

Issue 2 2005

THE GLOBE

Launch of Indian Alcohol Policy Alliance



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THE GLOBE

GLOBAL ALCOHOL POLICY ALLIANCE

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Indian Alcohol Policy Alliance

With the launch of the Indian Alcohol Policy Alliance, a global network of alcohol policy advocates continues to be built. IAPA's launch is the result of a two - year feasibility study, and the gathering together of an expert group from the Indian medical, social, public health, research and nongovernmental organizations, with core financial help from FORUT a Norwegian development agency.

The necessity for such an alliance in India may come as a surprise to many outsiders who consider India as an example of an abstinence culture. However, as this edition of the Globe shows, alcohol consumption is on the increase in India with a consequential rise in alcohol related harm. The launch of the new alliance is timely. The Indian economic growth rate is expected to increase over the next decades by 8% per year. Such an economic forecast makes India a prime target for the marketing strategies of the international drinks industry.

World Health Organization

In the last edition of the Globe we reported the placing by the WHO Executive Board of a resolution on the public health problems caused by alcohol on the World Health Assembly agenda for the first time since 1983.

The American delegation over the years has supported the demands of the alcohol industry to have its voice heard in Geneva. It came therefore as no surprise that the industry lobby was very active. Thailand made a determined effort to strengthen the resolution by including a critical review of the marketing strategies of the industry. Despite the fact that the move was

not successful (the resolution could have been lost) the concerns expressed by the Thais should not go unnoticed by WHO officials. It may be that the resolution appearing too atlantist and eurocentric caused the Iranians to insist on placing a caveat which defended those member states which do not endorse the use of alcohol.

Whilst we are supportive of the views of the Thai representatives, we congratulate WHO on the successful passing of a resolution which is both timely and welcome. We commend it to all advocates urging them to encourage its implementation (see pages 22-23).

Address of Dr S Arul Rhaj at the launch of the Indian Alcohol Policy Alliance



India is a country whose tradition, culture and values anticipated the temperance movement that started in the West in the middle of the nineteenth century. The Father of our nation, Mohandas Karam Chand Gandhi had asked us to “leave alone the vices of the West and strive

to adopt the best it has to give”. Today the scenario is entirely different. Alcohol consumption in India is not only growing but it has become a threat to public health. Western alcohol industries are targeting the Indian market. This is worrying in the light of the extent of the alcohol problem in India. Dr Arul Rhaj made the following points:

- Alcohol use is on the increase and it is estimated that there are 62.5 million users;
- Age of initiating consumption has declined from 30 to 19 years of age;
- More women have started using alcohol;
- Per capita consumption has gone up by 106.7% over a 15 year period;
- Sale of alcohol is growing at a rate of 8% per year;
- Alcohol related diseases are growing leading to the occupation of 1 in 5 Hospital Beds. This assertion is based on my three decades of experience in Cardiology and Intensive Care as a Senior Physician;
- Alcohol related liver, cardiac disorders, neurological and psychiatric problems are increasing;
- 20% of all traffic accidents and 35% of injuries treated in hospitals are alcohol related;
- 34% of all suicides are either committed under the influence of alcohol or related to alcohol use;
- 270,000 people die due to use and abuse of alcohol every year;
- Domestic Violence is on the increase - 3000 family abuse cases are registered every year.

In some states of India revenue from alcohol sales is Rs.250,000 million. Expenditure on health care and loss due to decrease in manpower is three times more than the revenue received. Yet, Government, on the one hand, needs this Revenue to meet its expenditure and, on the other hand, remains concerned about the social, economic and health hazards arising out of alcohol use.

The alcohol Industry is keen on increasing its business through a wide range of marketing strategies and through surrogate advertising circumventing advertising bans. In addition the media provides a great deal of information to the population including the message “alcohol is good for your heart” – a message which is inappropriate to India.

The Indian Alcohol Policy Alliance (IAPA) has a vision of promoting a “Healthy India”. It will strive to sensitize decision makers and the general public to understand the need for a comprehensive alcohol policy strategy.

IAPA’s Mission

The Indian Alcohol Policy Alliance will:

- be an advocacy body seeking to control availability and to reduce alcohol related harm. Achieving this through policy intervention and capacity building especially among youth and women;
- work in close association with Government both Central, State and Non Governmental Agencies;
- be a watch dog for the activities of the Industry more so on their promotional strategies;
- be an awareness creating body in society;
- invite research to assess the impact of use and abuse of alcohol on various fields such as family, occupation, and finance;
- will support and encourage abstinence, mainly while driving, at work, in sport and for pregnant women.

IAPA has to be culturally sensitive and pragmatic in its approach and message. Whilst the number of alcohol users grow, the majority of the population is abstinent. IAPA’s message is succinctly summed up in the slogan: Less is Better: Abstinence is Best

IAPA will give a platform to everyone interested in reducing the harms of alcohol use. In 2005 – 06 the focus will be on “Drinking and Driving”.

In a developing country health is the foundation upon which the wealth of the nation is built. “Health is wealth” but “Wealth is not Health” However, “Health with Wealth equals Strength”

IAPA wants to see a “Healthy India” progressing to a “Wealthy India” leading to a “Strong India”.

Let us all see a strong India through a healthy India free from alcohol abuse.

Indian Alcohol Policy Alliance launched

Dr Hariharan, Chief Executive reports:
The newly established Indian Alcohol Policy Alliance (IAPA) was launched in New Delhi in May this year.



The ceremonial lighting of the lamp was performed by Shri Yoganand Shastri, the Minister of State for Health & Family Welfare and Social Welfare of Delhi. In addressing the meeting he said the government would provide all possible help to the alliance in its work and “hoped that the association would go a long way in acting as a watchdog for the government assisting in formulating and implementing alcohol control policies”.

Dr S Arul Rhaj the President of IAPA is a former President of the Indian Medical Association; a Vice President of the Commonwealth Medical Association and honoured by the President of India with the Dr B C Roy National ~Award for Socio-

Medical Relief. In launching the Alliance Dr Arul Rhaj said that the increase in alcohol consumption in India was worrying and was a major contributory factor in road accidents and family violence. He wished to see a strong India through a healthy India free from alcohol abuse

Dr. Vivek Benegal pointed out that India is generally considered to be a dry culture and a rather large proportion of its people do not drink at all. Still alcohol consumption is quite high in some sections of the population. Both prevalence and consumption seems to be on the rise while the age of initiation to alcohol drinking has fallen drastically over the past decades.

