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THE GLOBE

Pacific Issue



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THE GLOBE

GLOBAL ALCOHOL POLICY ALLIANCE

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Editorial

Recognition that the world is facing an alcohol epidemic affecting every continent is evidenced from the WHO Global Burden of Disease. Globally alcohol causes 3.2 per cent of death and 4 per cent of ill health and disability. Thomas Babor comments: 'No other product so widely available for consumer use, not even tobacco, accounts for as much disability as alcohol.'

Evidence of growing international concern among social and health circles is seen by the decision of the WHO Executive Board to place a resolution regarding the public health problems caused by the harmful use of alcohol on the agenda of this year's World Health Assembly (see page 21).

Whilst the resolution fails to explicitly address the marketing strategies of the global alcohol industry that has contributed to the explosion in binge drinking, it does call upon the Director General to produce a report on evidence based strategies to reduce alcohol related harm.

This international concern is mirrored by the American Medical Association in placing on the agenda of the World Medical Association's Socio-Medical Affairs Committee in France a similar resolution to reduce the global impact of alcohol on health and society (see page 22).

Alcohol has become the leading risk factor in the disease burden of the Western Pacific.

Pacific islanders who a generation ago had little drinking and few problems have not escaped the epidemic. Alcohol certainly reaches all parts of the globe and no part remains immune from the problems associated with intoxication and dependence. This issue of the Globe gives coverage to governmental and non-governmental conferences of Pacific island people concerned about the growing alcohol epidemic from which they have not remained immune.

Derek Rutherford

Pacific people meet to discuss alcohol policy issues

Government officials from 17 Pacific islands and territories attended a meeting on "Alcohol and Health in the Pacific" at the Secretariat of the Pacific Community (SPC) headquarters in Noumea, New Caledonia. The meeting was sponsored by the Secretariat of the Pacific Community (SPC), the World Health Organization (WHO) and the New Zealand Ministry of Health.



The SPC has an extensive Public Health Programme but this was the first regional meeting in 20 years to look at alcohol and health in the Pacific

Dr Harley Stanton, SPC's health promotion adviser outlined the reason for the meeting: "Alcohol use in the Pacific has increased significantly and measures aimed at

reducing alcohol related health and social problems, such as violence, car crashes, domestic violence, sexual assaults, child abuse, suicide, have not kept pace. It is a cause of concern to the Secretariat of the Pacific Community."

Cheap alcohol is now sold widely through the Pacific. Twenty years ago, much of the Pacific was virtually alcohol-free but there are now rising rates of problem drinking in many Island countries. In Tuvalu and the Solomon Islands, only 20-30 per cent of the population drink alcohol, but rates are much higher in the Cook Islands, New Caledonia and Tahiti.

Pacific people meet to discuss alcohol policy issues

Drinking by young people is of great concern. "I have visited Kiribati for many years, and it is quite common to see young men wandering down roads drunk in the middle of the day," Dr Stanton said.

Participants presented island profiles during the meeting and these are summarised in this issue of the Globe. (pages 6-12) The profiles show the following trends :

- The percentage of alcohol users in populations varies quite significantly across the region from 20-30 per cent in some low use countries such as the Solomon Islands, Tuvalu and to some extent Vanuatu, up to 80-90 per cent of the population in French Polynesia, New Caledonia and Wallis and Futuna;
- There is a strong bias to male drinking in a number of countries including the Federated States of Micronesia, Papua New Guinea, Solomon Islands, Tuvalu and to a large extent Vanuatu;
- Within most countries, among those who do use alcohol roughly 20-30 per cent are heavy drinkers and exhibit problem drinking behaviours;
- Many Pacific drinkers drink episodically or in a "binge" way,

Recommendations of SPC/WHO Alcohol and Health Meeting

The Technical Report¹ of the meeting is circulated to governments, relevant organisations in the countries, donor organisations and relevant regional and international organisations;

A working group comprising interested members of the 2004 SPC/WHO meeting on alcohol and health in the Pacific with input from representatives from key non-governmental organisations, is convened by the SPC in collaboration with the Western Pacific Regional Office of the WHO during the first quarter of 2005 to enable follow up to this meeting and to develop a draft Regional Action Plan to reduce the harm done by alcohol, within the context of existing regional activities, including the Tonga Commitment and the Healthy Islands initiative;

Following the working group meeting, a broader meeting should be convened of the Pacific Island Countries and Territories, the SPC, the WHO, donors, regional organisations and relevant non-governmental organisations to further the development of the draft, and to prepare a coordinated plan for donor cooperation prior to wider consultation with and consideration by Pacific Island Countries and Territories;

Where these are not already in place, Pacific Island Countries and Territories are urged to convene inter-agency coalitions and partnerships, including representatives of governmental and non-governmental organisations, public health, health, law enforcement, social welfare, women's and youth groups to receive the report of the meeting and to strengthen national efforts through the development of appropriate national plans of action;

The country coalitions should consider the feasibility of increased and sustainable funding for alcohol policies and programmes through the establishment of a national health foundation or similar organisation, where such foundations or organisations are not in place, which could be funded through a proportion of tax on alcohol;

Mechanisms should be encouraged at the country level to enhance the efficient planning, coordination and

management of alcohol related projects and programmes;

The SPC and the WHO are requested to provide technical assistance and capacity building to the Pacific Island Countries and Territories to support their efforts to reduce the harm done by alcohol, including efforts to establish health foundations or similar organisations;

The SPC and the WHO are requested to work with the Pacific Island Countries and Territories to increase the availability and analysis of data on alcohol use, its health and social consequences and its economic costs, also linked to the broader context of NCD prevention and surveillance;

Donors are invited to consider expansion of the Pacific Action for Health project to as many Pacific Island Countries and Territories as possible, including reviews on existing alcohol policies;

The Pacific Island Countries and Territories and regional organisations should work to ensure that regional and global trade agreements such as the Pacific Islands Countries Trade Agreement (PICTA) do not limit the capacity of signatory countries to utilise taxation or other policy measures to prevent the public health and social disorder consequences of alcohol;

A network of representatives of Pacific Island Countries and Territories on alcohol policies and strategies should be established and supported by SPC in collaboration with the Western Pacific Regional Office of the World Health Organization and in partnership with the Global Alcohol Policy Alliance; and

The Western Pacific Regional Office of the World Health Organization is invited to include alcohol as a technical topic in its September 2005 Regional meeting. Further, Member States are invited to raise the issue of the prevention of the harm done by alcohol at the Pacific Islands Forum and at forthcoming regional meetings of ministers of health, trade and youth.

¹ SPC/WHO Meeting On Alcohol and Health in the Pacific, 28th-30th September, 2004, Noumea, New Caledonia, Secretariat of the Pacific Community, Noumea, New Caledonia, www.spc.org.nc/health

Pacific people meet to discuss alcohol policy issues



- particularly at weekend
- There is a widespread and increasing problem of youth drinking at earlier ages in a large number of the countries. This was reported from the Cook Islands, Federated States of Micronesia, Fiji, Guam, Kiribati, Marshall Islands, Palau, Tonga and Vanuatu.

The meeting agreed that strong political commitment was needed to support and finance coordinated responses to alcohol problems. The SPC and WHO were asked to help Pacific Island countries gather information on alcohol use, health and social consequences and economic costs. The SPC also undertook to support a network of Pacific people working on alcohol policies and strategies, in collaboration with the Western

Pacific Regional Office of WHO and in partnership with the Global Alcohol Policy Alliance.

Asia Pacific NGOs meet in Auckland

Prior to the governmental meeting in Noumea non-government organisations and public health agencies from the Cook Islands, Fiji, Kiribati, Niue, Samoa and Tonga met in Auckland, to discuss alcohol policy. There were also participants from China, Japan and Sri Lanka. A key purpose of the gathering was to begin building a Pacific network on alcohol policy issues.

The meeting was funded by New Zealand's Ministry of Health and hosted by Professor Sally Casswell, Director of the SHORE Centre, Massey University, Auckland.

SHORE's Pacific researchers and partner research group WhÇriki participated. There were also participants from New Zealand non-government organisations, Alcohol Healthwatch and NZ Drug Foundation and invited speakers from non-government umbrella organisations Eurocare and the Global Alcohol Policy Alliance.

A main discussion point of the meeting was a report commissioned by the Pacific Forum about the inclusion of alcohol and tobacco in the Pacific Island Countries Trade Agreement (PICTA). The report had looked at the impact of free trade in alcohol on the location and quality of production, local employment and tariff revenues for Pacific governments, but did not consider the social and public health impact of increased trade in alcohol or the economic consequences of these. (See Stanley Simpson's paper delivered at the meeting page).

An Action Plan that included suggestions on the minimum age of purchase, drink driving laws, licensing, controls on advertising and sponsorship, research capacity, community action and trade treaty issues was agreed.

In the Pacific Island profiles contributions from NGO representatives at the Auckland meeting are included.



The Auckland meeting pauses for a photo.

Pacific Island profiles

Participants at the Noumea and Auckland meetings shared information about alcohol and alcohol policies

In general, Pacific communities have lower proportions of drinkers than most Western countries but the rates are increasing. Drinking rates and average consumption rates per adult tell us little about patterns of drinking. Pacific people who do drink tend to drink until intoxicated. A study of future public health costs in Tonga, Vanuatu and Kiribati projects that:

the costs related to tobacco and alcohol use alone will increase from approximately 9 per cent of the non-communicable diseases treatment budget to 21 per cent by the year 2020. These financial burdens (which do not include any hospital outpatient or social costs to the community e.g. time off work, etc.) will have major impacts on the national economies of these countries.¹

Fiji Comprises over 300 islands. (Pop. 836,000)

Dr Odille Chang, St Giles Hospital, Suva informed the Noumea meeting that:

Alcohol is readily available and accessible. It is an accepted part of the culture and binge drinking is common. Fiji's average consumption per head of population between 1994 and 2003 was 22.79 litres for beer and 0.72 litres for spirits.

