Evaluating the progress of alcohol policies in Burundi against the WHO 'Best Buys' interventions: Implications for public health

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Abstract

Introduction: Alcohol use is a major global health risk, with Global South countries experiencing greater harm per litre of alcohol consumed than those in the Global North. In Burundi, a country with a low-income economy, 16.6% of people aged 15 and above engage in heavy episodic drinking, and over 30% of women drink during pregnancy. This paper examines current alcohol policies in Burundi, how well they match the World Health Organization (WHO) 'Best Buys' policy options, and stakeholder views on their implementation.

Methods: We identified policy documents via online searches, visits to government offices, and snowball sampling from contact with key stakeholders. Semi-structured interviews were conducted with 10 stakeholders. The WHO European Action Plan to Reduce the Harmful Use of Alcohol (EAPA) tool was used to analyse the extent to which Burundi has adopted recommended policy standards. Interviews were thematically analysed using NVivo software.

Results: Only nine of the 34 WHO EAPA indicators are addressed; seven out of 34 indicators are mentioned with no clear actions; and 18 are not addressed in the eight policy documents that met our inclusion criteria. The large proportion of indicators absent from Burundi policy relate to availability, pricing and taxation, drink-driving, and marketing. An absence of legislation to support existing policies, industry interference, corruption, and cultural norms around alcohol were identified as key barriers to implementation.

Conclusions: Burundi should enact laws to support existing policies and design regulations targeting taxation, marketing, and availability. Government and civil society coalitions should report and address any influence of the alcohol industry on policymaking and implementation.

Introduction

Alcohol is the eighth leading preventable risk factor for disease and the largest risk factor for disease burden globally among people aged 25 to 49 (Murray et al., 2020). Research suggests no amount of alcohol is safe for health (Murray et al., 2020), with an estimated 4.1% of all new cases of cancer globally in 2020 attributed to alcohol consumption (Rumgay et al., 2021). Alcohol also causes harm to non-drinkers and contributes to the spread of infectious diseases such as tuberculosis, human immunodeficiency virus (HIV), and other sexually transmitted infections (STIs; Berry & Johnson, 2019; Jernigan & Trangenstein, 2020; Parry et al., 2009). Low and middle-income countries (LMICs) experience greater harm per litre of alcohol consumed than those in the Global North high income countries (HICs), due to differences in economic wealth, higher mortality rates overall, and the complex interaction of other risk factors (Manthey et al., 2019; Rekve et al., 2019; Trangenstein et al., 2018; World Health Organization [WHO], 2018a).

A recent review by Morojele and colleagues (2021) covering data from 2000 to 2016, highlights that a majority of adult women in sub-Saharan Africa (SSA) remain abstainers, but a large proportion of men are not. Nonetheless, this review also shows that SSA has a higher burden of alcohol-related harm than the global average, as measured by the number of deaths and disability-adjusted life years (DALYs) per 100,000 population attributable to alcohol (Morojele et al., 2021). Alcohol consumption in Africa varies widely by country and

drink type, and a third of alcohol consumed is unrecorded (Ferreira-Borges et al 2015a; 2017). Similarly, policy action on alcohol also differs across the continent (Ferreira-Borges et al., 2015a; 2017), although limited research exists on alcohol policy and its implementation in Africa (Balenger et al., 2023; Room et al., 2022).

Burundi is a landlocked country in the East African region of SSA and is classified as amongst the 'least developed' countries (Organisation for Economic Co-operation and Development, 2023), with a GDP per capita of US$234.8 (World Bank, 2023). Burundi ranks 187 out of 191 on the Human Development Index (HDI) in the last United Nations Development Program report, and faces serious issues with regard to multidimensional poverty and gender inequality (United Nations Development Program, 2022). The majority of the population is Christian (85.9%), with Muslims only representing 2.5% (U.S. Department of State, 2021; World Bank, 2023).

The prevalence of alcohol use disorders is 6.8% of Burundi's population aged 15 years or above, compared to 3.7% in the rest of the World Health Organization (WHO) African region (WHO, 2016). The rate of heavy episodic drinking (consumption of at least 60 g or more of pure alcohol on at least one occasion in the past 30 days) is 16.6% of the population aged 15 or above (WHO, 2016). Alcohol has a high impact on the burden of disease in Burundi. A recent literature review in the country showed that alcohol increased the risk of breast, prostate, oesophageal, liver, and colorectal cancers, which are the five most frequent types of cancers in Burundi (Manirakiza et al., 2020). In Burundi, alcohol consumption also plays a significant role in road traffic accidents (WHO, 2018a).

The WHO 'Best Buys' are a set of evidence-based policies aimed at reducing harmful alcohol consumption (WHO, 2019). Recommendations from the WHO include regulating the availability, taxation, and marketing of alcohol to address non-communicable diseases (NCDs; WHO, 2017). Other evidence-based policies include access to alcohol screening; brief interventions and treatment; enforcing drink-driving countermeasures; minimum pricing; restrictions on time, place, and density of alcohol outlets; minimum legal purchase age; government monopoly of retail sales; and age restrictions on alcohol purchases (Babor et al., 2022; WHO, 2019).

It is essential to evaluate the effectiveness of such policies in different contexts (Babor et al., 2022). However, most research on alcohol policy evaluation and implementation occurs in HICs (Room et al., 2022), and findings indicate that some low-income countries have made little progress in implementing policies to reduce alcohol consumption, partly due also to the influence of the alcohol environment on both policy and consumption (Ferreira-Borges et al., 2015b; Morojele et al., 2021; Walls et al., 2020). The relatively limited evidence available on LMICs' alcohol policy implementation highlights specific challenges in implementing effective evidence-based policies, including a lack of commitment, political will, and a lack of resources, as well as industry interference in the policymaking process (Bakke & Endal, 2010; Barlow et al., 2022; Bertscher et al., 2018; Ferreira-Borges et al., 2017; Morojele et al., 2021; Mwagomba et al., 2018; Rekve et al., 2019).

Alcohol regulation remains weak on parts of the African continent (Ferreira-Borges et al., 2017; Morojele et al., 2021) despite attempts by actors such as the East African Community (EAC) publishing guidelines for policies that reduce the harmful effects of alcohol, drugs and other substances (EAC, 2019). A recent cross-sectional study evaluating the readiness of five EAC countries to prevent alcohol-related harm based on the views of different stakeholders returned an average readiness score of 39.7% for East Africa, but only 30.5% for Burundi, the least ready in the EAC (Swahn et al., 2022).

