ALCOHOL AND DEVELOPMENT

FORUT
CAMPAIGN FOR DEVELOPMENT AND SOLIDARITY

"As development occurs, in the absence of major mitigating influences such as religious prohibitions, alcohol consumption and resulting problems are likely to rise with increasing incomes."

From Room, R. et al. Alcohol in Developing Societies: A Public Health Approach"

ALCOHOL AND HIV/AIDS

Published by FORUT
– Campaign for Development and Solidarity
This publication is a part of FORUT's ADD programme; Alcohol, Drugs and Development.

Text: Øystein Bakke and Dag Endal
Cover photo: Eli Gunnvor Grønsdal
Other photos: Cascoli - Dreamstime; Antonella865 - Dreamstime; Alan Gignoux - Dreamstime; Dag Endal - FORUT.

Graphic design: Gry Thorleifsen, FORUT

ADD contacts:
Øystein Bakke, oystein.bakke@forut.no
Dag Endal, dag.endal@forut.no

ADD web site: www.add-resources.org
FORUT web site: www.forut.no

Print shop: Grøset Trykk AS
2014 - 1.000 copies
ISBN 978-82-999754-3-8

Can be downloaded from
www.add-resources.org

Intoxicants come in many forms. They all have, to various degrees, harmful effects on the body, on the mind, on human relations and on the society at large. Some are legal, others are illegal. Some are synthetic, others derive directly from nature.

This booklet addresses only alcohol, the most commonly used intoxicant worldwide and, according to international statistics, the one that causes the greatest amount of health and social problems.

FORUT
CAMPAIGN FOR DEVELOPMENT AND SOLIDARITY

Reducing alcohol harm — a development perspective

Researchers describe how alcohol consumption and alcohol-related problems will likely rise as incomes increase in developing societies (Room et al 2002). That trend is already evident in many countries in Africa and Asia.

Some people are dependent on the increasing attractiveness of alcohol. For them, producing or selling it represents a livelihood strategy amid conditions of high unemployment and limited access to formal employment markets. In large part, the alcohol markets in Africa and Asia are severely unregulated.

Global alcohol producers have seized on the new demand for alcohol, abetted by minimal regulation and the increasing purchasing power resulting from economic development. Industry aims product development and marketing strategies at all segments of the population; the growing middle class and poor people alike.

For poor people, alcohol may seem to present an easy way out of a very hard life. Industry steadily reinforces that image using marketing tactics that conjure a taste of luxury, recreation and the world beyond everyday worries.

A health problem...

Excessive alcohol consumption is a risk factor for premature death and ill health of individuals, including non-communicable diseases (NCD), mental health, TB, HIV/AIDS, intentional and unintentional injuries, traffic injuries. According to WHO's 2010 Global Burden of Disease study alcohol ranked fifth among leading risk factors for ill health and early death globally. In three regions of the world, Eastern Europe, Southern Sub-Saharan Africa and large parts of Latin America, alcohol counts as risk factor number one (Lim et al. 2012). Looking at men only, data show that alcohol represents an even more prominent risk factor. Alcohol-related harm results from several sources, including the toxic and dependency-producing consequences of long-term use and harm from intentional and unintentional injuries related to the acute effects of intoxication (see Figure 1). A causal relationship exists between alcohol consumption and more than 60 types of diseases and injuries (WHO 2002).

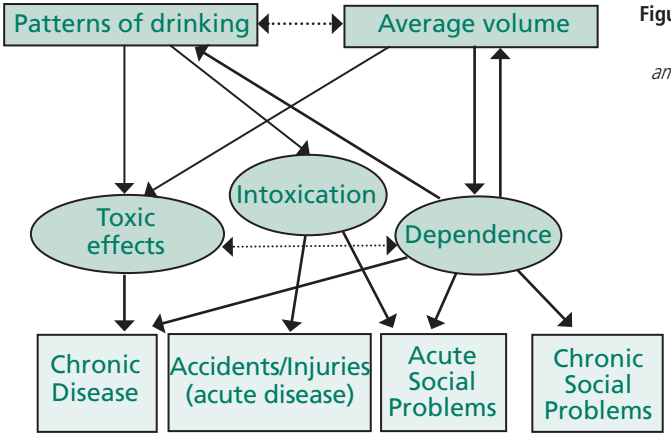


Figure 1: *Relations among alcohol consumption, mediating factors and alcohol-related consequences (Source: Babor et al. 2010. By permission of Oxford University Press).*

