

Guide to the modules:
**Training Program on Evidence-Based
Alcohol Policies in Developing Countries**





Many African countries are not prepared to fight effectively against problems that are created by the availability of alcohol.

To prevent these problems is even more challenging. In every society, easy available alcohol should be apposed by a strong national and local policy.

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This Training Program on Evidence-Based Alcohol Policies in Developing Countries has been developed for use in multiple settings in the African region. The contents of these training modules are based on internationally recognized research. This evidence base provides clear guidance to formulate effective interventions that will prevent alcohol-related harm.

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We also extend our gratitude towards the World Health Organization's AFRO office. Working for national policy changes as well as crafting new policy is a challenging task and such work at the national level depends deeply on the support of WHO AFRO. We have also been fortunate to have had the assistance of a highly skilled Reference Group for the training program, which has ensured high academic standards and enabled access to the most up-to-date research. The members of this group are involved in research and policy work all over the world, and have contributed to the content of the training modules. Professor Isidore Obot, Dr Neo Morojele and Dr. Joanne Corrigan have contributed considerably as trainers in some of the three-day training seminars, and Mr. George Hacker has given key input to this guide to the modules. We are very grateful both for their contribution and for that of the other Reference Group members. Last, but not least, we appreciate the warm welcome we have received in the countries in which we have worked. It is you, the national stakeholders, who are the ones who must carry this work forward and advocate and contribute towards the implementation of an efficient alcohol policy. Without you our efforts would be futile.

We do hope this module overview will assist you in your very important work. Should you have any questions, please do not hesitate to get in touch with any of us.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANOC	Alcohol No Ordinary Commodity
BAC	Blood Alcohol Content
CSR	Corporate Social Responsibility
DALYs	Disability Adjusted Life Years
HIV	Human immunodeficiency virus
ICAP	International Centre for Alcohol Policies
IFBC	International Federation of the Blue Cross
MAMPA	Monitoring Alcohol Marketing in Africa project
NGO	Non-governmental organization
PPT	Power Point Presentation
PSA	Public service announcements
RBT	Random Breath Testing
WHA	World Health Assembly
WHO	World Health Organization
WHO AFRO	World Health Organization's regional office in Africa



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INTRODUCTION

In many developing countries alcohol imposes a heavy burden on health and socioeconomic development. As incomes – and alcohol consumption – rise in the future, the role of alcohol problems in developing countries is expected to become even more important. For that reason, it is vital that alcohol problems be addressed in the context of development initiatives. In 2010 the World Health Organization (WHO) endorsed a Global Strategy to Reduce the Harmful Use of Alcohol, which highlighted strong evidence behind effective policy interventions to reduce alcohol harm.

The alcohol industry routinely develop and implement business and political strategies in host countries that often ignore public health concerns in pursuit of profit. Those strategies seek to avoid legal and social interventions that evidence shows will lead to eliminating or reducing the sale of their products. Producers, distributors, and retail vendors generally do not support effective alcohol policies; they distort and misinterpret the guidance offered in WHO's Global Strategy to Reduce the Harmful Use of Alcohol; and lobby aggressively against effective public health measures at all levels of government. Consequently, their actions fail to contribute to the prevention or reduction of the harmful use of alcohol in any meaningful way, and may do more harm than good. This threat to public health is what motivated Blue Cross Norway and FORUT to launch the Training Program on Evidence-Based Alcohol Policies.

Starting in 2009, Blue Cross Norway, in cooperation with the International Blue Cross (IFBC) and FORUT has provided training for motivated NGO leaders, politicians, government staff, and media in selected developing countries. That training has equipped participants to advocate and mobilize for a more comprehensive alcohol policy (including control mechanisms such as availability, price, age restriction, and drink-driving interventions) within their country's specific socioeconomic-situation. The project has so far focused on selected countries in Africa and trainings have taken place in Botswana, Malawi, Namibia, Chad, Lesotho, Madagascar and Zambia.

This guide to the modules of the training reflects the content and messages delivered in the trainings. It can serve as a continuing resource for conducting refresher training for former participants in the trainings. Moreover, we have organized the guide so that it can be a useful tool and a source for information for those who have not attended the training themselves. When sufficiently contextualized and adapted to local circumstances, this material will apply in all parts of the world.

Blue Cross Norway, established in 1906, is a non-denominational Christian organization that offers prevention, treatment

and aftercare/rehabilitation services to people suffering from substance abuse. Management of the Training Program on Evidence-Based Alcohol Policies is headquartered at Blue Cross Norway's offices in Oslo, Norway. In addition to this program, Blue Cross Norway also runs projects in prevention and treatment in Lesotho, South-Africa and Russia. Blue Cross Norway is a member of the International Blue Cross. FORUT is a Norwegian development organization established in 1981. FORUT has project activities in Sri Lanka, Nepal, India, Sierra Leone and Malawi. The organization has four program areas, all tied to development: Alcohol, Drugs and Development (ADD), Child Rights, Gender Equality and Women's Rights, and Crises Response and Recovery. FORUT assists Blue Cross Norway in the implementation of the Training Program by providing technical input and training capacity in some of the trainings.

It is important to stress that Blue Cross Norway, FORUT and all persons and organizations involved with the development and implementation of this training program are free from conflict of interest, and thus have no links, including financial, with any part of the alcohol industry.

Given the stakes for public health and safety and stable economic growth in developing countries, there is a well-documented need among relevant stakeholders for increased and accurate knowledge about evidence-based alcohol policies. Those stakeholders include government workers as well as NGO personnel. We hope that you will use this material and continue to contribute to increasing knowledge in this area, either through trainings or in other ways working to influence the process of developing an evidence-based alcohol policy in your country.



The training held in Namibia in 2010 hosted participants from several sectors. Cross-sector cooperation is key when developing and implementing comprehensive evidence-based alcohol policies. (Photo: D. Endal)

1. GETTING STARTED

This chapter will introduce the basic concepts and methodologies used in this training program. We recommend that you read this chapter first. Note that we have injected some repetition into the text to make it easier to read and use one module at a time. This chapter will introduce you to:

- The purpose, scope and contents of the training program
- Evidence-based alcohol policies
- Instructions on how to use this training package, and
- The suggested program for the three-day training on evidence-based alcohol policies.

1.1. THE PURPOSE, SCOPE AND CONTENTS OF THE TRAINING PROGRAM

This training program consists of several modules. The template for a three-day training groups the different modules in the following manner:

Day 1: Defining the problem.

Day 2: Addressing the problem.

Day 3 (half day): Using new won knowledge to find solutions to the defined problems; making concrete plans and assigning responsibilities on how to address the defined problems in the time following the training.

Although alcohol has been part of most societies for ages, the use of alcohol has been regulated by traditions, social norms and natural limitations. Too often, however, traditional types of alcohol use are implicated in alcohol problems in a village or urban setting. Alcohol problems can be associated with imported or domestically licensed products as well as legal or illegal home brews and homemade spirits. The introduction of new products and marketing strategies by alcohol producers designed to increase sales and attract new consumers in developing countries will no doubt create additional problems. At a time of rapid socio-cultural change and growing cultural globalization, increasing use of drugs and alcohol can be anticipated, unless effective preventive counter-measures are implemented. This has already been the experience in many developing societies. Therefore, taking into account the negative impact that increased consumption of alcohol has on individuals and society as a whole, current trends signal the need for timely interventions.

Even though evidence-based knowledge provides a solid basis for the formulation of effective policy and implementation of other interventions to prevent and reduce alcohol-related harm, this knowledge is often not widely available. The need to mobilize and train motivated NGO leaders, politicians, civil servants and media representatives to put them in a position to effectively and sustainably advocate for an evidence-based alcohol policy has never been greater. The best research indicates that an effective alcohol policy will include mechanisms to regulate the availability, price and marketing of alcoholic beverages, among other potential interventions.

Section 2 of this manual provides in-depth information about each of the training modules in this program. Each module explains its contents and the suggested methodology for how best to present it to others. The module also includes a suggested relevant curriculum.

While it is of course very useful for anyone involved with or interested in the prevention of alcohol-related harm/protection/public health issues to attend the actual training, we know that's not always possible. For that reason, this training package offers extensive guidance and material to instruct and inform anyone who takes the time to read through it. Any questions that arise can be directed to the authors of this package. Contact details can be found on page 4.

We sincerely hope that the use of this training package will assist you in the development or improvement of alcohol policies, be your work on a local, regional or national level. We encourage you to find ways to create change, and to act locally while thinking globally. The best way forward involves choosing a strategy that is best suited to your resources, capacity and objectives.

1.2. WHAT IS AN EVIDENCE-BASED ALCOHOL POLICY?

“Alcohol policy,” as a collective noun, refers to the set of measures in a jurisdiction or society aimed at minimizing the health and social harms from alcohol consumption. A national alcohol policy consists of a set of individual policies, strategies, and implementing actions.

A national alcohol policy is an authoritative decision on the part of governments that seeks to minimize or prevent alcohol-related harm in any way. Normally this written document identifies the desired outcomes that are sought through the adoption and implementation of the policy. The policy may include stated goals related to the use of alcohol and the prevention and treatment of abuse, including alcohol dependence. Those goals can best be reached by including specific strategies in the policy that effectively counter alcohol problems, such as

moderating high consumption by increasing taxes on alcohol and/or allocating resources to reflect priorities in prevention and/or treatment efforts. National policies on alcohol consumption can be complemented by the adoption of alcohol policies by businesses, schools, NGOs and other institutions.

In essence, public policy should be used to ensure a good quality of life for a country's citizens. An alcohol policy should specifically serve the interests of public health and social well-being. It should focus on containing and reducing the level of alcohol-related harm within a country.

Who will such a policy affect? An alcohol policy should contribute to the well-being of the whole population. However, in practical terms the population of drinkers in a society will be the most likely to be directly affected by the strategy. Specifically, high-risk drinkers, groups considered to be particularly vulnerable to the adverse effects of alcohol (e.g. adolescents), and persons who are already manifesting harmful drinking and alcohol dependence will be those whose alcohol consumption is most directly affected by the strategies chosen for an alcohol policy. Others who would benefit include persons who are affected by another's drinking.

An evidence-based policy is one that includes defined goals and strategies based on the foundation of sound research of effectiveness in helping to prevent or reduce alcohol-related problems. As will become clear throughout this training package, not all strategies are equally effective, and some of the most 'popular' strategies may be among the least effective. This distinction is an important point for policy makers, who should be basing (consistent with available resources and technical capabilities) their policy choices on sound research and evidence of what intervention strategies are most likely to make a lasting positive impact in a country.

An evidence-based approach is necessary to respect the pleasurable drinking of some, while carefully addressing the many problems associated with alcohol consumption that affect both individuals and the entire society. Solid evidence links alcohol consumption and some non-communicable diseases such as cirrhosis and some types of cancer; additionally, some evidence suggests a link between alcohol and the negative outcomes of diseases like tuberculosis and HIV/AIDS. Moreover, the 2011 Global Status Report on Alcohol and Health of the World Health Organization (WHO) clearly states that alcohol consumption not only can be harmful to the drinker through direct impact on the person's health, but also can threaten the well-being of others through the actions of intoxicated people. Examples include drink driving, interpersonal violence, and the potential harm to a fetus and child development associated with heavy drinking.

Global data tell a distressing story about the impact of alcohol

in many societies around the world. The results from the Global Burden of Disease study identified alcohol as the fifth leading risk factor for death and disability in 2010. Alcohol use accounts for 3.9% of disability adjusted life years (DALYs) lost. Globally, alcohol is the leading risk factor for death and disability among persons aged 15-49. Alcohol is also the leading risk factor for death and disability in large parts of the world, including Southern sub-Saharan Africa. The key factors include alcohol-related road traffic crashes, unintentional and intentional injuries, and alcohol's role in the spread of Tuberculosis. Had the study included the impact of alcohol on HIV/AIDS, the alcohol-attributable burden in this region would have been even higher. Alcohol is also associated with a number of social and economic issues such as violence, neglect and abuse of children, and absenteeism and loss of productivity in the workplace.