In 2016, Burundi launched its National Alcohol Policy (NAP) and stated its ambitions to reduce alcohol harm. However, to date and to our knowledge, no studies have analysed Burundi's current alcohol policies and their implementation or progress. Our paper addresses this gap by exploring how the Burundi national alcohol policy, and a number of other key alcohol policies align with WHO 'Best Buys' recommended interventions (WHO, 2018c), and by exploring perceived barriers to and opportunities for implementing effective alcohol policies in Burundi. The aim of the study was to analyse all key alcohol policy documents in Burundi against the benchmark from the WHO 'Best Buys', and to explore key informants' perceptions of the alcohol policies implementation and progress to date.

Methods

The study was conducted in Bujumbura from May 2022 to March 2023. We used a multi-method qualitative methodology composed of a documentary analysis comparing Burundi's main alcohol policies with the WHO 'Best Buys', supplemented by in-depth interviews with key informants exploring their views and experiences of the current alcohol policies and their implementation. The Burundi National Ethics Committee (CNE/18/2022) approved the study.

Document Analysis

Sampling

We included policy documents published after 2010 (the date WHO Member States adopted a resolution to combat the harmful use of alcohol) containing sections on alcohol regulation, even if their focus was on other issues, e.g., NCDs (WHO, 2010). We also included policy documents written in English or French. The types of policy documents included were plans, guidelines, policies, legislations, regulations, or strategies. We excluded documents in other languages, non-policy statements, and non-official documents.

Document Searches

We searched for publicly available documents using a Google search engine with keywords (e.g., alcohol policy, Burundi, alcohol law) from June to September 2022. We also used other websites, such as IWACU and Burundi Net. We visited key government office libraries (e.g., *Centre d'Etudes et de Documentation Juridique* [CEDJ]) to search for publicly available documents not easily accessible online and identified a number of other documents this way. The last few were sourced via snowball searching after contacting key civil society and government stakeholders working within the alcohol policy context.

Document Analysis

The included documents were viewed as embedded in the Burundi context in which they were produced, as informed by the READ approach to document analysis (Dalglish et al., 2020). The acronym READ comprises four stages of analysis: (1) ready your materials, (2) extract data, (3) analyse data and (4) distil your findings. A data extraction spreadsheet was created (EH/IU) based on the WHO-European Action Plan to Reduce the Harmful Use of Alcohol (EAPA) tool (provided in the supplementary material; WHO, 2018b). It comprises 34 summary indicators categorised in the 10 action areas of the EAPA. The WHO-EAPA tool was used primarily because there is no equivalent in Africa, and also to assess its usefulness to the African context. We piloted the data extraction tool and refined it, and EH completed the extraction and analysis. Two researchers (GM, EH) further analysed and reviewed the results presented here.

Stakeholders' Interviews

Sampling

A mix of purposive and snowball sampling was used to recruit participants for the semi-structured interviews (Clark et al., 2021). The first author (EH) contacted known stakeholders in alcohol policy or alcohol-related work and then asked participants to recommend other potential interviewees who met our criteria.

Data Collection

Due to the very sensitive nature of alcohol policy work in Burundi and the limited number of actors working in this sector, we only give high-level characteristics of the participants who took part in the study below in order to protect their identity and avoid any potential deductive disclosure (Ellersgaard et al., 2021). Semi-structured interviews were conducted with 10 participants, including government representatives ($n = 5$) and civil society representatives (e.g., representatives of NGOs and multilateral organisations; $n = 5$). The first author undertook all the interviews in French (the official language in Burundi). Participants were given an information sheet and allowed time to ask further questions, and all provided written consent before the interview. Authors EH and IU developed a topic guide based on the WHO SAFER Framework and the areas of interest to the research questions (WHO, 2019).

Interviews were audio-recorded and transcribed by EH, who is fully bilingual in French and English. Interviews were recorded and ranged between 29 to 56 minutes (some were shorter due to the constraints in interviewing people in elite positions; Gupta & Harvey, 2022). Interviews were translated from French to English by an external transcriber and anonymised. The translation was quality-assured by EH. All transcripts were transferred securely to a special Teams channel at the University of Stirling (where IU and GM work) and later transferred to the NVivo software to support the analysis.

Data Analysis

Two researchers (IU, EH) developed an initial thematic coding framework and piloted it on two transcripts. Thereafter, the coding framework was refined and EH coded the remainder of the transcripts. Quality assurance to coding undertaken by EH was applied by IU (also bilingual in French and English). We conducted a thematic analysis informed by the Braun and Clarke framework of analysis (Braun & Clarke, 2023). We used a mix of deductive (using research questions and topic guide questions) and inductive (from reading and analysing transcripts data) approaches to our analysis. After the data was coded, the team used a framework approach (using framework matrices in NVivo) to complete the analysis and developed more detailed analytical memo which formed the basis of the first draft of results.

Results

Documentary Analysis

Eight documents met our eligibility criteria and are listed in Table 1. We identified one health policy document, two strategic plans, a vice president decree, a ministerial ordinance, and three laws. In Burundi, there are different types of policy documents, such as policies (*politiques*), strategic plans (*plans stratégiques*), protocols (*protocoles*), laws (*lois*), ministerial ordinances (*ordonnances ministérielles*), action plans (*plans d'action*), presidential decrees (*décret présidentiel*), and vice presidential decrees (*arretées*). Although all could be classified as policies, they may have different implementation modalities depending on the issuing authority. Ministry of Health and AIDS Control issues ordinances, strategic plans, action plans, policies, and protocols. Vice-presidential decrees are only rarely used, in certain situations. The Republic's president signs presidential decrees and laws resulting from multisector consultations. The President's decrees are legally the most powerful.

Only nine of the 34 WHO-EAPA indicators (WHO, 2018b) were addressed, seven out of 34 indicators were mentioned with no clear actions, and 18 were not addressed in the policy documents we reviewed (see Table 2). Indicators addressed with clear actions include the availability of a national alcohol policy, education/awareness activities, community-based interventions, a legal maximum BAC (Blood Alcohol Content) limit when driving a vehicle and penalty in the case of a violation, drinking age, screening and brief interventions, and illegal alcohol manufacture and sale.

The large proportion of indicators absent from Burundi policy largely relate to WHO 'Best Buys' policies, including specific measures related to availability and pricing, as well as a range of legally enforceable restrictions on marketing, including sports and youth event sponsorship and sales promotions. Indicators addressing reducing the negative consequences of drinking and alcohol intoxication, and monitoring and surveillance are absent. In addition, definitions of key terms such as 'standard drink' are also lacking.

