Addressing policy change through multilevel approach - public sector and civil society:

TRAINING MANUAL TO SUPPORT EVIDENCE-BASED POLICY DEVELOPMENT IN LOW INCOME SETTINGS

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Summary

With rapid economic growth and young populations, the African continent is an attractive market for an alcohol industry looking to recruit new consumers. The development and strengthening of regulatory frameworks, and the effective implementation thereof, is key to protecting populations from alcohol related harm. This approach is strongly support by an internationally recognized evidence base, presented in Alcohol: No Ordinary Commodity and a number of the World Health Organizations (WHO) documents.

The challenge is to raise awareness of the problem and develop capacities to both put regulation in place and oversee its implementation. In an attempt to address this challenge in Africa, Blue Cross Norway and FORUT have, since 2009, implemented a Training Program on evidence-based alcohol-policies, in partnership with NGOs, Ministries of Health (MoH)and the WHO, in selected countries in the Southern-African region. A Training Manual was launched, a publication which can assist anybody anywhere to both learn and train others in evidence-based alcohol policy making, and which is available in both English and French. The content is module based, well tested and informative, both on topics relevant to policy making and the practical conduct of training.

The objective of the training program is to contribute to the development or strengthening of policy frameworks by promoting knowledge sharing with key stakeholders in low income settings. The modules are specially designed to be context sensitive and ensure a participatory approach. They may be used separately or combined into a comprehensive 3-day training.

Working in partnership with civil society organizations in Southern-Africa, the training program was found to have had significant positive impacts on national alcohol policies that are being developed or revised in countries in the region. Through its activities the program was also instrumental in establishing regional and national alcohol policy alliances. Based on these experiences a comprehensive guide to the training modules has been developed and may be used by anybody at any time to teach, learn and act in order to promote development and implementation of evidence-based alcohol policies in their context.

Counterbalancing vested interest through sharing of knowledge

Alcohol imposes an ever increasing burden on many developing countries, impairing their citizens' health and socioeconomic development. As incomes – and alcohol consumption – rise in the future, it is expected that addressing the problems generated by alcohol in developing counties will become even more urgent.[1]

In 2010 the World Health Organization (WHO) endorsed a Global Strategy to Reduce the Harmful Use of Alcohol, which highlighted the strong evidence for effective policy interventions reducing alcohol harm.[2] Dr. Margaret Chan, Director General of WHO, has clearly stated that this strategy stipulates that member states have the primary responsibility for formulating, implementing, monitoring and evaluating public policies which will reduce the harmful use of alcohol.[3]

Yet it is well known that the alcohol industry routinely develops and implements business and political strategies that often ignore public health concerns in pursuit of profit.[4] 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[5], 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 a meaningful way, and may do more harm than good.

In those contexts where there is limited knowledge on the most effective strategies to prevent the harmful use of alcohol, the industry will have greater space to secure profit friendly environments. In several of the countries we conducted the 3-day training; the industry was already actively pushing their agenda. This was generally aimed at convincing governments to adopt alcohol policies that, by themselves, are proven to neither reduce consumption nor harm, clearly protecting industry profits while bringing very little adjustment to the context in which they were to be implemented.[6]

Blue Cross Norway and FORUT, seeing the need to counterbalance the alcohol industry`s influence on national alcohol policies in several African countries[7], believing that all governments should be given easy access to the relevant research, and knowing that civil society organizations working to reduce alcohol related harm in many of these countries lacked knowledge and resources, realized that we had to act. The Norwegian annual TV-Campaign in 2008 raised funds for all of Blue Cross' activities, both in Norway and

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[1] Room, R. *et. al.* (2002) Alcohol in Developing Societies; A public health approach, Finnish Foundation for Alcohol Studies/WHO, Helsinki, 2002.
[2] WHO (2010), Global Strategy to Reduce the Harmful Use of Alcohol, World Health Organization, Geneva 2010
[3] Chan, M. (2013), 'Re: Doctors and the alcohol industry: an unhealthy mix? Letter in reply to BMJ feature on the alcohol industry', British Medical Journal, Volume 346,
URL: http://www.bmj.com/content/346/bmj.f1889/rr/640534
[4] Global Alcohol Policy Alliance (2013), 'Global public health community issues warning on alcohol industry conflict of interest', URL: http://www.globalgapa.org/news/news050413.html
[5] Ibid
[6] Bakke, Ø. and D. 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
[7] Ibid

internationally, giving us the resources and opportunity to address this challenge. Consequently, our organizations jointly developed and launched the Training Program on evidence-based alcohol policies.