The development and implementation of an evidence-based alcohol policy can help prevent many of those consequences for individuals and society.

1.3. HOW TO USE THIS GUIDE TO THE MODULES

There is a well-documented need among relevant stakeholders in developing countries for additional, accurate information about the positive impact that the implementation of an efficient evidence-based alcohol policy will have in a country. Those stakeholders include people working for governments as well as NGOs.

This new knowledge will suit all parts of the world, provided that it is sufficiently contextualized and adapted to the local circumstances.

The Training program on evidence-based alcohol policies is module based. We have chosen this format to provide for flexibility in its use. On the one hand, the program's three-day training works well when the objective is to provide an instant kick-start for a policy process. However, because circumstances differ, it might sometimes be more appropriate – and sufficient – to present only one module or a half-day training in order to address a particular topic/challenge. Also, we know that not all policy work has to be at the national level with all stakeholders present. It can be equally important to train work colleagues, or youth and other relevant groups in the different topics that the modules address. The training could even be presented as a series, in which one module is addressed one night per week for as long as needed.

Tips for the trainer

In order to successfully run a training session you must be as well-prepared as possible. If you have already attended the three-day training program, you are already well-acquainted

with this material. However, it is always useful to review the suggested background material before beginning the presentation itself. It's also a good idea to keep abreast of the latest and current developments regarding alcohol-related harm, policy discussions, and the implementation of regulations, etc. Often, the decision to present a particular training session is a consequence of circumstances in your community or at a national and/or regional level. Your presentation will be far more engaging and relevant if you include current events and/or concerns in the discussion.

It is important to keep in mind that training participants may have different levels of knowledge about this topic. In order to have a successful training you must know your audience and adapt your presentation and chosen methodology to them!

We hope that you will use this material and continue to contribute to building knowledge about evidence-based alcohol policy, either by training others or by working in other ways to influence the policy process in your country.

Should you have any questions, feel free to contact any of us listed on page 4.



Learning about the most effective ways of preventing alcohol related harm, puts you in a good position to advocate for change. Here from a training in Lesotho in 2013. (Photo: T. Saether).

1.4. TEMPLATE PROGRAM FOR A THREE-DAY TRAINING

This training program is module based, you may choose to run just one module at a time, or present three in a half-a-day program. To provide maximum flexibility, the guide includes a template program for a three-day training. This design has proved to work well from a practical perspective, but more importantly to facilitate learning. Some changes may be necessary to accommodate the specific context of the training, including considerations of country, participants, level of existing knowledge, adequacy of training facilities, etc.

DAY 1 – Defining the problem.

09:00 – 10:15 Opening session

Welcome address by local organizer or/and government representative.

Opening address by host (if different from local organizer). Other protocol matters according to local traditions.

10:15 – 11:00 Presentation of program, participants and materials.

If time allows: Group photo

11:00 – 11:20 Tea/coffee break

11:20 – 12:15 “Real life” – alcohol problems as the participants see them

Group discussions (for proposed questions for groups, see chapter 2.1.2.).

12:15 – 13:00 Plenary presentation of conclusions from the groups

13:00 – 14:00 Lunch

14:00 – 14:45 Understanding the challenge

Presentation and PowerPoint followed by conversation between trainer and participants.

Optional: Show video clip from “Global Hangover”; Relevant time slot is 12:10- 15:00 Slums and bars in Uganda.

14:45 – 15:45 Alcohol-related harm in the host country

Presentation by local expert followed by plenary comments and questions.

15:45 – 16:00 Tea/coffee break

16:00 – 17:00 The Global Picture – the role of alcohol in a global context

Presentation and PowerPoint.

Optional: Show video clip from “Global Hangover”; Relevant time slot is 03:23 – 05:24 Street children/APSA, Bangalore

17:00 Adjourn for the day.

DAY 2- Addressing the problem

08:30 – 09:00 Reflections on day 1 by the participants

09:00 – 10:00 A comprehensive approach to the prevention of alcohol-related harm

Presentation and PowerPoint on:

- The prevention triangle
- The WHO Global and Regional Strategies for Reducing Harmful Drinking.

10:00 – 11:00 Existing policies and legislation in [host country]

Presentation by local expert

11:00 – 11:20 Tea/coffee break

11:20 – 13:00 Evidence-based policies to reduce alcohol-related harm

Presenting key findings, the “consumers’ guide”, from the book, *Alcohol: No Ordinary Commodity*.

PowerPoint presentation by an alcohol policy expert who is free from conflicts of interest.

13:00 – 14:30 Lunch

14:00 – 15:00 Evidence-based policies, continued

Group work and plenary discussions on selected evidence-based interventions.

(Interventions to be selected before the training, based on local realities and needs).

Tea/coffee break when time allows.

17:00 Adjourn for the day.

DAY 3 – Planning future steps.

The third day of the training should be structured to accommodate local circumstances, even more so than the two first days. This to ensure that work to revise/develop evidence-based alcohol policies will take place.

08:30 – 09:00 Reflections on day 2 by the participants

09:00 – 09:45 The role and goal of the alcohol industry in Africa

Presentation, PowerPoint, video clip, followed by comments, questions and plenary discussions.

09:45 – 11:00 The next steps: Identify national needs and plan activities for the coming months.

Group discussions and/or plenary session to discuss what should be done by the participants, individually and as a group after the training.

11:00 – 11:20 Tea Break

11:20 – 12:00 The next steps: Plenary presentation and discussion

12:00– 12:50 The way forward

Organizers summarize the training (Blue Cross, FORUT, national operator).

Evaluation (filling out evaluation forms).

12:50 – 13:00 Closing remarks by organizers

13:00 Lunch

14:00 End of Training Program



Dr. Neo Morojele from the South African Medical Research Council has substantial experience in research on how to best prevent the harmful use of alcohol. Here she is presenting on the evidence-base in the training in Lesotho in 2010. (Photo: T. Saether).



Discussions were lively in the training in Lesotho in 2010. This is good since it is important that all participants are heard in order to facilitate effective learning. (Photo: D. Endal).

2. THE TRAINING MODULES.

In this part of the guide we will introduce the different modules. The modules are categorized according to their themes. Because the modules have been developed to suit any situation, allowing a wide range from which to choose, you may find some repetition if you read all of them. Overall, the organization of the training modules follows the logic of the three-day training program. They describe:

- the current situation
- opportunities for positive change, and
- possible strategies and positive steps.

2.1. MODULES DESCRIBING THE CURRENT SITUATION

The objective of the modules within this thematic area is to ensure that the participants at the training develop an understanding of the magnitude, character and complexity of the alcohol problem at the global level and appreciate the different ways those challenges present themselves in developing societies. These sessions include brainstorming and asking participants to share their own experience and thoughts about the issue. This discussion creates “ownership” of the issue among the participants and emphasizes the point that the reduction of

alcohol-related harm is something that will benefit all members of society.

2.1.1. UNDERSTANDING THE CHALLENGE

The objective of this module is to give the participants an understanding of the complexity of the challenges related to alcohol and the development of alcohol policies. The module highlights the importance of using an evidence-based approach to policy and program development. Contents include:

- Introduction – the importance of knowledge
- The evidence base – what research can tell us about alcohol-related harm and effective prevention strategies, and
- Alcohol as a development issue.

The importance of knowledge

When discussing alcohol-related harm, it is quite common that participants in the training first point to drunkenness and focus especially on alcohol dependency. Those problems, although severe and important, rarely account for all alcohol problems within a society, and for that reason policy measures to counter alcohol problems need to address drinking throughout the

whole population. That is the key message communicated in this module: a public health approach. Essentially, taking this approach means that we look at the general population in a country when discussing harms from alcohol consumption. Importantly, it means that 'health' includes more than an individual's physical and mental well-being when consuming alcohol. Health also includes the effect that alcohol consumption has on other people's health and well-being, in particular whether one's drinking causes harm to others. The most effective measures to address these harms/problems are:

- Evidence-based (not all strategies we think of as effective really are)
- Knowledge based, and
- Experience based.

In most places, alcohol has always been a part of life. Its role in society has changed with time and place. Depending on the society, alcohol may be viewed as food, drug, and beverage and also as a revered cultural artifact with important symbolic meaning. Drinking alcohol often serves as a social lubricant and a means for socialization and enjoyment. Many have also come to believe, based on some evidence in developed countries, that light, regular consumption of alcohol may have health benefits. This is, however, only the case for people at risk such as older people and those recovering from a Myocardial Infarction. Most experts think it's too soon to recommend that people drink for their health, particularly because the risks of intoxication and dependence may be considerable and the benefit very low—if any – among those who are at highest risk for alcohol problems. The research suggests exercising extreme caution because alcohol is far from being an ordinary commodity.

The evidence-base

When developing alcohol policies, knowledge about the range of alcohol problems and the effectiveness of different strategies to prevent the negative effects is of the utmost importance. It is equally important to understand the ineffective strategies, because those are repeatedly promoted by the alcohol industry.

Other important elements that will strengthen the design of a public-health oriented alcohol policy include a thorough awareness of issues related to the production/sale/consumption of alcohol in the country or region of interest and the harm that results from its use. When referring to the evidence base, the principal resources for this guide include:

- *Alcohol: No Ordinary Commodity*
- *Global Health Risks*
- *Alcohol in Developing Societies: A Public Health Approach*
- *Global Status Report on Alcohol and Health*
- Selected articles (see suggested curriculum with each module and Chapter 3. Suggested Litterature).

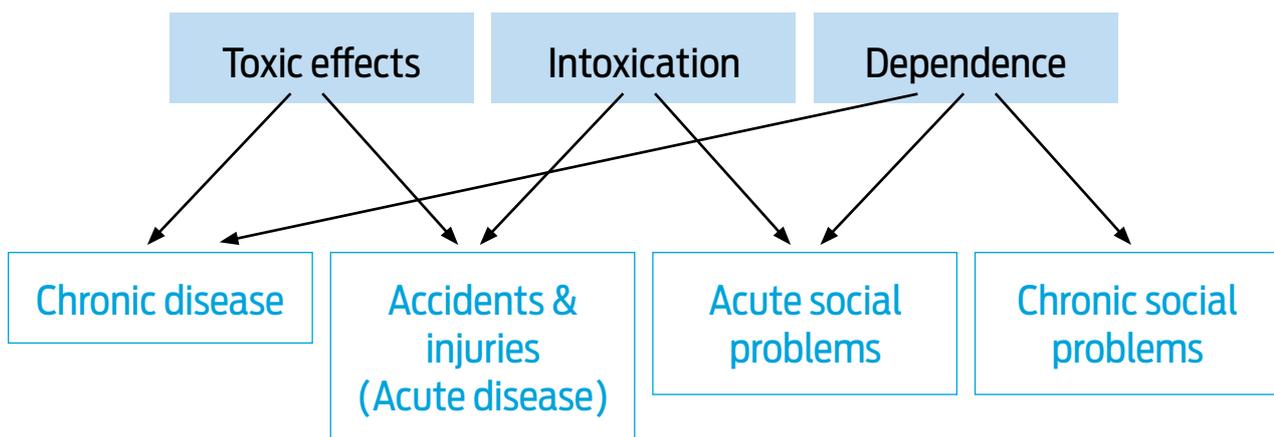
For more details on these, refer to the listing of the relevant material towards the end of this module.

What does this evidence-base teach us?

