Alcohol and development

– a manual for civil society organisations

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IOGT·NTO
MOVEMENT

Alcohol and development –
a manual for civil society organisations

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This booklet can also be downloaded from *www.iogtntororelsen.se/internationellt* or *www.add-resources.com*.

Contents:

INTRODUCTION:

Alcohol – a development issue

Alcohol consumption is on the rise in many developing countries. Alcohol-related problems hamper development in many ways, and NGOs and institutions working within the development sector – as well as the developing world – would benefit greatly from addressing the issue in a better and more structured manner.

"... the negative effects of alcohol are disproportionally larger in lower and lower-middle-income countries."

Alcohol is an obstacle to development and a crosscutting, harmful factor in many areas of life. Alcohol causes massive health problems and is a factor in gender-based violence and the spread of HIV. The list goes on. A majority of the 17 Sustainable Development Goals are in one way or another affected by alcohol.

Globally, alcohol is the fifth biggest risk factor behind premature death, illness and injury. Annually, 3.3 million people die because of alcohol. The social costs amount to hundreds of millions of dollars every year.

The industrialisation of production and the globalisation of marketing of alcohol contribute to increasing consumption as well as to an increase in harms related to alcohol.

Even though alcohol causes harm in all corners of the world, the negative effects of alcohol are disproportionally larger in lower and lower-middle-income countries. People living in poverty are worse affected, with the disease burden per unit of alcohol consumption being larger than in high-income populations.

Who is this booklet for, and how can it be used?

If you are involved in a development organisation and wish to learn more about or engage in the issue of alcohol and development, this booklet is for you.

Perhaps you represent a donor organisation or are involved in development projects closer to target communities.

This manual aims to provide you with:

- Knowledge about how and why alcohol can have an adverse effect on development.
- Tools for your organisation to analyse the situation in your projects: Is alcohol a limiting or damaging factor, if so how?
- Tools for developing strategies to minimise the negative effects of alcohol in your projects and project areas.
- Tools for advocacy work towards local or national government in developing effective policy and prevention interventions.

The first part of the booklet covers a model of alcohol prevention that we find to be useful. Keeping the three corners of the prevention triangle in mind when planning interventions and programs to prevent harm from alcohol has helped us a lot.

The middle part is the manual. The idea is to give you basic tools that with some adjustments can be used within your own development work. We assume that you already have experience in methods of facilitating discussions in your organisation and within your target communities. The tools we provide are essentially lists of questions that need to be discussed, as well as checklists that we find useful in later stages of developing alcohol prevention strategies.

The last part aims to give the reader some background on the topic of alcohol and development. We go into some detail when it comes to the relationship between alcohol, health, poverty and other development issues. While it is certainly possible to skip parts of this section if you find it too technical, it could be important to increase the knowledge of other key staff members within your organisation.

In between the three main sections of this booklet you will find interviews with civil society organisations that have managed to improve the outcome of their programs after integrating alcohol prevention into their work. Consider this as a small sample of best practices.

It should be said that not every stakeholder in this field will, or even should have the ambition to, become an expert on alcohol. But given the serious harm caused by alcohol, with direct implications on development, projects and interventions may have a lot to gain from adding some alcohol prevention components. We hope that this booklet will give you useful guidance in that process. ■

In between the three main sections of this booklet you will find interviews with civil society organisations that have managed to improve the outcome of their programs after integrating alcohol prevention into their work.

Photo: Helena Goldon

Photo: Helena Goldon

CHAPTER 1:

Approaching alcohol prevention – a model

There are two profoundly different approaches to preventing harm from alcohol use. The first approach, often promoted by the alcohol industry, is all about targeting problem drinking and problem drinkers. At first glance this makes sense: Why not go right to the core of the problem? A bonus is of course that the general public –who manages to drink "responsibly" – does not have to be penalised by restricted availability or increased prices on alcohol.

"The number of heavy drinkers, and the level of harm, increases with the total consumption of alcohol"

The second approach is grounded in a public health perspective with broader, population level interventions. It is also evidence-based. When the world's leading alcohol researchers reviewed available studies it became very clear that public health interventions are effective while information campaigns to change people's drinking behaviour generally do not work.[1]

The theory behind the approach presented here predicts that the number of heavy drinkers, and the level of harm, increases with the total consumption of alcohol, and vice versa. Many studies support this theory. Most of them are done in Western settings, but the same conclusions seem to be applicable in other cultures as well.

1 Babor T., Caetano R., Casswell S., Edwards G., Giesbrecht N., Graham K. et al. *Alcohol: No Ordinary Commodity—Research and Public Policy*. Oxford, UK: Oxford University Press; 2010

Research also shows that most of the alcohol-related harm actually comes from moderate drinking.[2] Individually the risk of being harmed is of course lower compared to heavy drinkers, but collectively the risk is higher because of the much larger number of moderate drinkers.

In conclusion, reducing overall consumption of alcohol in a society is the most effective way to prevent alcohol-related harm. Supporting and protecting non-drinking behaviour – still common in many cultures – would also fit this model.

The prevention triangle

The prevention of alcohol-related harm requires a comprehensive approach. This could be described as the "prevention triangle".[3]

The three corners each represent an approach to prevention that will have some effect by itself. However, implementing these measures together will give much better results – one plus one no longer equals two, but three or four. So, let us have a look at the three corner stones of alcohol prevention:

