Education Department

2017 Kit

World Woman's Christian Temperance Union

This educational kit provides opportunities for every adult and child to know the facts about fetal alcohol spectrum disorder, domestic violence, alcohol, tobacco, and illegal drugs; to use every available setting - home, school, church, community organizations to accomplish this goal. A basic list of projects for this department is given below. Use the interests and creativity of your members to add other projects but use the purpose of each department as a guide for the correct placement of the projects.

Sarah Oh, World Director
sarahoh@yuhs.ac

Introduction

Purpose:

The purpose of the Education Department is to make the facts about alcohol, tobacco, and illegal drugs known to everyone and to offer contests to further this effort.

Have a 10 - 15 minute lesson on alcohol, tobacco, or other drugs at each meeting so your members will be well-informed and up-to-date on the facts. Try to obtain a teacher or member who is skilled at presenting information in an interesting way to present these lessons. **Try to memorize at least five interesting facts from this booklet (statistics included)!**

1. Uses DVDs, power points, demonstrations, charts, fact sheets, and quizzes at the meetings to enhance learning.
2. Distribute drug-prevention literature to churches, teachers, mothers, health workers, doctors' offices, and public places such as libraries, shopping centers, etc.
3. Use bulletin boards or other display areas to promote the WCTU message of total abstinence, particularly on specially-designated days such as FAS Awareness Day.
4. Hold contests for children and youth including picture coloring, essay, poster, and speech.
5. **Read up on the latest literature about the harms of alcohol, tobacco, and other drugs.** Good websites to employ as starting points include:

http://www.jsad.com/

http://www.drugfree.org/

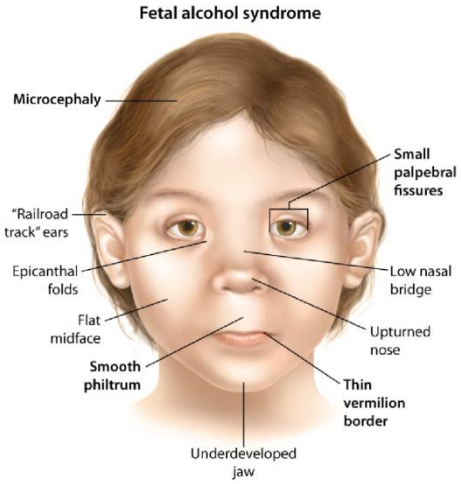
http://www.who.int/topics/en/.

Contents

Fetal Alcohol Spectrum Disorder (FASD)

◆ What is Fetal Alcohol Syndrome?

The most notable features of fetal alcohol syndrome involve the face and eyes, and include microcephaly, short palpebral fissures, an underdeveloped philtrum and a thin upper lip.



Evidence of intrauterine or postnatal growth retardation, mental retardation or other neurologic abnormalities, and at least two of the typical facial features are necessary to make the diagnosis. Newborns with the syndrome may be irritable, with hypotonia, severe tremors and withdrawal symptoms. Mild mental retardation, the most common and serious deficit, and a variety of other anomalies may accompany fetal alcohol syndrome. Sensory deficits include optic nerve hypoplasia, poor visual acuity, hearing loss, and receptive and expressive language delays. Atrial and ventricular septal defects, as well as renal hypoplasia, bladder diverticula and other genitourinary tract abnormalities, may occur. Complete abstinence during pregnancy is recommended, since alcohol consumption in each trimester has been associated with abnormalities, and the lowest innocuous dose of alcohol is not known (Lewis and Woods, 1994).

◆ Paternal Contribution to Fetal Alcohol Syndrome

While it is possible that drinking fathers contribute to a wide variety of anomalies in offspring only because of 'social facilitation' (i.e. mothers drink more when in the company of men who drink heavily), there is also a growing body of preclinical evidence, reviewed in the next section, indicating that many of the other effects associated with maternal alcohol exposure are also the result of paternal alcohol exposure.

Epidemiological Studies

Epidemiologically, paternal alcohol consumption has been associated with abnormalities in offspring, such as decreases in birth weight and increases in ventricular septal defects in children — effects which are typically associated with maternal alcohol exposure. In addition, there is also suggestive evidence that hyperactivity and diminished cognitive abilities in some children are related biologically to an alcoholic father rather than to an adoptive alcoholic

father. Despite these suggestive relationships, very little epidemiological research has been directed at this issue.