Mr. Derek Rutherford of the Global Alcohol Policy Alliance stated that for him it was not a question of what the world could teach India, but what India could teach the



Above: The lighting of the lamp and the unveiling of the logo

Right: School choir at opening ceremony



Indian Alcohol Policy Alliance launched



Answering press questions: Ms Monica Arora and Dr Hariharan



Below: Derek Rutherford



specific social contexts and changing the social climate and attitudes towards drinking. A successful policy initiative includes involving multiple stake holders: Government and non government, presenting clear, specific 'do-able' policy suggestions based on data, developing policies that have fairly immediate and direct effects as well as those with more indirect and long-term effects by changing the general social climate.

IAPAs' objectives include providing a forum for alcohol policy and to disseminate information on alcohol



Cherian Varghese of WHO India chairing the seminar

policies and best practice in policy advocacy. The alliance will encourage and promote governmental and non-governmental efforts to prevent and reduce alcohol-related harm and bring attention to the social, economic and health consequences of alcohol use. It will monitor advertising, marketing and other activities of the alcohol beverage industry including their social aspect organizations; encourage research on all aspects related to alcohol use and policies; conduct awareness programmes and organise de-addiction camps. IAPA will co-operate and encourage partnership with local, national and international organizations and civil society to prevent and alleviate alcohol-related harm.

world. Alcohol consumption in the west had reached a very high level and it is worrying if countries like India and China would follow on that path. The drink industry saw both countries as emerging and promising markets for expansion. He said: "Growth rate in India is expected to be around 8% per year and that by 2040 India is likely to be the third largest economy after the USA and China. With such an expected growth rate, the international drinks industry clearly sees India as a lucrative market with enormous potential for shareholder profit."

Dr. Shanthi Ranganathan, chief executive of the well known T T Ranganathan Clinical Research Foundation and Rehabilitation Centre in Chennai is the honorary secretary of IAPA. Presenting the road map of IAPA she stated that the focus would be on controlling the availability of alcohol, addressing



Dr Hariharan, Ms Monica Arora, Oystein Bakke (FORUT), Derek Rutherford (GAPA), Dr S Arul Rhaj, Dr Shanthi Ranganathan, Mr Johnson Edayaranmula and Dr Shobhangi Parkar.

India: Alcohol and public health

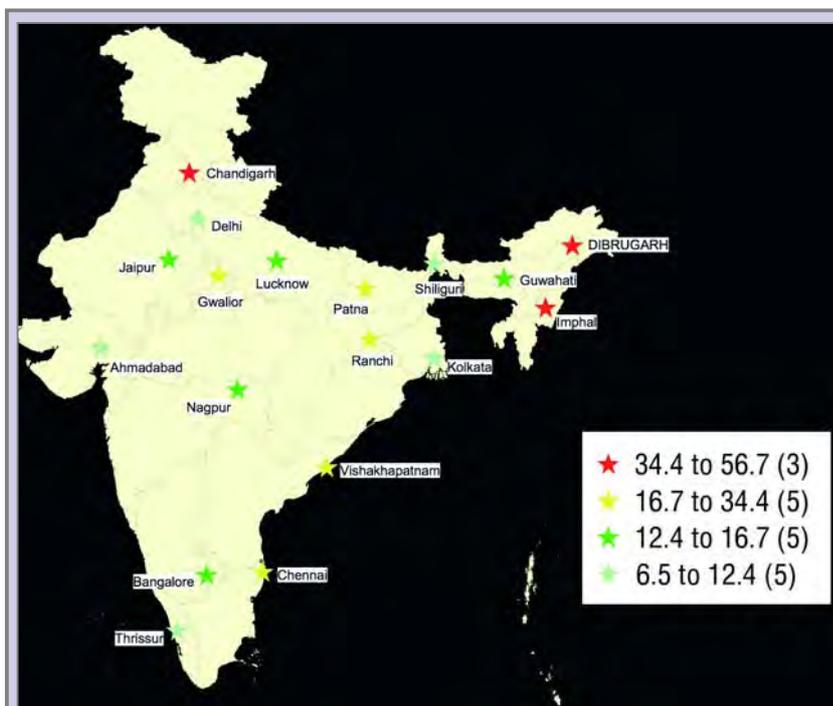
Dr Vivek Benegal
Associate Professor of
Psychiatry
National Institute of Mental
Health and Neurosciences,
Bangalore



Prevalence of alcohol use

India is generally regarded as a traditional 'dry' or 'abstaining' culture. A recent National Household Survey of Drug Use in the country, the only systematic effort to document the nation-wide prevalence of drug use, recorded alcohol use in only 21% of adult males. Expectedly, this figure cannot accurately mirror the wide variation that obtains in a large and complex country like India. The prevalence of current use of alcohol ranged from a low of 7% in the western state of Gujarat (officially under Prohibition) to 75% in the Northeastern state of Arunachal Pradesh. There is also an extreme gender difference. Prevalence among women has consistently been estimated at less than 5 per cent but is much higher in the Northeastern states. Significantly higher use has been recorded among tribal, rural and lower socioeconomic urban sections).

The per capita consumption is 2 litres/adult /year (calculated from official 2003 sales and population figures). After adjusting for undocumented consumption, which accounts for 45-50% of total consumption, this is likely to be around 4 litres, but still low compared to that in wet nations. Licit and illicit spirits i.e. government licensed country



