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Letters to the Editor

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ALCOHOL MARKETING AND YOUTH DRINKING IN ASIA

Recently, Jernigan *et al.* [1] pointed to alcohol marketing as a facilitator of alcohol-related harms to youth, with controls on the marketing often insufficient. However, most of the relevant studies have been in western countries, and the role of alcohol marketing, youth drinking and alcohol-related harms in Asia is rarely discussed.

Asian countries such as China, India, Laos, Thailand and Vietnam have been targeted by global alcohol corporations as emerging alcohol markets in recent decades [2]. A recent report by Canadean shows that Asia has become the fastest-growing alcohol market, with more than 30% of global alcohol sales in 2014 and an estimated increase of 176% from 2000 to 2019 [3]. This dramatic increase was associated with substantial rates of health and social harms in young people [4]. The Global Burden of Disease Study 2015 found that nearly 50 000 deaths and 3.9 million disability-adjusted life years were attributable to alcohol use among Asian youth aged 18–24 years [5].

Several Muslim-majority countries in Asia (e.g. Malaysia, Indonesia and Iran) have implemented a total ban on alcohol advertising and sales promotions, and China, Thailand and Vietnam have implemented a partial ban. However, many countries have not had any alcohol advertising regulations (e.g. Japan and Laos) [6]. Moreover, regulations in Asian countries still have many loopholes in marketing, monitoring and regulation; for instance, on digital marketing and sponsorship. Problematic promotional campaigns are common; for instance, wine and rice spirits are promoted as being good for health in China, Japan and South Korea [7]. In contrast, although alcoholic beverages can be advertised in print media and cinemas in Malaysia, alcohol advertising is fully banned on broadcast media [8]. A review report argues that it has been difficult to regulate alcohol advertising on social media in many Asia countries, and that alcohol brands also adopt viral marketing strategies to promote their products via the internet, social networking websites, e-mails and text messages to consumers. Young people are the main targets in this marketing strategy [8]. Alcohol companies are sponsors of major music and sports events where youth are heavily involved, sponsoring the International Music Summit in China, the Japanese team in the Olympics and World Cup soccer. British and Thai football teams are sponsored by Thai alcohol companies [9]. While Sri Lanka, Mongolia, some Indian states and Muslim countries have control on alcohol sponsorship, most Asian countries do not [6].

At the international level, the pressure has been to reduce rather than strengthen restrictions on alcohol advertising and promotion, using the World Trade Organization (WTO) dispute settlement system [10] or by raising specific trade concerns about alcohol regulations to the WTO Technical Barriers to Trade committee [11]. Current free trade agreements take little account of alcohol-related harms, allowing heavier marketing; the results have been sky-rocketing alcohol imports in some Asian countries such as Thailand and China [12,13]. Reducing the harmful use of alcohol as a public health aim needs to be taken into account in new international trade agreements involving Asia.

Declaration of interests

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POTENTIAL IMPACT OF EXPOSURE DEFINITION WHEN EXAMINING NON-MEDICAL USE OF PRESCRIPTION OPIOIDS AMONG US VETERANS

In the recent paper by Banerjee *et al.* [1], the authors explored the non-medical use of prescription opioids and heroin initiation among US veterans. This was an insightful paper, given the current concern about prescription opioid use in the United States and its potential consequences; however, we were concerned by the definition of non-medical use used within this study. In the first two waves of the survey, non-medical use was defined as 'any use of prescription opioids' in the past 12 months. This is not a clear definition of non-medical use, because it could also be interpreted as medical use. Although the Limitations section acknowledged this possibility, the solution to adjust for receipt of an opioid prescription does not seem to address this issue. It is known that non-medical use can arise from use of a patient's own prescription in a way other than prescribed, e.g. by using higher doses, and that those with valid prescriptions may also be obtaining prescription opioids through other sources [2–4]. There is no consideration of this limitation in the paper, so the extent of the impact is unclear and could affect the conclusions of the study.

One potential way to explore the extent of this limitation would be to conduct a sensitivity analysis using data from the last three waves of the survey only. In these waves, non-medical use was defined as use of 'any prescription pain reliever that was not prescribed for you or that you took only for the experience or feeling that it caused'. This definition is more consistent with the literature, and comparing the results from the last three waves alone to all five waves would reveal if the association with heroin use remains consistent despite the discrepant definitions.

Did the authors consider conducting a sensitivity analysis using data from the last three waves only? We believe this is an important question to consider, given the conclusion of the study that: 'New-onset non-medical use of prescription opioids (NMUPO) is a strong risk factor for heroin initiation among HIV-infected and uninfected veterans in the United States who reported no previous history of NMUPO or illicit opioid use'.

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