Table 1

List of Documents Reviewed

Document Reference Code	Document Title	Document Type	Issuing Authority	Document Description
D1	National Policy Against Harmful Use of Alcohol (2016-2025) [*Politique Nationale De Lutte Contre L'usage Nocif De L'alcool 2016-2025*]	Policy	Ministry of Public Health and AIDS Control	A national policy that sets out government actions to reduce alcohol harms; provides orientation with strategies but no information on activities
D2	Strategic Plan to Combat armful Use of Alcohol (2016-2025) [*Plan Stratégique De Lutte Contre L'usage Nocif De L'alcool 2016-2025*]	Strategic plan	Ministry of Public Health and AIDS Control	A policy guidance document setting out planned activities to implement the national policy
D3	Integrated National Strategic Plan for Non-Communicable Diseases (NCD) (2019-2023) [*Plan Stratégique Intégré de Lutte Contre Les Maladies Non Transmissibles Au Burundi (2019-2023*)]	Strategic plan	Ministry of Public Health and AIDS Control	A strategic plan that sets out both objectives related to, and activities to address NCDs and associated risk factors
D4	Order No. 1 of 10 June 2014 on the regulation of drinking establishments, restaurants and other establishments open to the public as well as the prohibition of the manufacture, marketing and consumption of certain beverages and liquors [*Arrêté N° Du 10 1 06 12014 Portant Réglementation des débits de boissons, Restaurants Et Autres Établissements Ouverts Au Public Ainsi Que L'interdiction De L A Fabrication, La Commercialisation Et La Consommation De Certaines Boissons Et Liqueurs*]	Vice Presidential decree	Cabinet of the First Vice President of the Burundi Republic	A vice president decree issued to regulate the consumption of certain beverages, marketing and provide regulation of alcohol outlets. The decree prohibits the manufacture of certain beverages
D5	Law n°1/27 of 29 December 2017 revising the Penal Code [*Loi N°1/27 Du 29 Décembre 2017 Portant Révision Du Code Pénal*]	Law	Ministry of Justice and Keeper of the Seals	Legislation on how crimes are investigated and punished. The document has sections on crimes related to the production and consumption of alcohol
D6	Law No. 12 of 30 May 2018 establishing the code of healthcare supply and services in Burundi [*Loi N°1 / 012 Du 30 Mai 2018 portant code de l'offre des soins et services de Santé au Burundi*]	Law	Cabinet of the President of Burundi Republic	Legislation providing guidelines on healthcare supply and services. Comprises 328 articles covering chapters and sections on various health topics, including alcohol (sections 5,14,86,87). Section five (article 101) declares an aim to fight against alcoholism and any other drink harmful to health
D7	Law No. 1/ 26 of 23 November on the road traffic code [*Loi no 1/26 du 23 novembre 2012 portant code de la circulation routière*]	Law	Cabinet of the President of Burundi Republic	Road traffic legislation. The document has sections dedicated to the regulation of and penalties for driving under the influence of alcohol
D8	Order No. 530/1394 of 12/08/2014 implementing Articles 3 and 5 of the Order of the First Vice-President regulating bars, restaurants and other establishments open to the public and prohibiting the manufacture, marketing and consumption of certain drinks and liquors [*Ordonnance no 530/1392 du 12/08/2014 portant application des articles 3 et 5 de l'arrêté no 1 du 10 Juin 2014 portant réglementation des débits de boissons, restaurants et autres établissements ouverts au public ainsi que l'interdiction de la fabrication, la commercialisation et la consommation de certaines boissons et liqueurs (DO8)*]	Ministerial ordinance	Ministry of Interior	Legislation (also named an ordinance) from the Ministry of Interior to provide clarifications on article 3 and 5 of the vice president decree regulating alcohol trading and consumption

Table 2

Summary of WHO-EAPA Indicators Addressed in Burundi Policy Documents Studied*

WHO-EAPA policy action areas (in order of most to least addressed)	Policy action area mentioned (Y/N)	Indicators addressed; clear actions provided (in order of most to least addressed)	Indicators addressed; no clear actions provided	Indicators not addressed
Community action	Yes D6 (Objective 4, p. 28), D1 (Objectives 3 & 4, p. 14)	I1.Existence of school related based programs (D2, D3) *"Create and revitalise health clubs in schools and associations working to combat harmful use of alcohol per year and per provincial education authority"* (D3, pp. 51-52) I3.Existence of community-based interventions (D3)*"Organise one awareness-raising workshop per year and per region" (D3, p.*56)	I2.Existence of a workplace -based alcohol prevention and counselling program (D6) [partially addressed] *"The hospital area is non-smoking, and the introduction of alcoholic beverages is prohibited" (D6, p.13)*	None (all indicators at least partially addressed, and actions provided)
Leadership, awareness, and commitment	Yes D1 (Objective 3, p. 14)	I1: A national policy on alcohol (D1) I4.A focus on consumer protection awareness activities (D3) *"Community awareness activities, raising awareness of the harmful effects of harmful alcohol us" (D3, p.50)*	None	I2.A definition of alcoholic beverage I3.A definition of a standard drink
Availability of alcohol	Yes D6 (Objective 3, p. 28)	I1.The legal drinking age for on-premises alcohol service and off-premises alcohol sales (D4, D5) *"Access to drinking establishments is forbidden to minors under eighteen years of age whom an adult does not accompany…Under no circumstances may alcoholic beverages be served to minors under 18. Violating this provision entails the shared responsibility of the minor and the person who served the alcoholic beverage" (D4, article1,p. 2)*	I6.Alcohol-free public environments (D4) *"Alcohol, brandy and liqueurs may only be served in public houses, restaurants and other establishments open to the public" (D4, Article 7, p. 3.)* I2.Control of retail sales (D4, Articles 4, 5) I3.Existence of time constraints on availability (D4, Article 3; D8, Article 2) I4.Existence of restrictions on alcohol by location (D4, Article 13; D6, Article 14)	I5.Existence of sale restrictions at specific events
Drink-driving policies and countermeasures	Yes D7 (Organise two advocacy meetings to promote availability of breathalysers, p. 56)	*I1.*A legal maximum BAC limit when driving a vehicle (D7) *"A driver with a blood alcohol level of more than 80 mg of alcohol per 100 ml of blood is considered to be under the influence of alcohol" (D7,Article 192, p 52.)* I4.The type of penalties for violating the drink-driving policies (D7) *Removal of driving license (D7,article 193, p.52)*	I3.Policy enforcement through random breath-testing (D7) Random breath-testing: *The breath sample ordered by the qualified officer shall be directed directly to the detection apparatus, and the sample shall be taken only on the spot (D7,Article 191, ,p.52)*	I2.Use of sobriety checkpoints in the enforcement
Health services' response		I1.Screening and brief interventions for harmful and hazardous alcohol (D2, D3) *"Establishment and strengthening of addiction services with equipment in healthcare facilities" (D3, p58)*	None	I2.Inclusion of special treatment programs in the policy implementation I3.A section on pharmacological treatment

