

**ALCOHOL AND HARM REDUCTION**  
**AN INNOVATIVE APPROACH FOR COUNTRIES IN TRANSITION**

Edited by:

Ernst Buning, Mônica Gorgulho, Ana Glória Melcop and Pat O'Hare

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International Harm Reduction Association (IHRA [www.ihra.net](http://www.ihra.net))

Contact address:

ICAHRE

Vijzelstraat 77

1017 HG Amsterdam, The Netherlands

Tel: + 31 20 3303 449

Fax: + 31 20 3303 450

Email: [info@icahre.org](mailto:info@icahre.org)

Web: [www.icahre.org](http://www.icahre.org)



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**FOREWORD**

During visits to several developing countries in recent years, usually on projects related to injecting drug use and HIV, I have often been struck by the even greater prominence of problems resulting from alcohol consumption. In many developing countries these days, alcohol consumption is increasing steadily, though usually from a fairly low base. In most of these developing countries, there is little experience of alcohol-related problems to draw upon. There is, for example, no tradition of self-help groups for alcohol. The health care system in many such countries struggles to cope. People often drive long distances over poor roads in relatively dilapidated but crowded vehicles and often in hot and thirsty conditions. Alcohol consumed in these conditions causes even more havoc than in developed countries.

The last decades has seen the emergence of a new group of countries, often called 'transitional', to reflect their journey from central command to free market economies. Increasing alcohol consumption has accompanied the political and social turmoil of transition in the countries of the former Soviet Union, and resulted in a sharp reduction of life expectancy and an increase in social problems. Many other transitional countries have experienced similar developments though mostly on a smaller scale. Attempts to reduce demand and supply of alcohol continue in these countries, albeit with great difficulty. These endeavours need to be buttressed by other measures designed primarily and directly to reduce the health, social and economic costs of hazardous and harmful alcohol consumption. These countries share some of the characteristics of developed countries. There is, for example, often a long history of dealing with alcohol-related problems.

The recent burden of illness studies organised through the World Health Organisation have documented the ravages of alcohol in many resource poor

countries. As economic growth brings new wealth to these countries, alcohol consumption often starts to rise. New ports, airports and highways speed up the importation of alcohol from other countries. Before long, new industrial facilities are constructed to produce alcoholic beverages domestically in the name of import substitution. This acts as a further stimulus to increase alcohol consumption. With more economic growth, increasing drift of populations from rural to urban settings in search of employment is likely to result in further increases in alcohol consumption.

During the last quarter century, there have been many advances in the prevention of alcohol-related problems. These advances have mostly been applied in developed countries where alcohol consumption and alcohol-related problems have generally been declining in recent decades. Developed countries usually have some experience of alcohol-related problems to draw upon. Most research into the control of alcohol-related problems takes place in the industrialised world. Prevention of alcohol-related problems in the developed world is based on a large number of policies of known effectiveness including attempts to reduce demand by gently raising excise, reducing supply by constraining the density, hours of opening and modifying the conditions of operation of alcohol outlets, reducing sales of alcohol to intoxicated persons in licensed premises, implementing a raft of interventions which have been found to be effective in reducing alcohol-related road crash deaths and injury and assisting people consuming alcohol at higher risk levels to reduce or eliminate their alcohol consumption.

Many of these measures are much more difficult to apply in resource poor settings where populations are much more likely to live in rural settings. Here alcohol can easily and quickly be fermented from readily available fruits or vegetables in the generally hot conditions. As demand and supply control are much more difficult to apply in less developed and transitional countries, is



there a comparatively greater role for harm reduction in attempting to reduce alcohol-related problems?

Although the concept of harm reduction is more often associated with illicit drugs, especially since the dawn of the HIV/AIDS era, harm reduction has been applied to alcohol from time immemorial. In ancient China, authorities erected barriers around canals to stop intoxicated citizens from slipping into the icy waters in winter and dying of hypothermia. Of course, this did not preclude efforts to reduce intoxication but these efforts rarely succeeded in eliminating intoxication. Accepting that intoxication like the meek would always be with us, alcohol policy researchers a generation ago talked of ‘making the world safe for drunks’. This was a time when safety belts were developed for cars to ensure that after efforts to reduce drink driving had been fully implemented, any intoxicated drivers and their passengers might still survive a crash unscathed. Critics at the time raised the prospect of drivers wearing safety belts compensating for their now greater safety by driving more recklessly. The ‘risk compensation hypothesis’ is still alive and well after all these years and should always be considered when possible new harm reduction measures are contemplated. The risk that new measures introduced with the best of intentions could have unforeseen and serious negative effects should never be dismissed lightly.

The International Harm Reduction Association grew out of a series of annual conferences which began in Liverpool in 1990. Already at the third of these conferences, in Melbourne in 1992, the question of applying harm reduction to alcohol (and tobacco and illicit drugs) was well and truly on the agenda. It has remained on the agenda of most conferences in this series ever since. Four out of every five people in the world live in a developing or transitional country. It is high time that far greater emphasis was placed on finding effective ways of reducing alcohol-related problems in these resource poor settings. Harm

reduction approaches will need to be considered alongside demand and supply control. The aim should be to reduce the health, social and economic cost of our favourite beverage recognising the magnitude of these costs and especially the large proportion of the population every year experiencing negative social consequences from the alcohol intoxication of others. Cardiovascular disease is comparatively less common in the young populations of developing countries (though increasing) and thus attempting to reduce overall mortality in older individuals by promoting moderate consumption is less of an issue than in the older populations found in developed or transitional countries. Moreover, virtually all studies of moderate consumption and overall mortality have been conducted in developed countries.

The International Harm Reduction Association is delighted to have been associated with the 1<sup>st</sup> International Conference on Harm Reduction and Alcohol and the book emerging from the conference. Let us hope this activity leads on to greater endeavours culminating in benefits to the lives of people living in developing and transitional countries throughout the world.

*Dr Alex Wodak*, President

The International Harm Reduction Association

**PREFACE**

Putting a book together about Alcohol and Harm Reduction was the first challenge and specifically focussing on countries in transition, was the second challenge. We set out to put this book together for compelling reasons. We were alarmed at the gross human suffering and economic losses related to harmful drinking. We were taken aback by the lack of public attention and the seemingly biased attitude of the media in not providing a broader coverage on this subject while public attention and huge public investments could be seen in the field of illicit psychoactive substance use and Aids.

Many countries in transition are now on the brink of developing public policies. We feel this is the right time to call for attention in an effort to curb the effects of harmful drinking.

Now that it is here, we can see the efforts were worthwhile: a book which highlights harmful drinking from different angles, which is informative and sometimes provocative and which gives enough food for thoughts. A book that puts forward new approaches to explore in an attempt to complement conventional alcohol policies with pragmatic non-judgemental and innovative interventions.

We hope that you, the reader, will be motivated to join ICAHRE, the International Coalition on Alcohol and Harm Reduction, and share your expertise and experiences with other members of the coalition. Pooling our collective intellect, using our common-sense and ensuring our commitment will undoubtedly result in more effective policies in reducing the harmful consequences of alcohol use.

April 2003

The Editors



## INTRODUCTION

ICAHRE, the International Coalition on Alcohol and Harm Reduction, hopes that this book will further contribute towards the development of sensible and innovative policies in reducing alcohol related harm in countries in transition. Such policies are urgently needed. We call on politicians, policy makers and the media to take active steps in addressing this problem and thus, giving it the attention it deserves. No longer can we afford to turn a ‘blind eye’ to problems related to alcohol use while –at the same time- an overwhelming interest in issues related to the use of illicit substances prevails. Alcohol related harm ‘deserves better’.

The developed world has had a long tradition of alcohol policies which, to a certain extent, have proven to be effective. Countries in transition, by contrast, have their own reality and cultural context; their own specific histories of alcohol consumption and their own way of addressing individual and societal problems. In view of this, it is therefore questionable (a) whether present western alcohol policies can be relevant to the local context of countries in transition and (b) whether new concepts should emerge and be developed. To break new ground, ICAHRE presents a first draft of such new concepts, which could serve as a basis for policy development.

Most of the contributing authors of this book are specialists in the drug field and not in the alcohol field. On the one hand, it can be argued that this is a drawback and that a new group of players in the field will ‘invent the wheel all over again’. On the other hand, the collective expertise of the contributing authors on harm reduction, drug use and realities of countries in transition, might well serve to taking a fresher view and approach in tackling these challenges in an unconventional way.

The editors recognise this dilemma and invite everybody to join ICAHRE and contribute their expertise in developing more effective interventions to reduce alcohol related harm.

#### **SHORT HISTORY**

In August 2000, the Latin American Travelling Seminar (LATS) took place in Recife, Brazil. LATS focuses on stimulating local drug policies based on principles of creating synergy, human rights, involvement of civil society and pragmatism. During this seminar, the organisers were confronted with countless questions about the role of alcohol and organisers' views on alcohol and harm reduction. Beyond question, harm caused by alcohol far outweighs harm caused by drugs, and yet much more attention has been given to the use of illicit drugs. Since August 2000, the organisers of LATS have worked on further elaborating the concept of '*Alcohol and Harm Reduction*'. As a result of this initiative, a major conference was organised in Recife in August 2002: '*The first International Conference on Alcohol and Harm Reduction, towards a comprehensive alcohol policy in countries in transition and developing countries*'. This eventful conference attracted over 600 delegates, representing not only alcohol experts, researchers and policy makers, but also groups of persons who are directly affected by the harmful consequences of alcohol, such as prisoners, indigenous people, sex workers, street children and community representatives. At the end of the conference, the International Coalition on Alcohol and Harm Reduction (**ICAHRE**) was launched.

**ABOUT ICAHRE**

The objectives of ICAHRE, the International Coalition on Alcohol and Harm Reduction are:

- To promote alcohol policies aimed at reducing alcohol related harm, which are:
  - pragmatic: based on facts rather than on beliefs;
  - realistic: alcohol consumption is an integral part of many societies with both negative and positive effects;
  - non-judgmental: those who have and/or cause alcohol related problems should not be condemned;
  - aimed at empowerment: strengthening individual responsibility along measures based on external control;
  - inclusive: instead of talking ‘about’ individuals and communities which face alcohol related problems, they should be actively involved in the development of policy and interventions;
  - creating synergy: stimulate co-operation between all stake holders and respect and recognise differences and see these differences as challenges rather than obstacles.
- To promote alcohol education, which is honest, factual and aimed at strengthening personal responsibility;
- To urge the alcohol industry to:
  - refrain from promoting alcohol to youth;
  - refrain from associating alcohol consumption with a successful image;

- print warning markers on products about (1) the risks of drinking and driving and (2) alcohol consumption during pregnancy;
- To promote the exchange of information and experience;
- To stimulate research and evaluation of alcohol harm reduction interventions, assessment studies of alcohol related harm and to facilitate the dissemination of the results;
- To give special attention to the development of alcohol harm reduction policies and interventions in countries in transition and developing countries;

#### **ABOUT THIS BOOK**

The purpose of this book is to facilitate and stimulate the discussion about managing alcohol related harm in a pragmatic way. It provides *'food for thoughts'* rather than give instant solutions. It is a first step in mapping alcohol related harm and it focuses mainly on countries in transition. The justification for this choice is that most countries in transition are now in the process of further developing comprehensive alcohol policies where choices have to be made. Although countries in transition might benefit from successful experiences elsewhere, it should be acknowledged that the reality in countries in transition and the cultural environment differs significantly from developed countries, making a direct transfer of policy and interventions less effective. This book addresses the reality of countries in transition and sketches specific issues to consider when developing alcohol policies.

This book is not about promoting abstinence, as we acknowledge there are positive effects related to moderate use of alcohol, such as relaxing, socialising, at celebrations etc. Furthermore, moderate use of alcohol (3 to 4 glasses per



week) seems to have a protective effect on cardiovascular diseases for people over 45.

Having said that, there is no reason to deny the harmful effects of alcohol on the short or long term. The harm related to **chronic use** of alcohol is well known and documented: medical problems, such as liver cirrhosis and cardiovascular disease and social problems such as distortion of social relationships, loss of employment etc. The World Health Organisation (WHO)<sup>1</sup> estimates that 50% of harm associated with alcohol can be contributed to chronic use.

Notably, 50% of the harm can be attributed to **acute alcohol intoxication**. It often concerns those who can not be classified as alcoholics or problem drinkers, but rather 'normal people' who have caused harm while drinking too much. Examples of such harm are: interpersonal violence, unsafe sex, impaired driving injuries and fatalities, accidents caused by drunken pedestrians, injuries after falls, accidental poisoning, suicide and absenteeism from work.

In Chapter 3, Ernst Buning describes the present situation regarding alcohol and harm in countries in transition. It is clear that there is a lack of reliable data on per capita consumption. In cases where funds are scarce, it might be advisable to focus more on the collection of data on alcohol related harm than per capita consumption.

Data about harm related to chronic alcohol use are well documented and mainly stem from research in the developed world. Data on harm related to acute intoxication (often involving those who are not labelled as alcoholics) is scarce. Therefore, some cases are presented and more research is recommended.

In Chapter 4, Bill Stronach gives a clear definition of Harm Reduction and discusses the merit of the Harm Reduction paradigm for the alcohol field.

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<sup>1</sup> *International Guide for monitoring alcohol consumption and related harm, World Health Organisation, 2002*

Important consideration is that Harm Reduction complements conventional policies rather than competes with them.

In Chapter 5, Ewa Osiatynska draws a concise picture of health related harm due to alcohol consumption. She describes a number of situations where the use of alcohol should be at zero, i.e. pregnant or breast feeding women, children and youth, driving, handling of machinery and for people with specific diseases where alcohol use is contraindicated. The chapter concludes with 6 clear recommendations.

In Chapter 6, Mónica Franch treats the issue of alcohol and violence from the perspective of a country in transition, i.e. Brazil. She focuses on violence among youth. She describes some spontaneous strategies youngster adopt in trying to protect themselves from violence when they drink and the limitations of such spontaneous strategies. The chapter ends with a reminder to the reader, that Harm Reduction policies in countries in transition must take into account the enormous social inequalities and should try to improve citizenship of the population.

In Chapter 7, Pauline Duarte discusses Harm Reduction in the workplace. She presents rather alarming data on the percentage of people in the workforce with alcohol problems and its effects and consequences (absenteeism, accidents in the workplace, additional costs for employers). The importance of the role of occupational health and human resource professionals is also stressed. She gives an example of a very practical campaign just before Carnival, where employees are encouraged to have fun and behave in such a way as not to harm themselves and others. Responsible use of alcohol is part of this campaign.

In Chapter 8, Ana Glória Melcop treats the issue of alcohol and traffic. She raises an important question: are alcohol related traffic accidents intentional or un-intentional? She makes a case that people who drink and drive know that they are putting themselves and others at risk and that an alcohol related traffic accident should therefore be classified as intentional and thus as 'violence'. This provocative point of view certainly provides food for thoughts. She sums up a

number of concrete strategies to avoid and/or reduce traffic risk situations for pedestrians and drivers.

In Chapter 9, Mônica Gorgulho discusses the role of the Media. The Media play an important role in the re-presentation of psychoactive substance use in the general population. She describes the huge differences between the treatment in the media of licit and illicit psychoactive substances. She recommends that actions should be undertaken to make the Media an active ally in changing the general perception on psychoactive substance use and to open the doors for a more effective alcohol policy.

In the last chapter, the various ingredients for an innovative alcohol harm reduction policy for countries in transition are discussed. Firstly, different models, such as the medical model, the abstinence oriented model, the AA model and the WHO model are discussed. Subsequently, the reality of countries in transition is highlighted from various angles followed by a paragraph on the difference between licit and illicit psychoactive substances. The chapter concludes with an elaboration on the Harm Reduction paradigm, its usefulness for the development of alcohol policies and a summing up of concrete challenges which are ahead when implementing Harm Reduction strategies.



## ALCOHOL USE IN COUNTRIES IN TRANSITION AND DEVELOPING COUNTRIES

Ernst Buning

In this chapter information about alcohol consumption in countries in transition and developing countries is provided. Most available data refer to per capita consumption. The value of the available data for public policy making is discussed.

Table 1. shows the recorded alcohol consumption in various regions of the world and the changes which occurred in the period 1990-1999. Although a drop has been reported in the last decade, the recorded alcohol consumption in Europe still scores the highest.

**TABLE 1. TOTAL ALCOHOL CONSUMPTION BY WORLD REGION (1990-1999)**

REGION	NUMBER OF COUNTRIES INCLUDED	TOTAL ALCOHOL CONSUMPTION PER CAPITA 1990 (LITRES OF PURE ALCOHOL)	TOTAL ALCOHOL CONSUMPTION PER CAPITA 1999 (LITRES OF PURE ALCOHOL)	PERCENTAGE CHANGE 1990-1999
WESTERN EUROPE	20	8.60	8.09	-5.9
EUROPEAN UNION	15	9.89	9.29	-6.1
EASTERN EUROPE	10	5.96	7.19	20.6
LATIN AMERICA	11	3.84	3.99	3.9
NORTH AMERICA	2	7.38	6.66	-9.8
AUSTRALASIA	2	8.55	7.48	-12.5

REST OF THE WORLD	14	1.66	2.39	43.7
WORLD TOTAL	59	3.41	3.85	12.3

*Please note that these figures are limited by the availability of data, and are based on those countries featured in the World Drink Trends 2000 book.*

In the following tables, recorded alcohol consumption in various regions which could be considered as 'in transition' and 'developing' are summarised. Some Central and Eastern European countries, such as Slovenia and the Czech Republic score very high. In Latin America and the Caribbean recorded alcohol consumption is lower than in the Central and Eastern European Region (see table 2.). In Asia, only the Republic of Korea and Thailand score high.