A survey in 1999 showed that drinking was more common among males – 26 per cent of men were drinkers compared with 9 per cent of women - and men's drinking increased with age. Asked if they had ever been drunk, 21 per cent of men in the survey said yes, as did 6 per cent of women, 15 per cent of Fijians, 11 per cent of Indians and this was most common among the

older students. Sixty-nine per cent of the male drinkers, 54 per cent of females, 74 per cent of Fijians, and 58 per cent of Fijians reported binge drinking, and this also increased with age. Nearly half of all male drinkers and a third of females had started drinking at less than 10 years of age.

In 2003, 21 per cent of all road traffic fatalities and 11 per cent non-hospitalised casualties were alcohol-related. Injuries were up 51 per cent from 2002. Most occur on Saturdays and Sundays at peak times of 3pm-8pm and 9pm-12pm.

Fiji is an alcohol producing country. In 2003 it exported 661,000 litres (\$1.8m) of liqueurs and spirits, particularly rum (\$1.5m), beer (\$0.166m) and wines (\$0.11m). It imported even more alcohol: liqueurs, spirits (\$5.2m); beer (\$0.558m), 1.8m L (\$12m) and

wines (\$5.9m). Customs tariffs are charged at rates of \$1.55 to \$68.66 per litre, or 27 per cent of total value depending on the type of beverage and its alcohol content.

The Liquor Act 1975 regulates the sale and consumption of alcohol. The Act was reviewed in 2002-2003 and a Bill is currently being prepared. There is currently no national policy on alcohol.

Tonga (Pop. 98,300)

Dr Viliami Puloka, Head of Promotion & Non-Communicable Diseases told the Noumea meeting:

Until 1989 there was a general prohibition on alcohol consumption, with some specific allowances. Now this has been lifted and there are limited restrictions. Currently, 21.3 per cent of Tongans are drinkers. Thirteen per cent report having been drunk at least once. There is no data available to show trends, but anecdotal evidence indicates a steep rise in consumption since 1989. Some local church-based programmes address alcohol issues, and there is some financial support from the Pacific Action for Health Programme.

Alcohol and tobacco were responsible for 10.4 per cent of the non-communicable disease hospital admissions and 19.6 per cent of all hospital expenditures in 2002. Tonga's Non-Communicable Disease National Strategy has alcohol as a key focus area. An interagency alcohol sub-committee has been formed.

Ofa-Ki-Levuka Guttenbeil-Likiliki, reporting to the Auckland meeting stated that there are no policies or laws to

regulate alcohol advertising in Tonga. Alcohol is advertised on television, radio and the newspaper in Tonga. There are occasional posters and also alcohol signage around the rugby field. Around 80 per cent of young people on Tongatapu would be exposed to these media, although exposure would be lower on the outer islands.

Tonga's small brewery, the Royal Beer Company, is part-owned by the royal family, but Carlsberg also has a 49 per cent share. Its beer brand names are Royal and Ikale ('sea eagle').

Samoa (Pop. 170,000)

Viliamu Emanuele, Sautiamai Catholic Family Ministry and Tautala Mauala, Samoa Red Cross Society reported to the Auckland meeting:

Government policy has been to encourage economic development and increase employment opportunities by creating a positive environment for local and foreign investment. The Samoan beer industry is subject to government policies, including price regulation, but there is no regulation for imported alcohol products, including wine and spirits other than tariffs which are being reduced under World Trade agreements. Some Samoan businesses engage in manufacturing and importing spirits. Several supermarkets import and sell wines.



The manufacture and sale of all alcohol beverages containing 2 per cent pure alcohol or more is controlled by the Liquor Act 1971, amended in 1997. Alcohol may be sold to any person aged 21 or over, unless they are subject to a prohibition order. It is an offence for any person under 21 years to drink alcohol or have alcohol in their possession in any hotel, club, resort or public place. Hotels, bars and clubs must obtain a licence from the Liquor Board. Alcohol may not be sold on Sundays or 'as the Licence Board directs from time to time', and bars and nightclubs close at midnight.

The Liquor Act explicitly states that alcohol advertising must not target young people, and all media advertising must comply with government regulations to avoid offensive or problematic advertising. However, over 40 per cent the population is aged 5-19 and is exposed to alcohol advertising. Alcohol is often marketed through 'incidental' promotion in other advertising – by showing wine bottles and people drinking cocktails in advertisements for hotels and restaurants. Billboard advertising for alcohol have been erected around the islands.

Young people are targeted with advertising for Coca-Cola and it is well-known in Samoa that Coca-Cola and Valima beer are Samoa Breweries' two main products. So Coca-Cola advertising and sponsorship can be interpreted as an indirect and long term approach to growing the future local alcohol market. Through the Coca-Cola brand, Samoa Breweries' sponsors youth development activities, school sports and other events. It provides sponsorship, prizes and drink discounts for the primary schools netball tournament and the Champ of Champs schools competition.

Samoa Breweries provides alcohol sponsorship for adult sports events,

including logos on sports clothing. Valima beer sponsors Samoan rugby, particularly the NPC Valima Cup, and club rugby such as the Marist Sevens and Motua Tens. This includes hosting fund-raising events and providing alcohol products for match events. It has also sponsored cultural events such as the Teuila Festival and for Miss Teuila 2004

Niue (Pop. 1,600)

Minemaligi Asu Hetutu Pulu, Public Health Department reported to the Noumea meeting:

The current prevalence of drinking is estimated to be around 20 per cent among both males and females aged 16-20 and 30 per cent for those aged 21-30.

Among people aged 31 to 50 it is 30 per cent for women and 50 per cent for men. Among those aged over 50, around 20 per cent of men and 10 per cent of women are drinkers. Weekly drinking and binge drinking are very common.

Niue currently has no national policy on alcohol. However, the Liquor Act 1975 prohibits the sale of alcohol to people under 18 years of age. A licence is needed to sell alcohol. A Liquor Board oversees licensing, sales, opening and closing hours and consumption issues.

Ben Tanaki, Niue Association of NGOs, reported to the Auckland meeting

The government is the sole importer of alcohol. Take-away alcohol is sold from the government's Bond Store. The Act provides for licensing to manufacture alcohol, as an import substitution policy, but this has not happened since a local venture producing Fiafia ('happy') lager ceased operation in the early 1990s.

Broadcast advertising of alcohol has been restricted by the Broadcasting Corporation of Niue.

Forms of alcohol sponsorship do exist, however, in that a government

beer tax of NZ\$1 per can goes to a special fund earmarked for local sport organisations or activities. The Treasury also distributes at its discretion promotional materials received from New Zealand breweries – posters, free beer and other products such as sports equipment carrying brand names and logos.

Another example of sponsorship is by the Nuku Club, licensed to sell alcohol on and off the premises, which sponsors the annual local outrigger canoe race on the day of the Constitutional Celebration. This competition is a national event, with prizes (mainly cash) primarily sponsored by the Nuku Club. There is a significant presence and attendance of young peoples during the event.

In August 2004, the Liquor Board was seeking the view of the public on whether alcohol should be sold in the country's supermarket and in other small retail shops in town as well as in the villages. Niue is not immune to the constant pressures of economic changes and development which, if we are not very careful, could inflict unnecessary and undesirable social consequences.

Kiribati (Pop. 98,549)

Teurakai Ukenio, Ministry of Internal & Social Affairs

informed the Noumea meeting:

In Kiribati, the only alcohol produced locally is a sour palm toddy called kaokioki. All beer and other alcohol is imported from Australia. Two out of seven importers of alcohol to Kiribati are government owned, Abamakoro and BKL, and these import over 60 per cent of the available beer. There is an informal agreement that beer should only be imported in aluminium cans, but there appears to be increasing imports of glass stubbies. A recent assessment of quantities of alcohol imported in

2002 compared with the 2001 and 2000 years shows a 24.5 per cent increase for beer, increases of 77.6 per cent and 73.8 per cent respectively for spirits and ready-to-drink spirits, with wine dropping by 46 per cent. The 2002 data provides a per capita intake of 2.92 litres per head of population aged 20 and over. This does not include local toddy.

Recently, some concerns about alcohol sales have been raised – minors being sent to buy alcohol for a parent, underage drinkers being able to buy alcohol with showing an ID, and minors going into nightclubs, which are open until 2 am. The police have recently been visiting venues popular with young people to curb underage drinking, with a significant number of arrests and closures of sour toddy outlets. Some schools have recent petitioned for nearby outlets to be closed during daylight hours. Amendments to the current Liquor Ordinance are expected in early 2005. Police officers have been trained on breathalyser use through a Pacific Police Project, but the required regulations under the new Road Traffic Act have not yet been finalised.

Recent assessments at Bikenibu and Betio hospitals indicate that 5-25 per cent of those seeking treatment out of hours are affected by alcohol. Data on alcohol related orders such as liver disease is poor because of difficulty distinguishing this from Hepatitis B which is endemic in Kiribati. Imported films and DVDs are a main source of entertainment, but these do not have alcohol advertisements. However, we strongly believe that the effect of watching people smoking, drinking and abusing drugs in the movies provides our young people with temptation to adopt such behaviours and attitudes.

