

Epidemiology

of alcohol use in the WHO
South-East Asia Region



World Health
Organization

REGIONAL OFFICE FOR South-East Asia

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Preface

This publication aims to summarize the current information related to alcohol use in the Who South East Asia Region. It draws information from many authoritative sources including the WHO Global Status Report on Alcohol and Health 2014, The WHO Global Information System on Alcohol and Health (GISAH) and several respected high-impact journals. It is mainly in two parts, the first part outlining the current information available at Global, Regional and Country level, and the second part provides a picture of what needs to be done in the context of the Region to address harms of alcohol use, possible barriers and how to overcome them. These two parts can be read independently of each other.

Graphs and tables which clarify the text have been carefully selected from different sources and also generated using data from WHO GISAH, specifically for this publication. As this publication is aimed at a general audience that can include readers with different requirements related to alcohol use information, care was taken to include aspects that will be of interest to a broad audience ranging from policy makers, researchers, advocates to students.

Abbreviations

CSR	corporate social responsibility
DALYs	disability adjusted life-years
GATS	General Agreement Trade-Related Services
GISAH	Global Information System on alcohol and health
HED	heavy episodic drinking
IARD	International Alliance for Responsible Drinking
ICAP	International Center for Alcohol Policies
RTA	road traffic accident
SEAR	South-East Asia Region
SEARO	South-East Asia Regional Office
SPS	Sanitary and Phytosanitary Measures
TBT	Technical Barriers to Trade
TRIPS	Trade-Related Intellectual Property Rights
WHO	World Health Organization

1. Global Situation

Summary Points

The highest numbers of deaths caused by alcohol are from cardiovascular diseases, followed by injuries, gastrointestinal diseases and cancers

Alcohol consumption is the world's third largest risk factor for disease and disability; in middle-income countries, it is the greatest risk

Harmful use of alcohol is the leading risk factor for death in males ages 15–59, mainly due to injuries, violence and cardiovascular diseases

In poorer countries, the morbidity and mortality risks are higher per litre of pure alcohol consumed than in higher-income countries

Worldwide, 61.7% of the population aged 15 years or older (15+) had not drunk alcohol in the past 12 months

Abstinence rates are very important as any lowering of the rate will signal increased population- level harms

Overall, alcohol consumption is associated with multiple health risks that, at the population level, clearly outweigh potential benefits.

An individual's risk of an acute alcohol-related condition, such as injuries and heart attacks, becomes higher with the frequency of consumption. This risk rises exponentially, when increasing volumes are ingested in each drinking occasion

At an individual level, the larger the total volume of alcohol consumed in one's life, the higher the risk of chronic alcohol-related conditions

1.1 Current epidemiological information

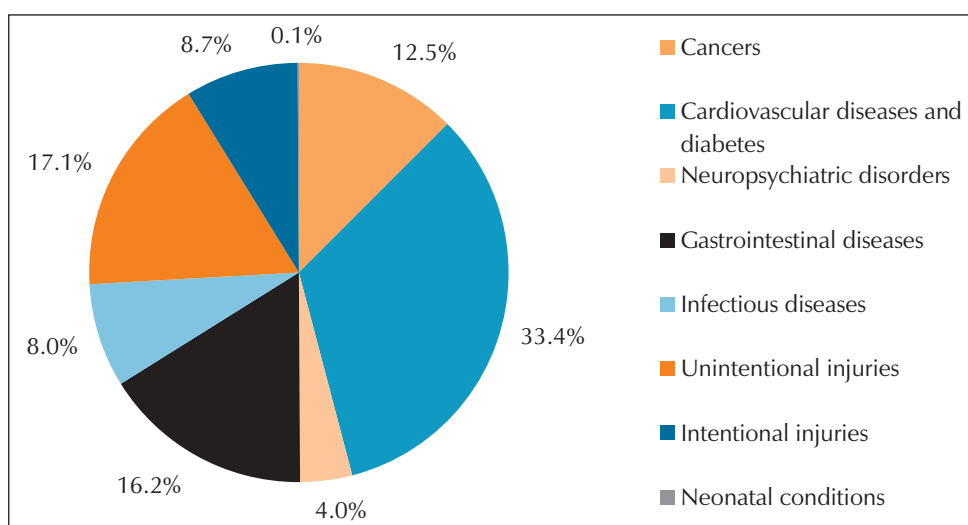
Alcohol is a causal factor in more than 200 health conditions and results in approximately 3.3 million deaths each year. This accounts for almost 6% of all deaths. In addition, 5.1% of the global burden of disease is attributed to alcohol. Alcohol is also associated with many serious social issues, including violence, child neglect and abuse, and absenteeism in the workplace.

Researchers have identified dose-response relationships for most diseases and injuries causally impacted by alcohol. One such example is alcohol-attributable cancers – the higher the consumption of alcohol, the larger the risk for these cancers. Overall, the highest numbers of alcohol-related deaths are from cardiovascular diseases, followed by injuries, gastrointestinal diseases and cancers as shown in figure 1.

Alcohol consumption and problems related to alcohol vary widely around the world, but the burden of disease and death remains significant in most countries. Alcohol consumption is the world’s third largest risk factor for disease and disability. In middle-income countries, it is the greatest risk.

Due to the growing global population and the predicted global increase in alcohol consumption, alcohol-attributable disease burden as well as the social and economic burden will keep increasing unless effective prevention policies and interventions are implemented worldwide. Significantly, **in poorer countries, the morbidity and mortality risks are higher per litre of pure alcohol consumed than in higher-income countries.**

Figure 1: Alcohol-attributable deaths, as a percentage of all alcohol-attributable deaths in 2010



Total number of deaths – 3.3 million

Source: Data from Global Status Report on Alcohol and Health 2014, Figure 15.

Unfortunately, in general, alcohol control has received a low priority in many countries in public policy, despite the large health, social and economic burden associated with its use.

Abstinence rates are very important as any lowering of the rate will signal increased population-level harms. Worldwide, 61.7% of the population aged 15 years or older (15+) had not drunk alcohol in the past 12 months. In all WHO regions, females are more often lifetime abstainers than males. There is a considerable variation in prevalence of abstinence across WHO regions.

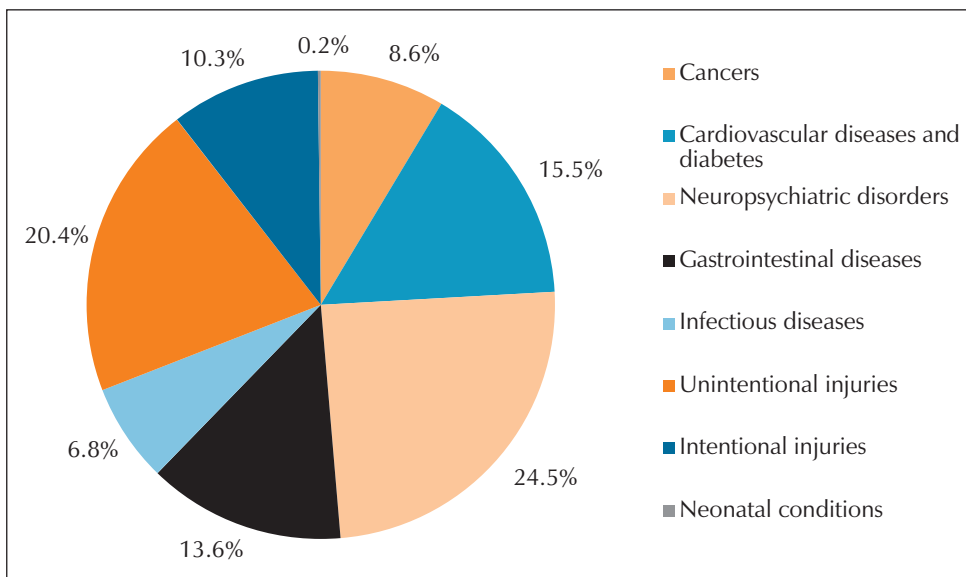
Heavy episodic use of alcohol is a significant factor in acute and chronic health and social harms of alcohol. Around 16.0% of drinkers aged 15 years or older engage in heavy episodic drinking (HED) worldwide.

Harmful use of alcohol is a particularly grave threat to men. It is the leading risk factor for death in males ages 15–59, mainly due to injuries, violence and cardiovascular diseases. Globally, 7.6% of all male deaths are attributable to alcohol, compared with 4% of female deaths in 2012.

In men, the commonest cause of alcohol-related deaths was injuries, while in women it was cardiovascular diseases. Men also have far greater rates of total burden attributed to alcohol than women – 7.4% for men compared with 2.3% for women.

There is also evidence that women may be more vulnerable to alcohol-related harm from a given level of alcohol use or a particular drinking pattern. Men outnumber women four to one in weekly episodes of heavy drinking – most probably the reason for their higher death and disability rates. Men also have much lower rates of abstinence compared with women. Lower socioeconomic status and educational levels result in a greater risk of alcohol-related death, disease and injury – a social determinant that is greater for men than for women.

Figure 2: Alcohol-attributable burden of disease, as a percentage of all alcohol-attributable DALYs, 2010



Total disability-adjusted life years (DALYs): 139 million

Source: Data from Global Status Report on Alcohol and Health 2014, Figure 15.

Figure 2 shows the morbidity related to alcohol which is a significant contribution to global disability adjusted life-years (DALYs). Unlike alcohol related deaths, neuropsychiatric conditions consist of a significant proportion of alcohol related DALYs.

Alcohol consumption also affects society at large. Harmful alcohol consumption is risky both for the drinker and for other people. An intoxicated person can put people in harm's way by involving them in traffic accidents or violent behaviour, or by negatively affecting coworkers, relatives, friends or strangers. Death, disease and injury caused by alcohol consumption have socioeconomic impacts, including the medical costs borne by governments, and the financial and psychological burden to families. The hazardous and harmful use of alcohol also impacts on workers' productivity. Perhaps the biggest social impact is crime and violence related to alcohol consumption, which create significant costs for justice and law enforcement sectors.

1.2 Individual-level risks

The risk of an acute alcohol-related condition increases from zero consumption in a dose–response manner with frequency of drinking and exponentially with the amount drunk on any one occasion.¹ This means that the risk of an acute alcohol-related condition, such as injuries and heart attacks, becomes higher with the frequency of consumption. This risk rises exponentially when larger and larger volumes are ingested in each drinking occasion.

The risk of a lifetime-attributable death from a chronic alcohol-related condition is found to increase linearly from zero consumption in a dose–response manner with the volume of alcohol consumed. In other words, the larger the total volume of alcohol consumed in one’s life, the higher the risk of chronic alcohol-related conditions, such as cancers, cirrhosis and heart diseases.

Although a beneficial effect on cardiovascular diseases and ischemic strokes have been shown for very low levels of consumption, it disappears in with heavy drinking occasions. This lowering of risk is not seen for hypertension, haemorrhagic stroke and cancers regardless of the drinking pattern. For example, consumption as low as one drink per day will substantially increase the risk of breast cancer.

1.3 Population-level risks

Drinking at low levels without episodes of heavy drinking may be associated with a reduced risk of several types of cardiovascular outcomes **in some segments of the population**. However, these effects tend to disappear if the patterns of drinking are characterized by heavy episodic drinking. As alcohol causes many other diseases in addition to cardiovascular diseases, **overall, alcohol consumption is associated with multiple health risks that, at the population level, clearly outweigh potential benefits.**²

¹ Evidence for the effectiveness and cost–effectiveness of interventions to reduce alcohol-related harm. World Health Organization 2009. http://www.euro.who.int/__data/assets/pdf_file/0020/43319/E92823.pdf. Accessed 01 October 2014.

² Mendis S. Puska P. Norrving B. Eds. Global Atlas on Cardiovascular Disease Prevention and Control. World Health Organization, World Heart Federation and the World Stroke Organization 2011.

2. Comparative Situation in SEAR

Data published in the 2014 Global Status Report on Alcohol and Health show that the global total per capita consumption (15+ years) has increased slightly between the years 2006 and 2010. Significantly, as shown in table 1 below, when the WHO regions are analysed, regional increases in consumption were only seen in the WHO South-East Asia Region and the WHO Western Pacific Region. In contrast, there has been a decrease in per capita consumption in the WHO African Region, the WHO Region of the Americas and particularly in the WHO European Region. But yet, the adult per capita consumption of alcohol in WHO-SEAR was the second lowest at 3.4 litres in 2010.