WHO-EAPA policy action areas (in order of most to least addressed)	Policy action area mentioned (Y/N)	Indicators addressed; clear actions provided (in order of most to least addressed)	Indicators addressed; no clear actions provided	Indicators not addressed
Reducing the public health impact of illicit alcohol and informally produced alcohol	Yes *D1 (Objective 1, p. 14)*	I3. Existence of legislation to prevent illegal manufacture and sale of alcohol beverages (Articles 520 and 521 of D5 [p. 103]; Article 10 of D4 [p. 4])	None	I1. Use of duty-paid or excise stamps on alcohol containers I2. Estimation of unrecorded alcohol consumption
Pricing policies		None	I2. Plans to increase the cost of alcoholic beverages *(D3, p. 54, Planned activity 1.12)* *Organise two meetings to lobby decision-makers on the issue of increasing taxes and excise duties on alcoholic beverages (D3, p.54)*	I1. The level of taxation adjusted for inflation I3. Other price measures
Marketing of alcoholic beverages	Yes *D1(Objective 1, p. 14), D3 (Planned activity 1.13, p. 55): Organise two advocacy meetings per year for the implementation of total restrictions on alcohol advertising, promotion, and sponsorship.*	None	None	I1. Existence of legally enforceable restrictions on alcohol advertising I2. Existence of legal restrictions on product placement I3. Existence of any legally enforceable restrictions on industry sponsorship of sporting and youth events I4. Existence of legally binding restrictions on sales promotions by manufacturers, retailers, and pub and bar owners
Reducing the negative consequences of drinking and alcohol intoxication		None	None	I1. A server training policy in place I2. Inclusion of health warnings in the policy
Monitoring and surveillance	Yes *D1(Objective 2, p. 14), D2(Strategic axe 3, p. 25)*	None	None	I1. Existence of a national system for monitoring alcohol consumption I2. Existence of a plan to conduct national alcohol survey

*Specific policies and/or actions that address an indicator are listed in italics.

Results of the Interviews

We identified nine themes related to areas of alcohol policy progress in Burundi: availability, marketing, driving, pricing policies, industry interference, Burundian alcohol culture, corruption, lack of funding, and scarcity of alcohol research. Below, we integrate and contrast insights from the documentary analysis with the interview findings.

Who is Involved in Initiating and Drafting the Alcohol Policy in Burundi?

In terms of agenda-setting, in the policy documents we reviewed, senior advisors and technical officers in the Ministry of Health and AIDS Control (D1, p.16; D2, p. 28); NGOs, including the Scout Association, the Guides Association, the Burundi Alcohol Policy Alliance (BAPA; an NGO alliance in Burundi), WHO, and others such as the International Organisation of Good Templars – National Templar Order (IOGT-NTO) are formally listed as being involved in design of the policies (D1 and D2). Yet stakeholders interviewed had varied perceptions of how and by whom the NAP and other alcohol-related policies had been initiated. Nonetheless, a large proportion of interviewees agreed that BAPA had played a major role in bringing alcohol harm to the agenda and into the successful development of the NAP:

> I believe that BAPA was the first organisation that was concerned about the misuse of alcohol by young people. So, BAPA has been the initiator of all the initiatives taken at the national level about the regulation of alcohol. [Civil society representative, INT3].

Some of the participants who were government officials also highlighted the role of the Ministry of Health in initiating the NAP. They expressed that the Ministry consulted other stakeholders from the sector, such as BAPA, as is the usual practice in policy formulation in Burundi:

> Normally, to produce a working or strategic document at the ministry level, there is always the need to set up a steering committee and a technical committee responsible for drawing up this document. And we ensure that all the stakeholders can intervene in the two commissions to elaborate such a document. [Government official, INT10].

One government official stated having a key role in adding a chapter to the policy D6 (Legislation providing guidelines on the healthcare supply and services), a legal code that sets the direction for health care organisations and the provision of health services, and which covers services pertinent to harmful alcohol consumption and alcohol disorders.

Implementation and Progress of Policies to Address Alcohol Harms

One of the key elements of the WHO-EAPA tool and the SAFER guidelines in terms of effective implementation is the adoption of policy action areas and of key measurable indicators (WHO, 2019). Yet, of the alcohol policy documents reviewed in this study, few have trackable indicators (D2 and D3). Most have stated policy actions but no indicators (D4, D5, and D7). Lastly, some policy documents were only for orientation purposes (D1, D6, and D8). Only two documents (D2 and D3) included budgets and monitoring systems. The NAP, a policy orientation, includes its indicators in D2.

Most participants made the point that some alcohol control policies in Burundi had been better implemented than others. A large proportion of our interviewees, both from government and civil society, expressed that policies raising awareness of the dangers of alcohol consumption and those addressing labelling (e.g., to indicate minimum age) were better implemented.

> There have been improvements because the alcohol company has made labels on the bottles indicating that the beer is reserved for those under 18, even if they are in small print. Previously, the bottles were unlabelled. [Civil Society Actor, INT 1].

One civil society representative expressed that very few policy areas in the NAP had been effectively implemented.

> Unless you give me the ones implemented that were implemented first? I don't see them. I don't see them. I think they have developed the document (the vice president's decree), but some, maybe, measures to determine the pubs' opening hours of the pubs…. It's been implemented, but often it's not very respected. [Civil Society actor, INT 7].

Nearly all the participants expressed that there were several major barriers to the successful implementation of the NAP and other alcohol policies in Burundi. One of the main barriers identified is the failure to transform the NAP into a law, which would facilitate implementation and enforcement. Some participants – including government representatives – mentioned the lack of progress in ratifying the law that should accompany the NAP and its strategic plan in order to lead to effective implementation. One government representative even stated that the NAP draft legislation is still pending after five years, and has been rejected by the Council of Ministers with the argument that it needs further clarification. An NGO representative also stated:

> There must be a law and operationalisation tools, such as ministerial orders, to go with the law. As a result, the ministries involved should have enacted ordinances to put an existing law into effect finally. The law has yet to be voted on at the National Assembly level. I'm sure there were reasons for drafting this law. At one point, a bill was initiated at the level of the Ministry of Health, but it did not progress because it was only tabled at the level of the National Assembly, without making much progress on the issue. [Civil society actor, INT 4].