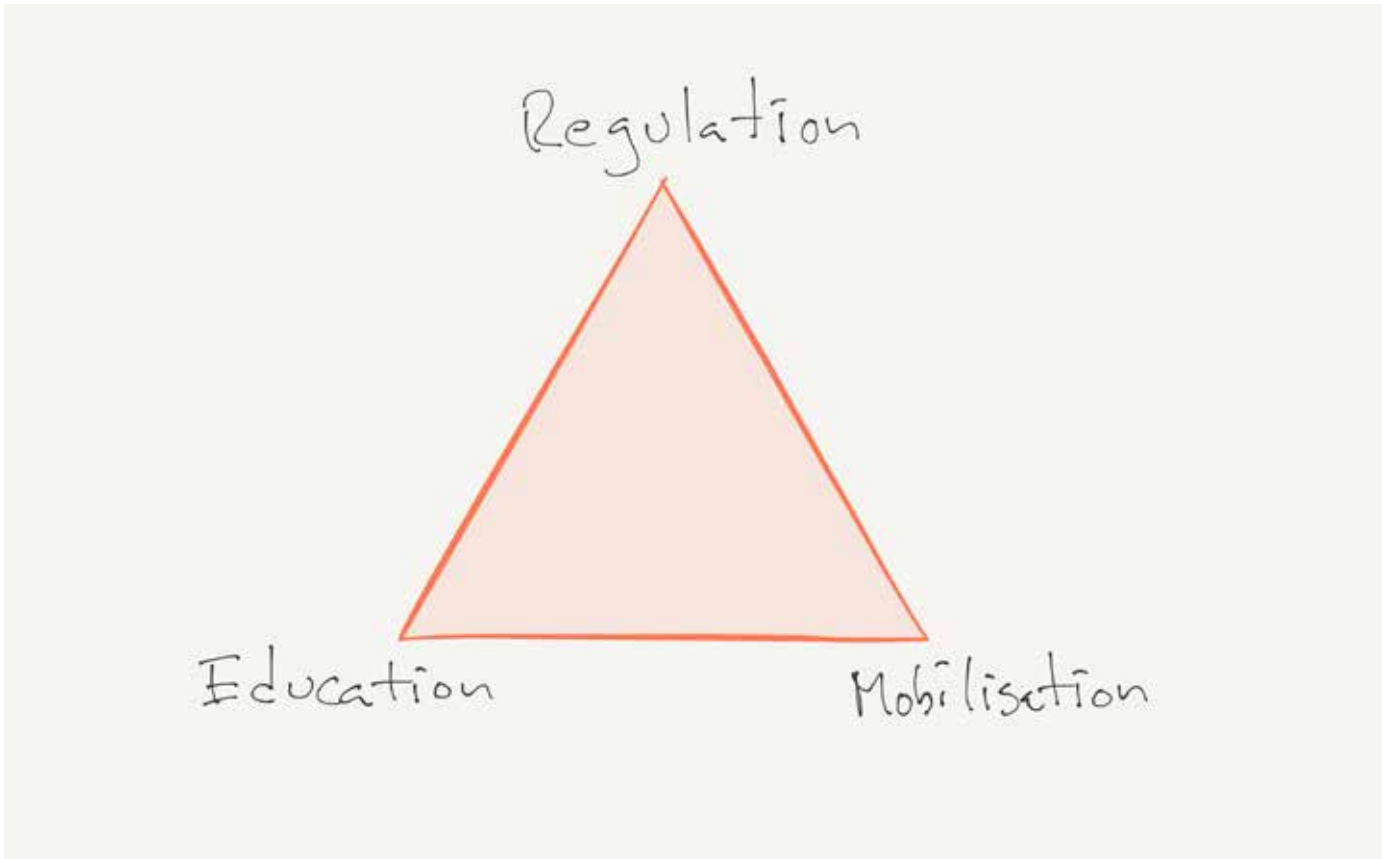
1. Regulation of markets

The single best measure when it comes to alcohol-prevention is government policy and regulations. WHO recommends "three best buys" in alcohol policy that have shown to be both cost-effective and affordable for all countries to implement:

- Regulate alcohol availability by limiting the number of outlets, hours of sale, age limits, etc.
- Increase the price of alcohol for example by using high excise tax on alcohol products.
- Restrict or ban alcohol advertising and promotion.

Available evidence suggests that these inter-

More WHO recommendations regarding alcohol policy can be found in "The Global Strategy to Reduce Alcohol Related Harm", adopted in 2010.



2 Aasland, O. G. (1989). *Prevention of alcohol-- related damage through restrictions on availability: The Nordic experience. Addictive behaviors: Prevention and early intervention.* T. Løberg, W. R. Miller, P. E. Nathan and G. A. Marlatt. Lisse Netherlands. Swets & Zeitlinger Publishers: 139-153

3 Bakke Ø & Endal D, *Alcohol and Development*, Forut, 2014

ventions are effective across cultures and levels of economic development.

Many low- and middle-income countries have at best weak alcohol policies. In some cases, there are policies in place that are outdated or rarely enforced. Unfortunately, the same countries often lack good quality data about the level of alcohol consumption and level of alcohol-related harm.

Government regulation of alcohol can be challenging. The interventions described above are almost always opposed by the alcohol industry that sees them as a threat to profits and expansion, especially in important so-called emerging markets.

In many cases the alcohol industry will try to make the argument that a reduction in sales of alcohol will be detrimental to the economy of the country (less tax income, less jobs created in the industry, etc.). This argument bears little or no merit. As we have seen above, the total cost of alcohol-related harm by far outweighs any income from sales of alcohol. Furthermore, if people spend less money on alcohol they tend to spend more money on other things, thus creating jobs in other areas.

For more on regulation of markets, see Toolkit 3 – A checklist for effective alcohol policies.

”Using a variety of tools, the program managed to raise awareness about alcohol-related harm in the community.”

2. Education

Studies have shown that education and information alone are not very efficient when it comes to preventing alcohol-related harm.[4] It is very difficult to change people’s behaviour using only this kind of intervention and it should therefore be used as part of a comprehensive strategy.

As part of a comprehensive strategy, education is important, for two reasons: People have a right to know the basics about alcohol and its consequences in order to make informed decisions – and education is often a good way of building support for more strict regulation policies.

A key objective of an education strategy is sensitizing politicians and decision-makers about the negative consequences of alcohol for society and for individuals, and how that harm can be prevented in a cost-effective way. Educational methods can also be used to explain and rally support for government regulations or to train professionals, such as doctors, police, teachers and others.

3. Mobilisation

Mobilisation includes community involvement and community-based approaches to address local problems. It may also include advocacy efforts that civil society engages in to put pressure on local and national governments to adequately address alcohol-related harms.

Actions within the community can be used to address problems connected to alcohol. In Burundi, the Burundi Girl Guides Association and the Burundi Scouts Association (BSA) established a prevention program. The program used a comprehensive approach with the aim of raising awareness on harmful effects of alcohol among youth, parents, community leaders and religious leaders, and to advocate for a national policy on alcohol.

Using a variety of tools, the program managed to raise awareness about alcohol-related harm in the community. Through advocacy efforts they also managed to create changes in policy: education about alcohol is now obligatory in Burundi schools, and the sale of alcohol in sachets (cheap liqueur, popular among students) has been banned.

Some countries lack the technical capacity to develop and implement evidence-based alcohol policies, and there may not be any civil society organisations to advocate for change or to act as a balancing force against the alcohol industry. In these cases, strengthening government capacity and supporting the growth of competent civil society organisations should be high on the agenda. ■

4 Babor T., Caetano R., Casswell S., Edwards G., Giesbrecht N., Graham K. et al. *Alcohol: No Ordinary Commodity—Research and Public Policy*. Oxford, UK: Oxford University Press; 2010

NOTES

Yonatha Ngingo is one of the women in Iringa who previously earned her living through brewing and selling beer. Photo: Helena Goldon

Alcohol prevention based in local community

In and around Iringa, Tanzania, a local NGO has started a project to reduce harm from alcohol use, as part of their development program. A central part of the strategy is to involve local communities from the start.

IDYDC, the Iringa Development of Youth, Disabled and Children Care, is working in and around Iringa, Tanzania, and was established in 1991.

IDYDC, a local NGO in Iringa, Tanzania, noticed that the region surrounding the city had changed.

– This used to be a region famous for its food production but the productivity in the villages has really decreased. There are many reasons of course, the HIV epidemic is a major factor, but when we speak to villagers they all mention alcohol as well, says Naomi Nyalusi, program officer at IDYDC.

IDYDC uses a community-centred approach in their project. By involving community leaders, government development officers, youth groups, religious leaders and other key stakeholders they aim to make sure that all activities are firmly anchored in the local community.

– The community needs to have complete ownership over the activities for this to be sustainable. This is what we aim for and in most cases we are successful.

Johan Sundqvist is the regional manager in East Africa for the IOGT-NTO Movement that

Photo: Helena Goldon

has supported this project from the start.

– The participatory approach is key. IDYDC has an important role as facilitators, but it's really the people in the community who define the problems and find the solutions. As facilitators they also contribute by getting local experts, like medical personnel, police or social workers into the conversation.