Non-communicable diseases

The 2011 United Nations High Level Meeting on NCDs recognized a global need to develop and implement prevention strategies designed to control the disease burden related to alcohol and three other risk factors: tobacco, unhealthy foods, and lack of physical exercise. The four disease categories in the UN's NCD basket include cancer, cardiovascular disease, chronic lung disease, and diabetes, which together account for two-thirds of all deaths and half of all disability worldwide (UN 2011). Although not directly included in the UN process, mental health conditions also significantly contribute to the NCD global chronic disease burden (Murray et al. 2012). Alcohol is a factor in many of those conditions.

Generally portrayed as problems besetting the more wealthy countries, NCDs constitute a significant portion of the disease burden in low- and middle-income countries as well. Many of those diseases and conditions are closely related to inequity and inequality, both in rich and poor countries. Viewed in this context, the global discussion about NCDs should emphasize the role of broader social and environmental drivers of NCDs, rather than just considering how to correct the unhealthy choices made by individuals.

Injuries and traffic fatalities

Violence and injuries make up a considerable proportion of the global, alcohol-related disease burden. That burden includes a serious and growing problem of traffic deaths and injuries in many low- and middle-income countries. Globally, 1.2 million people die in road traffic accidents every year – 90% of them in low- and middle-income countries. The trend in traffic crash deaths in those countries is rising steeply. A number of factors combine to aggravate the rate of deaths: high speed, alcohol, poor roads, and the failure to use a seat belt or motorcycle helmet.

Globally, 30% of road deaths are related to drink driving; in some African countries the proportion is 60% or more. The lack of surveillance of the major causes of the crashes makes accurate statistics hard to compile (Bergh et al. 2013).

Infectious diseases

Although not covered in the Global Burden of Disease study, the role of alcohol in infectious diseases, particularly HIV/AIDS and Tuberculosis (TB), may be even more relevant in a development context.

Some have pointed to alcohol as the forgotten drug in HIV/AIDS (Fritz et al. 2010). A growing body of research in Sub-Saharan Africa has revealed consistent evidence of a strong correlation between alcohol use and high-risk sexual behaviour (e.g., sex without a condom) and alcohol use and HIV/STI infection (Woolf-King et al. 2013, Schuper 2010).

Recent research has also determined that alcohol directly causes risky sex intentions (Schuper 2013). In addition, the effect alcohol has in impairing the immune system increases the vulnerability to infections for those exposed to the virus. Despite this evidence, further research is needed to substantiate causality between alcohol use and HIV/AIDS incidence (Schuper 2010, Parry et al. 2009, Rehm et al. 2009a).

HIV/AIDS researchers have concluded that heavy drinking is a cause for the worsening of the disease course in those already infected with the disease. Alcohol consumption degrades HIV/AIDS patients' adherence to antiretroviral and other forms of treatment and negatively affects the immune systems of those patients (Schuper 2010).

Research provides sufficient evidence for a causal relationship between alcohol and the incidence of Tuberculosis, a significant contributor to the global burden of disease (Shield et al. 2013). For TB patients, alcohol plays a negative role both in acquisition of the disease and in its clinical course. People who drink heavily or suffer with alcohol use disorders show higher relapse rates, a higher probability of an unfavourable clinical course, and a higher probability of experiencing the most destructive forms of TB. These consequences result from the interruption of treatment that often follows heavy alcohol use and from the altered pharmacologic effects of medicines used in treatment of TB (Rehm et al. 2009b). The influence of alcohol on treatment compliance is a growing concern, due to the spread of new, drug-resistant strains of TB.

... and a development problem

While health consequences of excessive alcohol consumption are often apparent for individual users, the long term effects of alcohol use and the acute effects of intoxication often visit third parties as well, in families, work places and communities. The extent of harm to others than the drinker frequently supplies a rationale and impetus for community interventions to reduce such harm.

Heavy alcohol use and the resulting alcohol-related harm represent a substantial impediment to development by exacerbating already existing social problems and poverty. An increasing volume of research shows that harmful use of alcohol is a risk factor for several of the most important development challenges, such as poverty, gender-based violence, child-rights violations, health problems and lack of education.