Talking up the public health approach in Africa – the importance of being backed up by international experts

The Training Programme is made up of one complete 3-day training program, comprised of several independent thematic modules. This allows for a certain flexibility, modules may be taught separately or together, and can be used by anyone in any setting. So far the focus has been on selected countries in Africa, and trainings have taken place in Botswana, Malawi, Namibia, Chad, Lesotho, Madagascar and Zambia.

Research on alcohol related harm and the prevention and reduction thereof, is not carried out to a satisfactory degree in the African region. However by working in line with WHO's Global Strategy[8], as well as WHO AFRO`s Strategy to Reduce the Harmful use of Alcohol[9], and alongside international experts from the South African Medical Research Centre, the Centre for Research and Information on Substance Abuse (CRISA) in Nigeria and other institutions globally, from the onset of the program, we were assured that the population wide public health approach is the ideal message to put forward in the Training Program. Recent research shows that we were not mistaken in this, as patterns of, and reasons for, alcohol consumption in African countries are found to be consistent with what is observed in industrialized countries in that mean consumption rates are very much linked to levels of problem drinking and its associated societal consequences.[10]

At an initial phase of policy making, and our trainings often have been a part of that, it is absolutely critical to have recognized experts, from both the region and the country, involved in the presentation of the different modules. This is especially so for the daylong module on the effectiveness of different policy strategies to reduce alcohol related harm. Several of the t 3-day trainings have stirred up media interest, and for our local partners to say that they are putting forward what the experts say is giving them credibility. This has also contributed momentum to policy development, if not kick starting the process altogether. This was very much the case in Madagascar for example, where a policy draft had been around for some time, but, with the visit of Professor Obot, and a very outspoken local partner, the Malagasy Blue Cross, the media and the government listened and a fresh policy development process began, charged with new energy and knowledge.

Working with civil society – gaining the attention of the public sector

It is the responsibility of government to protect the health of their citizens, however in many low-income countries, national authorities and civil-society organizations alike, struggle to

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

[9] WHO AFRO (2010), Resolution: Reduction of the Harmful Use of Alcohol: A Strategy for the WHO African Region (Document AFR/RC60/4), World Health Organization Regional Office for Africa, Malabo, Equatorial Guinea 2010

[10] Rossow, I. and T. Clausen (2013), 'The collectivity of drinking cultures: is the theory applicable to African settings?', Addiction, Volume 108, Issue 9, pp1612-17

access valid information on proven and effective strategies which prevent the harmful use of alcohol. Since 2009, the Training Program on Evidence-Based Alcohol Policies has worked to promote the transfer of knowledge to key stakeholders in selected developing countries. In the early days of the programme, accessing national authorities in countries in which trainings were given was perceived as difficult, thus the program focused on reaching dedicated civil-society organizations.[11] FORUT and Blue Cross Norway looked to identify local NGO partners already working with, or dedicated to working on, the promotion of evidence-based alcohol policies in their particular setting/country.

However, it soon became clear that national authorities were positive, both towards attending the training and then actively involving civil society in national policy development processes. In Lesotho in 2011, it was the ministry responsible for the country's alcohol policy which invited Blue Cross to give the training there. This is mostly due to a particular Minister's personal desire to develop an evidence-based, rather than industry crafted, alcohol policy for her country. In Namibia the year before, there was an overlap of persons actively involved in both Blue Cross Namibia and the Department on Substance Abuse in the Namibian Ministry of Health, thus the training completed there in 2010 was done in full involvement with both sectors. In Malawi, where the 3-day training was conducted in 2009, FORUT's partner organization, Drug Fight Malawi, was already well placed in the ongoing alcohol policy revision process, working with Malawi's Ministry of Health as well as the Ministry of National Security. The cooperation between the different stakeholders, be it on the 3-day training or the policy revision process that followed, was documented by WHO AFRO as best practice in policy making.

