

**SUMMARY REPORT OF  
A WORLD HEALTH ORGANIZATION MEETING ON  
DISSEMINATION OF BRIEF INTERVENTIONS FOR ALCOHOL  
PROBLEMS IN PRIMARY HEALTH CARE:  
A STRATEGY FOR DEVELOPING COUNTRIES**

**Alicante, Spain, 24-27 September 2002**



**World Health Organization  
Management of Substance Abuse  
Department of Mental Health and Substance Abuse**

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## INTRODUCTION

Hazardous and harmful alcohol use can cause or predispose one to an array of physical, psychological, and neuropsychiatric disorders, thereby contributing to the burden of disease in society. Alcohol-related death and disability account for even greater costs to life and longevity than those caused by tobacco use. This places an enormous economic burden on countries, especially developing nations, as valuable resources needed for more pressing health and welfare needs may be diverted to curb this problem. Recognising that screening and brief intervention (SBI) for alcohol-related problems in primary health care can be an effective and efficient way to reduce alcohol consumption by hazardous and risky drinkers, a WHO meeting was held to begin the task of disseminating SBI to the rest of the developing world. Two countries were selected for this project: Brazil and South Africa. A group of international experts, consultants and representatives from the two country sites convened in Alicante, Spain from 24-27 September 2002 to begin discussions on the matter.

The scope and purpose of the meeting included the following:

- (1) To understand the current responses to alcohol problems in sites in Brazil and South Africa and the organization of their health system,
- (2) To review experiences and results with the dissemination of brief interventions in developed countries and other settings,
- (3) To delineate steps needed to implement and widely disseminate brief interventions in developing countries,
- (4) To discuss training needs and materials available, or to be developed, for supporting the project in each of the sites,
- (5) To discuss mechanisms for evaluating plans in each site, and
- (6) To develop a common framework for the dissemination of brief interventions in developing country settings.

Some long-term objectives or expectations that would hopefully transpire from this meeting include making screening and brief intervention part of health care systems; helping people with potential alcohol problems recognize the value of early intervention; reducing the stigma associated with alcohol problems; developing local expertise for implementing SBI; raising the profile of alcohol problems in health practice, policy making and the media; making it easy and meaningful for people to seek help for alcohol problems; and mobilizing partners, e.g. NGOs and religious groups to work on alcohol problems collaboratively.

## **AUDIT and brief interventions**

In 1980, a WHO expert committee stressed the need for efficient methods to identify persons with harmful and hazardous alcohol consumption before health and social consequences become pronounced. There was an urgent call for the development of strategies that could be applied in primary health care settings with a minimum of time and resources. Within this context, the WHO Collaborative Project on Identification and Treatment of Persons with Harmful Alcohol Consumption was initiated in 1982 to develop a scientific basis for screening and brief interventions in primary care settings. Phase I of the project linked six collaborating centers representing a broad variety of cultural groups in developing a simple instrument to screen for persons at high risk of alcohol problems in both developing and developed countries. The result of this phase was the introduction of the Alcohol Use Disorders Identification Test (AUDIT). Phase II of the project was a cross-cultural randomized controlled trial to test the usefulness of alcohol screening when it is linked to brief intervention.

Some preconditions necessary for a public health approach to screening and early intervention include:

- (1) Adequate definition of problem and operational criteria for diagnosis.
- (2) Natural history of problem understood, as well as risk factors and populations at risk.
- (3) Screening tests available: brief, easy to administer, reliable, and valid.
- (4) Effective intervention and treatment methods available.

The effectiveness of SBI. Four major meta-analyses show low to moderate effects. The evidence for the effectiveness of brief opportunistic interventions after identification of hazardous and harmful consumption is now substantial, with 29 of 32 randomized controlled trials evidencing a significant treatment effect (Moyer, Finney, Swearingen, & Vergun, 2002).

Particular attention was drawn to the domain and item content of the AUDIT manual. Given its proven sensitivity and specificity, the AUDIT is now the dominant screening tool used. It was also noted that revised manuals were using a more public health approach, were more comprehensive, and had a more systematic approach to risk and dependence and specifically assigned intervention modes.