**TABLE 2. RECORDED PER CAPITA CONSUMPTION OF PURE ALCOHOL (LITRES) HIGHER THAN 4.0 PER ADULT 15 YEARS OF AGE AND OVER IN 1996 IN COUNTRIES IN TRANSITION AND DEVELOPING COUNTRIES (SOURCE WHO)**

CENTRAL AND EASTERN EUROPE, NEWLY INDEPENDENT STATES (NIS) AND RUSSIA		
RANK	COUNTRY	TOTAL
1	SLOVENIA	15.15
4	CZECH REPUBLIC	14.35
8	YUGOSLAVIA	13.17
9	SLOVAKIA	13.00
10	HUNGARY	12.85
15	CROATIA	11.75
29	BULGARIA	9.52
35	LATVIA	8.70
39	BOSNIA AND HERZEGOVINA	8.25
41	BELARUS	8.14
42	RUSSIAN FEDERATION	8.08
43	ESTONIA	8.07

44	POLAND	7.93
47	KAZAKHSTAN	7.71
55	LITHUANIA	6.23
68	THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA	4.86
70	GEORGIA	4.50
72	AZERBAIJAN	4.16
LATIN AMERICA AND CARIBBEAN		
RANK	COUNTRY	TOTAL
5	GUYANA	14.03
12	BAHAMAS	12.09
25	PARAGUAY	9.71
27	ARGENTINA	9.58
31	VENEZUELA	9.41
34	NETHERLANDS ANTILLES	8.78
37	BARBADOS	8.37
40	URUGUAY	8.17
49	CHILE	7.06
53	HAITI	6.55
54	COLOMBIA	6.41
57	DOMINICAN REPUBLIC	5.90
58	BELIZE	5.85
59	PANAMA	5.74
60	COSTA RICA	5.72
62	BRAZIL	5.57
65	MEXICO	5.04
69	SURINAME	4.68
74	PERU	4.00
ASIA		
RANK	COUNTRY	TOTAL
2	REPUBLIC OF KOREA	14.40

36	THAILAND	8.64
51	PHILIPPINES	6.77
64	CHINA	5.39
73	LAO PEOPLE'S DEMOCRATIC REPUBLIC	4.12
AFRICA		
RANK	COUNTRY	TOTAL
46	SOUTH AFRICA	7.72
52	GABON	6.76
61	LIBERIA	5.68
71	MAURITIUS	4.33

*Sources: FAO Statistical Databases 1998; Produktschap voor Distilleerde Dranken, 1997; United Nations Statistical Office, 1997; United Nations Population Division 1994 .*



**SOME QUESTIONS RELATED TO PER CAPITA CONSUMPTION**

The data presented above are based on formal registration. These data have not been corrected for the following:

- Smuggling
- Correction for use of alcohol by tourists
- Overseas consumption
- Stockpiling
- Duty-free purchases
- Home produced alcohol
- Informally produced and traded alcohol

If the same method is used each year, data about per capita alcohol consumption are useful to monitor trends, i.e. increase or decrease of per capita consumption as well as variations in the kind of alcohol consumed (beer, wine, spirits). Such trend data could be useful for public health policies. However, per capita consumption data should never be the sole source of information. To illustrate this, we include data from the WHO about studies which aimed at calculation real per capita consumption. As can be seen in table 3., there are major differences between recorded and adjusted per capita consumption. For example, in Brazil the real consumption is estimated to be over 2.5 times higher than the recorded consumption. In Ecuador this would be 4 times higher and in Kenya even 7.5 times higher.

## ALCOHOL USE IN COUNTRIES IN TRANSITION AND DEVELOPING COUNTRIES

COUNTRY	YEAR	RECORDED	ADJUSTED	ADJUSTMENT
BRAZIL (DUNN & LARANJEIRA, 1996)	1996	5.07	14.01	ADJUSTED FOR GOVERNMENT ESTIMATE OF 1 BILLION LITRES OF UNRECORDED PINGA PRODUCTION.
CHILE (PAHO, 1990)	1990	7.86	9.43.	INCREASED BY 20 % TO ALLOW FOR CLANDESTINE PRODUCTION
ECUADOR (PAHO, 1990)	1990	2.10	8.40	ADJUSTED FOR CLANDESTINE PRODUCTION ESTIMATED AT THREE TIMES OFFICIAL PRODUCTION.
ESTONIA (JERNIGAN, 1997)	1995	8.07	10.74	ADJUSTED FOR POLICE ESTIMATES THAT THE BLACK MARKET REPRESENTS 25 % OF THE TOTAL MARKET.
HUNGARY (FEKETE, 1995)	1995	11.47	14.52.	INCREASED BY 2.5 LITRES PER CAPITA TO REFLECT UNRECORDED ALCOHOL CONSUMPTION
KENYA (PARTANEN, 1993)	1990	2.29	17.29	ADJUSTED TO REFLECT THE ESTIMATED 80-90 (85) % OF TOTAL ALCOHOL DERIVED FROM THE INFORMAL SECTOR.
REPUBLIC OF MOLDOVA (VASILIEV, 1994)	1993	12.67	18.1	ADJUSTED TO REFLECT ESTIMATE THAT UNREGISTERED CONSUMPTION ACCOUNTS FOR 70% OF TOTAL CONSUMPTION.
RUSSIAN FEDERATION (HARKIN, 1995)	1993	6.99	14.49	ADJUSTED TO REFLECT ESTIMATE THAT PER CAPITA UNRECORDED CONSUMPTION WAS 7.5 LITRES.

SLOVENIA (CESABEK- TRAVNIK, 1995)	1993	14.90	24.19	ADJUSTED TO REFLECT ESTIMATE THAT UNRECORDED CONSUMPTION WAS BETWEEN 7 AND 8 LITRES PER CAPITA.
SOUTH AFRICA (PARRY, 1997)	1995	7.81	10.0	ADJUSTED TO INCLUDE ESTIMATE OF TOTAL PRODUCTION OF BEER FROM SORGHUM.
REPUBLIC OF MACEDONIA (JOVEV, 1993)	1992	6.33	12.66	ADJUSTED TO REFLECT ESTIMATE THAT 50 PER CENT OF TOTAL PRODUCTION IS HOME MADE.
UKRAINE (KRASOVSKY & VIJEVSKY, 1994)	1993	4.17	13.00	ADJUSTED TO REFLECT ESTIMATE THAT TOTAL UNRECORDED CONSUMPTION WAS 7.0 LITRES PER CAPITA.

**TABLE 3. PER CAPITA CONSUMPTION OF PURE ALCOHOL (LITRES) PER ADULT, 15 YEARS OF AGE AND OVER ADJUSTED FOR UNRECORDED PRODUCTION AND TRADE (SOURCE: WHO)**

*Sources for recorded consumption estimates: FAO Statistical Databases; Produktschap voor Distilleerde Dranken, 1997; United Nations Population Division 1994.*

Clearly, the present method in which per capita consumption data are gathered is unsatisfactory. In this respect, the WHO recommends 'Given the important role that adult per capita consumption estimates may play in the planning and assessment of public policies, international collaborative research should be commissioned to refine methods for obtaining basic information to aid countries to make more accurate per capita consumption estimates'. Although this is a sound recommendation, we believe that, if only limited resources are available, priority should be given to recording alcohol related harm rather than per capita consumption. In the end, proper insight into the types of harms related to alcohol use, their prevalence and the

situations in which they occur, give far better indications for public policy than mere per capita consumption.

#### **RECORDED ALCOHOL RELATED HARM**

Data about alcohol related harm in countries in transition and developing countries are difficult to find. Studies are rare and clear international standards are still lacking. A first attempt has been made by the WHO in their International Guide for monitoring alcohol consumption and related harm (2002).

Indicators of problems mainly attributed to **long-term use** of alcohol are: diseases of the liver, mental health problems, foetal alcohol syndrome, cancers, and cardiovascular disease. The data presented in the WHO report are mainly based on research in the developed world. This should not be seen as a hindrance, as it concerns the influence of alcohol on the human body and it is not likely that research in developing countries would come up with different findings.

In their 1996 publication 'The global burden of disease', Murray and Lopez presented an overview of DALY 's (Disability Adjusted Life Years) for various diseases. They calculated that world wide in 1990, over 47 million disability years could be attributed to alcohol use, which is about the same as the number of DALY's attributed to unsafe sex. Alcohol related mortality world wide is estimated to be 774.000 persons per year.

Indicators of harm attributable mainly to the **short-term effects** of drinking alcohol mentioned in the WHO Guide are:

- Alcohol related traffic crashes
- Alcohol related unintentional injuries and death
- Suicide

- Interpersonal violence

The majority (34 out of 39 studies referred to) were conducted in developed countries. Assuming that the WHO has good access to research databases, this might very well indicate that countries in transition and developing countries either lack resources for conducting studies on harm related to short-term effects of alcohol or still give this insufficient priority. In light of the above, some case studies are presented.

#### **UGANDA**

Researchers from the Medical Research Council Programme on AIDS in Uganda questioned 2,374 sexually active adults from 15 villages in the Southwest of the country. Drinking alcohol can increase the risk of HIV infection by reducing the chances of condom use, increasing sexual activity and weakening personal control, the study suggested.

#### **MEXICO**

A cross cultural study undertaken by Cherpitel and colleagues (1993) in Mexico and the United States found a higher rate of alcohol involvement among emergency rooms attenders in Mexico (21% vs 11%), but a higher proportion of heavy drinkers in the United States (21% vs 6%).

According to the National Household Survey 73% of the alcohol related problems that include family, job, accidents and police problems, were the responsibility of people that had not reached the dependency criteria. This high rate of problems derived from events of acute intoxication is expected to be due to the prevailing drinking pattern (Medina-Mora et al. 1991).

**ZAMBIA**

In a study among 1095 persons (aged 15 years and over) in Zambia, Lusaka and Mwachisomp interviewees indicated personal and social consequences of alcohol use. 16% of the men indicated that they sometimes get drunk even when there is an important reason to stay sober (vs 4% of the women). Around 17% of men (versus 7% of women) had in the year preceding the interview felt the effect of alcohol while on the job. The rural population reported more problems than the peri-urban population. (source: Ritson E.B. 1985)

**INDIA**

Chengappa (1986) estimated that in India 25% of road accidents is alcohol related

**SOUTH AFRICA**

In the World Report on Violence and Health, the relationship between alcohol and violence is debated: whether alcohol is a stimulating factor, reduces inhibitions, clouds judgements and impairs individual's ability to interpret cues. It is discussed that in some cultures, the collective expectation is that drinking excuses certain behaviours. In this respect, a rather disturbing example from South Africa was quoted from a 1999 study by Tyberberg, Centre for Epidemiological Research in South Africa, Medical Research Council, which states: '.....In South Africa, for example, men speak of using alcohol in a premeditated way to gain the courage to give their partners the beatings they feel are socially expected of them...'

**CONCLUSION**

Since reliable data are not available, it is difficult to assess whether countries in transition and developing countries have a similar level of alcohol consumption than countries in the developed world. Nevertheless, in some cases, harm related to the consumption of alcohol has been recorded. We strongly

recommend that the Guidelines of the World Health Organisation are followed through, so that a clearer picture comes into view of the magnitude of alcohol related harm in countries in transition and developing countries. Such information is essential to build further alcohol strategies.

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**ALCOHOL AND HARM REDUCTION**

Bill Stronach

Alcohol is the most widely used psychoactive drug in most countries. Alcohol is used to celebrate and commiserate. It acts to release inhibitions. People use alcohol to help them relax and have fun. For many people it is an accompaniment to most social occasions. For most people, on most occasions, consumption is at relatively low risk levels – both to the drinker and to others.

But there is another side to alcohol use. It is responsible for much harm at the societal and individual level. After tobacco, alcohol is the second greatest cause of drug related deaths. In most countries it has a much greater impact in terms of death, injury and economic costs than illicit drugs. By any scale of disease burden, alcohol has a significant impact. Importantly, it impacts across all age groups in a direct or indirect manner. Any meaningful and comprehensive public health policy must seek, as a major priority, to change the amount of alcohol used, the patterns of that use and the resultant harms.

**SOME PRELIMINARY CONSIDERATIONS**

To most people in countries where alcohol use is common and legal, alcohol is a socially acceptable substance. Until recent years many people talked of alcohol and other drugs with the implicit suggestion that alcohol was somehow different to ‘other drugs’.

Also, the fact that alcohol is legal in most countries often implies it is somehow safer than other drugs. Legality does not confer safety.

It is incumbent on the community to understand the impact of alcohol beyond the trauma of car accidents or the occasional media reports of alcohol induced violence. Drugs like heroin and ecstasy are endowed with much more fearsome characteristics and potential harms than alcohol.

**SO WHAT ARE THE HARMS FROM ALCOHOL USE?**

It is useful to take a broad view here. The short term harms and problems are often traumatic like car accidents, violence and assaults, unplanned or unwanted sexual activity, conflict with the law or with an employer. Accidental deaths, such as from drowning, are often associated with drinking alcohol. In some communities where there is widespread production of illicit alcohol poisoning can be a common occurrence. Usually these outcomes arise from heavy or binge drinking episodes. Longer term harms are usually derived from consistent heavy (or high risk) drinking over a longer period of time. Damage to physical organs (heart, liver), loss of personal relationships or employment, or financial problems may arise from sustained and heavy alcohol consumption.

**RESPONDING TO THE OUTCOMES OF ALCOHOL USE**

The traditional response to alcohol use/misuse has been based on the demand:supply paradigm. Most societies have restrictions on the manufacture, sale and promotion of alcohol. However, in many communities where illicit alcohol production is rife, such government sanctions are obviously ineffective. The details of particular laws may vary from country to country or region to region, but supply control can play an important part in managing alcohol use. Modifying the demand for alcohol through community or school education programs are often favoured strategies. In terms of reducing use they have limited impact. Likewise, taxation and pricing can alter and reduce consumption patterns. There is ample evidence that reduced overall consumption will reduce overall problems.

But there are significant limitations to the scope and impact of the demand:supply model and this is where harm reduction approaches can play a significant and complementary role. Before any further exploration of harm reduction's role as a complementary strategy to manage alcohol related problems it is important to define our terms.

## A WORKING DEFINITION OF HARM REDUCTION

The International Harm Reduction Association defines harm reduction as “policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individuals drug users, their families and their communities”. (see Policy Papers on [www.ihra.net](http://www.ihra.net)).

This is a most useful and succinct definition. Its focus is on managing the outcomes of drug use rather than just reducing the use of a particular drug. It can be applied equally appropriately to legal as well as illegal drugs. Likewise, it can be applied to alcohol that is commercially and legally produced, or produced illegally in a home or village.

This definition requires two comments. Firstly it does not condone or encourage drug use because it recognises that there are risks involved and problems may follow. Secondly, harm reduction, as defined above, does not reject abstinence. In fact, some claim the most effective means to reduce harm is not to engage in drug use in the first place.

Whilst harm reduction policies and practices have been undertaken under other titles for decades it was the AIDS epidemic that focused the medical and public health fields to respond to a global threat in particular and pragmatic ways. Sexual abstinence and the cessation of the use of injectable drugs was not an option for many people so a realistic and pragmatic series of strategies needed to be put in place. These characteristics – ‘realism’ and ‘pragmatism’ are the spirit of harm reduction.

In countries that have responded relatively effectively to the AIDS epidemic policy has focused on the **outcomes** of certain behaviours as much as on the eliminating or changing of the behaviour itself.

**HARM REDUCTION IS AN EVERYDAY STRATEGY**

Before examining harm reduction's application to alcohol use it is worth stressing that everyone applies the principles of harm reduction in everyday life. Road safety is the classic example where seat belts, protective road barriers and 'crumple zones' on the front of cars means the chance of injury is reduced in an accident. People will still drive cars – some will drive dangerously despite road laws – but the chances of harm are reduced.

Drinking water is a necessary part of human existence but in some parts of the world this is a risky behaviour. So we can boil water to reduce contamination, or drink bottled water. Likewise with skateboarding – a potentially perilous exercise for the young. They will still seek the thrill of the sport but by wearing knee and elbow pads, helmets and similar attire the harms can be reduced. The list of everyday experience in which the principles of harm reduction are present is endless.

**HARM REDUCTION AND ALCOHOL**

The IHRA policy paper referred to above is a good starting point.

'Harm reduction has a long and distinguished record in alcohol control policies. Attempts to directly reduce alcohol related problems without necessarily reducing alcohol consumption complement, rather than compete with better-known demand and supply strategies'.

Whilst harm reduction has traditionally been identified with illicit drugs, it is equally applicable to alcohol and other legal substances like tobacco. Given that alcohol use will continue, and that alcohol misuse is also likely to continue harm reduction principles and strategies are logical and demonstrably effective. The key elements of harm reduction are universal. These elements, or characteristics should underpin any public health policy or intervention strategies that seek to apply harm reduction principles. These elements are:

- Harm reduction is a complementary strategy that sits beside supply control and demand reduction;
- Its key focus is on outcomes rather than actual behaviours per se;
- It is realistic and recognises that alcohol will continue to be used extensively in many communities, and will continue to create problems for some individuals and some communities;
- Harm reduction is non-judgemental about the use of alcohol, but is focussed on reducing the problems that arise;
- It is pragmatic – it does not seek to pursue policies or strategies that are unachievable or likely to create more harm than good;

Harm reduction recognises individual human rights – it is rooted in an acceptance of individual integrity and responsibility.

## **HARM REDUCTION AND ALCOHOL: PUTTING IT INTO ACTION**

### **THE SUBSTANCE**

The production of low alcohol products and its ready availability provide options. Many people will take this option so that they can enjoy their alcohol with a lesser chance of becoming intoxicated, ill or endangered.

There are real attitudinal challenges here. For many, and particularly younger males, the notion of low alcohol drinks is an affront to their manhood. There is a need to change this culture and this is a long term exercise. It includes modifying the way alcohol is marketed and promoted as well as changing accepted community views.

In some countries additives like Thiaman (Vitamin B) are added to the product and this is proven to reduce some of the health related risks.

**THE ENVIRONMENT**

The drinking environment can be made safer so that those who choose to drink alcohol can do so in relative safety. This also affects the non-drinker – a safer environment means that they will not be the recipient of collateral damage. There is considerable research indicating that noisy, crowded, inaccessible bars create problems. Licensed venues that tolerate intoxication or allow bar staff to serve intoxicated people are recipes for problems.

Alcohol's link with violence is well documented. Alcohol and glasses go together so licensed venues can serve drinks in unbreakable or plastic receptacles. The dangers of a broken glass being used as a weapon is eliminated as is the chance of accidental harm from broken glassware.

Many sporting venues, whilst still providing alcohol to patrons, have created 'dry areas', or do not allow alcohol to be brought into the venue. It must be purchased on-site and the venue managers may only provide low alcohol drinks, or exclude spirits, or permit the purchase of only one drink at a time.

**THE ACTIVITY**

Drinking is usually a social activity conducted in groups. If alcohol is the focal point of this activity it is likely to create problems. But if the 'activity' also involves food or dancing, or playing pool it is likely that alcohol will be less prominent and some problems are likely to be reduced.

A very practical strategy is for the drinker to plan their optimum level of expenditure before they commence drinking – and most people will be able to manage their behaviour to that level.

**THE DRINKER'S PLAN**

One of the most obvious manifestations of excessive alcohol use is in traumatic incidents, often car accidents. Most people know when they are likely to be drinking alcohol. Planning ahead is a sensible and effective harm reduction strategy. As well as setting limits on actual drinking, plans can be put in place to

ensure that problems do not arise. Don't drink alone; ensure transport will be available without an alcohol-affected driver; establish the budget; know what is actually in a mixed drink; don't take drinks from a stranger.

#### **THE DRINKERS KNOWLEDGE**

The provision of alcohol information and education has been promoted as an effective prevention strategy for decades. However, its impact on ultimate behaviour is debatable. The assumption that school based alcohol education would effect ultimate drinking behaviour (perhaps years in advance) has proven unrealistic.

However, it is reasonable to assume that some understanding of the effect of alcohol on the body and human behaviour is useful. It means that someone embarking on a drinking episode has some understanding of the problems that can ensue. It does not mean that they will change their behaviour, or even reduce the problems – but for some that will be the result.

The provision of information and education about how to 'manage' their drinking and that of their friends is important. Many young people may be new or inexperienced drinkers who are subject to strong peer pressure to take normal 'adolescent risks'. Basic first aid is a pragmatic tool that may be useful among fellow drinkers.





## **ALCOHOL AND HEALTH**

Ewa Osiatynska

Innumerable factors affect health. Only genetic makeup and random mishaps are beyond our control. Most other factors influencing health can be regulated and adjusted. That, of course, depends on knowledge, awareness and enlightened maturity, as well as living conditions, of an individual. People have not always thought so; such approach and understanding of one's own health has obviously resulted from the development of civilisation, popular health consciousness and progress in medical research.