Over the years this training have been conducted, it has become very clear that inviting and involving not only civil society organizations, but also government and political leadership, into the trainings, as both presenters and participants, has contributed not only to knowledge transfer to a broad section of society, but also ensured critical momentum, alongside ownership and dedication, to putting in place alcohol policies that will effectively protect society and people from alcohol related harm. An important step in achieving this is working together with a local partner. This partner needs to have a strong enough standing nationally, not only to ensure that all relevant stakeholders find their way to the training, but also to follow up on the subsequent policy development process. This has not been a success in every instance, but in all the countries we have conducted trainings, including Chad, we have seen slow but substantial steps towards the development of effective alcohol polices.

In summary, over the years of running this programme, we have learned that there seems to be three factors that determine success, both in the course of the training itself, but also, more critically, in the follow up and policy development processes[12]. These are:

- connections between the local partner and key persons or institutions in powerful positions,
- cooperation from the Ministry of Health and the WHO country office,
- and the strength and reputation of the local partner.

[11] Blue Cross Norway and FORUT (2009), Project Proposal: Training Program on Evidence-Based Alcohol Policies, Unpublished.
[12] Goos, C. (2011), Mid-Term Evaluation Report – Training Program on Evidence-Based Alcohol Policies in Developing Countries, Vienna 2011 (Unpublished)

Academia meets the practitioners – bringing together our experiences into one module at a time

Our intention is that the training and its modules can be taught in any kind of setting, and at any level, even when these may be of great variation. Keeping this in mind, continuous focus has been given to the development of a module based training 'kit'. This will help people choose training modules based on the needs and interests of their specific country or setting. The modules may be run in accordance with the template program of a full three day training session, or modules can be presented separately in any setting, big or small, to provide input to a particular challenge.

The modules are divided into three categories, catering for different stages of learning. The first set of modules aims to explore the types of harm alcohol causes in the setting where the training is being given, drawing on the experiences of participants to correctly identify challenges as they present themselves in their context. The second set of modules strives to give and develop answers to these challenges. The module on evidence-based policies to reduce alcohol related harm is of course the most important module here. The final set of modules is designed to ensure that the process does not stop after training, but can be continued by the participants and/or others, calling for and/or reviewing or developing an evidenced-based alcohol policy for their country or local setting.

The thematic modules:

Modules describing the current situation	Modules describing opportunities for positive change	Modules outlining possible strategies and future steps
Understanding the challenge	A comprehensive approach is needed	Planning the next steps
"Real life" – alcohol problems as the participants see them	Existing policies and legislation to prevent alcohol-related harm in the country in question	Relevant literature and other follow-up activities
The global picture – the role of alcohol in a global context	Evidence-based policies to reduce alcohol-related harm	Closing session
Alcohol related harm in the country in question		
The role and goal of the alcohol industry		
Unrecorded consumption		
The WHO Global Strategy to Reduce the Harmful Use of Alcohol		

From the start of the programme this set of training modules was loosely developed. With continuous input from the academic reference group, it was decided that, given the immediate challenges faced by the region in which the trainings were to be held, not only the evidence base but also the impact alcohol is having internationally had to be addressed. It is clear that the alcohol industry is a vector for health and social problems in Africa, because it exists

purely to encourage the consumption of an addictive substance by unfair means, and unless opposed, will threaten the rights of young people and vulnerable groups in particular.[13] This made it necessary to include modules specifically on the objectives and activities of the alcohol industry globally, but also, specifically, in the region itself.

To date the full 3-day training was conducted by FORUT, Blue Cross Norway and our partners in seven countries, initially piloted in Botswana, Malawi, Namibia and Chad. The pilot phase was extremely useful. Close dialogue with our partners and in-country visits by the manager a few months prior to the trainings enabled us to identify key challenges and topics needing to be addressed in particular settings.