Some participants from the government and most from civil society organisations perceived the absence of the ratification of this legislation as a significant obstacle to the effective implementation of the NAP. They reported that a law could cover regulations on marketing, sponsorship, and price measures, which are not currently well covered by

areas in the NAP policy. In fact the NAP policy document itself mentions the importance of turning this policy into law (D1, p. 12).

A large number of participants mentioned that other major barriers to alcohol policy implementation and progress were the lack of funding for alcohol initiatives and the prevalence of a drinking culture in Burundi.

> *Another obstacle, I would say, is poor funding. It's not just alcohol. In terms of non-communicable diseases, there is low funding. To be able to carry out activities, as I have already told you, to finance awareness-raising meetings at the level of leaders, at the level of decision-makers, but also at the level of practitioners to really show the harmful role of alcohol on the population's health.* [Government official, INT 10].

A few participants – mostly government representatives – mentioned the absence of solid monitoring systems for alcohol policy progress, a lack of research and expertise in alcohol policy, and a lack of political will.

> *I see the gaps in the sense of lack of monitoring. There is no monitoring and evaluation mechanism to be able to hope to have perceptible results.* [Government official, INT 8].

A few actors from civil society also raised an additional, perhaps more insidious, barrier to policy implementation in Burundi, which is that of corruption.

> *There are obviously producers and bar owners among them, as well as some consumers who oppose these policies. Others are opposed indirectly because corrupt administrators implement decisions that have been made ineffective.* [Civil society actor, INT 2].

Alcohol Industry Interference: A Key Barrier to Progress in Alcohol Policy Progress and Implementation in Burundi

Despite two policy documents (D1 and D6) specifically stating that public health must take precedence over and above any conflicting interests, including economic interests, nearly all the participants in our study stated that alcohol industry interference is currently a barrier to alcohol policy progress and implementation in Burundi. Viewed by most participants as economically and culturally dominant, the alcohol industry was perceived to be undermining policy-making, legislation, and effective implementation. A few participants from civil society expressed that some industry actors also exert pressure on stakeholders to attempt to slow regulation in the area of alcohol control.

> *Yes, we have already experienced some threats, but that was in the 2019s about one of the industries here in Burundi. Threats that told us that we were not going to go ahead until we were associated with them. So that was an obstacle, an obstacle that also, I would say, stifled us a little bit concerning publishing our works. Because if we published what we had done, it was a threat to us. So, we took some time to stifle our work, to make our work in the lobby like that. And we think the*

> *alcohol industry is important in stifling this policy or this law.* [Civil Society Actor, INT 3].

Some government officials themselves described the alcohol industry as a threat to effective policymaking and implementation and advocated for strict laws to forbid such activity.

> *The obstacles, I think, are the alcohol industries trying to put up obstacles so that this law to implement the NAP cannot see the light of day. But the truth is that these very industries are paralysing the progress of this text.... The alcohol industries are, therefore, blocking any initiative to combat alcohol abuse..... And so, as no law can regulate all aspects related to the fight against the production and abusive consumption of alcohol, they have a free hand to do their activities.* [Government Official, INT 9]

Notably, a minority of stakeholders interviewed reported a range of intimidation attempts by an alcohol industry actor, particularly when stakeholder activity conflicted with commercial interests.

Perceptions of Key SAFER Policies Action Areas for Harm Reduction

Alcohol Pricing and Taxation Policies. Amongst the documents reviewed, only D3 proposes advocacy activities to increase the cost of alcoholic beverages, such as organising advocacy meetings with decision-makers to increase taxes and excise duties on alcoholic beverages (p. 54, Planned activity 1.12). None of the other documents reviewed mention any policy measures that aim to increase the price of alcoholic beverages, such as adjusting the taxation level for inflation and policies that reduce the affordability of alcoholic beverages or minimum unity price (MUP).

By contrast, many of those we interviewed for the study – from civil society to government representatives – expressed support for such measures, particularly where they are accompanied by other measures such as raising awareness or equipping the police to deal more effectively with law enforcement, prohibiting the sale of specific beverages, and limiting advertisements, particularly targeted at young people.

> *Increasing taxes on them [alcohol beverages] can be a solution. Still, it must be combined with other strategies, including awareness-raising, particularly the efforts of the police to curb this type of fraud. The effort of the police to curb especially the drinks that have already been declared prohibited.* [Government official, INT 6].

However, one civil society participant expressed that price increases may not have a huge impact in Burundi because alcohol consumption is very prevalent, and drinking is now seen as part of the culture (particularly amongst men).

> *Because of the price increase, is it less affordable and available? Yes, accessibility, particularly by young people, particularly by young women. But men in Burundi, and this is why I was saying it a little*

differently, no, it's alcohol; it's a culturally significant object in Burundi. This culture dictates that even if something is expensive, Burundians, particularly men, will purchase it. Because the right to ownership is much more secure for men in Burundi than it is for women, I tell myself that if the price rises, men will always buy it because there are even men in the countryside who would accept that their families do not eat to get a bottle of beer. That's all. [Civil society actor, INT 4].

Policies Regulating the Availability of Alcohol and Marketing and Other Policies to Tackle Harmful Consumption. Among the policy documents we reviewed, actions to regulate the availability and marketing of alcohol lacked coherence and strong indicators. The document which establishes the code of healthcare supply and services in Burundi (D6, p. 28), contained only broad objectives to limit the population's access to alcohol and any other beverage harmful to health, and to protect them.

Other documents, such as D4 and D5, only mentioned regulations on the legal drinking age for on-premises alcohol sales and off-premises alcohol sales, especially where access to drinking establishments is forbidden to minors under *"eighteen years of age whom an adult does not accompany"* (D4, Page 2, Article 1). Other policy control measures covered by D4, such as alcohol-free public environments, control of retail sales (Articles 4 and 5), time constraints on availability (Article 3), and restrictions on alcohol by location, such as on streets unless it is on a terrace or a designated area (Article 13).

None of the eight policy documents reviewed contained regulations on sales restrictions for specific events. The NAP provides a broad orientation to strengthen legislation on the production, marketing, and consumption of alcohol (D1, Objective 1). Planning meetings to implement restriction on alcohol advertising, promotion, and sponsorship are suggested by D3 (Planned Activity 1.13, p. 55). However, key indicators such as legally enforceable restrictions on alcohol advertising, legal restrictions on product placement, legally enforceable restrictions on industry sponsorship of sporting and youth events, and legally binding restrictions on sales promotions by manufacturers, retailers, and pub and bar owners were lacking.