Discussions in the community have resulted in a number of interventions to prevent harm from alcohol.

– Very often the communities end up creating local legislation around alcohol, very much in line with evidence on the role of availability, outlet density and opening hours, says Johan Sundqvist.

The effects are often clear and visible to everyone. According to Johan Sundqvist, neighbouring villages also see the positive effects and want to be part of the project.

– And just to be clear, there's no money for the villages participating in this project, the only motive for wanting to be part of it is the results.

A relatively small intervention, such as reducing the opening hours of the local bar, can have important effects.

– It leads to more men going out on the fields to work; it's actually as simple as that, says Johan Sundqvist. From the evaluations of the project we can also see that more children now go to school, the number of reported cases of violence has gone down and through micro-financing many alcohol producers have found other sources of income. ■

"...more children now go to school, the number of reported cases of violence has gone down and ... many alcohol producers have found other sources of income."

CHAPTER 2:

Toolkits for developing alcohol prevention interventions

The following toolkits will be helpful in analysing the situation regarding alcohol and development in the work that your organisation is involved in. They will further help you to discuss and develop strategies to minimize alcohol-relate harm in your target communities.

These toolkits are centred around questions. According to our experience, discussing these questions within your organisation and with relevant stakeholders is a vital part of both the analysis and the development of effective strategies.

Keeping the prevention triangle (chapter 2.1 above) in mind will be helpful. We have also included some examples of successful strategies and interventions that we have come across over the years.

How to use the toolkits

You can use these toolkits separately or as a part of a more comprehensive strategy process. If the latter is the case, the process could look something like this:

1. Use the 'Ten steps to effective alcohol prevention' as a process guide.
2. In this process, you could – especially during step three – use the toolkit 'A rapid assessment of the alcohol situation' to help get the information you need.
3. You will likely be discussing the use of local policy interventions in target communities. When analysing existing policies or developing your own policy proposals, the toolkit 'A checklist for effective alcohol policies' comes in handy, as do the various examples of successful interventions published in this book.

More guidance on how to use the toolkits is provided within the toolkits themselves. It should be said that this is not a manual that will tell you exactly what to do, when. The toolkits should be seen as a framework, adaptable to your specific situation and needs. ■

TOOLKIT 1:

Ten steps to effective alcohol prevention

Why:
You want to know how alcohol affects your development efforts and you want to develop strategies to minimize alcohol-related harm in your target communities.

Who:
Organisations have many different ways of decision-making and structuring their work, so this is not a one-size-fits-all situation. We suggest looking at this as a project that will go on for a period of time, led by a project group with participants from different parts of the organisation.

This group will do the analysis and make suggestions for strategies, but will have to involve other stakeholders, both internally and externally, in the process.

How:
The first five steps of this toolkit aim to define the problem and understand the challenges, while the latter five guide the planning of interventions.

Some of the steps are done internally within your organisation, while some need input from other stakeholders. We do believe that you already have effective ways of holding meetings and communicating with your target groups – but we will still give you some tips along the way.

1 First look – Do we have a problem with alcohol?

By asking the following questions, briefly describe the problem as experienced by your staff, a local partner organisation or individuals from the target population:

- How do alcohol problems manifest themselves in your project area or within the target group?
- Which groups (social, gender, age, etc.) are involved as users? Are groups other than the users affected by the problem?

Our experience is that it is best to discuss these questions face to face. Questionnaires (by mail or online) could be used as a backup, but meeting people will most likely give better results.

Use the above questions as a guide, but don't hesitate to dig a bit deeper if people tell you something you think is interesting and relevant. "What do you mean when you say that…", "Can you give me some examples of when…" are the kind of follow-up questions you should be posing. Keep questions open; avoid questions that could be answered by a simple yes or no.

You probably already have meetings with your target communities and could bring up these questions in that context, or arrange a separate meeting. It is probably wise to avoid trying to get answers to these questions in large meetings; often you will get a better and more focused discussion in somewhat smaller groups.

Make sure that the discussion is documented properly.

2 Get more knowledge – time to read up

The available knowledge of alcohol-related problems, in all their aspects, is extensive.

Fortunately, successful prevention does not depend on mastering the available research in its entirety. Working together with more specialised stakeholders and organisations will complement your expertise and may offer a better strategy for attacking alcohol-related problems, at least during an initial phase. Nonetheless, it is likely that some staff members need a basic understanding of the issue, beyond what they know from common-sense beliefs and myths.

Chapters 4-6 of this booklet are a good starting point. We recommend that at least the project group read up on some of the theory and research on alcohol harm and prevention. If you feel the need to dig even deeper there is a list of suggested reading at the end of this booklet.

3 Problem definition – get into the details

As you start reading the basic literature on alcohol harm and prevention, you will acquire a both broader and more precise understanding of the problems you have discovered.

Use the information you gathered during step 1 together with the basic theories and research you have read to craft a description of the problem. This is a useful starting point for designing interventions.

This exercise serves several purposes: You need to define whether the problem is of a character and magnitude that can/should be handled by your organisation or if you would be better off cooperating with others. You need to determine if there are specific aspects of the problem that are more relevant to your organisation or target population, and you will need to choose effective prevention strategies to address the problems.

This problem definition does not need to be a highly scientific report. Most organisations will not have the resources to conduct substantial research before taking action. A reasonable approach to problem identification and description would involve compiling and analysing data that is already available:

- Finding existing research and documentation (reports, official statistics, etc.)
- Collecting experiences from the target groups, your partners, field workers, local governments, etc.
- Integrating the mapping of the alcohol/drug situation in the baseline for your programme. A problem definition could start by elaborating on the issues identified in step 1 by using the methodology described in the toolkit "A rapid assessment of alcohol problems".

Again: How ambitious you are in this step is up to you. More data will give you a better foundation for designing effective interventions, but there is no need to develop your own research department on alcohol prevention. The most important aspect of this step is your answer (in some detail) to the question: "What are the problems we want to solve?"

4 Are we (still) prepared to commit to this issue?

Becoming involved in alcohol prevention will necessarily result in additional work, even if the new activities are integrated into already existing programs. Recognising this reality early on is helpful, and a discussion among your organisation's decision-makers is essential. How much time and money are you prepared to invest in a preliminary assessment of the problem, and on possible interventions?

Presenting the analysis you have made so far to relevant decision-makers in your organisation is highly recommended. You do not want to end up investing a lot of effort into something that will not be used, due to other priorities in the organisation.

5 Identification of stakeholders

Based on the description in step 3 and your organisation's experience, who are the stakeholders in this particular case? Which groups, institutions and individuals are involved in or affected by the alcohol/drug use problems?

This is a discussion you can probably have in your project group, given that it involves representation from different parts of your organisation. One way of developing the list of stakeholders could be doing some kind of mind-map on a big board – sometimes it helps in discovering more stakeholders along the way.

Likely stakeholders include:

- Users of alcohol/drugs
- Users' families and relatives
- Third parties affected by users' drinking or drug-taking
- The village or the local community
- Vested interests in production, distribution and sale of alcohol/drugs
- Government institutions
- Political parties
- The health and welfare system
- Community-based organisations, faith-based organisations, non-governmental organisations
- Local police
- Other professions
- Media, educators, other groups.