A framework for alcohol policy has been set out proposing changes in



taxation and liquor availability. A Government action plan for youth sets out an integrated approach to reduce harm done by youth drinking, counselling services and increasing taxation on imported alcohol beverages by 10 per cent to fund prevention and counselling services and to establish a national youth coordinating body.

Cook Islands (Pop. 14,000)

Tuaine Teokotai, Chief Health Inspector, Department of Public Health

The Cook Islands government is committed to addressing alcohol issues, including advertising. The current focus is the promotion of moderation and reducing alcohol related problems. Average annual alcohol consumption in 2000 was 4.8 litres per person, but there is very little information on current patterns of drinking. A survey back in 1993 found that 91.3 per cent of male drinkers and 85 per cent of female drinkers had start drinking at 16 years of age.

In 1991-1992, a Sale of Liquor Act established a Liquor Licensing Board, and policy development and legislation are of the Ministry of Health's current work programme. However, no specific resources are allocated for alcohol control. Alcohol health promotion is funded from the budget allocation for health and for health education. Educational materials in Cook Islands Maori and English are distributed, and the Ministry has identified training and production needs in the area of information and communication.



In 1998 the Cook Islands Healthy Island committee established a sub-committee to review the sale of liquor. It recommended:

- a liquor licensing fee that would help fund an alcohol education programme
- making public venues and events alcohol-free
- banning all forms of advertising and sports sponsorship by alcohol companies
- imposing a tax on alcohol, with revenue going towards health promotion and treatment.

The Ministry is working with all interested parties on initiatives to inform the public about the impacts of alcohol and to develop a National Alcohol Strategy. The goal is to reduce alcohol related problems, focusing on the following areas in particular:

- Alcohol and young people
- Road crashes and accidents
- Alcohol and sports
- Drinking environments
- Alcohol related violence.

'If you drink and drive, you're a bloody idiot': the message against drink-driving on a festival float, Rarotonga.

Papua New Guinea

(Pop. 5,695,300)

Kaii Len Dagam, Director of Public Health

Consumption of alcohol, including that of teenagers, is causing enormous social problems in the area of accidents, crime and domestic violence. No consumption figures are available, but it is known to be high, with high levels of binge drinking. Teenage drinking is increasing, with boys as young as 12 already drinking. A recent survey found that 26 per cent of 13-18 year

olds drank alcohol regularly. It is mainly males who drink, mainly those living in the towns.

Far fewer women drink but the proportion is increasing. Binge drinking occurs mainly during the weekend, but also during the week and at parties. Fifty per cent of hospital admissions are related to trauma, and alcohol is thought to be implicated in 96 per cent of cases. Upper respiratory tract cancers are very common.

Alcohol was banned until 1962, when the legislation was repealed and an Alcohol Consumer Commission was set up. Papua New Guinea is now an alcohol producing country – the South Pacific Brewery is based there – and there are also alcohol imports from Australia and South East Asia. Traditionally produced alcohol is homebrew, and kava is also drunk.

Liquor licensing laws cover requirements for the sale of alcohol, restricted operating hours, and a minimum age for selling, buying and consuming alcohol. There is no clear, co-ordinated national alcohol plan, and no Public Health Act that deals with alcohol or tobacco. The National Health Plan 2001 to 2010 focuses on health education, health promotion and community involvement.

Solomon Islands (Pop. 460,100)

Albby Lovi, Director of Health Promotion Services

Data from 1994 provides an average alcohol consumption figure of 0.7 litres of pure alcohol per adult (aged 15+). This low level partly reflects the concentration of alcohol outlets in Honiara and the other provincial centres and the fact that 90 per cent of Solomon Islanders live in rural villages and have limited involvement in the cash economy.

In the towns, alcohol is sold widely and 60 per cent of young people

drink – mostly males. A 1992 study found that 54 per cent of reported criminal offences in the Solomon Islands were alcohol-related. Alcohol-related road traffic accidents have been increasing and drink-driving legislation has been enacted.

Traditionally, home brew and palm toddy have been produced, and kaleve is also consumed. By 1994, locally manufactured beer accounted for some 80 per cent of pure alcohol consumed. Around 17 per cent was imported beer and 3 per cent was imported spirits.

There is a 15 per cent import tax on alcohol products, and 10 per cent general sales tax is payable on alcohol products made in the Solomons. The Solomon Brewery Company now produces 2.7 million litres of beer annually.

There is currently no government policy on alcohol control and harm prevention. Community alcohol awareness programmes that take place are usually church-based. A non-communicable diseases unit was established two years ago and there are plans to strengthen this unit. In 2005, the Ministry of Health plans to launch a Community Awareness on Alcohol project and to improve data collection on alcohol consumption, alcohol-related disease and social problems.

Federated States of Micronesia

Kerio Walliby, Chief of Section for Substance Abuse and Mental Health Department of Health, Education and Social Affairs informed the Noumea meeting that:

The Federated States of Micronesia consists of 4 states, Chuuk, Pohnpei, Yap and Kosrae. The total population is 107,008, according to the 2000 census.

Alcohol was clearly a Western contribution to Micronesia by the European and American contact

with the islands in the mid-nineteenth century.

2.6 per cent of boys and less than 1 per cent of girls drink in the age group 10 to 14; this grows to 32.4 and 5.5 among 15 to 19 year olds; among young adults 63 per cent of males and 8.1 of females in the age group 20 to 29 drink, rising to 69.5 and 14.6 respectively for those between 30 and 34 years.

The low female rates of alcohol use are indicative of the strong cultural prohibition on female drinking that persists even today. The proportion of drinkers decrease in those aged over 45 years.

90 per cent of all arrests of young people under the age of 18 were for “illegal possession and consumption of alcohol; disturbing the peace, assault and battery, burglary and larceny to get alcohol or money to purchase alcoholic beverages”. This trend appears to continue until the late twenties and early thirties in most Micronesian Societies.

The Federated States of Micronesia does not have any jurisdiction to regulate alcohol laws except to impose import tax. The National Government has a current policy of 6 per cent import tax on alcohol and each state has its own implementation of sales tax (excise tax).

In Pohnpei State, any business which offers for distribution, wholesale sale, retail sale, use or consumption of alcoholic beverages and /or any tobacco products are prohibited from advertising these products in any way:

The National Plan of Action has the following three objectives:

To build regional capacity and infrastructure at the state and community level by strengthening the capacity to train prevention specialists, school faculty, and staff and to make this training available regionally, nationally and

internationally. Currently substance abuse prevention functions are under-staffed, under-funded and under utilised.

To prevent the onset and reduce the progression of substance abuse including childhood and underage drinking by using an effective model prevention program that will be implemented to improve behaviour.

To reduce substance abuse-related problems in communities by developing capacity of regional agencies to establish effective community substance abuse prevention systems.

French Polynesia

Dr Marie-Francoise Bruginoux, Alcohol and Drug Consultant, Ministry of Health reported:

Alcohol consumption in 1968 was 10.4 litres per capita declining to 6.6 in 1968, rising to 8.2 in 1993 and has been just under 7 litres since 2000.

Surveys of students have shown that among 14 to 15 year olds 30 per cent have experienced bouts of drunkenness; 64 per cent of 16 to 17 year olds and 70 per cent among 18 to 19 year olds. 6 and 11 per cent of Children 10 to 11 and 12 to 13 years respectively have also experienced bouts of drunkenness.

Alcohol has been one of the main causes of road accidents -1 in 3 cases of physical injury and 1 in 2 fatal accidents. In 2003, the official statistics recorded 328 accidents, with 439 people injured and 38 fatalities. These figures are underestimated. The 2001-2003 figures were 153 killed, 536 seriously injured and 849 slightly injured.

Responses to the alcohol problem has been action on alcohol consumption in public places (1959); ban on sales of alcohol to minors since 1959 with penalties made more severe in 1999; lowering of legal blood alcohol limit to 0.5g/l in 2001; direct and indirect

advertising for alcoholic beverages banned in sports venues and at sports meetings in 2003 and limitations on advertising of alcoholic beverages but no ban.

Taxes on alcoholic beverages to fund prevention activities; establishment of a State/Territory committee on prevention of drug addiction to coordinate prevention work and the launching of an annual territorial alcohol-free day.

Guam

Peter Roberto, Director of the Department of Mental Health:

Data from 2003 indicate that 5.7 per cent of adults are at risk of heavy drinking and that 18.7 per cent of adults are binge drinkers. Both heavy drinking and binge drinking are more prevalent among males. Heavy drinking is more common among younger adults (18-24), those with lower incomes and lower educational attainment. Binge drinking appears to be more common among young and middle aged adults, and those with mid-level incomes.

Underage drinking is prevalent. Among youth, the 2003 youth survey reports that 71.3 per cent of High School students have had at least one drink of alcohol, with 8.5 per cent of all High School students having had their first drink at 8 years old or younger.

Over 17 per cent of high school students state that they have gone binge drinking, 10 per cent have driven a car after drinking alcohol and 37.6 per cent have ridden in a vehicle in the past month driven by someone who had consumed alcohol. Guam Police Department statistics reveal that in the year 2000 over half of fatal motor vehicle crashes were alcohol and drug-related.

Current policies include a legal drinking age of 18, a 0.08 Blood Alcohol Concentration limit and

mandatory assessment and treatment of driving under the influence offenders. Taxes on alcoholic beverages not manufactured on Guam were increased as of May 2003, with 50 per cent of tax revenues going to the “Safe Homes, Safe Streets Fund” established to address the prevention of underage drinking, the promotion of traffic safety and the enhancement of alcohol and drug treatment programs. There are no advertising restrictions for alcohol.

