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# The global health network on alcohol control: successes and limits of evidence-based advocacy

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Global efforts to address alcohol harm have significantly increased since the mid-1990s. By 2010, the World Health Organization (WHO) had adopted the non-binding Global Strategy to Reduce the Harmful Use of Alcohol. This study investigates the role of a global health network, anchored by the Global Alcohol Policy Alliance (GAPA), which has used scientific evidence on harm and effective interventions to advocate for greater global public health efforts to reduce alcohol harm. The study uses process-tracing methodology and expert interviews to evaluate the accomplishments and limitations of this network. The study documents how network members have not only contributed to greater global awareness about alcohol harm, but also advanced a public health approach to addressing this issue at the global level. Although the current network represents an expanding global coalition of like-minded individuals, it faces considerable challenges in advancing its cause towards successful implementation of effective alcohol control policies across many low- and middle-income countries (LMICs). The analysis reveals a need to transform the network into a formal coalition of regional and national organizations that represent a broader variety of constituents, including the medical community, consumer groups and development-focused non-governmental organizations. Considering the growing harm of alcohol abuse in LMICs and the availability of proven and cost-effective public health interventions, alcohol control represents an excellent 'buy' for donors interested in addressing non-communicable diseases. Alcohol control has broad beneficial effects for human development, including promoting road safety and reducing domestic violence and health care costs across a wide variety of illnesses caused by alcohol consumption.

**Keywords** Alcohol, networks, governance, advocacy, health policy, addiction, policy analysis

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**KEY MESSAGES**

- Alcohol harm represents a rapidly rising health problem in low- and middle-income countries (LMICs).

- A network of scientists and activists played a crucial role in putting alcohol control on the global agenda and prompting the adoption of a non-binding international agreement to reduce alcohol harm.

- The effectiveness of future activism in this area is predicated on broadening alliances by transforming the current network into a coalition of organizations with a shared agenda of domestic, regional and global mobilization.

## Introduction

Networks play an increasingly important role in advancing global health issues by agitating for their specific cause, raise resources and get policies adopted and implemented. Some of these networks are made up of committed individuals sharing principled ideas, while others are broad, multi-sectoral coalitions of organizations temporally joined for a particular purpose. While awareness of these networked activities is growing (Shiffman 2009), we still lack a systematic understanding of how such networks form, how they sustain collective action, and what makes them effective contributors to the policy process, including agenda setting, formation of specific policies and the implementation of effective solutions.

The goal of this study is to analyze the activities of a network of scientists and activists that took shape during the 1990s and played a crucial role in putting alcohol harm on the global agenda. The purpose of this research is to uncover the significance of network activities in raising global awareness and in advancing a global agreement to address alcohol harm based on specific policy interventions favoured by a public health perspective. Apart from looking backward at what this network has accomplished during the past decades, the study also addresses its future effectiveness in remaining an important policy actor in the process of implementing recommended alcohol control policies at national levels, mainly in low- and middle-income countries (LMICs).

The global burden of disease caused by alcohol use has steadily increased over the past decades. Between 1990 and 2010, the global number of disability-adjusted life years (DALYs) lost to alcohol increased by 32% (Institute for Health Metrics and Evaluation 2013, p. 31). In the age group between 15 and 59, alcohol is the leading global risk factor for mortality and morbidity (World Health Organization 2011, p. 32). Harm caused by alcohol is increasing rapidly in LMICs, where levels of alcohol-attributable deaths, on average, are significantly higher than in high-income countries (World Health Organization 2011, p. 28).

Awareness of growing global alcohol harm did not emerge out of nowhere but was driven by a network of scientists and activists producing and disseminating evidence focused on the importance of this risk factor as well as effective policy solutions reducing harm. By 2010, the World Health Organization (WHO) adopted a non-binding 'Global Strategy' recommending a set of policies to address harmful alcohol use. In 2011, the United Nations high-level meeting on non-communicable diseases (NCDs) included alcohol among four major risk factors requiring policy responses.

What explains the relative success of networked activism in raising global awareness during the past two decades, and how can such an analysis offer insights into the future role of such networks in shaping global and national policy development aimed at reducing harm in LMICs? Much of the literature focused on explaining growing attention to alcohol harm as well as obstacles to adopting effective policies highlights broad cultural and structural factors (Gleeson and Friel 2013), including the expansion of global trade (Zeigler 2009) or the perceived failure of earlier prohibition policies (Gusfield 1986; Okrent 2010). These are all important issues to consider, but they ignore the active role of individual and collective actors whose actions define not only what is considered a social problem, but also what public policies are viewed as acceptable solutions.

Global alcohol control efforts have been shaped in important ways by a distinct global health network that formed during the 1990s and began to globalize during the 2000s. This particular community generated scientific evidence regarding harm and effective interventions, ultimately prompting the WHO to adopt many of its recommendations as best practices. But these successes have yet to translate into major financial commitments by donors or widespread adoption of national policies reducing harm. By 2013, less than one-third of the 194 WHO member states had adopted a national policy on alcohol control (World Health Organization 2013a). These challenges of moving beyond agenda setting and policy adoption point to specific weaknesses of the current network which has to move beyond bringing together individuals with shared interests and become a democratic platform of organizations sharing a common agenda of reducing alcohol harm in LMICs.