6 Identify potential partners

Using your knowledge of the community, make a list of organisations, institutions, groups and individuals who could be mobilised as partners in prevention.

Some possibilities include:

- Social groups: women, students, youth
- Civil society organisations, churches, community-based organisations
- Resource persons in local governments, the scientific community
- Local or national government agencies and personnel
- Professional groups: doctors, social workers, teachers, nurses, police
- Other development organisations
- Media persons
- Community leaders, traditional chiefs, religious leaders, celebrities, etc.

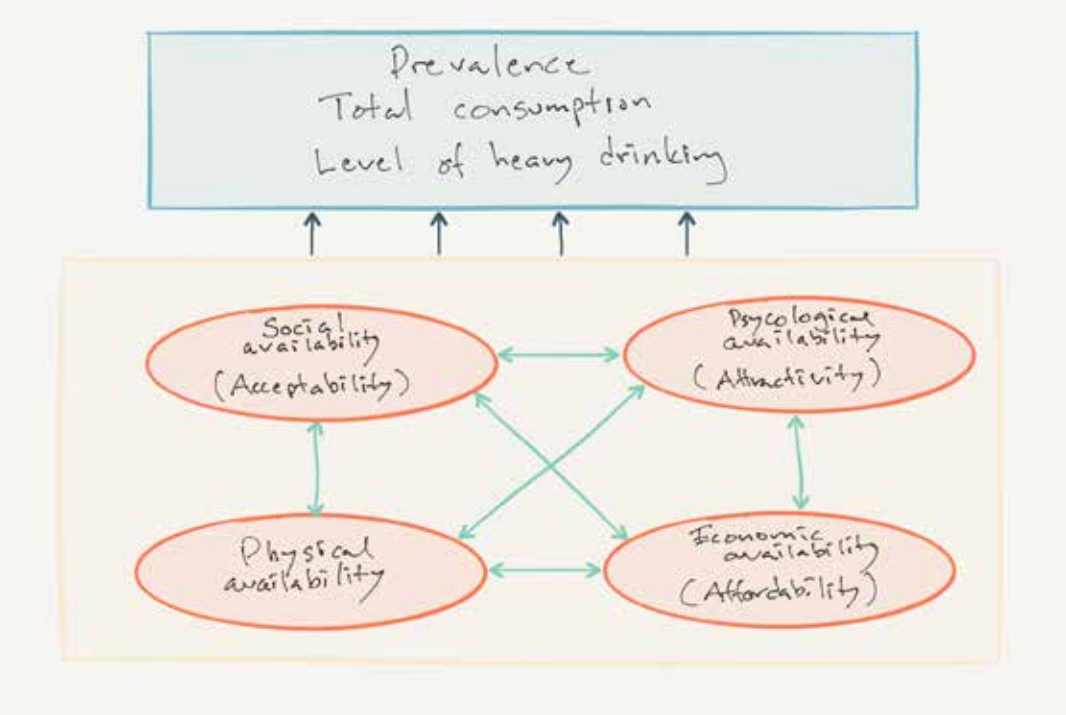
Bear in mind that not all relevant stakeholders will necessarily be good partners. This should be apparent, particularly when dealing with commercial vested interests.

7 Defining and understanding the determinants of alcohol-related harm

Designing the most effective interventions requires a thorough understanding of the reasons and mechanisms – also called determinants – that attract or encourage persons to drink, which over time leads to consumption, risky consumption and dependence.

The availability of alcohol is a key determinant of the prevalence of use, as well as how and when such use takes place.

The figure below indicates that four factors independently influence consumption levels and patterns. The four aspects of availability also interact and influence each other.



If alcohol is easily accessible, social acceptance tends to increase. If less available, social acceptance decreases. If alcohol is highly acceptable socially and attractive for individuals, the demand for easy access can increase and decision-makers may be less empowered to regulate sales.

This model can be used to define which determinants in a given culture and community contribute towards increased use of alcohol. Some questions to ask in relation to the model:

- How easy is it to buy alcohol? How many retail outlets are there? What are the hours and days of sale? What are the costs relative to the income level of the population? Are discounts or cheap products used to promote increased consumption?
- How attractive is alcohol for the population? What effects do people attribute to the use of alcohol? What expectations do people have in relation to the effects? Are there prevailing myths and misbeliefs around alcohol? Is advertising and other promotions used to influence peoples' attitudes and habits?
- What social value is attached to the use of alcohol? How is it tied to the projection of personal image? What expectations do people have related to the social effects of alcohol? Do individuals believe that others have certain expectations of them when drinking? How are non-drinkers perceived? What do people think/fear will happen if they choose not to use alcohol?

8 Step 8: Define strategies and interventions

This part of the process will help define which determinants (from step 7) are susceptible to influence from your interventions.

Choosing the right strategies and interventions is key to effectively using the Ten Steps for prevention of alcohol problems. Of critical concern in choosing among possible interventions is the "return on investment"; that is the aim of achieving the maximum results with a minimum of resources.

Fortunately, a broad evidence-base provides solid guidance in selecting among the range of less and more effective interventions. This international evidence is summarised in the WHO-sponsored study "Alcohol – No Ordinary Commodity" (Thomas Babor et al).

The study concludes that restricting the sale and promotion of alcohol is the most cost-effective way to reduce alcohol-related harm. That kind of regulatory approach should be complemented with education and mobilisation efforts, as described by the prevention triangle (see chapter 2).

"Predictably the most effective measures, which involve restrictions on availability, are also the most controversial."

Predictably the most effective measures, which involve restrictions on availability, are also the most controversial. The more popular interventions (providing information, etc.) are generally among the least effective, especially if they are implemented as stand-alone or one-off activities. Substantial evidence suggests that a comprehensive approach that incorporates numerous, coordinated interventions is more effective than single or isolated activities.

Once determinants have been identified and measured (see step 7), we move on to selecting strategies and activities for the prevention of alcohol-related problems: how can we influence the most important, identified determinants? What would be the most effective and practical approach?

- How can the physical availability of alcohol become more reasonably restricted in the target area? Are new regulations needed? Or is poor implementation of already existing regulations the real problem? If so, how can enforcement of regulations be improved? Example: In Iringa, Tanzania, a local organisation is working together with communities to find solutions to minimising alcohol-related harm. This organisation has been very successful in using locally adopted policies that limit opening hours, outlet density, etc.
- How can alcohol use be made less socially attractive in the local context? Example: Use the data and analysis on what kind of problems alcohol causes in the community and present that to the community. What do they think about this? What norms do they see around alcohol? Does alcohol give privileges to the drinker (using it as an excuse)? Do they want a change?
- How can prevailing alcohol expectations in the target population be effectively challenged? Can the social acceptance and condoning of bad behaviour by intoxicated people be confronted? How can the glamorisation of alcohol or drug use be reversed? Example: Same as above.
- What are some effective means of providing powerful, truthful information about the real effects of alcohol to the public? How can prevailing myths be challenged? Example: Using forum theatre as a method can be effective both as an eye-opener and as a starting point for continued discussion. These are short plays, acting out different situations connected to alcohol, often letting members of the audience replace actors to examine if there are alternative ways of solving the problem that is illustrated.
- What approaches are available to sensitise people about the harm to innocent persons around the user? Mobilising local communities, a strategy recommended in the WHO Global strategy to reduce the harmful use of alcohol (WHO, 2010) has proved to be effective in

reducing alcohol and drug problems. That strategy seeks to stimulate changes in collective, rather than only in individual, behaviour. Example: Mobilising women around the issue of alcohol and gender-based violence. Often this can be done through existing networks or organisations.