Recent developments that may augment alcohol control efforts include the creation of the Governor’s PEACE Council for substance abuse prevention, and the strong likelihood that the a five year multi-million dollar grant for substance abuse prevention and early intervention will be awarded, with a focus on the reduction of underage drinking.

A special ballot raising the alcohol drinking age to 21 years, introduced during the November 2002 elections on Guam, did not receive a majority vote.

Other current challenges include poor enforcement of laws, heavy advertising of alcoholic beverages in all media, cultural acceptability of alcohol use and the availability of alcoholic beverages, such as during events at the University of Guam Fieldhouse.

An area of concern are the proposals to give tax credits against tobacco and alcohol taxes for corporations that donate money for various purposes such as building a sports complex, funding the Guam Memorial Hospital, and maintaining the Paseo.

No island-wide alcohol prevention plan of action exists.

New Caledonia

Dr Bernard Rouchon, Medical Director of Health Prevention Department of Health

Over the past 10 years there has been a steep rise in alcohol

consumption reaching 9.8 litres per capita in 2002.

Of those who drink alcohol, it is estimated that 40 per cent are occasional drinkers, 22 per cent light drinkers, 15 per cent heavy drinkers and 21 per cent weekend binge drinkers.

The 2002-2004 programme has the overall objective of reducing the health and social consequences arising from alcohol. There are three specific objectives:

Influence attitudes, representations and choices in order to find individual and collective responses to the events of life other than through alcohol.

Educate users and develop a sense of collective awareness of risky and harmful consumption patterns in order to reduce the prevalence of heavy drinkers.

Optimise and strengthen care systems for accessible, rational, diversified and graduated care to combat harmful alcohol use and alcohol-dependence.

Development of research and evaluation of care and prevention

The ‘Alcohol Risk Prevention Unit’ is responsible for overall programme coordination, in particular the setting up of a prevention and care system, training partners and evaluation. The ‘Alcohol Abuse Prevention Association’ (APAA) plays a primary prevention role. The ‘Alcohol Therapy Centre’ (CATA) offers care. The rest of the system is integrated into New Caledonia’s health and social facilities.

Palau

Dr Sylvia Andres, Chief of the Division of Behavioural Health, Ministry of Health

A 1997 survey of 802 men and women found a lifetime prevalence rate of 46.8 per cent. Problem drinkers were 17.8 per cent of the entire sample.

The youth risk behavioural survey found in 1997 that 29.5 per cent of students had drunk five or more drinks in a row on one or more of the past 30 days. The proportion was 31.5 per cent in 1999 and 30.4 per cent in 2001.

There is a law that restricts vending machines for alcohol. The import tax on alcohol was increased in 1997 and decreased by 50 per cent in 2002. There is a law that extended curfew hours to 4am including the sale of alcohol.

Of Palau’s’ total budget, about 16 per cent comes annually from the local budget. There is Federal Funding from SAMHSA.

Republic of the Marshall Islands

Gerard Mejborn, Coordinator of Human Services, Ministry of Health.

The Republic of the Marshall Islands consists of 1,225 atolls scattered over 750 square miles of ocean. Of these atolls, there are five single islands and 29 groups of coral-atolls. The population is approximately 53,000.

Majuro Atoll, which is also the capital city, and Ebeye, Kwajalein Atoll, which is the second most populated location, are the only places in the Republic of the Marshall Islands in which it is legal to sell or consume alcohol.

The Republic is currently experiencing severe problems relating to the use of alcohol. The problems are mostly concerned with young adults, around the ages of seventeen to thirty years of age

The Law Enforcement authorities such as the National Police Force and the Local Government police are constantly called upon to intervene in mostly domestic problems related to high alcohol consumption. Police estimate that up to 70 per cent of the arrests for criminal behaviours involve alcohol as a major contributing factor, and

these include theft, sexual-violence, assault, auto-incidence and improper conduct in public areas.

The Islands have one of the highest rates of suicide in the world, mostly amongst young people. The problem of suicide parallels the alcohol consumption in two ways. It is predominantly a male related problem and it is estimated that 93 per cent of the individuals who attempt suicide have alcohol as a major contributing factor. The mood depressant effect of alcohol is a major contributor to the loss of life through suicidal behaviour.

While resources are scarce, there are a few agencies and institutions (religious, educational, etc) that are addressing the problems of alcohol, tobacco, and other illegal drug addiction and related behaviours.

Tokelau

Dr Petelo Alapati Tavite, Public Health Policy Adviser, Department of Health
Tokelau has been a territory of New Zealand since 1948 and is located 480 km north of Samoa and comprises three low lying atolls of 12sqkm size with 127 islets, only four of which are occupied. The atolls are widely separated by sea, with Atafu inhabited by 700 people, Nukunonu by 300 people, and Fakaofu by 500 people.

50/100 cartons of 270ml and 150ml Vailima Samoa beer respectively and 1-4 cartons of spirit are imported fortnightly. There is local production of toddy. 75 per cent of the population consume alcohol. 70 per cent of alcohol consumers are men and 30 per cent are women.

Alcohol policy takes place at the village level. The minimum drinking age is 18 years. Only the village store can order alcohol, and is open two days a week. The limit of sale is 2 x 270ml or 6 x 150ml cans of beer a day for men and 1 x

270ml or 3 x 150ml cans of beer a day for women and 1 bottle of spirits a week. There are no national plans and no budget allocation for alcohol related programs.

Tuvalu

Fanoanoaga Patoro, Chairman, Tuvalo National Alcoholic Drinks Licensing Committee.

Tuvalu comprises nine Coral islands with a land area of 26 sq km spreading over a sea area of 900,000 sq km. About 48 per cent of the total population of 9,500 (2002 Census) resides on the urbanised island of Funafuti

22.2 per cent of the population consume alcohol with 46 per cent of the male population 15 years and over drinking. Alcohol consumption is predominantly prevalent between the ages of 18 and 40 years.

Alcohol is mostly imported into the country. The volume of beer has fluctuated over the last 6 years, but there has been an increase in the volume of both imported wine and spirits.

Most alcohol policy issues are covered under the Alcoholic Drinks (1990 Revised Edition) Act, Control and prevention of alcohol programs have largely suffered though a lack of resources. Donor partners (SPC, WHO) have facilitated support and assistance in public health. The government receives \$15,000 annually from alcoholic licences, of which only \$350 is spent annually on the control and surveillance of alcohol consumption.

The government is planning, through its alcohol licensing committee, to create a national forum to develop a national policy. The forum is part of a project that is to be submitted for donor assistance. The project is called "strengthening alcohol controls and publicising awareness".

Wallis and Futuna

Geraldine Danigo, Health Agency
Wallis and Futuna has a population of 10,071 people in Wallis and 4873 in Futuna. 50 per cent are aged 0-19 years, 43 per cent 20-59 years and 7 per cent 60 years or older.

The largest section of the population who drink are 20 to 29 year olds – 72 per cent males and 13 per cent females; 30 to 49 year olds follow with 64 per cent and 3 per cent respectively 50 to 59 – 40 and 1 per cent. Young people aged 15 to 19 – 44 and 1 per cent. The most frequent drinkers are the 50 to 59 age group.

Alcohol related harm – accidents, illness and hospitalisation is experienced most by the 20 to 29 age group.

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Alcohol and Pacific Island countries' trade agreement

Stanley Simpson
Pacific Network on
Globalisation, Fijiⁱ

Pacific free trade negotiations on alcohol

Globalisation is contentious the world over – even more so for the small vulnerable economies of the Pacific. International agreements are opening up these economies to free trade in goods and services by lowering or eliminating tariffs and other regulations. Unrestricted trade in alcohol and tobacco is currently being considered under the Pacific Island Countries Trade Agreement (PICTA). So far, the debate among political leaders and trade negotiators is about impacts on local production, employment and government revenue versus the benefits of a wider choice of products and lower prices.

But the adverse health effects of alcohol and tobacco are well established. It is disturbing that governments are exploring strategies to help companies make alcohol and tobacco more available in the Pacific at lower prices. We need to look at the dangers that these changes pose for the health and social stability of Pacific communities.

Increased importation of alcohol, together with advertising and other marketing by multinational companies, will lead to increased consumption. We do not even have statistics and costings for the alcohol and tobacco related harm already happening in the Pacific today, yet we are preparing to open up our markets and our people to greater exposure.

PICTA and PACER

A free trade area among Pacific Island Forum countries was endorsed by leaders in 1999, and two documents were finally signed in 2001. The Pacific Island Countries' Trade Agreement (PICTA) lays this out for Pacific Island countries excluding Australia and New Zealand. The region's biggest trading partners were not included because Pacific Island countries were concerned about the huge adjustments local companies would face trying to compete with much larger Australian and New Zealand companies if tariffs were removed. The Pacific Agreement on Closer Economic Relations (PACER) – insisted on by Australia and New Zealand – stipulates that Pacific Island countries must begin negotiations for free trade with Australia and New Zealand eight years after PICTA comes into force, or earlier if Pacific Island countries enter into free trade negotiations with another developed country.ⁱⁱ

The purpose of PICTA is to liberalise trade with the aim of bringing economic and social benefits and improving the living standards of all peoples of the Pacific region. The elimination of tariffs and other barriers to trade will be gradual, with clear rules and conditions of fair competition:

- with a view to the eventual creation of a single regional market among the Pacific island economies in accordance with the respective social and economic objectives of the parties, including the advancement of indigenous peoples...ⁱⁱⁱ

These globalisation processes are happening at a rapid pace and Pacific countries are being pushed by their more developed trading partners into complying with the free trade agenda. In my opinion, we are not fully aware what we are getting ourselves into.