## Conceptual framework

This study is part of the Global Health Advocacy and Policy Project (GHAPP), a research initiative examining networks that have mobilized to address six global health problems: tuberculosis, pneumonia, tobacco use, alcohol harm neonatal mortality and maternal mortality. Its aim is to understand how networks crystallize around health issues and why some are better able to influence policy and public health outcomes. GHAPP studies draw on a common conceptual framework grounded in theory on collective action from political science, sociology and economics (Snow *et al.* 1986; Stone 1989; Powell 1990; Kingdon 1995; Finnemore and Sikkink 1998; Kahler 2009;). The introductory article to this supplement presents the framework in detail (Shiffman *et al.* 2016).

The GHAPP studies examine network outputs, policy consequences and impact. Outputs are the immediate products of network activity, such as guidance on intervention strategy, research and international meetings. Policy consequences pertain to the global policy process, including international resolutions, funding, national policy adoption and the scale-up of interventions. Impact refers to the ultimate objective of improvement in population health.

The framework consists of three categories of factors (see Shiffman *et al.* 2016). One category, 'network and actor features', concerns factors internal to the network involving strategy and structure, and attributes of the actors that constitute the network or are involved in creating it. This category covers characteristics of individuals and organizations that shape their capacity to act and influence their environment. A second category, 'the policy environment', concern factors external to the network that shape both its nature and the effects the network hopes to produce. The third category, 'issue characteristics', concerns features of the problem the network seeks to address. GHAPP studies begin with the presumption that no single category of factors takes precedence. Instead, analysis focuses on how factors within each category interact with one another to produce policy and public health effects.

### Network and actor features

Among network and actor features, the existence of effective 'leaders' (factor 1) may be one reason networks crystallize in the first place, and why, once they appear, they are able to achieve their objectives. The quality of 'governance' (factor 2) may also matter, in particular the arrangements created by network members to steer themselves toward collective goals (Buse and Walt 2000). A third factor is 'composition' (factor 3). Diverse networks that link scientists, advocates, policy-makers and others from both high- and low-income countries may achieve better outcomes because diversity improves collective understanding as well as external perceptions of legitimacy (Page 2007). The fourth factor is 'framing strategy' (factor 4) (McInnes *et al.* 2012): how network actors publicly position an issue to attract attention and resources.

The global health network on alcohol harm represents a mixture of an epistemic community integrated by shared causal beliefs (Haas 1992; Stone and Maxwell 2004) and an advocacy network that is based on shared principles (Keck and Sikkink 1998, p. 9). Underlying the network are (1) assumptions of a direct relationship between per capita consumption and alcohol-related health problems, (2) emphasis on the reduction of alcohol supply and (3) rejection of any collaboration with the alcohol industry. The network consists of scientists as well as non-governmental activists who have increased their collaboration and have formed a relatively tightly knit community of individuals sharing a particular public health approach to reducing alcohol harm. Anyone accepting funding from industry is not allowed to be part of the network, although such groups are part of the overall 'issue network' (Heclo 1978) which includes everyone 'who shares an interest in an identifiable problem, but who might have conflicting, or even diametrically opposed solutions' (Read 1996, p. 31). Individuals or organizations working with industry to improve self-regulation (Gornall 2013) may share the basic objective of reducing alcohol harm, but not the constitutive norm that a fundamental conflict of interest prevents industry from playing a positive role in policy making (Global Alcohol Policy Alliance 2013).

Transnational networks addressing alcohol harm emerged in the 19th century. Largely based on the shared idea of temperance (moderate or no alcohol consumption) as a response to social disorder, the domestic success of these movements varied according to existing institutional structures that filtered their impact (Schrad 2010). These movements pushed successfully for international treaties aimed at protecting colonial populations in Africa as well as curtailing illicit trade of alcohol across international borders (Fidler 2001). World War I as a catalytic event led to the establishment of prohibition regimes in Russia/the Soviet Union (1914–25), the United States (1920–33), Finland (1919–32) and Norway (1916–27), but the influence of these transnational networks declined again during the 1930s. Remnants of these organizations mostly based in Scandinavian countries remain active today and have typically replaced the moral activism with a public health perspective.

### Policy environment

Important among factors in the policy environment are 'potential allies and opponents' (factor 5). Availability of potential allies as well as ability of a network to form coalitions are crucial to increasing both legitimacy and influence. Opponents, such as the alcohol industry, can both hinder and facilitate activism: they seek to discredit the network outputs, but may also inspire collective efforts to counter commercial influence. Substantial 'funding' (factor 6) is often crucial for a network to flourish; however, a network entirely driven by donor funding may face legitimacy questions. 'Norms' (factor 7)—defined as standards of appropriate behaviour (Finnemore and Sikkink 1998)—matter because they may both shape the strategies of network members and provide external opportunities for mobilization. In the health sector, the Millennium Development Goals (MDGs) are a powerful external norm raising expectations for states and other actors (Fukuda-Parr and Hulme 2011).