On the one hand, alcohol is of course a widely available commodity. Alcohol is produced in many ways and comes in many forms, which include home brew, industrially produced indigenous beverages, local industrial production of 'international' beverages, and branded international beverages. The latter are increasingly marketed on a global scale. Clearly, the production and sale of alcoholic beverages is an important economic activity in many places. Its production involves a highly developed and complex supply chain that employs many people and the taxes that are imposed on the beverages brings in substantial revenue to countries.

On the other hand, it is clear that alcohol is no ordinary commodity. The benefits that the production, sale and consumption of alcohol bring come at a very large cost to society, a cost that is (in many ways) shared by all. Over the last 30 years remarkable progress has been made in documenting this harm. Alcohol can be physically toxic, create intoxication, and lead to dependence; all of which contribute substantial harm.

See figure below:



The levels of and types of harms produced by alcohol consumption depend on three factors:

- Societal levels of consumption
- Consumption patterns (the way in which drinkers consume a certain volume of alcohol in a given timeframe), and
- Drunken behavior.

Some prefer to refer to the so-called wine-drinking countries to suggest that a pattern of moderate, regular drinking, for example wine with a meal, will avoid the negative effects of alcohol. Evidence suggests, however, that such drinking can lead to health problems, such as cirrhosis of the liver due to the cumulative effect of steady alcohol use. Of all products sold for general consumption, alcohol is the one commodity with the widest-ranging adverse physical effects.

In contrast, what is often referred to as “binge drinking” (drinking a lot within a short timeframe), can lead to alcohol poisoning and cardiac arrhythmias, impairment of psychomotor skills, lengthened reaction time and seriously impaired judgment. Such a drinking pattern may not only cause harm to the drinker, but also to the people around the drinker (victims of accidents/acts of violence and so forth). Heavy, episodic drinking can also cause other social harms, such as failure to fulfill family obligations, including support through work, and upholding an acceptable public demeanor. A drinker’s behavior when drunk can be influenced by existing cultural norms of acceptable behavior. The type of social harms such heavy drinking causes may also be dependent on the characteristics of the drinker. For example, if the drinker is married or living with a partner and/or children, domestic violence might occur, while it would not if the drinker is living alone.

Finally, alcohol dependence is also a risk among those who start drinking at an early age, and drink regularly and heavily – as well as among those who may be genetically pre-disposed to alcohol dependence.

In general one can divide a country’s population into the following groups in relation to alcohol consumption:

- Alcoholics/dependents
- Heavy or hazardous drinkers
- Regular, moderate drinkers
- Occasional drinkers
- Non-drinkers, and
- Children and adolescents.

The total consumption model

The total consumption model asserts that there is a close connection between total (per capita) alcohol consumption in a population (country), and the proportion of drinkers exhibiting extremely high rates of alcohol consumption in that

population. Consistent with the total consumption model, research has generally found a close relationship between changes in total per capita alcohol consumption in a society and changes in the extent of alcohol-related harm and problems. In other words, as total consumption of alcohol in a population increases, harms also increase; if the consumption of alcohol decreases, so too will alcohol-related harm.

Alcohol as a development issue

Unlike in western countries, a high percentage of the populations in African countries are non-drinkers. Life-time abstinence dominates. However, in recent years there has been an increase in alcohol consumption and heavy drinking occasions in many lower-income countries. Many of the developing countries among them do not have policies/laws in place to regulate alcohol production, sale and availability, and the absence of adequate rules to govern the alcohol market is certainly an obstacle to development. The consumption of alcohol has many negative impacts on consumers’ health (see above), and in a population suffering from poverty, the consequences of worsened health can be even more severe than in richer countries. Moreover, many countries in Africa are now experiencing a rapid spread of HIV/AIDS. High-risk sexual behavior under the influence of alcohol contributes to the spread of the infection and can have devastating effects in many places. Alcohol is also a risk factor by interfering with the effect of drug treatment regimes for Tuberculosis and AIDS.

Alcohol represents an obstacle to development also as a socio-economic issue. When economically poor, even small changes can destabilize an already vulnerable economy, for example a family. Alcohol consumption is not only a major consequence of poverty, because it offers an escape from the drudgery of poverty, but also a cause; its use often necessitates a diversion of family funds from essential needs such as food and schooling. Importantly, there is a high correlation between alcohol consumption and domestic violence. Violence in the home adds a critical gender aspect to the other related alcohol harms. Current trends suggest that the alcohol-related health and socio-economic burdens experienced by developing countries are only likely to increase if the challenges posed by aggressive alcohol marketing are not addressed. That threat can be mitigated by the development of strict and effective alcohol policies to control the production, sale, and promotion of alcohol and ensure substantial governmental revenues in the form of alcohol taxes.

The following activities will assist in mitigating the negative consequences of alcohol:

- Prevention: Strategies that have been proven to reduce alcohol related harm. This through actively changing environmental factors by for example increasing the price of alcohol, reducing the availability of alcohol and banning/limiting alcohol advertisement.

- Early/Brief Intervention: Following initial screening to identify risk levels a person who is referred to this intervention will meet a health professional for one to three sessions of counseling and education to reduce high risk drinking.
- Treatment: Detoxification, medical and/or behavioral or psychotherapeutically in- or outpatient treatment for persons who have developed alcohol dependence.
- Rehabilitation and integration: Restoration to good health or a useful life, through support, therapy and/or education. The process includes quitting drinking and learning how to remain abstinent.
- Harm reduction: Policies or programs designed to reduce the harm resulting from the use of alcohol, without necessarily reducing alcohol use per se. Example: Programs that offer free rides home to persons who are too intoxicated to drive their own cars. Research suggests that harm reduction programs have only limited effect on reducing the harmful use of alcohol.

Before presenting this module, and for more in-depth knowledge on these topics, please refer to the material listed below.

For the trainer:

Time needed for this module: Approximately 30 minutes.

Methodology: Presentation by the trainer, who then invites the participants to discuss the issues that have just been presented.

Audiovisual tools that may be used for this module include:

PPT: Prevention of alcohol related harm – Understanding the challenge.

Video clip from the DVD “Global Hangover”;

Relevant time slot 12:10 – 15:00 Slums and bars in Uganda (available from FORUT).

Relevant material:

Babor, Thomas *et al.* (2010), Chapter 2, in; Alcohol: No Ordinary Commodity (2nd edition), Oxford University Press, 2010.

Bakke, Øystein (2008), *Alcohol, Health Risk and Development Issue*, in; Cholewka and Motlagh (ed.): Sustainable Socio-economic Development (Public Administration and Public Policy, CRC Press, USA, 2008.

Clausen, Thomas *et. al.* (2009), *Diverse alcohol drinking patterns in 20 African countries*, Addiction, Volume 104, Issue 7, pp 1147–1154

Room, Robin and David Jernigan (2000), *Alcohol Supply in Developing and Transitional Societies; The ambiguous role of alcohol in economic and social development*, Addiction, Volume 95, Issue 12s4, pp 523-35

WHO (2009), Global Health Risks – Mortality and burden of disease attributable to selected major risks, World Health Organization, Geneva 2009

WHO (2011), Global Status Report on Alcohol and Health, World Health Organization, Geneva 2011



In recent years there has been an increase in alcohol consumption and heavy drinking occasions in many lower-income countries. Heavy marketing of alcoholic products contribute to this rise and should be banned or at least regulated. (Photo: T. Saether).

2.1.2 "REAL LIFE" – ALCOHOL PROBLEMS AS THE PARTICIPANTS SEE THEM

This module is included in the training package because it will serve as a tool to link the training participants' own experience with the reasoning and technicalities of alcohol policy. It is best to complete it the first day of the training.

The session seeks to elicit participants' local knowledge of alcohol use and patterns of harm, as well as highlight the relevance of local context. Participants' memories in regards to personal experiences with alcohol consumption and alcohol-related harm will provide important background when discussing alcohol policy. The module will also help create among the participants a feeling of ownership of the process and its results, as well as serve as an "ice breaker" early in the training.

The module needs little introduction, other than to explain that all experiences are relevant, and that the reason for including this discussion is to show that the initiative to prevent the harmful use of alcohol is not just based on abstract theories, but is a response to urgent situations in each of our countries.

Divide the participants into groups of four to five persons (depending on how many are participating in the training itself). They will all be given the same set of questions (see below) and asked to answer them based on a discussion of their own experiences within the group. After about 45 minutes, and a short

break, ask one representative from each group to come forward and summarize the results of his/her group's discussions for all the participants. As a trainer you will need to moderate the presentations, by selecting groups, keeping accurate time, providing a summary of main points after all the presentations, and suggesting possible links between the presentations and the topic of evidence-based alcohol policies.

Questions for each group:

1. On which occasions is drinking prevalent in our culture?
2. Where does drinking alcohol take place?
3. What are the concrete consequences, if any, from the alcohol consumption in your country?
4. What specific consequences for children might result from adults' drinking?

For the trainer:

Time needed for this module: Approximately 2 hours.

Suggested methodology: Group discussions followed by plenary presentations. Divide the participants into groups of 4 to 5 people. Each group will then answer a set of questions (see above) by discussing them together (all groups will be given the same set of questions). After a break, the leader from each group will present the thoughts from their group. If possible it is good to have a flip chart available on which each group can write down the key findings before presenting.



The harmful use of alcohol affects both the drinker and the non-drinker. Such harms can be prevented through the development and implementation of evidence-based alcohol policies. (Photo: T. Saether).

2.1.3. THE GLOBAL PICTURE – THE ROLE OF ALCOHOL IN A GLOBAL CONTEXT

The objective of this module is to ensure that the participants in the training receive a thorough understanding of the global challenges related to the consumption of alcohol. This knowledge will enable them to put their own national situation into a global context. The presentation on global trends includes:

- The global burden of disease
- An exploration of the many forces influencing changes in global alcohol consumption, and
- WHO's Global Strategy to Reduce the Harmful Use of Alcohol (very brief, see separate point later)

Alcohol consumption and the global burden of disease

The level of consumption of alcohol varies around the world, and thus the burden of harm resulting from such consumption also varies. That said, the burden of disease and death from alcohol consumption remains significant in most countries. Globally, alcohol consumption is responsible for the fifth largest risk factor for disease and disability. For people between 15 and 39 years, alcohol is the leading risk factor for death and disability. The leading risk factor in Eastern Europe, Andean Latin America, and southern sub-Saharan Africa in 2010 was alcohol use".

FAQ: What are DALYs?

Short answer: Disability Adjusted Life Years = Number of years lost to premature death + number of years lost to disability x degree of disability.

Long answer: From Babor et.al. (2010:58): "...The term `DALYs` refers to a composite health summary measure used to estimate the burden of disease in a given country (...). It combines years of life lost to premature death with years of life lost due to disability. In this calculation, disability is indirectly calculated from morbidity, where time lived with disease is multiplied by a disease-specific weight. For example, major depression has a weight of 0,6, which means that an episode of depression in a single individual lasting 2 years would be counted as 1,2 DALYs (2x0,6)."

Alcohol is a causal factor in 60 types of diseases and injuries and a component cause in 200 others. Significantly, almost 5,5% of disability adjusted life years (DALYs - see box above) lost worldwide are attributed to alcohol. Globally, this amounts to 136 million years of life years lost through dying early or living with an alcohol-related disability. When one considers that alcohol is associated also with many serious social issues such as violence, child neglect and abuse, as well as abse-

teeism in the workplace, the true dimensions of harmful use of alcohol become readily understandable.

Gender matters

It is important to highlight the importance of gender when it comes to the burden resulting from harmful alcohol use. Among males between 15 and 39 years alcohol use is the leading risk factor for death and disability. This harm includes injuries, violence and cardiovascular diseases that accompany such use. Globally, men experience a much higher health burden of premature mortality and disease attributed to alcohol than women do: 5.5% versus 2.0%. The total burden refers to all acute and chronic health problems that can be attributed to alcohol.