Agreements 'lock in' Pacific nations

PICTA is seen as a 'stepping stone' to economic integration with the wider globalised world order. Businesses will begin to compete with multinationals, and governments will implement adjustments to tax systems, laws, regulations on standards and customs procedures. It is also seen as having political advantages, in that a regional trade agreement can:

- facilitate a 'lock-in' of economic policies so as to discourage backsliding by individual governments, responding to purely political imperatives rather than strong political rationale.

In other words, don't give them much room to pull out if they change their mind later.

This is a concern in regard to alcohol and tobacco. Once you have signed a free trade agreement, it is against the rules or almost impossible to withdraw your commitments – when adverse social and health costs begin to sink in. Future governments are bound by it.

Under WTO rules, if a product is excluded from a trade agreement for public health reasons and this exclusion applies to all countries, then it is unlikely to be contested. However, if barriers such as higher

tariffs by one country discriminate against the products of another country to protect local production or sources of government revenue, they are likely to face challenges and sanctions. These rules severely limit the ability of governments to control the importation, marketing and pricing of alcohol. They will be under strong pressure from trading partners to allow free trade to give consumers more choice and access to cheaper, high quality goods. This is after all the theoretical underpinning for free trade and globalisation.

Since public health is a valid reason for limiting the scope of WTO agreements^v, it may seem surprising that Pacific governments have not used arguments about health and social stability to keep alcohol and tobacco out of PICTA. It appears that early on in the negotiations trade officials had wanted to exclude alcohol and tobacco, but for reasons unrelated to health impacts:

- There were fears that reduction of duties might have a severe negative impact on some government's excise and custom revenues. There was also concern that some Forum Island Countries (FIC) breweries, distilleries and cigarette manufacturers might not be able to compete in a Pacific-wide FTA, with the consequent loss of 'unique' goods currently being produced in FICs.

Advice to Ministers omits social and health impacts

In 2003, the Secretariat of the Pacific Island Forum^v commissioned a study from Dr Wadan Narsey, University of the South Pacific, on the inclusion of alcohol and tobacco in PICTA.³ Although the report was not made public, Fiji is a small place and I was able to obtain a copy, together with the accompanying briefing paper for the 2003 Forum

Trade Ministers' meeting. The report, while quite comprehensive on options and opportunities for island countries, makes only brief mention of health effects. The narrow terms of reference confined the researcher to trade aspects only. The briefing paper makes no mention at all of the social or health costs of including alcohol and tobacco in Pacific free trade.

This is disturbing. It's as if they have turned a blind eye to any adverse social or health impacts of alcohol and tobacco. This omission in advice to Ministers raises serious questions about the whole free trade process and how our leaders are making decisions. It says a lot about where priorities lie and who is having influence in these negotiations.

Alcohol production in the Pacific

The Narsey study found that, in most Pacific Forum countries, alcohol and tobacco contribute significantly to government revenue and to domestic employment and income. There are two large breweries in Papua New Guinea and Fiji, two of moderate size in Samoa and the Solomon Islands, and five micro-breweries – two in Fiji and one each in Palau, Cook Islands and Tonga.

Spirits is produced by two distilleries in Papua New Guinea and Fiji. Narsey notes that only Fiji has a genuine distillery creating a distinct rum brand. The others are essentially blending operations. Alcohol is either crudely distilled locally or imported in bulk, then blended with essences and concentrates to produce the required spirit – rum, gin, whiskey, vodka, mixed drinks, etc. Except for locally produced sugar in Fiji and Papua New Guinea, nearly all ingredients and materials for beer and spirits production are imported (malt, barley, hops, bottles, labels, packaging, etc.).

Alcohol taxes are a significant part of government revenues. In Samoa, beer alone provides 7.2 per cent of the government's tax take and 6.6 per cent of its total revenue. In Papua New Guinea, beer tariffs and taxes provide 3.7 per cent of tax and 2.9 per cent of total government revenue. In Fiji, it is 3.2 per cent of tax and 2.4 per cent of total revenue. In Tonga, Vanuatu and the Solomon Islands, revenue from beer is around 1 per cent of revenue.

The Narsey report recommends the inclusion of alcohol and tobacco in PICTA. To protect government revenues while complying with free trade rules, it recommends that import tariffs on alcohol and tobacco be largely converted to excise taxes^{vi} that would apply to both domestic and imported products, and these can be harmonised across the region. The report provides three options for reducing import duties. If alcohol and tobacco products originate (>40 per cent added value) within the region, tariffs are to be eliminated by 2012; they may be included on the 'negatives lists' for which tariffs are to be eliminated between 2007 and 2016, or a new schedule of reductions can be developed. Tariffs will continue on alcohol and tobacco from non-PICTA trading partners (until PACER begins). However, the level of these 'should not be so high that imports of better quality and diverse range of products are completely shut out' (p.33).

The report discusses ways of protecting beers such as 'Fiji Bitter' and Samoa's 'Vailima' that are 'unique national products giving cultural identity and diversity to each country'. Yet it also notes that all the Pacific producers except the micro-breweries are part-owned and controlled by multinational alcohol companies. Health and sanitary standards in the breweries and distilleries are reported to be

often below accepted standards, with reference made to difficulties attracting skilled personnel. There is little or no health department monitoring of standards and this may be a particular risk in the production of mixed spirit drinks. The report notes 'the universal free market trend...for economies of scale to prevail and small regional breweries to succumb to the large multinationals'. Under PICTA, he suggests, Pacific breweries could cooperate on the purchase of essential inputs to reduce unit costs and increase competitiveness.

Competitiveness might be improved by the development of niche export markets for Pacific beers and spirits and the report also suggests 'the holding of annual Pacific alcohol product festivals for beers and spirits, to be rotated across the producing Forum Island countries, and that products to be entered in metropolitan beer and spirit festivals and competitions'. There is no mention of an annual conference to address the social and health impacts of increased alcohol consumption being promoted at these festivals.

In purely trade terms, the study may make good sense. But free trade will significantly increase alcohol use. If health and social issues are marginalised in negotiations, we are in for a rude awakening when the impacts finally hit.

I understand that Public Health Programme advisers at the Secretariat of the Pacific Community^{vii} are working to keep tobacco outside the free trade agreement. They note that the inclusion of tobacco in free trade agreements tends to lower the price and as a result increase the consumption of tobacco. From a health view point, there is good reason to ensure that the price of tobacco remains high. This thinking should apply to alcohol as well.

Conclusion

Free trade and globalisation is criticised by many people because of its focus on increasing markets and profits, with scant regard for the environment, health and social stability. Trade processes are often uneven and disadvantage small developing countries that face resource constraints and barriers to trade with developed countries, while struggling to ensure the survival of local industries. Developing countries are vulnerable to exploitation as cheap labour and the 'dumping' of surplus products from more industrialised countries. Dumping could be an issue as alcohol globalisation expands in the Pacific under PICTA and PACER. Cheap, left-over beers and spirits from more affluent countries could be lapped up by many Pacific Islanders in the same way they have lapped up cheap unhealthy mutton flaps from New Zealand.

Because Pacific governments have come to rely on alcohol and tobacco for revenue as well as employment, these industries may be given special consideration so that investment remains in the country. In effect, multinationals are rewriting Pacific rules and regulations. The current round of WTO negotiations includes provisions that could give 'investors' like the giant tobacco and alcohol corporations standing to challenge government regulations and seek compensation for lost profits if these do not comply strictly with trade agreements.^{viii}

Pacific young people are now exposed to alcohol marketing from all over the world. We turn on satellite channels in Fiji and see ads for Amstel and Budweiser. Other marketing strategies, such as the linking of alcohol and sporting events, are also worldwide. Fiji Bitter is known as 'the sportsman's beer', and Fiji Gold is being marketed to women as the 'diet coke of beers'.

These things are happening right under our eyes, with little response from health agencies and non-government organisations. We need to build our capacity to understand and influence trade policies, and to develop strategies to influence policy decisions. We must make strong efforts now to oppose the inclusion of alcohol, as well as tobacco, in the Pacific Island Countries Trade Agreement.

This article is based on a presentation to the Asian Pacific Meeting on Alcohol Policy on 23 September 2004 in Auckland.

Stop Press

A meeting of ministers for health in Samoa recently agreed to seek broad support to resist the inclusion of tobacco and alcohol in trade agreements.

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- vi Contrary to public health recommendations that excise tax rates should reflect the alcohol content of drinks (Brian Easton, 2002 Taxing harm: Modernising alcohol excise duties. www.alcohol.org.nz), the Narsey report recommends rates that are a per centage of price to 'ensure that the price competitiveness of cheaper products are not undermined'.
- vii Secretariat of the Pacific Community, New Caledonia, www.spc.org.nc Formerly the South Pacific Commission (and Council), this grouping was established in 1947 by Australia, France, New Zealand, the Netherlands (no longer a member), the UK and USA America. From the 1960s it expanded to now include 22 Island countries and territories as full members. It addresses a wide range of social and economic development issues, including a public health programme.
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Reading between the lines of the Narsey report

Linda Hill

The Narsey study advising governments to include alcohol and tobacco in the Pacific free trade agreement gathered evidence from a range of informants, including industry stakeholders. It provides insights on the alcohol industry and its stage of 'globalisation' in the region.ⁱ

The key question the report addresses is whether and how Pacific governments may legitimately protect local alcohol production – at least during a transition period while tariffs are gradually lowered. The report discussed the importance of local production in almost the same breath as it criticises quality and productivity. It becomes almost schizophrenic when it reveals that most production is 'local' only in the sense that factories are located on certain islands (see previous article). Most ingredients and material are imported, master brewers are mostly 'ex-patriots' – i.e., also imported – and local breweries are part-owned and controlled by Australasian companies now well plugged into the global alcohol oligopoly.