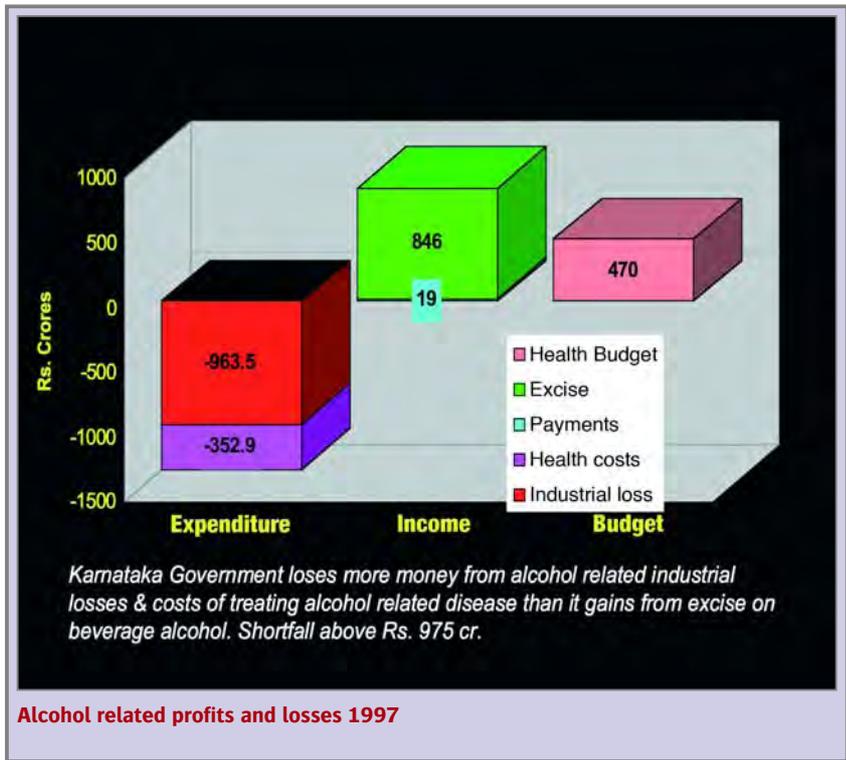
Prevalence of alcohol use in men in India.

National Survey Drug Abuse 2004

The article is published by kind permission of the Editor of Addictions. Copyright is retained by The Society of Addiction. References are available from The Society, National Addiction Centre, 4 Windsor Walk, London SE5 8AF.

Illustrations are from Dr Benegal's lecture at the IAPA Seminar.

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liquor (rectified spirit mixed with water at Indian made foreign liquors like whisky, rum, vodka and gin (42.8%v/v); and illicitly distilled spirits (of indeterminate composition) constitute more than 95% of the beverages drunk by both men and women. Beer accounts for less than 5% of consumption (70% of beer sales is dominated by strong beers at strengths over 8% v/v). Wine is a nascent but growing market.

The historical construction of an ambivalent drinking culture

However this tradition of abstinence, may be a construct of relatively recent origin. The extensive records of diverse fermented and distilled beverages produced from fruits, grains and flowers, archeological evidence of stills [circa 200 B.C.E.], the elaborate sets of rules governing production, sales, taxation and public intoxication, the lyrical descriptions of ritual fiesta drinking by both sexes in secular literature, the early recognition of the medical consequences of

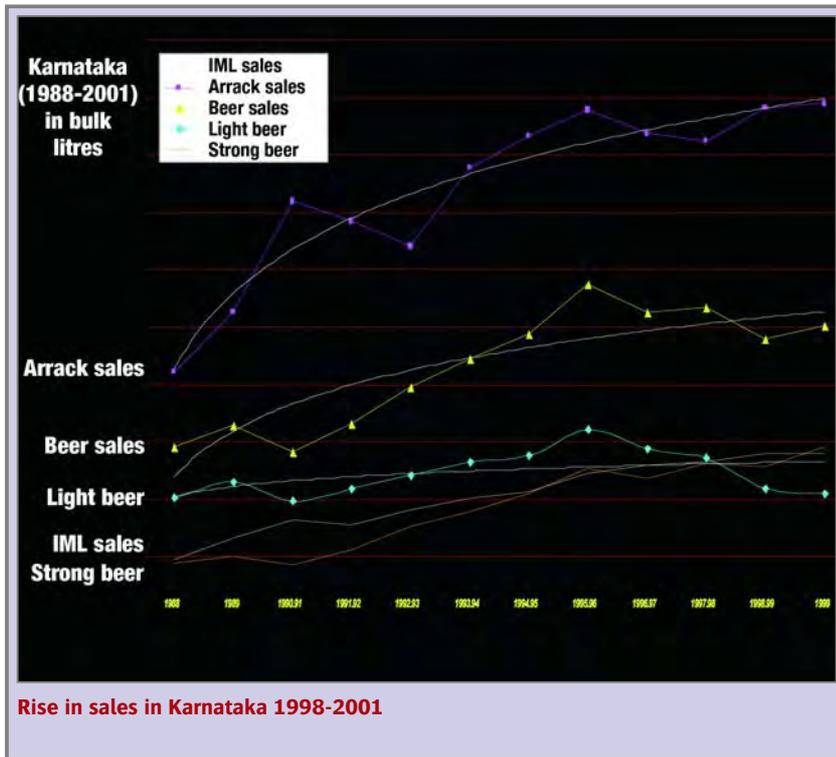
excess and the frequent admonitions against the use of alcohol by the priestly elite do not quite support the notion of a long-standing dry culture. The period of rapid social change during the colonial era, transformed a society, which barring a segment of the brahminical (priestly class) elite,

had until then what appears to be a relatively relaxed attitude to drink. The emergence of an urban middle class, participating in the rapid industrial development of the 19th century, led to socio-economic empowerment of the lower rungs of the caste hierarchy. Changes in dietary practices were one of the means adopted by the lower strata to acquire higher social status. As a result of this phenomenon of Sanskritisation the growing middle classes embraced upper caste norms of vegetarianism and abstinence from alcohol.

In parallel, the abkari (excise) policies of the colonial government, restricting manufacture of alcoholic beverages to licensed government distilleries, led to the rapid replacement of traditional alcoholic beverages by mass-produced-factory-made products, with greater alcohol content and less variety, which were progressively more expensive due to ever-increasing taxation. The enormous increase in the number of distilleries, and the practice of auctioning rights to distill and sell unlimited amounts



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The social cost of an ambivalent drinking culture

Expectedly, in such a situation where traditional social regulation of drinking has been supplanted by centuries of temperance or prohibitionist controls, no prescribed patterns of behaviour exist to regulate drinking behaviours. This is known to predispose to deviant, unacceptable and asocial behaviour, as well as chronic disabling alcoholism. Repeated observations have documented that more than 50% of all drinkers, satisfy criteria for hazardous drinking. The signature pattern is one of heavy drinking, typically more than 5 standard drinks on typical occasions.

There is surprisingly little difference between amounts drunk by men and women. Though a large proportion of drinkers of both genders, drink daily or almost daily, the frequency is significantly higher in men. Under-socialized, solitary drinking of mainly spirits, drinking to intoxication and expectancies of drink related disinhibition and violence add to the hazardous patterns.

Needless-to-say, this translates into significant alcohol related morbidity. Alcohol related problems account for over a fifth of hospital admissions but are under recognized by primary care physicians. Alcohol misuse has been implicated in over 20% of traumatic brain injuries and 60% of all injuries reporting to emergency rooms. It has a disproportionately high association with deliberate self-harm, high-risk sexual behaviour, HIV infection, tuberculosis, oesophageal cancer, liver disease and duodenal ulcer.