Table 1: Total alcohol per capita consumption (APC) and unrecorded APC (in litres of pure alcohol) and the proportion (%) of unrecorded APC of total APC, as well as the prevalence (%) of current drinkers, all among the total adult (15+ years) population by WHO region, 2005 and 2010

WHO regions	Total APC		Unrecorded APC		Proportion of unrecorded APC of total APC (%)		Prevalence of current drinkers (%)	
	2005	2010	2005	2010	2005	2010	2005	2010
AFR	6.2	6.0	1.9	1.8	31.4	29.3	29.2	29.8
AMR	8.7	8.4	2.0	1.2	23.1	14.4	58.3	61.5
EMR	0.7	0.7	0.4	0.4	56.2	54.5	3.5	5.4
EUR	12.2	10.9	2.7	1.9	21.9	17.1	68.8	66.4
SEAR	2.2	3.4	1.5	1.6	69	47.4	10.7	13.5
WPR	6.2	6.8	1.6	1.7	36.2	25.1	56.3	45.8
World	6.1	6.2	1.8	1.5	28.7	24.8	41.8	38.3

Source: Table 6 of Global Status Report on Alcohol and Health 2014.

2.1 Other comparisons

Compared with other regions (except the Eastern Mediterranean Region), the WHO South-East Asia Region had a lower percentage of alcohol dependents (2.2%) as seen below in table 2.

**Table 2: Regional prevalence of alcohol dependence 2010
among adults (15+ years)
(International Classification of Diseases and Related Health Problems
Revision 10: F10.2 Alcohol dependence)**

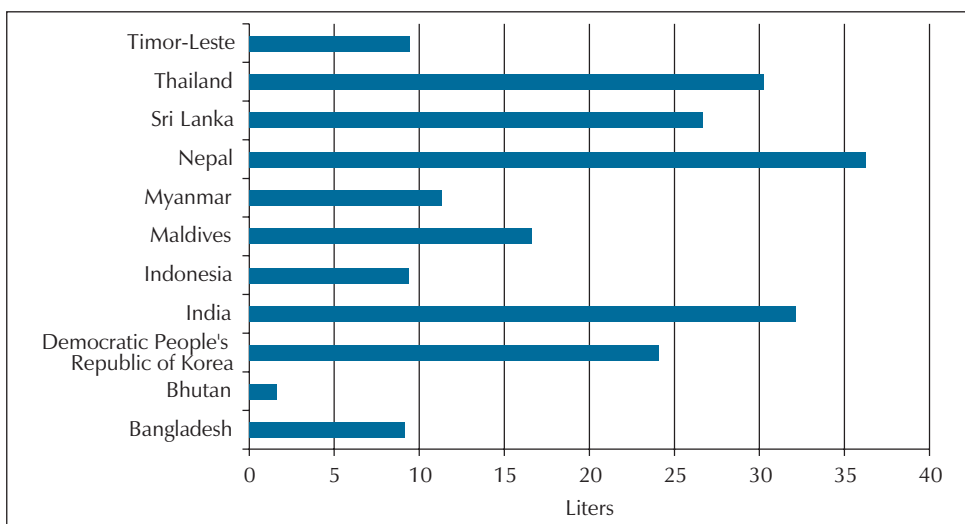
WHO Region	Prevalence (%)
Africa	3.3
Americas	6.0
South-East Asia	2.2
Europe	7.5
Eastern Mediterranean	0.3
Western Pacific	4.6
Global	4.1

Source: WHO Global Information System on Alcohol and Health, accessed 1 October 2015.

- Worldwide, the alcohol-attributable fraction of all-cause death was 5.9, while it was 4.6 in SEAR. The WHO European Region has the highest rate – 13.3.
- The picture is similar when the alcohol-attributable fractions of all-cause DALYS are taken into account. Worldwide, the fraction was 5.1 and in SEARO, it was 4.0; EURO has the highest fraction of 12.8.
- Unrecorded consumption is relatively high – almost 50% of per capita consumption in SEAR. In some SEAR countries, it is several times the recorded per capita consumption. In lower middle- and low-income countries in the WHO South-East Asia Region, such as Bhutan, India, Nepal and , home-made spirits constitute a high proportion of total alcohol consumed.
- When the types of alcohol consumed are taken into account, SEAR is in a unique situation where more than 77% of the recorded consumption is in the form of spirits. Here, the proportion of consumption of beer at 22.3% is the lowest among all regions. Worldwide, the average consumption of sprits is 50.1% and for beer, it is 34.8%.

- Overall, 21.7% of adults and 5% of females were current users of alcohol. It is relatively low compared with other regions, such as Europe (73% and 60%) and the Americas (73% and 58%). However, the overall average in SEAR will be largely influenced by two mega countries, Bangladesh and Indonesia, where the consumption rates are very low.
- When rates of abstention are considered, SEAR is still in a relatively good situation. 76.6% of adults above the age of 15 did not consume alcohol during the past year, in 2010 or were lifetime abstainers or ex-users. Abstention from alcohol use in a population is an important mediating factor determining the level of alcohol-attributable harm in that population. Any diminution in abstention levels could have a significant impact on the burden of disease caused by alcohol.
- Although the percentage of population that abstained from consuming alcohol is high in most SEAR countries, the per capita consumption of male alcohol users above the age of 15 was also high in several countries as seen in figure 3.

Figure 3: Per capita consumption of adult male (15+) alcohol users in 2010 – SEAR



Source: Generated using data from WHO Global Information System on Alcohol and Health.

- In SEAR, 12.4% of users indulged in Heavy episodic Drinking (HED). HED is an indicator of the pattern of alcohol consumption defined as 60 or more grams of pure alcohol on at least one single occasion at least monthly. Many

acute consequences of alcohol, such as injury and violence, are related to the volume of alcohol consumed on a single occasion.

- Drinking large quantities of alcohol in drinking occasions brings detrimental consequences even if the average level of alcohol consumption of the person concerned is relatively low. Although it is comparatively low when other regions are considered, the absolute numbers are very large due to the very large population in the Region.
- In the adolescent age group (15–19 years) in SEAR, over 85% are abstainers. This is significantly above the world average of 53.9%.
- Prevalence of alcohol use disorders was 1.7% in SEAR in 2010, which was relatively low compared with the Americas. Europe, the Western Pacific. The global average was 2.9, as shown in table 3 below.

Table 3: Regional prevalence of alcohol use disorders during 2010 among adults (15+ years) (International Classification of Diseases and Related Health Problems Revision 10: F10.1 Harmful use of alcohol and F10.2 Alcohol dependence)

WHO Region	Prevalence (%)
Africa	1.4
Americas	3.4
South-East Asia	1.7
Europe	4.0
Eastern Mediterranean	0.2
Western Pacific	2.3
Global	2.9

Source: WHO Global Information System on Alcohol and Health, accessed 1 October 2015.

A study conducted by WHO-SEARO³ found that “pay-day drinking” was common in the three countries where the survey was conducted. This refers to consuming alcohol when they receive their salary (usually monthly) or when farmers, fishermen, etc. obtain cash when they sell their products. This practice sees relatively large parts of their earnings spent on alcohol. Consuming large amounts of alcohol on these

³ Programme on reducing harm from alcohol use in the community. Alcohol Control Series No.7. World Health Organization Regional Office for South-East Asia 2009.

occasions exposes these users to acute consequences of alcohol use, such as injuries and accidents. Such outcomes can further exacerbate widespread poverty owing to the economic impact and also breadwinners of families being affected.

The same study found that the use of alcohol in “special” occasions, such as social gatherings, festivals or other instances where groups of people gather, is common in the Region. This indicates the “alcoholization” of special social and cultural occasions and will contribute to promoting alcohol use among different groups.

Summary Points

Globally, the adult per capita consumption has increased between 2005 and 2010, driven only by the increases in WHO South-East Asia and Western Pacific regions

Unrecorded consumption is almost 50% of per capita consumption in SEAR. In some SEAR countries, it is several times the recorded per capita consumption

Over 75% of the recorded consumption is in the form of spirits in SEAR. The global figure is 50%

Over 75% of the population of SEAR abstained from drinking alcohol in 2010. In several countries, this rate was over 90%. Any reduction in abstention levels could have a significant impact on the burden of disease caused by alcohol

In the 15–19 year age group in SEAR, over 85% are abstainers. This is significantly above the world average of 53.9%

This Region has a low percentage of alcohol dependents and harmful users

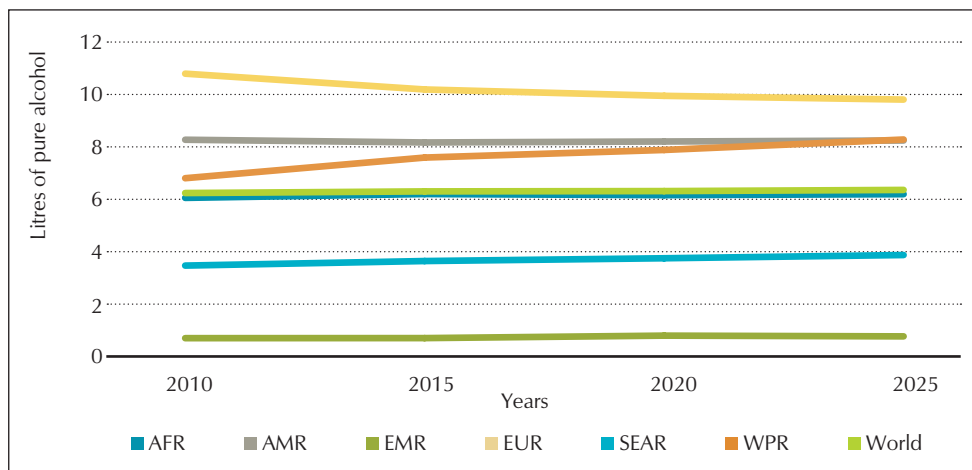
Pay-day drinking and using alcohol on special social and cultural occasions are two factors that are in attention in SEAR

3. Projected trends in consumption

3.1 Projected per capita consumption of alcohol 2010–2025 in WHO regions

Per capita alcohol consumption is expected to rise in the WHO South-East Asia Region between 2010 and 2025 as shown in figure 4. Such an increase will also occur in two other regions as well. Overall, the global per capita consumption will increase as a result.

Figure 4: Total alcohol per-capita (15+ years) consumption by WHO region, 2010–2025



Source: Figure 13, Global Status Report on Alcohol and Health 2014.

Calculation of per capita (or per person) consumption in the future is confounded by population growth. It is expected that the population of SEAR will also increase during the period 2010–2025 as seen in table 4 below. Thus, the projected increase in alcohol consumption in SEAR will occur in an increasing population. Therefore, in simple terms, the number of alcohol users as well as alcohol use per user will increase in SEAR between 2010 and 2025.

Table 4: Projected total per capita consumption in WHO-SEAR countries 2015–2025

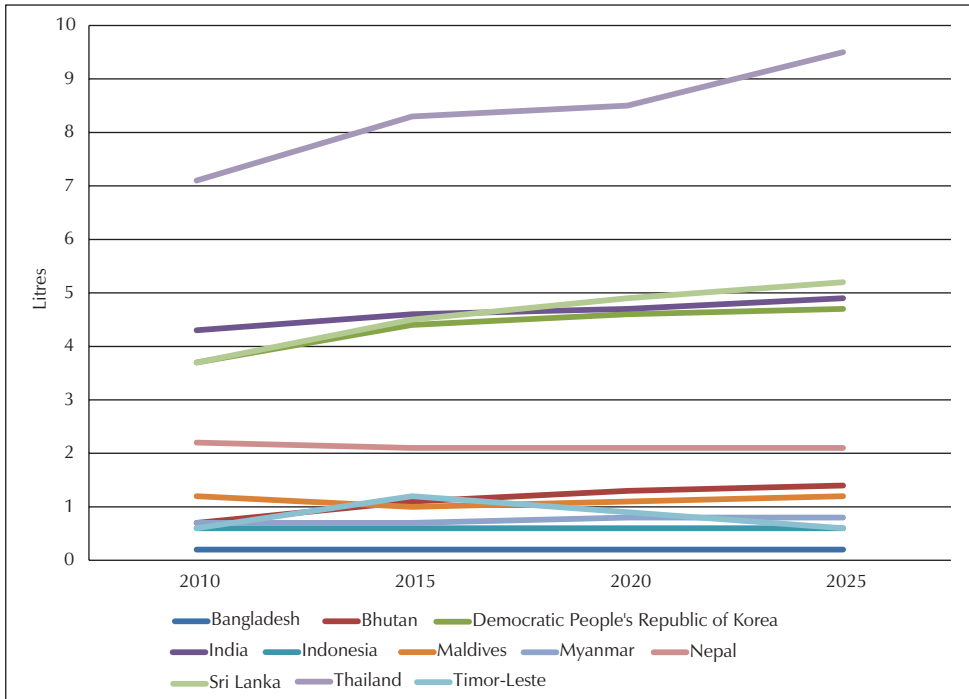
	2015	2020	2025
Bangladesh	0.2	0.2	0.2
Bhutan	1.1	1.3	1.4
Democratic People's Republic of Korea	4.4	4.6	4.7
India	4.6	4.7	4.9
Indonesia	0.6	0.6	0.6
Maldives	1.0	1.1	1.2
Myanmar	0.7	0.8	0.8
Nepal	2.1	2.1	2.1
Sri Lanka	4.5	4.9	5.2
Thailand	8.3	8.5	9.5
Timor-Leste		0.9	0.6

Source: WHO Global Information System on Alcohol and Health, accessed 1 October 2015.