The policy process literature identifies agenda setting, policy formulation, policy adoption and policy implementation as distinct phases (Andrews and Edwards 2004; Pelletier *et al.* 2011) which create shifting venues and mobilization environments. Agenda setting targeting international institutions will require different expertise and tactics compared to domestic-level efforts to implement adopted policies. In the alcohol case, the 'producer network' (Marsh and Rhodes 1992) representing industry interests dominates based on its superior financial resources, but it faces competition from other networks that organize scientists, the medical community, patients, or consumers. Figure 1 offers an overview of the main parties interested in global alcohol policies.

### Issue characteristics

Among issue characteristics, 'severity' (factor 8), 'tractability' (factor 9) and the nature of 'affected groups' (factor 10) may be particularly influential. Networks may be more likely to emerge around issues of high mortality, morbidity or social disruption. It may also be easier to mobilize around problems which have clear solutions or for affected populations that inspire sympathy (Stone 1989). In the alcohol case, important issue characteristics lead to different problem definitions focused on short-term harm (e.g. drunken driving, domestic violence) or long-term conditions (e.g. heart disease, cancers). Different groups in the broader alcohol policy issue network advance different harm reduction strategies (Déry 1984), ranging from the industry's focus on heavy drinking or illicit alcohol to the emphasis on population-level alcohol consumption highlighted by the global health network studied here.

## Methodology

This study used a process-tracing methodology involving in-depth examination of social and political processes with the aim of uncovering causal mechanisms that account for policy outcomes observed as well as for failed efforts by the network studied (Yin 2008; Bennett 2010). GHAPP researchers used the same methodology, began with the same basic set of questions and were in regular communication in order to share insights as the studies unfolded.

The study relied on a combination of interviews with experts, careful study of documents and archival materials, and information collected at relevant professional meetings (see for a
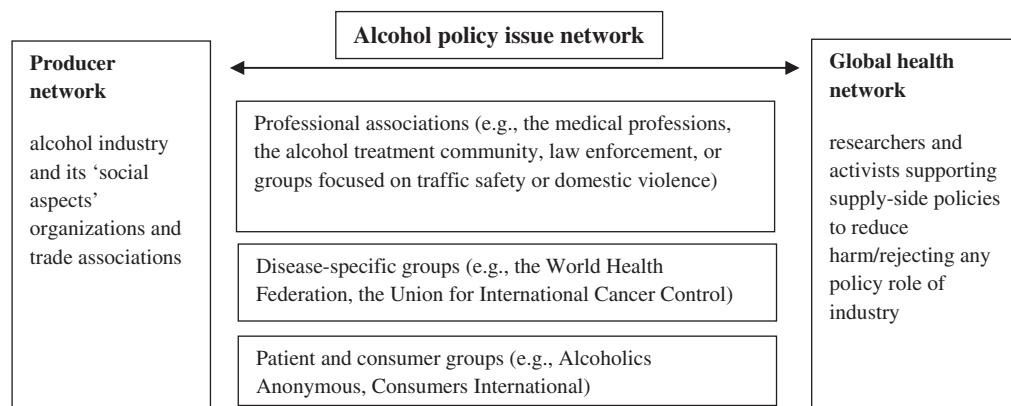
**Figure 1** Mapping the issue network on global alcohol policy.

similar approach: Mamudu *et al.* 2011, p. e10).[1] Documents and archival materials used consisted of more than 500 scholarly articles, policy submissions of network members to international bodies, editorials, press releases and WHO background documents on the consultation processes with various stakeholders on alcohol control issues.

An initial list of interviewees was established based on authorship of important scientific studies, while snowball sampling was used to expand the list of experts queried. The semi-structured interview protocol focused on (1) how individuals became involved in alcohol control issues, (2) what they viewed as key explanations for the past successes and current challenges of global action on alcohol and (3) how they collaborated with other scientists and activists. A total of 31 interviews were conducted in 2011 and 2012. Twenty interviews took place with members of the network while the others surveyed representatives of organizations that regularly interact with the network, including funders and collaborators in other NGOs or intergovernmental agencies. Interviewees were drawn from organizations such as Eurocare, the Center for Science in the Public Interest (CSPI), the Brazilian Association for the Study of Alcohol and Other Drugs (ABEAD), the Global Alcohol Policy Alliance (GAPA), Consumers International, the WHO, the Centre for Social Research on Alcohol & Drugs (Stockholm University), the Johns Hopkins Bloomberg School of Public Health, Alcohol Justice, and the Solidaritetsaksjon for Utvikling (FORUT, Oslo). Interviews lasted typically for an hour and were recorded. Twenty-six of the interviews were conducted with representatives from Europe or North America, and only a minority with network members from a LMIC. This reflects the continued dominance of developed countries in the network, an issue explicitly raised at the end of the study.

Additional interviews and background conversations were conducted in 2013 at several conferences where initial results of the study were presented.[2] Interviewees and other experts received drafts of the case study throughout 2013. Five key informants provided detailed written feedback on the close-to-final draft.

## Results

After the end of alcohol prohibition in the United States in 1933, the role of religious groups in advancing the temperance cause declined and the frame of 'alcoholism' as a medical condition rose in prominence (Roizen 1991). This frame is today still promoted by the alcohol industry, but it lost currency during the 1950s when scientists and activists increasingly adopted a public health perspective (Beauchamp 1980, p. 155; Babor 1993). The results section is divided into three main parts. The first part provides a background on the emergence of the public health frame in alcohol control policies and its early rise at the WHO. The second part traces the formation of the network during the 1990s and its role in increasing global awareness of alcohol harm. The third part focuses on the role of the network and its members during the negotiations of the Global Strategy from about 2005 until 2010.