This situation appears to make nonsense of the report's proposed option on 'rules of origin' for alcohol and tobacco products, as products are only considered to originate within the free trade region if 40 per cent or more of their value is created in a PICTA member country. All the options proposed merely offer different time schedules for eliminating barriers against imported alcohol and tobacco. Even 'negative lists' of

products 'excepted' from PICTA must have their import tariffs removed by 2016. Negotiations under PACER will mean additional schedules to reduce tariff barriers against New Zealand and Australian products from around 2012.

The Narsey report provides information about the productivity of the various alcohol production plants within the region. All operate below capacity, usual working only two or three days a week. He reports that the Fiji and Papua New Guinea breweries are on 'a completely different tier of productivity' from older plants in other Islands.

Economies of scale could perhaps allow one firm to supply the entire PICTA market, meaning reduced share, closure and employment losses for others. This information on productivity/ capacity also suggests that employment is unlikely to increase much in the 'winning' country.

Narsey suggests that competition from freeing up trade might not always be 'feasible or desirable', as the conflicting interests of multinational owners – predominantly the Fosters Group – may account for missed opportunities, such as marketing



'unique' local beers to Pacific communities in Pacific Rim countries. There may be other conflicting interests among local owners. SPC's Dr Stanton notes that lack of restrictions on alcohol consumption in the Pacific region may suit some individuals in power who have financial interests in the liquor industry.ⁱⁱ

Viewed from the perspective of industry interests, rather than governmental ones, the report makes clear that the PICTA free trade area will enable the rationalisation of alcohol production and supply across the Pacific region. Increased production of beer in Fiji, Papua New Guinea may displace Australian and New Zealand imports in other Island countries. However, when PACER extends PICTA to include Australia and New Zealand, further rationalisation of production across the whole Pacific can be expected. While beer distribution from Fiji may still make sense to Fosters, Narsey notes that local spirits production is 'virtually certain not to survive'.

This prediction is supported by news that distillers from around the world are lobbying the World Trade Organization for further liberalisation of 'trade and services' in alcohol. New Zealand's Distilled Spirits Association (whose members include the New Zealand branch of the global spirits corporation Diageo) believes that export potential is currently hobbled by excessive trade barriers and tariffs. New Zealand exports gin, vodka, liqueurs and alcopops to more than 30 countries, including the Pacific. "International trade reform, especially a reduction in tariffs or duties, would help New Zealand

bottled and bulk spirit exporters, making our pricing more competitive and therefore more profitable," says chief executive Thomas Chin.ⁱⁱⁱ

What can be expected from regional rationalisation of alcohol production is economies of scale that increase availability and marketing of low priced alcohol in the Islands – with few policies in place to address this.

The likely result is a rise in hazardous drinking among Pacific people, with social and health consequences. This is the experience of Pacific peoples – particularly young people – living in

the already saturated alcohol markets of New Zealand and Australia.

Doctor Hill is employed by the Global Alcohol Policy Alliance to further its objectives in the Western Pacific region. She can be contacted at Linda.hill@actrix.co.nz

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Changing patterns of Pacific drinking in Aotearoa NZ

Changes in drinking patterns among Pacific people who have emigrated to Aotearoa New Zealand show the likely effects of increased alcohol availability and advertising that Pacific Islands countries could experience under free trade.

People of Pacific Islands origin are the third largest ethnic group in Aotearoa New Zealand, and Auckland is often called the largest Polynesian city in the world. Since the 1970s, Pacific people have come to New Zealand for employment or higher education, establishing distinctive Island communities and raising New Zealand-born children and grandchildren. For many Pacific people, drinking alcohol has been part of the migration experienceⁱ – and there is concern that Pacific teenagers are now binge drinking like many of their Palangi peers.ⁱⁱ

Pacific New Zealanders are Samoan (50 per cent), Cook Islands Maori (23 per cent), Tongan (18 per cent), Niuean (9 per cent), Fijian (3 per

cent) and Tokelauan (3 per cent). Samoans, Tongans and Fijians have mainly come via immigration permit systems. The Cook Islands, Niue and Tokelau have relationships with New Zealand that allow unrestricted access, and more than half of the population of these groups now lives in New Zealand. Seventy per cent of the Cook Island Maori and Niueans in New Zealand and 66 per cent of the Tokelauans are New Zealand born.

Pacific people make up around 3 per cent of the New Zealand population, with two-thirds living in the Auckland area. This means that national surveys have collected data from relatively small numbers of Pacific respondents, allowing

limited analysis. However, data from national surveys in 1978, 1992 and 1996ⁱⁱⁱ and more recently all showed a similar pattern of alcohol use among Pacific New Zealanders. Fewer Pacific New Zealanders drink alcohol than among the population as a whole, but those that do drink tend to drink heavily.

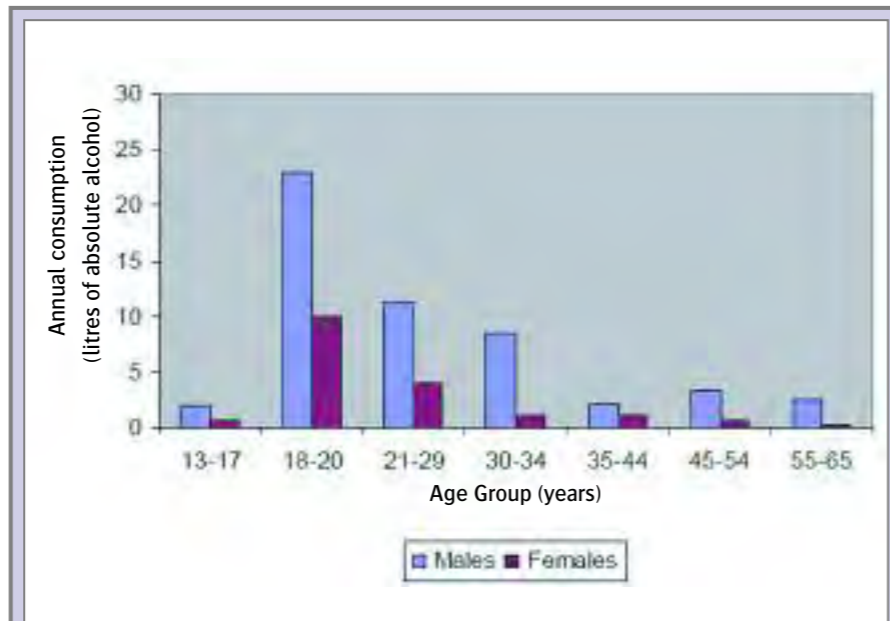
It must quickly be said that binge drinking has a very long history among New Zealanders and Australians of English, Irish and Scots and other origins. Although a higher proportion of the Palangi population drinks alcohol, and many do so moderately, a sizeable proportion drink at hazardous levels – particularly young males. Over the 1990s, under liberalised alcohol policies, both amounts and frequency increased among teenagers and among women of all ages. Alcohol related harm has a high impact on New Zealand society and its economy.

Recent studies

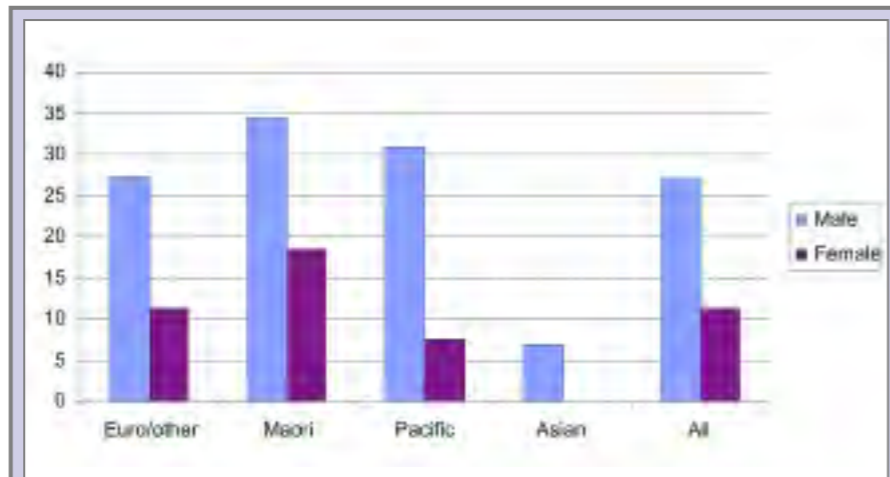
Three recently published reports explore patterns of drinking and harm among Pacific New Zealanders.

In 2002-2003, a computer assisted telephone survey asked 1,103 Pacific people aged 13-65 about their use of alcohol and drugs (tobacco, kava, marijuana and other illicit drugs), gambling and related harm. The full report provides findings for all respondents together, with separate chapters on Samoans, Cook Island Maori, Tongans and Niueans.¹

The survey showed 57 per cent of Pacific New Zealanders drank alcohol in the last 12 months – compared with 47 per cent in previous surveys. Over the age of 20, men were more likely to be drinkers than women, but there was little difference among males and females at younger ages. Among the drinkers, males aged 18-35, particularly 18-19 year olds, drank most frequently – more than twice a week on average. Males were averaging around 9.5 standard drinks on a typical drinking occasion, although 5-6 drinks is the recommended limit for males. Males aged 13-17 were drinking almost as much as 18-29 year old males, although much less frequently. More than 40 per cent of male drinkers and a quarter of women drinkers reported drinking ‘enough to feel drunk’ at least once a week. The women averaged 6 drinks per drinking occasion, although the recommended limit for women is 3-4 standard drinks. Women aged 18-20 were drinking almost as much as men their age, but more frequently drinking among males meant men aged 18-20 were consuming by far the highest amounts on an annual basis – around 27 litres of absolute alcohol a year, or three times the national average per head of population aged 15 and over.