Paternal alcohol effects in animals: body and organ weights

Recent studies indicate that paternal alcohol exposure can result in an increase in the percentage of fetuses with the human equivalent of low birth weight. For example, a study by Wayne State University's Department of Obstetrics and Gynecology and Psychology has found an increase in the number of 'runts,' defined as individual birth weights two or more standard deviations below the mean for ad libitum control fetuses, as well as an increase in the percentage, not necessarily in 'runts,' of offspring with physical malformations, in animals whose fathers were treated with alcohol. These effects were associated with both acute and long-term alcohol treatments of adult males. These outcomes occurred when the data were analyzed on the basis of total population (total of runts and anomalies) and on the basis of litters (proportion of fetuses affected in each litter).

Organ weights and physiological effects

Other studies have found offspring of animals whose fathers were treated for several weeks with alcohol prior to breeding, have increased adrenal weights at birth, decreased spleen weights at weaning, decreased testosterone levels at sexual maturity, various behavioral effects and an increased susceptibility to Pseudomonas bacterial infection. In the latter case, the increased susceptibility was almost identical in severity to that of animals whose mothers consumed alcohol during pregnancy. The implication is that both short- and long-term treatments can affect offspring, but perhaps in different ways due to different biological mechanisms.

Behavioral effects

Hyperactivity. In the 'open-field', hyperactivity is one of the more robust effects of both maternal and paternal alcohol exposure in rats. This effect in paternally alcohol-exposed animals is strain-dependent, occurring in Sprague-Dawley rather than Long-Evans rats or mice. This increased activity may be the animal counterpart to the hyperactivity seen in children with FAS and ARBDs mentioned earlier.

Learning/memory deficits. In a variety of learning tasks, learning/memory deficits have often been reported in animals prenatally exposed to alcohol. Rats sired by alcohol-treated fathers also have greater difficulty in certain learning tasks (e.g. passive avoidance). One explanation for the difficulty of learning a passive avoidance task is that the same result that causes rats to be more active in the open-field also causes them to be more active in the passive avoidance situation. This escape response is maladaptive in passive avoidance and results in an

increased number of trials to criterion. Deficits in spatial learning have also been noted in rats sired by alcohol-treated fathers.

***Hyperresponsiveness to stressors*.** Children with FAS cope poorly in stressful situations. Results of testing in animals prenatally exposed to alcohol have corroborated these clinical observations and suggest that prenatal exposure to alcohol results in increased stress responsiveness mediated by enhanced corticosterone responses to stressors. Some of the abnormal behaviors of animals sired by alcohol-treated fathers can also be interpreted as exaggerated responses to stress. One such behavioral situation is the forced swim test, which we have studied in some detail. In this test, rats prenatally exposed to alcohol and those sired by alcohol-treated fathers41 exhibited decreased immobility (an indication of greater 128 Ernest L. Abel stress) in the forced swim test compared with controls.

Source: http://onlinelibrary.wiley.com/doi/10.1080/13556210410001716980/epdf

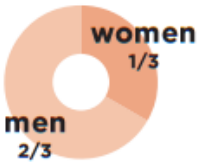
Alcohol and health

World Health Organization

3.3 million deaths every year

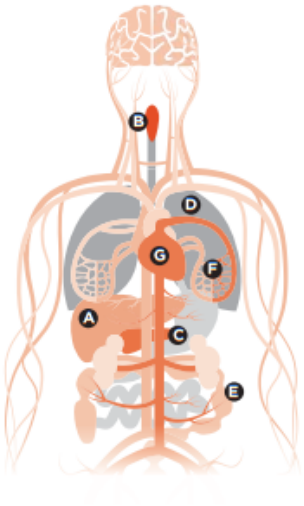
6 deaths every minute

from harmful use of alcohol



Harmful use of alcohol causes

- **100%** of fetal alcohol syndrome
- **100%** of alcohol use disorders
- **22%** of suicides
- **22%** of interpersonal violence
- **15%** of traffic injuries



- **A 50%** of liver cirrhosis
- **B 30%** of mouth and throat cancers
- **C 25%** of pancreatitis
- **D 12%** of tuberculosis
- **E 10%** of colorectal cancer
- **F 8%** of breast cancer
- **G 8%** of heart disease