Presence of alcohol in culture and habitual behaviours of people in many a nation bestows on the substance a rightful citizenship. Despite harmful effects resulting from alcohol misuse, it is hard to imagine total removal of alcohol from our life. However, some circles of anti-alcohol crusaders identify any alcohol use with alcoholism (or potential alcoholism). Such approach, observed in several East European countries, appears unrealistic and ineffective. Moreover, physicians and medical researchers have repeatedly claimed that alcohol used moderately by healthy adult consumers, may contribute to wellbeing, good health and even prevent a number of ailments.

### **HIGH RISK GROUPS**

Discussion of the harmful effect of alcohol on health calls for emphasising four categories of potential consumers for whom extremely harmful may be any - therefore even moderate and infrequent - alcohol use.

Children and the young before reaching full physiological maturity will suffer an array of damaging effects of alcohol consumption. Alcohol consumed with any regularity may hinder psychological and emotional development and

contribute to a variety of developmental disorders of the central nervous system; it may also damage function of vital internal organs.

Research indicates that harmful effect of alcohol consumed (also in moderate quantities) by pregnant or breast-feeding women may be observed on development of foetus and behaviour of babies. Two serious disorders: Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Effect (FAE) have been identified as direct consequences of alcohol use in pregnancy.

Patients treated for illnesses requiring strong counter-indication of alcohol consumption (diabetes, disorders treated with psychotropic medication, liver and pancreas conditions, inflammation of mucosa, diseases of larynx, trachea and bronchus, diseases related to disorders of immunologic system, etc.). This category includes also a very specific group: recovering alcoholics whose continuous and relapse-free recovery requires total abstinence.

The fourth category comprises people who might safely consume alcohol but not in specifically identified situations. The situations that call for total abstinence relate to driving and working technical or industrial machinery.

#### **HARM RESULTING FROM ALCOHOL CONSUMPTION**

World Health Organisation recommends replacing the former diagnostic term “alcoholism” by “alcohol dependence syndrome” or “alcohol addiction” (statistical No. F10.2; ICD 10) and “harmful alcohol consumption” (No.F10.1).

The term “harmful drinking” rather closely describes what is meant under the concepts widely used today, such as: “alcohol abuse”, “alcohol misuse”, or “alcohol related problems”.

Harmful drinking may result in a variety of complications, such as:

1. Health problems: onset and/or aggravation of numerous diseases as well as an increased incidence of traumatism and/or physical injury;

2. Psychiatric and psychological problems including aggressiveness, depression, anxiety disorders, alcohol related psychotic episodes;
3. Social and interpersonal problems:
  - a. family conflicts often related to domestic violence resulting in a variety of physical and/or psychological traumatic effects both short- and long-term among the members of the family of an irresponsible drinker;
  - b. disruption of neighbourhood harmony;
  - c. workplace problems (also accidents);
4. Conflicts with the law may include driving under the influence of alcohol (DUI); violent crimes committed after or during alcohol consumption; misdemeanours related to aggressive or antisocial behaviours resulting from alcohol abuse.

Worthwhile mentioning is that not only the two first categories include health-related harm of alcohol use. “Social” and “Law related” harm includes also the effects which may, directly or indirectly, cause health problems in physical and/or psychological functioning (especially of other people). Harmful drinking of an employee may result in accidents causing severe damage to the co-workers and the workplace as such. The prolonged interpersonal conflict, often accompanying heavy drinkers’ behaviour, may affect well-being and the general atmosphere of the workplace.

The harm listed under the “legal” category results often in concrete health-related problems, as in the cases when alcohol is involved as a factor in violent crimes.

Therefore, the discussion of health damages resulting from “harmful drinking” should perceive the harm in a broader context rather than just the effects of

Ethanol on the specific internal organs or systems of the drinking person. This, however, will be the next part of this Chapter.

#### **ALCOHOL EFFECTS ON INTERNAL ORGANS AND SYSTEMS**

##### **LIVER**

The liver responds relatively fast to alcohol consumption and is prone to damage. Pathogenesis of alcohol related problems has been researched in depth; we know that the most dangerous damages may include: fatty degeneration of liver, hepatitis and cirrhosis. Cirrhosis is a serious progressive and irreversible, life threatening disease. Drinking women are prone to liver cirrhosis even more frequently than men.

##### **DIGESTIVE SYSTEM**

Prolonged drinking may irritate mucosa and, in result, cause inflammation of oesophagus. Not quite clear is the role of alcohol in cancer of oesophagus. Liver cirrhosis may cause oesophagus varices (often accompanied by lethal bleeding).

It has also been confirmed that alcohol is a significant factor contributing to gastric ulcers, cancer of colon, pancreatitis and, in result, an increased risk of hypoglycaemia and diabetes.

##### **NUTRITION DEFICIENCY**

Mechanisms of nutrition deficiency in heavy alcohol drinkers are complex and not fully researched. Noteworthy is the fact that alcohol, as a highly energetic substance, may satisfy the urgent calories' demand of the body thus satiating the hunger. This phenomenon, combined with the decreased absorption and disrupted function of alimentary canal, may contribute to vitamin deficiency, deterioration of absorption of proteins, zinc and other nutritional substances.

Heavy alcohol consumption causes the most severe deficiency of vitamin B1, folic acid and vitamin A.

#### **CIRCULATORY SYSTEM**

Alcohol strongly affects mechanism regulating blood pressure. It is a common knowledge that the larger quantities of alcohol consumed, the greater proneness to the increased arterial blood pressure. Heavy drinking increases the risk of anemic heart condition.

It is sometimes claimed that alcohol may have a beneficial effect on prevention of coronary disease; however, those who insist so, usually are themselves heavy drinkers.

#### **ENDOCRINE SYSTEM**

Heavy alcohol drinking may cause a variety of hormonal disorders including abnormal secretion of testosterone and luteotropine as well as a decrease of spermatozoon motility and their structural damage. Male drinkers may then suffer from effemination (overgrowth of mammary glands, testicle atrophy, abnormalities in hair growth, decrease of facial hair, etc.). Female drinkers may suffer from ovary atrophy and masculinization (appearance of facial hair, low voice, etc.). These changes may be accompanied by the decreased sexual drive, irregularities of menstrual cycle, sterility and premature menopause. Alcohol affects also secretion of thyroid and supraenal glands.

#### **SEXUAL DYSFUNCTION**

Despite a popular notion of alcohol is beneficial and stimulating role in sexual performance, the facts prove to the contrary. Alcohol disinhibits (decreases shyness) and thus may stimulate sexual drive. However, the prolonged heavy use of alcohol by men may cause impotency. Considerably high concentration of alcohol in blood results in erection disturbance, delayed ejaculation and weak

orgasm. Many female drinkers suffer from the decreased sexual drive, decreased vaginal lubrication and irregular ovulation.

#### **IMMUNOLOGIC SYSTEM**

Prolonged alcohol consumption hinders the functions of immunologic system which results in an increased proneness to infectious diseases, pneumonitis, tuberculosis, and even cancer. Alcohol damages lymphocyte activity in production of antibodies and decreases their activity. It may be said that intensive alcohol consumption affects in a damaging or disruptive way all functions of the immunologic system.

#### **SKIN PROBLEMS AND SEXUALLY TRANSMITTED DISEASES**

Skin problems (rash, itching, hypochromatism etc.) result directly or indirectly from alcohol effects on liver and other organs of the digestive system.

Research confirms that the drinking population is 5 times more prone to venereal diseases than abstinent; the ratio among women is 29.

Alcohol abuse is also responsible for a greater risk of HIV infection (and, because of a weaker immunologic system, also higher incidence of the full AIDS symptoms).

#### **CANCER**

The oncogenic role of alcohol has been for a long time one of the research subject. However, probably because of the unquestionable significance of alcohol as a contributing factor in so many ailments, diseases and illnesses, it may be contended that alcohol plays part in development of certain forms of cancer, especially of liver, stomach, larynx, oesophagus, trachea, colon and prostate.

Breast cancer among drinking women has been observed with a greater frequency than among the non-drinking women; this fact may be attributed to

the alcohol damaging effect on the immunologic system rather than the direct influence of alcohol on the organ.

#### **PREGNANCY AND FOETUS**

It has been confirmed that after 40-60 minutes after alcohol intake by a pregnant woman, the foetal blood alcohol concentration will reach the same level as in the blood circulation of the mother. As alcohol affects toxically especially the very young organisms, women drinking during pregnancy have a higher incidence of premature birth, precipitate or missed labour and spontaneous miscarriages.

New-born babies of mothers who consumed alcohol during pregnancy may demonstrate mild to severe withdrawal symptoms (tremor, trembling, muscular tension, feebleness, sleep problems, weepiness, sucking difficulty, etc.). Further problems may include delayed growth, concentration and attention difficulties. The most serious complication results from the Alcohol Foetal Syndrome (first defined in 1968). The symptoms include low birth weight, poor health factors, delayed developmental prognosis and high frequency of developmental disorders.

#### **PSYCHIATRIC AND PSYCHOLOGICAL PROBLEMS**

Acute alcohol psychotic disorders (*Delirium tremens*, delusional or paranoid disorders, Korsakoff disease, etc.) appear almost exclusively in chronic alcoholics characterised by the most destructive drinking pattern. Those persons may also suffer from the chronic depressive disorder.

Alcohol abusing but not addicted persons, however, may cover with the drinking compulsion some psychiatric disorders. Prolonged toxic effect of alcohol on brain may result in personality changes including deterioration of emotional life, narrowing of the interest area, decrease of pro-social motivation, weakening of the ability of planning, organisation, etc.

Obviously, the negative characterological changes affect the quality of interpersonal relations and life style (parental, marital, professional) and may significantly diminish functioning in the family and workplace.

#### **INJURIES**

Drinking persons are more prone to accidental injuries. The reason for that is, caused directly by alcohol, decrease of concentration, perception and assessment of the situation. Research indicates correlation between drinking and various traumatic accidents (including lethal) resulting from car accidents, falling off, fire, drowning or injuries (including workplace causes).

Alcohol related injuries are considered a serious social and medical problem both in the developed and developing countries. The statistics in the Western countries claim that injuries are the fourth cause of death (after heart attack, stroke and cancer). In the population below 40, alcoholic injuries are the most frequent death cause.

As early as 1500 years b.Ch. an Egyptian scribe wrote that the immoderate drinking may cause bone fractures and other injuries. We know the best of the Number One cause of injuries among the drinking drivers. Drunk drivers cause far more road accidents with casualties than the drivers who were not under the influence while the accident occurred.

#### **ALCOHOL RELATED VIOLENCE**

The widespread aggressive behaviours are to a large extent connected with alcohol consumption. This fact may be perceived both in a criminal environment and in the private homes. It is not easy to interpret significance of such words as: “violence”, “aggression”, “crime”, especially when they refer to the intention of harm toward another person. However, many studies have indicated that consumption of alcohol may cause violent behaviours to a higher degree than just incidental.



Another important fact that should be taken into consideration is a percentage of alcohol abusers among the recidivists in prisons (in all countries where such statistics have been carried out).

What is interesting is that not only the violent perpetrator but also the victim/s may have consumed alcohol before or during the criminal act. Alcohol has been also traced down to in most investigated cases of violent rape, and also in other sex related crimes.

#### **DOMESTIC VIOLENCE**

Several studies indicate that up to 50% of all cases of wife battering are directly related to alcohol consumption by the batterer. Analysis of the investigated cases of child abuse or neglect in Canada has shown that alcohol is consumed by the violent adult in 87%. Sexual abuse and incestuous acts toward children have also been proven as acts committed mostly under the influence of alcohol. Studies and statistical data indicate mostly harmful physical effects of violent abuse. However, psychological damage and post-traumatic disorders should not be minimalised or ignored. Victims of violent domestic life style may experience long term or incurable problems including disorders of affective, neurotic or developmental nature.

#### **RECOMMENDATIONS**

1. It is necessary to inform (consequently and continuously) potential alcohol consumers of the realistic and research based facts related to harmful effects of irresponsible alcohol use.
2. The Governments should adopt as their priority the education of medical personnel (general- and family physicians, internists, gynaecologists, emergency medicine staff and nurses) in the area of prevention and early assessment of harm caused by alcohol misuse or abuse.

3. The workplace programs of prevention of alcohol abuse should be introduced to all companies employing large groups of employees. Training of managers and supervisors in early recognition of the problem drinkers should be offered.
4. Drivers involved in DUI cases should be offered, beyond legal consequences, the possibility of adequate education on alcohol effects on the human body and mind.
5. Violent criminals including perpetrators of domestic violence, in all cases when alcohol may have been considered a factor, should be offered special education (with the possibility of referring to treatment of various levels of alcohol problems in professional facilities).
6. Advertising of alcoholic beverages has been considered a major factor significantly influencing the youngest population of potential drinkers. It should be verified and, consequently, undertaken to take the appropriate legal regulations reducing the eventual harm.

The above recommendations may require new regulations in the criminal, family, workplace or traffic law in individual countries. It might be useful to establish a non-governmental body of professionals qualified to co-operate with the appropriate agencies to propose and undertake the concrete actions addressing the above problems in order to find the most effective ways to reduce harm resulting from the use, and especially, abuse of alcohol in our societies.

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## A TOAST TO LIFE

### THOUGHTS ON VIOLENCE, YOUTH AND HARM REDUCTION IN BRAZIL

Mónica Franch

Gabriel lost his life Sunday at dawn a few yards from his home in a poor neighbourhood in the city of Recife, Northeast Brazil. He met his assassin a few hours before his death in one of the countless live-music bars proliferating in the outskirts of the big city. The one telling the story was Lu, a 17-year-old kid who had dated Gabriel and used to hang around with him during weekends. According to the former girlfriend he didn't use drugs and was "straight". But every time he went out for a drink he got into trouble. *"He always stood by his friends. If one of his friends got into a brawl he felt he had to fight too, that he had to back his friend up."* The night he was killed, Gabriel honoured his macho reputation one more time. He punched and kicked to protect his friend. The reason for the fight no one knew. It seemed to have been over a trifle matter: *"sometimes a bad look is enough."* When he was coming home, he was shot by one of his opponents. He was only 19 years old.<sup>2</sup>

Stories like Gabriel's are common in the principal capitals of Brazil. The concentration of violent deaths in the 15 to 24 age group makes us think the younger generation has incorporated violence.<sup>23</sup> Violence that has reached epidemic levels in the country. The problem nevertheless, extends way beyond our borders. Violence victimising youths, especially of the male gender, is an event experienced in five continents, principally in the so-called "developing countries" and in nations that have gone through fast economic and social transition processes, like in the East European countries.<sup>3</sup> The relation

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<sup>1</sup> Lu's interview was made in 1999, as part of a survey (Masters) on the free time of young people living in the outskirts of Recife (Franch, 2000). All names are fictitious.

<sup>23</sup> Castro (2002:6).

<sup>3</sup> Krug et al. (2002:25)

between violence victimising young people and drinking and what can be done to minimise risks are the principal issues of this essay.

**NOTES OF A DISTURBING CHRONICLE; VIOLENCE IN BRAZIL OF TODAY**

In the last decades, violence has become one of the main concerns of Brazilians. The subject is present in important discussions and in informal conversations. It affects business, stock markets, love relationships, leisure, family relations, art, religious speech, journalism and political agendas. Until recently poets praised Brazil as being “blessed by God”, with natural beauty and the joy of a peaceful and sensual people. Now metaphors such as the “broken city”, the “silent war” and “social apartheid” seem to prevail. Brazilians are immersed in a “culture of fear ” the outstanding expression of which is the so- called “security industry”, for a long time not limited to the elite. Gratings, platting, private security guards, etc. are commonplace. <sup>4</sup> Have Brazilians or has the perception of violence changed?

**PLACING SCRIPTS - RE-DEFINITIONS AND LACK OF DEFINITIONS.**

The History of Brazil, as in many of the countries in the World, is permeated by violence. The founding violence of colonisers against the colonised, violence inflicted to Negroes by slavery, sexual violence of White men against women of other ethnic groups have, very early in time, expressed the practice of submission through force and that has become rooted in the Country. Nevertheless, it would be useless to think that all of these manifestations were identified at the time of their occurrence as grave violations of human rights. Because violence is above all imposition of the will, the ones holding the power

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<sup>4</sup> For a more in-depth study refer to *Velho and Alvito (1996), Pereira et alli (2000) and Zaluar (1994,1998)*. The expression “the broken city” appeared for the first time in *Ventura (1994)*.

<sup>5</sup> To amplify these concepts refer to: *Abramovay (2002), Castro (2002), Pereira et alli (2000), Diógenes (1998)*.

usually exert it. Whoever is more powerful generally legitimises this power at a social level.

To perceive a certain act as an act of violence depends on the social, historical and cultural context varying considerably among different groups in a given society. The definition of violence is rarely consensual or stable. It is processed on a battleground where norms, institutions, values, social hierarchies and different actors are at play.

Violence is expressed through human actions by individuals, groups, classes, nations, relationship dynamics, resulting in physical, emotional, moral and spiritual harm to others. In reality violence is not an isolated fact, it can be perpetrated in many ways, as an exacerbated form of social conflict the specifics of which need to be known. It is deeply rooted within social, economic and political structures as well as in individual consciences in what consists of a dynamic relationship between given conditions and subjectivity [...] This concept may be understood in the field of personal and institutional relations as restriction of rights on one side, or as the long wailing cry of the oppressed on the other side of the coin. (Minayo, 1998:14).

Violence, therefore, is not singular; it is plural. That is why many authors rather use the expression “*forms of violence*”. It is linked to practices, sensitivity and awareness of other individuals. Violence oppresses and denies difference acceptance required by Democracy. However, it may also express the grievances of a group facing a specific social reality. From this point of view violence is the language of those who do not have access to expression <sup>5</sup>. To charge another of being “violent” do those commonly use a strategy in power to disqualify social struggles threatening their privileges. To differentiate, to refine and redefine what common sense grasps in the vague concept of “violence” is the first step to unravel other hidden or symbolic meanings.

Frequently, visibility of a certain type of violence relates to social struggles attempting to broaden the scope of human rights. That is what happened in Brazil with violence against women, in the old days considered a domestic issue. The recognition of a new form of “violence” is a process that frequently crosses national borders involving groups advocating for human rights, multilateral organisations such as the UN and other actors of the international scenario. Similarly, violence dynamics ignore customs and controls. Clandestine business such as the traffic of weapons and illegal drugs move complex international networks of production, distribution and consumption with profits being deposited in fiscal havens scattered all over the World.<sup>6</sup>

Violence in Brazil has to do with the enormous inequalities that rip the social tissue apart, and sets the stage on which day to day violence occurs. According to a study by IPEA <sup>7</sup>, economic differences among Brazilians are enormous: 10% of the rich possess 28 times more income than 40% of the poor. In the World Development 2000 – 2001 report from the World Bank, Brazil ranks third in inequality with a Gini index of 60.0 (1996) second only to Sierra Leone , 62.9 (1989) and the Central Republic of Africa 61.3 (1983). Because of their position in Society, youths are very vulnerable to this underlying violence – although they are capable of offering more creative responses.

## **LIVING IS DANGEROUS**

### **THE IMPACT OF VIOLENCE ON YOUTHS**

Some care must be taken to relate violence and youth. It is true that youths are the ones more impacted by violence and are the leaders of all external deaths statistics. It is also true that the world of crime exerts an undeniable fascination among urban periphery youths, who find in this world a way to access goods

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<sup>6</sup> *To redefine violence refer to Castro (2002), Suárez and Bandeira (2002), Pereira et al. (2002).*

*The global dimension of criminality is emphasized by Zaluar (1994, 1998).*

<sup>7</sup> *Barro et al. (2000)*



and to obtain prestige and power. Equally, the “golden youth” of the big cities have reached the headlines because of their involvement in violent actions that range from common felonies to violence of great impact on public opinion such as parental homicide or ethnic crimes.