Not surprisingly, some conditions and behaviours are relatively easy to change, while others are more difficult. For that reason, it may be advisable to first direct advocacy work towards interventions and policies that are the easiest to adopt and enforce. At the same time, it is important to keep the long-term objectives and strategies in mind.

9 Integration – How does this fit with existing strategies?

It will be easier to make alcohol and drug prevention activities successful, both internally and externally, if the planned efforts are linked to already established programs and activities. That linkage creates synergies and allows planners to more effectively involve already existing resources – human or otherwise – within the organisation.

Clarifying this question within the organisation is of critical importance: How can new activities in the field of alcohol/drug prevention best be integrated into existing strategies and programmes?

10 Training of staff and partners

Key staff will need extra training on the topics and activities you have chosen. Many others will need basic education and, most importantly, guidance and motivation for their own involvement.

The staff members involved in the project group can do some of the training, as they will have gained a lot of knowledge on the way. Some training may need to be done by external resources, such as medical personnel, police or other NGOs who are more experienced.

TOOLKIT 2:

A rapid assessment of the alcohol situation

Why:
You want to gain a deeper understanding about how alcohol effects your target communities and the outcome of your programs.

Who:
Many times this work is done within a larger project, perhaps as outlined in the toolkit above ("Ten steps to effective alcohol prevention"). This toolkit could also be used on its own, either by a group within an organisation or perhaps by an external consultant.

How:
The following questions provide a simple tool for making a systematic, though not entirely scientific, assessment of the alcohol and drug situation in a given country or population, using a combination of statistical data and practical experience.

Hard data from research reports will be available for some of the issues, but practitioners will have to rely on alternative sources of information, such as interviews, anecdotal evidence, oral reports and experiences from the field. Useful information can be obtained from local health personnel, police, traditional leaders or other key persons in the community, who have close contact with the local population.

These questions can be used to initiate a discussion within your organisation or your project about alcohol and alcohol-related harm. You could also use them as a base for a more ambitious assessment that could supply valuable information for creating a baseline description at the start of a programme planning process. There may be good reasons to address the questions in an order different from what is presented below.

This toolkit was made with the prevention of alcohol in mind. Nevertheless it is possible to use the same methodology for preventing harm of illegal drugs if that is a concern in your target community.

The consequences of alcohol use

Which are the most frequently observed negative consequences associated with the use of alcohol and drugs for:

- the users
- their families
- friends, colleagues, neighbourhood
- the local community
- society at large

2. Priority issues

From the list in question 1, which do you consider to be the most serious problems resulting from alcohol and drug use in your context?

3 Types of substances

Which types of intoxicating substances are available and used in your project area?

- Alcohol
- Medicines, legal and illegal
- Solvents for sniffing
- Illegal drugs
- Which of these create the most severe problems?

The next topics relate primarily to alcohol, which is generally the most used of the intoxicating substances. The questions can, however, easily be adjusted to be used also for other substances.

4 Types of alcoholic beverages

Which types of alcohol are the most common in the population?

- Homemade traditional beverages
- Industrially produced traditional beverages
- International beverages produced domestically
- Imported international beverages

Which of these of beverages dominate the market in your context? Are there any differences in their use by persons of different socio-economic or cultural groups?

5 Distribution systems

- How are alcoholic beverages distributed and sold to consumers?
- Who are the producers or sources for the various types of alcohol?
- Who are the distributors and retailers?
- Which other vested interests are involved?

6 Who are the users?

In most cases there will be little statistical data available describing the prevalence of alcohol use in local populations. Very few countries have such data for specific regions or population groups. In the absence of such data, practitioners must estimate alcohol use based on experience in the target area and from discussions with persons who know the population well.

Such discussions can be highly enlightening and educational, even if the conclusions do not meet scientific standards.

7 Questions for discussion:

- What are the proportions of non-users and users in the target population?
- What is the number of heavy users?
- Gender differences among drinkers/non-drinkers?
- Age differences among drinkers/non-drinkers?
- Are there differences between religious, ethnic or socio-economic segments of the target population?
- Are there special risk groups/vulnerable groups among the users?

8 Consumption levels

How much do people drink? Is it possible to find data on consumption levels in the target population? In many cases, in particular in developing societies, such information is not available or not very reliable, especially in areas where there is a high level of unrecorded alcohol consumption.

- Recorded consumption
- Unrecorded, legal consumption
- Consumption of unrecorded and illegal beverages

The WHO Global Status Report on Alcohol (2011), which contains prevalence figures on national alcohol use for all countries, can be used as reference material.

9 Drinking situations

- In what kind of situations is alcohol being used?

• Regularity of drinking: How often does drinking occur?

- Amount consumed in different drinking situations?
- Risky consumption situations: Is drinking taking place in situations where the risk for accidents, violence etc. is high?
- Risky user patterns: Is alcohol used in a way that leads to serious intoxication, reduced control, etc.?

10 Drinking contexts

Under what circumstances does alcohol consumption take place?

- In a traditional context (traditional beverages, drinking situations and user groups)
- A ritual context (linked to religion, rites or rituals)
- A poverty context (urban or rural)
- A modern context (westernised values, globalisation)
- A crisis context (conflict, war, disaster)

11 Alcohol expectations

"Alcohol expectations" represent outcomes that people in a given culture attribute to the consumption of alcohol. Those outcomes can result from the chemical effects of the beverage or from other psychological mechanisms.

- Which expectations are attributed to alcohol use within the particular context, by the users and by people around the users?
- What types of behaviour do people expect from a drunken person?
- What do people want to express about themselves by drinking alcohol or by using certain beverage types or brands?
- Are individuals permitted or expected to behave in other ways when drunk than they would when sober?
- Is misbehaviour by drunken people accepted and pardoned?
- How much do people typically know about the real effects of alcohol?

TOOLKIT 3:

A checklist for effective alcohol policies

Why:
You want to evaluate a set of policy measures intended to minimise harm from alcohol. These policy interventions (limitations on availability, regulation of marketing etc.) could already exist or be developed by you together with target communities.

The list can also be used as a tool for advocacy, to influence the development of more effective alcohol policies.

Who:
This analysis could be done by staff members within your organisation or by external consultants. It is also possible to use the checklist as part of training in alcohol prevention, by letting the participants do the analysis (or parts thereof).

How:
The list below is compiled from recommendations in Alcohol: No ordinary commodity and other important documents in the field, such as the WHO Global strategy to reduce harmful use of alcohol. Compare existing or proposed policy to the list below.

If you want to monitor developments over the years you could use the checklist to make a scorecard where you give high points if legislation is in line with the recommendations in the list (and properly implemented). This way you can easily evaluate if the situation is improving or not.

The checklist:

Today there is largely consensus among alcohol researchers: We know what works and what does not work when it comes to preventing alcohol-related harm. This is probably best described in the book Alcohol: No ordinary commodity by Thomas Babor et al (second edition published in 2010). The book is based on a meta-study of almost all the latest available findings by some of the best researchers in the alcohol policy field – looking carefully at no less than 42 commonly used alcohol policy interventions.