Reduce harmful use of alcohol

Best buy interventions

- **Regulate availability**
- **Restrict advertising**
- **Use pricing policies**

More key interventions

Prevent and treat alcohol use disorders

Raise awareness of alcohol-attributable health burden

Support community action to prevent and reduce the harmful use of alcohol

Provide consumer information on alcohol containers

Regulate informally produced alcohol

Implement drink-driving policies

Develop surveillance systems for alcohol consumption, health consequences and policy

10% reduction in the harmful use of alcohol by 2020

Alcohol

Introduction

Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. The harmful use of alcohol causes a large disease, social and economic burden in societies. Environmental factors such as economic development, culture, availability of alcohol and the level and effectiveness of alcohol policies are relevant factors in explaining differences and historical trends in alcohol consumption and related harm.

Alcohol-related harm is determined by the volume of alcohol consumed, the pattern of drinking, and, on rare occasions, the quality of alcohol consumed. The harmful use of alcohol is a component cause of more than 200 disease and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers and injuries. The latest causal relationships established are those between alcohol consumption and incidence of infectious diseases such as tuberculosis and HIV/AIDS.

A wide range of effective global, regional and national policies and interventions are in place to reduce the harmful use of alcohol, with a promising trend over the past few decades.

Alcohol Consumption:

- Worldwide consumption in 2010 was equal to 6.2 liters of pure alcohol consumed per person aged 15 years or older, which translates into 13.5 grams of pure alcohol per day.
- A quarter of this consumption (24.8%) was unrecorded, i.e., homemade alcohol, illegally produced or sold outside normal government controls. Of total recorded alcohol consumed worldwide, 50.1% was consumed in the form of spirits.
- Worldwide 61.7% of the population aged 15 years or older (15+) had not drunk alcohol in the past 12 months. In all WHO regions, females are more often lifetime abstainers than males. There is a considerable variation in prevalence of abstention across WHO regions.
- Worldwide about 16.0% of drinkers aged 15 years or older engage in heavy episodic drinking.
- In general, the greater the economic wealth of a country, the more alcohol is consumed and the smaller the number of abstainers. High-income countries have

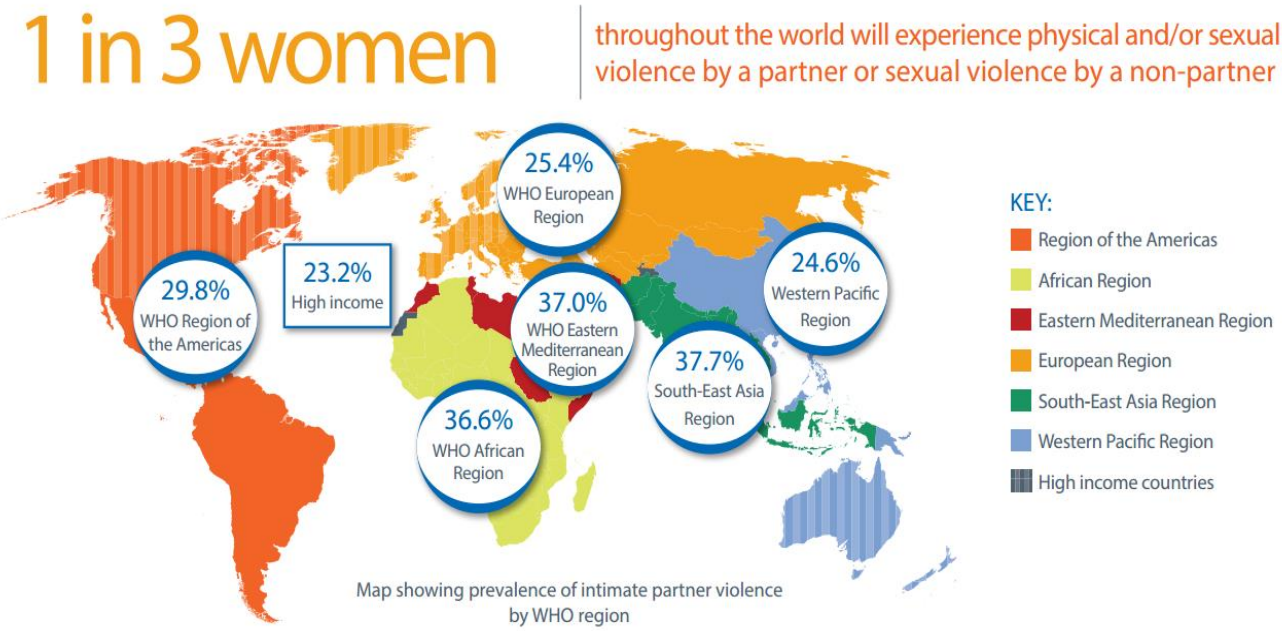
the highest alcohol per capita consumption (APC) and the highest prevalence of heavy episodic drinking among drinkers.