Annual consumption in litres of absolute alcohol by gender and age
Source: Pacific Drugs & Alcohol Consumption Survey 2002-2003, figure 12, p.50.



Hazardous drinking pattern in adults, by ethnic group and sexvii
Source: Ministry of Health (2004) Portrait of Health, Fig. 64, 2002-2003 data.
NB. Sample of female Asian hazard drinkers was too small to be statistically significant.

The most commonly reported harm from drinking was ill effects the next day (reported by 48 per cent), followed by being unable to remember what they had done. Of women drinkers who were currently pregnant or who had been pregnant in the last three years, 70 per cent said they had stopped or reduced their drinking. A quarter of all respondents (not just drinkers) reported that their lives were affected by other people’s drinking.

This included adverse effects on home life, role in church,

friendships, health, work and finances. Women were more likely to think other people’s drinking harmed their home life, church roles and friendships, while more men thought alcohol was beneficial to their social life. Other harms reported from someone else’s drinking were car accidents, injuries, assaults and sexual harassment.

Another survey in 2002-2003, the New Zealand Health Survey, included an over-sample of New Zealand Maori and Pacific people to

ensure analysis by gender and age group would be possible.^{iv} It showed that 71 per cent of Pacific men and 39 per cent of women aged 15 and over had drunk alcohol in the past year. This compared with 84 per cent of Maori men and 78 of Maori women, and 91 per cent of men and 84 per cent of women of European/non-Asian ethnicities. However, of the Pacific drinkers, a high proportion of males were drinking at hazardous levels – 32 per cent, compared with 25 per cent of Palangi male drinkers and 38 per cent of Maori male drinkers. Hazardous drinking was defined as scoring 8 or more on questions from the World Health Organization’s Alcohol Use Disorders Identification Test (AUDIT).^v

Far fewer Pacific women were drinking hazardously – under 9 per cent. This is about the same as for Palangi women and less than half the 21 per cent of Maori women who drank hazardously.

These surveys show that among Pacific peoples hazardous drinking is particularly a male problem. This is also the case among Palangi New Zealanders, reinforced by alcohol marketing that links brands to male sports and nationalism.^{vi}

Drinking by teenagers

A recent report on drinking among Pacific young people analyses data from the 1997-1998 Auckland High School Heart Survey.^{viii} This surveyed 2,549 year 11-13 students aged 16-18 at ten Auckland high schools, including 1,025 Pacific Island students: 456 Samoan, 223 Tongan, 147 Cook Island Maori and 109 Niuean.

The Pacific young people had similar drinking patterns to Maori and Palangi students, with Asian students drinking less. Samoan boys and girls and Tongan girls were the least likely to drink. Cook Island and Niuean young people started

drinking at earlier ages than other Pacific groups.

Cook Islanders were more likely to drink more heavily. Pacific students who had started drinking before the age of 16 were twice as likely to binge drink weekly. Those who drank frequently were more likely to binge-drinking. More frequent drinking among those born in New Zealand is consistent with findings about drinking by Pacific adults.

The study linked heavier drinking to being male, New Zealand born and from a school with higher socio-economic status. It was also linked to smoking, underestimating the harm from tobacco and alcohol, seeing adults take illegal drugs or drink-drive; and feeling unhappy. Those who felt happy all or most of the time were half as likely to drink on a weekly basis. Drinkers were more likely to report poor health and/or having worse health than a year earlier. Those Pacific students who were unsure whether alcohol was harmful were twice as likely to drink, and those who thought alcohol was not harmful were three times as likely to drink at least weekly.

The researchers also found a link between frequent and binge drinking and outdoor activities, which needs more investigation. They thought it might indicate a Pacific youth culture in public areas away from family surroundings. A study of alcohol in the adult Samoan community, described below, suggests it might perhaps also relate to the strong links between outdoor male sports and alcohol that are part of the wider New Zealand culture.

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- ix Ministry of Health, Sector Analysis (1997) Inu Pia: The place of alcohol in the lives of Tokelauan people living in Aotearoa New Zealand. ALAC Research Monograph Series: No 3; Na tabili kavoro: The place of alcohol in the lives of Fijian people living in Aotearoa New Zealand. ALAC Research Monograph Series: No 4; Vai Mamali: The place of alcohol in the lives of Niuean people living in Aotearoa New Zealand. ALAC Research Monograph Series: No 5; Kapau tete to ha fu’u siaine he ‘ikai tete ma’u ha talo pe koha ‘ufi ko e fu’u siaine pe: The place of alcohol in the lives of Tongan people living in Aotearoa New Zealand. ALAC Research Monograph Series: No 6; Kaikava me kare Inuiuu: The place of alcohol in the lives of Cook Islands people living in Aotearoa New Zealand. ALAC Research Monograph No.7; O le a’ano o feiloaiga: The place of alcohol in the lives of Samoan people living in Aotearoa New Zealand. ALAC Research Monograph Series: No 8. Wellington. www.alcohol.org.nz under Publications.

Asian news round-up

Bangkok bourse delays Thai Beverages float on Stock Exchange

At least 20,000 protestors with 500 Buddhist monks marched on the Stock Exchange of Thailand SET in March to protest at the proposed listing of Thai Beverages. The brewer, which produces Chang Beer and a top-selling whisky, had planned to raise more than 1 billion US Dollars by floating on the exchange. The listing of Thai Beverages, which is part of the empire of Thai billionaire Charoen Sirivadhanabhakdi, would be a first by a local liquor company. Its rival the Boon Rawd Brewery, the country's oldest and maker of the Singha brand, reportedly had plans to follow suit. The President of the Stock Exchange, Kittiratt Na Ranong, said the exchange's board had postponed its decision because they wished to be free of outside pressure.

The demonstrators argued that consumption among young people had surged in Thailand. According to the health ministry Thailand was the world's fifth-largest consumer per capita of alcoholic beverages, Prime Minister Thaksin Shinawatra rejected speculation that his

administration was behind SET's indefinite postponement of the listing.

"Government did not interfere with the stock market ... but many in the public still oppose the listing so the stock market should be more prudent in its listing considerations," Thaksin told reporters.

"Today is a day of relief for the Thai people who are concerned over an ill society already damaged by excessive alcohol consumption," the network said in a statement

Bhutan confronts alcohol problem

Alcoholic drinks have played a significant role and are interwoven with the traditions of the Himalayan kingdom of Bhutan. They are part of all ceremonial and religious occasions, with almost every household brewing its own rice-based liquor.

However, health officials now say they are concerned about the increasing cases of alcoholism being reported at the national hospital in the capital, Thimphu.

"We acknowledge that alcohol is a problem," says Dr Sangay Thinley, Bhutan's health secretary. He

accepts that alcohol is one of the biggest causes of adult mortality in Bhutan.

The fact that, in the psychiatric ward of the Jigme Dorji Wangchuk National Referral Hospital in Thimphu, half of the eight beds are occupied by alcoholics underlines Dr Thinley's concern.

Dr Chencho Dorji is the only psychiatrist in Bhutan. He counsels patients suffering from depression, anxiety, epilepsy, and psychosis, but he says dependence on alcohol is the most common problem in Bhutan. In the past three years he has treated more than 1,500 patients, at least 10 per cent of whom have been alcoholics. He claims that 30 per cent of deaths in all hospital wards are due to alcoholism.

Government officials confirm the extent of the problem, admitting that the number of alcoholics in Bhutan is growing rapidly.

The acceptance of drinking in Bhutanese society, the widespread availability of alcohol, and growing economic prosperity have come together to make matters worse.

Dr Thinley, the Health Minister, says that the government is preparing awareness campaigns to encourage drinking in moderation. He also points out the importance of keeping a check on the liquor brewed at home.

The danger of excessive consumption of alcohol and the threat of full-scale dependence cannot be avoided even in one of the world's most remote countries.

Alcohol and road traffic deaths in Asia

Of the one million people killed on roads during 2000, nearly 75 per cent died in developing countries, almost half of them in Asia. According to research carried out by Dr G. Guturaj of the National Institute of Mental Health and Neuro-Sciences in Bangalore, India, road traffic injuries in the South Asia Region constitute the second or third leading cause of death in the 5-44 year old age group and alcohol is a major risk factor. In Bangalore, night-time crashes account for 30-40 per cent of road traffic injuries. The risk of mortality increases 2.2 times among those under the influence of alcohol.