Why do the numbers differ so much for men and women? Globally, men are much more likely than women, by a ratio of four to one, to engage in weekly episodes of heavy drinking. That behavior is likely the reason for their higher deaths and disability rates. Compared to women, fewer men abstain from drinking alcohol. In addition, lower socioeconomic status and educational levels also increase the risk of alcohol-related death. This social determinant is greater for men than women. Men tend to create more problems than women when drunk. These differences occur in most societies because it is usually more culturally acceptable for men to drink alcohol than women.

Consumption levels vs. consumption pattern

When reviewing global statistics one may start to wonder if consumption levels and drinking patterns are the same everywhere. Clearly they are not. See FAQ box below for more on how to measure alcohol consumption.

Currently the highest alcohol consumption levels are found in the developed world, including Western and Eastern Europe. Generally, the high-income countries also have the highest levels of alcohol consumption. Consumption levels, however, are not the only factor that influences the nature and rate of alcohol-related problems, but also the pattern of drinking within a country.

For example, if a person drinks one alcohol unit with dinner each day of the week, and another person drinks seven alcohol units all on Saturday night, they both have the same consumption level. The former's drinking could be considered low-risk, and the latter's definitely high-risk drinking. This distinction, in addition to safer roads and good health care, may explain why in Western Europe, which has some of the highest alcohol consumption rates, the net alcohol-attributable mortality rates (deaths due to alcohol use) are relatively low (although alcohol-related disease burden may be high). In the case of Eastern Europe, many countries face the challenge of having the highest alcohol consumption combined with risky patterns

of drinking. Those countries therefore suffer high levels of alcohol-related deaths and disabilities. In the Commonwealth of Independent States (some of the nations that previously made up the Soviet Union), every fifth death is due to harmful drinking. Similarly, rates of disease and disability attributable to alcohol use are also quite high in Mexico and most South American countries, where high consumption, risky drinking patterns, and fewer safety and health resources combine to put people at risk. In 2005, global average consumption of alcohol per person equaled 6.13 liters of pure alcohol. In addition to measuring commercial production, those WHO data include estimates of alcohol made at home and beverages illegally produced or sold outside of normal government controls.

FAQ: How is the level alcohol consumption in a population measured and reported?

Alcohol consumption is generally expressed in liters of ethanol (100% pure ethanol) consumed per capita. Alternatively, it is expressed in liters of ethanol consumed by each person over the age of 15 (children do not drink alcohol in most countries). One can also measure liters of alcohol consumption only among drinkers (ignoring the entire population). In this case nondrinkers (abstainers) are excluded from the calculation. When comparing consumption per adult drinker, rather than among all adults, one can for example find that in countries with the same overall consumption levels, each drinker drinks more or less than the drinkers in the different country (Babor et.al. 2010:24).

Most people do not drink

Despite the high levels of alcohol consumption in some societies, a majority of the world's current population does not drink alcohol. Globally, close to half of all men and two thirds of women have not consumed alcohol at all in the past year. In high-income and high-consumption countries such as in Europe, abstention rates are low. In North African and South Asian countries that have large Muslim populations abstention rates are higher. Female abstention rates in particular are very high in those countries.

Why is this fact important? A country's abstention rate has a very important influence on overall per-capita (15+) consumption levels. Abstention rates are a significant factor in the when looking at alcohol consumption globally, and represent one of the strongest predictors of the magnitude of alcohol-attributable burden of disease and injuries within populations. It should come as no surprise then that lifetime abstention from alcohol means that the non-drinker will be spared any personal alcohol-attributable disease, injury or death, unless harmed by someone else's drinking and subsequent behavior. Given the relationship of consumption and harm, especially in high-

abstention countries, any decrease in the number of abstainers and increase in the numbers of drinkers could have a sizable negative impact on the burden of disease that is associated with the harmful use of alcohol. Increases in per capita consumption levels could also have substantial effects.

Alcohol in developing societies

Are global alcohol consumption levels changing, and if so, why? Answering this question is somewhat difficult and limited by the inability to accurately measure all consumption within a society. International comparisons of changes in levels of consumption over time are made only on the basis of recorded consumption, which does not measure changes in levels of unrecorded (home and illegally produced alcohol) consumption. High-consumption countries have experienced a general decline in per-capita consumption between the early 1970s and early 2000s. In contrast, the general trend in developing countries has been the exact opposite. It is important to note that the increase in reported consumption, based on higher industrial production and imports, could also reflect a comparable decrease in unrecorded consumption. Nonetheless, compared to the developed world, alcohol consumption in developing countries is still relatively low. Essentially, the situation looks like this:

- A high proportion of unrecorded beverages
- A large segment of non-drinkers
- An unbalanced distribution of the alcohol consumers and consumption (fewer people in developing societies drink, so each drinker consumes a higher portion of the total amount of alcohol consumed there), and
- A relatively high proportion of drinkers consumes alcohol at dangerous levels or has risky patterns of consumption.

Notably, however, alcohol consumption varies greatly among the countries of the African continent. That variance results from ethnic diversity, religious differences, a wide range in the levels of social welfare programs and industrialization, the availability of alcohol, the acceptability of alcohol within the society, and the country's political and economic stability. In general though, the lower-income countries suffer a disproportionately higher disease burden per unit of alcohol consumed than do countries with high-income populations. (i.e. Europe). In southern Sub-Saharan Africa alcohol-related road traffic crashes, unintentional and intentional injuries, and alcohol-related tuberculosis contribute to the substantial toll of death and disability. Had the impact of alcohol on HIV/AIDS been included in the above data, the alcohol-attributable burden in this region would have been even higher. In developing countries that have been able to decrease the rates of child and adult mortality, alcohol is now the leading risk factor.

Poor people are more vulnerable than others to even small changes in their living conditions, and may resort to drinking

as a means of escaping their misery. In those cases, alcohol serves as a direct cause of downward socioeconomic mobility. As economic development takes hold in many places in Africa, alcohol consumption will increase along with higher incomes, partly to symbolize personal success. Such "progress" increases the likelihood that alcohol problems will multiply alongside increases in people's income.

The bottom line: Alcohol consumption represents an important global factor for understanding and determining health and well-being, subject, of course, to many national variations. It is also very much a development issue, and poses a direct obstacle to development. Global, national and local action is therefore needed. Much work has already been done, and more information on that will follow in later modules.

For the trainer:

Time needed for this module: Approximately 1 hour.

Methodology: Presentation by the trainer.

Audiovisual tools that may be used for this module:

PPT: The global picture – the role of alcohol in a global context. Video clip from "Global Hangover"; Relevant time slot: 03:23 – 05:24 Street Children/APSA (available from FORUT).

Relevant material:

Babor, Thomas *et. al.* (2010), Chapter 3, 4 and 15, in; Alcohol: No Ordinary Commodity (2nd edition), Oxford University Press, 2010

WHO (2009), Health Risks – Mortality and burden of disease attributable to selected major risks, World Health Organization, Geneva 2009

WHO (2011), Global Status Report on Alcohol and Health, World Health Organization, Geneva 2011

WHO (2012), World Health Statistics 2012, World Health Organization, Geneva 2012



A society where effective strategies to prevent the harmful use of alcohol is implemented, will be a better society to live in for all. (Photo: D. Endal).

2.1.4. ALCOHOL-RELATED HARM IN THE COUNTRY IN QUESTION

The objective of this module is to give the participants knowledge of the alcohol situation in the specific country in question, subject to the availability/existence of relevant data.

Preferably, the program should identify and recruit a national expert to present country-specific information. The expert should be assigned to discuss relevant country reports, research findings, national laws, etc. This source material may be summarized or provided in its entirety to participants, either in hard-copy (paper) or on a CD or thumb drive.

The ideal person to do this presentation is someone who knows the field very well and has a proven understanding of why the country needs an evidence-based alcohol policy. Fundamentally, this means that the speaker should have no relationship – financial or otherwise -- with the alcohol industry. Someone working at a university or in a research or medical facility would be a good candidate. It's important to identify a skilled presenter who is very familiar with the topic. The more credibility that the expert possesses helps ensure that her/his message will be respected and that it will withstand objections and questioning by potential critics. When inviting an expert, be very clear about the topic and purpose of the training so his/her presentation and materials focus only on relevant issues, and not on important, but not-so-relevant concerns, such as the rehabilitation of alcohol dependent persons. In preparing the expert for the training, ensure that he/she understands who will attend the training. This guidance will help the expert tailor his remarks to participants, who may not need a discussion of the technicalities of research design, but rather need to learn key messages about alcohol-related harm in the country. Sensitivity to the composition of the participant audience is important, given that not all (or perhaps even some) of the participants will be people who work in the fields of medicine or academic research of any kind.

Depending on availability, the presentation may include data such as:

- Production, sales and consumption statistics, and
- Registered and non-registered consumption.
- Consequences/impact of alcohol consumption in relation to the following areas:
 - o Crime
 - o Domestic violence
 - o The spread of diseases
 - o Traffic
 - o Poverty
 - o Children/Child rearing
- Other country-specific areas of importance.

For the trainer:

Time needed for this module: Approximately 1 hour (can be increased)

Methodology: Presentation by the national expert, followed by plenary discussion.

Note on relevant material:

As with the other modules, the presentation in this section of the training should be accompanied by relevant hand-out materials for the participants, including a short report and copy of the PowerPoint presentation. The PowerPoint presentation should include key data on the alcohol situation in the country. If those data are not on hand, organizers should collect all available data before the event and compile them in a report/PowerPoint presentation prior to the time of the training.

Relevant material:

WHO's country report for the country in question.

Report/PPT building on relevant data in the country.



Children worldwide suffer under parents' harmful use of alcohol. This can be prevented and mitigated by the implementation of a comprehensive alcohol policy. (Photo: A. Smyth).

2.1.5. THE ROLE AND GOAL OF THE ALCOHOL INDUSTRY

The objective of this module is to provide insight into the workings of the alcohol industry, its objectives, strategies and activities.

The module aims to inform the participants in the training about the different sides of the alcohol industry, which does not limit itself to producing and selling alcohol. When considering new policy, it is imperative that alcohol-policy makers adequately understand and take into account the alcohol industry's objectives, strategies and activities related to the marketing of their products.

The presentation must touch on these topics:

- Exposing the industry's dual agenda; the roles of the industry in the market place and in the political arena
- Who's who in the alcohol-beverage industry: Multinational actors and structural developments
- Vested interests?
- What does the alcohol industry do?
 - o Policy activities
 - o Advertisement
 - o Marketing activities in a broader sense
 - o Social aspect organizations (e.g. ICAP).

The alcohol industry focus on emerging markets

Within the past two or three decades, alcohol consumption in the industrialized countries has stabilized, and alcohol producers have cast their eyes upon potential new markets. Stakeholders within the alcohol industry recognize that further growth will be secured by establishing themselves in new emerging and unregulated markets. Industry's new game plan raises concerns about the future health of the developing world, where current evidence in some of those countries already documents that alcohol is the leading risk factor for injury and disease.

Economic growth and development represent positive forces for low-income countries; however, the economic gains are often threatened by the increasing alcohol consumption that accompanies higher incomes. For example, the assumed benefits for a developing country from new alcohol production financed by multi-national companies, which creates jobs and sports sponsorships, may likely to be outweighed by the negative social and economic effects (harms) of alcohol.

To understand why the industry is bullish about the developing world, it's instructive to consider a statement by Heineken's CEO Jean-François van Boxmeer in an interview with 'Just-Drinks' in May 2011:

"Africa won't be left at the side of the road; the rest of the

world needs Africa. I see big improvements there, it's the cornerstone of our business. We have been multiplying the profits from our operations in Africa by five in around eight years – it's one of the biggest growth engines we have."