Alcohol misuse wreaks a high social cost

A study from the state of Karnataka in South India estimated that

of beverage alcohol led to increased consumption, drunkenness and crime. Increasingly, viewed as an unpopular imposition of English rule and drinking a peculiarly English vice, alcohol use, came to be regarded by the power elite as an atavistic trait of the primitive and poor (tribals and the socially backward drinking to transcend their miserable existence) or a licentious affectation of the upper classes.

Gandhi and the nationalist movement harnessed the temperance aspirations of the middle classes into mass movements against drinking as a symbol of colonial oppression. Fired by the belief that the Indian nation should be ritually pure, they evolved a demand for total prohibition. The Constituent Assembly of independent India included prohibition as one of the Directive Principles of state policy.

In practice, alcohol policy devolved to individual states to formulate their own regulations and levy

their own taxes. Most states derive 15-20% of their revenue from taxation on alcohol, which is the second largest source of the states' exchequers after sales tax. This has created an "ambivalent" drinking culture – neither dry nor wet. Alcohol use attracts social opprobrium at the same time that governments and alcohol manufacturers promote alcohol sales in pursuit of profit. In several states renewal of retail licences are contingent on meeting stiff sales quotas which are revised upwardly from time to time.

The alcoholic beverage industry, visibly influences the political process with contributions to political parties and in the form of inducements to voters during elections. A few years ago, the Prime Minister designate of the country flew in for his investiture ceremony in the private aeroplane of a prominent liquor manufacturer! Nevertheless, alcohol use for the majority is furtive and guilt-ridden!

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monetizable direct and indirect costs attributable to people with alcohol dependence alone, was more than 3 times the profits from alcohol taxation and several times more than the annual health budget of that state.

All these studies on morbidity are regional estimates, but given the ubiquitous presence of hazardous drinking patterns, should be generalizable across the country. Yet, there is inadequate recognition that alcohol misuse is a major public health problem in India.

Economic liberalization, social change and changes in drinking patterns

Indian society is currently undergoing another tectonic shift in its socio-economic fabric. The impact of globalisation and economic liberalization (exposure to satellite television, rapid socioeconomic transition and growing disposable incomes) appears to have influenced a widespread attitudinal shift to greater normalization of alcohol use.

There has been a significant lowering of age at initiation of drinking. Data from Karnataka showed a drop from a mean of 28 years to 20 years, between the birth cohorts of 1920-30 and 1980-1990. Alcohol sales have registered a steady growth rate of 7-8% in the past three years. The largest expansion is seen in southern India, which has been driving most of this economic growth. It is visibly focused on the non-traditional segment of urban women and young people, with a noticeable upward shift in rates of drinking among urban middle and upper socioeconomic sections. The country liquor and whisky segment that earlier accounted for over 95% of documented consumption, has seen stagnation; the growth is in the non-traditional sectors of beer,



Changing trends ?

- Media reports
- Liquor industry targeting of women & young people. RTD's

white spirits and wine. A new segment of consumers is forming and a novel, convivial pattern is supplanting older drinking norms.

The local alcohol industry, quick to seize upon this emerging market, has introduced new products such as flavoured and mild alcoholic products, aimed to recruit non-drinkers, targeted primarily at women and young men. The industry circumvents bans on advertising by surrogate advertising, and the subject of alcohol advertising (surrogate and point-of-purchase) has changed from voluptuous pinups (targeting the traditional market of middle aged male consumers), to lifestyle advertisements promoting the spirit of good times, clearly aimed at women and youth.

Multinational alcohol beverage companies redeploying from shrinking markets in the developed world have identified India, with its growing consumer base, vast unexploited markets and commitments to the World Trade Organisation to reduce quantitative restrictions on alcohol imports as one of the most attractive markets for investment.

The trade papers in recent times have reported a spate of buy-outs

of local beverage companies by MNCs. The revenue aims of state governments are at odds with their health and welfare aims, as they push sales by imposing annually incremental quotas on production and sales.

As the rising prevalence converges on the signature pattern of frequent heavy drinking, the burden of health attributable to alcohol will mount dramatically. It is often assumed that non-communicable diseases affect higher social classes disproportionately, as mortality levels fall and national incomes increase.

In low-income countries, like India the prevalence of alcohol and tobacco use is higher among the poor, which increases the risk of cardiovascular disease, cancer, liver disease, and injuries among the poor relative to the better off. There is also a strong association between use of tobacco and alcohol, and impoverishment through borrowing and distress selling of assets due to costs of hospitalization.

Alcohol misuse in India is a prominent node in an inter-related matrix of high risk behaviours which has begun to impose an ever

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growing burden on the social and economic health of the nation. These include violence and injuries, high-risk sexual behaviours and HIV infection, industrial losses, retarded economic development of individuals and families which ultimately impact on national growth.

The official response to the alcohol problem

Unfortunately, the official response remains focused on the visible tip of the alcohol problem, – persons with alcohol dependence (around 4% of the adult male population) instead of on the emerging crisis due to hazardous drinking in more than 20% of the adult population. This is reflected in the approach to alcohol control policies at federal and state levels. The focus is exclusively on supply reduction (prohibition-centric) and tertiary prevention.

Every attempt by individual state governments to prevent misuse through prohibition has been hastily reversed in the face of mounting revenue deficits, costs of policing smuggling from neighbouring states and resulting underground alcohol economies, notwithstanding evidence of decreased consumption and improved indices of economic well being. Increased taxation has been used in other countries, to reduce consumption. In India, the impact of such measures is weak as consumers have easy access to undocumented (illicit and excise evaded) alcohol, beyond the purview of taxation.

There is also concern that alcohol as a commodity is relatively price inelastic and, therefore, an increase in its price would simply increase the expense of alcohol consumers aggravating the economic hardship of their family members, without necessarily reducing any of the other negative impacts.

Regulatory laws pertaining to hours of sale, sale to minors and drunken driving are observed in the breach. The Indian Motor Vehicles Act specifies a blood alcohol cut-off of 30mg.% for drivers, which is arguably one of the strictest in the world. Yet, a recent study in Bangalore city across a calendar month, found 40% of drivers were over the legal limit.