Poverty

There are strong links between alcohol use and poverty, but the relationship is complex. High levels of harmful alcohol consumption may cause poverty; alternatively, poor people may resort to drinking to cope with their hardships. The two responses may also interact in a downward spiral, making many types of problems even more severe. Adding to the severity of this result is the well-established finding that the same amount of alcohol may cause more harm among poor people than in more affluent populations.

Expenditures on alcohol are often deeply intertwined in the conditions of poverty. For example, men in Malawi, who were interviewed in a study, reported buying and drinking beer and smoking chamba [marihuana] regardless of how little money they had (Braathen 2008). Another study in Sri Lanka found that more than 10 percent of male respondents spent as much as or more than their regular income on alcohol (Baklien and Samarasinghe 2003). Still, the researchers discovered that calculations of the expenditures on alcohol grossly underestimate the real costs, which included the loss of education, persistence of health problems, reduced work capacity, and impaired well-being of families and societies.

Gender equality and gender-based violence

Generally, men consume more alcohol and cause more problems related to that drinking than women. Gender-based violence around the world is one of those significant problems. In several studies, women report that their husbands had been drinking when violent incidents occurred. Several studies also identify higher risks of being exposed to violence associated with men's or women's excessive drinking patterns or having an alcohol-dependent intimate partner. Some of the studies support the conclusion that alcohol may play a direct precipitating role in domestic violence (WHO 2004). Not surprisingly, the nature of the association is complex and it would be ill-advised to draw simplistic conclusions.

Children

Millions of children all over the world are innocent victims of adults' use of intoxicating substances. Such victimization occurs in western and developing societies. Children experience a broad range of harm, including physical and sexual abuse, long-term neglect, and incidents of violence, threats, and verbal abuse that can lead to a lack of security and trust. Many children experience a kind of "co-dependence" with the family member who suffers from alcohol dependence.

Adults' substance use may damage young people far beyond their childhood and adolescence. Research affirms that children who live in families dominated by alcohol and drug problems run a much larger risk of acquiring mental, somatic and social problems later in life, including serious alcohol problems.

Harm from alcohol is an important, but largely neglected child rights issue. Despite the clarion call of the international Convention on the Rights of the Child that children have the right to survive, to be protected from harm and exploitation, to develop fully and to participate in decisions affecting their well-being, those rights are being violated daily by excessive adult drinking -- particularly heavy drinking among fathers -- in millions of cases all over the world. Regrettably, very few child-rights organisations have made the connections between children's rights violations and alcohol abuse.

Alcohol consumption

Alcohol consumption varies greatly around the world. Societal differences include the number (or proportion) of the population that drinks, what they drink, how much they drink, and their patterns of consumption.

Alcohol consumption within a country is normally measured in litres of pure alcohol consumed per capita by the total adult (15 years and older) population. The most recent WHO data on alcohol consumption estimate a global average of 6.13 litres of pure alcohol per person.

The WHO estimate – and estimates for individual countries -- includes consumption of a large portion of unrecorded alcohol, which is not taxed and is beyond the usual system of government control. WHO estimates that unrecorded alcohol constitutes more than a quarter of the global total, and its share of consumption generally increases in regions where total consumption is less. In those often poorer or developing countries where alcohol use is rather low, much of the alcohol use derives from homemade or illegally produced sources. While illegally produced alcohol may sometimes present a particular health hazard due to adulteration, harm from these brews derives mainly from its large contribution to total alcohol consumption within the population.

Non-drinkers make up nearly half the world's adult population (45% has never consumed alcohol). That proportion increases to about 60% when former drinkers who have not consumed alcohol during the past twelve months are included (WHO 2011).

The role of gender in alcohol consumption is striking. Among men globally, 35 per cent have never used alcohol; the rate for women is 55%. In some WHO regions 90% of women do not drink. Those rates are strongly affected by religion and culture. In Europe and the Americas some 20% of adults abstain from drinking alcohol; in contrast, more than 80% of the population of Southeast Asia abstains. In the Middle East the abstention rate is as high as 90%. Variations in drinking behaviours also occur within the world's regions. For example, studies in 20 African countries reveal that non-drinking rates ranged between 41 and 99 per cent (Clausen et al. 2009, Martinez et al. 2011).