Note: As discussed previously, projections of average per capita consumption is complicated by increasing populations. Even in countries where the per capita consumption is static, the number of users will increase as the population increases, and the total amount of alcohol consumed by the entire population will increase.

As seen in figure 5, some SEAR countries will experience significant increases in per-capita consumption of alcohol in the medium to long term.

Figure 5: Projected total per capita consumption of population above 15 years in SEAR countries, 2010–2025



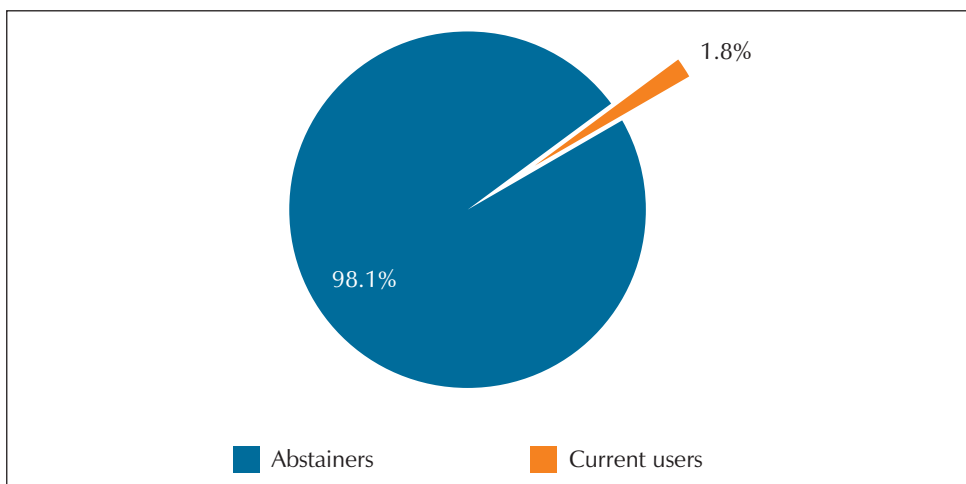
Source: Generated using data from WHO Global Information System on Alcohol and Health. The 2010 data points were obtained from the Statistics Annex of the Global Status Report on Alcohol 2014.

4. Country-specific issues in SEAR: Summary of current epidemiological data from countries⁴

Bangladesh

- Bangladesh records almost zero consumption according to available statistics. Over 98% of those above the age of 15 were abstainers in the year 2010 as shown in figure 6.

**Figure 6: Abstainers and current users above the age of 15
in 2010 in Bangladesh**



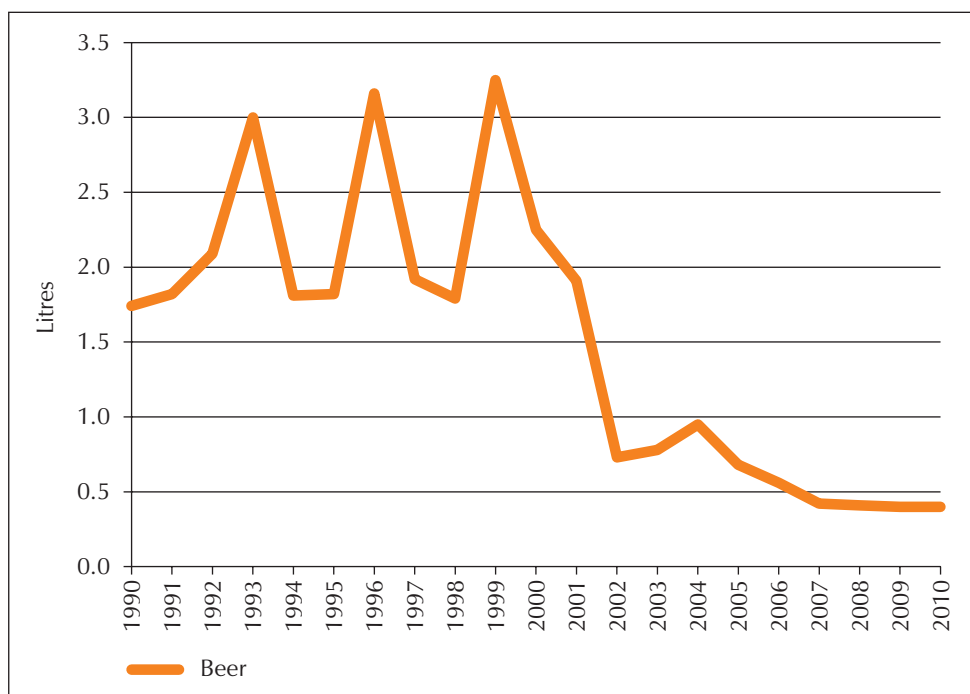
Source: WHO Global Information System for Alcohol and Health.

⁴ Unless otherwise specified, the data are from the WHO Global Status Report on Alcohol and Health 2014 and the WHO Global Information System on Alcohol and Health (GISAH).

Bhutan

- Unlike all other SEAR countries, the recorded per capita consumption was exclusively in the form of beer.
- The total annual average adult per capita consumption was low at 0.7 litres, of which 0.3 litres were unrecorded alcohol. Studies suggest that even the unrecorded consumption is mainly home-made fermented drinks, which are consumed in many social and religious occasions.⁵
- Though the per capita consumption fluctuated during the 1990s, there has been a significant drop starting from around year 2000 as seen in figure 7 below.

Figure 7: Tend in adult per capita consumption of alcohol in Bhutan, 1990–2010



Source: WHO Global Information System for Alcohol and Health.

Note: The total recorded per capita consumption in 2010 consisted exclusively of beer in Bhutan.

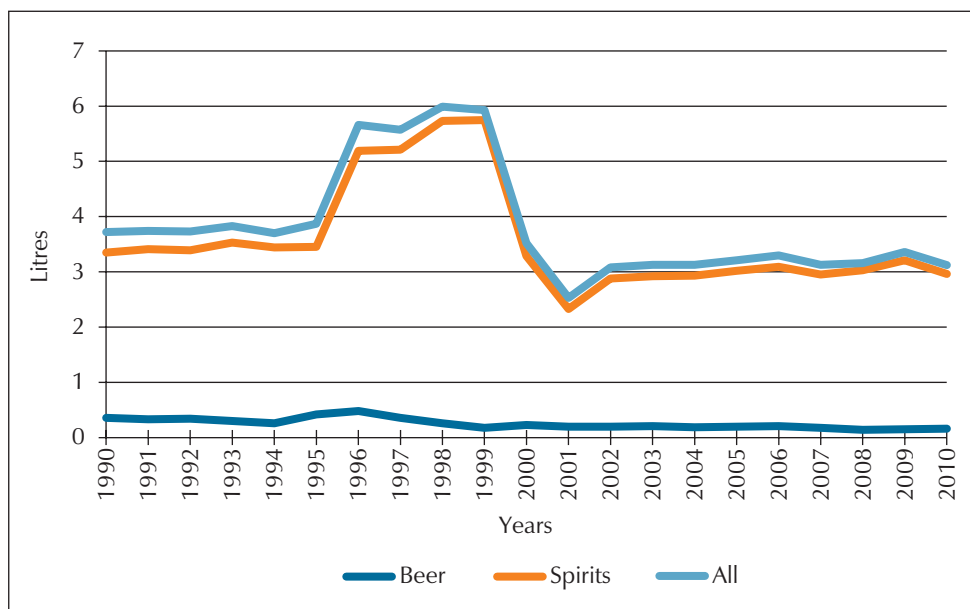
⁵ Report of the Meeting of Experts on Noncommunicable Diseases including Mental Health and Neurological Disorders Yangon 24–26 April 2012. World Health Organization Regional Office for South-East Asia 2012.

- The rate of abstainers was high at 89.7% for those above 18 years in 2010.
- The prevalence of Heavy Episodic Drinking among males, the per capita consumption of adult male alcohol users and the prevalence of alcohol use disorders were relatively low compared to other SEAR countries.
- Alcohol-attributable fractions for deaths from cirrhosis and road traffic accidents of males above 15 years were very low at 10% and 1% respectively.

Democratic People's Republic of Korea

- Similar to several SEAR countries, spirits consumption was dominant. In 2010, the proportion was very high at 95%. Consumption of wine and other types of alcohol was almost non-existent.
- Unlike in most other countries, there has been a significant fluctuation of the recorded adult per capita consumption, where the consumption has risen sharply, reached plateau, and then declined sharply between 1995 and 2002, a 7-year period. The consumption did not change significantly between the next seven years – 2003–2010 as seen figure 8 below.
- The recorded annual adult per capita consumption was 3.12 litres in 2010.
- This major fluctuation is seen in the consumption of spirits, which decides the trend due to its dominant position among the alcohol products. Beer consumption, though small, steadily decreased by more than half between 1990 and 2010, from 0.33 litres to 0.14.

Figure 8: Trend in recorded adult per capita consumption of alcohol in Democratic People's Republic of Korea, 1990–2010



Source: WHO Global Information System for Alcohol and Health.

- The proportion of abstainers among males above the age of 15 was 69.2% in 2010. It was 87.9% among females of the same age group. Conversely, this translates to 30% of males and 12% of females above 15 being alcohol users in 2010.
- Having a relatively high percentage of abstainers with a modest level of per capita consumption still translated to a relatively high per capita consumption of 24 litres among males above 15 years in 2010.
- Prevalence of Heavy Episodic Drinking among users was almost 30%, which was high.
- Prevalence of alcohol use disorders was 5.1% and the alcohol-attributable fraction for liver cirrhosis was 57.5%

Points to note

The consumption has not changed significantly between 2003–2010

High male alcohol user per capita consumption of 24.1 litres, though the overall figure is 3.1 litres

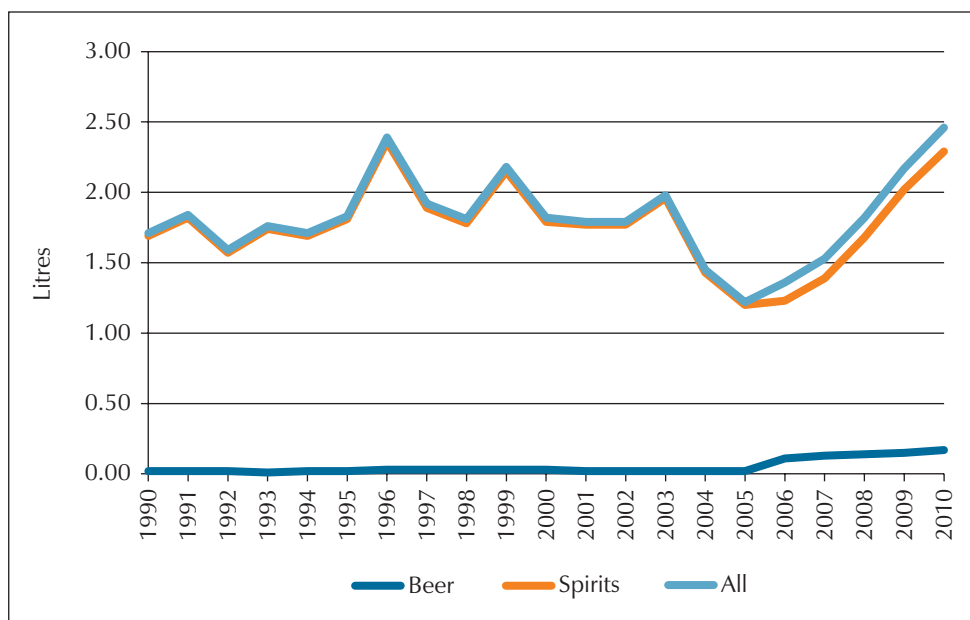
HED among alcohol-using males above 15 was 30%

92% of the recorded adult per capita consumption is in the form of spirits

India

- Between 2005 and 2010, there has been a significant increase in recorded adult per capita consumption, driven mainly by spirits, as shown in figure 9. The recorded consumption doubled from 1.22 to 2.46 litres during this time.

