Countries	Survey	Year*	Responsible agencies	Funders	Sample size(n)**	Variables	Level of survey	Note
	GENACIS[67]	2003	WHO	WHO	2979 respondents, aged 15 and above	Alcohol consumption patterns and health and social harms	subnational level	
	STEPS survey[68]	2004, 2007	Ministry of Health and Family Welfare Government of India, National Institute of Medical Statistics, National Institute of Communicable Diseases and Indian Council of Medical Research	World Bank	38 054 individuals, aged 15–64 years	Frequency, volume and age onset of drinking	subnational level	
	Global School-based Student Health Survey[69]	2007	Central Board of Secondary Education	NA	8130 respondents, aged 13–15 years	Place of drinking, alcohol advertisement, and familial environment for alcohol[70]	National level	
Indonesia	Indonesia demographic and health survey 2012: adolescent reproductive health[71]	2012	Statistics Indonesia, National Population and Family Planning Board and Ministry of Health	Government of Indonesia and U.S. Agency for International Development (USAID)	43 852 households, aged 15–24 years	frequency, volume, age onset of drinking and heavy drinking	National level	
	STEPS survey[72]	2001, 2003, 2006	Centre for Disease Control Research, Development NHRD Ministry of Health and WHO	WHO Regional Office, WHO Headquarters, WHO Country Office, WHO SEARO and WHO KOBE Centre	1927 respondents, aged 25–64 years	Frequency, volume and binge drinking	National survey in 2001 and 2003 and 2006 are subnational survey	Survey is included smoking, alcohol consumption, diet, physical activity, physical measurements, blood pressure, and biochemical measurements

Countries	Survey	Year*	Responsible agencies	Funders	Sample size(n)**	Variables	Level of survey	Note
	Global School-based Student Health Survey[73]	2007	Ministry of Health, Indonesia, World Health Organization, and Centre for Disease Control and Prevention	NA	3116 respondents, aged 13–15 years	Frequency, volume, social supply, heavy drinking, health and social consequences[74]	National level	
Maldives	National Drug Use Survey[75]	2012	Government of Maldives and United Nation Office on Drugs and Crime	European Union and Government of Sweden	932 current drug users aged 15–64 years	Prevalence, age onset of drinking, and alcohol dependence	National level	
	Global school- base student health survey[76]	2009	Ministry of Education, Ministry of Health and Family, World Health Organization and Centre for Disease Control and Prevention	World Health Organization and Centre for Disease Control and Prevention	3241 sample from 39 schools, aged 13–15 years	Prevalence, age onset of drinking, frequency of drinking, volume, heavy drinking	National level	
	Maldives study on women's health and life experiences[77]	2006	Ministry of Gender and Family	UNICEF and the United Nations Population Fund (UNFPA)	2584 households, women aged 15–49 years	Domestic partner related to alcohol consumption of partners	National level	
Myanmar	STEPS[78]	2004, 2009	Ministry of Health Myanmar and WHO	WHO	7429 individuals, aged 15–64 years	frequency, volume and binge drinking	Subnational in 2004 and national level in 2009	
	Global School-based Student Health Survey[79]	2007	World Health Organization and Centre for Disease Control and Prevention	NA	2806 students, aged 13–15 years	Age onset, frequency of drinking, volume, beverage types, social supply, heavy drinking, and health and social consequences	National level	

Countries	Survey	Year*	Responsible agencies	Funders	Sample size(n)**	Variables	Level of survey	Note
Nepal	Noncommunicable diseases risk factors: STEPS survey Nepal 2013[80]	2008, 2013	Government of Nepal, Ministry of Health and Population, Nepal Health Research Council and WHO Country Office Nepal	WHO Country Office Nepal and Government of Nepal	4200 individuals, aged 15–69 years	frequency, volume and binge drinking	National level	
	Alcohol and drug use in Nepal with reference to children[81]	2000	Child Workers in Nepal Concerned Centre	FORUT, Norway	2333 households, adult members and children age 10–17 years	Pattern of alcohol use, beverage types, familial environment for alcohol use and problems in family	National level	
Sri Lanka	SPOT survey2012[82]	Biannually since 1998	Alcohol and Drug Information Centre	NA	2242 male respondents, aged 15 years and above	Prevalence, frequency, types of alcohol use, age onset and social supply	Subnational level	
	GENACIS	2001	World Health Organization	World Health Organization	1200 respondents, aged 15 years and above	Alcohol consumption, health and social consequences	National level	
	National Survey on Emerging issues among adolescents in Sri Lanka[83]	2004	Medistat Research (Pvt) Limited and UNICEF Sri Lanka	NA	29 911 at school-going adolescents (10–19 years) and 10 079 out-of-school adolescents (15–19 years)	Prevalence, age onset, beverage types, attitudes towards alcohol, and harms from father's drinking	National level	
	Demographic and health survey[84]	1987, 1993, 2000, 2007	Department of Census and Statistics and Ministry of Healthcare and Nutrition	World Bank	14 692 respondents, ever-married women age 15–49 years	Frequency, beverage types, onset of drinking	National level	
	STEPS[85]	2003, 2006	Directorate of Non-communicable disease, Ministry of Healthcare and Nutrition	NA	12 500 individuals, aged 15–64 years	Prevalence, frequency and volume	2003 at subnational level and 2006 at national level	