Understanding the challenge

Approaches to addressing the harm caused by alcohol come from two very different perspectives.

The public health perspective focuses attention on drinking within population groups in assessing the risk of harm from alcohol use and prescribes broad interventions to reduce this harm. This perspective asserts that when alcohol policy is informed by public health considerations, it is more likely to achieve its goal of providing a public good (outcomes that benefit the entire population) (Babor et al. 2010).

The opposite perspective suggests that only a small group of irresponsible alcohol users are the source of problems and harm. This perspective is often promoted by alcohol producers and the alcohol industry in order to protect their commercial interests. Those interests claim that alcohol control measures cannot eliminate the problems and that such measures will penalize the majority of individuals who consume alcohol responsibly.

Support for the public health perspective derives from the theory of the collectivity of drinking patterns, which predicts that an increase in per capita consumption will lead to an increase in the number of heavy drinkers and a corresponding increase in harm from alcohol use. Although the research underlying this theory reflects western settings, the same conclusions seem to apply in other cultures as well, including in Africa. Part of the explanation for this mechanism involves the social component of drinking, namely that a person's drinking is influenced by the drinking of people around her/him. Consumers at all levels of consumption tend to move in concert up and down the consumption scale (Rossow and Clausen 2013).

This logic clearly supports efforts to prevent alcohol-related harm by reducing overall societal per capita consumption. It is also the logic behind population-based alcohol-policy measures (Babor et al. 2010), which posit that less drinking results in less alcohol-related harm. Limiting the increase in the number of drinkers within a population would also fit the model and serve to protect non-drinking behaviour.

Ironically, most alcohol-related damage occurs among moderate drinkers. This "prevention paradox" reflects that although their individual risk is much lower, their collective risk is much higher, due to their much larger numbers (Aasland 1989). All these factors together warrant a broad look at alcohol prevention.

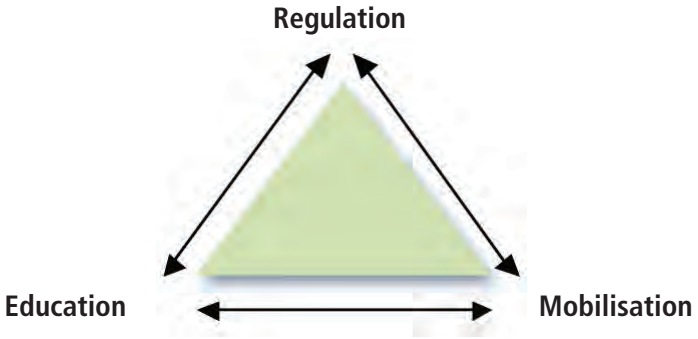
A comprehensive approach

Preventing an increase in alcohol-related harm following economic development requires a comprehensive approach, illustrated by "The prevention triangle" model (below).
Each corner in the triangle represents a singular approach to prevention. Implemented together, however, those measures will have greater effect. Although government systems for the prevention of alcohol problems may vary in different countries many similarities pertain.
Government regulation of alcohol markets: the WHO has recommended several control policies that are very cost-effective and affordable for all countries (WHO 2013):

– Regulating commercial and public availability of alcohol
– Restricting or banning alcohol advertising and promotions, and
– Using pricing policies such as high excise taxes on alcoholic beverages.

The scientific evidence indicates that those interventions are effective across cultures, drinking patterns and levels of economic development. Such measures are often strongly opposed by the alcohol industry, which views them as threats to its profits and the potential for future expansion in new markets.

Alcohol policy measures usually occur within a national policy context and generally fall within the jurisdiction of national and/or regional governments. The implementation of regulations is often delegated to local authorities. Many factors influence the policy environment. Those influences include international normative recommendations and trends; international regulations, including relevant trade agreements, and; local culture. Evidence about the level of alcohol consumption and harm, perceptions about alcohol harm, and the role that alcohol traditionally plays in society also represent important policy-determining factors. Social and political contexts vary greatly, but one factor seems a constant: low- and middle-income countries (LMIC) often have very weak alcohol policies, if any at all. Existing laws are often outdated and, even when in place, rarely enforced. These countries also often lack adequate national data about the levels of alcohol consumption and alcohol-related harm.