- **Health Consequences**
  - In 2012, about 3.3 million net deaths, or 5.9% of all global deaths, were attributable to alcohol consumption.
  - There are significant sex differences in the proportion of global deaths attributable to alcohol, for example, in 2012 7.6% of deaths among males and 4% of deaths among females were attributable to alcohol.
  - In 2012 139 million net DALYs (disability-adjusted life years), or 5.1% of the global burden of disease and injury, were attributable to alcohol consumption.
  - There is also wide geographical variation in the proportion of alcohol-attributable deaths and DALYs, with the highest alcohol-attributable fractions reported in the WHO European Region.

- **Policies and Interventions**
  - Alcohol policies are developed with the aim of reducing harmful use of alcohol and the alcohol-attributable health and social burden in a population and in society. Such policies can be formulated at the global, regional, multinational, national and subnational level.
  - Delegations from all 193 Member States of WHO reached consensus at the World Health Assembly in 2010 on a WHO Global strategy to reduce the harmful use of alcohol.
  - Many WHO Member States have demonstrated increased leadership and commitment to reducing harmful use of alcohol over the past years.
  - A significantly higher percentage of the reporting countries indicated having written national alcohol policies and imposing stricter blood alcohol concentration limits in 2012 than in 2008.

Source: http://www.who.int/topics/alcohol_drinking/en/

Domestic Violence



- **Key Facts:**
  - Violence against women - particularly intimate partner violence and sexual violence - are major public health problems and violations of women's human rights.
  - Recent global prevalence figures indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.
  - Globally, as many as 38% of murders of women are committed by an intimate partner.
  - Violence can negatively affect women's physical, mental, sexual and reproductive health, and may increase vulnerability to HIV.
  - Factors associated with increased risk of perpetration of violence include low education, child maltreatment or exposure to violence in the family**, harmful use of alcohol**, attitudes accepting of violence and gender inequality.

- There is evidence from high-income settings that school-based programs may be effective in preventing relationship violence (or dating violence) among young people.
- In low-income settings, primary prevention strategies, such as microfinance combined with gender equality training and community-based initiatives that address gender inequality and relationship skills, hold promise.

◆ Introduction

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Intimate partner violence refers to behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviors.

Sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object."

BOX 1: Extent of intimate partner violence

Most reported intimate partner violence is perpetrated by men towards women *(1)*. However, violence is also committed by women towards men *(2)* and within same sex relationships *(3)*. Variations in methodologies and definitions of violence between surveys make the extent of intimate partner violence and differences between countries hard to estimate. However, the *WHO multi-country study on women's health and domestic violence against women (4)*, one of the few studies to report comparable data, shows that between 15% (Japan) and 71% (Ethiopia) of women reported experiencing physical and sexual violence by an intimate partner over their lifetime, and between 3.8% (Japan) and 53% (Ethiopia) as experiencing such violence within the past year. In a survey of 24,000 men and women in Canada, 7% of women and 6% of men reported having been victims of intimate partner violence in the last five years *(5)*.

◆ Scope of the Problem

Population-level surveys based on reports from victims provide the most accurate estimates of the prevalence of intimate partner violence and sexual violence in non-conflict settings. The first report of the "WHO Multi-country study on women's health and domestic violence against women" (2005) in 10 mainly low- and middle-income countries found that, among women aged 15-49:

- between 15% of women in Japan and 71% of women in Ethiopia reported physical and/or sexual violence by an intimate partner in their lifetime;
- between 0.3–11.5% of women reported sexual violence by someone other than a partner since the age of 15 years;
- the first sexual experience for many women was reported as forced – 17% of women in rural Tanzania, 24% in rural Peru, and 30% in rural Bangladesh reported that their first sexual experience was forced.