In spite of the evidence one must be extremely careful not to accuse youths, especially poor youths, of being responsible for this feeling of public insecurity recently overwhelming the Country. Our proposal is to displace the axis of repression towards understanding, avoiding stigmatising youths, for that would not help at all to improve life for this age group.

#### **THE DEATH TOLL**

Since the mid-70's homicide rates have rapidly grown in Brazil as well as in many Latin American countries. Coincident with the downfall of the military regime, political violence began to decrease in the region. However, Democracy was not followed with the expected social peace. Major Latin American cities helplessly watch as criminality increases and crime organisations become stronger. In Brazil, hold-ups and robberies skyrocketed. Clandestine businesses such as frauds against financial organisations, drug and trafficking of sophisticated weapons have become rampant.<sup>8</sup> Although, as we said, violence cannot be equated to criminality, this has been, without any doubt, its most visible expression.

Growing homicide rates have been a strong concern of public officials and of Brazilians in general. According to the Ministry of Justice, in 1979 the homicide rate was of 9.44 homicides per 100.000 inhabitants. In 1985, this rate had already reached 14.98 and since then it has not stopped growing. In 1990, there were 20.83 homicides/100.000 inhabitants; in 1995 the rate was of 23.85 and in

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<sup>8</sup> *Kant et al. (2000), Peralva (2000), Zaluar (1998).*

2000, 27<sup>9</sup>. The death toll has a definite Geography. It is concentrated in the social and economically depleted neighbourhoods of the big cities. It also has a race (Negroes die earlier), gender and age connotation: the victims are mostly young men.

In 2000, for example, 12.2% of deaths in the total population resulted from the so-called “external causes” (traffic accidents, homicides and suicides). In the age group of 15 to 24 years old, the percentage has reached nothing less than 70.3% of which 39.2% were homicides. Violent deaths are increasing in the age groups going from 15 to 19 years old and from 20 to 24 years old as opposed to the age group from 10 to 14 years old. As for the distribution by gender, homicide rates speak for themselves: in 2000, there were 97.1 homicides per 100.000 young men (15 to 24 years old) and 6.0 per 100.000 young women. Firearms caused the majority of these murders (74.2%).<sup>10</sup> Racial violence becomes visible when victims are identified. In a newspaper survey performed by the National Movement for Human Rights in Salvador (1996 to 1999), only 1% of murder victims was White. 30.7% were Negroes and 68.3% were not identified by race.

<sup>11</sup>

The international map of young people deaths indicates a very unequal distribution. In 2000 9.2 per 100.000 youths (from 15 to 29 years old) in the World were murdered, according to the *World report on violence and health* of the World Health Organisation. The lower rates, with an average of 0.8 homicides per 100.000 inhabitants refer to the richer countries in Europe, in parts of the Asian continent and in the Pacific. Homicides increased to 17.6 per 100.000 inhabitants in Africa and reached the highest rates in Latin America.

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<sup>9</sup> Source: CENEPI/IBGE/MJ-SENASP, with exception of the homicide rate for 2000 (Source: SIM/DATASUS, IBGE).

<sup>10</sup> Data can be found in *Waiselfisz* (2002).

<sup>11</sup> Information appears in *Castro* (2002:20). It's important to note that race and color vulnerability began to be perceived in Brazil very recently. The majority of statistics does not depict this information.

36,4/100.000. With a rate of 32.5 homicides per 100.000 youths (15 to 29 years old) Brazil ranks fifth and is almost four points below the Region's average. Among the so-called developed countries only the United States have rates above 10 homicides per 100.000 inhabitants (rate of 11).<sup>12</sup> Mortality caused by homicides among youths is therefore, a problem of “developing countries” or “emerging countries, and is one more expression of the growing inequalities in the World.

**A GAP THROUGH WHICH LIVES ARE LOST.**

When trying to understand the extraordinary growth of violence hitting the young, individual, family, social, cultural and political factors should be taken into account. The list that we propose is only one of the possible interpretations of the phenomenon specially focusing the Brazilian situation.

*a) The doors of Paradise – poverty, consumption and juvenile expectations.*

In “developing” and “emerging” countries, economic crisis and the implementation of structural adjustment policies had sombre effects on the majority of people, including young people. *“...real wages have often declined sharply, laws intended to protect labour have been weakened or discarded, and a substantial decline in basic infrastructure and social services has occurred. Poverty has become heavily concentrated in cities experiencing high population growth rates among young people<sup>13</sup>”*. To live in poverty in a society that constantly exhibits all that money can buy is violence at its worst especially for the young. Certain goods are lifestyle symbols, a show of power assuring peer prestige and success in love. Clothes, cars and certain drinks and drugs such as whisky and cocaine. How to deal with the impossibility of attaining these goods? It's not poverty in itself that explains the high rates of mortality by violent causes. However, when this situation is

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<sup>12</sup> Krug et al. (2002).

<sup>13</sup> Krug et al. (2002:36)

compounded with the appeal of a consumer's society and the progression of an individualistic ideology, a basic tension emerges precipitating some of the young people into the world of crime. <sup>14</sup>The involvement of youths from the privilege classes in violent crime is many times linked to the urgency encouraged by these same consumers' society.

*b) The role of the State – impunity, omission and violence*

The role of the State in enforcing the law, as well as the promotion of security policies to protect the more vulnerable population is fundamental in facing the problem of violence. On the opposite, the generalisation of impunity acts as an encouragement to break the law, ultimately fuelling violence. In Brazil, impunity is fragrant in crimes that are perpetrated by the dominating classes, many times against public patrimony (corruption and funds embezzlement), causing scepticism of the democratic principle of equality for all. Blood and sexual crimes affecting the poor generally go unpunished. Impunity feeds power abuses of the rich against “second class” citizens, just like criminal groups impose their will in those areas where public power is absent. It is a dangerous component to be added to the wish of doing justice with one's own hands, a call on loyalty many times placing youths in the cutting edge of violence. <sup>15</sup>

In addition to impunity, the State may generate violence against youths, as with police violence. Brazilian police abuses have grown alarmingly since the military regime and the generation of “death squadrons” (Vigilante organisations). The exterminated victims almost always have the same profile: “*in their great majority they are young, Negroes or mulattos, with no previous criminal record*” <sup>16</sup>Police violence has an enormous symbolic power for it's the State itself, through its armed

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<sup>14</sup> *Zaluar (1994) has a good view on this issue*

<sup>15</sup> *Abramovay (2002), Soares (2002).*

<sup>16</sup> *Peralva (2000:88)*

branch, acting to exterminate deprived youths. The experience of being the victim of unjust police coercion has led some youths to turn their backs to the law and to embrace the world of crime.

The State also increases juvenile vulnerability when refusing to implement social protection measures to benefit them. Not offering the majority of youths the access to good healthcare services, quality education, citizenship education and cultural assets restrains their development possibilities and impoverishes their vital experience. Alcohol and illegal drugs therefore, are used to brighten the present for the future is perceived as gloomy. Overvaluing the present is a strong cultural trait that helps understanding youths' exposure to risk situations.

*c) Perpetrating violence – illegal drugs and weapons trafficking.*

In some of the Brazilian cities, the issue of drug and weapon trafficking is strongly related to juvenile vulnerability to violence. As we mentioned before, this is a national phenomenon with global implications, the scope of which is impossible to calculate. Youths emerge as the intermediaries of this commerce, they are the participants and they carry drug use into their lifestyles, as they become favoured consumers.

Motivation for youths involvement in the clandestine trade of arms and drugs are usually attributed to the impact in the consumer society among youths living in the periphery of big cities (although not restricted to them) and the loss of the value of work as a moral reference, among other aspects <sup>17</sup>. It's important to emphasise, nevertheless, that the increase of drug trafficking related violence has a close relationship with the Brazilian government drug policy in the last years: “ *This has to do with the emphasis on reducing the offer in detriment to education, preventive and therapeutic proposals to reduce demand and resulting*

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<sup>17</sup> Refer to Zaluar (1985, 1994).

*consumer harms*<sup>18</sup>. The result of following the North-American model has been the recurring victimisation of Brazilian youths.

*d) The cultural matrix of violence – the gender issue*

Not only men lead the statistics of homicide victims but they are also the principal aggressors of men and women in Brazil and in the World. The understanding of this difference is necessarily related to the understanding on how men and women are socialised and what role violence and risk play in the construction of the male social being. Many studies have called the attention to the existence of a male *ethos*, associating violence and masculinity, although there are variations depending on social position and cultural context.

Resorting to violence happens when men consider the necessity of recuperating threatened honour, authority or power. Violence against women in marital relationships is a good example of this mechanism. Because male honour is dependent upon women's sexual behaviour, men feel they have to "punish" their wives when such behaviour is at stake.

In their youth, men and women generally suffer great social pressure to adopt their gender roles. Among men, the surveillance of adults and peers results in an environment instigating virility, courage and ultimately, aggressiveness. This is the cultural matrix favouring the involvement of young men in violence: bar brawls, criminality, sexual, racist and homophobic violence, etc. The dissemination of firearm use has led to the tragic unleashing of many of these events. Cultural elements encourage youth violence in every social context. However, although youths from less favoured social classes have the chance of gaining social prestige through professional careers thus becoming consumers,

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<sup>18</sup> *Bastos e Carilini-Cotrim (1998:658).*

youths living in poverty sometimes resort to violence to obtain social prestige in their environment.<sup>19</sup>

In general, the factors depicted here could be considered risk factors, i.e. social and political circumstances leading to the involvement of youths with violence. Nevertheless, studies on violence also attempt to analyse the dynamics of violence itself, where two or more people are involved and where factors such as drinking can be decisive. This is what we'll see next.

### **WORSE THAN A HANGOVER**

#### **INTERFACE BETWEEN JUVENILE VIOLENCE AND DRINKING**

In people's lives, the periods of adolescence and youth are the ones when one drinks more, not only in terms of quantity but in terms of frequency as well. To drink for the first time is one of the most well understood initiation rites in Brazilian society and in many other countries where alcohol is the most widely consumed substance. Researches performed by the Centro Brasileiro de Informações sobre Drogas Psicotrópicas – CEBRID indicate that the age for this type of initiation has dropped in the Country. 50% of adolescents between 10 and 12 years old according to the last home survey had already consumed alcohol at least once<sup>20</sup>. Concurrently, the drinking frequency is growing too. In 1989, 14% of Brazilian youths (from 10 to 18 years old) from the public school and private school systems in the principal capitals, consumed alcohol over six times a month, in 1996 the proportion grew to 19%. Professionals working in the drug area have been calling the attention, for some time now, to the possible consequences of the change in the juvenile drinking pattern.

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<sup>19</sup> *Authors consulted for the themes on violence and masculinity: Connell (2001), Graham and Wells (2001), Greig (2001), Hautzinger (2001), Heilborn (1996), Nolasco (2001), Fonseca (2000).*

<sup>20</sup> *Carlini et al. (2002)*

Frequently, drinking initiation happens inside the family, even before the legal drinking age – 18 years old in Brazil- is reached. Although family initiation may respond to the desire to protect youths who are beginning to drink, it also indicates a double standard in drugs judgement: drinking is encouraged whilst illegal drugs is condemned. Notwithstanding the presence of the family in the acquisition of habits and perceptions related to alcohol use, drinking in youth is undeniably related to the sphere of socialising. In a recent research involving youths from public and private school systems in 14 Brazilian capitals, Castro and Abramovay (2002) noted that the act of drinking is part of juvenile socialising rites, providing closeness and identification among group members, it's an important leisure component and helps to overcome shyness and to facilitate love and sexual contacts.

As with any other cultural element, alcoholic beverages symbolise differences. Therefore, drinks that are more expensive convey greater status and vice-versa, there are different standards for alcohol consumption depending where youths are placed in the social ladder. At the same time, gender relations, determine different drinking expectations among men and women. It's important to note that alcohol consumption among women has been increasingly and rapidly growing reflecting cultural changes of gender behaviour in the World.

The value of alcohol for juvenile recreation is perceived and encouraged by the market. Beverage industries sponsor recreational events for the juvenile public in sports events, mega-shows and mass celebrations such as Carnival, obtaining high profits with the sale of drinks to youths. In bars, night-clubs and showplaces, marketing strategies encourage alcohol consumption until one is drunk.

The economic power of the industry can be seen by the quantity and quality of publicity in all types of media where alcohol consumption appears associated to



glamour, youth, beauty and joy. More than publicity targets, youth is their principal market appeal. *“Alcoholic beverages are the youth elixir and sold as White, upper middle class, joyful and in situations of leisure, party and sports”*<sup>21</sup>.

In Brazil, the access of young people to alcoholic beverages is very easy. There is a law prohibiting the sale of alcohol to people under 18 years old, and in practice, it does not function for lack of enforcement and awareness of those selling drinks. In fact, there are many sales points close to schools. In the media, the great majority of information for young people are drug related but little is said of the possible consequences of alcohol consumption, not even about how to avoid the unpleasant effects of alcohol intoxication. Therefore, youths’ knowledge of this drug is acquired through personal experience complemented by other people’s reports that also became knowledgeable through experience. This process of learning, alas, can have a very dear cost.

#### **BECOMING AGGRAVATED**

Many of the researches focused on the understanding of violence in the midst of Brazilian youths take into consideration the use and trafficking of illegal drugs, but do not pay much attention to drinking among the younger population.

In part this unequal emphasis results from the impact of drug trafficking on the violence affecting the Country. Other factors influencing this difference is that alcohol consumption is seen as something natural and also the lack of tradition of testing blood alcohol concentration in violence victims. But, the extent of alcohol use among adolescents and youths would justify further efforts in this direction especially considering that there are strong indications on the existence of an interface between the use of alcoholic beverages and the occurrence of aggressions in different population groups. In a study performed

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<sup>21</sup> *Castro e Abramovay (2002:138)*.

on homicides in the periphery of São Paulo, 12% of the incidents surveyed were attributed only to “bar brawls” or “alcohol” by the respondents or by police reports <sup>22</sup>. Another survey performed during Carnival in the city of Recife indicated that 85.2% of the victims (fatal and non-fatal) of violence had alcohol in their blood. In this case, one should consider that Carnival, just like in other major celebration, is a period during which alcohol consumption considerably grows <sup>23</sup>.

In the absence of specific surveys, one of the indicators suggesting the influence of alcohol in violence among young people is the homicide rates seasonality. UNESCO violence maps have been indicating that juvenile violence occurs principally during leisure time. Homicides grow over 70% in weekends as compared to other days of the week <sup>24</sup>.

Because drinking is more frequent during these days, the link between these events surely needs to be further studied. To consider the link between alcohol and violence does not imply in stigmatising people who drink or to incur in repression interfering with human rights. It is, above all, shedding the light on a phenomenon that remains hidden because it is deeply ingrained in social life and in economic interests.

In general, it's not possible to draw a simple causal relationship between drinking and aggressive behaviour and violence. The World Health Organisation for example considers that drinking acts as a situation factor capable of transforming potential violence into real violence, as in the case of violence among the young. As for violence principally affecting women, the use

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<sup>22</sup> *Minguardi apud Bastos and Carlini-Cotrim (1998).*

<sup>23</sup> *Research by the Instituto Reid in 1997 (Ualcohol use in violence and traffick accidents victims during Carnival in Recife). Coincident with international data on violence, the profile of the victims has shown prevalence of young men (60% were 20 and 29 years), the majority of which were attacked by firearms (41,6%).*

<sup>24</sup> *Waiselfisz (2002:51)*

of alcohol is seen as an important risk factor. When consumed by the aggressor (usually a man), alcohol may reduce inhibitions and affect the ability to judge and interpret signs, precipitating cases of sexual violence and other violence perpetrated by intimate partners. Drinking considerably increases women's vulnerability for it interferes with the perception of danger and reacting capacity<sup>25</sup>.

Studies performed in different countries focusing aggression among youths in bars provide significant elements for discussion. Graham and Wells<sup>26</sup> have noted that notwithstanding the existence of important differences between countries and population groups, drinking seems to play an important role in the incidence of violent crime among young men. When drunk, many people express difficulties in dealing with contingencies, overvalue their power, are willing to accept more risks and respond more aggressively when provoked. These changes exasperate the elements of conflict present in male socialising, resulting in struggles for honour, loyalty, and frustration or simply as one more alternative for having fun. It's important to clarify that the relationship of alcohol and violence is expressed especially in states of alcoholic intoxication. The fact that the consumer/aggressor has a history of alcoholism does not seem to influence aggression as much as the quantity of alcohol consumed at the moment of confrontation<sup>27</sup>.

Other aspects to be considered relates to the environment where youths drink and their drinking expectations. Noisy, smoky places, attracting crowds and with sharp edged objects have a greater probability of becoming the scenarios of fights. Permissive attitudes related to alcohol use and violence also increases

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<sup>26</sup> In their work , Graham and Wells (in Press) analyse the literature on the theme indicating research in Canadá men 20 to 24 years, involved in 21 incidents in bars,

<sup>27</sup> Wells et al. (2000).

this probability.<sup>28</sup> In other words, there are more fights in places where youths are encouraged to drink and there are no efficient measures to prevent conflicts. As for expectations, in many societies being drunk is like taking a “time out” a permission to behave out of line without being socially accountable.<sup>29</sup>

Therefore, it is expected that individuals express their aggressiveness (including the possibility of sexual violence) without suffering the same consequences of a similar behaviour when sober.

In Brazil, all of these issues need to be noted within a context where social tensions have emerged in an outstanding way the last two decades. Easy access to weapons by the population is one of the factors that should be considered. In many bars, for example, there is no weapons control. In others, clients leave their guns when entering and receives them when leaving. This strategy preserves the bar but not the lives of clients who may find an unpleasant surprise when getting home. To chose where to drink, the friends with whom to party, in addition to avoid “getting into trouble” are spontaneous strategies of harm reduction that many youths use to have fun with less risk. The numbers of juvenile mortality by external causes indicate however, that the efficacy of such measures is limited.<sup>30</sup>

On the other hand, drinking among youths is not restricted to bars. We focusing on a specific group of young people in poor neighbourhoods, where vulnerability to violence is greater, whose homes or streets are many times made into leisure places with the possibility to drink more for less money in the company of friends and neighbours.

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<sup>28</sup> *Graham e Wells (in Press)*

<sup>29</sup> *Data from the bibliographic review on alcohol and aggression by Graham et al. (1998).*

<sup>30</sup> *Franch (2002).*

In this case, youths have more control in relation to the companies they keep but are more exposed to revenge and other problems involving people who are close to them <sup>31</sup>. Many young people are frequently killed near their homes. It is also in the neighbourhoods, more specifically at home, where violence against women happen and being drunk is a factor encouraging the aggressor and increasing the victim's vulnerability. Strategies pursuing the reduction of harm and risks of violence among alcohol consumers should, therefore, consider a multiplicity of scenarios, times and motivations.