In another story Just-Drinks quotes an unnamed Heineken spokesperson: *"Heineken is bullish about Africa and the possibilities for ongoing growth in the region."*

Ensuring industry friendly environment – the alcohol industry in the political arena

In order to reach its goal of profit making, the industry seeks to have a seat at the table when new policy is made. Alcohol producers want minimal government regulation of their products, akin to the regulation of other commodities. Industry players have fought the regulation of marketing, arguing that voluntary self-regulation is preferable and effective to curb abuses, and they have steadfastly opposed increases on current (usually low) levels of taxation.

Additionally the industry often creates the illusion that it is sincerely interested in preventing harmful use of alcohol by promoting education and public information campaigns about the adverse effects of "irresponsible" drinking. Industry messages to 'Drink Responsibly' in alcohol advertisements or on container labels may sound nice, but there's no evidence that they are effective to reduce harmful consumption or harm. The key industry message communicates that drinking alcohol is both normal and healthy, or even expected. Abstaining from drinking on the other hand is portrayed as socially aberrant behavior. The industry view of prevention does not incorporate a public health perspective, but rather looks only at the individual drinker and places the responsibility for preventing and reducing alcohol problems solely on that person. In other words, alcohol is not the problem; it's what the drinker does with it that is. It's your problem if you become intoxicated or dependent, not ours'.

The alcohol industry's broad marketing activities

The alcohol industry's expansion in the emerging markets of Africa, Asia and Latin-America is supported by heavy marketing. Products are tailored for different market segments (different kinds of drinkers) and developed to be within economic reach of all potential customers. The marketing of these products is similarly specialized. The various companies use the traditional marketing strategies like posters, billboards, and advertising in printed and electronic media, but have also expanded into the use of innovative digital marketing as well.

As potential new consumers, young people are aggressively targeted by the alcohol industry. Marketers use social media to attract and develop relationships with young persons in particular, who are more likely to visit popular social networking sites and become acquainted with these products. Anyone

who has visited a sports event or youth-oriented music concert has certainly been exposed to heavy alcohol promotions. Those venues are a favorite place for alcohol-product sponsorships.

The industry is also skilled at marketing their products indirectly while simultaneously advancing their policy interests by engaging in philanthropic giving and social responsibility activities (so-called Corporate Social Responsibility, CSR). As long ago as in 2004 researchers documented that the alcohol industry had been setting up social aspect organizations for 20 years.

These organizations operate on all levels -- from country to global -- and seek to manage issues that are detrimental to the alcohol industry, while pretending to be part of the solution to alcohol problems. In some cases, they have been effective in influencing alcohol policy in international and national governmental organizations. Their methods include joining different official committees responsible for policy making, recruiting scientists, hosting conferences, promoting high profile publications, among others. One example of such an organization is the International Centre for Alcohol Policies (ICAP) which was created in 1996. It is fully funded by the world's largest alcohol producers, Diageo, SABMiller, Heineken, and others.

Social aspect organizations, in the same way as their funders, have vested interests in increasing the sale of alcohol. For that reason -- because their mission conflicts with public health interests -- they should not be included in any part of the alcohol-policy development process. The WHO expert committee recommends that "any interaction should be confined to a discussion of the contribution the alcohol industry can make to the reduction of alcohol-related harm only in the context of their roles as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion."

For the trainer:

Time needed for this module: Approximately 45 minutes

Methodology: Presentation by the trainer and plenary discussion among the participants.

Audiovisual tools that may be used for this module include:

PPT: Alcohol Policy -- The role and goal of the alcohol industry in Africa. A challenge for civil society.

Other relevant material:

Anderson, Peter (2004), *The beverage alcohol industry's social aspects organizations: a public health warning*, Addiction, Volume 99, Issue 11, pp 1376-77

Anderson, Peter et. al. (2009), *Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies*, Alcohol and Alcoholism, pp1-15, 2009, Oxford University Press

Anderson, Peter (2009), *Is it time to ban alcohol advertising?*, Clinical Medicine, Volume 9 no 2 April 2009, pp 121-124.

Babor, Thomas et. al. (2010), Chapter 5, Alcohol: No Ordinary Commodity (2nd edition), Oxford University Press, 2010

Bakke, Øystein and Dag Endal (2010), *Vested Interests in Addiction Research and Policy Alcohol policies out of context: drinks industry supplanting government role in alcohol policies in sub-Saharan Africa*, Addiction, Volume 105, Issue 1, pp 22-28

Chester, Jeff et. al. (2010), *Alcohol Marketing in the Digital Age*, Center for Digital Democracy & Media Studies Group, a project of the Public Health Institute, USA.

de Bruijn, Avalon (2011). Monitoring Alcohol Marketing in Africa, World Health Organization 2011

Hastings, Gerard et. al. (2010), *Failure of self regulation of UK alcohol advertising*, British Medical Journal, Volume 340 pp 184-6, BMJ Publishing Group Ltd. UK

Jernigan, David H. (2009), *The global alcohol industry: an overview*, Addiction, Volume 104, Issue supplement s1, pp 6-12

Jernigan, David H (2012). *Global Alcohol Producers, Science, and Policy: The Case of the International Center for Alcohol Policies*, American Journal of Public Health, January 2012, Vol. 102, No. 1, pp. 80-89

Overview of Social Aspect Organizations,
Available at: http://www.ias.org.uk/resources/publications/the-globe/globe200203/gl200203_annex.pdf

Up to date Alcohol Policy Drafts from selected countries.

2.1.6. UNRECORDED CONSUMPTION

The objective of this module is to give the participants an overview of the problem of unrecorded consumption of alcohol. The section will address these issues:

- What is unrecorded consumption?
- How much alcohol consumption is unrecorded?
- Registered vs. unrecorded consumption, and
- Policy implications where there is a high proportion of unrecorded alcohol consumption relative to total consumption.

Unrecorded alcohol consumption is by definition not included in official statistics of production and distribution in a country. It is ordinarily beyond the reach of governmental control, whether for the imposition of taxes or for other public-health based policies. Most countries have some level of unrecorded consumption. The illicit products may include beer or spirits, unbranded or counterfeit, produced at home or in covert semi-industrial production sites. The very fact that these beverages are unrecorded obviously makes it difficult to assess the size of this consumption.

Estimates of recorded and unrecorded alcohol in different regions of the world indicate that the proportion of unrecorded beverages varies greatly across the globe. Where perhaps ten percent of the alcohol consumed in Western Europe is unrecorded, it is estimated that unrecorded alcohol accounts

for two thirds of total consumption on the Indian subcontinent, about half of consumption in Africa and a third in Latin America.

The poorest people of the poorest countries tend to consume illicit liquor as their main source of alcohol. News media occasionally report incidents of alcohol poisoning due to contaminations in various home brews. Some illicit producers even add various dangerous ingredients to make their beverages even more 'potent'. Such stories have fueled the widespread perception that illicit alcohol is generally unsafe because it is not 'wholesome', in contrast to legal alcohol, which is perceived to be a 'wholesome' product. These perceptions are often used to promote policies that offer cheaper and more available commercial products as substitutes for the unrecorded, dangerous products. The contaminated illicit alcohol undoubtedly causes serious damage. Nonetheless, the rare, highly publicized incidents seldom constitute a major public health threat, globally or in any region.

Using the outbreaks of poisoning from contaminated alcohol as the bases for policy formulation overlooks the reality that alcohol, whether illicit or licit, contributes to widespread harm within a society. The contributions of both licit and illicit production should be considered in crafting alcohol policy. Of course, in regions where the unrecorded alcohol consumption is high, it should be taken into account when planning strategies and interventions to reduce alcohol-related harm.



Unrecorded alcohol being sold by the main road into Chad's capital N'djamena. Interventions directed to legally produced and sold alcohol should be combined with actions to control the unrecordede market. (Photo: T. Saether).

Focusing on illicit production should not be used to ignore the need for evidence-based interventions to control the availability of alcohol (taxes, licenses, hours of sale, etc.). On the contrary, interventions directed to the formal, legal production and sale of alcohol should be combined with actions to control the unrecorded market. From a fiscal, public health, and policy perspective, governments have substantial interests in eliminating illicit production and sale and bringing informal supply under the taxation system.

For the trainer:

Time needed for this module: Approximately 30 minutes

Methodology: Presentation by the trainer and plenary discussion among the participants.

Audiovisual tools that may be used for this module:

PPT: A framework for discussion: Unrecorded Alcohol. The Global Picture.

Other relevant material:

Lachenmeier, Dirk W. and Jürgen Rehm (2009), *Unrecorded alcohol: a threat to public health?*, *Addiction*, Volume 104, Issue 6, pp 875–7

Molamu, Louis and Dave Macdonald (1996), *Alcohol Abuse Among the Basarwa of the Kgalagadi and Ghanzi Districts in Botswana*, *Drugs: Education, Prevention, and Policy*, Volume 3, No 2, pp 145-152

Room, Robin and David Jernigan (2000), *Alcohol Supply in Developing and Transitional Societies: The ambiguous role of alcohol in economic and social development*, *Addiction*, Volume 95, Issue 12s4, pp 523-35

Samarasinghe D. (2009), *Unrecorded Alcohol*, FORUT – Campaign for Development and Solidarity, Oslo, Norway, 2009



The WHO is a global authority on health. (Photo: T. Saether).

2.1.7. THE WHO GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL

The objective of this module is to inform the participants of the WHO Global Strategy to Reduce the Harmful Use of Alcohol, and to discuss its possible impact.

This module requires an explanation of the following aspects:

- What is the content of the strategy?
- The background and process that lead to the adoption of this Strategy by the World Health Assembly, and
- Particular challenges for developing countries in the implementation of the strategy; for governments and for NGOs.

In May 2010, the 193 country members of the 63rd World Health Assembly endorsed the Global Strategy to Reduce the Harmful Use of Alcohol. Thus, the strategy represents a universal commitment to sustained action by these member states. The strategy and its endorsement are the result of close collaboration in political and technical consultations between member states and the WHO secretariat, and among themselves. The strategy builds on several WHO global and regional strategic initiatives and on WHO relationships with other stakeholders, such as civil society groups and economic operators.

The Global Strategy to Reduce the Harmful Use of Alcohol is the result of work over many years, occurring in ‘waves’

at WHO since the 1950s. During that decade three expert committees and sub committee meetings met on the alcohol theme. The next wave came in the 1980s with one expert committee meeting and the passage of two World Health Assembly (WHA) resolutions on this topic. Finally, we now appear to be experiencing a third wave, in which many developments have taken place to prevent the harmful use of alcohol. This wave began around the year 2000; since then we have seen one expert committee meeting (2007), two WHA resolutions (2005 and 2008), as well as several other issue-specific WHO-sponsored – or co-sponsored – conferences and meetings.

The rationale behind the Strategy is the growing recognition that the harmful use of alcohol is one of the leading contributors to death and ill-health around the world. Alcohol causes are responsible for an estimated 2.7 million deaths every year, making alcohol the fifth leading risk factor for poor health around the globe. Harmful drinking accounts for 5,5% of the global burden of disease as measured in disability-adjusted life years (DALYs) lost. Moreover, the close links between the harmful use of alcohol and hampered socioeconomic development have been increasingly well documented and indisputable. These data particularly impact young people.

The contents of the strategy can be summarized as follows: It proposes four areas of global action and also focuses on 10 areas of policy options and interventions at the national level (i.e., for the member countries to implement). The key objectives of the strategy include:

- Complementing and supporting public health policies in Member States
- Providing guidance for action at all levels, and
- Setting and defining the priority areas for global action. These are:
 - o Public health advocacy and partnership
 - o Technical support and capacity building
 - o Production and dissemination of knowledge, and
 - o Resource mobilization.

