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Alcohol control policies in low- and middle-income countries: Testing impacts and improving policymaking practice

Alcohol is a major contributor to the global burden of disease (Lim et al., 2012), and is a major source of health and social harm in many middle- and low-income countries, as well as in high-income countries. In recognition of this, a Global Strategy to Reduce the Harmful Effects of Alcohol was adopted in 2010 by the World Health Organization's governing body, the World Health Assembly (WHA) (WHO, 2010). Since then, there has also been increasing international recognition of alcohol's role in social problems, including crime, family problems, and lost work productivity: "beyond health consequences," WHO notes, "the harmful use of alcohol brings significant social and economic losses to individuals and society at large" (<http://www.who.int/mediacentre/factsheets/fs349/en/>). New emphasis has been put, too, on alcohol's major contribution as a risk factor for non-communicable diseases (NCDs) such as cancer, heart disease, and liver cirrhosis; WHO's global goals for NCD control include the (somewhat fuzzily defined) goal of a 10% reduction in the "harmful use of alcohol . . . as appropriate" by 2020 (WHO, 2013). Together, these steps reflect a greater international recognition of alcohol as a major issue to be addressed in improving global health.

From a public health and welfare perspective, these are the positive sides of the situation at the international level. The negative sides are many, and are often sufficient to thwart effective action aimed at reducing rates of alcohol problems. The resources devoted by international agencies to alcohol issues are tiny—no more than a handful of international civil servants are working on alcohol issues (at WHO's headquarters and regional offices), compared to dozens for tobacco and hundreds for substances covered by the drug treaties. WHO has found it extremely difficult to raise extra-budgetary funds for alcohol programs. International nongovernmental organizations with a focus on alcohol are also thin on the ground. Meanwhile, global alcohol producers and governments influenced by them work effectively to minimize international action to limit damage from alcohol. Much of this activity occurs behind closed doors; as Sornpaisarn and Kaewmunkan (2014) note, researchers have no access to internal alcohol industry documents, and can observe only the public side of the industry's public relations, primarily through its Social Aspects Organizations (Room, 2006). Meanwhile, alcohol is treated essentially as an ordinary item of trade by the World Trade Organization (WTO) and in international trade agreements, so that national restrictions are often overturned in trade disputes (Ziegler, 2009).

For these reasons, many countries are largely on their own in seeking to control their national alcohol markets and limit the damage from drinking. For instance, this was Malawi's situation in 2007, when it accepted a national alcohol policy formulated by an alcohol-industry-funded consultant from Australia (Bakke & Endal, 2010). Ferreira-Borges et al. (2014) give an encouraging report on later developments in Malawi, which, at the time their article was written, was close to adopting a final version of a new national alcohol policy, following the extensive consultations described by the researchers. Even so, Ferreira-Borges and her colleagues emphasise the "challenge" of managing the influence of stakeholders on the process, noting that "vested interests have accelerated their lobbying and have sought to change the document and slow its progress."

The paper by Sornpaisarn and Kaewmunghun (2014) illustrates vividly the influence that vested industry interests can exert on alcohol policy in a major developing country, although the paper also makes the point that industry interests are not necessarily unified. The extent of industry influence

noted in the paper is remarkable, considering that Thailand has a position of considerable leadership in global alcohol policy—for instance, in the WHA; in Thai Health’s leading role in WHO’s strand of work under the global alcohol strategy on alcohol’s harm to others; and in Thailand’s announced intention to require graphic warnings on alcohol containers—a move which is being strongly resisted, in WTO technical barriers to trade negotiations, by many high-income alcohol-exporting countries (O’Brien, 2013).

The paper by Tantirangsee et al. (2014) further illustrates the broad scope of Thai research on alcohol, with an interesting analysis of a series of large surveys of schoolchildren. It may be a coincidence that the paper’s finding of a decrease in drinking among early teenagers parallels other recent findings in culturally different circumstances (Livingston, 2014). But it is interesting to speculate whether there is something in common behind the shifts. In an era when global panic over the drugs under international control appears to be subsiding, there seems to be a growing willingness to recognise that, in fact, alcohol is among the most problematic of psychoactive substances. Through such mechanisms as increased parental concern, it is possible that such a shift in thinking might be showing up widely in the behavior of younger teenagers.

Parry’s paper (2014) uses the structure of WHO global alcohol strategy as a matrix for eliciting expert opinions on the status of alcohol policy in South Africa. Informants were asked to give ratings from one to 10 on each of 12 dimensions, with endpoints for each range defined by the investigator, and asked to rate South African policy on each dimension both contemporaneously and five years before. The highest mean contemporaneous rating was 4.59, while the highest for five years before was 3.16, suggesting, on the one hand, that the informants had a quite critical view of national policies, and on the other, that they perceived there had been some improvement. While the paper proposes the use of this “score card” for comparisons across countries, it acknowledges potential barriers to this, such as the possibility of “variations in the degree to which members of different societies tend to be critical of government policy and implementation.” It remains a question for further study whether the approach this paper takes—using general ratings based on the judgement of experts—will prove more useful cross-nationally than the scores based on specific policy provisions used in previous cross-national comparative ratings.

The paper by Kolosnitsyna et al. (2014) offers an interesting update on alcohol control policies in Russia; as well, it takes advantage of a one-year window in which there was regional control over opening hours to provide an invaluable analysis of the differential effects of variations in restrictions on hours for alcohol sales. The paper finds that greater restrictions, particularly on how late in the evening sales were permitted to continue, did have an effect in lowering alcohol consumption, both of beer and of all alcoholic beverages (mostly spirits), whether measured in official sales statistics or by respondents’ self-reports in successive cross-sectional surveys. These strong findings extend into a new sociocultural setting the general findings that the paper notes in the previous research literature—mostly from Nordic countries, North America, Britain and Australia (e.g., Kypri et al., 2014; Rossow & Norström, 2012) but also including Brazil (Duailibi et al., 2007)—that restricting opening hours, and particularly night opening hours, reduces not only consumption, but also alcohol-related problems.

Taken together, the papers in this issue make a significant contribution to the knowledge base for alcohol policymaking in low- and middle-income countries. The papers by Kolsnitsyna et al. (2014) and Tantirangsee et al. (2014) contribute to our understanding, essential for informed policymaking, of what strategies work under what circumstances in such countries. While there has been a slow accumulation of such studies (Medina Mora et al., in press; Room et al., 2002), there is an urgent need for much more work of this kind. Also needed is a global clearinghouse, provided through WHO or otherwise, which would be able to advise countries and localities and provide the relevant evidence on public-health-oriented alcohol policy measures and their implementation. In setting priorities for policymaking, countries also need ways of evaluating where they stand on different dimensions of alcohol policymaking, and the paper by Parry (2014) is a contribution in this regard.

The papers by Sornpaisarn and Kaewmungkun (2014) and Ferreira-Borges et al. (2014) are a reminder of the complexity of the actual policymaking process, where interests other than public

health and welfare must be taken into account. There is a need to develop a knowledge base in this area as well, building on case studies like these two papers to develop rules of practice for ensuring that proper priority is given to health and welfare interests in the formulation and implementation of alcohol control policies. The results from the comparative risk analyses of the Global Burden of Disease (Rehm et al., 2013) remind us that, in most parts of the world, we still have far to go in minimizing the harmful use of alcohol.

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