The Government of India, has funded 483 detoxification and 90 counselling centres country-wide, under the auspices of the National Drug Deaddiction Programme, to treat people with substance abuse disorders. 45% of people seeking treatment in these centres are for alcohol dependence. Most of these are defunct as they received a one-time grant. Paradoxically, the rates of help seeking in these centres are the lowest in states with the highest prevalence of alcohol use and the overall efficacy of treatment programmes provided is low.

The evidence from India is substantial that the direction for policy is to focus on macro environments and make them more conducive to promoting health behaviours than bank on individual behavioural change. But that is hardly likely as state governments publicly recant their beliefs in prohibition and alcohol control and try to extricate themselves from public funding of health care. Private expenditure already accounts for 82% of the total expenditure on health.

The popular media favour lurid descriptions of alcohol related violence and heroic accounts of sporadic, short-lived anti-alcohol agitations by women's groups. These paradoxically serve to further marginalize the issue and detract from a balanced public discourse. Since the subject is of low priority, funding for research is

low; there is little by way of a body of published literature, which can inform public policy, by projecting the socio-economic impact of alcohol misuse on a national scale.

Social aspect organizations of the liquor majors advocating safe drinking and sections of the mainstream English language media extolling the health benefits of alcohol have invaded that space. Hopefully, the impetus for a rational public health approach to alcohol policy will stem from the efforts of non-governmental organizations which are waking up to the sizeable negative impact that harmful alcohol use has on the delivery of their health and development programmes.

An alcohol policy for the 21st century

A combination of

- a) a population-based approach reducing overall consumption, and
- b) a high-risk approach targeting high-risk behaviours is essential to reduce the impact of the signature pattern of hazardous alcohol use in the country.

This requires an urgent shift to a public health paradigm in the approach to alcohol use. Health systems, especially at primary care levels must be geared to play a greater role in the early detection and prevention of alcohol related harm, perhaps through brief, cost-effective interventions that have been demonstrated to be useful.

The social welfare system and the criminal justice system, often the first to come into contact with alcohol related problems, can be sensitized in identifying and assisting individuals and families at risk from heavy drinking and acting as early referral systems. Extensive opportunities exist to lessen alcohol problems through community education and the

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prevention of drink driving, domestic violence, public disorder, unintentional injuries and criminal damage .

Community programmes supporting healthier lifestyles, mass media campaigns that present the advantages of reduced consumption rather than the dangers of heavy alcohol and community development in general, (job creation, skills development and upgrading infrastructure or recreational facilities in communities with high levels of alcohol abuse) should be utilized to encourage alternatives to drinking among the young and disadvantaged. Community action can also serve to shape attitudes, values and norms about drinking. Recently, several effective temperance campaigns have been led by heads of certain Hindu religious orders, though the impact has been limited to their immediate followers.

Existing legislation relating to controls on availability and marketing, restrictions on advertising and especially minimum drinking age, need to be rigorously enforced. Simulations have demonstrated that implementing a nationwide legal drinking age of 21 years can

achieve about 50-60 per cent of the alcohol consumption reducing effects of prohibition. Each year that drinking is delayed, significantly reduces the likelihood of developing alcoholism and the lifetime risk of alcohol abuse.

Dialogue and a degree of consensus between the health and revenue arms of government is crucial to reduce the centripetal directions of profit and welfare. A proportion of the considerable revenue on alcohol should be ploughed back into treatment and research. The priority for alcohol researchers in India surely is to focus on the public health dimensions of alcohol misuse and to focus on appropriate interventions. It is equally important for research findings to be published and publicized.

Hopefully, the imminent centralized system of value added taxation, will reduce the inequities in alcohol taxes between states, and thus diminish inter-state smuggling, which nullifies the potential benefits of increasing alcohol prices to reduce consumption. Volume-based-taxation (wherein a litre of beer is taxed equally as a litre of spirits) that promotes excess consumption of spirits requires rationalization

and stricter control on the entry of illicit (often toxic) alcoholic beverages into circulation is essential. There is also a need to consider public health interests in issues relating to trade agreements. Investment in alcohol production and distribution by trans-national companies in India and the removal of tariff barriers is likely to increase availability and consumption and limit the effect of prevention programmes.

For all this to happen, a vital first step is for health planners and other stakeholders to debate and draft an explicit and rational alcohol policy, appropriate for India as it marches into the uncertain future of the 21st century.

The platform at the official launch with the Minister of Health Shri Yoganand Shastri in the centre with Dr Arul Rhaj at the podium.



Embrace Life. Avoid Alcohol.



Supporting Alcohol Control Policies and Advocacy

Alcohol control

happy f

healthy upbringing

Our Vision

- IAPA aims to prevent and reduce the health, economic and social impact due to alcohol abuse, by steering the attention of policy makers towards formulating policies for alcohol control in India.
- It aims to mobilize society for the promotion of alcohol policies that safeguard individuals and families from the negative consequences of alcohol use through awareness and advocacy campaigns.



Supporting Alcohol Control
Policies and Advocacy



families

ing development of children social tolerance

Protecting health for positive changes increase in productivity

The cultural change sweeping across various layers of Indian society and the economic disharmony has resulted in more and more people resorting to habitual drinking. This change in consumption pattern has alarming consequences in the development of a healthy society, the impact of which is evident in the form of disintegrated families, premature mortality, unhealthy upbringing and development of children, social violence, temperamental change, loss of productivity etc. There is a need for committed social organisations that can address various issues of alcohol abuse and help the government in reducing this menace that is ruining the social infrastructure, particularly in the lower segment of society and children of affluent families. The most prevalent ailments arising out of alcohol abuse are : –



- Nervous breakdown
- Neurological disorders
- Blood pressure
- Liver & Kidney diseases
- Vision impairment
- Mood swings & Psychosemic problems
- Insomnia
- Skin diseases

Our Objectives

- To provide a forum for alcohol policy advocacy through meetings, information sharing, publications, electronic communications and other appropriate means.
- To disseminate information on alcohol policies and best practice in policy advocacy.
- To encourage and promote governmental and non-governmental efforts to prevent and reduce alcohol-related harms.
- To conduct awareness programmes and organise de-addiction camps.
- To co-operate and encourage partnership with local, national and international organizations and civil society to prevent and alleviate alcohol-related harms.
- To encourage research on all aspects related to alcohol use and policies.
- To monitor advertising, marketing and other activities of alcohol beverage industry including their social aspect organizations.
- To bring to the attention of governmental and non-governmental agencies and communities, the social, economic and health consequences of alcohol use.
- To carry out other activities conducive to fulfil the primary objectives of IAPA.