### **Phase III and Phase IV of the brief interventions project**

The rationalization of Phase III component of the brief interventions project stemmed from the realization and desire to promote the incorporation of brief alcohol interventions within primary care. Fourteen countries from Europe, the Asia Pacific region and North America were involved, and a representative sample of medical practitioners engaged in primary health care was obtained from each participating country. Participants were asked about their current practices in preventive medicine,

training and knowledge in preventive medicine, self-efficacy, role acceptance and perceived barriers to delivering preventive medicine.

The rationale for the Phase IV project was to oversee the development and application of strategies for the widespread, routine and enduring implementation of SBI in the primary health care systems of the 13 participating countries. Delegates were referred to the Phase IV website to access more information: <http://www.who-alcohol-phaseiv.net/> In the Phase IV project countries adopt different strategies to meet these objectives, in line with local conditions and needs. In this way, the implementation of strategies to promote the uptake and sustainability of brief interventions is flexible in nature.

The central framework of the strategy adopted in the Phase IV work consists of four components that were adapted from a document prepared in the USA by Drs. Higgins-Biddle and Babor: (1) customization of materials and services appropriate for local conditions, (2) reframing the understanding of alcohol issues by the community and by practitioners, (3) establishing a lead organization and building a strategic alliance among organizations and individuals interested in widespread and routine implementation on SBI, and (4) carrying out a demonstration project to demonstrate that routine implementation of SBI in primary health care is feasible and has wider health and economic benefits for the community.

The Phase IV project has the following features: (1) Evaluation of the extent to which the study aims have been achieved, especially the overall impact of the study on the country-wide implementation of SBI, (2) Economic evaluation ,e.g., cost of implementing SBI per patient, health and other economic benefits for primary health care and for the wider community, possible cost-offsets, etc. It was noted that presenting potential economic benefits or savings to health care systems could be a powerful political ammunition in garnering support for the project, (3) action research – an iterative process which aims to impact real-world primary health care service delivery as well as increase knowledge, and (4) use of qualitative and quantitative methods.

Progress among participating countries were variable and that funding remained a major problem in some countries. It was further noted that the central aim of the project was extremely difficult to achieve in all countries, and at worst, the project could be seen as the beginning of a long process. Mainly for this reason, a report will be written in 2004 describing the extent of progress in each country and elaborating plans for the future.

## **EXPERIENCES OF DEVELOPED COUNTRIES WITH SBI**

### **EU project to develop guidelines for brief interventions**

The aim of this project was to try and integrate health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily clinical work. This aim further supports the EU's Public Health strategy, the European Charter on Alcohol, and the European Alcohol Action Plan of the WHO. The activities of the project include the following: (1) Preparation of European recommendations and clinical guidelines for health care purchasers and providers, (2) Development of an European training program for primary health care professionals, (3) Development of a comprehensive Internet site database on good practice covering the domains of efficacy, economics, health and policy – it was proposed that the database be integrated with the WHO Phase IV International database, and (4) Preparation of a series of strategies for dissemination experiences in various pilot sites and country-wide initiatives.

The tools and strategies will draw upon existing scientific knowledge and experience and will be prepared through consensus building meetings, involving all partners and, where relevant, focus groups. The methodology of the project would involve the creation of two distinct groups: (1) an European expert group of public sector, health care professionals, non-governmental, scientific and private sector organizations to endorse the project, and (2) country-based action groups of public sector, health care professionals, non-governmental, scientific and private sector organizations to drive the project at a country level.

Evaluation of the success of the project will be undertaken by: (1) case study method, with evidential documentation of the tools of the project, and (2) through documented experiences and measures of activity of primary health care-based health promotion interventions for hazardous and harmful alcohol consumption. Finally, the products of the project would not only be available online, but also actively disseminated to all relevant national and international governmental, non-governmental, health care professional, scientific and private sector organizations.

The project's start date is currently set for January 1, 2003 and the estimated duration of the project is 24 months. The proposed budget for the entire project is 700,000 Euros.

A brief mention was made of the Spanish experience in developing materials and services for SBI, specifically a training package for both trainers (alcohol specialists) and trainees (primary health care workers), and a SBI package (the Beveu Menys Package which is an adaptation of the Drinkless Package).

### **The Finland Phase IV Project Experience**

Having established a long tradition in preventive health care in Finland, there was ample interest in SBI administration (with three dissertations and four studies having been conducted) and the issue was considered important at a local and ministry level.