## Using research and public health views to empower the WHO, 1970s–1980s

Since the 1950s, the WHO's leadership on alcohol control has fluctuated considerably (Room 2005). A public health perspective on alcohol was first fully expressed in 'Alcohol Control Policies in Public Health Perspective' (Bruun *et al.* 1975). This study was sponsored by WHO's Regional Office for Europe (WHO-Euro), but considered too controversial by headquarters in Geneva (interview 8). The new public health framing[3] of alcohol harm became a basis for two distinct research and policy claims. First, it justified a government role in controlling alcohol consumption using taxation and limits on marketing. Second, it prompted researchers to study the alcohol industry and its practices as a 'vector of disease' (Jahiel and Babor 2007). This new perspective gave rise to a small community of scholars and activists based in the United States and Europe whose initial home became the research-focused Kettil Bruun Society.

While the public health perspective offered a new way of thinking about alcohol harm, the network of scientists had yet to find a policy window with 'opportunities for action' (Kingdon 1995, p. 165–6). This window opened in the late 1970s when the campaign against the marketing of breast milk substitutes pushed for a more expansive role of the WHO (interview 12) and the adoption of the 1981 'International Code of Marketing of Breast-Milk Substitutes' set a precedent of the WHO promulgating rules for industry behaviour. Led by Jim

Mosher and in collaboration with the United Nations Conference on Trade and Development (UNCTAD), a group of researchers decided 'to concentrate more broadly on the impact of trade and marketing on public health' (Selvaggio 1983, p. 10) as well as the role of the alcohol industry (Cavanagh and Clairmonte 1983).

Powerful member states quickly intervened and blocked efforts to establish international guidelines designed to limit alcohol harm. In particular, the US government led by the Reagan Administration threatened to withhold funding from the WHO (Grimm 2008, p. 862) and WHO leadership responded in 1983 by cancelling funding for these activities and refusing to publish research on the alcohol industry (Selvaggio 1983). The World Health Assembly (WHA) adopted a final alcohol-related resolution (WHA 32.40) in 1983 and the issue would disappear from its agenda for more than a decade.

But activities focused on limiting alcohol harm expanded at the US domestic level, where the first Alcohol Policy Conference held in September 1981 brought together a broad coalition of researchers, community practitioners, and public officials sharing the idea that individual treatment was no longer enough. The Center for the Science in the Public Interest (CSPI) started a campaign focused on restricting alcohol marketing, increasing taxes, and adding consumer information on alcohol containers. The 1983 publication of *Booze Merchants* (Jacobson *et al.* 1983) became the basis for building two broad-based coalitions whose membership included important membership organizations outside of the alcohol field (Lerner 2011, p. 104–106). Although alcohol industry, advertisers and the broadcast media were able to block most of the measures, Congress ultimately adopted in 1988 legislation requiring warning labels on alcohol beverages.

Although the 1970s and 1980s saw a failure of raising the issue's prominence on the international agenda, new forms of collective action and mobilization persisted. The brief mobilization at the WHO and the more sustained activism in the United States led to the formation of the Kettil Bruun Society in 1986, which had started out as a section of the International Council on Alcohol and Addictions (ICAA). KBS and subsequent organizations represented the emergence of a distinct identity which combined a public health approach with an emphasis on the industry as a major contributor to the problem. Since ICAA did not explicitly ban members from entering funding relations with industry, other venues now served as new focal points for individuals sharing a specific understanding of alcohol harm.

## Network formation and agenda-setting success, 1990–2005

The alcohol-focused global health network benefited greatly from the publication of the first Global Burden of Disease (GBD) study in the early 1990s. The GBD offered a first global picture of major diseases and risk factors, and established the significant harm of alcohol especially in LMICs. It found that alcohol was responsible for 3.5% of global disability (DALYs), placing it, tied with unsafe sex, in third place behind malnutrition and poor sanitation (Murray and Lopez 1997, p. 1440). But those seeking to capitalize on this wake-up call faced three

significant challenges. First, free trade agreements emerged as a major obstacle to establishing global regulations for alcohol control (Grieshaber-Otto 2000). Second, the alcohol industry had already begun pushing into markets of LMICs, selling their products in countries with very limited alcohol control policies (Jernigan 1997). Third, the industry accompanied its push into new markets with proactive corporate social responsibility policies promising to reduce alcohol harm through self-regulation only. This strategy included creating its own civil society groups,[4] which rejected a public health perspective on alcohol and promoted a narrow problem definition focused only on drunk driving and severe cases of abuse.

Despite those challenges, the increasing harm and marketing efforts of the industry motivated a renewed push for collaboration among public health advocates. In 1990, nine national non-governmental organizations formed 'Eurocare' with the aim of pushing the European Union to ensure that 'interests of collective health take precedence over individual economic interests' (Eurocare 1990). By 1992, WHO-Euro adopted the first 'European Alcohol Action Plan' (EAAP). By 1995, sustained transatlantic exchanges led to a first meeting bringing US-based scholars to London to develop a joint statement for a WHO European Ministerial meeting which adopted the 'European Charter on Alcohol'.