The prevention triangle

The WHO AFRO alcohol strategy: "Priority interventions"
Develop and implement alcohol control policies. Alcohol control policies, legislation and regulations should be based on clear public health goals and best available evidence and should reflect national consensus regarding their implementation at country level. The policies require strong leadership and political commitment and are necessary to ensure transparency, continuity and sustainability of the measures adopted by all the relevant partners (WHO AFRO 2010).

National alcohol policies serve several functions. They:

– Strengthen national political awareness and political will to address alcohol as a health and development issue;
– Provide a political basis for development and enforcement of relevant legislation;

– Establish a framework for establishing national institutions to implement policies, monitoring developments and documenting results;
– Offer a framework for the implementation of local interventions, and;
– Help rally political and financial support from civil society and academia.

Education includes a variety of methods to provide myth-busting and factual information about alcohol and training of school children and adults to influence their knowledge, values, and behaviour concerning alcohol. This process aims to help people decide and act responsibly about whether to drink alcohol at all, how much to drink, or how often and with whom in which settings. Research evidence reveals that the expected effects of alcohol education alone are minimal (Babor et al. 2010). For that reason, we suggest that an education strategy be used as only one part of a comprehensive prevention plan.

A key target of an education strategy should include sensitizing politicians and decision makers about the harm alcohol causes within society and to 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 and to train professional groups, such as doctors, police, teachers, and others.

Mobilisation reflects community involvement to address local problems and could also describe advocacy that NGOs engage in vis a vis governments to adequately address harm from alcohol. This organized approach is critical in demonstrating broad support for the development and implementation of alcohol control policies. Alcohol prevention strategies fit well as a part of the agenda for social/political movements, and can be used to link alcohol harm prevention with other relevant policy issues (for example HIV/AIDS prevention, child protection and poverty reduction). Social mobilisation that involves NGOs whose agendas go beyond alcohol-specific concerns tends to be the most effective.

One promising approach to education, information and community mobilisation relies on challenging people's expectations related to alcohol. This approach has yielded good results in communities in Sri Lanka. Expectations exert strong influences on human behaviour, not only in connection with drinking habits, but also with regard to other behaviours as well (e.g., gender roles). Alcohol expectancies may affect not only the intoxicating impact of the substance alcohol itself, but also the impact of the social effects of drinking.

Alcohol consumption and related problems vary greatly among countries. In addition, variations within a country may also be substantial; for example, between urban and rural areas, between communities of different religious beliefs, and especially between men and women. Those internal differences occur throughout the world. This diversity reinforces the need for community programs to be adapted to local conditions and targeted to specific populations.

Community action can successfully address problems associated with alcohol use. Women's movements in a developing society in South Asia have curtailed long-standing alcohol problems. Such mobilization focused on goals beyond merely changing individual behaviour. It specifically also targeted the "supply side" of alcohol commerce, an approach whose effectiveness has been discussed above. Community action often arises from a strong interest in addressing an identifiable community (or national) problem. Samarasinghe argues that such action should be guided by analysis of the actual determinants of alcohol problems in the relevant setting (Samarasinghe 2009).

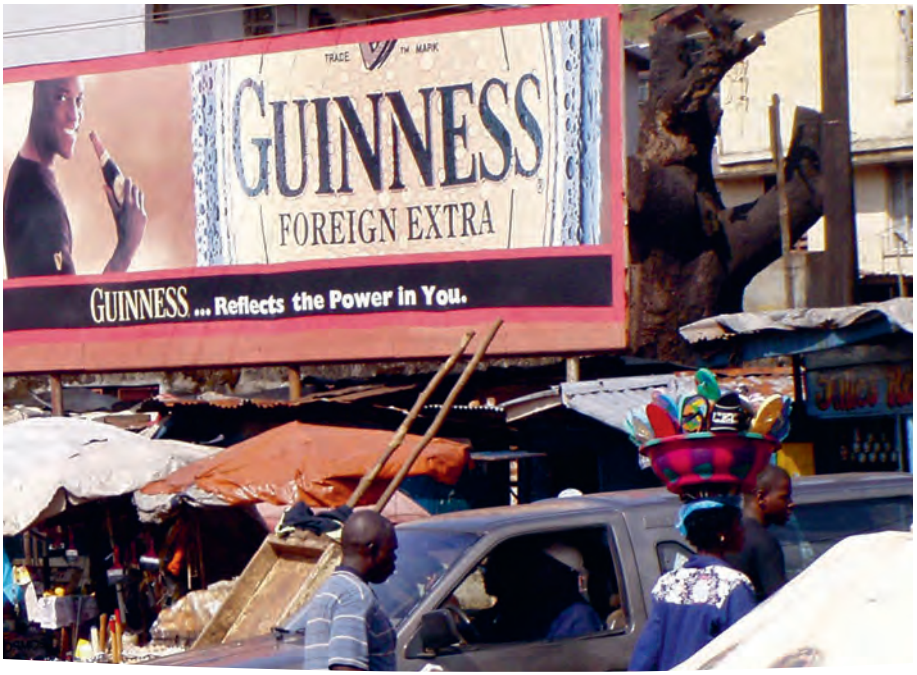
Many states, however, lack the technical capacity to work on evidence-based alcohol policies, and many countries also lack NGOs that could advocate for change or function as effective community monitors. Strengthening government capacity and developing competent civil society organisations represent key challenges for development efforts. Strong NGOs could also help balance the influence of industry vested interests that advocate for weaker health policies.