The Finnish demonstration project involved two sites: (1) the project area which was the city of Tampere (population 190,000; 80 General Practitioners; 160 nurses) and (2) the control area which was the city of Turku. This was a 3-year implementation project that involved a participatory approach whereby General Practitioners would be the owners of action. Baseline measures were taken to assess the health professionals' attitudes, knowledge and skills (questionnaire administered to personnel), and also their activity (questionnaire administered to patients). Post-testing was carried out and this involved exit interviews with patients and video recordings of routine consultations. Results of focus groups revealed some obstacles, namely, confusion about the target group of SBI, lack of self-efficacy, lack of time, need for simple guidelines and uncertainty of the justification of SBI. Suggestions by primary health care workers included wanting more practical training, more information on studies, personal training and additional pay.

Based on questionnaires administered to primary health care workers and patients, results from focus groups and recommendations from staff members, the implementation phase in Tampere involved usage of a mini-model (including AUDIT and patient handout) and a project nurse in close contact with the health center. It was noted that there was no golden rule for implementation and measurement and that the Tampere project utilized several methods simultaneously. Examples include availability, telephone contacts, press releases, scientific articles, seminars and new questionnaires.

Preliminary analysis revealed little change in SBI activity at the project site. She further stressed on some major problems encountered by the project and these included finding ways to reach those not interested as well as the major issue of having a lack of time whereby physicians cannot leave their busy practices in order to receive training. A suggestion was made from the floor that having the other staff members (i.e., nurses) do the screening tasks might actually 'pressure' the General Practitioners to follow-through and remove the bulk of the responsibility that seemed to be placed upon them. However, the final decision to implement SBI was in the hands of the General Practitioner and that the other staff members felt 'powerless' to take action unless the General Practitioner agrees to do it.

### **The U.K. Phase III Experience**

Phase III of the WHO project consisted of a cross-cultural study on disseminating and supporting SBI in primary health care. The study comprised of three different strands: (1) questionnaire survey of General Practitioners, (2) qualitative interviews with General Practitioners and key informants, and (3) a randomized-controlled trial of methods of uptake and utilization of SBI by General Practitioners.

Some main barriers to implementation of SBI which included the following: (1) Doctors are too busy dealing with the problems people present with, (2) Doctors are not trained in counselling for reducing drinking, (3) Government health policies do not support doctors who want to practice preventive medicine, (4) Doctors do not believe that patients would take their advice and change their behavior, (5) Doctors do not have suitable counselling materials available, and (6) The Government health scheme does not reimburse doctors for time spent on preventive medicine. Likewise, some main incentives for SBI implementation included the following: (1) If support services were readily available to refer patients to, (2) if early intervention for alcohol was proven to be successful, (3) if patients requested health advice about alcohol consumption, (4) if public health education campaigns made society more concerned about alcohol, (5) if quick and easy counselling materials were made available, and (6) if salary and working conditions were improved.

The Phase III trial of marketing strategies design comprised of the following: postal marketing (mailing a promotional brochure to General Practitioners), telemarketing (following a script to market the program over the telephone), and personal marketing (following the same script during face-to-face marketing at General Practitioners' practices). Results from the trial showed that personal marketing was the most effective overall dissemination strategy but telemarketing was the most cost-effective strategy.

The study also found that General Practitioners who were trained (received the program plus practice-based training in program usage) and supported (received the program plus practice-based training and a support telephone call every two weeks) were significantly more likely to implement the SBI program than controls who received the program with written guidelines only or trained General Practitioners who did not receive additional support. It was concluded that training and support were not only effective in SBI implementation but also cost-effective in the long run.

### **Cutting back: a sensible approach to drinking and health (The USA Story)**

It was stressed that reducing alcohol problems would involve not only alcohol-dependent people but also risky drinkers. Given that SBI is backed by 20 years of research, he reiterated the fact that SBI cannot only identify degree of risk and likelihood of a condition but also help patients reduce hazardous and harmful drinking and refer more severe cases to specialized alcohol treatment. The American National Cutting Back Study involves five different managed care sites across the country. Implementation procedures included site visit briefing of key leaders, manual-guided, condition-specific planning and training which incorporated clinics, and technical assistance. All screening was done by patients' self-report either by paper or computer. Two models of delivery intervention were utilized, namely, by physicians and nurses-educator specialists.