The Strategy also lists and explains policy options and measures that could be considered for implementation, adjusted as appropriate at the national level:

- Leadership, awareness and commitment
- Health services' response
- Community action
- Drink-driving policies and countermeasures
- Availability of alcohol
- Marketing of alcoholic beverages
- Pricing policies
- Reducing the negative consequences of drinking and alcohol

intoxication

- Reducing the public-health impact of illicit alcohol and informally produced alcohol, and
- Monitoring and surveillance.

The Strategy envisions improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to the harmful use of alcohol and the social consequences that result. Inherent in the points above, the strategy intends to promote and support local, regional and global actions to reduce the harmful use of alcohol.

A special strategy for the African region was also adopted in 2010. The sixtieth session of the meeting for the WHO Regional Committee for Africa approved a Resolution for the reduction of the harmful use of alcohol: A Strategy for the WHO African Region (Doc: AFR/RC60/4). Its contents parallel the Global Strategy but also address particular challenges in Africa, regarding the informal production of alcohol and the crucial links between alcohol and the use of illicit drugs, high-risk sexual behavior, and infectious diseases, such as tuberculosis and HIV/AIDS (AFR/RC60/4).

For the trainer:

Time needed for this module: Approximately 30 min

Methodology: Presentation by the trainer followed by a brief discussion among the participants.

Audiovisual tools that may be used for this module: Make short PPT based on the two strategies listed below.

Other relevant material:

Rekve, Dag (2010), PowerPoint presentation at WHO Geneva briefing May 2010: *A global strategy to reduce the harmful use of alcohol*, [World Health Organization](#), Geneva 2010.

WHO (2010a), [Global Strategy to Reduce the Harmful Use of Alcohol](#), World Health Organization, Geneva 2010

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The key message at the Global Alcohol Policy Conference in 2012 was: *We know how best to prevent the harmful use of alcohol – Now we must act!* (Photo: D. Endal)

2.2. MODULES DESCRIBING OPPORTUNITIES FOR POSITIVE CHANGE

The modules listed in this chapter focus on alcohol policy options. The first modules in this section will propose that a comprehensive approach to alcohol policy making is needed. The following modules provide an overview of the existing options and best practices in choosing evidence-based interventions, as well as detailed information about selected interventions. Throughout the modules, readers will be reminded that evidence-based interventions must always be chosen with careful consideration of the situation in the country in question.

2.2.1. A COMPREHENSIVE APPROACH IS NEEDED

The objective of this module is to highlight why a comprehensive approach to policymaking is needed, presenting the details of well-tested interventions:

- The combination of control policies, education/training, early intervention and social mobilization
- The prevention triangle (Control policies – Knowledge – Mobilization), and
- Primary, secondary and tertiary prevention.

Alcohol is not an ordinary commodity

- Alcohol as a product is embedded in the economy of most countries, involving producers and manufacturers, distributors, advertisers, bar-staff, and taxes that provide revenue to the government. In many places unrecorded alcohol is brewed at home, and women often depend on income from such production.
- Alcohol is a commodity, but it is not an ordinary commodity. Alcohol cannot be categorized as a commodity like rice or bread. The principal reason for this distinction reflects the reality that alcohol imposes high costs, both for individuals and for society.
- Alcohol is a toxic substance that affects organs in the body.

- Alcohol has an effect on the brain that causes intoxication and thus alters drinkers' behaviors.
- Alcohol is a potentially addictive, dependency-inducing drug.

Consuming bread and rice does not have these effects. Alcohol is far from being an ordinary commodity.

A comprehensive approach to policy making is necessary

There are many levels of interventions to avoid alcohol-related harm:

- Prevention
- Early interventions
- Treatment
- Rehabilitation
- Harm reduction

For a fuller explanation of these interventions see chapter 2.1.1.

Most of us assume that knowledge influences our behavior. However, research has repeatedly demonstrated that the common sense assumption that knowledge influences our values, which automatically trigger behavioral change, is not well-supported by the evidence. Also, awareness campaigns are very costly to carry out. It is natural to think that educating young people about the harmful effects of alcohol is a good idea, because one assumes that having this knowledge will stop them from drinking. However when such education/awareness-raising programs are carried out in the absence of supportive control policies, evidence shows that they have very minimal intended effect. People drink regardless. A more comprehensive

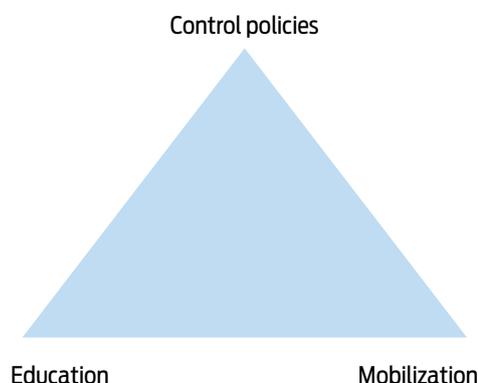


Professor Isidore Obot, Head of the Department of Psychology at the University of Uyo, explained in depth about the need for a comprehensive approach to alcohol policy making at one of the trainings.

approach is therefore needed to effectively prevent the harmful use and effects of alcohol.

What do we mean when we say 'comprehensive approach'? Ideally, what's contemplated is a broad set of interlinked and coordinated interventions that can be employed to prevent harm related to alcohol use. Each of these categories of interventions serves a specific purpose, and together they create synergies and strengthen each other. The prevention triangle model below makes it easier to visualize the exact logic of the comprehensive approach

The prevention triangle



Control policies

Control policies are top-down approaches that are defined as the regulation of markets by governments to reduce the accessibility of a substance and to guarantee – from a health/social point of view – the safest possible production and distribution system. In this case we mean the production, marketing and distribution of alcohol.

Education

Education provides myth-busting and factual information and training to people to influence their knowledge and values. The assumption is that this will help people decide and act appropriately in determining whether to drink alcohol at all, how much to drink, how often and with whom to drink, and when and where to drink. Education can also be offered to professionals to increase their skills and understanding (i.e., teaching police officers about blood alcohol content limits and how to measure it; teaching doctors about the use of brief interventions to help problem drinkers, etc.). Education can also be used to raise awareness around important issues, for example, to prevent underage drinking or to inform neighborhoods about the set closing time for bars. Lastly, education can also be an important component in identifying the need for and in motivating people to support the implementation of alcohol control policies. For example, people must be informed about how alcohol physically harms the human body and how that harm imposes large financial costs on society if they are

expected to support a policy that aims to lower consumption. It's important to understand that education alone changes little.

Mobilization

Mobilization is critical both in order to gain support for the development of an alcohol policy and also its efficient implementation after adoption. Alcohol prevention needs/strategies can be made part of the agenda for social/political movements, and can be used to link alcohol harm prevention with other relevant policy issues (for example, HIV/AIDS prevention). This can be done by involving leaders and members of a number of different organizations. Examples of such organizations include:

- Youth- and children's organizations
- HIV/AIDS and health promotion NGOs
- Women's organizations
- Trade unions and professional groups
- Organizations for poverty reduction
- Community-based organizations (CBOs), and
- Faith-based organizations (FBOs).

The different strategies/interventions available will be covered specifically in the module, 'Evidence-based policies to reduce alcohol-related harm', chapter 2.2.3.

Recommendations made by the WHO

The WHO has taken the lead in calling for controlling alcohol and for the need to do it in a comprehensive manner.

The Global Strategy recommends action that is in keeping with the comprehensive approach to alcohol policy making as described above. It contains a portfolio of policy options and measures that can be considered for implementation and adjusted as appropriate at the national level.

For more on the Global strategy to reduce the harmful use of alcohol see chapter 2.1.7.

For the trainer:

Time needed for this module: Approximately 30 min

Methodology: Presentation by the trainer who will discuss each intervention and explain its level of proven effectiveness and the associated costs. Following the presentation, participants in the training will join the discussion.

Audiovisual tools that may be used for this module:

PPT presentation: A comprehensive approach to the prevention of alcohol related harm.

Other relevant material:

Babor, Thomas *et. al.* (2010), Chapter 2 and 13, [Alcohol: No Ordinary Commodity \(2nd edition\)](#), Oxford University Press, 2010

Samarsinghe, Diyanath (2009): [Reducing Alcohol Harm; things we can do](#), FORUT – Campaign for development and solidarity

2.2.2. EXISTING POLICIES AND LEGISLATION TO PREVENT ALCOHOL-RELATED HARM IN THE COUNTRY IN QUESTION

The objective of this module is to give the participants an overview of existing relevant legislation in the country in question, the processes involved in working to change existing legislation, and how they can most efficiently contribute to policy development.

A national expert should be invited to introduce participants to the legislative framework in the country. The presentation should include the following topics:

- A comprehensive presentation on existing legislation relevant to the subject matter, and
- An introduction to the country's policy-making process, with a particular emphasis on processes related to reducing the harmful use of alcohol.

For the trainer:

Time needed for this module: Approximately 1 hour

Methodology: Presentation by a national expert followed by discussion among the participants.

Material: Global Status Report on Alcohol and Health 2011, World Health Organization, Geneva

Other relevant documentation:

Babor, Thomas *et. al.* (2010), Chapter 15, [Alcohol: No Ordinary Commodity \(2nd edition\)](#), Oxford University Press, 2010

2.2.3. EVIDENCE-BASED POLICIES TO REDUCE ALCOHOL-RELATED HARM

The objective of this module is to give the participants an overview of the efficacy of different interventions for reducing alcohol consumption and harm.

The presentation by the trainer should address these issues:

- Introduction to Alcohol : No Ordinary Commodity, background and definitions
- A brief overview of the different interventions presented as a “consumers guide” in Alcohol : No Ordinary Commodity
- A special focus on the three most relevant policy options for the country in question and
- Group discussion of the relevance of the three suggested interventions in the specific country and of the potential need to adapt these to local realities.

	20 cl	30 cl	50 cl
Coca Cola, Fanta, Limonade, Sprite, Soda fruit, Tonic	2 000 Ar		2 000 Ar
Coca Cola, Fanta, Limonade, Sprite, Soda fruit (PET)	2 200 Ar		4 000 Ar
Coca Cola Zero	2 200 Ar		4 000 Ar
Sirop de Mandarine, Prunier, Grenadine, Orange, Citron		2 400 Ar	
Stella zero	2 500 Ar		
XXX	2 800 Ar		
Sansevier	2 200 Ar		3 000 Ar
Jus de fruit frais		1 400 Ar	
Cocktail de Jus	1 800 Ar		
Cocktail Ravinala	2 500 Ar		
Milk Shake		3 200 Ar	
LES MINÉRALES			
Eau Vite	1 800 Ar		2 900 Ar
Crystalline		2 200 Ar	
Crystal	2 200 Ar		3 800 Ar
LES AUTRES			
	20 cl	30 cl	50 cl
Vini	2 500 Ar		4 000 Ar
Vini	2 800 Ar		4 000 Ar
Vini Blanc/ Ambré	3 100 Ar		
Vini	2 200 Ar		3 800 Ar
Whisky		3 800 Ar	
Whisky		3 800 Ar	
Whisky		3 800 Ar	
Whisky		4 000 Ar	

Using taxation and minimum pricing is a proven best practice in preventing alcohol related harm. This restaurant menu from Madagascar shows that alcohol is not priced much higher than other drinks. NGOs and national authorities are working together to change this. (Photo: T. Saether).

Introduction

Evidence-based alcohol policies to reduce alcohol-related harm comprise a big topic. Essentially, however, the subject describes strategies shown by extensive unbiased research to reduce alcohol consumption and the harm that follows from the harmful use of alcohol. Examples of such strategies include taxation of alcoholic products, limitations on the number and density of alcohol outlets, age minimums for purchasing alcohol, and other policy interventions. A key feature of such strategies is that they should be cost-effective, delivering their objective at a reasonable and affordable cost.