A more recent analysis of WHO with the London School of Hygiene and Tropical Medicine and the Medical Research Council, based on existing data from over 80 countries, found that globally 35% of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Most of this violence is intimate partner violence. Worldwide, almost one-third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner, in some regions this is much higher. Furthermore, globally as many as 38% of all murders of women are committed by intimate partners.

Intimate partner and sexual violence are mostly perpetrated by men against women. Child sexual abuse affects both boys and girls. International studies reveal that approximately 20% of women and 5–10% of men report being victims of sexual violence as children. Violence among young people, including dating violence, is also a major problem.

◆ Risk Factors

Factors associated with intimate partner and sexual violence occur at individual, family, community and wider society levels. Some factors are associated with being a perpetrator of violence, some are associated with experiencing violence and some are associated with both.

1. **Risk factors for both intimate partner and sexual violence include:**

- lower levels of education (perpetration of sexual violence and experience of sexual violence);
- exposure to child maltreatment (perpetration and experience);
- witnessing family violence (perpetration and experience);
- antisocial personality disorder (perpetration);
- harmful use of alcohol (perpetration and experience);
- having multiple partners or suspected by their partners of infidelity (perpetration); and
- attitudes that are accepting of violence and gender inequality (perpetration and experience).

2. **Factors specifically associated with intimate partner violence include:**
   - past history of violence;
   - marital discord and dissatisfaction;
   - difficulties in communicating between partners.
3. **Factors specifically associated with sexual violence perpetration include:**
   - beliefs in family honor and sexual purity
   - ideologies of male sexual entitlement and
   - weak legal sanctions for sexual violence.

◆ **Health Consequences**

Intimate partner and sexual violence have serious short- and long-term physical, mental, sexual and reproductive health problems for survivors and for their children, and lead to high social and economic costs.

- Violence against women can have fatal results like homicide or suicide.
- It can lead to injuries, with 42% of women who experience intimate partner violence reporting an injury as a consequence of this violence.

- Intimate partner violence and sexual violence can lead to unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV. The 2013 analysis found that women who had been physically or sexually abused were 1.5 times more likely to have a sexually transmitted infection and, in some regions, HIV, compared to women who had not experienced partner violence. They are also twice as likely to have an abortion.
- Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies.
- These forms of violence can lead to depression, post-traumatic stress disorder, sleep difficulties, eating disorders, emotional distress and suicide attempts. The same study found that women who have experienced intimate partner violence were almost twice as likely to experience depression and problem drinking. The rate was even higher for women who had experienced non partner sexual violence.
- Health effects can also include headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health.
- Sexual violence, particularly during childhood, can lead to increased smoking, drug and alcohol misuse, and risky sexual behaviors in later life. It is also associated with perpetration of violence (for males) and being a victim of violence (for females).

◆ Impact on Children

Children who grow up in families where there is violence may suffer a range of behavioral and emotional disturbances. These can also be associated with perpetrating or experiencing violence later in life. Intimate partner violence has also been associated with higher rates of infant and child mortality and morbidity (e.g. diarrheal disease, malnutrition).

◆ Social and Economic Costs

The social and economic costs of intimate partner and sexual violence are enormous and have ripple effects throughout society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children.

- **Prevention and Response**

Currently, there are few interventions whose effectiveness has been proven through well designed studies. More resources are needed to strengthen the prevention of intimate partner and sexual violence, including primary prevention, i.e. stopping it from happening in the first place.

Regarding primary prevention, there is some evidence from high-income countries that school-based programs to prevent violence within dating relationships have shown effectiveness. However, these have yet to be assessed for use in resource-poor settings. Several other primary prevention strategies: those that combine microfinance with gender equality training; that promote communication and relationship skills within couples and communities; that reduce access to, and harmful use of alcohol; and that change cultural gender norms, have shown some promise but need to be evaluated further.

To achieve lasting change, it is important to enact legislation and develop policies that:

- address discrimination against women;
- promote gender equality;
- support women; and
- help to move towards more peaceful cultural norms.

An appropriate response from the health sector can play an important role in the prevention of violence. Sensitization and education of health and other service providers is therefore another important strategy. To address fully the consequences of violence and the needs of victims/survivors requires a multi-sectoral response.