The implementation findings include: (1) a systems approach is essential - leadership is key, (2) SBI can be implemented in primary health care, (3) both physician and specialists models work, and (4) training and materials are effective.

Some implementation factors relevant to the study:

- (1) **Predisposing Factors.** E.g., provider perception of peer approval, perception of organization's approval, frequency providers ask, educate and advise about alcohol risks, stable patient membership and organizational stability.
- (2) **Enabling Factors.** E.g., having time, staff turnover, competing priorities, having an influential leader, staff involvement in planning, number of staff trained.
- (3) **Reinforcing Factors.** E.g., organizational support.

It was concluded that alcohol prevalence indicated a high need for SBI, there existed high patient acceptance to the idea of SBI, and implementation is feasible and should be done in order to reduce risky drinking.

### **The Belgium Experience**

Some conclusions from the Phase III study and reported three dimensions of barriers: feeling of competence, legitimacy of task, and practice constraints. Training needs were in the three areas of knowledge, skills and attitudes. Qualitative research involved having focus group research to identify problems in actual care and dissemination strategy, and a Delphi study to develop broadly based consensus. The hypotheses of the study stressed that increasing competence alone was insufficient and that attitudinal and practice factors were to be included in the strategy.

The development of the Flemish project included the following:

- (1) Formalized recommendation and Quality Assurance (QA) guidebook
- (2) An array of choices from EIBI with questions (3/5/10) to clinical strategies (Trauma)
- (3) Approaching local General Practitioner groups: training and QA
- (4) Individualized support with practice materials
- (5) Telephonic follow-up by peers
- (6) Group incorporation in community projects

Some final conclusions:

- (1) Data collection to start participatory reflection
- (2) Awareness of existing groups and agendas
- (3) Support to increase local expertise
- (4) Comprehensiveness and long term view
- (5) Research agenda: cost utility of local strategies

## **Spanish Experience with SBI**

The detection of hazardous drinking is already a regional goal for the three Spanish sites: Cantabria, Galicia and Comunidad Valenciana. One of the main goals is to have SBI as a normalized and generalized part of the primary health care routine. Main support for the program will come from the Regional Drug Commissioners, which in the case of the Valenciana region is the Drug Commissioner. Support was also available from scientific organizations such as SEMFYC, SET and Sociodrogalcohol. Support and expert advice would be sought from professionals in other regions (e.g., Catalans) and the WHO. Budget was not viewed to be a major concern but rather the issue of time pressure for General Practitioners and the monumental task of creating an adequate culture that would favor implementation of SBI in the health care system. The AUDIT had already been translated into Spanish and that there were three versions available (all validated). Work was currently underway to translate the Brief Interventions manual into Spanish as well. The duration of the project was three years and for the regional and implementation evaluation, an audit would be conducted by an external agency before the beginning of the program and periodically thereafter. A similar demonstration project is currently being undertaken in Catalonia which involves 310 primary health care centers, 80 trainers and over 3,000 primary health care workers.

## **SITE PROPOSALS**

### **BRAZIL SITE 1: São Paulo City**

#### **I. Setting**

The São Paulo City administration is divided into 41 districts whose coordinators have some level of autonomy. The Alcohol and Drug actions are developed under the supervision of the São Paulo City Mental Health Coordinator in agreement with the District Managers. In each district, there are three levels of care: primary (basic units), secondary (specialized outpatient services), and tertiary (hospitals, emergency rooms). The practice sites proposed for implementation of the project involve all 41 districts with Sacomã District being the pioneer site (population 100,000). The target population is estimated to be around 10% of São Paulo City's inhabitants (roughly 1.8 million in total) over the age of 12.

The health professional teams of Sacomã District have reported an interest in SBI techniques but possess no specific training in this kind of intervention. Currently, there is no systematic assessment of alcohol problems and identified patients are usually just referred to the few specialized services available in other districts. The Municipal Secretary of Mental Health and Substance Use had recently promoted meetings with the health professionals in order to discuss theoretical aspects of alcohol and other substance misuse. They have also created a new Policy on Alcohol and Drugs for the city which includes aspects of control and selling as well as training initiatives for health professionals. Dr Formigioni noted that her team at the Department of Psychobiology at

the Federal University of São Paulo could facilitate such training which would involve both theoretical and practical activities.