Countries	Survey	Year*	Responsible agencies	Funders	Sample size(n)**	Variables	Level of survey	Note
Thailand	Cigarette Smoking and Alcoholic Drinking Behaviour Survey[86]	Every 3 years since 2001	National Statistical Office	Centre for Alcohol Studies and National Statistical Office	All members from 66 300 households age 11 years and above	Prevalence, frequency, volume, beverage types, binge drinking, unrecorded alcohol, location of drinking and sale, alcohol expenditure, health and social harms and law enforcement	National level	
	National Health Exam Survey[87]	Every four years since 1991	National Health Examination Survey Office and Health System Research Institute	Health System Research Institute, Ministry of Public Health, Thai Health Promotion Foundation, National Health Security Office, and Health Information System Development Office	30 000 individuals, age 1 year and above	Prevalence, frequency, beverage types, volume, binge drinking, age onset of alcohol drinking, unrecorded alcohol, alcohol use disorder and health and social harms	National level	
	Global School-based Student Health Survey[88]	2008	Department of Health, Ministry of Public Health, World Health Organization and Centre for Disease Control and Prevention	World Health Organization	2767 individuals, aged 13–15 years	Prevalence, heavy drinking and health and social harms	National level	
	Health Welfare Survey[89]	Since 1996 every 2 years	National Statistical Office	National Statistical Office	All household members from 27 960 households, aged 11 years	Prevalence of drinking, frequency and beverage types	National level	

Countries	Survey	Year*	Responsible agencies	Funders	Sample size(n)**	Variables	Level of survey	Note
	Household Socioeconomic Survey[90]	Biannually since 1957 and annually since 2008	National Statistical Office	National Statistical Office	52 000 households	Alcohol expenditure	National level	
	Behavioural Risk Factor Surveillance System[91]	2003, 2004, 2005, 2007, 2010	Department of Disease Control, Ministry of Public Health	Department of Disease Control, Ministry of Public Health	130 849 respondents, aged 15–74 years	Prevalence, heavy drinking and binge drinking	National level	
Timor-Leste	Demographic and Health Survey[92]	2009	National Statistics Directorate, Ministry of Finance	USAID, Government of Australia (AusAID), Government of Ireland (IrishAID), UNFPA, UNICEF, UNDP and WHO	15 600 respondents, aged 15–49 years	Drinking of husbands and drinking during sexual intercourse	National level	
	Timor-Leste Household Income and Expenditure Survey 2011[93]	2011	National Statistics Directorate and General Directorate for Analysis and Research, Ministry of Finance	National resources	4800 households	Alcohol expenditure	National level	
DPR-Korea	STEPS[94]	2005, 2007, 2008	Department and Prevention and NCD Programme, MOPH and WHO	WHO	5742 individuals, aged 25–64 years	Prevalence of drinking, volume and heavy drinkers	Subnational level	

Note: * refers to the years that surveys were taken place.
** Sample size means the respondents that complete interviews/questionnaires.

This report on 'Alcohol Policy in the WHO South-East Asia Region' enumerates the progress made in alcohol policy development in WHO South-East Asia Region Member States since the endorsement of the Global Strategy to Reduce the harmful Use of Alcohol in 2010. The purpose of this report is to review the situation of alcohol policy interventions in the WHO South-East Asia Region Member States, based on the Global Strategy to Reduce the Harmful Use of Alcohol. Evidence shows that the overall situation of policy implementation and intervention to address harms from alcohol in the WHO South-East Asia Region are far from adequate. The report aims to help policy-makers and programme managers identify the areas that need attention and to work towards effective implementation and enforcement of policies and legislations.

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