During the pilot period one of the key findings was that in order to succeed in knowledge transfer, we needed to cater for the widely differing background of participants in our trainings. It is not a given that participants in trainings, even if actively involved in work thematically linked to the prevention of alcohol related harm, are knowledgeable about what we often refer to as `the evidence-base`. People are in this type of work for a number of different reasons, each having their particular areas of expertise. Even a medical doctor or skilled psychiatrist/psychologist, involved in the treatment of alcohol dependent persons, may not be aware of the 'best buys' when it comes to effective prevention and reduction of the harmful use of alcohol. On the other hand, we found that many policy-oriented participants, despite being passionately opposed to alcohol, often from a moral point of view, lacked a clear understanding of exactly how alcohol harms the human body. In Chad for instance, where we encountered this, a medical doctor from Madagascar, who works on the rehabilitation of alcohol addicted persons, was flown in to present specifically on this. However, in terms of the current content of the Training Manual, we touch only briefly on the medical and biological aspects, and focus more on structural issues and best practices in policy making.

When piloting the Training Programme and its different modules, we looked not only at the contents of the modules, but also to the order in which to present them, and how much time each module would require when allowing for both questions and discussions. Ensuring a high degree of participation in the trainings was a priority. All persons participating are there for a reason, and can often contribute meaningfully to learning outcomes, and pushing the subsequent policy process in the right direction. Therefore the first day of the training, as per the suggested program for the three day training, is dedicated to defining the problem(s) according to the perception of the participants themselves, contextualizing the training to the setting/country where the training is held. Additionally enough time for questions and discussions are suggested in all modules of the manual. Having experienced the lively discussions that may occur when reviewing different strategies, having a a capable and eloquent facilitator, to both guide the discussions and ensure sufficient time for them, is important in order to ensure all voices are included and that the training moves forward in a manner that serves the process.

There are two strategies that tend to cause more discussions than others; education/persuasion strategies and taxation/ minimum pricing. Many organizations working for the prevention of alcohol related harm have behavioral change through educational measures as their number one objective and activity. When somebody suggests that what you may have dedicated your life to will have very little long term effect unless other, more structural, strategies are in

[13] Obot, I. (2013), 'Alcohol Marketing in Africa. Not an ordinary business', Written specifically for Blue Cross Norway's series of seminars in Norway on the topic of alcohol marketing in Africa.

place, it can be a shock to the system. The same goes for pricing and taxation strategies, especially among those who are working in the rehabilitation of alcohol dependent persons. They often express deep concern over such measures because they fear these will lead to even less money for food etc. in drinkers' households, and believe for these reasons that prices and taxes on alcohol must remain low. These are very understandable concerns, which it has to be discussed properly, not just dismissed.

Further concerns are raised that increasing the price of alcohol will affect those who drink a lot. However, there is research indicating that the theory of collectivity of drinking cultures is applicable in Africa too. This theory explains the relations between the mean consumption and the proportion of heavy drinkers; the higher the mean consumption the higher the prevalence of heavy drinkers and vice versa.[14] This has some implications for prevention. The theory suggests that effective measures aimed at all drinkers are likely to reduce both the total consumption and the prevalence of heavy drinkers, thereby also reducing the associated problems.[15]

A third concern that is commonplace is that curtailing alcohol sales or increasing prices will only lead to an increase in illicit production and consumption. If we want to address alcohol problems, both licit and illicit alcohol should be addressed. Illicit production cannot remain endorsed forever as something impossible to change in today's corrupt world. The shift is not one to one. By neither addressing licit nor illicit products, the competition between them usually leads to additional alcohol use rather than a substitution of one for another. As always, multiple strategies that address more than one issue will be more effective. Dealing with illicit alcohol is often related to other issues such as limiting corruption and developing good governance. Where measures are taken to limit law enforcement officers taking bribes to turn a blind eye on illicit alcohol, effects of regulations will be better. The existence of a large illicit component in the alcohol consumption in many developing countries may complicate the matter. Still, this should be an argument for adapting alcohol policies to the local situation, rather than a justification for doing nothing.[16]

What comes after the trainings – supporting local and national research efforts

Sometimes the outcomes of the 3-day trainings have included a question from the group of participants on how to find more data and if they do not already have it. While as much data as possible has been collected and presented in the trainings, it is a fact that not enough research is carried out on the topic of the harms of alcohol on person and society in many African countries.