The goals of the Brazil Site 1 Project in relation to the regional health system include:

- Training health professionals in early detection and brief intervention of alcohol misuse.
- To assess alcohol-related problems at the participating basic health units.
- To evaluate the impact of early detection and brief intervention training of the health professionals team.

An analysis of who would benefit from the implementation include: (1) governmental units – the Secretary of Health would have more data available in order to plan its actions in the field, (2) Patients would have their alcohol use evaluated at an early stage and prevention steps taken if necessary to avoid future harmful use of alcohol, and (3) General population – besides having an impact on health in general, a possible reduction in alcohol-related problems may reduce social problems such as alcohol-related violence, family disputes, motor vehicle accidents, etc.

A few obstacles that would be expected for the successful implementation of this project (and some possible solutions) include:

- Health professionals having a lack of time and/or interest to participate  
Strategy to overcome: use of focus groups to motivate and integrate the participants in the project and to develop skills for dealing with problematic alcohol users.
- Political changes and/or conflicts in the health coordination system  
Strategy to overcome: creation of a committee with representatives from all relevant sectors.
- Financial problems due to current Brazilian economic situation  
Strategy to overcome: to submit the project to Brazilian and also non-Brazilian governmental support sources.

## **II. Regional Implementation Plan**

### **A. Description of Implementation Team and Organizational Chart**

- UNIFESP
  - Department of Psychobiology, Discipline of Medicine and Sociology of Drug Abuse,
    - Drug Dependence Unit
    - COSFAC (linked to the Family Health Program)
  - São Paulo City Mental Health Coordinator
  - São Paulo City District Coordinator
  - Brazil Site 2 – Ribeirão Preto
  - International advisors and consultants

## **B. Description of Individual Responsibilities**

Drug Dependence Unit

Coordinator: Dr Maria Lucia O. Souza Formigoni

Trainers: 4 psychologists, 2 psychiatrists, 1 social worker

- Will be in charge of preparation of the didactic materials, theoretical presentations, supervision of cases and coordination of focus groups that will be used in training.

Evaluators: 2 psychologists, 1 statistician, 1 secretary

- Will develop evaluation instruments, create and analyse the specific databases that will be used to organize the qualitative and quantitative data. Also responsible for technical reports.

Administrative: 1 secretary, 1 financial controller

- Responsible for organization of materials, correspondence, financial control and elaboration of financial reports.

International Consultants: different consultants will be invited to work as advisors during the implementation and evaluation of the project.

A committee composed of representatives of the municipal government (Mental Health Secretary and District Representatives), COSFAC (UNIFESP) and the UDED team will be responsible for the decisions related to strategies in implementing the protocol at the basic units as well as to supervise the project implementations. The UDED team will have weekly meetings to organize action as well as to discuss problems and derive solutions for the project implementation. At the local level in each participating unit, there will be a coordinator designated by the local team who will act as a key informant concerning the process of implementation. He or she will also function as the communication channel between trainers and the project coordination committee.

Some local financial and non-financial support available include: (1) UNIFESP – may contribute part of an office for the coordination of the project and organization of materials as well as contribute human personnel, (2) São Paulo City Health Coordinator – may contribute personnel and some didactic material, and (3) FAPESP (the São Paulo State Foundation that supports research efforts) – may support part of the evaluation component of the project.

## **III. Site Implementation Plan**

- Authorization to implement – coordinator of the Mental Health System of the São Paulo City Health Secretary.
- A draft proposal will be presented to the coordinator of the Mental Health System of the São Paulo City Health Secretary and after her approval, the proposal will be presented and

discussed with the District Managers. Subsequently, discussions will be held with the family health teams, and together with them, the UDED team will discuss and establish the set goals for each team.

- UDED team will prepare the training structure including a course to be given to the family health teams. This would include theoretical presentations, discussions of philosophy and rationale for the project, practical activities and case supervisions.
- An evaluation project will be developed including data collection before and after the implementation of the project. Multiple indicators will be considered: number of patients evaluated, number of patients who received SBI, client satisfaction, concepts of health professionals involved in project, etc.
- Technical assistance for problem resolution will be provided through daily telephone supervision and/or monthly personal supervision.
- Regular reports (every quarterly) directed to the health workers and District Directors providing the latest project data and statistics.