### **MAKING WAY**

#### **INDICATORS FOR STRATEGIES OF HARM REDUCTION FOR YOUNG PEOPLE**

For many young people, to drink is not only an important rite of sociability but it also symbolises one of the most pleasant events of their week's routine. Drinking until drunk, in fact is part of the exaggeration of someone who knows that this is a social attribute of age and of the process of experimenting with drink, with their own body and with others. For some young people, violence is a context for survival, a language to express dissatisfaction or to look for excitement. An answer to humiliating life conditions, or, on the contrary, a way to express contempt in relation to others, whether the others are Negroes, women, poor people, homosexuals or Indians. For the majority of youths, nevertheless, violence is only a threat in the horizon and it does not prevent one from enjoying life, of making projects of being a citizen. Strategies for harm reduction should address all young people.

#### **YOUTHS FORWARD**

Any action aiming at reducing risks for young people involved with violence in situations of alcohol consumption needs, above all, the adoption of juvenile participation. This means promoting youths as subjects of interventions,

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<sup>31</sup> *Franch (2002).*

capable of actively participating in the definition of priorities, in the implementation of actions and in the evaluation of results. To bring youths into play it is necessary to redefine positions that are strongly rooted in school, in policies, in the community, in the family and in many other spaces where youths circulate. As a positive point, Brazil has countless successful experiences where juvenile participation is encouraged in addition to a long tradition of civil society organisation in the struggle for a more equitable Society. When thinking about harm reduction strategies related to alcohol consumption, these experiences may serve as a starting point.

One should not think, nevertheless that the encouragement for juvenile participation means estrangement of other actors in the struggle for reducing violence among this age group. To be effective, harm reduction strategies need to be designed together with the youths, they are the main stakeholders, but with support of the State, promoter of public policies, civil society, communities and families that should exercise social controls on these policies.

The issue of alcohol consumption and violence against young victims has some difficulties that need to be unravelled with a lot of thought and participation of the stakeholders. One of these obstacles is the legal issue of drinking. As we saw, the age of drinking initiation has been considerably reduced but the age in which young people are allowed to drink remains the same in Brazil. 18 years old. A young person who starts drinking at twelve, will drink illegally for six years.

The legal provision of a minimum age limit for drinking pursues the protection of adolescents, for drinking can affect physical, mental and social development. Nevertheless, any practice, which is hidden, has an added risk element. To overcome this paradox it is necessary to discuss this issue and to listen to the young people.

Another challenge that needs to be faced is the production and reproduction of cultural models encouraging youth's involvement, especially men, with violence. In Brazil, various groups working with the issue of gender have denounced the existence of male standards that make men more susceptible to risks and more willing to make use of physical violence against other men and against women. To change violence values one must consider gender issues, involving men in the struggle for a more equal society for men and women. Other efforts have been made to build a "peace culture" prioritising dialogue and tolerance in lieu of imposing ones will at any cost.<sup>32</sup>

In changing cultural values, a special emphasis should be given to the representation of illegal drugs versus legal drugs in relation to young people. On one hand, Society has given illegal drugs the *status* of the principal risk that can afflict youths in modern times. The other side of the coin is the existence of a practically unrestrained acceptance of drinking among this same public. We therefore witness a process of "demonising" drugs such as marihuana, parallel to the normalcy of another drug, which is alcohol. This is contradictory for it denies the principal element that could make young people decide and exert control on drug use: information.

Finally, harm reduction strategies in relation to violence should take into account two last aspects: 1) the role of firearms in juvenile mortality by homicides; 2) the existence of a silent violence that needs to be publicised.

#### INTEGRATING TO REDUCE HARM

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*32 An interesting experience is the "Campanha do Laço Branco – Homens pelo fim da violência contra a mulher – The White Bow Campaign – Men for the End of Violence Against Women promoting a series of events focusing on men with the purpose changing the mentality that violence against women is normal. As for the promotion of a "peace culture", UNESCO is the more visible organization.*

International and national experiences in the drug area and/or work with youths have indicated the value of accomplishing integrated actions in various relevant aspects of juvenile experience. The comments below serve as an indication of actions that can be disseminated, as well as questions that need to be posed in the pursue of adequate strategies.

*The school* – Youths, as we saw, obtain information on drugs and on drinking through friends or through the media. School, as one of the institutions for secondary socialisation, needs to open the discussion in a non-repressive manner. Actions involving young students as subjects of education have been very efficacious in and out of Brazil.

*Bars* and leisure locations are privileged scenarios for alcohol consumption. Some of the international experiences show that it is possible to make these locations safer, avoiding crowds, sharp objects and other dangerous elements. It's important to make waiters and bar proprietors not to encourage drinking to the state of intoxication. Equally, it is necessary to think together with these actors of more efficacious manners of dealing with the conflicts that occur in those places. Many youths carry weapons to these bars. To keep their weapons until they leave is not sufficient to assure the safety and the life of those who are clients. There is an urgent need to discuss this, because bars can be included as locations for advances of alcohol consumers wearing weapons;

*Major events* such as Carnival, mega-shows, etc. are challenges on how to mingle fun and security. Effective actions may include stricter control on the sale of drinks, which nowadays does not exist, care with the transportation of youths, information on how to drink safely, etc.;

*Media* – Notwithstanding the fact the Beverage Industries are powerful, society needs to exert more social control over publicity and information publicised. To negotiate spaces for information programs and “counter- propaganda” are some of the more common suggestions;



*Family/community* – We need to encourage work focused on cultural changes and to improve the access of people to valid information on alcohol, other drugs and violence. To strengthen existing work is a good way of integrating the community and making strategies more adequate.

As we saw, the issue of violence victimising youths affects principally “developing countries” and “emerging countries”, where the exercise of citizenship is confronted with many class, gender and race inequalities having the strong inequalities among the nations of the World as a background. That is why effective action for harm reduction should be linked to public policies of a major scope promoting social equality and offering better perspectives and conditions of life to young people. In the I International Conference of Alcohol Consumption and Harm Reduction (2000) the need to integrate harm reduction and struggles for citizenship, was perhaps the most important message of the national and international community gathered in Recife.

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## HARM REDUCTION AT THE WORKPLACE

Paulina C.A.V. Duarte, MSc.

The 1<sup>st</sup> Household Survey on the Use of Psychotropic Drugs in Brazil, a study involving the country's 107 larger cities (CARLINI et al., 2001) has found that 11.2% of the Brazilian population in the age group of 12 – 65 years tested positive on screenings for alcohol dependence.

Such finding, associated with data published by the ILO – International Labour Organisation, suggesting that between 10% and 12% of the economically productive population, older than 14 years, have problems of alcohol abuse or dependence, suggests that far from being a problem that affects only certain groups or social sectors, alcohol abuse is in modern society with its contradictions a serious public health problem that calls for urgent action.

It is still common today to label alcohol abusers or dependents as people who have moral or ethic problems, whose main behavioural features are irresponsibility and insensitivity (BRASILIANO, 1993).

Certainly we all have childhood memories of the imminent danger a “drunkard” was to children. Furthermore, violence, broken families, lack of money among other problems help stress the prejudice which – rooted in society – makes it more difficult to address the issue.

Way beyond prejudice, however, the impact of such phenomenon on world health and economy has led specialists, entrepreneurs and government authorities to review the topic and the need to adopt a candid and objective attitude regarding issues such as costs, loss or reduction of the productive force, diseases resulting from or associated with alcohol intake, violence and death, among others (NATIONAL INSTITUTE ON DRUG ABUSE, 1998).

In the business community, a worker who is an alcohol abuser or dependent is 3.6 times more likely to cause labour accidents; 2.5 times more likely to miss 8 or more days of work without a clear motive; uses 3 times more the medical benefices; has his/her productive capacity reduced in 67%; is punished 7 times more for indiscipline; and complains 5 times more than non-abuser workers. Consequently, personal relations are extremely affected, jeopardising the work environment and quality of life (INSTITUTE FOR SUBSTANCE ABUSE RESEARCH, 1991).

#### **ALCOHOL INTAKE AND WORKPLACE – BRAZIL BACKGROUND**

The first discussions associating excessive alcohol intake with the workplace in Brazil date back to the late seventies and early eighties. Up to then, the issue was literally treated as a legal one pursuant to our Consolidation of Labour Laws (CLT), still in force today, in its article 482, section f which reads: *“habitual insobriety or insobriety at the workplace constitute just cause for an employer to terminate a labour agreement.”*

With the strengthening of union movements and the labourers’ struggle for better work and health conditions a new model came up and took shape at occupational health centres and human resources departments in companies that – surprised by innovative legal decisions ordering the readmission of laid-off employees – were compelled to find new ways to address the issue. The problems resulting from or associated with excessive alcohol intake or addiction were no longer addressed only in the medical and police milieu but became part of the agenda of occupational health and human resources professionals as well.

In that scenario, the first programs to prevent and treat alcohol abuse in companies were developed based on the American EAP (Employee Assistance Program). Implemented mainly at multinational and large state companies, such programs focused on identifying and treating chronic alcohol-dependent employees.



New demands arose and, after the first barriers against prejudice were surpassed, companies faced the use of illicit drugs, associated with alcohol intake or not. Soon other licit drugs such as tranquillisers and amphetamines (often, prescribed by the labour physician themselves) began to be used.

In the early eighties, emotional disorders and the “ghost” of AIDS, associated with the use of injectable drugs and unsafe sex became the new challenge, requiring much more skills from the involved professional and, especially, a review of their own concepts about the subject.

The nineties saw the first discussions about the risk associated with alcohol and other drugs affecting the performance of certain work tasks. It was then that the first and cautious drug testing efforts developed. Notwithstanding the reasons and pragmatic definitions of risk, this subject remains polemical and seldom discussed. Discussions about ethics and safety will certainly go on.

#### **OVERVIEW OF ALCOHOL INTAKE ASSOCIATED WITH THE WORKPLACE**

In Brazil, a study carried out in 1993 by the State of São Paulo Federation of Industries - FIESP (VAISMANN, 1995), suggests that around 10% to 15% of Brazilian workers tested positive on screening for alcohol dependence and abuse with the following consequences:

- Three times more medical leaves than leaves for other diseases;
- Five times more chances of labour accidents;
- Fifty percent of all absenteeism and medical leaves;
- Eight times more hospitalisation;
- Three more times use of Company provided medical and social assistance by the employee’s family.

The data above are consistent with CAMPANA’s (1997) findings.

The Industry Social Service (SESI - Serviço Social da Indústria), with a study carried out between 1994 and 1995 using a sample of 834 workers, representing a universe of 730,000 employees in the industrial area of the State of Rio Grande do Sul, indicated alcohol as drug most widely spread among workers. That study showed that 84.4% of the surveyed workers were regular drinkers, and 34% had a positive CAGE (screening test for alcoholism), referring to relationship and physical health problems due to alcohol use (SESI,1995).

Although international literature clearly points out the adverse consequences of alcohol abuse at the workplace and the associated indirect costs (THE EMPLOYEES ASSISTANCE PROFESSIONALS ASSOCIATION, 1996), in Brazil, scientific literature on the subject is scarce and restricted to formal labor (SESI,1995), disregarding the amazing increase of informal work in the country's productive force, and the participation of specific populations as rural workers and unemployed workers in urban areas.

#### **HARM REDUCTION AND ALCOHOL INTAKE IN THE WORKPLACE - BRAZIL' SCENARIO**

The little efficacy of traditional programs aiming at the early identification of performance problems at work related to alcohol use (CAMPANA, 1997) requires a more realistic attitude geared towards reducing the risk factors, with investments in effective actions to promote quality of life, health and safety in the workplace.

Lack of health professionals to deal with alcohol abuse and dependence has led companies to make policies and to establish guidelines addressing the issue, taking the responsibility on their own, fulfilling – albeit partly – the gap left by the public services that actually should be responsible for the productive workforce's health.

Ever increasing challenges have favoured the establishment of partnerships with the community and the search for prevention and early diagnostic strategies, gradually discarding the conventional “package” treatment adapted

from the Minnesota model focused on abstinence. However this does not seem to be enough to fulfil the demand, despite all the actions taken by the Ministry of Health that has been improving the model of assistance provided by the Integrated Health System (SUS) to drug dependents, that aims at forming a network of care to promote the rehabilitation and social reintegration of those people.

Within such context, Harm Reduction becomes a reasonable and feasible choice to be used at the workplace, although for many it is associated with a certain permissiveness towards behaviour and alcohol use. Changing this view implies breaking up the paradigm that abstinence is the only alternative to improvement. Rooted in organisational culture and in the practice of occupational health and human resources professionals, such paradigm ends up by diluting the few Harm Reduction efforts in isolated campaigns. By and large they are isolated actions that start with government programs, mostly addressed to prevent sexually transmitted diseases. Associated with educational campaigns involving condom and folder distribution among other things, the effectiveness of such efforts are hardly ever evaluated by companies.

#### **HARM REDUCTION POTENTIAL AT THE WORKPLACE**

There are no clear references about Brazilian experiences with Harm Reduction at the workplace in the literature, despite some evidence: a study about the effects of alcohol on homicides (DUARTE; CARLINI-COTRIM, 2000), in Curitiba, Paraná, shows that 58.9% of the criminals were under the effect of liquor when they committed the crime; the same applies to 53.6% of the victims. It is important to notice that in this study the criminals were young men, and in 86% of the cases were formally employed. Such data alone suggest that perhaps those men might have benefited from some kind of action at the workplace, and confirm data from other studies associating alcohol abuse with violence (EDWARDS et al.,1994; COLLINS and MESSERSCHIMIDT,1993).

Simple Harm Reduction strategies could be included in Prevention and/or Quality of Life Improvement Programs, provided that realistic, pragmatic and short-term goals are established.

In this case, understanding that abstinence is the ideal choice among a series of possible options would be the first step towards a more pragmatic, humane and non-judgmental approach. Therefore, any action to reduce harm associated to alcohol consumption risk shall be most welcome by the whole business community.

#### **A PRACTICAL EXPERIENCE OF HARM REDUCTION AT THE WORKPLACE**

A practical and successful example – albeit not clearly defined as a Harm Reduction action – is an annual thematic campaign which is part of a Brazilian company's program of Permanent Campaigns for Health Promotion.

The Permanent Campaigns program was implemented in 1997 and aims at providing employees with a clearer view and better understanding of topics regarding factors that may jeopardise quality of life. AIDS, stress, eating habits, alcohol abuse and drugs are some of the topics widely discussed. Workers are strongly encouraged to share the information thus becoming multipliers of that knowledge among their family, neighbours, relatives and friends.

Thanks to its positive repercussion, the campaign takes place every year in February, just before Carnival, the major Brazilian popular festival, as describe by CARLINI-COTRIM in the table below:

**DRINKING DURING CARNIVAL**

*First celebrated in Brazil in 1641, Carnival is a national holiday and a popular festival that begins exactly 40 days before Easter and typically lasts for three days (Sunday, Monday, and Tuesday). The morning after Carnival is known as “Ash Wednesday”, and is meant to be a day for recovery (for example, the business workday begins after noon on that day). During Carnival the great majority of Brazilians, usually in groups, dons costumes, play, dance, drink, and sing loudly in either the streets or in clubs. Carnival is a time-out in which the rules and rites of everyday life are turned upside down. People play and sing all night long and rest during the daytime. Men wear women’s clothes, housewives dress up as prostitutes, and the poor garb themselves as kings and queens. The social hierarchy is inverted, with the wealthy watching the poor take over the streets for their parades, and eventually joining them with the poors’ permission. Carnival is the only Brazilian national holiday that is not grounded in civic or religious observance (Da Matta, 1978). By definition, Carnival avowedly is not a time for moderation and control. Unsurprisingly, people drink heavily during this time, and they also sniff several different mixtures of ether and chloroform called loló or lança-perfume.*

*However, Carnival is not at base about drinking or drunkenness, but rather about joy and Happiness, with beer, cachaça, and loló simply among the ingredients of celebration. While records do not provide easily retrievable data on the matter, Carnival is well known to be a time when violent death, injuries, and accidents of all kinds occur much more frequently than is usual. To date no studies have examined the role of alcohol during Carnival. Some other Brazilian celebrations mimic the drinking style associated with Carnival, notably New Year’s Eve and some soccer games. However, the other components of Carnival are not found on these occasions.*

The 1999 version of the campaign was called Passport to Fun, and consisted of a passport-sized folder that was widely promoted. The campaign began on the Monday before Carnival, and every day of that week all the employees who used the computer (administrative and production areas) at the company’s 26 units upon starting their PC saw in the opening screen illustrated texts about the story of Carnival, interesting facts, hints and, especially, emphasising the campaign’s theme of safety and health promotion.

The tables below are examples of the texts shown via the intranet:

**"TWO MORE DAYS BEFORE THE FUN BEGINS"**

*See how it all began...*

*Carnival is the major popular culture festival in Brazil.*

*It originated from ancient pagan festivals and orgies, from Middle-Age dances, and masquerades in the Renaissance.*

*It takes place on varying dates in February or March. Forty days before Easter starting on Palm Sunday. Officially, it lasts three days, Sunday through Tuesday, and ends on Ash Wednesday.*

*Actually, it may last more.*

*Introduced in Brazil by the Portuguese in the 17<sup>th</sup> century, Carnival used to be called Entrudo, a street game in which people threw balloons filled with water and flour at each other.*

*By the late 19<sup>th</sup> century the first Carnival associations were formed, with their groups of people who paraded, danced and sung songs by anonymous composers.*

*In 1899, pianist Chiquinha Gonzaga (1847-1935) composed the march "Abre Alas", and became the first composer to compose especially for Carnival.*

*"Oh abre alas que eu quero passar. Eu sou da lira, eu não posso ficar"..*

**"ONE MORE DAY BEFORE THE FUN BEGINS . . ."**

*"Foi no carnaval que passou..." ("It happened last Carnival", lyrics of a Carnival song)*

*If you have a sad memory of some bad experience, remember:*

*In moderate doses alcohol makes you feel good, relaxed and uninhibited.*

*But with a few doses more...*

*you begin to have problems with motor coordination, thinking clearly and, very often, aggressiveness.*

*If you drink, drink moderately.*

*Don't turn your Carnival into turmoil.*

**"TIME FOR FUN!"**

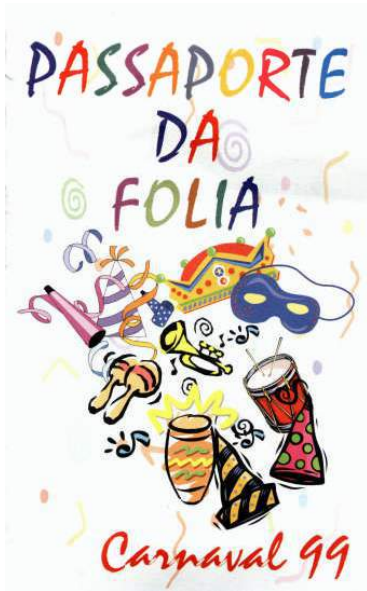
*"So much laughter, oh so much joy...  
 ... I will kiss you now, let me kiss you now, it is Carnival..."  
 Get in the mood, let it roll, set your joy free, set your smile free, set your dream free, set your illusion  
 free.  
 But never get rid of your protection.  
 Wearing a condom is about love.  
 It is about respecting your partner, respecting yourself and, most of all, respecting life.  
 Have fun!*

The focus on self-responsibility and "the day after" was strong, but no message ever told the target public "not to drink". On Friday, after all the awareness-raising messages, employees received – handed by a Pierrot and a Columbine – their Passport for Fun.