This lack of strong measurable action was echoed particularly by one government representative participant and a few civil society actors we interviewed, who stated that Burundi lacked proper marketing regulations. Some of the other participants from both government and civil society organisations stressed however, that the draft Bill, introduced in 2018 but which has not yet become legislation, did include welcome marketing restrictions.

When it came to the regulation on alcohol marketing, one civil society actor stated that the alcohol industry is a strong obstacle in this area also:

The advertisement includes young people because the Burundian population is predominantly young (60%). This is a strategy because alcohol producers need to attract young people to make a profit. They promote

alcohol through activities that appeal to young people using well-known Burundi Festivals. [Civil society actor, INT1]

Almost all participants expressed their views that the policies that restrict alcohol availability in Burundi are not sufficient, especially since young people can easily access alcohol.

Especially in terms of alcohol availability. Alcohol is available within a few metres of the bars. Young people, even those under 18, have unrestricted access to alcohol. They can buy alcohol in any of the bars. They are treated as adults with no reservations. [Civil society actor, INT 1].

Some of our participants recommended reducing advertisements targeting children and pregnant women, and enforcing policies that make it harder for young people to access alcohol. Some proposed regulating the availability of alcohol in places where young people socialise, thus creating more 'alcohol-free' spaces for the young.

Ideas for making alcohol less appealing." Worse, there are no appealing activities for young people, no playgrounds. There are no cinema spaces. I believe that there should be inexpensive play areas available for all young people to keep them occupied. Most parents return home late at night and do not have enough time. [Civil Society actor, INT 1].

Perceptions on the Implementation of Drink-Driving Policies. The main document reviewed in this area, D7, is the general code regulating all traffic-related activities, which includes some indicators with clear actions. This code states that a legal maximum BAC limit is required when driving a vehicle. The code has also laid out fixed penalties for those with drink-driving policies that result in the confiscation of a driver's license (Article 193, p. 52). Other indicators were contained in the code but without clear actions, such as policy enforcement through random breath testing (Article 191). However, D7 does not include the use of sobriety checkpoints in the enforcement, and includes plans to organise two advocacy meetings to promote the availability of breathalysers (p. 56).

The interviewees, however, expressed that drink-driving policies were not effectively implemented in Burundi. Many – particularly from civil society – blamed the lack of equipment, such as breathalysers, for this lack of drink-driving enforcement. A few government representatives stressed the potential corruption of some police officers on the ground as a potential barrier to implementing such policies.

The law enforcement officers start to put rigour in applying the alcohol-free driving policy initially, but after the drivers will tend to bribe police officers with money, that's it. [Government official, INT 10].

One government official blamed young people's behaviour and bar owners for not limiting alcohol consumption for

young people, and also blamed the lack of police controls in night time venues and in the streets at night.

Discussion

Out of the eight policy documents we reviewed, only nine of the 34 WHO-EAPA indicators recommended are addressed, seven out of 34 are mentioned with no clear actions, and 18 are not addressed at all. Indicators that are addressed with clear actions include the availability of a national alcohol policy, education/awareness activities, community-based interventions, a legal maximum BAC limit when driving a vehicle and penalty if violation, drinking age, screening and brief interventions, and illegal alcohol manufacture and sale.

The large proportion of indicators absent from the Burundi policy documents reviewed here relate to WHO 'Best Buys' policies. This includes specific measures related to availability and pricing, as well as a range of legally enforceable restrictions on marketing, including sports and youth event sponsorship and sales promotions. Definitions of key terms such as 'standard drink' are also lacking. Reported barriers to effective policies (and implementation thereof even when indicators are addressed) include a lack of legislation to support policy, industry interference, monitoring systems, funding, lack of political, corruption, and cultural norms around alcohol.

Our study adds to a growing body of policy implementation research in LMICs (Erasmus et al., 2014; Gilson et al., 2018). Many African countries have yet to fully implement evidence-based solutions to reduce the harm caused by alcohol (Ferreira-Borges et al., 2015a; 2017; Morojele et al., 2021). The gaps we report as absent or lacking clear actions are similar to those reported by Morojele and colleagues (2021), who found that alcohol policies least likely to have been implemented in Africa were those related to availability, drink-driving, screening and brief interventions, and alcohol advertising, sponsorship and promotion (Morojele et al., 2021). Our findings are also similar to a recent review of alcohol policy in Nigeria, which showed that the only WHO 'Best Buys' interventions for alcohol control which were effectively implemented were those limiting retail access to prevent underage drinking, whilst other policy areas, such as higher taxes and bans on alcohol advertising, were not implemented (Abiona et al., 2019).

A study by Juma and colleagues (2018) revealed that only 10 out of 46 countries in the region had recently adopted national alcohol policies and that there was a lack of coordination within and across government sectors (Juma et al., 2018). Similar claims have been made about the multi-sectoral action required in alcohol policy in Nigeria (Abiona et al., 2019). The WHO global status report on alcohol and health also identified a shortage of skills, knowledge, and resources to scale up adequate policy measures, particularly in LMICs (WHO, 2018a).

A number of publications we reviewed state different reasons for this lack of alcohol policy progress, such as a lack of information about the nature and extent of harmful use of alcohol; the alcohol industry's influence on policy; the presence of a significant unrecorded alcohol consumption;

weak enforcement of pricing and taxation policies; corruption and a lack of human resources and capabilities for the implementation of alcohol control policies (Ferreira-Borges et al., 2015a; 2017; Jernigan & Trangenstein, 2020; Morojele et al., 2021), as well as what Walls and colleagues (2020) call the the "alcohol environment" as the overall " system of alcohol provision, acquisition and consumption" on the African continent .

Other reasons for the absence of alcohol policy implementation in Africa include inadequate human and financial resources and frequent staff turnover, as well as difficulties in coordinating and aligning the views and interests of different sectors (Abiona et al., 2019; Ferreira-Borges et al., 2017; Mwagomba et al., 2018). The challenges posed by global trade treaties can increase competition, lower prices, and promote consumption, and thus can run contrary to what stricter control measures seek to achieve (Dumbili, 2016; Ferreira-Borges et al., 2017; Milsom et al., 2022).