Alcohol policies are typically understood as legal frameworks decided on by governments with the aim of preventing alcohol-related harm. In most countries this framework is found on a national level but there are important interventions that could be done on local level as well.

There are some interventions that have proven to be somewhat effective when implemented individually, but most interventions are more effective when combined.

1 Purpose of the policy

The purpose of the policy should be clearly stated with the ultimate aim being the prevention of alcohol-related harm and protection of public health and welfare.

2 Alcohol taxation.

Increasing economic cost of alcohol relative to alternative commodities will reduce demand, thereby reducing consumption and harm.

- Taxation revenues may be dedicated to alcohol prevention activities. Several countries have implemented “health promotion funds” to manage this.

3 Regulating physical availability is crucial. Recommended interventions:

- Minimum legal purchase age. Should be at least 18, preferably 20 or 21.
- Regulation of hours and days of alcohol sales.
- Restrictions on the density of retail outlets.
- Government monopoly on retail outlets sales.
- Licensing of alcohol producers and retail outlets.

4 Regulating or banning alcohol promotion and sponsoring.

Reducing exposure to marketing that normalises drinking and links it with social aspirations will delay the introduction to alcohol and reduce heavier drinking by young people. A total ban would be preferred, but partial regulations are certainly better than nothing.

5 Drink-driving countermeasures.

Recommendations include:

- Low BAC (blood alcohol content) limits – 0,5 mg or less.
- Even lower BAC limits for young drivers (zero tolerance).
- Sobriety checkpoints, random breath testing.
- Administrative license suspension or other swift punishment for drunk driving.

6 Brief interventions

Screening and brief interventions at primary health care units has proven to be a cost-effective way of helping people out of harmful drinking habits.

7 Education and information.

Available evidence shows that education and information alone are not effective in preventing alcohol-related harm. There is however a case to be made for a number of educational interventions to raise popular support for effective alcohol policy:

- Public campaigns to mobilise support for effective alcohol policies.
- Training programmes for relevant government officers and professions (medical personnel, police, teachers, religious leaders, NGO leaders etc.).
- Support to NGOs involved in alcohol prevention and treatment.
- Life-skills education and education on the effects of alcohol for young people.

8 Other recommendations:

- The purpose of the policy should be clearly stated with the ultimate aim being the prevention of alcohol-related harm and protection of public health and welfare.
- There should be a system in place to collect data on alcohol consumption and related harm.
- A specific authority or unit for implementation and follow-up of the policy and relevant laws and regulations.
- Protection from involvement of the alcohol industry in policy issues. One possible model is the strict regulations on government dealings with the tobacco industry in the WHO Global Convention on Tobacco Control.

Minsk. Photo: Alexander Kuznetsov / Flickr (Creative Commons)

Getting children out of institutions – alcohol a major factor

In Belarus, more than 25,000 children are raised in various institutions. The Swedish organisation Adoptionscentrum runs projects in the country to prevent boys and girls from being separated from their families – and has found that alcohol is a major contributor to the problem.

Adoptionscentrum's main work is helping families with adoptions, but they also do extensive work around the world to prevent children from ending up in institutions in the first place.

Every year authorities send about 4,000 Belarus children deprived of parental care to institutions. Orphans are only a small fraction of the total number.[1]

– We work mainly with adoptions, but in several countries we also run projects aimed at preventing children from being sent to institutions. We know that institutions are a bad environment for children, in many ways. In this work, especially in Belarus, we have seen that alcohol is a very strong contributing factor to this problem. About 85 % of the children in institutions come from an environment of alcohol abuse, and in order to really change anything we need to work on the issue of alcohol, says Ulrika Öberg, program coordinator at Adoptionscentrum.

Together with a local partner organisation Adoptionscentrum started self-help groups for parents who had been forced to give up their children due to alcohol problems.

– The organisation we cooperated with had

1 Belarus Digest online (read February 21 2017): http://belarusdigest.com/story/social-orphans-belarus-alcohol-takes-its-toll-12344

Ulrika Öberg. Photo: Pierre Andersson

experience of the Alcoholics Anonymous concept but parents were a completely new target group for them.

In Belarus, children who are taken into care first spend six months in a temporary children's centre. During that time parents are allowed to visit while authorities determine whether the family situation has changed so that the children can return home.

– We decided to start self-help groups at these children's centres. This concept was at the time totally unknown in Belarus and it took some time for it to gain acceptance. There is a huge problem with stigma around alcoholism, and even staff members at the children's centres were suspicious at first.

A precondition for children to be able to return to their families is that parents seek help for alcohol-related problems. This was a major motivating factor for parents to attend the groups. Holding the meetings at the children's centres was also helpful since parents were coming there to visit their children.

One of the key success factors was to train both staff at the children's centres and relevant government officials in alcohol-related issues.

– This helped us a lot. Gaining more knowledge created a deeper understanding about what we wanted to achieve, and our partner organisation got a lot of support from the local government after this. Parents also told us that they experienced better attitudes and treatment from the government's side after this training, says Ulrika Öberg.

"There is a huge problem with stigma around alcoholism, and even staff members at the children's centres were suspicious at first."

After the completion of the project, most of the self-help groups continued on their own.

– We are happy with the results. Many of the groups are sustainable and a lot of children have been able to return to their parents. ■

Photo: Helena Goldon

CHAPTER 3:

Alcohol and health

Alcohol consumption is one of the biggest contributors to death and disability worldwide.

The Global Burden of Disease study shows that globally, alcohol is one of the three largest risk factors behind premature death and morbidity.[1] The same study estimates that more than 3.3 million people die every year from alcohol.

In some parts of the world (Eastern Europe, Southern Sub-Saharan Africa and parts of Latin America) alcohol is the top risk factor. The same goes for 15-39 year-olds globally.

The connections between alcohol and health problems are complex and multi-faceted. Some links are easily visible and understood, such as people who develop drinking disorders, while others are not as obvious. There is a causal relationship between alcohol consumption and more than 40 different types of diseases and injuries.[2]

"The study estimates that more than 3.3 million people die every year from alcohol."

NCDs on the rise

Cardiovascular disease, cancers, chronic respiratory diseases and diabetes are the main non-communicable diseases (NCDs). Together they are the world's biggest killers – more than 36 million people die annually from NCDs.

NCDs are often portrayed as mainly affecting wealthier countries. In fact, low- and middle-income countries bear 86 per cent of the burden of these deaths, resulting in enormous economic costs and millions of people trapped in poverty.

Alcohol is one of the four main risk factors contributing to NCDs, together with tobacco, unhealthy diet and physical inactivity. In the

1 Lim, Stephen et al. *A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010.* The Lancet , Volume 380 , Issue 9859 , 2224 - 2260

2 Rehm, J., Gmel, G. E. Sr, Gmel, G., Hasan, O. S. M., Imtiaz, S., Popova, S., Probst, C., Roerecke, M., Room, R., Samokhvalov, A. V., Shield, K. D., and Shuper, P. A. (2017) *The relationship between different dimensions of alcohol use and the burden of disease—an update.* Addiction, 112: 968–1001. doi: 10.1111/add.13757.