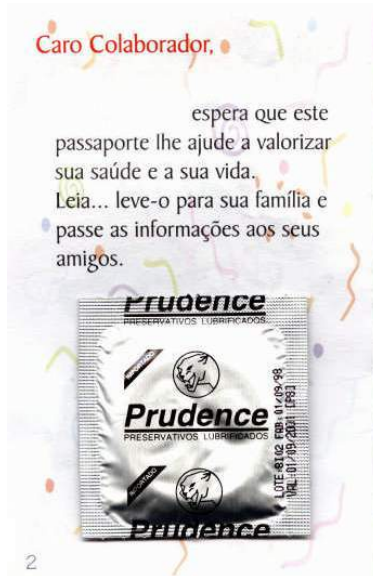
The topics addressed in the Passport for Fun related to reducing risk factors such as violence, acute intoxication, traffic accidents, unsafe sex, etc. associated with alcohol use.

On the back cover of the Passport for Fun employees found a condom. The condoms were donated by the Local Secretariat of Health through its AIDS and STDs prevention programs.

Below cover and back cover of the Passport for Fun:



*Passport for Fun  
Carnival 99*



*Dear Collaborator:  
(Company) hopes this passport will help you value  
your life and health.  
Read it ... take it home to your family and spread  
the information to your friends.*

Interestingly, this campaign was made by a company in the soft-drink and beer industry that caters for the states of Paraná and western São Paulo, that has approximately 3,000 employees and 10,000 dependents thereof.

This example clearly illustrates to occupational health and human resources professionals, and to the whole company that – after the initial shock - Harm Reduction can be exercised in a responsible and humane way, in an attempt to change the abusive use pattern, and to eliminate risk factors and behaviours without either mentioning alcohol intake or its prohibition.



Lastly, we believe Harm Reduction may also be a promising option in approaching issues relating to alcohol use in public agencies and state companies where employees usually have stable permanent jobs.

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**STOP HERE AND NOW****THE CHALLENGES OF APPROACHING HARM REDUCTION IN TRAFFIC  
VIOLENCE**

Ana Glória Toledo Melcop

**TAKING OFF****A FAST TRIP THROUGH THE HISTORY OF TRANSPORTATION AND DRUG USE**

Many think that traffic is an issue of modern times restricted to contemporary cities. That it is a matter of circulation, vehicles flow and that exact sciences such as engineering, information systems and electronics have the right tools to plan, operate and oversee the intense and violent traffic of large cities, solving all problems.

Coincidentally many also think that drugs are a modern invention, that they did not exist before and therefore it is very easy to do away with them. Nothing could be farther from reality.

History recalls traffic related problems as early as the Roman Empire when Julio Caesar prohibited the transit of wheeled vehicles in the centre of Rome for some hours during the day to clear the streets. It is also true that traffic accidents were reported and classified many years before the appearance of automotive vehicles. In 1840, approximately 800 people died in England because of accidents involving carriages, carts and wagons (CRESSWELL & FROGATT 1963).

By the end of the nineteenth century, the invention of automobiles and the increase of circulation in the cities resulted in the first truly modern traffic problems in large European cities. Urban development began to be marked by successive “interventions” to change space and functions. The downtown

areas, which happened to be the favourite places for residents, began to concentrate economic, administrative and financial activities driving part of the population to the suburbs, and that resulted in the building of road networks for automotive transportation. Accordingly, public officials began to implement norms, rules and legislation to regulate traffic, generally focusing on vehicles in detriment of pedestrians. The first traffic light, with the green and red colours was inaugurated in London in the year of 1870 (VASCONCELOS, 1985).

The growing use of automobiles as an essentially individual transportation means was then viewed as definite. Even the implementation of modern mass transportation projects, such as subways, was only justified, as they would free the way for automobiles. Access to big cities is through bridge and tunnel systems where only automotive vehicles circulate (KLEIN, 1994).

In the twentieth century, traffic began to emerge as a severe global urban problem. Nowadays, pollution, noise, traffic jams and accidents are part of an array of concerns of sanitary and public officials, traffic authorities and of the population as a whole.

At first, the issue of traffic accidents was not part of the public agenda for the majority of countries in the World. Accidents were considered disasters or casual events and viewed as fatalities. Deaths and disabilities produced by vehicles were considered inherent results of progress. The fast growth of the death toll caused by traffic accidents became a relevant public health issue. Furthermore, recently traffic has become a severe environmental problem.

Psychoactive substance consumption follows the lead of Humanity's History and has been present throughout the development of civilisation. Consumption circumstances nevertheless have varied with time and even today can be different depending on the context.

History shows that drug consumption increasingly acquired its own characteristics, going from ritualistic and religious use to medicinal use or aggregating use and more recently, protestation. Escololato <sup>2</sup> has stated that the history of drugs has shed its own light on the history of humanity and influenced not only the evolution of medicine, but also that of morality, religion, economy and politics.

Drug use in modern society reflects important social and economic changes taking place in the last centuries, resulting in deregulation of many behaviours, displacing community control mechanisms towards big corporations and anonymous institutions. As opposed to vegetal matter handcrafted into psychoactive substances nowadays, drugs are produced in series through laboratory procedures, either legally or illegally, and in scale as with other general consumption products.

Modern times have resulted in new motivations and new forms of procurement of psychoactive substances, not only by youths but also by adults from all social classes.

Notwithstanding the existence of new and different legal and illegal forms of drug consumption, the majority of people use psychoactive substances for recreation, such a fact does not harm the individual or Society.

Alcohol is perhaps one of the most intensively used psychoactive substances in the World and may, depending on quantity, frequency and circumstance be consumed without further problems. Nevertheless, recent studies indicate that a major portion of the population substitute recreational use for other risky or

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<sup>2</sup> Escololato \* *Historia general de las drogas* , 3ª ed. Madrid, España, 200

harmful uses that may generate severe physical, psychological and social consequences.

The theme of this article focuses on how the harmful use of alcohol associated to risky traffic situations partially account for the high death toll by external causes – accidents and violence – in countries where alcohol is the most widely consumed drug.

This article will analyse, among other drinking related problems, the impact it has on traffic accidents, legislation, prevention and harm reduction programs in some of the “developed” and “emerging” countries. However, we are already convinced of the need of a more in-depth analysis of the problem, due to the inadequate information and strategies implemented.

We hope this discussion will encourage and mobilise researchers, doctors, psychologists, social workers, politicians, administrators, drug users, among other stakeholders to think, study, design and create an efficacious and viable policy that will permanently pursue the reduction of traffic violence and security and the quality of life of the population in general.

#### **THE MIRROR ON A DRINKING GLASS, THE MIRROR IN THE CAR**

##### **CONSIDERATIONS ABOUT TRAFFIC RELATED POWER AND CITIZENSHIP**

The harmful use of drugs and traffic violence is a complex and dynamic phenomenon of community life permeated by social, economic and political issues related to human subjectivity. Therefore, the space on which people and vehicles circulate is the stage for power relations, for conflicts reflecting society’s inequalities. These conflicts and social strains are expressed in traffic conflicts and tensions.



Drinking and driving are symbols of social achievement. Automobiles and drink have increasingly been associated to success, wealth and status. The car in addition to being a means of transport has become an extension of the personality and body of the driver and an attribute of social empowerment. The automobile culture is so strong that historically cars have been considered more important than people interfering with the development of personal identity. Therefore, not only new and deluxe automobiles, but old and cheap ones too, endow the owners with a privileged position in relation to other traffic actors – pedestrians, passengers, bicyclists and motorcyclists – especially in the dispute for public spaces and locations. Cars are without any doubt competitive tools in the struggle for time and space. Outside the car, stand the majority who are not owners. The large number of people who cannot safely walk the streets (safety equipment such as protection islands, walkways, crossings etc. are scarce) are viewed as “second class” citizens whose rights are not enforced.

These are social values that cause and reinforce transgression, aggressiveness and risk in traffic. Alcohol consumption appears as an important cause of violence in traffic; this relationship has been established by surveys in several countries.

For decades, public policies for traffic and drugs in the majority of countries have chosen repression, very little is done in the fields of prevention, education and human rights.

Limiting traffic and drug use to a security issue, prevent us from seeing that they are features of democratic living, clearly providing an opportunity for the exercise of citizenship.

The citizenship concept implies, on one hand the fundamental idea of individuality and on the other – universal rules – a law system for everybody,

everywhere. Therefore, it is fundamental to emphasise the dimension of citizenship, as it relates to traffic, considering it should express a basic equality situation.

To drink and to drive, as well as to drink and to assume a situation of risk in traffic are practices that harm the basic concepts of democracy and citizenship, harming society as a whole. Accidents happen and the victims are accounted for in a predictable and growing balance throughout the World.

What we advocate here is individual freedom. The right to come and to go and the right to an altered state of conscience. However, this freedom should never compromise one's own life and the lives of others. The State is competent to assure safety in traffic and all citizens should be considered agents of a civilising process. Drinking is part of civilisation but it is necessary to civilise its usage. Alcohol and other drugs are not compatible with traffic.

#### **CIRCULATING INFORMATION**

##### **TRAFFIC ACCIDENTS IN THE WORLD**

Traffic accidents in the World are a major public health issue causing strong impact on population's morbidity and mortality rates. It is estimated that these events will cause 1.171.000<sup>3</sup> deaths and many cases of disability, resulting from human actions or omissions and of technical and social conditions – in all a complex problem.

Accident is defined, according to Manayo and Souza, 1993, as a non-intentional and avoidable event, causing physical and/or emotional harm, in homes and in other social environments, such as the workplace, traffic, and school, among others. As for the formulation of public policies, it is important to eliminate the

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<sup>3</sup> *World Health Organisation – Department of Accidents and Violence, 2001*

fortuitous and casual connotation of the term, understood as predictable and consequently, possible to be prevented.

Therefore, considering accidents as violence helps the design and implementation of public policies to prevent them. It's important to understand that this is not the perception prevailing in public health discussions. In the last World Health Organisation (WHO) report on violence, traffic accidents were excluded because one of the criteria defining violence is the intention to commit it. Accidents are not intentional, so they cannot be defined as violence. Our understanding is that intention in itself does not define an act as violent. Society produces violence structures. There are values and behaviour patterns that cause suffering and pain. To drive a car under the influence of alcohol or other drugs is an example of this type of violence.

Consequently, accidents and violence are a series of events causing harm to health that may, or may not result in death, among which are included the so-called accidental causes – attributed to traffic, work, falls, poisoning, drowning and other types of accidents – and to intentional causes. These series of events are defined in the International Disease Classification – under the denomination of external causes which in its 10<sup>th</sup> review (WHO, 1995) has presented changes principally affecting, traffic accidents. Up to 1995 (CID-9, 1995) these events were studied within the E810-E818 group – automotive traffic accidents – but following the review they were unified into \_ transportation accidents – considered as all events involving any type of transportation (bicycles, skates, wagons, etc.) on public streets.

In mortality dynamics, external causes, especially in the 80's were placed among the principal causes of death. Traffic accidents are the 10<sup>th</sup> cause of death in the World and the first among external causes, corresponding to 2.3% of all deaths (WHO, 1998).

The so-called “developing” and in “transition” countries account for 87.9% of all deaths caused by traffic accidents, while developed countries account for only for 12.1%.

Traffic accident distribution is a further expression of inequality between the “two worlds”, proving how difficult it is to be and to enjoy being a citizen out of the so-called “developed countries”. There is consensus in the World related to the relevance of reducing morbidity and mortality in accidents and in violence, through adequate and fast pre-hospital and hospital admittance which, according to data from North American and European literature in the 80’s, could reduce avoidable deaths by over 50%. Another aspect to be considered is the use of safety equipment on roads and in cars.

As for the traffic victims’ profile, the higher rates are among males, in productive age groups from the low and medium income brackets. One of the main accidents consists of pedestrians being hit by automotive vehicles. The numbers of pedestrians being hit denounce a socially unequal form of violence in traffic. Anyone can be hit, but the initiator is driving a vehicle, an asset which few people have access to, especially in developing countries.

#### **THE BROKEN MIRROR**

##### **THE IMPACT OF DRINKING IN TRAFFIC ACCIDENTS**

One of the most important problems related to the harmful consumption of alcohol are traffic accidents involving alcoholic beverage consumers. It is scientifically proven that the use of alcoholic beverages increase accident probabilities to the extent that it changes visual and hearing discrimination capacity, reduces movement co-ordination and reflexes, changes behaviour (lack of inhibition and euphoria, lack of judgement, a sensation of false security, etc) not only of drivers but of pedestrians as well (MELCOP & OLIVEIRA, 1997).

In the United States, one person dies from alcohol related traffic accidents every 30 minutes, corresponding to 41% of total deaths caused by traffic accidents (NHTSA, 2002), while in Australia (Victoria) another survey has indicated that 20.4% of individuals were tested positive for this drug (Institute of Criminology of Australia, 1998). The Pan-American Health Organisation reports that studies on traffic accidents in Chile indicate that drinking caused 71% of the deaths.

Based on data from the Fatal Accidents Report System (FARS) <sup>4</sup>Margolis & al. investigated the epidemiology of children fatalities related to automotive vehicles accidents <sup>1</sup>. In addition to children and adolescents under 16 years old riding as passengers, pedestrians and bicyclists in the years of 1991-1996 were included. The authors estimated that each year approximately 550 children (437 passengers and 113 pedestrians and bicyclists) were killed in drinking related traffic accidents which corresponds to 20% of all deaths in the same age group (in 67% of the accidents involving children with fatal injuries, the children were travelling with drivers who had been drinking and 11% were bicyclists or pedestrians). It was also noted that children travelling with drivers who had been drinking had lower probabilities of being securely restrained.

Among the studies accomplished in Brazil, outstanding data were obtained in 1995 by the Centro de Estudos e Terapia do Abuso de Drogas – Salvador/Bahia and in 1995 by the Instituto Recife de Atenção Integral às Dependências – Recife/Pernambuco. Both accomplished a regional study relating alcohol consumption and leisure situations with the driving of cars and motorcycles <sup>5</sup>. In Salvador, the study indicated that a major proportion of the

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<sup>4</sup> *Alcohol and Motor Vehicles – related deaths of children as passengers, pedestrians and bicyclists, Margolis, LH, JAMA, 2000.*

<sup>5</sup> *Álcool e Trânsito. Melcop et al. Ministério da Justiça, 1997*

interviewees (25.5%) reported previous traffic accidents while driving cars and of these 37.7 had been drinking at the time.

In Recife, 23% of respondents were legally prohibited from driving and of these 28% had already been in accidents. It has also been established that self-evaluation of the effects of drinking is a bad indicator of the driver's real conditions considering that the majority underestimated the negative influence of drinking and driving. Respondents disclosed an adequate perception in relation to what should be done after drinking – *to let someone else drive or to take a taxi* – but never did it.

A further important aspect noted in the two cities was that drivers not using safety belts had high blood alcohol concentration.

Another research accomplished in Brazil <sup>6</sup> broke the drink and driving paradigm – for it revealed that the second type of accident for the sample (1.114 victims) involved hitting accidents – and that the majority of the victims were under the effect of alcohol.

The indicated data fully revealed that at least great part of traffic accidents are not casual and can be prevented. Greenwood et alli suggested in 1919 that accidents were not totally random phenomena. Traffic accidents are the result of an individual related set of circumstances and factors linked to the car and to the streets. Harmful consumption of alcoholic beverages is among the individual factors.

The large incidence of accidents directly and indirectly caused by drinking may be related to behaviour changes, such as arrogance, the release of inhibitions and impaired judgement among drivers and pedestrians.

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<sup>6</sup> *Impacto do Uso de Álcool e outras Drogas em Vítimas de Acidentes de Trânsito. Nery Filho et all.*

It should be taken into account that the studies performed focused on harmful drinking and traffic risks and not dependency identification of people developing Alcoholism or the Alcohol Dependency Syndrome.

#### **FOLLOWING DIFFERENT DIRECTIONS**

##### **TRAFFIC LEGISLATION IN DIFFERENT COUNTRIES**

Traffic laws change in “developed”, “developing” and “in transition” countries. In relation to drinking different laws, establish different limits (BAC – Blood Alcohol Concentration- depicted in the chart below) and penalties in their legislation.

##### **BAC LIMITS (BLOOD ALCOHOL CONCENTRATION) PER DRIVERS**

COUNTRIES	BAC LIMITS	BAC LIMITS FOR YOUTHS
AUSTRALIA	0,5	0,2
AUSTRIA	0,5	0,1
BRAZIL	0,6	0,6
SPAIN	0,5	0,5
USA	0,8 - 1,0	0,0 - 0,2
FRANCE	0,5	0,5
JAPAN	0,0	0,0
NEW ZEALAND	0,8	0,3
PORTUGAL	0,5	0,5
SWEDEN	0,0	0,0

*SOURCE: On Dwi laws in other countries. NHTS, March 2000.*

When someone drinks the blood alcohol concentration will depend on height, weight, physical and psychic conditions. Because of these factors, a given concentration of up 0.2 gram per liter of blood (one glass of beer) does not generally cause any effect on the reflexes when driving. From then on the majority of people begin to suffer reflexes impairment compromising their ability to drive (refer to chart below). The risk starts to grow with whatever more is consumed and leaps at the 0.5 – 0.9 g/l interval (a nine time risk

increase of involvement in some type of accident). Drivers who have been drinking are not intoxicated, are not drunk but their driving is impaired. So are the reflexes of the pedestrians.

EFFECTS OF DRINKING AND DRIVING	
GRAMS/ALCOHOL - LITERS/BLOOD	EFFECTS
0.2-0.3 g/L - EQUIVALENT TO A GLASS OF BEER, OR A LARGE GLASSES OF WINE, ONE SHOT OF WHISKEY OR ANY OTHER DISTILLED DRINK - 0.2-0.3 g/L	MENTAL FUNCTIONS BEGIN TO BE IMPAIRED.
0,3 - 0,5 g/L - TWO GLASSES OF BEER, TWO LARGE GLASSES OF WINE, TWO SHOTS OF DISTILLED DRINK	THE DEGREE OF ATTENTION IS REDUCED AS WELL AS THE VISUAL FIELD. CEREBRAL CONTROL RELAXES AND THERE'S A SENSATION OF CALM AND WELL BEING.
0,5 1- 0,8 g/L - THREE/FOR GLASSES OF BEER, THREE LARGE GLASSES OF WINE, THREE SHOTS OF DISTILLED DRINKS.	REFLEXES BECOME RETARDED; THERE'S DIFFICULTY OF VISION ADAPTATION TO LUMINOSITY DIFFERENCES, OVERESTIMATION OF POSSIBILITIES AND RISK MINIMISATION AND AGGRESSIVENESS TENDENCY.
0,8 - 1,5 g/L	DIFFICULTIES OF DRIVING/CONTROLLING VEHICLES AND OF WALKING IN TRAFFIC - CO-ORDINATION IMPAIRMENT, FAILURE IN NEUROMUSCULAR CO-ORDINATION.

The alcohol content a person must drink to reach a 0.6- 1.0 BAC and the lack of effective enforcement conveys the impression that the laws in the United States, Brazil and New Zealand if not promoting, at least find moderate drinking and driving acceptable. In contrast, more reduced BAC levels for driving have been adopted in many industrialised countries such as in Australia, France and Holland where, paradoxically, there is a more tolerant policy related to other drugs consumption. The leader is Sweden where there's a zero tolerance policy in place since 1990 and to drive with a 0.2% BAC or more is



illegal. It should be noted that many American states have adopted a zero tolerance policy for drivers under 21 years old.