One of the distinctive features of our study is we identified that one of the main obstacles to the effective implementation of the NAP in Burundi is the failure to transform it into legislation. Whilst other publications have attributed policy implementation failures to a broad lack of integrated policies in alcohol, we suggest that national alcohol policies which are not backed up by legislation may lead to weaker implementation. We encourage further research in this area in Africa, perhaps using case studies such as Uganda's new Alcoholic Drinks Control Bill (introduced 2022), currently being reviewed in committees in the parliament, or the recently tabled Alcoholic Drinks Control Bill in Kenya (2019). We welcome a recent review about the recently passed legislation in Sao Tome and Principe that went through different steps and involved various stakeholders (Sanchez et al., 2022).

Another key finding in this article is the reporting by the participants of industry interference as a barrier to the progress of alcohol policies implementation in Burundi. In this respect our study adds to growing evidence of alcohol industry interference in policymaking across sub-Saharan Africa (Babor et al., 2015; Bakke & Endal, 2010; Bertscher et al 2018; Jernigan & Babor, 2015; Morojele et al., 2021; Mwagomba et al., 2018).

Notably, the nine indicators addressed within the existing Burundi alcohol policies are actions that are less likely to conflict with commercial interests and as such, remain those promoted by the alcohol industry over and above more effective policy options (Babor et al., 2018; Hoe et al., 2022; McCambridge et al., 2018). This may imply that the significant industry influence reported by some of our stakeholders may translate in reality into a lack of action on other control policies that would best address alcohol harms in Burundi, e.g. marketing, price, and availability. Intimidation was reported by a minority of our stakeholders, in ways similar to other evidence of the use of intimidation, incentives and bribery to support commercial positions across Unhealthy Commodity Industries (UCIs) globally (Hoe et al., 2022; Ulucanlar et al., 2023).

Framing is a crucial strategy used by UCIs to market themselves (and their products) as 'good' actors, and legitimate stakeholders promoting acceptable solutions (Ulucanlar et al., 2023). The seemingly dominant role of the alcohol industry in Burundi is concerning when considered in the context of existing work documenting similar activity in Botswana, Lesotho, Uganda, and Malawi (Bakke & Endal, 2010), South Africa (Bertscher et al., 2018) and industry focus on the Africa continent as a whole as a key market for growth (Beemen, 2021; Jernigan & Babor, 2015).

Further research is required on how industry framing influences the societal approach to alcohol in Burundi and more generally in Africa, and whether public support exists for evidence-based alcohol control policy. The alcohol industry and other UCIs are known to anticipate future developments (Hoe et al., 2022), and any further research study in Burundi should build in protection for participants and researchers due to the reports of intimidation documented here and elsewhere, and considering the legal threats that can occur when findings are produced that conflict with commercial interests (Mitchell & McCambridge, 2022; Ulucanlar et al., 2023).

Our study highlights not only a lack of policy implementation in Burundi, but also significant gaps in regulating alcohol availability and marketing, areas that are most likely to reduce alcohol harm. Many countries in Africa and the Americas, including Burundi, have no regulations on alcohol advertising, which poses a threat to public health as alcohol industries use new and fast-growing marketing strategies (Jernigan & Trangenstein, 2020). The self-regulation promoted by industry (Savell et al., 2015) has failed to protect the young and other vulnerable groups across Africa (de Bruijn, 2011) and elsewhere (Babor et al., 2022; Babor & Robaina, 2013).

Alcohol marketing can lead to people drinking at an earlier age and at increased levels (Anderson et al., 2009; Smith & Foxcroft, 2009; Swahn et al, 2011) and shapes people's attitudes and beliefs about alcohol (Bakke & Endal, 2010; Fleming et al., 2004). This evidence, combined with our findings, suggests that government action to prioritise tightening regulations on availability and marketing would be among the most effective actions to reduce alcohol harms in Burundi.

The WHO 'Best Buys' policies and the SAFER alcohol control initiative recommend pricing and taxation as two of the most effective measures to address alcohol harms (Babor et al., 2022; WHO, 2019). Research has shown that lower alcohol consumption is linked to higher prices and taxes, and different types of alcohol have different price sensitivities (Guindon et al., 2022). However, our study shows that in Burundi there are few alcohol price and taxation policies in place. This is similar to the situation in other LMICs, where beer taxes are not used to discourage alcohol consumption for health reasons, (Jernigan & Trangenstein, 2020). Addressing this gap is urgently required, but such policies are not easy to implement. For example, in Botswana a bill to raise the alcohol price in 2008 faced resistance from industry and was changed several times afterwards due to industry pressure (Morojele et al., 2021). Similarly in Uganda, the current alcoholic Drinks Control Bill was announced in 2022 and is still under scrutiny in the House Committee, and facing criticism from the alcohol industry who see it as a threat to the economy of the country (Chemonges, 2024). Other countries have had more success, for instance in South Africa, the government and other stakeholders passed a bill to increase alcohol taxation despite the opposition of the alcohol industry; the bill supported public health and aligned with international standards (Parry, 2010).

Strengths and Limitations

This is the first study in Burundi that specifically explores existing alcohol control policies, thus significantly adding to the sparse literature and contributing to South-to-South learning around alcohol policy analysis. Time and resource constraints prevented further in-depth exploration of each area of the SAFER framework. More detailed investigation is required of the specific gaps and barriers identified in this study.

Conclusion

Burundi's alcohol policies require further integration, and decisive multi-sectoral action at Government level, particularly in some key 'Best Buys' areas. Implementation and enforcement also remain weak. Moreover, there is a need to learn further lessons from effective alcohol control policies across the African continent and to foster South-to-South policy learning and transfers. Government and civil society coalitions should report and address any undue influence of the alcohol industry on policymaking and policy implementation. Further research and guidelines on how to address corruption and industry interference are required to foster more effective alcohol control policies in LMICs.

Authors' Contributions

Egide Haragirimana contributed to the development and design of the research, data collection, analysis and interpretation of the data, drafting and finalising the manuscript.

Isabelle Uny contributed to developing and designing the research, analysing and interpreting the data, drafting the manuscript, and making critical revisions.

Gemma Mitchell contributed to analysing and interpreting the data, drafting the manuscript, and making critical revisions.

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Supplemental Materials

The WHO-EAPA tool.