The US-based Marin Institute[5] then spearheaded an effort to create a permanent transnational group of activists, but a lack of resources delayed the effort until August 2000. A meeting in Syracuse, New York, brought together more than 200 alcohol policy and public health advocates from about 30 countries and inaugurated the 'Global Alcohol Policy Alliance' (GAPA).[6] The creation of GAPA reflected an effort to broaden the network beyond Europe and North America and focus attention on the increased marketing of alcohol in the developing world (interviews 3, 6).

Following the creation of GAPA, outreach to potential allies began with considerable initial success. In the early 2000s, a representative of the American Medical Association (AMA) attended a meeting of alcohol control advocates, learning about the effects of global trade agreements which 'really caught my attention and [I] brought it back to the AMA' (interview 1). By 2005, the World Medical Association (WMA) passed a resolution calling for a framework convention on alcohol similar to tobacco (Casswell 2008, p. 110), while the leading medical journal *The Lancet* followed up with the same demand in 2007. Funding from the Robert Wood Johnson Foundation (RWJF) not only facilitated the 2000 meeting in Syracuse, but it aimed primarily at domestic community- and college-based programmes to reduce alcohol harm. These new programme activities expanded the network, led to collective learning from the tobacco case (Lynch 2005), and allowed AMA staff to engage in lobbying, including pushing Congress to exclude alcohol from bilateral free trade agreements (interview 1). However, when RWJF decided in 2007 to discontinue its financial support, many of these new programme activities disappeared again (interview 1).

The absence of resources also severely limited the globalization of GAPA. Based at the Institute of Alcohol Studies (IAS) in London, it used the biannual journal, *The Globe*, to create a sense of a global community (interviews 13, 14) and received

some in-kind and financial support from FORUT (Goos 2013, p. 12). FORUT became a key source of supporting the daily operations of GAPA, including travel expenses facilitating participation of GAPA members at international conferences.

During the 2000s, GAPA leadership emphasized the creation of national and regional alliances in LMICs. The Indian Alcohol Policy Alliance (IAPA) emerged in 2004, followed in 2005 by the Asia Pacific Alcohol Policy Alliance, and the more recent East African Alcohol Policy Alliance as well as the Southern African Alcohol Policy Alliance. Thailand became a particularly important partner after the 2001 establishment of the Thai Health Promotion Foundation (ThaiHealth) which received more than $50 million annually from alcohol and tobacco excise taxes to promote public health programmes. Since 2012, GAPA and its partners organize annual global meetings for its membership. These conferences facilitate learning across national alcohol activists and also reflect a wider network which includes FORUT and IOGT International with affiliate organizations based in Asia, Africa, and Europe. Despite this expansion of the global network, GAPA remains constituted by the ties among independent individuals, rather than institutionalized co-operation across organizations pooling resources at domestic and international levels.

The situation is very different at the European level, where Eurocare's participation in policy-making has changed significantly over time (interview 15). As WHO-Euro was slowly replaced by the European Commission as the major player in regional policy development, Eurocare now receives substantial funding (2008 budget: €216 000) from the Commission and has to accept that the Commission provides equal access to both commercial interests and public health groups. The rise of the Commission as a key regional actor on alcohol policies has generated mixed results. On the one hand, the Commission has provided funding to a number of new research initiatives designed to increase knowledge about alcohol harm. New efforts included the creation of the Alcohol Measures for Public Health Research Alliance (AMPHORA), which specifically supports research and collaboration on alcohol-related harm in countries where little research has taken place in the past (Room 2011; Anderson *et al.* 2012).

At the same time, the Commission provides industry much more access during consultations than the WHO. The European Alcohol and Health Forum created in 2007 brings together industry and public health representatives and the Commission publications regularly feature policy solutions favoured by the alcohol industry, including self-regulation of alcohol marketing or training programmes for bartenders (European Commission 2012). In order to counter this greater access given to the industry at the Commission, Eurocare now relies more heavily on lobbying not only the Commission, but other institutions and national governments through its affiliates (interview 15). Such national ties are mobilized now to not only reach national bureaucracies, but also other institutions, including the Parliament. Although Eurocare supports the exclusion of the industry from policy-making at the WHO, it accepts its role at the Commission based on the different mandates of the two institutions (interview 15).

While Eurocare is an established and relatively well-funded player in Europe, GAPA's limited resources prevented it from establishing a permanent presence in Geneva. During the 2000s, the network made a difference largely based on the participation of individual researchers in informal technical networks that shaped the research output of the WHO on alcohol. These scientists were responsible for the first Global Status Report on Alcohol (World Health Organization 1999) published by the WHO in 1999[7] and the first edition of Alcohol. No Ordinary Commodity (Babor *et al.* 2003). Both publications represented a key network output that set the global agenda by offering a succinct summary of the most advanced research on harm and interventions. Key members of the global health network also later became main contributors to WHO's Global Status Report on Alcohol and Health, representing the defining international statement on harm and desired policies (World Health Organization 2011, p. vii).