Tools of the alcohol trade

Many traditional patterns of alcohol consumption thrive throughout Africa and Asia, and, to a large degree, the alcohol market in those countries is ineffectively or totally unregulated. Those relatively unregulated countries are prime targets for the penetration of globalised alcohol products, and global brands of beer and spirits steadily seep into those – and other – markets around the globe.

Globalisation is characterised by the creation of a global market for consumer goods, supported by a relaxation of market regulations and the execution of trade agreements to facilitate – or mandate – this process. Successful introduction of products into the global environment often yields global brand identities and accelerates the inevitable globalisation of cultural values. Drinking global brands of beer and spirits or serving wine is often viewed as a sign of personal success, and social or economic status. That's also the message that marketers use to sell those products to consumers for whom real success may be less attainable.

The corporate actors who supply these brands use a wide range of commercial tactics to expand business in what they perceive as new, emerging, and growth markets. They rely on heavy marketing, political influence and lobbying, mergers with and acquisitions of local alcohol producers, and enormous financial resources that they have available to invest. In numerous



reports to their shareholders and in various market reports, they portray their success in the emerging markets in the global south as key to future profits.

Natural conflicts of interest exist between public health policy making and the commercial interests of the alcohol industry. Corporate profits depend on increasing product sales, and corporations are duty-bound to reward shareholders with the highest returns. For that reason, companies involved in production, marketing and distribution of alcohol should not be involved in alcohol policy development.

Global policy context

In 2010 the Member States of the World Health Organisation (WHO) endorsed the "Global strategy to reduce the harmful use of alcohol," (WHO 2010) negotiated through a consultative process that lasted two years. The WHO strategy relies on strong research evidence about cost-effective interventions and recommends numerous specific measures to reduce harm from alcohol. Following WHO action, the African region of WHO adopted a Regional Strategy that same year to bring the Global Strategy to the African continent. That document starts by defining the scope of the challenge:

"No other product so widely available for consumer use accounts for so much premature death and disability as alcohol."(WHO AFRO 2010)

One portion of the disease burden caused by alcohol falls within the category of non-communicable diseases (NCD), addressed by the United Nations High Level meeting during the UN General Assembly in 2011 (UN 2011) and subsequently followed up by WHO. The UN identified four major categories of NCDs, cardiovascular disease, cancer, chronic lung diseases and diabetes, and four risk factors common to those NCDs: alcohol, tobacco, unhealthy diet and lack of physical exercise. The WHO Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020 (WHO 2013), endorsed by the World Health Assembly in May 2013, set goals for the reduction of those risk factors. The Plan sets a target of at least a 10% relative reduction in the harmful use of alcohol. The Plan also lists the policy options and proposed actions for individual states, and identifies indicators to measure progress. Those include:

- Per capita alcohol consumption (aged 15+ years old)
- Age-standardized prevalence of heavy episodic drinking among adolescents and adults, and
- Alcohol-related morbidity and mortality among adolescents and adults.

Recent global actions, including the WHO Global strategy to reduce the harmful use of alcohol, the various WHO regional strategies, and the UN Political Declaration from the High Level meeting on non-communicable diseases represent important advances in world-wide efforts to address the harm from alcohol use.