BAC legal limits reduction could be one of the efficacious measures to reduce traffic accidents in the World, if followed by education campaigns (training and information) and enforcement. Nevertheless, actions implemented in the majority of countries to reduce the number of traffic victims are repressive; they range from vehicle impounding, drivers license suspension, drivers' license revocation and drivers' imprisonment. Moreover, they are focused only on drivers, one of the traffic actors.

## **SIGNALLING TOWARDS LIFE**

### **TRAFFIC HARM REDUCTION**

To reduce harm means to reduce the aggravation stemming from the consumption of a given psychoactive substance. This harm could be organic for drug use can affect user health in different ways depending on the body, use frequency and quantity consumed. Nevertheless, harm does not result directly from drug use but from a series of risks to which the user may be exposed when under the effect of drugs.

Many expose themselves daily to traffic, driving or walking under the effect of drugs. Much of the harm not only affect those who consume alcohol or other drugs but other people as well in a chain reaction demonstrating that psychoactive substances use should not be restricted to individual choice. Harm reduction strategies attempt to respond to this multiplicity of situations within the scope of public policies.

Harm reduction policies principally pursue to reduce adverse consequences of drinking instead of reducing drinking itself. Is this possible in traffic?

Policies and laws have been essentially repressive and focused on driving behaviour: speed limits, alcohol and other drug consumption restrictions, age limits for obtaining driving licenses, in addition to penalties. Little is done in the prevention area, in education and community intervention to attempt to increase awareness, culture and social values in the population with relation to traffic and drug use.

Some recent interventions, within the principles of harm reduction have attempted to make vehicles safer – cars, motorcycles, bicycles, etc. – and roads safer, as well as to implement strategies to avoid and/or to reduce traffic risk situations for pedestrians and drivers, among those we list the following:

- Programs providing free transportation for people who have been drinking making it easier for these people to choose a safer way home.
- Driver assignment programs. These programs encourage a group of people who frequently party together to assign one of the group members not to drink on a given occasion. The idea is that this person may drive for the group, and avoid other risk situations as well. This assignment should be rotated among the group.
- Education blitz. Police officers and traffic educators intervening in vehicle and people transit requesting the use of equipment to measure alcohol concentrations and offering useful ideas on drinking and driving;
- Proprietors, managers, waiters and barmen education and training with the objective of providing information on legislation pertaining to suppliers responsibilities (the prohibition of serving alcohol to already intoxicated individuals and to children and adolescents), on the process

of alcohol effects and their social role in intervening in the risk situations of their clients.

- To include traffic as a subject in school curricula. Traffic viewed as an issue of citizenship, democracy and respect to life ;
- Education programs for adolescents and youths in schools and colleges on the safest way to drink;
- Inclusion of drug issues in driving schools ;
- Attractive Orientation Stands – distribution of information brochures and condoms and the use of alcohol concentration equipment – to dissuade risk behaviour in the traffic of big popular celebrations such as Carnival in Brazil and the Beer Festival in Germany, among others;
- Frequent education campaigns on safe and ethical behaviour encouraging safety, cordiality and solidarity in transit.

Other harm reduction strategies should be thought of and created in the attempt to gather groups that are naturally more vulnerable in traffic, such as pedestrians, elderly and illiterates. It is necessary to encourage and assure participation of alcohol consumers in the planning and implementing of all Harm Reduction actions. At last, it is important to emphasise that traffic and drug use in society today is an outstanding opportunity to learn more about citizenship and democracy, therefore, these issues should be discussed from a political viewpoint in the broadest sense of the term. If the question is looked at this way, it should then be inserted in the Harm Reduction Program in traffic, paving the way for new and consistent actions, which will shed light on still unexplored aspects of the theme and call upon new social actors that can significantly contribute to reduce violence in traffic.

## **A NECESSARY PASSAGE**

### **HARM REDUCTION THROUGH THE EXERCISE OF CITIZENSHIP IN TRAFFIC**

The reduction of the number of traffic accidents throughout the World is a great challenge. It requires hard and continuous work, with results that can be expected in the short, medium and long term. There is no doubt whatsoever of the need to invest in legislation, technology, and engineering, but above all, we need to invest in the education and training of all citizens. In addition to that, society's mobilisation and its control, related to traffic safety, is, nowadays, an important factor in any job and in any campaign.

Key to the issue is the absolute need for change in relation to the concept of traffic, automobile priority and the peaceful relationship with alcohol use within this context. Traffic as we see it, is not only a technical issue, it is principally a social and political issue for it represents the movement of people in public space, within a society of growing complexity. It is necessary to view the car as a means of transportation and not as an instrument of power and a symbol of social inequality. It is necessary to change the socially accepted behaviour of drinking by drivers and pedestrians.

International experience has indicated that the adoption of a stricter legislation, of a zero tolerance policy and of traffic engineering has resulted in the reduction of the number and severity of accidents. Many countries have developed national programs emphasising repression and were relatively successful in reverting the intolerable rates and numbers of traffic violence.

It is difficult to measure education and harm reduction projects that do not have, up to now, qualitative and quantitative evaluations on results in terms of accident reduction, economic viability and behaviour change. Nevertheless, it can be admitted that these programs, when dully executed, are efficacious,

because they promote and commit the population to human rights, citizenship and democracy.

To implement Harm Reduction Programs is a safe way to reduce risk behaviours associated to alcohol use and traffic.

For the record it is important to note that education and harm reduction added to adequate legislation and enforcement should assure economic gains much superior to the costs involved, in addition to invaluable social benefits in terms of life preservation, improvement of services quality and a more equal, safe and humane traffic system.

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STOP HERE AND NOW



## THE ROLE OF THE MEDIA IN PROMOTING RESPONSIBLE ALCOHOL USE

Mônica Gorgulho

According to the World Health Organisation<sup>8</sup>, the consumption of alcoholic beverages has been rated one of the top ten risks to health. It is, also, the leading health risk in some developing countries, causing 1.8 million deaths around the world, including 5% of all deaths of young people between 15 and 29. Globally, alcohol is estimated to cause 20-30% of esophageal cancer, liver disease, epilepsy, motor vehicle accidents, homicides and other intentional injuries. It is, also, estimated that, globally, 140 million people are suffering from alcohol dependence.

Although drinking alcoholic beverages is one of the most ancient behaviours of humanity, going back as far as 6 thousand years B.C.<sup>9</sup>, it seems that human beings have still not learned how to deal with this substance. Alcohol misuse is one of the causes of social disintegration, leading to the marginalization of many, although in a different way from that of illicit drug users. In Brazil<sup>10</sup>, this marginalization also occurs where it should least happen: inside the health care system. Alcoholics are seen by health care professionals as being weak, lazy and not as people in need of health assistance. Such prejudiced and moralistic conduct towards patients clearly shows that these professionals are not sufficiently prepared to deal with problems of this nature. Such attitudes and the insufficient care given to alcoholic patients in hospitals or health care units, shows how unfair the alcohol policy has been in the poorest regions of our planet, especially in developing countries.

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<sup>8</sup> WHO – *World Health Report*, 2002.

<sup>9</sup> MASUR, Jandira – “**O que é alcoolismo**”, São Paulo, Ed. Brasiliense, 1988.

<sup>10</sup> VILLAR, Margarita Antonia – “**Uso e Abuso de Álcool e Drogas**”, Ribeirão Preto, FIERP – EERP-USP/FAPESP, 2000.

This situation seems to be the result of the contradictory messages aimed at the general public. On the one hand alcohol is seen as an important public health issue, and on the other hand the mass media encourage people to use alcohol without taking any care to make them aware of the potential risks of this behaviour. The power of mass media, such as commercial communication (TV, cinema, billboards, radio, newspapers, magazines), sponsorship, promotion and Internet is already known. It is argued that this is a way of informing the general public about the products available, but at the same time one cannot deny that it is also the way the industries have of selling their products.

The International Advertising Association (IAA)<sup>11</sup> states that

“the marketing communications industry is under constant threat as new legislation is enacted and regulations are proposed restraining the way we do business. Internationally we face constant danger (...). The list of products and service categories under threat is ever growing, including beverage alcohol, (...). All corporations involved in marketing communications need a pro-active partner and advocate for freedom of commercial speech. (...) Given the absence of other established multidisciplinary organisations, IAA serves as the “Voice of the Industry”.

But the alcoholic beverage industry itself knows that special attention is necessary with regard to certain products. ICAP<sup>12</sup>, an agency for promoting discussions and partnerships between the alcoholic beverage industry and the public health community, recognises that advertisement and promotion of such beverages may need more careful regulation than that of other products. In one of its reports<sup>13</sup>, ICAP shows the regulation on the advertisement of their

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<sup>11</sup> IAA – International Advertising Association, [www.iaaglobal.org](http://www.iaaglobal.org)

<sup>12</sup> ICAP – International Center for Alcohol Policies, [www.icap.org](http://www.icap.org)

<sup>13</sup> ICAP – “**Self-Regulation of Beverage Alcohol Advertising**”, Reports 9, January 2001.

product in different countries. According to this document, statutory legislation is the most frequent manner of regulating the promotion of any kind of alcoholic beverages, followed by the combination of statutory legislation and self-regulation of the advertising companies. However, the situation changes when developing areas are taken into account. In Africa, for example, ten countries show no controls in the way alcohol is promoted, while six countries declared having statutory regulation, five of them simply banned the advertisement of alcohol, and four countries have developed self regulation for this sort of communication. In Latin America, three countries rely on the companies' self-regulation, two on statutory legislation, one on a combination of the two models above, and one just relies on some controls.

Comparing the data, one could say it seems that the developed countries have already realised how important this regulation might be to protect their citizens from the harms of alcohol misuse, and they do not hesitate in doing that. Some developing countries might not yet be aware of the harms related to this behaviour, or might not yet know how to deal with the problem, for example if it is feared that it could damage the economy and if they fear to oppose the alcoholic beverages industry. In trying to separate these two fields –public health and business–, the European Advertising Standards Alliance<sup>14</sup> “recommends that the body responsible for the practical application of the code should ideally be independent of the industry body responsible for its initial establishment and subsequent review”.

This measure could affect the media positively from the public health perspective. According to ICAP<sup>15</sup>, in a survey to identify priority areas for policy development, underage drinking is seen, world-wide, as the most important challenge (81% of the respondents), followed by public education (73%). For the emerging markets, regulation and law enforcement is the highest priority (88%), followed by underage drinking (78%) and public education (72%). As

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<sup>14</sup> EASA – *The European Advertising Standards Alliance*, [www.easa-alliance.org](http://www.easa-alliance.org)

<sup>15</sup> ICAP – *“Global Survey on Alcohol Policies”*, [www.icap.org](http://www.icap.org)

for priorities for the future, education is at the top (85%), followed by budgeting and funding (71%), enforcement of existing laws and regulations (67%), further regulations (54%).

Many countries are already aware of these urgencies. All of those that practice self-regulation agree that advertisement and other kind of communication involving alcoholic beverages should not be addressed to people under 18; should not promote irresponsible use such as drinking and driving and should not suggest the idea that drinking leads to better sexual, personal or professional achievement, among other measures. These points have stimulated the agencies to produce very beautiful campaigns, but the question is: do they work? It seems not, because people keep on drinking too much, not paying attention to their own responsibility, causing car and other kinds of accidents, producing their own illegal alcoholic beverages, and so on. The Brazilian statutory regulation, for example, is unsatisfactory since it exempts from control beverages with less than 12 percent alcohol, although it is widely known that beer is the most drunk beverage by young people. In addition, the official restrictions present in the federal law - like the ban on any suggestion of direct intake of alcohol beverages, the association with better sexual and social performance, and the restrictions on showing time – are not applied to this product.

This leads us to the huge possibilities and importance of the media, which could, if it took its role seriously, be of great help in developing better and more effective communication with society.

What happens when a group of people has to deal with something that is unknown and perceived as threatening? When official data, which could help an easier comprehension, are lacking, the group protects itself by creating its own explanations and interpretations based on the information available. <sup>16</sup>.

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16 MOSCOVICI, Serge – “A Representação Social da Psicanálise”, Rio de Janeiro, *Zahar Editores*, 1978.

Substance abuse is a very good example of this. The division between legal and illegal substances creates an attitude in support of the legal ones, and an over-estimation of the importance of the other. But reality is not so simple.

The social group reacts by creating its own answer, which ends up by affecting the behaviour of the larger society and communication among individuals. Each member of the group creates his own particular way of understanding the issues at stake, according to what she or he understands from her or his own source of information. This source is often limited to newspaper articles, television interviews and gossip, but the role of the media is paramount. Later, all of this is put together again, creating a new picture, since, according to Durkheim<sup>17</sup>, social representations are not just the sum of the representations made by individuals. It is something else altogether, reorganising the meanings attributed by all the individual members of the group. This is how groups build their ideas about complex subjects.

In our case (alcohol use) for example, the biggest difficulty in making people aware of its possible harm is the fact that the mass media only stress its positive side: alcoholic beverages are shown as good, related to positive situations, happiness, social acceptance, etc. This is well illustrated by a research carried out in Brazil in 1998, and repeated in 2000. In order to elicit the messages communicated by the media to the population, in 1998, CEBRID<sup>18</sup> - Centro Brasileiro de Informações sobre Drogas Psicotrópicas, analyzed the content of 502 articles published about drug use and health. The substances most mentioned were tobacco (18,1%), cocaine (9,2%), marijuana (9,2%) and alcoholic beverages (8,6%). Substance dependency was the consequence most mentioned in those articles (46%), followed by violence (9,2%), abstinence syndrome (8,0%) and AIDS (6,8%). Work and road accidents were mentioned in 5,6% of the cases. However, a series of national studies (period:

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<sup>17</sup> MOSCOVICI, Serge – *op. cit.*

<sup>18</sup> NOTO, Ana Regina e col. – “*Psicotrópicos, Saúde e a Imprensa Brasileira: uma análise dos artigos sobre psicotrópicos publicados nos principais jornais e revistas do país*”, CEBRID. SP, 2000 – no prelo

1987,1989,1993 and 1997) carried out by the same research centre<sup>19</sup>, where 16 000 students between 10 and 24 years were asked about their substance use, showed that alcohol was by far the most widely used drug (30% reported “heavy” use), followed by tobacco.

This shows how little the media reflect reality. Although alcohol is the drug most widely used in the country, concern about these beverages is much less than that with other drugs, coming only in 4<sup>th</sup> place in their agenda. On the one hand, there are a large number of articles discussing violence related to illicit drug dealing and use, and on the other hand, a large number of sophisticated advertisements promoting the consumption of alcohol and, at that time, tobacco as well. By giving such different treatments to drugs which are similar drugs from a medical point of view, the media encourage extremely incoherent social behaviour, bearing little relation to the real medical problems. And, when we talk about strategies, this discrepancy is also present. The strategies suggested by the Brazilian media, according to the same study, were treatment (33,5% of the articles), better legislation (26%), prevention (26%), repression (23,5%) and, in last place, harm reduction (6,8%).

This reveals the clear, although not necessarily conscious, tendency of the media to stress the negative aspects of illicit drug use. On the other hand, great emphasis is given to the positive aspects of the use of alcoholic beverages. This, in turn, points to a tendency to treat drug issue emotionally rather than in a rational and scientific way, thus helping to create the inappropriate social representation of psychoactive substances to be found all around the world. This is what leads people to believe that alcohol is harmless.

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<sup>19</sup>GALDURÓZ, José Carlos; NOTO, Ana Regina; CARLINI, Elisaldo – “IV Levantamento sobre o uso de drogas entre estudantes de 1º e 2º graus em 10 capitais brasileiras – 1997”, *CEBRID – Centro Brasileiro de Informações sobre Drogas Psicótropicas – Departamento de Psicobiologia da Escola Paulista de Medicina, Universidade Federal de São Paulo*, in: GORGULHO, Mônica – “Editorial”, *The International Journal of Drug Policy*, 11, (2000), 311-313

If, according to ICAP, as we saw before, public education is perceived as the highest priority for future actions, it is unacceptable that the media should receive scant attention. The speed of modern means of communication renders the mass media a very strong ally for many initiatives in this field. But we need very sincere analyses about how this is to be done. Unfortunately, up to now, this has not been a major concern of the health community. The mass media themselves, have already realised the necessity for a major commitment to the dissemination of trustworthy non-judgmental information. This is one of the reasons why the advertisement agencies have created their own internal code, in trying to establish better communication with the public.

A Brazilian network of media professionals<sup>20</sup>, for example, understands the importance of the mass media as a vehicle for promoting and defending social rights. Studying the behaviour of the mass media in relation to social issues, such as drugs, Aids, unplanned pregnancy, they have stressed the importance of an open and trustful dialogue with society. They have called their colleagues' attention to the limited strategies used by the media, and also to the general preference for focusing on only one side of the products' characteristics, such as the risks involved in the use of illegal drugs and the positive aspects of legal ones, including alcohol. The lack of attention given to the discussion of harm reduction strategies has also been pointed out. They consider that the mass media must become the real ally it could be in spreading preventive and adequate information throughout society.

## CONCLUSION

Although they have become a business involving millions of dollars, the mass media, as any other kind of business, must face up to their social responsibility such as their role in the prevention of HIV infection and in reducing the prejudice around Aids. And it has been insufficiently realised how much the

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<sup>20</sup> ANDI – Agência de Notícias dos Direitos da Infância, Publicações, ponto J, Boletim n° 10, Jan./Fev. de 2000 – [www.andi.org.br](http://www.andi.org.br)

media could be of help in dealing with the problems associated with drug use – legal or illegal. The mass media have already recognised the social responsibility of other kinds of business, but refuse to accept their own when it comes to helping society face the difficulties associated to complex issues such as alcohol consumption and related harm. By informing, pointing out solutions and strategies and by provoking discussions, the mass media would be showing they are aware of their responsibilities in the dynamic and controversial societies we have created. This would be in line with their own interest since it would help promote greater public trust in them and the products they sell.

A better informed society might be able to build an environment more conducive to effective solutions; might contribute to a broader view of the harms related to alcohol use; might stimulate discussions leading to more satisfactory strategies and results; might become aware of all the harms caused by the use of legal drugs, beyond mere dependency; might allow governments to reach more and less idealised solutions and might be able to force the authorities to offer better solutions for problems related to alcohol use and misuse.



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## DISCUSSION

Ernst Buning

In this chapter, a number of issues will be discussed, which are important to consider in developing alcohol policies and interventions.

Firstly, various models will be described, which are influential in present alcohol policies. For each model arguments for and against will be given. Secondly, issues will be addressed, which are significant for countries in transition and may have impact on alcohol policies. Thirdly, society's inconsistent attitude regarding various psychoactive substances (legal versus illegal) will be discussed. It will also be pointed out how these inconsistencies can create barriers in achieving realistic and pragmatic policies.

In the last paragraph, we will give our view on the role of the Harm Reduction paradigm in developing a coherent and innovative alcohol policy in countries in transition.

### DIFFERENT MODELS

Four different models will be discussed: (1) the disease model, (2) the abstinence oriented model, (3) the self help model and (4) the WHO model.

#### THE DISEASE MODEL

The disease model considers alcoholism as a chronic disease, where sober periods alternate with periods of binge drinking. Arguments for this model:

- People with alcohol problems are perceived as patients and are not made to feel guilty;
- The medical input guarantees a systematic and objective approach with good medical care, including medication, to help alcoholics to detoxify and stay sober. When medical treatment is combined with psycho-social care and ample attention is given to relapse prevention, such comprehensive treatment is an important tool in assisting alcoholics in reducing alcohol related harm.