But why did the network not expand much more rapidly during the 2000s when the issue of alcohol control became solidly placed on the global agenda? In contrast to the successful US-domestic coalition-building efforts by George Hacker and others in the 1980s, bringing together such alliances at the global level is more challenging, in particular since different organizations within the larger policy issue network (see Figure 1) continued to advance their own problem definitions and solutions. In addition, since the 1990s, these differences among activists dedicated to addressing alcohol harm have been systematically exploited by the alcohol industry which actively seeks out partnerships with groups willing to implement industry-sponsored strategies.

# Network participation in the negotiations of the Global Strategy, 2005–2010

Interest in putting alcohol back on the WHO agenda gathered steam in the early 2000s. However, during this time period, the WHO leadership focused its attention on the negotiations of the Framework Convention on Tobacco Control (FCTC), which represented the very first instance of an intergovernmental treaty negotiated under WHO auspices (Mackay 2003). Following the adoption of the FCTC in 2003, Nordic countries began in 2004 regional consultations to put together a new resolution to revive the alcohol agenda that had been dormant since 1983. Their proposals were forwarded to the Executive Board (EB) meetings and submitted to the WHA in May 2005. Broader consultations elicited responses ranging from the United States pushing for full industry participation in any policy development to Thailand and other developing countries arguing that the control effort was not ambitious enough. The Icelandic presidency of the EB ultimately bridged the differences and advanced a consensus approach (Bull 2005).

In 2005, when the WHO adopted a resolution pointing towards the Global Strategy, GAPA members increased advocacy efforts by attending important WHO meetings in Geneva and simultaneously working with national health officials in member states (interview 10). In 2009, George Hacker, a board member of GAPA, volunteered to spend four months over an eight month period in Geneva to represent GAPA during the final negotiations and adoption of the Global Strategy. The World Council of Churches provided an office, allowing Hacker

to focus on liaising with WHO staff and principled allies in Scandinavian missions, conduct briefings for other civil society groups, and educate country missions about alcohol harm and effective policies (interview 20). As other GAPA members joined temporarily for lobbying activities, this presence enabled GAPA to facilitate a periodic exchange of information between what was learned in Geneva and what their domestic allies reported about government positions at home. It also allowed GAPA to enter into more sustained collaborations with other civil society actors, such as the World Medical Association and the NGO Forum on Health (interview 10).

Building ongoing relationships with country missions became crucial for Hacker and its colleagues because it was the only way to learn about negotiations behind closed doors. This knowledge was central to challenging industry interests and simultaneously targeting country missions and domestic health officials (interviews 10, 15). It also allowed Hacker and others to directly intervene in the negotiation process. For example, when specific passages about the role of industry in the Global Strategy were negotiated, GAPA members noted ambiguous language in different translations and alerted allied country delegations. Thailand and New Zealand then set in motion a technical correction on the floor that clarified the limited role of the industry.

The adoption of the Global Strategy represented an important success for the global health network. However, its passage without a dedicated budget represents now a major challenge for the network's future effectiveness, and has created ongoing tensions between member states demanding funding commitments from the WHO core budget prior to dedicating their own resources (interview 10). Without much action from states (Zeigler and Babor 2011, p. 9–12), the alcohol industry has focused on disseminating their own legislative templates and using hundreds of projects around the world to cultivate key relationships with domestic policy makers, ostensibly claiming to offer their help in complying with the Global Strategy. While the vast majority of industry efforts have no proven effectiveness in reducing alcohol harm and are primarily designed to improve industry reputation (Babor and Robaina 2012), GAPA and its regional networks, IOGT International, and FORUT have developed a few successful domestic interventions, but remain hampered by insufficient resources.

In parallel to the run-up to the Global Strategy, the World Economic Forum (WEF) and the United Nations (UN) began debates about how to address the broader set of NCDs, including how to integrate NCDs into the next phase of the Millennium Development Goals (MDG+). In this context, a new set of civil society actors entered as the NCD Alliance, an umbrella group representing victims of diseases.[8] In preparatory meetings for the 2011 UN high-level meeting on NCDs, GAPA representatives offered their own statement at the June NGO forum (interview 20) and participated in a coalition of 150 NGOs demanding limits to the participation of industry in policy deliberations about NCDs (interviews 10, 14). GAPA members educated other NGOs about the specific problems caused by the alcohol producers, and overall contributed to keeping the issue on the agenda of UN member states and the NCD Alliance (interviews 10, 20). This collaboration produced the Conflicts of Interest Coalition,[9] which had some success in excluding commercial interests (Lincoln et al. 2011), but failed to group the alcohol industry in the same category as tobacco.

# Discussion: explaining successes and limits of evidence-based advocacy

This study elaborated the role of a specific alcohol-focused global health network across different phases of the policy process, primarily agenda setting, policy formation and adoption at the global level. The results section offers key lessons about the interactions between network and actor features, the policy environment and issue characteristics.

This global health network is composed of individual scientists and activists sharing a common problem definition and a focus on the alcohol industry as a 'vector of disease.' Since the mid-1980s, the network has grown its individual membership and slowly expanded to LMICs. KBS established a forum to exchange research results, while GAPA and its associated networks emerged as a focal point of regional- and global-level advocacy. Organizations such as FORUT and IOGT existed well before these two organizations, and have become significant allies extending the network in limited ways to domestic and local levels. These like-minded organizations play a crucial complementary role by focusing on domestic capacity-building and supporting the development of national alcohol policies in selected countries.