Public health problems caused by alcohol



The Executive Board of WHO, having considered the report on public health problems caused by alcohol,¹ recommends to the Fifty-eighth World Health Assembly the adoption of the following resolution:

The Fifty-eighth World Health Assembly, recalling resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA55.10 on mental health: responding to the call for action, WHA57.10 on road safety and health, WHA57.16 on health promotion and healthy lifestyles and WHA57.17 on Global strategy on diet, physical activity and health;

Recalling *The world health report 2002*,² which indicates that 4 per cent of disease burden and 3.2 per cent of all deaths globally are attributed to alcohol, and that alcohol is the foremost risk to health in low-mortality developing countries and the third in developed countries;

Recognising that the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that harmful drinking is among the foremost underlying causes of disease, injury, violence, especially domestic violence against women and children, disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities;

Emphasising the risk of harm due to alcohol consumption in the context of driving a vehicle, at the workplace and during pregnancy;

Alarmed by the extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people, in many Member States;

Recognising that intoxication with alcohol is associated with high-risk behaviours, including the use of other psychoactive substances and unsafe sex;

Concerned about the economic loss to society resulting from harmful alcohol consumption, including costs to

the health services, social welfare and criminal justice systems, lost productivity and reduced economic development;

Recognising the threats posed to public health by the factors which have given rise to increasing availability and accessibility of alcoholic beverages in some Member States;

Noting the growing body of evidence of the effectiveness of strategies and measures aimed at reducing alcohol-related harm;

Mindful that individuals should be empowered to make positive, life-changing decisions for themselves on matters such as consumption of alcohol,

1. Requests Member States:

- 1 to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol;
- 2 to encourage mobilisation and active and appropriate engagement of all concerned social and economic groups, including scientific, professional, nongovernmental and voluntary bodies, the private sector, civil society and industry associations, in reducing harmful use of alcohol;
- 3 to support the work requested of the Director-General below including, if necessary, through voluntary contributions by interested Member States;

2. Requests the Director-General:

- (1) to strengthen the Secretariat's capacity to provide support to Member States in monitoring alcohol-related harm and to reinforce the scientific and empirical evidence of effectiveness of policies;
- 2 to intensify international cooperation in reducing public health problems caused by the harmful use of alcohol and to mobilise the necessary support at the global and regional levels;

- 3 to produce a report on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol, to be presented to the Sixtieth World Health Assembly;
 - 4 to draw up recommendations for effective policies and interventions to reduce alcohol-related harm and to develop technical tools that will support Member States in implementing and evaluating the recommended strategies and programmes;
 - 5 to strengthen global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences, providing technical support to Member States, and promoting research where such data are not available;
 - 6 to promote and support global and regional activities aimed at identifying and managing alcohol-use disorders in health-care settings and enhancing
- the capacity of health-care professionals to address problems in their patients associated with harmful patterns of alcohol consumption;
- 7 to collaborate with Member States, intergovernmental organisations, health professionals, nongovernmental organisations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;
 - 8 to organise open consultations with representatives of industry and agriculture and distributors of alcoholic beverages in order to limit the health impact of harmful alcohol consumption;
 - 9 to report through the Executive Board to the Sixtieth World Health Assembly on progress made in the implementation of this resolution.

Seventh meeting, 20 January 2005 EB115/SR/7

1 Documents EB115/37 and EB115/37 Corr.1.

2 The world health report 2002. Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002.

Global impact of alcohol on health and society

A resolution submitted by the American Medical Association to the Socio-Medical Affairs Committee of the World Medical Association

Preamble

1. Alcohol use is deeply embedded in many societies. Overall, 4 per cent of the global burden of disease is attributable to alcohol, which accounts for about as much death and disability globally as tobacco or hypertension. Worldwide, approximately 2 billion people drink alcohol of whom about 76.3 million are diagnosed with alcohol use disorders. Alcohol, globally, contributes to 3.2 per cent of deaths (1.8 million) and 4.0 per cent of the disability-adjusted life years lost (58.3 million). Overall, there are causal relationships between alcohol consumption and more than 60 types of disease and injury including traffic fatalities. Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries. Beyond the numerous chronic and acute health effects, alcohol use is associated with widespread social, mental and emotional consequences. The global burden related to alcohol consumption, both in terms of morbidity and mortality, is considerable.
2. Alcohol-related problems are the result of a complex interplay between individual use of alcoholic beverages and the surrounding cultural, economic, physical environment, political and social contexts.
3. Alcohol cannot be considered an ordinary beverage or consumer commodity since it is a drug that causes substantial medical, psychological and social harm by means of physical toxicity, intoxication and dependence. There is increasing evidence that genetic vulnerability to alcoholism is a risk factor for some individuals. Fetal alcohol syndrome and fetal alcohol effects, preventable causes of mental retardation, may result from alcohol consumption during pregnancy. Growing scientific evidence has demonstrated the harmful effects of consumption prior to adulthood on the brains, mental, cognitive and social functioning of youth and increased likelihood of adult alcoholism and alcohol related problems among those who drink before full physiological maturity.
4. Similar to tobacco, another widely consumed product, alcohol is heavily marketed, including to youth. Alcohol advertising and promotion is rapidly expanding throughout the world and is increasingly sophisticated and carefully targeted. It is aimed to attract, influence, and recruit new generations of potential drinkers despite industry codes of self-regulation that are widely ignored and often not enforced.

5. Effective alcohol social policy can put into place measures that control the supply of alcohol and/or affect population-wide demand for alcohol beverages. Comprehensive policies address legal measures to: control supply and demand, control access to alcohol (by age, location and time), provide public education and treatment for those who need assistance, levy taxation to affect prices and to pay for problems generated by consumption, and harm-reduction strategies to limit alcohol-related problems such as impaired driving and domestic violence.
6. Alcohol problems are highly correlated with per capita consumption so that reductions of use can lead to decreases in alcohol problems. Because alcohol is an economic commodity, alcohol beverage sales are sensitive to prices, i.e., as prices increase, demand declines, and visa versa. Price can be influenced through taxation and effective penalties for inappropriate sales and promotion activities. Such policy measures affect even heavy drinkers, and they are particularly effective among young people.
7. Heavy drinkers and those with alcoholism cause a significant share of the problems resulting from consumption. However, the majority of alcohol-related problems in a population are not associated with drinking by alcoholics but rather with drinking by a large number of non-alcoholic "social" drinkers, particularly when intoxicated.
8. Although research has found some limited positive health effects of low levels of alcohol consumption in some populations, this must be weighed against potential harms from consumption in those same populations as well as in population as a whole.
9. Thus, population-based approaches that affect the social drinking environment and the availability of alcoholic beverages are more effective than individual approaches (such as education) for preventing alcohol related problems and illness. Alcohol policies that affect drinking patterns by limiting access and by discouraging drinking by young people through setting a minimum legal purchasing age are especially likely to reduce harms. Laws to reduce permitted blood alcohol levels for drivers and to control the number of sales outlets have been effective in lowering alcohol problems.
10. In recent years some constraints on the production, mass marketing and patterns of consumption of alcohol have been weakened and have resulted in increased availability and accessibility of alcoholic beverages and changes in drinking patterns across the world. This has created a global health problem which urgently requires governmental, citizen, medical and health care intervention.

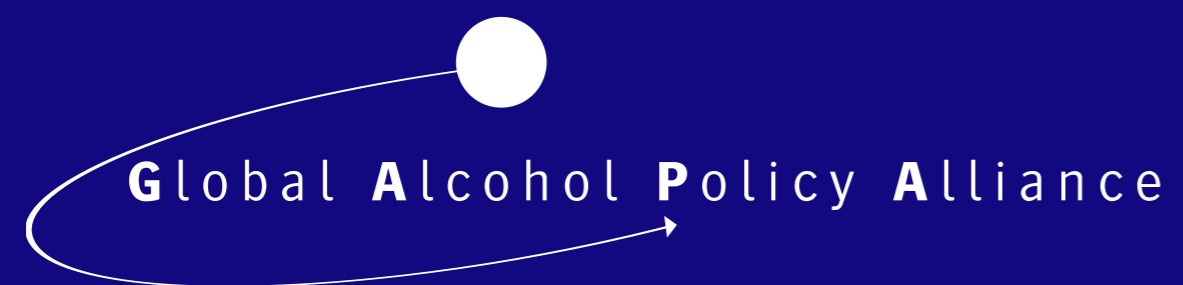
Recommendations

The WMA urges National Medical Associations and all physicians to take the following actions to help reduce the impact of alcohol on health and society:

1. Advocate for comprehensive national policies that incorporate measures to educate the public about the dangers of hazardous and unhealthy use of alcohol (risky

amounts through dependence), create legal interventions that focus primarily on treating or provide evidence-based legal sanctions that deter those who place themselves or others at risk, and put in place regulatory and other environmental supports that promote the health of the population as a whole.

2. Promote national and sub-national policies that follow "best practices" from the developed countries which with appropriate modification may also be effective in developing nations. These include setting of a minimum legal purchase age, government monopoly on retail sales, restricting hours or days of sale and the number of sales outlets, increasing alcohol taxes, and implementing effective countermeasures for alcohol impaired driving (such as lowered blood alcohol concentration limits for driving, active enforcement of traffic safety measures, random breath testing, and legal and medical interventions for repeat intoxicated drivers).
3. Restrict the promotion, advertising and provision of alcohol to youth so that youth can grow up with fewer social pressures to consume alcohol. Support the creation of an independent monitoring capability that assures that alcohol advertising conforms to the content and exposure guidelines described in alcohol industry self-regulation codes.
4. Work collaboratively with national and local medical societies, specialty medical organisations, concerned social, religious and economic groups (including governmental, scientific, professional, nongovernmental and voluntary bodies, the private sector, and civil society) in reducing harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving, and increasing the likelihood that everyone will be free of pressures to consume alcohol and free from the harmful and unhealthy effects of drinking by others. Promote evidence-based prevention strategies in schools.
5. Screen patients for alcohol use disorders and at-risk drinking, or arrange to have screening conducted systematically by qualified personnel. Promote self-screening/mass screening with questionnaires that could then select those needing to be seen by a provider for assessment. Provide brief interventions to motivate high-risk drinkers to moderate their consumption. Provide specialised treatment and rehabilitation for alcohol-dependent individuals and assistance to their families.
6. Promote consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control that took effect on February 27, 2005.
7. Furthermore, in order to protect current and future alcohol control measures, advocate for consideration of alcohol as an extra-ordinary commodity and that measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements.



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