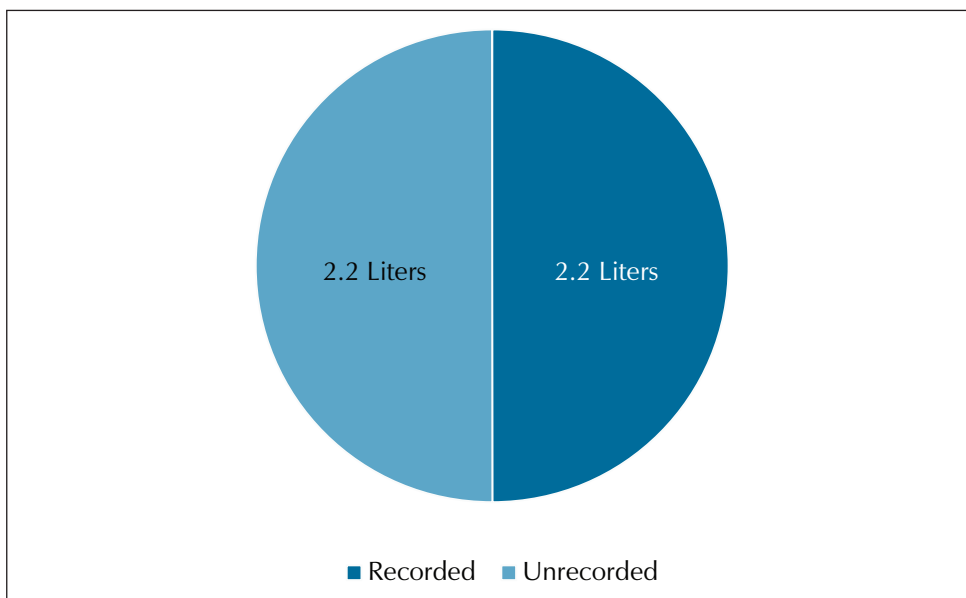
Figure 9: Tend in adult per capita consumption of alcohol in India, 1990–2010



Source: WHO Global Information System for Alcohol and Health.

- 93% of the adult per capita consumption was consumed in the form of spirits.
- Significantly, the average annual unrecorded consumption was 2.2 litres for the period 2008–2010 as shown in figure 10.
- The average annual per capita consumption of those over 15 during 2008–2010 was 4.4 litres. This hides the fact that among males of the same age group, it was 8 litres. Among females, it was only 0.5 litre.

Figure 10: Recorded vs unrecorded adult per capita consumption, in India, litres per capita, 2010



Source: WHO Global Information System for Alcohol and Health.

- Similar to other SEAR countries, India has a very large percentage of abstainers. In 2010, 75.2% of males and 95.2% of females above 15 did not consume alcohol. Therefore, a total of 85% of the population above 15 years did not consume alcohol.
- Among alcohol-using males above the age of 15, the total (recorded and unrecorded) per capita consumption was 32.1 litres in 2010, which was high, in the context of the Region.
- HED was almost 13% among alcohol users.
- Considering a population of over 1.2 billion, 70% of which were over 15 years, this is a situation requiring immediate action.

Indicators of harm

- The alcohol-attributable fraction for liver cirrhosis was almost 63%.
- One third of the road traffic accidents involving deaths of males above 15 years was attributable to alcohol in 2012. This translates approximately to one

third of over 180 000 deaths each year. Therefore, over 60 000 road traffic accident deaths of males above the age of 15 are attributable to alcohol.⁶

- The prevalence of alcohol use disorder (harmful use of alcohol and alcohol dependence) was 4.5% for males in 2010, more than double the average prevalence in SEAR.

Points to note

Adult per capita consumption doubled between 2005 and 2010

Unrecorded consumption is 50% of total adult per capita consumption

High annual adult per-user consumption of 32.1 litres in 2010

93% of the recorded adult per capita consumption is in the form of spirits

Very large number of alcohol-attributable road traffic accident deaths among males

Prevalence of 13% of HED among adult users will cause significant harm due to the large number, although the overall percentage of users is small

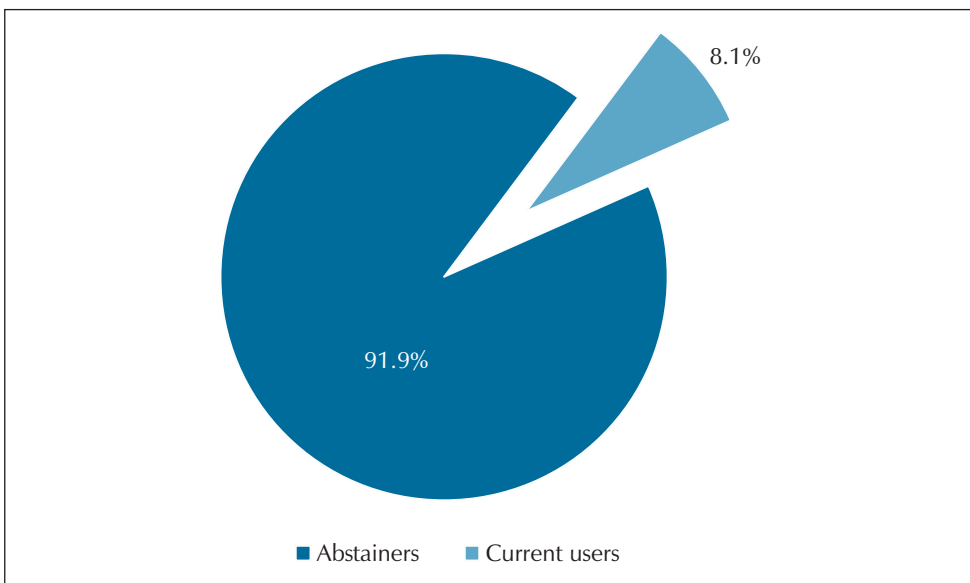
An urgent need to protect the 85% of adults who did not consume alcohol. Any diminution of the proportion of abstainers can significantly increase harm

⁶ This is a rough calculation based on the estimated male population of 15+ of 450 million (CIA World Factbook 2014) and the age-standardized death rate of 41.0 per 100 000 males above 15 years for road traffic accidents – WHO Global Information System for Alcohol and Health. Both accessed 14 October 2014.

Indonesia

- Indonesia, although with a very low level of recorded consumption, shows a “western” pattern of consumption with beer being the most used alcohol product unlike in many SEAR countries.
- But similar to a few SEAR countries, its total per capita consumption is dominated by unrecorded consumption, which is five times the recorded consumption. However, total consumption is still very low at 0.6 litre (average yearly alcohol per capita consumption of those above 15 years of age for the years 2008–2010).
- The percentage of abstainers above the age of 15 in 2010 was 91.9% as shown in figure 11.
- Only 11.4% of males and 4.8% of females above 15 years had consumed alcohol during the past year.
- The per capita consumption of alcohol-using males was 9.4 litres in 2010.

Figure 11: Abstainers and current users above the age of 15 in 2010 in Indonesia



Source: WHO Global Information System for Alcohol and Health.

Points to note

Low total adult per capita consumption

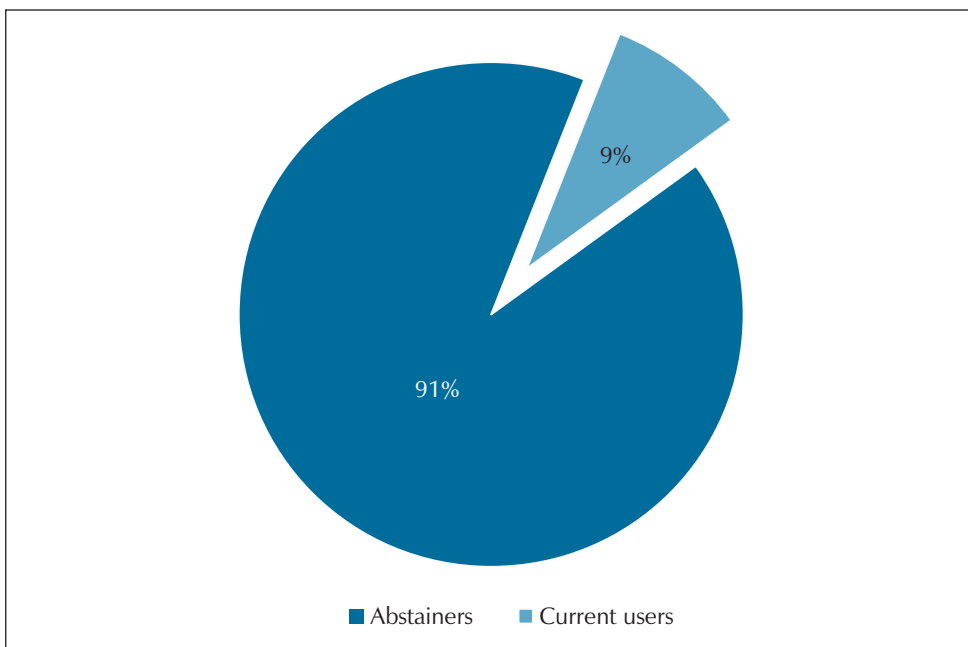
92% of those above 15 are abstainers

Unrecorded consumption is five times the recorded consumption

Maldives

- The recorded and total per capita consumption of alcohol in Maldives has been low and stable since the mid-1990s. There is a total ban on alcohol with alcohol only allowed to be sold in the tourist resorts.

Figure 12: Abstainers and current users in Maldives above the age of 15 in 2010



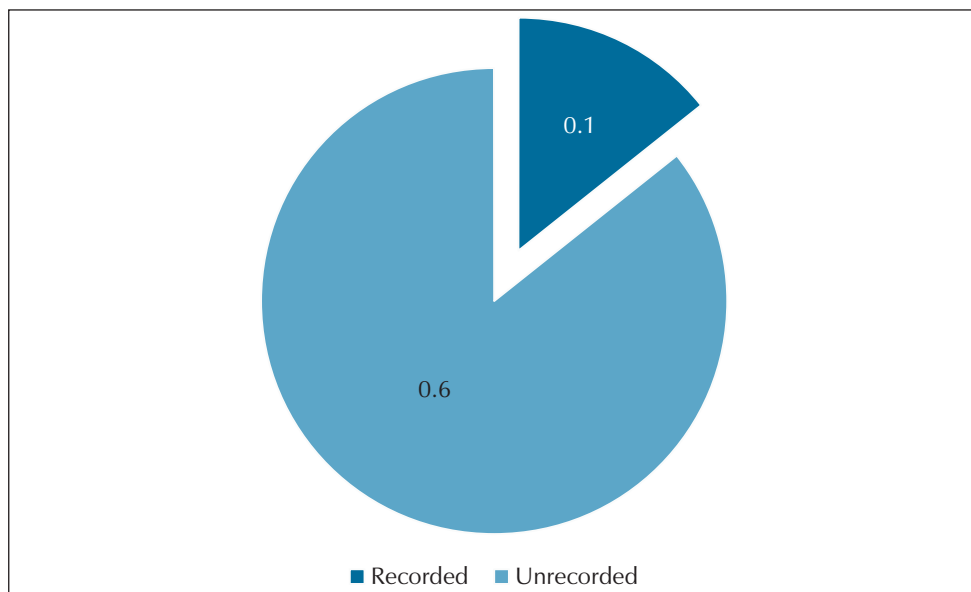
Source: WHO Global Information System for Alcohol and Health.

- The percentage of abstainers over the age of 15 is high at 91% as shown above.
- Prevalence of HED among male alcohol users was 6%, which was low compared with other countries.
- Alcohol-attributable fractions for liver cirrhosis (28.8%) and road traffic accidents (1.9%) were also quite low.

Myanmar

- In Myanmar, beer is the most prevalent alcohol product that is used. Of the recorded per capita consumption of alcohol, 82% is ingested in the form of beer. Spirits account for 12% of the consumption, while wine accounts for 6%.
- Similar to some SEAR countries, the unrecorded consumption was much higher than the recorded consumption as shown below. The average recorded consumption for 2008–2010 was 0.1 litre whereas the unrecorded consumption was six times higher at 0.6 litres.

Figure 13: Average recorded vs unrecorded adult alcohol consumption, litres per capita 2008–2010 in Myanmar



Source: WHO Global Information System for Alcohol and Health.

- Overall, the per capita consumption is low. Between 2003 and 2005, the average per capita consumption of those over 15 years of age was 0.6 litre. This average increased slightly to 0.7 for the period 2008–2010.
- In 2010 in Myanmar, 92.1% had abstained from using alcohol for the past one year, which is a very high rate. Only 12.4% of males and 3.8% of females above the age of 15 consumed alcohol.

- The converse of this is that although the per capita consumption is low, the high rate of abstinence means that those consuming alcohol consume relatively large amounts. The per capita consumption of alcohol-using males above 15 years old in 2010 was 11.4 litres in the country.
- Given the low consumption rates, the alcohol-attributable fractions for both liver cirrhosis and road traffic accidents were relatively low for both sexes.
- The 12-month prevalence of alcohol use disorders was 1.5% of those over 15 years in 2010, which was lower than the SEARO average of 2.2%.