Civil society has an important role to play in promoting the implementation of the WHO Global strategy. NGOs of all stripes should advocate for the inclusion and prominence of evidence-based alcohol policy measures in national alcohol-prevention strategies. National governments will need their support in developing alcohol policies and in protecting them from the vested interests of the alcohol industry. Although closely linked to the WHO global alcohol strategy, work on the NCD process maintains an independent dynamic, one that warrants additional advocacy for evidence-based measures and a counterbalance to the alcohol industry.

New international instruments to reduce alcohol related problems will soon be available through the WHO. Alcohol's undisputed massive, negative impact on development strongly suggests a need for it to be addressed in other UN processes, including in the formulation of the post-2015 development agenda. The figure below outlines the "global health map" relevant to alcohol.

The FORUT ADD Programme

"Alcohol, Drugs and Development" (ADD) is a specialized programme run by FORUT, a Norwegian development NGO, and supported by the Government of Norway through Norad. The programme operates in three areas:

- **Global advocacy:** Engaging in advocacy towards and competence sharing with intergovernmental organizations and civil society networks.
- **National policy:** Providing training programmes and technical advice to support governments and NGOs in developing national alcohol policies and other prevention programmes.
- **Community prevention:** Offering technical and financial support to local communities to mobilize their citizens for alcohol and drug prevention activities.

FORUT works collaboratively with local NGOs in six countries (Sri Lanka, India, Nepal, Sierra Leone, Malawi and Zambia) to develop and sustain substantive competence and partnership activities in the three areas. Competence Additionally, FORUT works with governments and civil society organizations in a number of other countries, primarily through the Global Alcohol Policy Alliance and its regional networks. In order to maintain a state-of-the-art competence, FORUT has established working relationships with the most prominent researchers and research networks globally.

The programme brings civil society organisations into global health processes and organises NGOs to establish a counterbalance to vested interests. FORUT serves as secretariat for the Global Alcohol Policy Alliance (GAPA) and has stimulated participation in the network by southern-hemisphere groups.

The ADD knowledge in FORUT is also integrated into the wider context of Global Health. This construct promotes a contextual rather than an isolated approach to policy and interventions. FORUT's ADD programmes integrate alcohol issues into various topics, such as non-communicable diseases, HIV/AIDS, gender-based violence, child rights, poverty, WHO governance and conflict of interest concerns, health promotion, and universal health access.

The ADD programme contributes to the production and dissemination of scientific data, knowledge, and practical experiences related to alcohol and drug prevention. FORUT endeavours to provide the widest range of programme partners access to state-of-the-art competence from the international arena, combined with local partners' knowledge of on-the-ground conditions in their respective project areas.

Commercial interests promoting the production and sale of alcohol represent an important driver of increasing alcohol use and related harm. Paramount among those interests are the multinational beer and spirits corporations that thrive and grow in a globalized marketplace. Substantial experience from many countries demonstrates that those vested interests have political, social, and economic agendas quite different from those of public health, welfare and safety. Accordingly, alcohol policies should be developed without undue influence by commercial interests. The ADD programme and FORUT do not accept any financial or other support from the alcohol industry and do not engage in any cooperative activities with such interests.

The programme's title (ADD) indicates that its work involves the prevention of problems related to both alcohol and (illicit) drug use. These two areas are both vast in scope and very complex. Although there are many similarities between alcohol and drug problems, they each present unique issues, mainly related to the illegality of drugs and the high social acceptance and integration of alcohol.

Due to limited resources in the ADD program it has been necessary to carefully prioritise which areas should be addressed by ADD interventions. Overall, highest priority is accorded the alcohol issue, in particular at the global level. Nonetheless, ADD activities are also designed to address local realities and problems defined by the target populations. Consequently, if a local project defines drug use as a major challenge, the amelioration of that problem would also be reflected in the strategies and interventions chosen for that project.

References:

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

Babor, T.F. et al. (2010). Alcohol: No Ordinary Commodity – Research and Public Policy, Second Edition. Oxford University Press. Oxford and London.