Arguments against this model:

- Research shows that treatment of alcoholism has limited success, since alcoholics are difficult to motivate to enter treatment and relapse is high;
- Attention is mainly paid to those who are classified as problem drinkers and/or alcoholics and too little consideration is given to harm caused by those who are not classified as alcoholics, but who cause harm related to acute intoxication;
- Alcoholics perceive themselves as patients, might not feel responsible for their drinking problems and get stuck into their role as patient with a disease;
- The general public is reinforced in their attitude that '*alcohol is not my problem*'. Such attitude might provide for an alibi to neglect the harm related to acute intoxication and thus inhibit an open discussion about possible negative effects of alcohol consumption within the general population.

Using the disease model can be beneficial for those who have severe alcohol related problems, but it neglects the substantial harm caused by those who are not classified as problem drinkers or alcoholics. As long as these limitations are acknowledged, there will be a place for the disease model in an overall alcohol policy.

#### **THE ABSTINENCE ORIENTED MODEL, PROHIBITION AND TEMPERANCE**

The abstinence oriented model proclaims that it is better not to use alcohol at all. This movement is old and has its roots in the Scandinavian countries. It has played an important role in the last century in making people aware of the negative aspects of alcohol use and was also a significant factor in the emancipation of the working class and an instrument in the socialist movement. Arguments for this model:

- The abstinence oriented model might be very useful for people who have conquered a difficult period in their lives where alcohol use was high. They might have come to the conclusion that they are much better off abstaining.

Arguments against this model:

- For most societies the abstinence model is not a feasible option as an overall national policy since alcohol is embedded in many social events and rituals and plays an important role in socialising.

In the final analysis the personal decision to abstain should be respected at all times. However, when it turns into a belief where people start to preach that such way of life is best for everyone, then it should be put aside. The positive as well as the negative aspects of alcohol should be recognised.

#### **THE SELF-HELP MODEL**

The AA is the best example of this philosophy. They have set up a world wide system of self help groups which have been beneficial to hundreds of thousands of people. In favour of this model are the following points:

- It is cheap;
- It is also available outside office hours;
- It does not force participants to say anything against their wish;
- It uses the same methodology all over the world.

The arguments against this model:

- The philosophy of ‘I’m powerless over my addiction and I trust a greater power (God) than myself’, gives the AA a ‘religious’ aspect, which might be counterproductive once people have left the AA;
- The AA does not fully acknowledge the scientific evidence that some alcoholics manage to become social drinkers. Here it should be noted that it is not yet evident which factors predict whether an alcoholic can become a social drinker or not.

A strong argument in favour of self-help groups is that participants have complete control over their own well-being. By refusing any governmental support, they remain independent. Because of its success for so many persons with alcohol related problems, it should be respected. At the same time the discussion about controlled drinking should be stimulated and held in an objective and non-moralistic way in order to allow people to make their own informed decision. In an overall alcohol

policy there is a place for the philosophy of self-help as long as it is not presented as the ‘cure for all’.

#### **THE WHO MODEL**

In their book *‘Global Status report on Alcohol’*, the WHO describes a number of areas to consider for an alcohol policy.

- Prevention:
  - Education and health promotion
  - Product labelling
  - Regulation of promotional activities
- Supply reduction
- Regulation of physical availability
  - Restriction on availability for young people
  - Monopolies and licensing system
  - Taxation and other pricing regulations
  - Deterrent policies
- Treatment:
  - Treatment strategies

The strong point of this model is that it is coherent and covers many areas. A weak point is that it relies very much on external control, regulation etc., which assumes that external measures can actually be implemented and executed.

#### **THE REALITY OF COUNTRIES IN TRANSITION AND DEVELOPING COUNTRIES**

##### **INTERNAL VERSUS EXTERNAL CONTROL**

In an ideal world, an alcohol policy should purely aim at strengthening the internal control of individuals, where one is conscious about the harm caused by alcohol and adopts responsible drinking behaviour. Unfortunately, we do not live in an ideal world and therefore one must be realistic: measures aimed at strengthening internal

control will not be sufficient to reduce alcohol related harm. External control is needed as well to find the right balance and stimulate individuals to adopt responsible drinking patterns. In some countries in transition, the development and implementation of external control measures might be problematic, because of their recent history of extreme external control, for example by a military or totalitarian regime. Once these regimes were abolished, the position and influence of the government had to be redefined. Often measures taken by the central governments are still received with suspicion: politicians are there to ‘fill their own pockets’ and can not be trusted. Some governments give special attention to this issue by stressing the importance of the involvement of civil society and actively stimulating citizenship.

Before external control measures are proposed as important elements in an overall alcohol policy, it is important to judge carefully how the government is perceived in a specific country and whether it has enough credibility to make such external control measures effective and enforceable.

#### **INDIVIDUAL OR GROUP**

Most developed countries stress the importance of individuality. From early age on, children are taught that they are responsible for their own life and that they are accountable as an individual person. The stress on individualism poses the question of boundaries: where does individualism turn into egocentrism and how does individualism relate to social responsibility. In many countries in transition more emphasis is placed on group identity: a person is foremost a member of a group. The rapid changes in countries in transition, the globalisation of the world and the influence of internet, all influence the issue of individualism versus group identity. It is important to take this into account when developing alcohol related interventions. When there is more emphasis on group identity, prevention campaign and interventions should be aimed at groups and strengthening group pressure. When there is a shift towards individualism, campaigns can be targeted more at the individual.

#### **THE FREE MARKET**

In countries, previously governed by a totalitarian regime, the newly acquired democratic freedom might be misinterpreted as liberty to ‘do anything you like’.

Entrepreneurs, including the alcohol industry, might use arguments related to democracy and free market economy, to oppose any government restriction on the sale and promotion of alcohol, such as restricted selling points and the introduction of minimum ages for purchasing and consuming alcohol. 'Supply and demand' are the buzz words and government influence on market mechanisms is seen as undesirable.

The same applies to taxation as an instrument to curb alcohol consumption. In the developed world, it is argued that taxation as an instrument to limit the consumption of alcohol is the most democratic way of curbing alcohol consumption: the same applies to everyone. In countries in transition the opposite might be true, since many live in poor circumstances and are relatively more affected by taxation than the small group of people who are well-to-do.

In countries in transition and developing countries, limitations to the alcohol industry might jeopardise employment in factories and revenues from alcohol advertising and sponsoring. This might be seen as a serious threat to the economy.

In most developed countries, a system is in place to encourage responsible driving by checking alcohol blood levels of motorists regularly. This is seen as a very effective way to curb drinking and driving and prevent harm. However, to effectively carry out such measures, countries in transition might face a number of specific challenges, for example underpaid policemen might be susceptible to bribing, where the 'well-to-do' gets away with socially unacceptable behaviour.

#### **EXCLUSION**

Unfortunately, large groups of people in countries in transition are still living below the poverty line. They have difficulty in finding a job, live in horrendous situations, have limited access to health care and are excluded from main stream society. Many live from day to day and develop their own survival strategy by turning to alcohol as a means of coping. Alcohol consumption might relieve immediate stress, but only worsens the situation in the long term. Interventions, which promote responsible drinking and are aimed at reducing alcohol related harm, could be difficult to 'sell' to people who see no light at the end of the tunnel. It is therefore important that an alcohol policy is incorporated in an overall strategy to address the situation of the poorest part of the population.



**ILLICIT AND LICIT SUBSTANCES**

The gap between policies on licit and illicit psychoactive substances is alarming. It concerns suppliers, consumers as well as policies on psychoactive substances.

The suppliers of licit psychoactive substances, such as alcohol, are seen as respected members of society. Suppliers create jobs, pay tax, ensure revenues through advertising, sponsor social events and are often partners of policy makers when new alcohol policies have to be designed.

The suppliers of illicit psychoactive substances are in an opposite position: overall, they are seen as outlaws, a danger to our children, as people with whom no one wants to be associated, criminals and most definitely not partners for policy makers. Although understandable, this discrepancy bears no relation in comparison to the extent of the harm caused by the different substances. According to reports by the World Health Organisation, harm caused by alcohol far outweighs the harm caused by illicit substances.

Some think that the alcohol industry is not *part of the problem* but should be seen as *part of the solution*. If this line of thinking is followed, it should be considered what the implication would be of a similar policy towards suppliers of illicit psychoactive substances. Without doubt, supplier of psychoactive substances have valuable information about marketing and could lend a helping hand in shaping policies to reduce harm related to psychoactive substance abuse. Involving *all* suppliers of substances (licit as well as illicit) in the process of policy making is a provocative proposal which should be discussed objectively, weighing out the pros and cons in a non-moralistic fashion.

At the consumer level, we can see that alcohol consumers are perceived differently from those who consume illicit substances. Most societies accept that people consume alcohol and might even appreciate it if someone is intoxicated in a specific setting. Group norms plays an important role. There is a marked difference in the attitude towards consumers of illicit substances: they are seen as outcasts, criminals, are feared and rejected. Again this might be understandable, but on purely rational grounds it makes no sense, since much more harm is caused by people under the influence of alcohol than by consumers of illicit substances.

At the policy level, we can see that many countries pay more attention to issues related to the consumption of illicit substances and less attention to policies aimed at reducing alcohol related harm.

Another interesting observation is that experts working in the alcohol field and experts working in the field of illicit substances, often have little to do with each other. Yet, both could benefit from experiences in the different fields and synergy could be created. ICAHRE hopes to build a bridge between the two fields.

### **THE HARM REDUCTION PARADIGM**

In a Harm Reduction approach, policy makers do not talk *about* alcohol users, but rather *with* them, listen to communities and groups who are affected by alcohol related harm. Policy makers seek solutions which are feasible and pragmatic in adopting interventions which work rather than making promises which sound nice to the public. In other words: an approach which is based on facts rather than beliefs, transparent and less ideological.

In a Harm Reduction approach, policy makers pay careful attention to human rights and find solutions which respect the alcohol consumer as well as their environment. Finally, a Harm Reduction approach looks primarily at *harmful drinking* and seeks practical solutions to reduce alcohol related harm rather than reducing per capita consumption *per se*.

### **ZERO-TOLERANCE**

In the International Harm Reduction movement, zero-tolerance is associated with the American war on drugs, violations of human rights, intolerance towards people of a different life-style and with a short-sighted, irrational and ineffective approach to a major public health problem. Such a view of the International Harm Reduction Movement is logical given the fact that this movement has –until now- mainly focussed at policies on illicit substances. In the field of illicit substances, it appears that more harm is associated with the fact that substances are illicit (criminalisation, corruption, harmful behaviour associated with the intake of drugs in secrecy etc.) than with the effects of the substances itself. In the field of alcohol, it is easier to take a more open attitude towards a zero-tolerance policy, since it can be narrowed down to specific settings rather than an over-all approach. In her chapter on alcohol and traffic, Ana Glória Melcop argued, that drinking and driving do not go together. Ewa Osiatinska (see chapter on Alcohol and Health) also mentioned a number of areas where a zero-tolerance policy would be advisable.

Although the Harm Reduction Movement might be tolerant towards unconventional behaviour and respect everybody's individual right to use psycho-active substances, an important notion for this movement is that it addresses both harm caused to the user himself as well as the harm caused *to others*.

Therefore, we come to the conclusion that a zero-tolerance could be promoted in cases where alcohol use could cause damage to others, such as:

- Drinking and driving;
- Drinking and working with technical or industrial machinery;
- Women who are pregnant or breast feeding.

Another situation where a zero-tolerance could be in place, is in situations where potential alcohol consumers are not (yet) capable of making informed decisions, for example children and the young. We feel that the selling of alcohol to them should not be allowed and that the alcohol industry should be forbidden to target children and the young in their advertisement campaigns. More problematic is the promotion of a zero-tolerance for people who have an adverse reaction to alcohol, for example because they use certain medication or are recovering alcoholics. Obviously, abstinence is in their own benefit and sobriety should be advised, though this would be difficult to demand or legally enforceable.

#### **HARM REDUCTION IN PRACTICE**

Based on the information in the previous chapters, we include a table of various kinds of harm and professionals involved. This table might be useful to prioritise training of professional groups.

<b><i>Harm</i></b>	<b><i>Example</i></b>	<b><i>Professionals involved</i></b>
<i>Immediate harm after acute intoxication</i>	<i>Road accidents Accidents caused by drunken pedestrians Interpersonal violence Child abuse Suicide Unintended poisoning</i>	<i>Police Ambulance staff Emergency rooms Primary health care Community workers Coroner Bartenders</i>

<i>Harm which shows up later after acute intoxication</i>	<i>Unwanted pregnancy after unprotected sex under the influence of alcohol STD &amp; Aids due to unsafe sex under the influence of alcohol</i>	<i>Maternity wards Primary health care Child care Staff STD clinics Aids prevention workers</i>
<i>Harm which show up later after long term alcohol use</i>	<i>Absenteeism from work Family disruption Disturbed personal relations Depression</i>	<i>Personnel workers and managers Community workers Primary health care</i>
<i>Chronic harm due to long term alcohol use</i>	<i>Medical problem Loss of job Divorce Alcohol related psychiatric problems</i>	<i>Primary health care Hospital wards Marriage counsellors Staff alcohol treatment centres Personnel workers and managers Psycho-therapists</i>

#### **MAKING THE ALCOHOL ISSUE MORE APPEALING**

A central matter is the question how the alcohol issue could be made more appealing to policy makers, politicians and the general public. Publishing facts about alcohol related harm and per capita consumption alone is not working. So, innovative strategies have to be tried out. The media might play a crucial role in such a strategy as argued by Mônica Gorgulho (see chapter Alcohol and the Media). They should become allies in creating better knowledge about alcohol related harm and assist in changing the way alcohol is re-presented to the public and start a discussion about the hypocrisy related to our views on licit versus illicit psycho-active substances.

Crucial in making the alcohol issue more appealing is stressing over and over again, that 50% of harmful drinking is done by persons who are not classified as alcoholics. This makes alcohol and harm an issue *for all of us* and means that it can no longer stay the exclusive area of a limited group of alcohol experts and researchers: all sectors have to be involved. If alcohol gets higher on the public agenda, more policymakers will be keen to be involved in the creation of public policies and they will get better support from the public.

## CONCLUSION

In his chapter about Alcohol and Harm Reduction, Bill Stronach already stated that Harm Reduction complements rather than competes with conventional approaches. It will be important -whilst exploring new roads of the Harm Reduction paradigm- to treasure what conventional approaches have accomplished in the last decades. On the new roads of the Harm Reduction paradigm, we can see the following challenges:

- Address *harmful* drinking and not drinking per se;
- Shift researchers' attention from collecting data about per capita consumption towards collecting data about alcohol related harm;
- Before applying external control measures from the 'developed' world to countries in transition, analyse whether such measures fit the cultural context, are feasible and enforceable;
- Include harmful drinkers and their family in the development of public policies and alcohol related interventions;
- Start a discussion about our hypocrisy regarding licit and illicit psychoactive substances;
- Focus on training and education of those professionals who are directly confronted with the effects of harmful drinking;
- Involve the media and make them your ally;
- Base actions on facts and not on beliefs and respect individual choices at all times;

We sincerely hope that this book has given food for thoughts and may help those who choose to explore new roads in their quest for a more effective and humane policy to reduce alcohol related harm.



**ABOUT THE AUTHORS :**

*Ernst Buning* is president of the ICAHRE, the International Coalition on Alcohol and Harm Reduction and director of Quest for Quality (Q4Q), an Amsterdam based company ([www.q4q.nl](http://www.q4q.nl)). He has been working in the area of public health and substance use since 1977. He was involved in the development of Harm Reduction policies in the Netherlands and is a founding member of the International Harm Reduction Association (IHRA, [www.ihra.net](http://www.ihra.net)). He is co-ordinator of Euro-Methwork ([www.euromethwork.org](http://www.euromethwork.org)) and the Latin American Travelling Seminar (LATS, [www.latseminar.org](http://www.latseminar.org)).

*Paulina C.A.V. Duarte*, MsC is professor and co-ordinator of the post graduate course on dependencies at the Pontifícia Universidade Católica do Paraná – PUCPR, Brasil and consultant to the Recursos Humanos e Programas de Prevenção.

*Mônica Franch* works at the Núcleo de Estudos de Família, Gênero e Sexualidade – FAGES, Universidade Federal de Pernambuco, Brasil and at the Centro de Prevenção às Dependências, Recife, Brasil

*Mônica Gorgulho* is president of Reduc- The Brazilian Harm Reduction Network ([www.reduc.org](http://www.reduc.org)), secretary to the board of the International Coalition on Alcohol and Harm Reduction (ICAHRE), member of the board of the International Harm Reduction Association (IHRA [www.ihra.net](http://www.ihra.net)) and regional co-ordinator of the Latin American Travelling Seminar (LATS [www.latseminar.org](http://www.latseminar.org)). Besides her work in the harm reduction field, she has her own private practice as a psycho-therapist.

*Ana Glória Melcop* is director of the Centro de Prevenção às Dependências in Recife, Brazil. She was the conference president of the 1st International Conference on Alcohol and Harm Reduction in August 2002. She is member of the board of the International Coalition on Alcohol and Harm Reduction (ICAHRE).

*Pat O'Hare* is executive director of the International Harm Reduction Association (IHRA [www.ihra.net](http://www.ihra.net)). In 1990 he took the initiative for the first International

Conference on Drug Related Harm and ever since he has been the main motor behind this early international event. For his outstanding contribution to the field of harm reduction he received the Rolleston Award in 2000. He is member of the board of the International Coalition on Alcohol and Harm Reduction (ICAHRE).

*Ewa Osiatynska* is director of the Regional Alcohol and Drugs programme for East Central Europe and Central Asia of the Open Society Institute, New York. Within this programme she has developed co-operation with 22 countries in the region. She is also director of the Commission on Alcohol and Drugs Education at the Stefan Batory Foundation in Poland. Since 1992, she has closely collaborated with the ILO in Geneva, as their consultant on the workplace programmes of prevention of alcohol and drug abuse, implemented in East Central Europe. In August 2002 she received the first international award on Alcohol and Harm Reduction for the work she has done in this field. She is member of the board of the International Coalition on Alcohol and Harm Reduction (ICAHRE).

*Bill Stronach* is director of the Australian Drug Foundation (ADF - [www.adf.org.au](http://www.adf.org.au)) and treasurer of the International Harm Reduction Association (IHRA [www.ihra.net](http://www.ihra.net)). In 2004, he will be the organiser of the International Conference on the Reduction of Drug Related Harm in Melbourne, Australia. He is treasurer of the board of the International Coalition on Alcohol and Harm Reduction (ICAHRE).



**INTERNET SITES**

ICAHRE, International Coalition on Alcohol and Harm Reduction:

[www.icahre.org](http://www.icahre.org)

IHRA, International Harm Reduction Association

[www.ihra.net](http://www.ihra.net)

World Health Organisation

[www.who.int](http://www.who.int)

Reduc, Brazilian Harm Reduction Network

[www.reduc.org.br](http://www.reduc.org.br)

DPA, Drug Policy Alliance

[www.lindesmith.org](http://www.lindesmith.org)

Quest for Quality B.V.

[www.q4q.nl](http://www.q4q.nl)