Taking into account the socio- economic environment and the prevalent infrastructure for educating the masses about the abuse of alcohol, it is suggested that an exhaustive community development programme be formulated and implemented in a phased manner. It will also include taking the help of volunteers like college students and political leader, in development and implementation of a sustainable programme.

Our Strength

Dr. S. Arul Rhaj
Chairman - IAPA

Dr. Shanthi Ranganathan
Hony. Secretary - IAPA

Dr. Hariharan
Chief Executive - IAPA

Dr. Vinay Agarwal
Hony. General Secretary - IMA

Mr. Johnson J. Edayarannula
Hony. Secretary - ADIC India

Ms. Monika Arora
Director - HRIDAY

Dr. Cherian Verghese
W.H.O.

Dr. Vivek Benegal
NIMHANS

Mr. Ashok Bhasin
Legal Advisor

Dr. Shubhangi Parkar
Psychiatrist

Dr. Nimesh Desai
Medical Supdt. - IHBAS

Dr. Kshithij Urs
Social Worker



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Treatment services and strategies

Dr. Shanthi Ranganathan
T T Ranganathan Clinical
Research Foundation
“TTK Hospital”
Indira Nagar, Chennai



Abuse of alcohol is not a problem restricted to metro and cities, it is also rampant in villages and in smaller towns. There is an increased incidence of multiple addiction and incidence of HIV is also high among them.

Uniqueness of this problem

The need for treatment is not widely known or accepted due to denial of the problem by the client and his family members. Unlike other illnesses, not only the addict but other family members are also affected psychologically. A condition where relapse is not uncommon, the clients and their family question the efficacy of and the need for treatment.

Availability of treatment

In India, the Ministry of Social Justice & Empowerment coordinates the treatment and rehabilitation services. Around 393 treatment-cum-rehabilitation centres and 53 counselling and awareness centres are offering services all over the country funded by the Ministry of Social Justice & Empowerment. 100 centres have been empowered to provide preventive support for HIV-AIDS. 15 workplace prevention programmes

have been set up in industries and enterprises.

For the first time in social service practice, minimum standards of care to be complied with by the NGOs who are providing rehabilitation services have been introduced. To help the NGOs to follow minimum standards of care, eight Regional Resource & Training Centres have been established in the south, north, east, west and north-east. The responsibilities of the Regional Resource & Training Centres are:

- Providing training to NGOs working in this region and helping them improve their quality of service and comply with the minimum standards of care;
- Preparing training materials in the form of manuals;
- Undertaking research activities and documenting them;
- Monitoring drug abuse situation in this zone.



Treatment services and strategies

Treatment – Research Findings

Cost of untreated addiction due to morbidity of people of working age, drug related crimes and health care cost are substantial. These expenses are a great burden to the government and society. Hence, treatment interventions are more cost effective than the non treatment criminal justice system.

The theme of United Nations Office on Drugs and Crime for the International Day against Drug abuse and illicit trafficking for the year 2004 was “Treatment Works”. Patients in treatment either reduce or stop alcohol and other drug use. They also make positive changes towards physical health, psycho social functioning, stability in employment, reduction in criminal justice involvement and prevention of relapses.

Principles of effective treatment – NIDA

The National Institute on Drug Abuse USA has recommended the following principles to ensure effective treatment and rehabilitation services:

- No single treatment is appropriate for all individuals. There is a need to offer a range of services based on individual needs;
- Treatment needs to be readily available;
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness;
- Treatment does not need to be voluntary to be effective;
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use;
- Addicted or drug abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way;



- Counselling and other behavioural therapies are critical components of effective treatment;
 - An individual’s treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs;
 - Possible drug use during treatment must be monitored continuously;
 - Treatment programme should provide assessment for HIV-AIDS, hepatitis B & C, tuberculosis and other infectious diseases and counselling to help clients modify or change behaviours that place themselves or others at risk of infection.
 - Recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment.
- Addiction treatment needs to be structured in a way that addresses the wide range of issues. Mann (1991) described the principles of treatment succinctly:
- Treatment does not cure the disease. The expectation is that, by instituting an achievable method of abstinence, the condition will be put into remission;
 - All therapeutic efforts are directed at helping the client reach a level of motivation that will enable him / her to commit to abstinence;
 - An educational programme is necessary to make the client familiar with the addictive process, giving the individual an insight into compulsive behaviour, medical complications, emotional problems and maintenance of physical, mental and spiritual health;
 - Group and individual therapy are directed at self understanding and acceptance with emphasis on how drugs have affected the client’s life;
 - The client is indoctrinated into the self-help programmes (AA/NA) instructed about the content and application of the 12 steps of the programme;
 - The client’s family and other significant persons are included in the therapeutic process to make them understand the problem of

Treatment services and strategies



addiction and the support they must extend to the client;

- Insistence on participation in a longitudinal support and follow-up programme based on the belief that, as in the management of all chronic disease processes, maintenance is critically important to the ultimate outcome of any therapy.

The popular model of treatment available in India

In India, the majority of the treatment centres provide residential care for a period of 21 – 30 days. Both detoxification and psychological therapy are offered as part of treatment. Some of the components of therapy are re-educative sessions, group therapy and individual counselling. In re-educative sessions, information and practical guidance on addiction, relapse and recovery and issues related to qualitative sobriety are provided. Group therapy is the most important therapy in treatment. Open sharing / mutual understanding and support are the benefits. Individual counselling is provided to deal with personal issues and developing an individualized treatment plan. Some of the goals of individual counselling are developing a therapeutic relationship and strengthening the motivation; assessment of addiction and related problems; identifying needs and resources; helping to develop recovery plans and support in sustaining recovery.

The need for family therapy

Addiction has an impact on each and every member of the family. In the process, trust, love, respect and cooperation are eroded. There is no healthy relationship between husband and wife, parent and children. There is emotional, financial and social damage. A series

of escalating crises intensifies over a period of time and reality is denied by blaming, rationalizing. This results in responding to the problem inappropriately and developing co-dependency traits.

Family support is the greatest asset India has.

All treatment centres provide family programmes of short duration. The goals of family therapy are to provide information about addiction and its effects on the family system; help the family understand their inappropriate responses and deal with their defects of character; to provide a safe and acceptable environment for the family to discuss and deal with their problems; to improve interaction among family members; to equip parents with the skills needed to raise adolescents / to improve marital relationship.