Points to note

Very low total annual adult per capita consumption of 0.7

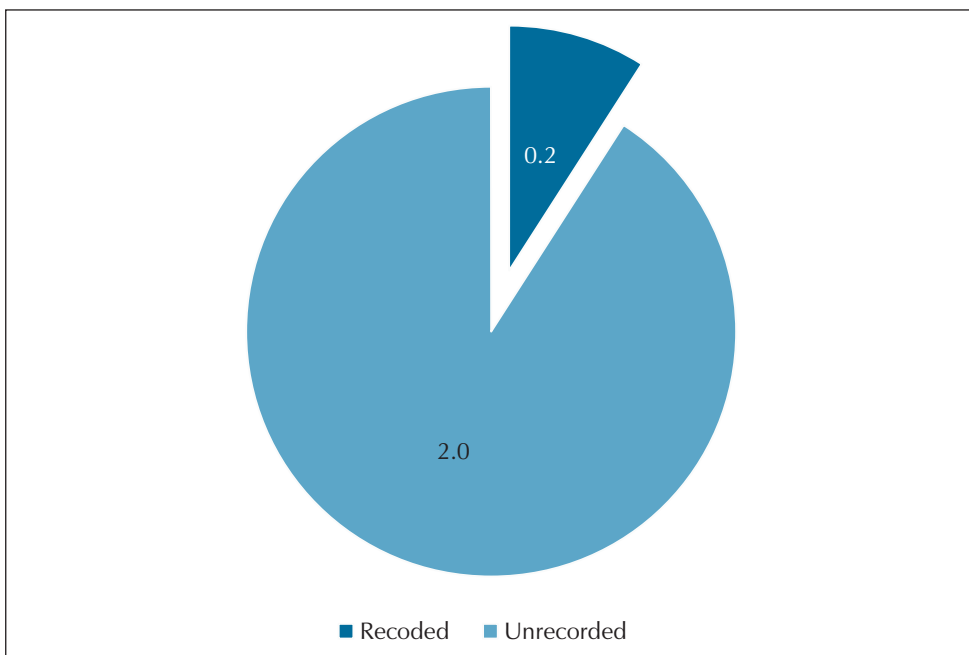
Even so, the unrecorded adult per capita consumption was six times (0.6 litre) the recorded consumption (0.1 litre)

High rate of abstainers in the above 15 population: 92%

Nepal

- Nepal is also a country where the unrecorded consumption is significantly higher than the recorded consumption. The average total per capita consumption between 2006 and 2010 was a relatively low 2.2 litres, of which 2 litres was unrecorded consumption as shown below in figure 14.
- A WHO survey of alcohol users found that around 76% of all alcohol users consumed home-made alcohol. Only around 5% admitted using illegally produced alcohol. It also showed that around 30% of daily or almost daily users were in the 15–24 year age group.⁷

Figure 14: Average recorded vs unrecorded adult alcohol consumption litres per capita 2008–2010 in Nepal



Source: WHO Global Information System for Alcohol and Health.

- Heavy Episodic Drinking was 5.1 among drinkers in 2010.
- As in many other SEAR countries, the proportion of abstainers in the population was high at 92.4% (88% for males and 96% for females) in 2010.

⁷ Programme on reducing harm from alcohol use in the community. Alcohol Control Series No.7. World Health Organization Regional Office for South-East Asia 2009.

- The total alcohol consumption per capita of male alcohol users over 15 years of age was 36.2 litres, which is the highest in the Region.
- Alcohol use disorders, (alcohol dependence and harmful use of alcohol) was 2.5% among all males over 15 years of age and 1.5 for females.
- The alcohol-attributable fraction liver cirrhosis for males over 15 was 44.9 per 100 000 population, while it was 15 for road traffic accidents.

Points to note

The annual per capita consumption of adult male alcohol users was the highest in the Region at 36.2 litres in 2010, although the overall adult per capita consumption was only 2.2 litres

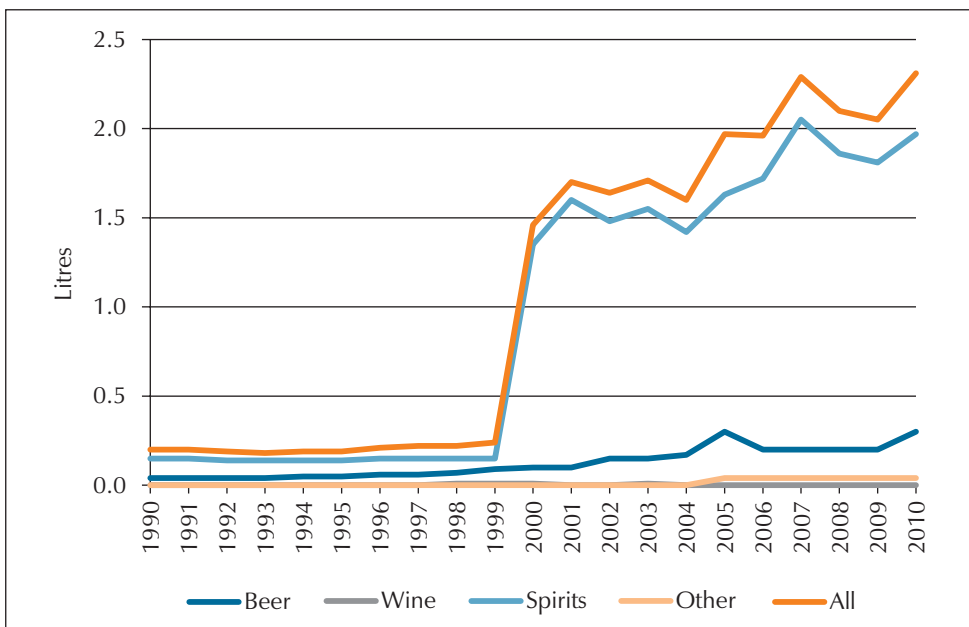
The unrecorded adult per capita consumption was 10 times (2.0 litres) the recorded consumption (0.2 litre)

Percentage of abstainers in the total population was high at 92%

Sri Lanka

- The average annual total recorded per capita consumption among those above 15 years of age was 3.7 between 2008 and 2010.
- As shown in figure 15 below, consumption has been increasing steadily since the late 1990s. Between 1999 and 2001, there has been an abrupt steep rise in the consumption of spirits, which has been rising steadily since then.

Figure 15: Tend in adult per capita consumption of alcohol in Sri Lanka, 1990–2010



- The consumption of spirits accounted for 85% of the recorded per capita consumption, while beer accounted for 13%.
- The prevalence of HED among male drinkers above the age of 15 was 3.1 % in 2010, which was a relatively low figure.
- 81.7% of the population above the age of 15% abstained from consuming alcohol in 2010. It was 72.8% among males and 90.1 among females.
- Therefore, 18.3% of the population above the age of 15 consumed alcohol in 2010, which was 27.2% of males and 9.9% of females.

- The total per capita alcohol consumption of male users above the age of 15 was 26.7 litres in 2010, which was relatively high compared with several other countries of the Region.
- The proportion of cirrhosis deaths among males above 15 due to alcohol in 2010 was 57%, which was among the highest in the Region.
- The same figure for road traffic accidents was 20%, which was also relatively high.

Points to note

The recorded per capita consumption is steadily increasing since the late 1990s

Over 80% of the recorded per capita consumption was in the form of spirits

Although the percentage of abstainers in the total population was high at 81.7% , the per capita consumption of male alcohol users above 15 years was 26.7 litres, which was also high

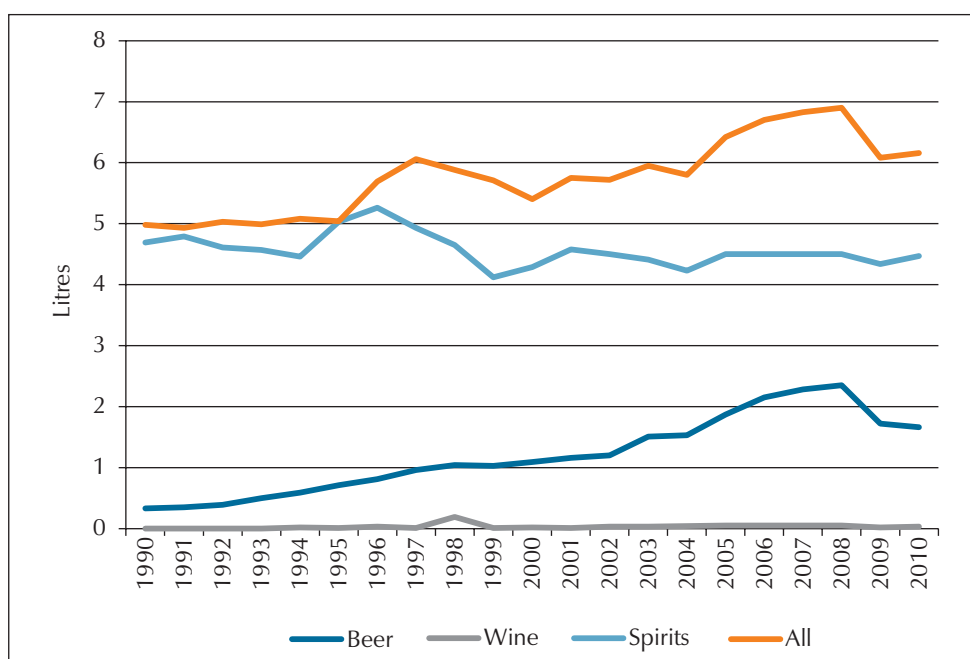
One fifth of the deaths from road traffic accidents of males above the age of 15 was attributable to alcohol

Thailand

Patterns of consumption

- Recorded per capita consumption of alcohol steadily increased from 1960 to the mid-1980s, reaching approximately 6 litres. Almost all the alcohol consumed during this period was in the form of spirits. By 1985, this dipped by about half, to around 3 litres.
- However, by 1990, spirit consumption had increased to just below 5 litres, and has been at that level until 2010. However, consumption of beer, which was negligible until the mid-1990s, has shown a steady increase reaching up to 2.3 litres by 2008. This increase, coupled with the steady level of consumption of spirits, has ensured the total per capita consumption to increase steadily from 1995 until around 2007, as shown in figure 16.

Figure 16: Trend in adult per capita consumption of alcohol in Thailand, 1990–2010



Source: WHO Global Information System on Alcohol and Health.

- The average per capita consumption stood at 6.1 litres in 2010. Currently, 73% of the per capita consumption is in the form of spirits, while around 27% is in the form of beer.
- More than half (54%) of males and three fourths of females (76%) were abstainers, making 70% of the total population abstaining from alcohol use.
- The per capita consumption among male users was high at 30.3 litres in 2010, compared with most other SEAR countries.

Indicators of population-level harm

- Prevalence of HED was 4.7% among male users over 15 years of age and 0.5% among females of the same age group in 2010.
- In 2010, the prevalence of alcohol use disorders was 9.1% among males and 1.5% of females over 15 years of age, making the population prevalence 5.0%. This was substantially higher than the average of 2.2% for SEAR countries.
- 25% of road traffic accident deaths of males above the age of 15 could be attributed to alcohol in 2012. This translates to a very significant number as the age-standardized death rate for RTA in Thailand is 70.3 for 100 000 males above 15, which is the highest in the Region.

Points to note

The recorded annual adult per capita consumption is the highest in the Region at 6.1 litres

Nearly three fourths of the recorded per capita consumption was in the form of spirits

Although the percentage of abstainers in the total population was 70%, the per capita consumption of male alcohol users above 15 years was 30.3 litres, which was high

25% of the deaths from road traffic accidents of males above the age of 15 was attributable to alcohol, which translates to a very significant number of deaths The recorded per capita consumption is steadily increasing since the late 1990s

Over 80% of the recorded per capita consumption was in the form of spirits

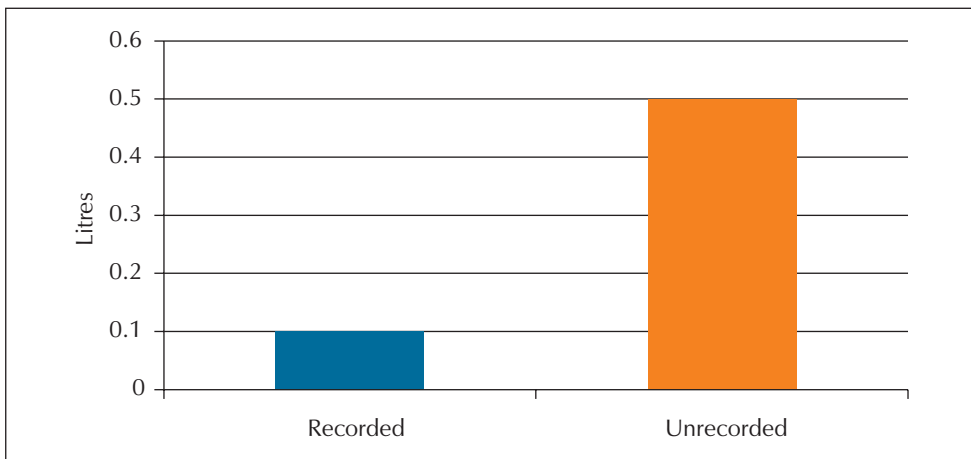
Although the percentage of abstainers in the total population was high at 81.7%, the per capita consumption of male alcohol users above 15 years was 26.7 litres, which was also high

One fifth of the deaths from road traffic accidents of males above the age of 15 was attributable to alcohol

Timor-Leste

- The recorded per capita consumption has been very low since 1990 as shown below in figure 17.
- The total average consumption between 2008 and 2010 was 0.6.
- The average unrecorded per capita consumption was 0.5 litre, five times the recorded consumption of 0.1 litre.