Our principal guide in this undertaking is the publication, *Alcohol: No Ordinary Commodity – Research and Public Policy*, by Babor et.al. 2010. This book was sponsored by The World

Health Organization and The Society for the Study of Addiction (UK) and is the result of a collaborative effort by an international group of alcohol policy experts. It presents accumulated scientific knowledge that has direct relevance to the development of alcohol policies at all levels. Alcoholic beverages are in many ways an important and economically embedded commodity. The production and sale of commercial alcoholic beverages generates profits for farmers, manufacturers, advertisers and investors. Alcoholic beverages also provide for employment to people in bars and restaurants and can yield substantial tax revenues for governments. In developing societies the production and sale of homebrew/illicit alcohol often has a role in the local economy. Despite its many roles in society and in national economies, the title of the book suggests that alcohol is by far no ordinary commodity. As we have learned in the previous modules, alcohol, because it is so widely and excessively used, has a visible negative impact on society and on many people's health and general well being.

The definition of an alcohol policy was explained in the first chapter of this guide. Its purpose is to contain and reduce alcohol related harm. Alcohol policy serves the interest of the public health through its impact on drinking patterns and level of consumption, on the drinking environment, and on the availability of health services to treat problem drinkers.

Alcohol: No Ordinary Commodity lists 42 policy-relevant prevention strategies and interventions included in the following categories:

- Pricing and Taxation
- Regulating Physical Availability
- Altering the Drinking Context
- Education and Persuasion
- Regulating Alcohol Promotion
- Drinking-Driving Countermeasures, and
- Treatment and Early Intervention.

The different strategies and interventions are rated according to 4 criteria:

- Evidence of effectiveness (the quality of scientific information)
- Breadth of research support (quantity and consistency of evidence)
- Extent of testing across cultures, countries, regions and sub groups, and
- Cost to implement and sustain (monetary cost and also other costs such as time and resources).

Rating scales are used to evaluate each criterion. These are indicated by symbols, 0, +, ++, +++ and ?.

In addition to assigning a rating, the evaluation of any intervention must include consideration of the possible side

effects of implementing the strategy/intervention. For example, to what extent might the intervention cause unwanted and unexpected consequences, such as possible tax evasion and the illicit production of alcohol that could follow a steep increase in alcohol taxes. Are these “side effects” sufficiently serious to reconsider the tax? One must also determine whether the intervention will reach a substantial number within the target population (the population reach). The feasibility of the intervention/strategy is also an important consideration. What economic or political hurdles exist? Will the population support the intervention/strategy? What other obstacles stand in the way?

The trainer will provide a brief introduction to some of the interventions tested in *Alcohol: No Ordinary Commodity*. Please be aware that some of the interventions and strategies presented are among those that have been proven to be ineffective.

Pricing and taxation

Evidence suggests that people increase their consumption of alcohol when prices decline, and decrease their consumption when prices rise. It is important to note that this evidence also holds for adolescents and problem drinkers. As a result, increasing taxes and prices on alcohol is associated with reductions in alcohol-related problems. Alcohol taxes provide two distinct benefits. They have the potential to generate substantial, direct revenue to the government and to help reduce alcohol-related harm. The main disadvantages sometimes associated with raising alcohol taxes include increased smuggling and higher levels of illegal in-country alcohol production. These can be addressed and prevented through the implementation of other measures.

Regulating physical availability

Putting restrictions on hours of sale, limiting the number of places for legal consumption, regulating the density of alcohol outlets, and setting a minimum legal age for drinking (i.e. making alcohol less easily available) will help prevent alcohol-related harm. Limiting the number of alcohol outlets forces buyers of alcohol to put more effort into obtaining it. This intervention policy has been found to reduce purchases and the consumption of alcohol. Notably, the cost of restricting alcohol availability is cheap relative to the cost of the health consequences related to drinking, especially heavy drinking. Research from economically developed countries supports the conclusion that as alcohol becomes more available in developing countries, heavier drinking and alcohol problems are likely to increase. Therefore, restricting the availability of alcohol can have large effects in nations or communities where there is popular support for those measures. The most common adverse effects of availability restrictions include increases in informal market activities such as cross-border purchases, home production, and illegal imports.

Altering the drinking context

This prevention measure seeks to re-define or change the contexts/environments, such as bars and restaurants, where alcohol is sold and consumed. Some evidence suggests that changes in the environment can reduce alcohol-related aggression and intoxication. The interventions include:

- Training bar staff to recognize when patrons are intoxicated
- Imposing voluntary house policies to refuse service to intoxicated persons
- Enforcing regulations, and
- Mobilizing neighboring communities to influence problem establishments.

The evidence base for these interventions suggests that they can have a moderate effect on limiting alcohol related harm, at a moderate cost. As is the case with voluntary self-regulation in other areas, such strategies as voluntary codes of bar practice have not demonstrated much positive impact.

Education and persuasion

This is one of the most regularly used strategies to prevent alcohol-related harm and also other types of behaviors leading to ill-health. People generally assume that information on health topics increases knowledge, changes people’s attitudes and thus alters their behavior to prevent drinking problems. The most popular educational programs are school-based interventions. These include:

- Offering information
- Clarifying values
- Building self-esteem
- Teaching general social skills, and
- Promoting ‘alternatives’ – approaches that encourage involvement in activities inconsistent with alcohol use (e.g. sports).

However, despite the wide use of this strategy to prevent harm from alcohol, the impact of such programs tends to be small at best. When researchers find that such education programs have had positive effects, those effects are generally short-lived. In other words, the impact of the education message fades rapidly. There is no question that educational programs have a role to play in a comprehensive approach to reduce alcohol consumption and harm, but they are best implemented within the framework of broader environmental interventions that address the availability of alcohol.

The evidence regarding the effects of public service announcements (PSAs) is also disappointing. Those messages, which are often sponsored by NGOs, health agencies and media organizations to encourage only responsible drinking or warn about the risks of drinking and driving, also have equally little effect on the issues they are trying to address. Despite their good

intentions, PSAs are an ineffective antidote to the high-quality, pro-drinking messages that appear much more frequently as paid advertisements in mass media.

Representatives of the alcohol industry are eager to promote education and persuasion strategies, which give the illusion of working to prevent irresponsible drinking. After all, who can quarrel with a sweet-sounding message that counsels: 'Drink responsibly'? Because such messaging is essentially ineffective, industry runs little or no risk of negatively impacting sales and consumption of alcohol. Profits are safe.

Significantly, compared to most control strategies, education and persuasion strategies are very expensive to implement. Standing alone, they are not a good investment in prevention.

Regulating alcohol promotion

The marketing of alcohol is a global industry. Alcohol brands are advertised on television, radio, in print, at point-of-sale-promotions, and through sport sponsorships; and, of course, on the Internet. Research has well documented that repeated exposure to high levels of alcohol promotion inculcates pro-drinking attitudes and increases the likelihood that the recipient of the advertising will engage in heavier drinking. Evidence has also established that exposure to alcohol advertisements predisposes minors to under-age drinking. Alcohol advertising promotes and reinforces perceptions of drinking as positive, glamorous and relatively risk-free.

Particularly due to advertising's effects on young people, a strategy that limits or prohibits the marketing of alcoholic beverages can be effective to prevent alcohol-related harm, especially among young people. The financial cost of implementing such a strategy is low, and public health gains substantial. Industry argues that it should be entrusted to regulate its members by establishing voluntary codes of advertising practice. These codes, generally written to accommodate industry norms, rather than actually restrict irresponsible marketing, are frequently unenforceable and threaten no penalties for lack of compliance. Quite simply, industry voluntary self-regulation has repeatedly been proven not to work. Regulation should be the domain of government, and industry should have the duty to comply.

Drink-driving policy options

Drink driving leads to traffic accidents, injuries and deaths. Evidence shows that drink driving can be effectively reduced through deterrence, punishment and social pressure. Random Breath Testing (RBT) has proven very effective. Such RTB programs involve police check-points, where motorists are stopped randomly and required to take a preliminary breath test. Motorists may be stopped even if they are not suspected of having committed an offence and have not been involved in an accident. This highly visible and non-selective testing can have

a sustained effect in reducing drink driving and the associated crashes, injuries and deaths.

Drink-driving countermeasures have been shown to produce long-term reductions of problems of between 5% and 30%. Deterrence-based approaches such as RBT, lead to few arrests but help reduce accidents substantially. Another effective measure involves the use of graduated licensing for novice drivers. Under such programs, new drivers operate vehicles under stricter conditions, until they have gained driving experience during the first few years of licensing.

Treatment and Early Intervention

A comprehensive alcohol policy should secure the availability of treatment for problem drinkers. Ensuring the implementation of screening and brief interventions in health care settings also helps to identify persons with alcohol problems and can lead to successful interventions. Exposure to any treatment tends to be associated with significant reductions in alcohol use and related problems. The benefits of treatments occur regardless of the type of intervention used, but most evidence suggests that behavioral treatments are more likely to be effective than insight-oriented therapies (i.e. psychoanalytical approaches).

Although there is no consistent evidence that intensive in-patient treatment provides more benefit than less intensive, out-patient modalities, residential treatment may be indicated (and especially useful) for those patients who

- are highly resistant to treatment
- have few financial resources
- come from environments that are not conducive to recovery, and
- have more serious, co-existing medical or psychiatric conditions.

Certain adjuncts to treatment, such as pharmaceutical therapies, have shown positive effects in the prevention of relapse (Naltrexone, an opioid antagonist, and acamprostate, an amino acid derivative). Also importantly, attending support groups like Alcoholic Anonymous may be better than no intervention at all and can have an incremental positive effect when combined with formal treatment.

Brief interventions have also been found to have good results for at-risk drinkers. These interventions consist of 1 to 3 sessions of counseling or advice usually delivered to the at-risk drinker in a medical setting and in connection with a harmful episode involving the use of alcohol (i.e., car crash, violent incident, etc.). Randomized controlled trials that have been conducted in a variety of settings indicate that clinically significant changes in drinking behavior and related problems can follow from brief interventions with non-alcoholic heavy drinkers. Brief interventions are relatively low cost to implement.

Summary

When developing an effective alcohol policy it should preferably include as many of the following measures that have been identified as best practices by researchers and WHO alike:

- Substantial alcohol taxes
- Minimum legal purchase age
- Limits on marketing
- Government monopoly of retail sales
- Restrictions on hours and days of sale
- Outlet density restrictions
- Sobriety check points
- Lowered BAC limits (Blood Alcohol Content) for drivers
- Administrative license suspension
- Graduated licensing for novice drivers, and
- Brief interventions for hazardous drinkers.

Less promising interventions/strategies (i.e., those that have shown no significant success in either reducing alcohol consumption, delaying the age of drinking initiation, or moderating harmful drinking patterns and dependence and thus potential harm to others, and which are relatively costly to implement) are listed here:

- Voluntary codes of bar practice
- Promotion of alcohol free activities
- Education about alcohol in school
- Education about alcohol among university students
- Public service messages
- Warning labels
- Designated drivers and “safe-ride” services (for example, free transport home for people too drunk to drive), and
- Voluntary industry self-regulation of advertising practices.

Conclusion

When considering the adoption and implementation of an alcohol policy in a country, it is important to think in comprehensive terms. The elements of the policy should include numerous strategies among the “best buys” listed above. Always anticipate the potential side effects that might accompany the different strategies and develop an ongoing plan to monitor, evaluate, and possibly revise policy change as necessary. Generally, such analysis requires routine inter-disciplinary research that can help guide and refine policy directions. Policy changes should be made with caution, and should be carefully tested to determine whether they have the intended effects.

Drinking patterns in Southern Africa are characterized mainly heavy episodic drinking. The policies most needed in a particular society should respond to the nature of the alcohol-related harm that most afflicts that particular society. Understanding the following factors can be very helpful when choosing strategies and interventions: 1) Volume of alcohol consumption in the country; 2) Pattern of drinking; 3) Harm that results.

