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Research Paper

Harm from others' drinking-related aggression, violence and misconduct in five Asian countries and the implications

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ABSTRACT

Background: Harm from alcohol-attributable aggression and violence is linked to diminished personal safety and reduced physical and mental health and wellbeing in many countries. But there has been limited evidence on these harms in low- and middle-income countries (LMICs). This study measured harm from others' drinking-related aggression, violence and misconduct in five Asian LMICs (Thailand, Sri Lanka, India, Vietnam, and Lao PDR), aiming to compare the magnitude and pattern of harm across countries by gender, age group, educational level, rurality, and country-level indicators.

Methods: Data from 9832 respondents from the WHO/Thai Health International Collaborative Research Project on the Harm from Others' Drinking undertaken between 2012 and 2014 were analysed.

Findings: 50–73% of respondents from five countries reported being harmed at least once in the past year. Public disorder and feeling unsafe due to someone else's drinking was frequently reported, followed by harassment, assaults and threats, traffic harm, and property damage. In most countries, men were more likely than women to report traffic harms, property harm, and assaults, whereas women were more likely to report feeling unsafe in public. Being young, less educated, living in urban areas, and one's own drinking were significant predictors of more harm from others' drinking for both genders.

Conclusions: This study revealed a consistently high prevalence of alcohol-related aggression and violence in the five Asian countries. Patterns of harm within countries and populations at most risk for different forms of harms were identified. Alongside services for those affected, efforts to strengthen alcohol policies are needed in each society.

Introduction

Alcohol consumption is a major contributor to the impairment of drinkers' physical and mental health, but, like passive smoking, can be harmful to the welfare of other people surrounding the drinker. Harm to others includes harms to the fetus associated with the drinking of the mother, injuries caused by drunk drivers, and interpersonal violence due to others' drinking-related aggression (Rehm et al., 2017). While the impacts on the health of others than the drinker have not been consistently recorded in the health system, the substantial magnitude of these problems is hinted at in the burden of disease data. For example, interactional harms, such as drink-driving, accounted for 21% and alcohol-related interpersonal violence accounted for 30% of total alcohol-attributable deaths worldwide (World Health Organization, 2009). Additionally, from the analyses of emergency departments across 14 countries, 63% of the violence-related injuries involved alcohol on the part of the victim, the perpetrator, or both (Cherpitel, Ye, Bond, Room, & Borges, 2012). Further, at the societal level, impacts of alcohol were estimated in terms of costs to the health system, the criminal justice and law enforcement sectors, with an estimated total cost burden of 0.1–0.6% of gross domestic product (GDP) in purchasing power parity worldwide (World Health Organization, 2011). Since only more serious cases of crimes and injuries are detained by the police or use health services, alcohol's burden has only been incompletely tallied: health- and police-recorded data underestimate the true social cost.

Additionally, considerations of alcohol's harm to others extend beyond public health issues. When one person's drinking negatively affects other people it impinges upon human rights and social safety. Social harms due to others' drinking include putting others in fear, harassment, threats, social disorder and property damage (Room et al.,

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Table 1
Country characteristics, drinking indicators and respondents' characteristics from the surveys.

	Thailand	Sri Lanka	India	Vietnam	Lao PDR
Country characteristics					
Asia region	South East	South	South	South East	South East
World bank income	Upper-middle	Low-middle	Low-middle	Low-middle	Low-middle
GNI per capita PPP[a]	9280	6030	3820	3620	2690
Total population (millions)	66.4	20.8	1210.0	89.0	6.4
Population in urban areas	34%	14%	44%	30%	33%
Drinking indicators					
APC[b] (litres)	7.1	3.7	4.3	6.6	7.3
APC per drinker[b] (litres)	23.8	20.1	28.7	17.2	15.2
Abstainers (%)	70.3	81.7	84.9	61.7	52.1
Drinking by beverage types	Spirits 73%	Spirits 85%	Spirits 93%	Beers 97%	Spirits 64%
Written national alcohol policy	Yes	No	No	No	No
Respondents' characteristics					
N (aged 18–65)	1603	2286	3284	1447	1212
Mean age (years old)	44.0	38.3	37.8	42.2	40.4

Data sources: World Development Indicators 2014 by World Bank for country data and the WHO Global Status Report 2014 for drinking indicators.
[a] Gross National Income per capita in purchasing power parity of 2012 (US$ equivalent).
[b] Alcohol per capita consumption among total population (APC) and among drinkers (APC per drinker).