Source: http://www.who.int/topics/gender_based_violence/en/

GET READY FOR PLAIN PACKAGING

No logos, colours, brand images or promotional information

Pack surfaces in a standard colour

Brand and product names in a standard colour and font

Graphic health warnings used in conjunction with plain packaging

- Reduce attractiveness of tobacco packaging
- Eliminate tobacco advertising and promotion
- Limit deceptive tobacco packaging
- Increase effectiveness of tobacco health warnings

World Health Organization

31MAY: WORLD **NOTOBACCO** DAY

www.who.int/world-no-tobacco-day #NoTobacco

Tobacco

Introduction

The tobacco epidemic is one of the biggest public health threats the world has ever faced, killing around 6 million people a year. More than 5 million of those deaths are the result of direct tobacco use while more than 600 000 are the result of non-smokers being exposed to second-hand smoke.

Nearly 80% of the more than 1 billion smokers worldwide live in low- and middle-income countries, where the burden of tobacco-related illness and death is heaviest.

Tobacco users who die prematurely deprive their families of income, raise the cost of health care and hinder economic development.

In some countries, children from poor households are frequently employed in tobacco farming to provide family income. These children are especially vulnerable to "green tobacco sickness", which is caused by the nicotine that is absorbed through the skin from the handling of wet tobacco leaves.

Surveillance is key

Good monitoring tracks the extent and character of the tobacco epidemic and indicates how best to tailor policies. Only 1 in 3 countries, representing one third of the world's population, monitors tobacco use by repeating nationally representative youth and adult surveys at least once every 5 years.

Second-hand smoke kills

Second-hand smoke is the smoke that fills restaurants, offices or other enclosed spaces when people burn tobacco products such as cigarettes, *bidis* and water-pipes. There are more than 4000 chemicals in tobacco smoke, of which at least 250 are known to be harmful and more than 50 are known to cause cancer.

There is no safe level of exposure to second-hand tobacco smoke.

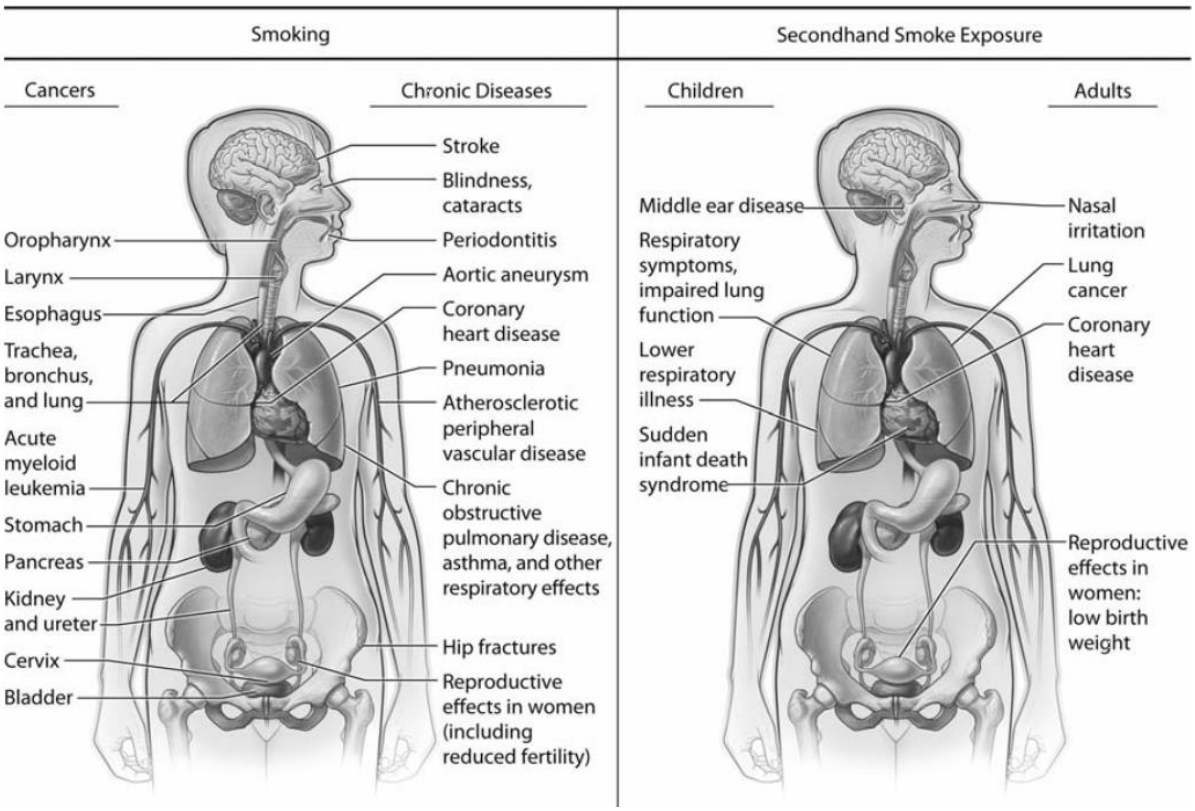
- In adults, second-hand smoke causes serious cardiovascular and respiratory diseases, including coronary heart disease and lung cancer. In infants, it causes sudden death. In pregnant women, it causes low birth weight.
- Almost half of children regularly breathe air polluted by tobacco smoke in public places.
- Second-hand smoke causes more than 600 000 premature deaths per year.