Seeing evidence as the cornerstone of all policies, FORUT and Blue Cross Norway have supported such efforts. In Madagascar Blue Cross Norway and the Malagasy Blue Cross joined forces with Madagascar's National Institute of Public and Community Health to look particularly at the consumption patterns among young people in Madagascar. A project is also in the pipeline in Lesotho, where research on the financial cost of alcohol to society is currently being developed. The latter project is being planned in cooperation with both the

[14] Rossow, I. and T. Clausen (2013), 'The collectivity of drinking cultures: is the theory applicable to African settings?', Addiction, Volume 108, Issue 9, pp1612-17
[15] Ibid / Babor, T. *et. al.* (2010), Alcohol No Ordinary Commodity (2nd ed.), Oxford University Press, 2010
[16] 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

WHO and Lesotho's MoH. While the study in Madagascar clearly shows that there is a need for prompt intervention based on existing best practices, we expect that the research in Lesotho will also feed into its current policy development process in a timely and much needed manner. Not only does such evidence inform policy, it also serves as a strong advocacy tool for those trying to argue for the development and implementation of such policies in their countries.

Policy outcomes – have there been change?

When the Training Program on Evidence-Based Alcohol Policies was evaluated in 2011, the report said that this program has had a relatively great output with relatively limited input.[17] As is often the case with NGOs, especially those working to reduce alcohol related harm; our activities have not involved large amounts of funding. We are proud of the changes we contributed to, and know we could not have done it without our dedicated partner organizations, training participants and the distinguished academics who joined the team of trainers time and time again.

Lesotho is the only country where an industry made alcohol policy made it all the way through the parliament before its origin was discovered.[18] There the 3-day training, after a slow start, made a significant impact. Following the course, the responsibility for revision for the alcohol policy was transferred to the MoH. A number of meetings in which the policy revision was discussed then followed in the MoH, and, participants from the 3-day training were especially invited to take part, given their knowledge on this topic. Lesotho has yet to put in place a health oriented alcohol policy, but due to the experience of the 3-day training, we were invited back into this process by the MoH in 2012. Then Dr. Morojele, who was also a trainer in 2011, presented the training module on the evidence-base once again, during the MoH's large stakeholder meeting on the policy draft. Furthermore, in Lesotho, civil society organizations stepped up their game to push for an evidence-based alcohol policy in the country. This year we saw the launch of Alcohol Policy Alliance Lesotho (APAL), which is made up of the organizations present at the training in 2011. The Alliance's number one objective is that an evidence-based alcohol policy is adopted in the nation.

Likewise in Madagascar, substantial efforts are being put into the policy development process. Given the difficult political situation in that country, the fact that the process is moving forward is an accomplishment in itself. An inter-ministerial body headed by the Prime Minister is overseeing the policy development process there, and the Malagasy Blue Cross is to a large degree coordinating all efforts, pushing the process forward. The 3-day training held in 2011 brought much attention onto the issue and great advantage has been taken of both the attention and the training. It is expected that the policy draft will be put to the Ministry of Justice before the end of the year the next step towards becoming law.

In Chad, where the 3-day training was held in 2010, it seemed that, due to the many difficulties of working in the country, the development of an evidence-based alcohol policy would be impossible.. Steadily however, Blue Cross Chad, in cooperation with the MoH, has

[17] Goos, C. (2011), Mid-Term Evaluation Report – Training Program on Evidence-Based Alcohol Policies in Developing Countries, Vienna 2011 (Unpublished)

[18] Bakke, Ø. and D. 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

developed an alcohol policy draft which is well in line with WHO recommendations. We look forward to following the development of this process.