#### **IV. General Issues**

- Duration of project: 3 years
- Regional evaluation will be done by the team of evaluators
- São Paulo and Ribeirão Preto sites will work as partners giving technical assistance to each other. Additional help would be provided by international consultants/advisors, WHO representatives. As no previous experience in this area exists in Brazil, any form of assistance would be greatly appreciated. These could be in the form of email communication, contacts in-person and some local site visits.
- If the experience proves successful, the governmental system responsible for the health system should work towards maintaining the system. The training of at least 2-4 professionals in each site should give them autonomy to be multipliers of the technique. Further expansion to other Brazilian cities and countries should follow the same dissemination process.

#### **BRAZIL SITE 2: Ribeirão Preto**

##### **I. Setting**

##### **A. Health Care Delivery Setting**

- State Administration Level: Regional Director of Health (DIR-XVIII) and Health Regional Commissions (CIR).
- City Administration Level: Municipal Health Foundations, City Health Departments, SUS – partially autonomous management of federal financial resources, Municipal Health Council, Municipal Health Department, Emergency Care, Private insurance reimbursement.
- Clinics Hospital – USP: Autonomous state health institution, central role for the tertiary level of health care linked directly to the state health administration.

## **B. Implementation**

Implementation of the project will occur at 3 levels:

1. **Family Health Program (PSF)** under responsibility of the **University of São Paulo**
  - 5 Unit: team composition – 5 family health physicians, 5 nurses, 10 assistant nurses, 20 residents in Family Medicine, 20 community health agents. Involved in assisting 20,000 inhabitants registered with the Family Health Program. From here, there is a possibility of disseminating the program to the whole West District (pop. 120,000).
2. **Family Health Program** under responsibility of the **Regional Director of Health**
  - 25 cities and 71 units assisting 1,047,000 inhabitants.
3. **Family Health Program** under technical responsibility of the **Regional Centers for Training and Continuous Education of Human Resources**
  - 232 cities and 6 Regional Directors of Health assisting 4,803,591 inhabitants.

The current status of alcohol screening and intervention involves a health agent completing a questionnaire per family whereby some questions pertaining to alcohol misuse are included. In some cases, treatment is sought directly by the patient through Family Health physicians. Patients with confirmed diagnosis can go to the local mental health team whereas the more serious cases are referred to outpatient clinics.

The goals of the project are:

- At the community level:
  - to reduce general social tolerance
  - to mobilize resources for a health sector
  - to improve the actions in other sectors
  - to reduce discrimination against alcohol patients
- At the health system level:
  - to enhance the engagement and the efficacy of the system
  - to educate health professionals adequately, integrating alcohol SBI into the routine practice of Family Health Program to aid in identification, management and referral (if necessary) of positive cases.
  - to improve the rate of recognition of risk drinking patients
  - to reduce the prevalence of severe cases and hospitalizations
- At the individual level:
  - to change attitudes of health workers about their own drinking

It is hoped that the project would benefit family health clinicians, employers, family health agents, regional health administrators, medical students, nurses, psychologists, social workers, the Education Department and the general public. Some

obstacles that might be encountered include: competing responsibilities, political changes, financial difficulties and funding problems.

## II. Regional Implementation Plan

### A. Description of Implementation Team and Organization Chart

Medical School	Department of Neurology, Psychiatry and Psychological Medicine-FMRP-USP	PAI-PAD	Prof. Dr. Erikson F. Furtado
		Community Health Promotion Program	Prof. Dr. Ricardo Gorayeb
	Department of Social Medicine	Family Health Program	Prof. Dr. Milton Laprega
Links to other institutions	Regional Centre for Training and Continuous Education of human Resources		
	Nursing School		
	City Health Department		
	Regional Direction of Health (DIR-XVIII)		
	Clinics Hospital Administration		
	Federal University of Sao Paulo (UDED- Drug Dependence Unit)		

### B. Description of Individual Responsibilities

(1) Erikson F. Furtado:

- Project Co-ordination
- Alcohol Treatment Referral Services co-ordination
- Mental Health Professionals Training
- Research and Development of Prevention Strategies

(2) Milton Laprega:

- Responsible for the co-ordination of the Family health Program and with “Regional Centres for Training and Continuous Education of Human Resources”
- Communication with the State Health Agencies
- Training of the Family Health Professionals
- Research and Development of Prevention Strategies

(3) Ricardo Gorayeb:

- Communication with the City Health Department
- Responsible for the Life Skills Training
- Qualitative methods for evaluation (focus group)
- Research and Development of Prevention Strategies

(4) Clarissa M. Corradi:

- Planning and development of educational activities and materials
- Organization and training of the health professionals
- Research and Development of Prevention Strategies

### **C. Decision making**

- Project team will meet twice a month
- Decision to be made by consensus
- Possible co-ordination of planning and decision-making with a Co-ordinating Committee composed of representatives of the participating agencies and institutions.

## **III. Site Implementation Plan**

The integration of SBI will take place through the health agents who would obtain data from each family during their home visits. The AUDIT will be integrated into the routine procedures used in home visits when new families are registered with the health agent. For registered families, the health agent will complete the AUDIT during the monthly home visit. If the AUDIT score is positive, a nurse or physician will be notified to confirm the results of the screening and to set up an appointment to conduct the intervention.

Training will be conducted as follows: Teams will be trained as units, with several being trained at the same time by university training leaders. Approximately 20 people can be trained per month during the first phase. The training program will be based on existing training materials that are available now in English (and perhaps Spanish). Based on these packages, training videos and related training materials will be developed in Portuguese.

### **SOUTH AFRICA SITE: Limpopo Province**

The target population for the project is estimated to be around 1,000,000 patients spread across 378 clinics in the Limpopo Province area. It was noted that this figure was a conservative number and that the actual figure might be higher than the reported one here.

The South African project would be divided into three distinct phases: the preparation phase, the pilot phase, and the dissemination phase.

#### **1. Preparation Phase**

This phase would involve establishing a lead organization and building a strategic alliance. Meetings would be planned with potential partners and stakeholders at both a national and provincial level. Included in these meetings would be members of the steering committee for brief intervention. The objectives of the meetings would be to discuss SBI for alcohol problems, evidence, WHO strategy (different models for nurses), alcohol plus depression, defining roles, support and resources. Briefings would also be held at a district level.

## **2. Pilot Phase**

**Design:** pre/post-intervention (timeline: 1 month)

**Objectives:** customization of materials and services, reframing understanding of alcohol issues, referral procedures, training and quality assurance

**Outcome:** To serve as model for wide dissemination

### **Method:**

**Sample** – 6 clinics, one per region

**Procedure** – Training 3 staff per clinic, implementation of SBI to all patients for 2 months, exit interviews with patients, interview with primary health care staff

**Instrument/AUDIT** – standard drink

**Instrument 2** – BI manual adapted to local context

**Instrument 3** – staff and patient leaflet

**Measures** – changes in SBI activity, patient attitudes, satisfaction, changes in attitudes towards SBI.

## **3. Dissemination Phase**

### **Design:**

- regional dissemination of SBI to all clinics
- pre/post intervention assessment of statistical and behavioral indicators
- timeline: 1 year

### **Objectives:**

- training of 2-3 nurses per clinic, quality assurance

### **Method:**

- training the trainers (6 trainer multidisciplinary teams)
- assessment of changes in SBI activity in 3 clinics per district at 6 and 12 months

### **Measure 1:**

- statistics on patient profile (one month) per district from clinics and hospitals (pre/post interview)
- statistics from police on violence against women, alcohol-related harm

### **Measure 2:**

- changes in SBI activity (no. of patients screened, brief advice given, brief counselling given, referrals)

### **Measure 3:**

- qualitative interviews with SBI provider

Financial support for the project would be obtained from the national health department. Suggestions were also made on how to obtain funding from various other sources like the EU and USAID.

## **ISSUES TO BE CONSIDERED**

### **→Research and implementation**

- This is not a rigorous, randomized control trial but action/participatory research (combining research/evaluation with service delivery, etc.)
- Qualitative procedures & action research: Focus groups (explorative), Exploration circle
- Quality circles (e.g., group of helpers and patients discuss a particular approach to improve implementation procedures), Delphi study (heterogeneous expert group to find acceptable agreement, e.g. on screening procedures).
- Inclusion of cost effectiveness measures may be relevant also for developing countries (depending also on needs of government) as it is included in EU Phase IV studies.