Baklien, B. and Samarasinghe, D. (2003). Alcohol and Poverty in Sri Lanka. FORUT/NIBR. Colombo. Sri Lanka. 2003

Bergh, A. et al. (2013) Trafikkulykker som globalt folkehelseproblem. Norwegian Institute of Public Health. http://www.fhi.no/artikler/?id=108267

Braathen, S.H. (2008). Substance Use and Abuse and its Implications in a Malawian Context – Pilot Project 1. SINTEF Health Research. STF A 6186. Oslo. Norway

Clausen, T. et al. (2009). Diverse alcohol drinking patterns in 20 African countries. Addiction, 104, 1147–1154 doi:10.1111/j.1360-0443.2009.02559.x

Fritz, K; N. Morojele and S. Kalichman. (2010). Alcohol: the forgotten drug in HIV/AIDS. The Lancet. Vol 376, 7 August 2010

Lim, S. (2012). A comparative risk assessment 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. Vol 380, pp. 2224-60, 15 December 2012

Martinez et al. (2011). Alcohol abstinence and drinking among African women: data from the World Health Surveys. BMC Public Health 2011, 11:160. doi:10.1186/1471-2458-11-160

Murray, Christopher C.L. et al. (2012). Disabilityadjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010, The Lancet 380, 2198-2223.

Parry, C., Rehm, J. Poznyak, V., Room, R. (2009). Alcohol and infectious diseases: an overlooked causal linkage?. Addiction, 104, 2009

Rehm, J. et al. (2009a) Alcohol, social development and infectious disease, Norwegian Ministry of Health and Swedish Presidency of EU, 2009

Rehm, J. et al. (2009b). The association between alcohol use, alcohol use disorders and tuberculosis (TB). A systematic review, BMC Public Health 2009, 9:450

Room, R. et al. (2002). Alcohol in Developing Societies: A Public Health Approach. Finnish Foundation for Alcohol Studies/WHO. Helsinki

Rossow, I and Clausen, T. (2013). The collectivity of drinking cultures: is the theory applicable to African settings?. Addiction, doi:10.1111/add.12220

Samarasinghe, D. (2009) Reducing Alcohol Harm: things we can do. FORUT. Oslo.

Schuper, Paul A. et a. (2010) Clinical Aspects: Causal Considerations on Alcohol and HIV/AIDS – A Systematic Review. Alcohol and alcoholism. Vol. 45, No. 2 pp 159-166

Schuper, Paul. (2013). Presentation "HIV and alcohol". UNDP seminar. Chisinau, Moldova 29 October 2013

Shield, K.D.;. Samokhvalov, A.V.; Rehm, J. (2013). Global burden of tuberculosis and lower respiratory infections attributable to alcohol consumption in 2004. International Journal of Alcohol and Drug Research. IJADR, Vol 2, No 1. 4 March 2013

United Nations (2011). Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. A/RES/66/2

Woolf-King, S.E; Steinmaus, C.M.; Reingold, A.L.; and Hahn, J.A.. (2013). 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. IJADR Vol 2, No 1. 4 March 2013

World Health Organization (2002). The World Health Report 2002; Reducing Risks, Promoting Healthy Life. WHO, Geneva, 2002

World Health Organization (2004). Global Status Report on Alcohol. WHO, Department of Mental Health and Substance Abuse. Geneva

World Health Organization (2010). Global Strategy to reduce the harmful use of alcohol. WM274. WHO. Geneva.

World Health Organization (2011). Global status report on alcohol and health. WHO. Geneva

World Health Organization (2013). WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. WHO. Geneva

World Health Organization, African Regional Office (2010). Reduction of The Harmful Use of Alcohol: A Strategy for The Who African Region. WHO AFRO.

www.forut.no
www.add-resources.org

FORUT, Campaign for Development and Solidarity
Box 300, N-2803 Gjøvik
Phone: +47 61 18 74 00
Fax: +47 61 18 74 01
Email: add@forut.no

Alcohol and development

"Alcohol, Drugs and Development" (ADD) is a specialized programme run by FORUT. It operates in three areas:

• Global advocacy: Engaging in advocacy towards and competence sharing with intergovernmental organizations and civil society networks.

• National policy: Providing training programmes and technical advice to support governments and NGOs in developing national alcohol policies and other prevention programmes.

• Community prevention: Offering technical and financial support to local communities to mobilize their citizens for alcohol and drug prevention activities.

This publication outlines the relevance of alcohol in development work.

ISBN 978-82-999754-3-8