The 3-day training in Botswana in 2009 took place at a time when its President had already taken the initiative to strengthen alcohol policy. In this regard, the country is in the lead in Southern Africa, having already implemented a substantial alcohol levy, a portion of which is dedicated to funding prevention activities. Thus, given that there was already strong momentum behind an evidence based alcohol policy, the impact of the training was, relative to other contexts, was less.

In Namibia, efforts to put in place a national alcohol policy were underway for some time. All told, six government ministries took part in the 3-day training given there in 2010, in addition to Blue Cross Namibia, several NGOs, community leaders and legislators. As such the Training Program was able to engage with the policy makers. Since the training, an Alcohol and Drug Control Bill is being developed concurrently with the nation's Alcohol Policy development process. Communities and other stakeholders are being consulted over the suggested policy changes, and the country's Youth Parliament and Blue Cross Namibia have been more assertive than others in asking for an alcohol policy which puts forward strategies recommended by the WHO. That said, the debate continues in the media and in the stakeholder meetings. Throughout this process, different entities representing the alcohol industry have been very active in pushing their views, Blue Cross Namibia and their partners have been very active in countering these however.

The training in Malawi in 2009 contributed to a process already under way. Local civil society organizations, supported by FORUT, were mobilizing to change an industry initiated alcohol policy process towards an evidence-based policy.[19] It was vital that all participants in this process be properly informed of the issues surrounding alcohol policy. Fortunately, all key persons, from both civil society and government sectors, attended the training. An evidence based alcohol policy is now for consideration by the Government.[20]

In Zambia training sessions were held in 2012 and 2013. These sessions informed an on-going alcohol policy process and helped mobilize civil society as active and competent partners of the process. Several groups and organizations with varied backgrounds have been working together to influence the draft alcohol policy, desiring that it be more evidence based, and a national policy alliance has been formed to structure the advocacy work of the NGOs.

Encouraging continued efforts in the region

When exploring the impact of the Training Program it is also worthwhile to explore recent regional developments. The Training Program was given in several countries in the Southern Africa region, where more and more civil society organizations have begun working for evidence-based policies..

[19] Bakke, Ø. and D. 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

[20] Ferreira-Borges, C., Endal, D., Babor, *et al*. 'Alcohol policy development process in Malawi'. Unpublished article accepted for publication by the International Journal for Alcohol and Drug Research

Moreover, as the alcohol industry is indeed global, advocates for societies free from alcohol related harm must be t likewise. A step towards this objective is the establishing of national policy alliances in several countries in Africa. Moreover, regional alliances are also being established. The first steps towards establishing the Southern African Alcohol Policy Alliance (SAAPA) were made in November 2010 when a Training of Trainers session on the Training Program was given to several previous training participants from all the countries in which it had been conducted. Last year we saw the full launch of SAAPA at the Southern African Alcohol Policy Forum in Johannesburg, and with the Eastern African Alcohol Policy Alliance (EAAPA) already in place, we are optimistic about alcohol policy development and subsequent implementation in the region.

We hope that all those organizations involved, and many others, will make use of this Training Manual, with its thematic modules both as an easy to access reference tool for the evidence-base, but also, and perhaps more importantly, to train new persons both within and outside of their organizations. Published in English and in French, we hope that anybody anywhere will make use of this Training Manual to both learn more themselves and use it as a guide in teaching friends and colleagues, so that together they can take the appropriate steps, in their respective settings and countries, to prevent and reduce alcohol related harm.

The evidence is available. The main resource for the training programme described here is "Alcohol: No Ordinary Commodity".[21] It describes recent advances in alcohol research that have direct relevance to the development of alcohol policy on the local, national, and international levels. Civil society can contribute to bringing this research to its intended audience of policy-makers who have direct responsibility for public health and social welfare. Ours is one such attempt. Several others are involved in similar efforts and it is our hope that these efforts will mutually strengthen each other, contributing to wide dissemination of evidence based alcohol policy. Where some countries take the lead, others will follow.

[21] Babor, T. *et. al.* (2010), Alcohol No Ordinary Commodity (2nd ed.), Oxford University Press, 2010