- In 2004, children accounted for 28% of the deaths attributable to second-hand smoke.

Every person should be able to breathe tobacco-smoke-free air. Smoke-free laws protect the health of non-smokers, are popular, do not harm business and encourage smokers to quit.

Over 1.3 billion people, or 18% of the world's population, are protected by comprehensive national smoke-free laws.

Diseases caused by smoking and exposure to second-hand smoke



- **Tobacco users need help to quit**

Studies show that few people understand the specific health risks of tobacco use. For example, a 2009 survey in China revealed that only 38% of smokers knew that smoking causes coronary heart disease and only 27% knew that it causes stroke.

Among smokers who are aware of the dangers of tobacco, most want to quit. Counseling and medication can more than double the chance that a smoker who tries to quit will succeed.

National comprehensive cessation services with full or partial cost-coverage are available to assist tobacco users to quit in only 24 countries, representing 15% of the world's population.

There is no cessation assistance of any kind in one quarter of low-income countries.

- **Picture warnings work**

Hard-hitting anti-tobacco advertisements and graphic pack warnings – especially those that include pictures – reduce the number of children who begin smoking and increase the number of smokers who quit.

Graphic warnings can persuade smokers to protect the health of non-smokers by smoking less inside the home and avoiding smoking near children. Studies carried out after the implementation of pictorial package warnings in Brazil, Canada, Singapore and Thailand consistently show that pictorial warnings significantly increase people's awareness of the harms of tobacco use.

Only 42 countries, representing 19% of the world's population, meet the best practice for pictorial warnings, which includes the warnings in the local language and cover an average of at least half of the front and back of cigarette packs. Most of these countries are low- or middle-income countries.

Mass media campaigns can also reduce tobacco consumption by influencing people to protect non-smokers and convincing youths to stop using tobacco.

Over half of the world's population live in the 39 countries that have aired at least 1 strong anti-tobacco mass media campaign within the last 2 years.

- **Ad bans lower consumption**

Bans on tobacco advertising, promotion and sponsorship can reduce tobacco consumption.

- A comprehensive ban on all tobacco advertising, promotion and sponsorship could decrease tobacco consumption by an average of about 7%, with some countries experiencing a decline in consumption of up to 16%.
- Only 29 countries, representing 12% of the world's population, have completely banned all forms of tobacco advertising, promotion and sponsorship.
- Around 1 country in 3 has minimal or no restrictions at all on tobacco advertising, promotion and sponsorship.

◆ **Taxes discourage tobacco use**

Tobacco taxes are the most cost-effective way to reduce tobacco use, especially among young and poor people. A tax increase that increases tobacco prices by 10% decreases tobacco consumption by about 4% in high-income countries and about 5% in low- and middle-income countries.

Even so, high tobacco taxes is a measure that is rarely implemented. Only 33 countries, with 10% of the world's population, have introduced taxes on tobacco products so that more than 75% of the retail price is tax. Tobacco tax revenues are on average 269 times higher than spending on tobacco control, based on available data.

Source: http://www.who.int/mediacentre/factsheets/fs339/en/