WHO Global Action Plan to prevent NCDs (adopted 2013) one of the objectives listed is a reduction of the harmful use of alcohol by at least 10 per cent before 2020.

HIV and Tuberculosis

Alcohol is linked to the acquisition of both HIV and tuberculosis (TB). It is also linked to poor adherence to antiretroviral therapy (ART) and TB treatment, which could affect disease progression and mortality.[3]

Several studies show a link between alcohol use and HIV transmission. The main problem seems to be binge drinking, but several meta-analyses[4,5,6] have also shown that individuals who reported consuming any alcohol were 78 per cent more likely to become infected with HIV compared to non-drinkers.

The same studies show that binge drinkers are more than twice as likely as non-binge drinkers to become infected with HIV, and among those who drank before or during sex, 86 per cent were more likely to become infected.

Unprotected sex is almost twice as common when alcohol is involved and studies also show that drinking alcohol results in weaker condom negotiation skills.[7,8]

Alcohol is also a known risk factor for TB. When combined with other risk factors such as tobacco or diabetes it gets even worse. Active tuberculosis is three times more prevalent among consumers of more than 40 grams of alcohol per day compared to non-drinkers.

Alcohol use is also linked to poorer treatment outcomes. One reason behind this is that alcohol suppresses the body's immune response, resulting in heavy drinkers being twice as likely to contract TB. However, it is important to remember that even moderate alcohol consumption leads to poorer tretoutcomes.[9]

Alcohol and HIV treatment

Adherence to treatment is essential. Resistance to ART (Antiretroviral Therapy) can develop in patients who miss as few as 5 per cent of their doses. Studies show that adherence is significantly lower among alcohol drinkers, and even worse among heavy drinkers. The more people drink the worse adherence gets. One study among drinkers showed that 3,8 per cent missed doses of medication on non-drinking days, 6,2 per cent missed dosed of medication on days with moderate drinking and that more than 14 per cent missed doses of medication when binge-drinking.

Traffic injuries and fatalities

The global burden of alcohol-related harm includes a large and growing problem of traffic deaths and injuries. Globally 1.2 million people die in traffic accidents each year, 90 per cent of them in low- and middle-income countries.[10] More people die from traffic accidents than from malaria.

While there is a downward trend in most high-income countries, the number of accidents in low- and middle-income countries is rising sharply. More vehicles on the roads, failure to use seat belts or helmets and poor infrastructure are contributing factors that together with alcohol all too often constitute a deadly combination.

Almost one third of traffic deaths in the world are related to alcohol. In some countries in Africa the proportion is 60 per cent or more. One study in Ghana showed that almost six per cent of drivers on a given day had more than 0.8 mg alcohol per litre of blood in their system. In another study from Vietnam, 45 per cent of respondent males stated that they have driven a vehicle after drinking alcohol.[11] ■

3 Williams E. C., Hahn J. A., Saitz R., Bryant K., Lira M. C., Samet J. H. *Alcohol use and Human Immunodeficiency Virus (HIV) infection: Current knowledge, implications, and future directions*. Alcohol Clin Exp Res 2016; 40: 2056–2072.

4 Baliunas D, Rehm J, Irving H, Shuper PA. *Alcohol consumption and risk of incident human immunodeficiency virus infection: a meta-analysis*. Int J Public Health, 2010;55:159-166

5 Fisher JC, Bang H, Kapiga SH. *The association between HIV infection and alcohol use: a systematic review and meta-analysis of African studies*. Sex Transm Dis. 2007 Nov;34(11):856-63

6 Woolf-King, S., Steinmaus, C. M., Reingold, A. L. & Hahn, J. A. *An update on alcohol use and risk of HIV infection in sub-Saharan Africa: Meta-analysis and future research directions*. International Journal of Alcohol and Drug Research 2013. 2(1), 99-110

7 Scott-Sheldon L, Carey KB, Cunningham K, Johnson B, Carey MP; MASH Research Team. *Alcohol Use Predicts Sexual Decision-Making: A Systematic Review and Meta-Analysis of the Experimental Literature*. AIDS Behav. 2016 Jan;20 Suppl 1:19-39. doi: 10.1007/s10461-015-1108-9

8 Rehm J, Shield KD, Joharchi N, Shuper PA. *Alcohol consumption and the intention to engage in unprotected sex: systematic review and meta-analysis of experimental studies*. Addiction. 2012 Jan;107(1):51-9. doi: 10.1111/j.1360-0443.2011.03621.x.

9 Simet, S. M., & Sisson, J. H. (2015). *Alcohol's Effects on Lung Health and Immunity*. Alcohol Research : Current Reviews, 37(2), 199–208.

10 Bergh et al, *Trafikkulykker som globalt folkehelseproblem*, Norwegian Institute of Public Health

11 *STEPS Study*, WHO Vietnam 2015

Photo: Helena Goldon

CHAPTER 4:

Alcohol and development

The harmful effects of alcohol are not only about health. The use of alcohol also has substantial consequences on a wide range of development issues, such as poverty and hunger, gender and human rights.

From a macro standpoint, these effects are often quite fundamental. On micro level the harm from alcohol use varies widely in different contexts, depending on how alcohol is used and what kind of protective alcohol policies are in place.

”The links between alcohol and poverty are complex. Alcohol use can clearly impact poverty, but the link also seems to go the other way, with poverty impacting how alcohol is used.”

The global problems connected to alcohol are recognised by many within the development field. In 2010, WHO adopted a global strategy on alcohol and in more recent years the issue has been raised by among others UNDP and the World Bank. Alcohol and other drugs are also part of the Sustainable Development Goals (and one of the indicators connected to the improved health goal is indeed to measure decreased alcohol consumption).

Alcohol and poverty

The links between alcohol and poverty are complex. Alcohol use can clearly impact poverty, but the link also seems to go the other way, with poverty impacting how alcohol is used.

Expenditures on alcohol is a big part of the problem. A study from Sri Lanka[1] found that ten per cent of male respondents regularly spent all (or even more) of their income on

1 Baklien and Samarasinghe, Alcohol and Poverty in Sri Lanka. FORUT, 2003

Photo: Helena Goldon

alcohol. A study from Malawi[2] found similar results, with one 34-year-old man stating *"I used up all the money I received as salary in December on beers. Whenever I try to recall on what happened I feel sorry for myself because the following month I starved very much because I had nothing to feed the family."*

Spending a large part of the family income on alcohol increases the risk of effects that can further worsen the situation. Health problems leading to health care costs and reduced working capacity, or inability to send children to basic education, are all examples of indirect harm from alcohol.

On a national level, harmful use of alcohol has a negative impact on key human development outcomes on education, health and nutrition and is one of the key factors behind chronic poverty.

Gender-based violence

The roots of gender-based violence are found in unequal power relations between men and

2 Braathen, Substance Use and Abuse and its Implications in a Malawian Context, SINTEF Health Research, 2008

Alcohol and social costs

Lost productivity, health care costs, alcohol-related crime and property damage all constitute a substantial economic burden for many nations. Measuring this burden is notoriously difficult. Not only are the costs hard to estimate accurately, researchers also debate what kinds of costs to include. Despite these difficulties, a number of high-quality studies have been made.