### **→Sites in developing countries**

- Need to learn from implementation experience to replicate and disseminate in other developing countries
- Implementation issues: legitimacy of who is implementing SBI (Spain at primary health care: General Practitioner screening, nurse intervention; Brazil: health agent only pre-screening, then refer for screening and intervention to family health General Practitioner). The WHO SBI allows a flexible approach to deal with different levels of alcohol drinking from risky to dependency problems and also dealing with it at different levels of the health care system. Traditional and faith healers may be targeted because of their role in primary health care for SBI, especially in South Africa.
- Possibility of staging wider dissemination of SBI programmes from smaller to larger regions and from restricted levels (e.g., primary health care nurses) to other levels (e.g., General Practitioners or emergency care, etc.)
- Example of training curriculum (Spain): Part I Theory, Part II (debate, practice): 1) introduction, 2) drugs and society, 3) risk factors, 4) preventive strategies, 5) referrals. Plus manuals, video on risk pattern of drinking for patients and trainers, booklet targeted for women, patients.

### **→Target population**

- primary health care and risk groups of hazardous alcohol drinkers. Emergency care may not be part of primary health care but may be an important target group. Special target groups with risk drinking may be men, pregnant women (e.g. Brazil, South Africa), binge drinking youth may be reached through not only primary health care but also through life skills/schools programmes.

→**Strategic issues:** National health policy, alcohol policy, legislation, advertising on alcohol and counteradvertising, the importance of positive/best practice models, approach with health managers also evidence based but mainly cost issues, importance of study/project as part of WHO strategy.

→**Funding**

-national funding agencies, WHO, EU through bilateral agreements, NIAAA via research program on stigma, Spain (Valentian government), USAID to pay for consultants.

→**Technical assistance** (WHO, consultants)

→**Development of a website** where all information relevant to the project could be accessed. A suggestion was made to have some form of collaboration and sharing of knowledge and information to avoid overlapping or redundancy (e.g., having HTML Links between sites).

## RECOMMENDATIONS

### 1. Proposed Timetable (for Year 1)

Sept. 2002	: Development of draft implementation plans (completed)
Nov. 2002	: Send revised protocols to WHO
Dec. 2002	: Review of site protocols, feedback and finalization of implementation plans.
Jan. 2003	: Development of a common protocol/evaluation plan (consultants, project coordinators, WHO)
Jan-Feb. 2003 :	: Adaptation of WHO materials, development of new materials
Feb. 2003	: Develop site time tables and sequence of activities. Scheduling of training programs and site visits.
March 2003	: Implement project activities
Sept. 2003	: Meeting of consultants and project participants, annual progress reports

**Coordination:** Links to Phase IV Project, EU Centre, projects in Spain

**Sharing of training materials:** Development of country/language-specific training materials. Terminology issues in various languages, e.g. at risk drinking in simple patient-provider language.

### **Evaluation**

- Common evaluation plan
- Human subjects approvals
- Evaluation questions, Process, Outcome
  1. What to measure
  2. How to measure it

### 3. How to record our learning

#### Level 1: Health care professionals

- a) No. of people trained out of target universe
- b) No. of people screened out of target universe per month
- c) No. of trainers trained
- d) Pre-post changes in knowledge, attitudes, self-efficacy, intentions (e.g. sample 1 out of 10 nurses)
- e) use of pseudo patients (possibly real heavy drinkers, potential ethical problems)
- f) quality of intervention (tape/video recording)

#### Level 2: Patients

- a) No. of people screened, screening records completed
- b) No. of positive cases receiving brief intervention
- c) No. of referrals made
- d) No. of patients engaged in treatment
- e) Effects of SBI on patients/families/satisfaction (random sample)

#### Level of programme

- Site activity log: activities, trainings, problems, achievements, meetings, obstacles, solutions, etc. (e.g. done by one team member in clinic)
  - Team activity log
  - Trainings conducted
  - Materials distributed
  - Resources expanded to accomplish activities e.g. staffing
- N.B. Assessment of quality of various activities, materials is important.

#### Level of community

- Indicators of alcohol related problems
- Possibly quasi-experimental approach
- Community survey, selected sample of households (questions such as when was last GP/clinic visit, questions about alcohol use).