The family programme components are re-educative sessions, group therapy, self-help group meetings (Al-anon) and counselling.

Follow-up is an important aspect in the rehabilitation of addiction. The goals of follow-up are to enable clients attain whole person recovery – alcohol / drug free, crime free, gainfully employed and having a healthy family relationship. Follow-up also helps clients who have had relapses and to assist family members in their own recovery.

Some of the components of follow-up are medical care and counselling client and family members: Relapse Prevention Programme; self-help groups, home visits and other methods of communication are also used to provide support to clients who are not regular for follow-up.

Factors facilitating recovery

- Group setting contributes to deeper understanding of the problem and enables support from one another.

- Medical and psychological issues handled.
- Structure provides discipline and opportunities to take up responsibilities.
- Offering emotional support to family members and motivating them to provide support during recovery.
- Long-term follow-up and recognition of sobriety by awarding medals.
- Specific programme to deal with relapses.
- Taking efforts to contact patients who do not turn up for follow-up.

Strategies for improvement

- Community approach of treatment which is cost effective to be promoted in villages / small towns.
- Accessibility of treatment through primary health centres which are available in the entire country.
- Availability of flexible treatment modalities to suit individual needs by networking with other NGOs. Longer treatment for patients with psychiatric problems, poor social support, lack of employment. Longer retention in treatment through short term in patient care followed up by out patient care in the community.
- Incorporating relapse prevention and long term after care services into existing programmes.
- Opportunities for vocational rehabilitation / training.
- Medical insurance to cover treatment cost.
- Organising regular training programmes to upgrade the knowledge and skills of staff.
- Documentation and evaluation to be made essential components.

Drink driving in India

Dr Vinay Aggarwal, Secretary General Indian Medical Association.

Little or no recorded data are available on drink driving in India. Attempts have been made to discuss the issue with the departments of social preventive medicine and forensic and emergency wards at hospital. Similarly views have been collected from Drivers of Trucks, Taxies, Buses, Two Wheelers, and Cars. The matter was also discussed with police officers and a few top officers of Government Roadways Transport Corporation. The summary of the information available on drink driving in India is given below:



Drink driving is prevalent among drivers after sunset. There are at least 5 to 6 truck accidents on Sher Shah Suri Marg (National Highway) between Ambala Cantt and New Delhi (A stretch of 200km) at different locations daily. 50% of these accidents are said to be due to drunken driving. Most of the truck drivers indulge in drug abuse, too.

Car owners who attend dinners / parties tend to get drunk, indulge in rash driving and are unable to control the vehicle and meet with accidents. About 60% and 65% of accidents are being caused by drink drivers of cars and two wheelers during the night and early hours of the morning.

A recent survey about drinking and driving in Delhi found that more than 45% vehicles are driven by drivers who had consumed alcoholic drinks. Youngsters particularly students of 9th and 10th

standards and college students mix drink with driving for “a high” or exhilaration and meet with accidents. “Speed thrills but kills is very much applicable to this class of drivers. The incidence of drink driving practices is increasing among the students and younger professional drivers. Drink driving and road accidents among women have also increased.

Accidents in pub city

A study reported under the title “High spirits take toll on Bangalore roads” reveals that driving under the influence of alcohol is common among Bangalore residents on Saturdays and Sundays leading to accidents, death.

The pub capital of India - Bangalore city, reports the highest number of road accident deaths on week ends between 6.00 p.m. and 10.00 p.m. and there is little reason to believe

that this could be for any reason other than drink driving, say the city police, 579 road accident deaths in 1993, 106 were on Saturday nights and an average of 60-90 deaths were reported on the other days of the week. In 1994, there were 91 deaths on Sundays, 89 on Saturdays and an average of 70-80 on weekdays.

What is one of the most difficult factors to determine is whether an accident was because of drinking and driving. The drivers invariably abscond, only to be found later when the effect of alcohol would have safely worn off. The people at the accident spot concentrate on getting the injured to hospital rather than nabbing the driver responsible and if they do find the driver, he would be badly beaten.

Besides the swank pubs which are the toast of the city, smaller bars have sprung up along the high ways causing accidents to rise on these

Percentages of accidents that are alcohol related

Vehicle	Trucks & Matadors	Cars	Two Wheelers	Pedestrians	Cyclists	Buses
Percentage	40	60	65	5	5	2
Age-group (years)	15-20	20-30	30-45	>45		
Percentage	25	50	15	10		
Students involvement	School (9th & 10th standard) and college students			Professional colleges		
Percentage	10%			20%		

already dangerous roads. There is not a single stretch of highway in India where no accident takes place during 24 hours. The most effective way to regulate traffic on highways is primarily to check drink driving. The abundance of liquor shops, bars and 'ahtas' on highways are the major causes for the rising incidence of fatal accidents on highways. Trucks and Buses parked close to liquor shops on highways is a common sight. In some bigger cities, there are tests to detect drink driving. But there are no such facilities on highways. And also there is no equipment available to check effectively on drink driving. The old method of blowing into a balloon has become obsolete.

It is desirable that the prohibition and excise departments frame regulations to be observed by bars and liquor shops to make highways safe for drivers and people travelling by road.

Laws on drink driving

Though the laws to check drinking and driving do exist in India, there is a need to effectively implement the law. The motor vehicle Act, 1939, amended in 1989 contains clause 117 which reads as:

Driving by a drunken person or by a person under the influence of drugs - whoever while driving or attempting to drive a motor vehicle or riding or attempting to ride, a motor cycle - (a) has in his blood, alcohol in any quantity, howsoever small the quantity may be or (b) is under the influence of a drug to such an extent as to be incapable of exercising proper control over the vehicle shall be punishable for the first offence with imprisonment for a term which may extend to six months or with a fine which may extend to two thousand rupees or with both; and for a second or subsequent offence, if committed within three years of the commission of the previous similar offence, with

imprisonment for a term which may extend to three thousand rupees, or with both". The above law is very effective only if imposed. But the psychology of drunken drivers is such that they get away by paying some money to the police.

1994 – Amendment

Any alcohol in the blood, however small the quantity, had been an offence till November 1994 but after November 1994 the law was amended. Since then up to 30 milligrams of intake per 100ml of blood has been permitted to drivers before getting behind the wheel. A research agency conducted a survey in the capital to know the public reaction to the 1994-Amendment. 86% felt that this would increase the number of road accidents and 88% felt that it would render roads unsafe. Across the world governments have defined different acceptable blood alcohol levels. The Swedes allow 20ml of alcohol in the blood; the Irish 80 and the U.S. 100.

