The Global Health Community on Alcohol Control: successes and limits of evidence-based advocacy

Hans Peter Schmitz

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Acknowledgments

This case study is part of a series of analyses examining the influence of global health policy networks on agenda-setting, policy adoption and intervention scale-up for public health issues affecting low-income countries. It is funded by the Bill and Melinda Gates Foundation and designed to identify the factors that shape the effectiveness of global health policy networks.

Research question

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- What explains the evolution of global attention to alcohol harm?

- Specifically:
  - How can we understand the important recent advances made in addressing alcohol harm globally, including the adoption of the 2010 strategy and the growing institutional support within the WHO for alcohol control?
  - Why do we continue to see a significant gap between the severity of alcohol as a global health problem and the attention it receives in terms of policy adoption, resources, and policy efforts?

Analytical framework

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Three broad sets of factors account for the global response to health problems:

- Issue characteristics
  - Inherent: severity and tractability
  - Ascribed: nature of affected groups
- Policy environment
  - Material: trade rules, commercial interests (alcohol industry), competing causes
  - Ideational: history of issue (prohibition), competing causes (MDGs, communicable diseases)
- Global health community and network
  - Structure: membership, leadership, governance,
  - Strategies: research, advocacy, coalition-building, mobilization

Alcohol at the WHO, 1970s

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- Rise of public health perspective after World War II
  - Emergence of population-level approach
- 1970s Global Campaign Against the Marketing of Breast Milk Substitutes
  - 1981 International Code of Marketing of Breast-milk Substitutes
  - Emergence of focus on industry as possible 'vector of disease'
- These framing shifts fail to translate into immediate action, but create the basis for a more organized response in the 1990s.

Alcohol at the WHO, 1980s

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- Alcohol advocates (Robin Room, Jim Mosher, and others) sought to capitalize on the Nestlé Campaign by beginning similar research on restricting alcohol marketing.

- Result: Pushback from member states
  - Reagan Administration threatens WHO funding stop.
  - WHO leadership caves in and stops research; issue disappears from agenda until mid-1990s.

Nascent network, 1990s/2000s

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- Organizing and networking while being pushed out of the WHO
  - Emerging organizations: Kettil Bruun Society (1986), Eurocare (1990), GAPA (2000)
  - Increased collaboration: begins in the transatlantic context (GAPA)
  - Shared ideas: assumption of a causal relationship between per capita consumption and population-level health problems

- Other players organizing:
  - **Industry**: responds with embracing focus on 'heavy drinking'/individual responsibility; seeks to avoid errors committed by tobacco industry.
  - **Civil society at national levels**: Mothers Against Drunk Driving (MADD) or Remove Intoxicated Drivers (RID); focused on limited issues and often co-opted by industry.
  - **Treatment community, AA**: continue to hold onto an individual focus, not a population-level approach.

Globalizing the network

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- From the initial 2000 Syracuse conference to GAPC 2013
- Significant expansion of the network in the middle- and low income countries.
  - Facing increasing problems of alcohol abuse and industry efforts to expand markets (Jernigan's pioneering *Thirsting for Markets*, 1997).
- Babor, et al, *Alcohol: No Ordinary Commodity*, 2003.

Network output

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- Research on harm, interventions, and role of industry
- Organizing globally through GAPA
- Lobbying at WHO and national levels/health ministries

Network successes

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- At the WHO
  - Recognized as technical experts at WHO and national levels
  - Global Status Reports on Alcohol (1999, 2004, and 2011)
- Mobilization of support
  - AMA and WMA, 2005
  - The Lancet op-ed pages (2007)
- Adoption of non-binding Global Strategy, 2010
- Inclusion in the 2011 NCD UN High-level Meeting and WHO agenda

Network impact

- If we understand ‘impact’ as the measureable reduction of mortality and morbidity caused by alcohol consumption, especially in low- and middle-income nations, then there remains much to be done.

Challenges

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- Challenges
  - Global strategy lacks follow-up and funding commitments;
  - Alcohol industry is very effective in its lobbying;
  - NCD agenda carries risk of putting alcohol industry on equal footing with other commercial interests (alcohol/food vs. tobacco?);
- How can these challenges be overcome?
  - Building broader coalitions with other groups that may share the fundamental goal of improving public health in low- and middle-income nations;

What can the network do?

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- Many issues make it difficult to address alcohol harm effectively, including powerful commercial interests, expanding free trade agreements, and lack of awareness among the public.

- What can a network of interested activists do?

- Build coalitions. And broaden membership.
- Develop more effective advocacy strategies.

Coalition building

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- Potential allies:
  - The medical community (challenge: competing priorities)
    - WMA, AMA, The Lancet, etc.
  - Organizations addressing diseases (challenge: competing priorities)
    - IDF, WHF, UICC (how to insert 'alcohol' in the broader NCD agenda)
  - Treatment community/self-help groups (challenge: identity may exclude public policy engagement; may have different problem definition)
    - Alcoholics Anonymous
    - Domestic violence groups
  - Governments (challenge: competing priorities, how to explain benefits)

Advocacy

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- Need to make collective decisions about priorities for advocacy
  - Specific campaigns (youth?)
  - What issues within the Global Strategy need to be highlighted? (learn from FCTC!)

- Need to fundraise from major donors (Gates, Bloomberg, others) explicitly for advancing global agenda.

Contact information

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- Paper is available upon request.
- Comments are much appreciated!

- Hans Peter Schmitz, Maxwell School of Citizenship and Public Affairs, hpschmit@maxwell.syr.edu

- TNGO website