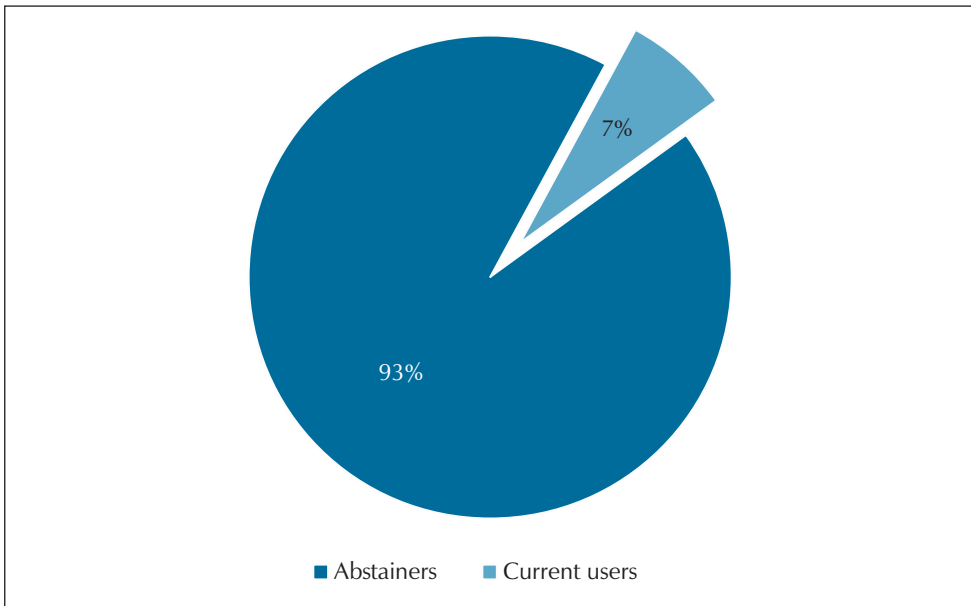
Figure 17: Recorded vs unrecorded adult consumption, Timor-Leste, litres per capita, 2010



Source: WHO Global Information System on Alcohol and Health.

- Unlike all other countries in SEAR, 76% of the recorded consumption was in the form of wine.
- The percentage of abstainers above the age of 15 was high at almost 93% in 2010 as shown in figure 18 below.

Figure 18: Abstainers and current users in Timor-Leste above the age of 15 in 2010



Source: WHO Global Information System on Alcohol and Health.

Points to note

Very low total annual adult per capita consumption of 0.7

Even so, the unrecorded adult per capita consumption was five times (0.5 litre) the recorded consumption (0.1 litre)

High rate of abstainers in the above 15 population: 93% in 2010

5. Factors that could increase alcohol consumption and harm in SEAR

The following issues should be given close attention

Innovate methods of promotion of alcohol use, such as

- **Social media promotions, events and sales**
- **Product placements and movie storylines**
- **Pop lyrics and music videos**

Introduction of different types of alcohol products, such as Alcopops

Alcohol industry interference in development and implementation of policies

International Trade agreements

5.1 Innovative methods of promotion of alcohol use

Social media promotions, events and sales

It is well established that exposure to alcohol advertising affects the drinking behaviour of young people. Empirical and review studies supporting this have been published in peer reviewed journals^{8, 9, 10, 11, 12} and by the Science Group of the Alcohol and Health Forum of the European Commission.¹³ However, in these articles, the main focus lies on traditional media (magazines, newspapers, TV, radio and movies).

⁸ Grenard JL, Dent CW, Stacy AW. Exposure to alcohol advertisements and teenage alcohol-related problems. *Pediatrics*, Vol 131:2 pp, e369-379 February 2013.

⁹ McClure A.C., et al., Alcohol Marketing Receptivity, Marketing-Specific Cognitions, and Underage Binge Drinking. *Alcoholism: Clinical and Experimental Research*, 2013. 37: p. E404-E413.

¹⁰ Anderson P, De Bruijn A, Angus K, Gordon R, Hastings, G. Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44, 229-43. 2009.

¹¹ Smith, L.A. and D.R. Foxcroft, The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. *BMC Public Health*, 2009. 9: p. 51.

¹² Gordon R, MacKintosh A, Moodie C (2010), The impact of alcohol marketing on youth drinking behaviour: a two-stage cohort study. *Alcohol and Alcoholism*, 45(5), 470-480.

¹³ Science Group of the European Alcohol and Health Forum, Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? - a review of longitudinal studies. 2009.

Social media is characterized by its interactive nature, unlike traditional web sites. In September 2014 alone, the Facebook page of Heineken was able to attract over 250 000 new fans. By the end of this month, the “top” 40 alcohol brands on Facebook had over 2 million users each, the highest being 18 million fans.¹⁴ Many leading brands now spend most of their digital marketing budgets on social media promotions, instead of on “web sites”. Social media promotions are not restricted to the web alone. They promote real events that take place – beach parties, dances, day outs, etc. where fans can physically take part. “Post-event” promotions, such as uploading of photographs and videos, is a part of such activities as well. Such a level of engagement will contribute to stronger emotional attachments to brands as well as the culture of alcohol use, which goes beyond mere brand promotion.

It has been shown that when adolescents use computers for their recreation, their lifetime drinking was related to hours spent on the computer. Additionally, past month drinking was significantly related to hours spent on the computer.¹⁵ This suggests again a strong relationship between drinking and recreational computer use. A 2011 US survey of teen and parent attitudes on substance abuse also found that 70% of the respondents who were daily users of social network sites were three times more likely to use alcohol than others.¹⁶

In 2012, results of a multicountry European study in which over 9000 adolescents in Germany, Italy, the Netherlands and Poland were questioned indicated a dose-response effect on consumption: the association with binge drinking becomes stronger with high levels of exposure to online alcohol marketing. This effect is described as robust and consistent in various national contexts.¹⁷

Product placements and movie storylines

Movies are very popular among young people in most countries of the Region. During the recent past, ways of viewing movies has become significantly varied. Whereas in the past, one could go to the movie theatre, purchase a ticket and watch

¹⁴ <http://www.webcitation.org/63PYDLUKZ>; accessed 26 September 2014.

¹⁵ Epstein, J.A., Adolescent computer use and alcohol use: What are the role of quantity and content of computer use? *Addictive Behaviors*, 2011. 36(5): p. 520-522.

¹⁶ National Center on Addiction and Substance Abuse, National Survey of American Attitudes on Substance Abuse XVI: Teens and Parents, 2011, The National Center on Addiction and Substance Abuse: New York.

¹⁷ Bruijn de A, Exposure to online alcohol advertising and adolescents' binge drinking: A cross-sectional study in four European countries, in *Alcohol Policy in Europe: Evidence from AMPHORA*, Anderson P, Braddick, F, Reynolds J, Gual, A, Editors 2012, The AMPHORA Project: Barcelona. p. 56-64.

a movie, now those in even remote areas can view movies through cheap DVD and satellite television at home, on personal computers, mobile phone and other mobile electronic devices. Therefore, with the range of movies available to those in countries of the WHO South-East Asia Region, the ease of viewing has increased remarkably. Traditional restrictions of movie viewing (e.g. parental guidance, etc.) have no meaning in this context.

With marketing restrictions on alcohol products through traditional outlets gradually gaining ground during the last decade, other forms of promotions are becoming increasingly visible. Studies published over several years have shown that alcohol use and alcohol branding in popular films are common, even in children's animated films.^{18, 19, 20} Even recent studies show that this trend is continuing, even in US films cleared for those as young as 13 years old.²¹ Such Hollywood films are very popular in countries of the Region.

Glamourized drinking in films is so persuasive that it can encourage young people to initiate use and to consume more alcohol. This comes in the backdrop of studies as far back as 2004 showing that product placement in the media is an effective means of marketing to children and young people.^{22, 23}

Although the effects of such portrayals have been questioned in the past, recent studies published, which have come in the wake of increasing portrayals of alcohol in the movies, conclude that such portrayals do persuade young people to start and

¹⁸ Dal Cin S, Worth KA, Dalton MA, Sargent JD. Youth exposure to alcohol use and brand appearances in popular contemporary movies. *Addiction* 2008; 103: 1925–32.

¹⁹ Hanewinkel R, Tanski SE, Sargent JD. Exposure to alcohol use in motion pictures and teen drinking in Germany. *Int J Epidemiol* 2007; 36:1068–77.

²⁰ Sargent J, Wills TA, Stoolmiller M, Gibson J, Gibbons FX. Alcohol use in motion pictures and its relation with early-onset teen drinking. *J Stud Alcohol Drugs* 2006; 67:54–65.

²¹ **Bergamini E, Demidenko E, Sargent JD.** Trends in tobacco and alcohol brand placements in popular US movies, 1996 through 2009 *JAMA Pediatr.* 2013 Jul; 167(7):634-9.

²² Auty S, Lewis C. Exploring children's choice: the reminder effect of product placement. *Psychol Market* 2004; 21(9):699–716.

²³ Anderson P, De Bruijn A, Angus K, Gordon R, Hastings, G. Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44, 229-43. 2009.

consume alcohol,^{24, 25} and even have immediate cognitive and behavioural effects on the viewers.²⁶

Pop lyrics and music videos

Young people spend increasing amounts of time listening to popular music. Studies show that positive references to alcohol are common in English language pop music. This is relevant to SEAR as English pop music is very popular among the younger age groups in almost all countries of SEAR. Even very young age groups are frequently exposed to such music, especially in the expanding middle class in countries of the Region. In a study published in the United Kingdom, it was found that prevalence of alcohol references increased sharply between 2001 and 2011, when almost one in five (18.5%) songs referred to alcohol and one in eight (12.6%) to heavy drinking. In multivariate analyses, alcohol-related lyrical content was associated with urban music genres, such as R&B, Rap and Hip-Hop, and artists from the United States of America. Alcohol-related references were often positively framed, linking alcohol use to valued attributes and favourable outcomes. Up to 3.0% of songs contained branded alcohol references.²⁷

This has been followed by visible portrayals of alcohol use in music videos. Videos of several international pop “super stars” who have a wide following in SEAR countries are seen to positively portraying alcohol use. There is now conclusive evidence that such portrayals do push young people to initiate use and also to consume more.^{28, 29, 30}

²⁴ Hanewinkel R, Sargent JD, Hunt K, Sweeting H, Engels RC, Scholte RH, Mathis F, Florek E, Morgenstern M. Portrayal of alcohol consumption in movies and drinking initiation in low-risk adolescents. *Pediatrics*. 2014 Jun; 133(6):973-82.

²⁵ Koordeman R¹, Anschutz DJ, van Baaren RB, Engels RC. Effects of alcohol portrayals in movies on actual alcohol consumption: an observational experimental study. *Addiction*. 2011 Mar; 106(3):547-54.

²⁶ Koordeman R¹, Kuntsche E, Anschutz DJ, van Baaren RB, Engels RC. Do we act upon what we see? Direct effects of alcohol cues in movies on young adults' alcohol drinking. *Alcohol and Alcoholism*. 2011 Jul-Aug; 46(4):393-8.

²⁷ Hardcastle KA, Hughes K, Sharples O, Bellis MA. Trends in alcohol portrayal in popular music: A longitudinal analysis of the UK charts. *Psychology of Music September 30, 2013*. doi: 10.1177/0305735613500701.

²⁸ Sloane K, Wilson N, Imlach Gunasekara F. A content analysis of the portrayal of alcohol in televised music videos in New Zealand: changes over time. *Drug Alcohol Rev*. 2013 Jan; 32(1):47-52.

²⁹ Koordeman R¹, Anschutz DJ, Engels RC. Alcohol portrayals in movies, music videos and soap operas and alcohol use of young people: current status and future challenges. *Alcohol and Alcoholism*. 2012 Sep-Oct; 47(5):612-23.

³⁰ Engels RCME, Hermans R, Van Baaren RB, et al. Alcohol portrayal on television affects actual drinking behaviour. *Alcohol and Alcoholism* 2009; 44:244-9.

5.2 Introduction of different types of alcohol products

One of the best examples to marketing alcohol products to entice children are alcopops. Experts have repeatedly argued that this product will entice younger people to initiate use of alcohol. These appear acceptable and harmless in the surface. These products consist of distilled alcohol combined with fruit and other flavours. Alcopops appeared in the American and European markets in the mid-1990s.

Studies have found that the overall effects of such beverages are the same as other alcohol products when corrected for the total alcohol content.^{31, 32} This once very popular product has been somewhat brought under control through specific taxes in many countries.

However, such products could appear in SEAR countries. When such products appeared in the markets of Europe and the United States of America, it took almost a decade for them to be brought under control through taxation. With large youth populations in SEAR, which are expanding, and very large percentages of those who refrain from using alcohol, countries in SEAR could be attractive propositions for new markets for these products.