The analysis revealed that the mobilization during the 2000s was primarily based on an evidence-based focus on severity and tractability (factors 8 and 9), framing as a public health issue (factor 4), and some successes in forming a nascent global network (factor 3). Network members were the key actors prodding the WHO to record and track global increases in health problems due to alcohol. Their research on severity as well as policies to address harm was instrumental in turning a condition into an issue. But this research did not yet succeed in overcoming major challenges to broader coalition-building which continue to be hampered by disagreements about problem definition (heavy vs regular drinking) and the proper focus of policy solutions (drunk driving, alcohol dependency and recovery). This persistent wide range of responses to alcohol harm prevents the emergence of a broad coalition. In addition, the alcohol industry is effective in exploiting these differences by supporting selected civil society efforts it deems beneficial to its own image (factor 5).

Debates about the implementation of appropriate national policies derived from the Global Strategy also pit the global health network directly against a much more well-resourced alcohol industry that uses its own lobby groups, sponsorships, and research to establish an alternative problem definition focused on heavy drinking only (Jernigan 2011; Babor and Robaina 2012; Casswell 2013). The alcohol industry champions self-regulation and educational campaigns in LMICs (Bakke and Endal 2010) and favours public–private partnerships as a strategy to attain full participation rights in both domestic and global policy-making processes (interview 13). The increasing activities of industry have mobilized the global health network, but have also drawn a lot of the resources of the network into a reactive position focused on containing industry influence (e.g. Global Alcohol Policy Alliance 2013).

Many GAPA members over the years became part of both the 'technical networks' (World Health Organization 2013b, p. 3), but also more organized advocacy efforts supplementing the research. These advocacy and framing efforts have been important in putting alcohol control on the global agenda (factor 4). But compared to tobacco alcohol control did not get consistent high-level support within the WHO, largely because it is viewed as a highly controversial topic (interviews 22, 24) that requires significant efforts of diplomatic consensus making. In addition, GAPA lacks the resources to establish a permanent advocacy presence at the WHO (factor 6). The current policy of the WHO of giving privileged access to organizations with resources further penalizes groups such as GAPA. Finally, since GAPA is still mainly a loose coalition bringing together like-minded individuals, it lacks the organizational capacity and governance structure needed to bring together a broad institutional membership and increase its influence in important policy negotiations regarding NCDs (factor 2).

## Implications

The health network studied here faces significant future challenges in competing for attention with other rising global problems. This competitive environment requires developing new strategies designed to expand its funding base and build broader alliances (interviews 5, 8, 13 and 17). The 2010 adoption of the Global Strategy signifies a new stage of shifting attention from global agenda setting to developing specific policy instruments and moving towards national implementation.

While the results of this study document the important ways in which network members have shaped global policies against alcohol harm, they also confirm that the network needs to greatly expand its institutional membership and global footprint to remain an effective player in the future. For this network to further expand its influence, increased funding (factor 6) is a key step. But more funding will likely only be forthcoming and benefiting the network if it goes along with changes in leadership, governance, composition and underlying norms (factors 1–3, 7). In order to be an important policy player, the network needs to focus on better representing local interests internationally as well as generating broader political support through alliance building for its global advocacy. This requires establishing a more 'mature network' (interview 24) that goes beyond the bringing together of like-minded individuals and establishes more robust mechanisms of governance and decision making (Goos 2013, p. 16). Such an evolution is also a precondition to coalition-building with other groups (factor 5) and would also respond to the WHO's desire to have civil society groups present their perspectives with a more unified voice (World Health Organization 2013b).

The absence of significant funding (factor 6) is a key explanation for why this network has not yet developed the capacity to sustainably link mobilization at the domestic, regional and international levels. Beyond leadership and internal governance, the core issue that has limited coalition-building and fundraising in the past is the difficulty of expanding a consensus about how to define and address the problem. Although it is clear that alcohol abuse plays a major role in domestic violence, road safety or mental health, groups focused on these issues have yet to sustainably join the network and support its policy approaches. Potential allies and donors have to be convinced that alcohol control is a central part of removing roadblocks to economic and human development in LMICs (Room 2013). Alcohol control is certainly more controversial today than tobacco control, but it represents a good 'buy' for major donors because reducing alcohol harm creates many community benefits when reduced alcohol use leads to safer roads, less violence, and increased productivity.

Increasing efforts at expanding the network (factor 3) should target groups with mandates that are affected by alcohol consumption (see Figure 1). Natural allies should be organizations representing the medical community (e.g. the World Medical Association), organizations representing victims of diseases (e.g. the International Diabetes Foundation, the World Heart Federation, or the Union for International Cancer Control), injury or trauma, and organizations interested in questions of economic development adversely affected by alcohol use (e.g. major development NGOs). There are also a number of organizations explicitly engaged in regulating industry marketing in other sectors, including Consumers International or Oxfam International. A recent review of GAPA commissioned by FORUT highlighted the need to think more systematically about extending the 'alliance towards non-alcohol specific agencies' (Goos 2013, p. 16). GAPA members have built such temporary coalitions at domestic levels and temporarily for the Global Strategy and the NCD agenda, but getting sustained broader support for alcohol control measures is crucial to enhancing legitimacy and power (interviews 10, 20, 22, 24).