2010). Measuring the social consequences of alcohol misuse in general population surveys and from the perspective of the victim or those who were affected provides more complete data than is available from the registers of health and social agencies, yet has still not been widely undertaken, especially in low-and middle-income countries (LMICs) (Room, 2000). The issue is of increasing importance in many of these countries, since traditionally less alcohol was consumed in LMIC (though commonly in more risky ways). But this is changing, with substantial increases in consumption in many LMICs, particularly where economic conditions have improved (World Health Organization, 2014).

Research groups in high-income countries have begun to investigate these gaps in knowledge and revealed the substantial prevalence of harm from others' drinking (Casswell, Harding, You, & Huckle, 2011; Greenfield et al., 2009; Laslett et al., 2011). Pursuing this research agenda in LMICs, and providing a model to promote cross-national comparability in measurement, a WHO-ThaiHealth Research Protocol was developed to comprehensively measure alcohol's harm to others in particular societies. In a collaboration between the World Health Organization and the Thailand Health Promotion Foundation, a project implementing this protocol was undertaken by national investigators and staffs in seven LMICs (Rekve, Laslett, Room, Thamarangsi, & Waleewong, 2015).

This paper reports on part of the WHO-ThaiHealth research project, with a focus on harm from others' drinking-related aggression, violence and misconduct in Asian countries taking part in the project. The aims of this paper are to (1) to measure and compare the magnitude of five forms of harm from others' drinking-related aggression, violence and misconduct in five South and South-East Asian countries (Thailand, Sri Lanka, India, Lao, and Vietnam), as measured in probabilistic population surveys and (2) to examine relationships within countries between male and female respondents' experiences of harm according to their characteristics and drinking status. Further, we discuss relations between reported harm from others' drinking and the contexts of the five selected countries such as the level of economic development and level of drinking in the population, and address the implications of the study's findings.

Methods

Population surveys were undertaken in five LMICs in the Asian region. Thailand, Sri Lanka, India, Laos, and Vietnam were included in this study. Each employed the WHO-ThaiHealth Research Protocol mentioned above (Rekve et al., 2015). Ethical approval was gained in each country from the relevant local ethics committee, as well as for the WHO-ThaiHealth protocol as a whole from the World Health Organization Ethics Review Committee, and by the Eastern Health Research and Ethics Committee (LR51/1314) to collate and house the data at the Centre for Alcohol Policy Research in Australia.

Study design, sample design, and participants

Details about sampling and methods for data collection used in each country have been specified elsewhere (Callinan et al., 2016). In brief, a nationally representative probability adult sample was selected using a stratified multi-stage sampling technique in all countries except India. The sampling frames in each country differed according to local factors, modality and resources: in Thailand five provinces from five geographical regions were sampled, in Vietnam six provinces from six socio-economic regions, in Lao PDR three provinces from three geographical regions, and in Sri Lanka all nine provinces in the country. In India, a state-representative sample was obtained from the selected state (four regions in Karnataka State in southern India). At the village level, households were randomly sampled using the listing of all households in the village or the village map, and one eligible household member was randomly selected in sampled households to be interviewed. Different sites used different methods for probability selection; for example, Thailand used the Kish Grid method. All interviews were conducted face-to-face in local languages (using instruments in these languages previously back-translated to ensure comparability) by trained interviewers between 2012 and 2014. The analyses reported here included only respondents aged 18 to 65 years. The total number of respondents was 9832, with response rates between 93% and 99%. The high response rates, common for household surveys in LMICs, may reflect endorsement of participation or liaison with trusted locals such as village health workers or heads of villages and adoption of a minimum of 3 call-back visits that is often economically doable in LMIC settings, but may also reflect some substitution by interviewers of available for absent respondents. Table 1 shows details of the numbers and mean age of respondents from the surveys in each site.

Variables

Outcome variables

Operational definitions of the categories of harm from others' drinking-related aggression, violence and misconduct (Outcome variables) were developed for this study. This study defined harm from others' drinking-related aggression, violence and misconduct based on the UN International Classification of Crime for Statistical Purposes