5.3 Alcohol industry interference in alcohol policy development and implementation

The alcohol industry is an influential multinational industry that has the power and the resources to delay and weaken development and implementation of alcohol control policies. The goals of public health and the goals of alcohol industry are directly in conflict. To reduce harm from alcohol, total per capita alcohol should be reduced. To increase profits, alcohol consumption has to be increased.

But unlike the tobacco industry, the alcohol industry is sometimes seen as a partner in providing the solutions rather than what it really is – a part of the problem.³³ Global alcohol companies may have succeeded as showing themselves as “good” corporate citizens. They are framing arguments with a focus on drinkers. This obscures the

³¹ Metzner C, Kraus L. The impact of alcopops on adolescent drinking: a literature review. *Alcohol and Alcoholism*. 2008 Mar-Apr; 43(2):230-9.

³² Kraus L, Metzner C, Piontek D. Alcopops, alcohol consumption and alcohol-related problems in a sample of German adolescents: is there an alcopop-specific effect? *Drug Alcohol Dependence*. 2010 Jul 1; 110(1-2):15-20.

³³ Gilmore AB, Savell E, Collin J. Public health, corporations and the New Responsibility Deal: promoting partnerships with vectors of disease? *Journal of Public Health (Oxf)* 2011 Mar; 33(1):2-4.

contribution supply and marketing to address alcohol-related harm, and has also contributed to failure by governments to adopt effective supply-side policies.³⁴

The Portman Group, International Center for Alcohol Policies (ICAP) and the newly formed International Alliance for Responsible Drinking (IARD) are all alcohol industry-funded organizations that publish “research” and engage the public and policy-makers on issues related to alcohol.^{35,36}

One of the more successful strategies that the alcohol industry uses is “self-regulation”. This has been often used to delay implementation of effective policies. For such “self-regulation” to be effective, it has to bring down consumption and harm. Studies conclude that such “regulations” are ineffective and should not form part of the solution to alcohol-related problems.³⁷

Alliances between the tobacco and alcohol industries to oppose tobacco taxation, clean indoor air laws and advertising restrictions have been documented.³⁸

How countries of SEAR can address industry influence is outlined in a subsequent section.

The WHO Framework Convention for Tobacco Control (Article 5.3 – the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry) and its Guidelines clearly spells out how the influence of the tobacco industry should be addressed.^{39,40}

The global alcohol industry has already come out in “support” of the WHO Global Strategy to address the harmful use of alcohol, and is trying to become a partner in its implementation. Global public health experts have opposed this move.⁴¹

³⁴ Casswell S. Vested interests in addiction research and policy. Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry? *Addiction*. 2013 Apr; 108(4):680-5.

³⁵ <http://www.portmangroup.org.uk/> accessed 18 October 2014.

³⁶ <http://www.icap.org/>. Accessed 18 October 2014.

³⁷ Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, Lincoln P, Casswell S; Lancet NCD Action Group. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *Lancet*. 2013 Feb 23; 381(9867):670-9.

³⁸ Jiang N, Ling P. Alliance between tobacco and alcohol industries to shape public policy. *Addiction*. May 2013; 108(5): 852–864.

³⁹ WHO Framework Convention on Tobacco Control. World Health Organization 2003.

⁴⁰ Guidelines for implementation of the WHO Framework Convention on Tobacco Control. World Health Organization 2013.

⁴¹ Global public health community issues warning on alcohol industry conflict of interest. *The Globe*, Issue 2, 2013. Global Alcohol Policy Alliance.

5.4 International trade agreements

Global Trade agreements can weaken alcohol control policies and laws

However, there are clauses in some trade agreements that can be used to protect public health

Bilateral and the newer types of multilateral agreements can make the situation more complex, which will benefit the multinational alcohol trade

The WHO Global Strategy to reduce harmful use of alcohol attempts to address this issue

The second report of the WHO Expert Committee on Problems Related to Alcohol Consumption⁴² notes that the growth of supranational common markets and international trade agreements results, in some jurisdictions, in eroding the position of freestanding national alcohol policies, and public health considerations are subordinated to the logic of the free market and free trade. Time after time, countries in one or another part of the world have been forced under such agreements to weaken or abandon important aspects of their alcohol policies, when alcohol in the context of such markets and agreements has been treated as a commodity like any other economic commodity.

One of the most insidious and serious threats to effective control of alcohol-related harms in the future will be from the sphere of international trade agreements and laws. Such laws and agreements supersede national laws and regulations. Therefore, poorer, less “powerful” countries may find themselves in helpless positions related to public health measures to control harms from substances, such as alcohol, tobacco and even from unhealthy food, which multinational corporations trade in. In addition to international agreements, such as General Agreement Trade-Related Services (GATS), Agreement on Technical Barriers to Trade (TBT Agreement) and Trade-Related Intellectual Property Rights (TRIPS) are some examples relevant to public health. However, there are bilateral and multilateral agreements, which also deal with the same issue, making the situation complex.

How Free Trade Agreements can impact on harm from alcohol

‘Free’ trade agreements can reduce trade barriers, increase competition and promote alcohol consumption through lower prices and other means.

⁴² Second report, WHO Expert Committee on Problems Related to Alcohol Consumption. (WHO technical report series; no. 944), World Health Organization 2007.

Usually international treaties are negotiated by experts in free trade. They collaborate closely with corporate lobbyists and without much public consultation. There is minimal public health input, if at all. Therefore, it is no surprise that such treaties contain significant provisions that will result in increased alcohol consumption. It may also challenge public health measures of other nations as constraints on trade.

National and subnational alcohol control measures seek to reduce access to alcohol, reduce consumption, raise prices and restrict advertising and product promotion. Conversely, the alcohol industry seeks to influence agreements and can be expected to work through trade agreements to reduce tariffs, increase market access and seek to restrict effective domestic regulations. Therefore, trade agreements challenge effective alcohol control policies.⁴³

World Trade Organization (WTO) agreements relevant to public health⁴⁴

WTO rules, which govern technical barriers to trade applied for reasons of protecting human health, are covered by either the Agreement on Technical Barriers to Trade (TBT Agreement) or the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement). Under both these agreements, health is considered a legitimate objective for restricting trade. Both these agreements allow countries to restrain trade for legitimate reasons, including health, but they also require that such measures not unnecessarily restrict trade.

Trade-Related Intellectual Property Rights (TRIPS)

The Doha Declaration on the TRIPS Agreements and Public Health and paragraph 6 of the Doha Ministerial Declaration made clear that WTO rules and health policies can go hand in hand, that public health considerations are important in implementing WTO rules, and that trade and health policies can be made mutually supportive.

General Agreement Trade-Related Services (GATS)

This agreement has limited relevance to determinants of health (e.g. alcohol, tobacco) as it deals mainly with services. GATS imposes only very limited general obligations on Members, who are free to choose which service sectors to open up and which modes of service to liberalize.

⁴³ Ref: Zeigler DW. The alcohol industry and trade agreements: a preliminary assessment *Addiction*. 2009 Feb; Vol:104 Suppl 1:13-26.

⁴⁴ World Trade Organization Agreements and Public Health. A Joint Study by World Health Organization and WTO Secretariat, 2002.

Newer types of trade agreements that threaten public health

The new breed of trade agreements that impact on public health has been described as follows: “The days when these treaties were about eliminating import restrictions and discriminatory measures on alcohol and tobacco products are long gone. Trade is now seen as globally integrated flows of capital, services, products, information and elite personnel. A new generation of agreements promotes the systemic integration of markets, supply chains and commercial players by reducing ‘behind the border’ barriers to their seamless operation”.⁴⁵

One such example is the multilateral agreement “Trans-Pacific Partnership (TPP)”, which is currently being finalized. It is possible that several countries of SEAR will be partners of this treaty once it becomes operational. Public health experts and citizens groups have already voiced many concerns related to this treaty.^{46,47,48}

The WHO Response to World Trade Agreements in relation to alcohol specified in the WHO Global Strategy on Harmful Use of Alcohol is as follows:⁴⁹

Section 6. Challenges and Opportunities

Policy-makers face the challenge of giving an appropriate priority to the promotion and protection of population health while taking into account other goals, obligations, including international legal obligations, and interests. It should be noted in this respect that international trade agreements generally recognize the right of countries to take measures to protect human health, provided that these are not applied in a manner which would constitute a means of unjustifiable or arbitrary discrimination or disguised restrictions to trade. In this regard, national, regional and international efforts should take into account the impact of harmful use of alcohol.

⁴⁵ New-generation free trade agreements threaten progressive tobacco and alcohol policies. Kelsey J. *Addiction* Volume 107, Issue 10, Editorial, October 2012.

⁴⁶ The Trans-Pacific Partnership Agreement: challenges for Australian health and medicine policies. Faunce TA, Townsend R *Medical Journal of Australia*. Volume 194:2 pp83-86, 2011.

⁴⁷ The Trans-Pacific Partnership. A Gold-plated gift for the global tobacco industry? Kelsey J. *American Journal of Law and Medicine*. Vol 39: pp 237-264, 2013.

⁴⁸ Trans-Pacific Partnership. *Medicins Sans Frontiers*. <http://www.msf.ca/en/trans-pacific-partnership>. Accessed 2 October 2014.

⁴⁹ Global strategy to reduce harmful use of alcohol. World Health Organization 2010.

Section 48. Secretariat will provide support to member states by ...

(d) advocating appropriate consideration by parties in international, regional and bilateral trade negotiations to the need and the ability of national and sub-national governments to regulate alcohol distribution, sales and marketing, and thus to manage alcohol-related health and social costs;

Technical Support and capacity building

51 (f) responding to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health.

6. Responses required to address current consumption and possible future increases in alcohol-related harms in the context of SEAR

6.1 International aspects of alcohol policies and interventions

In most countries where alcohol policies and plans exist, it is almost exclusively handled in a national or subnational level. But with the increasing reach and influence of multinational alcohol companies and the advent of International treaties on trade and services, alcohol production, marketing and retailing has many international dimensions. Therefore, international cooperation and taking into account the international context in national and subnational policies are vital when developing and implementing national and subnational alcohol policies.

This is very important in the context of SEAR where the total per capita consumption is relatively low in many countries. Unless the international dimension is taken into account, the multinational alcohol industries will be able to expand their markets substantially in the Region, even to the extent of negating the relatively modest increases in consumption, which have been projected.

The international actions necessary and how countries and regions can address this issue are specified in detail in the sections 43 to 58 of the WHO Global Strategy on Alcohol and Health. Of the issues outlined in these sections, technical capacity-building and resource mobilization are the most important aspects in the context of SEAR.

6.2 National and subnational aspects of alcohol policies and interventions

Applying effective national legal and regulatory measures in the context of the Region

Priority legal and regulatory interventions needed in the context of SEAR

Reducing affordability

Restricting availability

Addressing formal and informal promotions

Regulating newer types of alcohol products

Counteracting alcohol industry influence

1. Reducing affordability

Increasing the price of alcoholic beverages is one of the most effective interventions to reduce harmful use of alcohol. The evidence shows that young people's consumption is particularly sensitive to price. Policies that increase alcohol prices have been shown to reduce the proportion of young people who are heavy drinkers, to reduce underage drinking and to reduce per occasion binge drinking. Higher prices also delay intentions among younger teenagers to start drinking and slow progression towards drinking larger amounts.⁵⁰ This aspect is further elaborated in sections 32–34 of the WHO Global Strategy to Reduce Harmful Use of Alcohol. Addressing direct and indirect discounts by the alcohol industry and the retailers, and considering minimum pricing for alcohol products are issues that SEAR governments should also start considering.

However, it should be noted that this type of intervention will only have an impact in the recorded or formal alcohol products. As the unrecorded production is quite significant in SEAR, tax measures, while very effective on a section of alcohol users, alone is not adequate. The issue of illicit and home-brew alcohol is discussed in a subsequent section.

⁵⁰ Second report/WHO Expert Committee on Problems Related to Alcohol Consumption. World Health Organization 2007.

2. Restricting availability

Availability of alcohol is also a major determinant of use and harm. Measures controlling the availability of alcohol include age limits for the purchase, monopolies or licensing systems for alcohol distribution, bans on the sale of alcohol through vending machines, petrol station and limits on the hours and days that it can be sold.

There is conclusive evidence that increasing the density of alcohol retail outlets increases consumption, including under-age consumption.⁵¹ Social harms, such as violence,⁵² child abuse⁵³ and intimate partner violence⁵⁴ have been shown to be directly related to availability of alcohol.

Restrictions on times, locations, etc. are in place in many countries. However, there are trends such as allowing alcohol sales in supermarkets, which can circumvent restrictions that are in place.