Challenges regarding such coalition building vary depending on who is targeted and how the problem is framed (factor 4). Most difficult will be building coalitions with self-help groups (e.g. Alcoholics Anonymous, AA) and the recovery and treatment communities, in particular when such groups firmly embrace a frame of individual responsibility.

> ''And this is part of our frustration too because you have the treatment community, the people who deal with the addicts [...] and their whole orientation is toward the individual'' (interview 1)

For groups focused on diseases as well as associations representing the medical professions, addressing alcohol consumption may compete with other health priorities. In addition, while the global health network described here champions mostly supply side policies (regulations on pricing, availability and marketing), such preventative approaches may be seen as directly competing with efforts to increase funding for research and treatment of cancer and other health issues. None of these challenges to coalition-building are impossible to overcome, as the example of CSPI's 1980s campaign shows (interviews 3, 20). The public health perspective resonates particularly well with a human rights framework and offers an important basis for coalition-building. Compared to the industry's singling out of a small minority of individuals as 'fundamentally different from normal drinkers' (Beauchamp 1980, p. 181/2), the public health approach rejects stigmatization and could become a powerful basis for coalition building.

While expanding the network is crucial to increasing political influence, the analysis also shows that successful network

expansion requires constant attention to goal alignment. When the AMA and the *Lancet* demanded a framework convention on alcohol in the mid-2000s, some GAPA members felt an immediate backlash among WHO member states in Geneva. The call for the framework convention was seen as counterproductive since any such demand raised levels of resistance against global action significantly. For those trying to move forward in getting the non-binding agreement adopted, the discussion about a framework convention turned out to be very distracting (interview 20). Once a network moves from simple agenda setting to policy formation, leadership and governance play an increasingly important role in ensuring that network members feel properly represented, but also can be asked to support an agreed upon strategic approach.

This case study contributes also broader lessons to the study of global health issues and transnational alliances. First, the alcohol case focuses attention on the conflict between global health networks and powerful industry interests. This differentiates this case from health conditions where the disease itself or the public's fatalism represents the main challenges to overcome. The study provides important insights into how the presence of powerful opponents has ambiguous effects on the network's evolution and alliance building efforts. Second, the case study confirms the importance of popular support for transnational mobilization. Researchers organized in epistemic communities can be highly effective in shaping agendas and policy adoption based on their privileged access via elite networks to decision makers. But beyond the creation of agendas and consensus at important meetings, different types of networks with broader popular support are needed in order to mobilize sustained support for the domestic implementation of specific policy instruments.

While this study's conclusions emerged from detailed document analysis and expert interviews, there are important limitations to consider when assessing the ability to generalize the results to other cases. The single case study design and the availability of data represented the most important limitations. In terms of information gathering, limited written documentation about network creation and evolution as well as difficulties to confirm results based on several independent sources represented core challenges. To address some of the limitations of using interviews, anonymity was guaranteed, and interviews consistently focused on eliciting different views on crucial events. Comparative lessons drawn are not based on this single case, but only emerge from the joint evaluation of the alcohol and tobacco cases (Gneiting and Schmitz, 2016) as well as situating the alcohol case within the larger framework of the GHAPP studies.

## Acknowledgements

## Endnotes

1 Based on its focus on public policy and an assessment of minimal risk to informants, the study was granted exempt status by the Institutional Review Boards of American University and Syracuse University.

2 Results were presented at the 2012 American Public Health Association meetings, the Alcohol Policy 16 conference (April 2013), the International Studies Association meetings (April 2013), and the Global Alcohol Policy Conference in Seoul, Republic of Korea (October 2013).

3 ''Adherents of this [new public health] approach tended to search for defects in the community and the environment rather than in the individual; to emphasize predictability and usualness rather than random deviance; they tried to think about prevention rather than merely repairing and treating'' (Ryan 1971: 15/6).

4 From 1986 to 1996, worldwide activities of so-called 'social aspect' organizations increased by 150 per cent, primarily pushing educational programmes and seeking to improve the image of the alcohol industry (Houghton 1998). In 1995, Marcus Grant left his position at the WHO as director of alcohol programmes to become the first president of the newly founded International Center for Alcohol Policies (ICAP) based in Washington D.C. ICAP is entirely funded by major alcohol producers.

5 The Institute was founded in 1987 and renamed *Alcohol Justice* in 2011.

6 Core funding for the two-day conference came from the Institute of Alcohol Studies, IAS, based in London ($65 000), the Robert Wood Johnson Foundation ($50 000), and the WHO ($10 000).

7 The report was modeled after *Tobacco or Health: A Global Status Report* released by the WHO in 1997. Two subsequent reports published in 2004 and 2011 continued to track alcohol harm.

8 The four founding members are: the International Diabetes Federation (IDF), the World Heart Federation (WHF), the International Union against Tuberculosis and Lung Disease (The Union), and the Union for International Cancer Control (UICC).

9 The coalition is led by Baby Milk Action, the organization that also led the Nestlé boycott.

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