One systematic review found that the average total social cost in a number of high-income countries is 2.5 per cent of GDP[1]. Another study found the cost of alcohol-related harm in Thailand to be 2 per cent of GDP[2], while a study in South Africa found the number to be as high as 10 per cent.[3]

1 Rehm et al, Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders, Lancet 373, 2009.

2 Thavorncharoensap et al, The economic costs of alcohol consumption in Thailand, BMC Public Health, 2006

3 Matzopoulos, R. G. and Corrigall, J. (2014): The cost of harmful alcohol use in South Africa. South African Medical Journal, February 2014, Vol .104, No. 2, (127-132).

women. There is however substantial evidence to show the links between alcohol and gender-based violence. The issue is complex, but it is becoming increasingly clear that alcohol is one of the components that must be addressed when attempting to prevent gender-based violence.

Alcohol is often included in the construction of a dominant, power-exerting and many times violent male role. In a masculine norm system, the occurrence of alcohol can exacerbate oppression of women. Alcohol fuels violence, in part by exacerbating destructive norms of masculinity. Destructive norms of masculinity also fuel drinking, creating a vicious circle of alcohol, destructive masculinity and violence.[3]

Several studies tell the story of men drinking before violent incidents. For example, one study conducted by Men Engage in Rwanda concludes that violence is more prevalent in families where the husband drinks alcohol (34 per cent of the drinkers showed violent behaviour compared to 19 per cent of the non-drinkers)[4]. The study also states "the comparative analysis indicated that consumption of alcohol is correlated with violent behaviour of men towards women".

Alcohol and the SDGs

"Many of the 17 Sustainable Development Goals ... are in various ways affected by consumption or production of alcohol."

The links between alcohol consumption and health problems are clear and recognised. As described above, there are also obvious connections between alcohol and poverty. What is often missing from the discussion is the impact of alcohol on a wide range of development issues, particularly in low-income countries.

Many of the 17 Sustainable Development Goals, adopted by the UN General Assembly in September 2015, are in various ways affected by consumption or production of alcohol. Let's look at some examples:

- **Goal 8 (economic development):** Studies show that alcohol-related problems cause substantial productivity loss – and even when the contribution from the alcohol industry (taxes, job creation etc.) is taken into account, the net economic effect appears to be negative.

- **Goal 4 (education):** In many communities, especially in low-income countries, parents' excessive alcohol consumption is one of the largest contributors to high dropout rates among school children.

- **Goal 6 (clean water)**: According to the UK consultancy Water Strategies it can take as much as 300 litres of water to produce one litre of beer. Another study, made by WWF (together with the alcohol industry), claims the number to be lower, between 60 and 180 litres.[5] Production of beer is often located in areas where water is a limited resource – an issue that will become even more significant with the ongoing climate change.

- **Goal 5 (gender equality):** Violence against women and girls is one of the most common human rights violations in the world. WHO estimates that one in three women have experienced physical and/or sexual intimate partner violence or non-partner sexual violence. The roots of the problem are complex and involve unequal, destructive power structures and norms around masculinity. Alcohol consumption is a factor associated with increased risk of perpetration of violence.

In summary, it is clear that alcohol needs to be taken into account when planning development, sustainability and human rights efforts. The effects of alcohol consumption are crosscutting and there is great potential for progress in many areas if effective prevention measures (such as local, national or international evidence-based alcohol policies) are implemented. ■

3 Miles E es al.Masculinities, Alcohol and Gender-Based Violence: Bridging the Gaps, Men Engage Africa

4 Slegh H, Kimonya A. Masculinity and gender based violende in Rwanda, Men Engage, 2010

5 The Guardian, Breweries across the world strive to decrease beer's water footprint, 16/8/2011 (https://www.theguardian.com/sustainable-business/brewing-companies-water-usage-footprint) Accesed in january 2017.

CHAPTER 5:

Thirsting for new markets – tactics used by alcohol industry

The alcohol industry is investing heavlily in so called "emerging markets" – often low- and middle income countries with weak or non existing alcohol policies.

Alcohol markets in the western world are largely saturated. Sales are even decreasing in many western countries, due to more effective policies and current trends leading to many people choosing a healthier lifestyle.

The alcohol industry is trying to meet these developments by increasing their efforts in so-called "emerging markets": mostly low- and middle-income countries in Africa, Asia and South America. In these countries, the average alcohol consumption is often lower and there is, in the eyes of the alcohol industry, potential for increased drinking and associated profits.

These companies have enormous market power – which all too often translates to political power on both state and global level. This is a big challenge to public health policy, as stated by WHO Director General Dr. Margaret Chan at the Health for All Conference in Helsinki in 2013, "Efforts to prevent non-communicable diseases go against the business interests of powerful economic operators. In my view, this is one of the biggest challenges facing health promotion."

Many low- and middle-income countries still lack an effective, coherent and evidence-based alcohol policy. In contrast to the tobacco industry, the alcohol industry still plays a role in policy-making in many countries. The industry is attempting to delay the introduction of various evidence-based policy interventions, using techniques well known from tobacco corporations.

These tactics include falsely disputing evidence and rationale for effective policy measures, engaging in various corporate social responsibility (CSR) initiatives in an effort to increase their goodwill, as well as aggressive lobbying towards decision-makers on all levels.

The industry policy proposals ignore, or choose selectively from existing international research on alcohol prevention developed by independent researchers and disregard or disparage public health approaches to alcohol problems[1]. They tend to focus on individual drinkers (by promoting so called "responsible drinking") while ignoring evidence-based interventions.

Civil society and alcohol industry

When the alcohol industry engages in CSR projects, they often seek cooperation with civil society organisations. Accepting financial support is of course tempting for most civil society organisations, but there is reason for concern.

Cooperation with civil society will lend credibility to alcohol companies and give them an aura of responsibility.

For civil society – especially if your organisation is in any way involved in public health, gender issues, human rights or development work – it is crucial to stay clear of cooperation with vested interests.

A lot of the alcohol industry's CSR and lobbying efforts is done collectively, through stakeholder organisations that exist both nationally and internationally in the form of brewer's associations, alcohol trade associations, beverage institutes and so on. The largest international alcohol industry organisation is IARD, the International Alliance for Responsible Drinking. ■

1 Bakke & Endal 2009. Vested Interests in Addiction Research and Policy. Addiction, Volume 105, Issue 1

Suggested reading

Publications

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Alcohol and development, Dag Endal, 2014. Available from www.add-resources.org.

Prevention works, Dag Endal, 2014. Available from www.add-resources.org.

Cheers to the family – Intimate partner violence and alcohol, Helena Wannberg, 2010. Available from www.add-resources.org.

Global Hangover, Pierre Andersson, 2009. Also available in Swedish: Världens baksmälla (latest edition 2017). Available from www.iogtntororelsen.se/internationellt.

Addressing the harmful use of alcohol – A guide to developing effective alcohol legislation, WHO WPRO, 2011. Available from http://www.wpro.who.int

Web resources

Alcohol, Drugs and Development (Forut Norway) – http://www.add-resources.org

WHO, Management of Substance abuse – http://www.who.int/substance_abuse/publications/en/

IOGT-NTO-rörelsens internationella arbete (mostly in Swedish) – www.iogtntororelsen.se/internationellt

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