3. Addressing formal and informal Promotions

The WHO Global Strategy for Reducing Harmful Use of Alcohol comprehensively deals with policy options and interventions to address the harmful use of alcohol. Therefore, this section will only highlight some issues that will be important to address possible future increases in alcohol use and harms especially among the younger age groups. In the context of SEAR, it is an important aspect as most SEAR countries already have a sizable population of young people and it is predicted that the numbers in this group will increase.

As discussed in a previous section, the projected increase in per capita consumption in SEAR as well as in individual countries look numerically insignificant. But this measure taken alone is deceptive. This is because in most SEAR countries, the young populations are increasing. Therefore, the number of alcohol users can increase in a country due to the growth of number within the young age group, without the per capita consumption increasing significantly. In such countries, when the per capita consumption increases, it means that the number of users as well as the amount of

⁵¹ Second report, WHO Expert Committee on Problems Related to Alcohol Consumption. (WHO technical report series; no. 944), World Health Organization 2007.

⁵² Preventing violence by reducing the availability and harmful use of alcohol. World Health Organization 2009.

⁵³ Child maltreatment and alcohol, Factsheet. World Health Organization 2006 http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_child.pdf Accessed 10 October 2014.

⁵⁴ Preventing intimate partner and sexual violence against women taking action and generating evidence. World Health Organization 2010.

alcohol used by individual users has increased. As alcohol control policies are still evolving in the Region, specific factors need urgent attention to arrest this scenario.

4. Regulating newer types of alcohol products

Countries should also be vigilant for the possible introduction of new types of alcohol products, such as alcopops (discussed before), which are attractive to young people. Although tax measures have brought a semblance of control of these products in other parts of the world, a potentially vast market exists for these products in the countries of the Region.

5. Counteracting alcohol industry influence

There are several ways that industry influence on alcohol policies can be minimized and eliminated. Systems to prevent conflicts of interest, steps to ensure that those funded by the alcohol industry for research and other projects are excluded from the policy process, prevent sponsorship and support by the alcohol industry to government agencies, phasing out all corporate social responsibility (CSR) projects and strictly limiting and ensuring transparency of interactions between government officials and the alcohol industry are some of the measures that can be implemented in the context of the Region.

Implementing national- and subnational-level non-legal actions in the context of the Region

Priority non-legal interventions needed in the context of SEAR
Addressing unrecorded alcohol consumption
Establishing non-traditional surveillance systems
Contesting policy myths through evidence
Addressing pay-day drinking and alcohol use on special occasions
Community empowerment for community-level responses
Keeping issue of alcohol-related harm high in the media agenda
Capacity-building – policy-makers and legal fraternity
Helping users

1. Addressing unrecorded alcohol consumption

The unrecorded consumption is a substantial percentage of total per capita consumption in SEAR. In countries such as Indonesia, Nepal, Myanmar, and Timor-Leste, unrecorded per capita consumption is at least five times the recorded per capita consumption. In India, it is equal to recorded consumption. Overall, unrecorded consumption is nearly 50% of the per capita consumption in the Region.

Unrecorded alcohol, according to the WHO,⁵⁵ is alcohol that is not taxed in the country where it is consumed, because it is usually produced, distributed and sold outside the formal channels under government control. Unrecorded alcohol consumption in a country includes consumption of traditional drinks that are produced and consumed in the community or in homes, such as fermented products made from sorghum, millet, maize, rice, wheat or fruits. It also includes smuggled alcohol, and alcohol brought into countries after cross-border shopping.

This is a great challenge in SEAR countries, where strong policies for so-called “legal” alcohol products exist, but all unrecorded products escape such measures. Making the situation more complex is the fact that in several countries, such alcohol is not mainly produced by criminal syndicates or illegal production facilities. They are home brewed and form a part of sociocultural practices of different ethnic groups and geographic areas, and is bound strongly with traditions and “normal” day-to-day practices.

Therefore, simply strengthening laws related to illegal alcohol or improving enforcement alone will not address this issue. In this Region, in addition to law enforcement where appropriate, a greater emphasis should be needed to be placed on addressing social and cultural norms that promote home production as well as consumption of unrecorded alcohol.

When principals of health promotion are applied, community empowerment efforts cannot differentiate between “legal” and “illegal” alcohol products. Therefore, in addressing informal production, social and cultural norms that promote alcohol use at individual, family, group and community level should be addressed. This will, therefore, entail addressing the substance alcohol, regardless of its legal status.

As far as illicit production of alcohol is concerned, there are examples from some countries where community pressures has reduced or totally eliminated illegal alcohol production. This can be done with or without the assistance of enforcement agencies.⁵⁶

⁵⁵ WHO Global Status Report on Alcohol and Health, World Health Organization 2014.

⁵⁶ Programme for reducing harm from alcohol in the community, Alcohol Control Series No.7. World Health Organization Regional Office for South-East Asia, 2009.

2. Establishing non-traditional surveillance systems

Traditional surveillance systems keep track of alcohol use patterns, morbidity and mortality. To combat the current and possible future harms of alcohol, this surveillance should include as many proximal determinants of alcohol use as possible.

Alcohol availability is one determinant, which contributes to increasing consumption, violence and injuries. One aspect is that simply the availability of legal or illegal alcohol can have a positive influence on the social availability of alcohol, which contributes to changing social and cultural norms. This will in turn promote alcohol use and associated harm.⁵⁷ Therefore, availability of alcohol at the community level or specific geographical areas can determine harms to their respective populations.

Basic Information required for addressing alcohol use
Availability
Affordability
Norms, symbolisms and expectations attached to alcohol
Methods of promotions, messages and types of media used
Usage patterns, demographics and contexts
Morbidity and mortality

Affordability of alcohol is also a key driver in initiation and maintenance of use. Affordability of different types of alcohol is often not monitored by public health agencies. This factor was discussed in a previous section. Affordability, therefore, be a key component in a surveillance system.

Social and cultural norms and beliefs on the symbolism and effects of alcohol are major drivers of initiation and maintenance of alcohol use.^{58, 59, 60} The alcohol industry promotes alcohol use through molding these norms and expectations in communities and larger populations. When norms and expectations change, it is related to the substance alcohol, irrespective of whether it is recorded or not. Changing norms can signal a changing trend in alcohol consumption in either direction. Therefore,

⁵⁷ Second report, WHO Expert Committee on Problems Related to Alcohol Consumption. (WHO technical report series; no. 944), World Health Organization 2007.

⁵⁸ WHO Global Status Report on Alcohol and Health, World Health Organization 2014.

⁵⁹ Second report, WHO Expert Committee on Problems Related to Alcohol Consumption. (WHO technical report series; no. 944), World Health Organization 2007.

⁶⁰ Reducing harm from use of alcohol: community responses. Alcohol Control Series, No. 5 WHO Regional Office for South-East Asia 2006.

surveillance of such norms and expectations can inform policy and programme development.

As discussed in a previous section, different methods of promotion, ranging from the traditional to the newer, personalized social media and mobile technology strategies will be a major determinant in initiation and maintenance of alcohol use. Therefore, surveillance systems should be looking at such methods that are being used in order to understand the strategies used by the alcohol industry and inform development of strengthening of policies and regulations.

Recommendations for surveillance are also included in section 42 of the WHO Global Strategy on Harmful Use of Alcohol.

3. Contesting policy myths through evidence

There are several common myths that are used to oppose and weaken national-level policies and laws aimed to reduce harm from alcohol. These are used by the alcohol industry to weaken and delay effective measures that will bring down consumption, and with it, the harms.

Some examples of policy myths used to weaken alcohol control

Whole population measures to address alcohol use are ineffective to address harm

Discontinuing advertising is ineffective

Taxation does not have an impact, as users will keep using and also will switch to illegal products

The more stringent the control of “legal” alcohol, the more crime and production of illegal alcohol will increase

Interventions and restrictions should only be placed on heavy users of alcohol

Voluntary regulation by the alcohol industry is the best way forward

Most of these arguments may appear reasonable at face value. It is probably easy to convince policy-makers, programme planners and the media that such arguments are true. However, all of these are false. Evidence showing misleading nature of such arguments have been widely published by the World Health Organization and other agencies. Such evidence should be given wide media publicity and used in advocacy and lobbying for effective alcohol control.

4. Addressing pay-day drinking and alcohol use on special occasions⁶¹

These two factors have contributed to alcohol-related harms, especially social harms in SEAR, according to surveys and expert opinion. In the context of the Region, there are many types of special occasions where alcohol use is common – weddings, births, funerals, harvesting and religious occasions. In addition to obvious economic and social consequences, this overall use, especially the use on special occasions, normalizes alcohol use and makes use more attractive.

Pay-day alcohol use, in addition to the economic consequences, can lead to heavy episodic alcohol use and also asocial behaviour following use.

Addressing this phenomenon “alcoholization” of social occasions is best carried out through community interventions. Successful interventions to address pay-day alcohol use and use of alcohol in special occasions have been documented in SEAR countries, which can be applied context-sensitively to other settings in the Region.

5. Community-level responses

National-level policies and programmes have to be ultimately implemented at the community level to address harms and changes in behaviours. Therefore, community-level responses should be given priority when addressing harm from alcohol use. In the context of the Region, there are many characteristics of alcohol use and harm that can be addressed through community interventions. One is the differences in contexts of use even within countries. Alcohol use in social occasions and pay-day drinking are two other factors that were discussed before. The widespread use of unrecorded alcohol, and to address which laws and taxation are not effective, are additional issues that requires community action.

The second report of the WHO Expert Committee on Problems Related to Alcohol Consumption recognized that there are approaches to community action that can be used in settings such as SEAR. This approach encourages communities and mobilizes public opinion to address local determinants of increased alcohol consumption and related problems.

Communities can address determinants of alcohol by counteracting the attractiveness of the image of alcohol, reducing unfair privileges attached to alcohol

⁶¹ Reducing harm from alcohol use: Good Practices. World Health Organization Regional Office for South-East Asia 2012.

use (which promote violence, etc.), improving recognition of nature and magnitude of health and social consequences of use of alcohol to their own community, recognizing and counteracting the influences that encourage increases in alcohol consumption, encouraging stopping, reducing or changing patterns of consumption and encouraging the implementation of effective local and national policies.

This approach is detailed in a WHO SEARO publication.⁶² It should be noted, however, that such initiative cannot be conducted overnight. It is very low cost and sustainable and has shown results. But it needs patience, time and ingenuity on the part of the implementers and community workers and practical application of the principals of health promotion.

6. Keeping issue of alcohol-related harm high in the media agenda

The second report of the WHO Expert Committee on Alcohol and Health recognized that there is a need for public health interests to recognize the significance of mass media in the policy debate at the national and local levels. Media coverage of specific issues has an agenda-setting function – that is, influences whether policy-makers perceive a problem and how salient that problem is seen to be. Media advocacy can also be used to support a shift in public opinion for policy changes.⁶³

In the context of the WHO South-East Asia Region, debates and discussions on the hidden and visible harms of alcohol, which are specific to countries, states, different communities and geographic areas, should be placed in media space. Such discussions can be initiated through traditional media, such as newspapers, radio and television as well as through newer social media. Tobacco control benefited from such discourses. To lead to individual, community, population and policy level change, such publicity should be sustained over a period of time. Such a process, if initiated within countries or states in larger countries, will help empower individuals and communities to address harms of alcohol use as well as create a demand for effective and context-specific local and national alcohol control policies that cannot be ignored.

⁶² Reducing harm from use of alcohol: community responses. Alcohol Control Series, No. 5 WHO Regional Office for South-East Asia 2006.

⁶³ Second report, WHO Expert Committee on Problems Related to Alcohol Consumption. (WHO technical report series; no. 944), World Health Organization 2007.

7. Capacity-building – policy-makers and legal fraternity

The capacity – human, institutional and financial – for development and implementation of alcohol control policies needs to be strengthened in most countries of the Region. This subject is spelt out in more detail in the WHO Global Strategy on Harmful use of Alcohol. However, this is one of the most pressing needs in the Region to combat the potential future harms of alcohol, and should be addressed on a priority basis. As far as human capital is concerned, policy-makers, the legal profession and bureaucracies should be given high priority, as alcohol control goes well beyond the sphere of health. It is urgent to initiate this building process as capacities cannot be improved overnight. It will be a long drawn-out process, and also will be difficult to sustain in the context of this Region.

8. Helping users

In the context of the Region, the most suitable and cost-effective approach is brief interventions. It is a low-cost, effective and easily trainable method that can even be adapted to work at community clinics. This approach aims to identify potential alcohol-related problems of individuals and tries to motivate the user to do something about it. This approach is discussed further in the WHO Global Status Report on Alcohol and Health 2014.

This publication outlines public health aspects of alcohol use and harm in WHO South East Asia Region Countries. It summarizes Global Regional and country specific data and also discusses aspects of alcohol control that are important in the context of the Region. The possible future trend of alcohol use in the Region is also analysed and current and future barriers to effective alcohol control in countries of the Region are discussed.



**World Health
Organization**
REGIONAL OFFICE FOR
South-East Asia

World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India
www.searo.who.int

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