An effective alcohol policy will always include the proven best practices. These practices are often opposed by the alcohol industry, which instead advocates policies and/or programs that you now know are likely to be weak and ineffective. Implementing strategies that are effective in countering the effects of alcohol promotion strategies of the industry should be a high priority. Because many countries in Africa have severely limited resources to devote to alcohol control, it is important to focus on implementing those that are evidence-based and have been proven to be effective strategies and interventions. Those will be the most cost effective as well.

Advocates must keep up with the latest science and research findings on alcohol use, harm, and policy effectiveness so that the information can be analyzed, organized, interpreted, simplified, and communicated regularly to policy makers and the public on an ongoing basis.

Policy makers should use the Precautionary Principle in crafting alcohol policy. Essentially, when considering public-health policy they should weight the interests of protecting the public from likely risks above the competing interests of potential industry profits and other economic gain. These considerations should occur in deliberating:

- The introduction of new alcohol products
- Removal of restrictions on hours of sale, and
- The promotion of alcohol through marketing and advertising.

Optimally, policy must be guided by the best scientific theory and evidence supporting best practices.

For the trainer:

Time needed for this module: Approximately 5 hours.

Methodology: Extensive presentation by the trainer followed by a plenary discussion among all the participants. The participants should then be divided into groups. Each group will be assigned to discuss one intervention, and will later present a summary of its discussion to the other participants.

Audiovisual tools that may be used for this module:

PPT: Effective Alcohol Policies – Best practices in prevention.

Other relevant material:

Babor, Thomas *et.al.* (2010) Chapter 1, 2, 7, 15 and 16, in; Alcohol: No Ordinary Commodity (2nd edition), Oxford University Press, 2010

WHO (2011), Addressing the harmful use of alcohol. A guide to effective alcohol legislation, World Health Organization Western Pacific Region, Manila 2011

2.4. MODULES OUTLINING POSSIBLE STRATEGIES AND FUTURE STEPS

This last chapter will focus on the opportunities and steps that the participants can take to help implement a high-quality, evidence-based alcohol policy in their country. By the end of the training the group of participants as a whole, and also subgroups within it, will have reached their goal and have developed a clear understanding of what must be done and what immediate steps must be taken. Importantly, the group will have identified and assigned discrete areas of responsibility so that the work will move forward. Undoubtedly, the outcomes of these training modules will vary from one training or one country to another, depending on numerous factors, including country and context.

2.4.1. PLANNING THE NEXT STEPS

This session will use creative tools to guide the participants in planning the next steps, assigning roles and responsibilities among themselves, their organizations, and as a group. The objectives include:

- Assessing the need for action and identifying the challenges that the participants will face after the training session
- Developing ideas for action, and
- Discussing and agreeing on a division of tasks and responsibilities among the participants, as well as deciding how they will communicate and cooperate following the completion of the training.

For the trainer:

Time needed for this module: Approximately 3 hours

Methodology: The trainer provides an introduction, outlining the goals for the module. That introduction will stress the importance of continued efforts and the dedication necessary among the participants to promote change to reduce harm caused by alcohol. Following this introduction, the participants will be divided into groups appropriate for the purpose of the exercise. In some settings grouping the participants randomly will work, while in others they should be grouped according to their organization or employer or profession, so they can actually brainstorm and propose concrete plans for action by their organization. The different groups will present the results of their discussion to the other participants. Finally, each group should write a plan or schedule for action.

2.4.2. RELEVANT LITERATURE AND OTHER FOLLOW-UP ACTIVITIES

The objective of this module is to enable the participants to identify and use relevant material and resources.

The trainer will inform the participants about:

- Relevant literature and other types of documentation
- Additional courses, possible further education
- Information regarding the follow-up seminars
- Other organizations working on alcohol policy
- Additional available resources (key people, research institutions, etc.), and
- Our contributions (Blue Cross Norway, FORUT, the organizer and so forth).

For the trainer:

Time needed for this module: Approximately 20 minutes.

Methodology: Presentation by the trainer, followed by the distribution of links and information about the resources presented.

2.4.3. CLOSING SESSION

The objectives of the closing session are to (1) provide a brief summary of the contents of the training and (2) motivate participants to formalize the next steps of the continued process by providing a toolkit and stressing the participants' obligation to engage in advocating for, and even develop, evidence-based alcohol policies for their context/country.

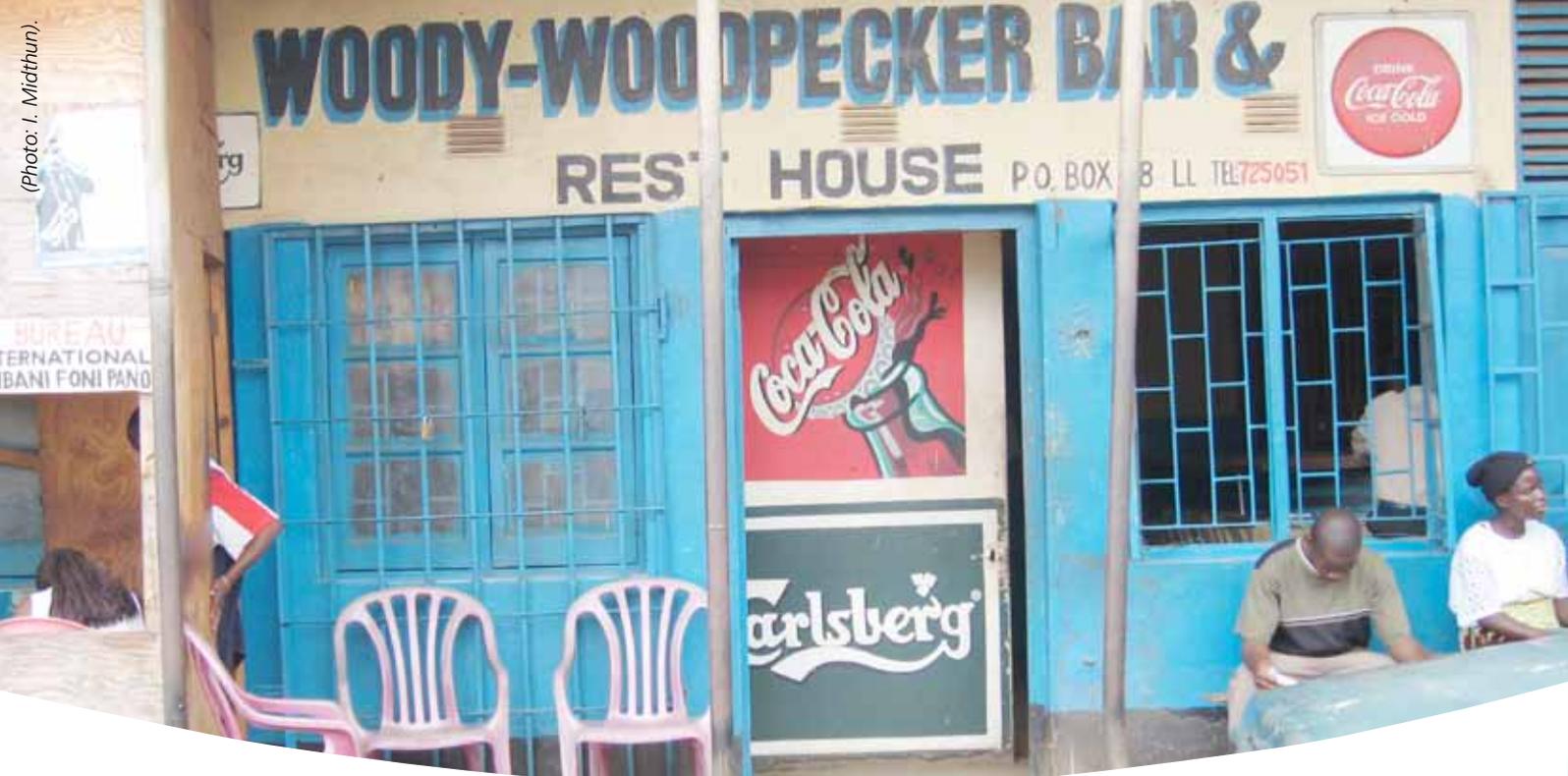
This session will include:

- a. A brief summary of the contents of the training
- b. A description of what the organizer of the training can/will offer after the training
- c. A discussion of a next opportunity to meet
- d. Distribution of CDs or flash stick containing relevant material
- e. Thanks to participants, speakers, organizers, and supporters, and
- f. An evaluation.

For the trainer:

Time needed for this module: 1 hour.

Methodology: Presentation by the trainer. CDs containing relevant material can be distributed. Where custom dictates, the trainer/organizer may also want to hand out certificates of appreciation/participation to the trainees. The trainer should thank the participants, speakers, organizers, and supporters. Others may also want to share their observations or appreciation with the group, and those participants should be invited to do so.



3. SUGGESTED LITERATURE.

Action Aid (2010), *Calling Time: Why SABMiller should stop dodging taxes in Africa*, Action Aid UK (2010), Available at: http://www.actionaid.org.uk/sites/default/files/doc_lib/calling_time_on_tax_avoidance.pdf

Anderson, P. (2004), *The beverage alcohol industry's social aspect organizations: a public health warning*, *Addiction*, Volume 99, Issue 11, pp 1376-77

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Bakke, Ø. (2008), *Alcohol, Health Risk and Development Issue*, in: Cholewka and Mothlag (ed.): *Sustainable Socioeconomic Development (Public Administration and Public Policy)*, CRC Press, USA, 2008

Casswell, S. (2013), *Vested interests in addiction research and policy: Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry?*, *Addiction*, Volume 108, Issue 4, pp 680-85

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Available at: <http://www.digitalads.org/documents/BMSG-CDD-Digital-Alcohol-Marketing.pdf>

Clausen, T. et. al. (2009), *Diverse alcohol drinking patterns in 20 African countries*, *Addiction*, Volume 104, Issue 7, pp1147-54

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Hastings, G. et. al. (2010), *Failure of self regulation of UK alcohol advertising*, *British Medical Journal*, Volume 340 pp 184-6, BMJ Publishing Group Ltd. UK

Jerningan, D. H. (2009), *The global alcohol industry: an overview*, *Addiction*, Volume 104, Issue supplement s1, pp 6-12

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Lachenmeier, D. W. and Rehm, J. (2009), *Unrecorded alcohol: a threat to public health?*, Addiction, Volume 104, Issue 6, pp 875-7

Molamu, Louis and Dave Macdonald (1996), *Alcohol Abuse Among the Basarwa of the Kgalagadi and Ghanzi Districts in Botswana*, Drugs: Education, Prevention, and Policy, Volume 3, No 2, pp 145-152

Parry, C. and J. Rehm (2013), *Alcohol Grows as a risk factor for death and disability in 2010 GBD Study*, The Globe, Issue 1, 2013, pp 3-4

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FORUT is a small, cost effective and flexible development organization based in Norway, working in four program areas:

- Alcohol, Drugs and Development (ADD)
- Child Rights and Development
- Gender Equality and Women's Rights
- Crisis Response and Recovery

FORUT is currently working with partners in Malawi, Zambia, Sierra Leone, India, Sri Lanka and Nepal.

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Blue Cross Norway is a diaconal and inter-denominational organization working in the field of treatment and prevention of alcohol and drug problems.

BCN has 41 local institutions in Norway offering treatment, education, housing services, job training, and counseling. BCN also works directly with partners in Southern Africa and in Russia. It is a member of the International Blue Cross. National Blue Cross Organizations can be found in 40 countries throughout the world, predominately in Europe and Africa and to a lesser extent in North and South America and Asia.

The headquarters of the International Blue Cross is situated in Bern, Switzerland.

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