Less is better but abstinence is the best

Delhi police consider that the existing breath analyser will have to be supplemented by more sophisticated equipment approved by the Union Government. The present tube and plastic bag breath analysers just indicate the presence of alcohol. They give no idea of the amount of alcohol. "Anybody can be called a drunkard," says one official. Several Ayurvedic medicines, common cough syrups and other preparations, have alcohol. And a driver who had any of these may well fail the present test.

IAPA'S Role:

Keeping in view of the above factual situations IAPA plans to launch a "CAMPAIGN AGAINST DRINKING & DRIVING" with the aim of putting science into action with the following objectives:

- To undertake experimental studies on drinking and driving for correct assessment of traffic safety situation on Indian roads;
- Blood alcohol screening should be routinely performed;
- Major publicity campaigns will need to be mounted to inform drivers on drinking and driving, the harm that results from drinking and driving and the penalties;
- A monitoring system, with common and agreed measurement and reporting procedures across India should be put in place with BAC to be zero if possible otherwise not more than 0.02%;
- Describing the implementation of any new measures and monitoring the progress towards achieving the target of halving drink driving related death and disabilities;
- Road side liquor shops, bars and 'ahtas' should be shifted minimizing their use by drivers;
- Strict enforcement of Motor Vehicle Act on drink driving;
- Developing the high taxation policies for alcohol beverages which reduces the buying power of drivers;
- Time of Sales to be restricted to 8pm. National Holidays, and pay day closure of outlets.

Conclusions

An intensive drive against drink driving is needed to promote road safety. Alcohol causes deterioration of driving skills even at low levels and the probability of crashes increases with rising blood alcohol levels.

Drivers aged 16 to 21 years have highest rate of alcohol involved fatal crashes in United States even though lower average BACs were found than in older drivers. But in India (where significant research in this field is lacking) this age group can be identified between 20 to 25 years.

Road accidents in Kerala

Report from Johnson J. Edayarammula, Director ADIC India

The number of road-accident deaths in Kerala State has risen steeply, with 3,066 people being killed and 51,352 injured in 41,306 accidents in 2004. Statistics compiled by the State Crime Records Bureau show that the annual figures for such deaths in the State crossed 3,000 for the first time last year. The number was 2,905 in 2003; 2,792 in 2002; 2,674 in 2001; and 2,710 in 2000. There were 50,917 vehicles damaged in 2004.

As per the road accident data compiled by the National Transportation Planning and Research Centre (NATPAC), Kerala has become the second most accident-prone State in the country after Maharashtra. The total cost on account of fatalities, injuries and vehicles damaged in the 41,306 road accidents that occurred in the State during 2004 has been estimated at Rs. 4537.8 million which is roughly 1.5 per cent of the State's GDP. The cost on account of road accidents, which was Rs. 3160 million in 1998, is going up five to

six per cent annually according to the Chief Project Coordinator of NATPAC Mr. Mahesh Chand.

The analysis of the accident costs has revealed that 57% was due to loss of production, 14% due to medical expenses, 7% due to administrative expenses of police and insurance companies, 6% due to court related expenses and 16% due to notional value for pain, grief and suffering of the victims. Of the 41,306 accidents, 11,106 took place in the National Highway stretches passing through the State, 5,184 in State Highway and the remaining in other roads.



A study conducted by the Alcohol & Drug Information Centre (ADIC)-India revealed that around 40% of the road accidents have occurred because the driver was under the influence of alcohol. In the case of accidents in national highways, more than 72% was related to drink driving. The number of Road accidents in Kerala has a close link to the alcohol per-capita consumption in the State. Kerala has one of the highest per capita consumption of alcohol in the country and hence it is not surprising that in Road Accidents too Kerala tops the country's list.

Source: State Crime Records Bureau, Kerala

Year	2000	2001	2002	2003	2004
Road accidents	37,072	38,361	38,762	39,496	41,306
Killed	2,710	2,674	2,792	2,905	3,055
Injured	49,403	49,675	49,460	48,640	51,352

FIFTY-EIGHTH WORLD HEALTH ASSEMBLY May 2005

Public health problems caused by alcohol



Reaffirming 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 the Global Strategy on Diet, Physical Activity and Health;

Recalling The world health report 2002,¹ which indicated that 4% of the burden of disease and 3.2% 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;

Recognizing 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;

Emphasizing the risk of harm due to alcohol consumption, particularly, 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;

Recognizing 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;

Recognizing the threats posed to public health by the factors that 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;

Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of alcohol, and emphasizing that use of the word “harmful” in this resolution refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way,

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 mobilization 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;

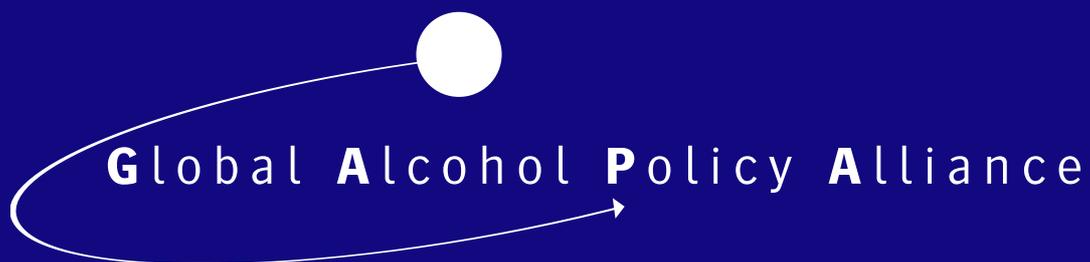
2. REQUESTS the Director-General:

- 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 consider intensifying international cooperation in reducing public health problems caused by the harmful use of alcohol and to mobilize the necessary support at global and regional levels;
- 3 to consider also conducting further scientific studies pertaining to different aspects of possible impact of alcohol consumption on public health;
- 4 to report to the Sixtieth World Health Assembly 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;

- 5 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 recommended strategies and programmes;
- 6 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;
- 7 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 of their patients associated with harmful patterns of alcohol consumption;
- 8 to collaborate with Member States, intergovernmental organizations, health professionals, nongovernmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;
- 9 to organize open consultations with representatives of industry and agriculture and trade sectors of alcoholic beverages in order to limit the health impact of harmful alcohol consumption;
- 10 to report through the Executive Board to the Sixtieth World Health Assembly on progress made in implementation of this resolution.

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



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