References

Abiona, O., Oluwasanu, M., & Oladepo, O. (2019). Analysis of alcohol policy in Nigeria: multi-sectoral action and the integration of the WHO "best-buy" interventions. *BMC Public Health*, *19*(1), 810. https://doi.org/10.1186/s12889-019-7139-9

Anderson, P., de Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol and Alcoholism, 44*, 229–243. https://doi.org/10.1093/alcalc/agn115

Babor, T. F., Casswell, S., Graham, K., Huckle, T., Livingston, M., Rehm, J., Room, Robin, Rossow, Ingeborg, & Sornpaisarn, B. (2022). Alcohol: No Ordinary Commodity-A summary of the third edition. *Addiction, 117*(12), 2976–3178. https://doi.org/10.1111/add.16003

Babor, T. F., Robaina, K., Brown, K., Noel, J., Cremonte, M., Pantani, D., Peltzer, R. I., & Pinsky, I. (2018). Is the alcohol industry doing well by ' doing good '? Findings from a content analysis of the alcohol industry's actions to reduce harmful drinking. *BMJ Open, 8*(10), 12–15. https://doi.org/10.1136/bmjopen-2018-024325

Babor, T. F., Robaina, K., & Jernigan, D. (2015). The influence of industry actions on the availability of alcoholic beverages in the African region. *Addiction, 110*(4), 561–571. https://doi.org/10.1111/add.12832

Babor, T. F., & Robaina, K. (2013). Public health, academic medicine, and the alcohol industry's corporate social responsibility activities. *American Journal of Public Health, 103*(2), 206–214. https://doi.org/10.2105/AJPH.2012.300847

Bakke, Ø., & Endal, D. (2010). Vested interests in addiction research and policy alcohol policies out of context: Drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. *Addiction, 105*(1), 22–28. https://doi.org/10.1111/j.1360-0443.2009.02695.x

Balenger, A., Umenze, F., Dumbili, E., Sako, B., Obot, I., & Swahn, M. H. (2023). Developing an alcohol harm prevention research agenda in West Africa: A mixed methods approach. *Health Promotion International, 38*(4). https://doi.org/10.1093/heapro/daab208

Barlow, P., Gleeson, D., O'Brien, P., & Labonte, R. (2022). Industry influence over global alcohol policies via the World Trade Organization: A qualitative analysis of discussions on alcohol health warning labelling, 2010–19. *Lancet Global Health, 10*(3), e429–e437. https://doi.org/10.1016/S2214-109X(21)00570-2

Berry, M. S., & Johnson, M. W. (2018). Does being drunk or high cause HIV sexual risk behavior? A systematic review of drug administration studies. *Pharmacology, Biochemistry, and Behavior*, *164*, 125–138. https://doi.org/10.1016/j.pbb.2017.08.009

Bertscher, A., London, L., & Orgill, M. (2018). Unpacking policy formulation and industry influence: The case of the draft control of marketing of alcoholic beverages bill in South Africa. *Health Policy and Planning, 33*(7), 786–800. https://doi.org/10.1093/heapol/czy049

Braun, V., & Clarke, V. (2023). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health, 24*(1), 1–6. https://doi.org/10.1080/26895269.2022.2129597

Chemonges, T. (2024). *Uganda's long walk to alcohol regulation: Will the new Bill bear a toxic free generation?* Parliament Watch. https://parliamentwatch.ug/blogs/ugandas-long-walk-to-alcohol-regulation-will-the-new-bill-bear-a-toxic-free-generation/

Clark, T., Foster, L., Sloan, L., & Bryman, A. (2021). *Bryman's Social Research Methods* (6th Ed.). Oxford University Press. https://global.oup.com/ukhe/product/brymans-social-research-methods-9780198796053?cc=gb&lang=en&

Dalglish, S. L., Khalid, H., & McMahon, S. A. (2020). Document analysis in health policy research: The READ approach. *Health Policy and Planning, 35*(10), 1424–1431. https://doi.org/10.1093/heapol/czaa064

de Bruijn, A. (201 1). *Monitoring alcohol marketing in Africa: Findings from the Gambia, Ghana, Nigeria and Uganda*. https://eucam.info/wp-content/uploads/2014/04/mampa-2010-report-findings_final-version-22-june-2011.pdf

Dumbili, E. W. (2016). The influence of alcohol industry-sponsored "Gulder Ultimate Search" reality television series on the drinking behaviors of Nigerian youths. *Journal of Substance Use, 22*, 159–167. https://doi.org/10.3109/14659891.2016.1166271

East African Community (EAC). (2019). *East African Community regional policy on prevention, management and control of alcohol, drugs and other substance use*. EAC Secretariat. https://idpc.net/publications/2019/05/east-african-community-regional-policy-on-prevention-management-and-control-of-alcohol-drugs-and-other-substance-use

Ellersgaard, C., Ditlevsen, K., & Larsen, A. (2021). Say my name? Anonymity or not in elite interviewing. *International Journal of Social Research Methodology, 25*, 1-14. https://doi.org/10.1080/13645579.2021.1932717

Erasmus, E., Orgill, M., Schneider, H., & Gilson, L. (2014). Mapping the existing body of health policy implementation research in lower income settings: What is covered and what are the gaps? *Health Policy and Planning, 29*, iii35–iii50. https://doi.org/10.1093/heapol/czu063

Ferreira-Borges, C., Dias, S., Babor, T., Esser, M. B., & Parry, C. D. H. (2015a). Alcohol and public health in Africa: Can we prevent alcohol-related harm from increasing? *Addiction, 110*(9), 1373–1379. https://doi.org/10.1111/add.12916

Ferreira-Borges, C., Esser, M. B., Dias, S., Babor, T., & Parry, C. D. H. (2015b). Alcohol Control Policies in 46 African Countries : Opportunities for Improvement. *Alcohol and Alcoholism, 50*(4), 470–476. https://doi.org/10.1093/alcalc/agv036

Ferreira-Borges, C., Parry, C. D. H., & Babor, T. F. (2017). Harmful use of alcohol: A shadow over sub-Saharan Africa in need of workable solutions. *International Journal of Environmental Research and Public Health, 14*(4), 346. https://doi.org/10.3390/ijerph14040346

Fleming, K., Thorson, E., & Atkin, C. K. (2004). Alcohol advertising exposure and perceptions: Links with alcohol expectancies and intentions to drink or drinking in underaged youth and young adults. J*ournal of Health Communication,   9*(1),   3-29. https://doi.org/10.1080/10810730490271665

Gilson, L., Orgill, M., & Shroff, Z. C. (2018). *Health policy analysis reader: The politics of policy change in low- and middle-income countries*. Alliance for Health Policy and   Systems   Research. https://ahpsr.who.int/publications/i/item/a-health-policy-analysis-reader

Guindon, G. E., Zhao, K., Fatima, T., Garasia, S., Quinn, N., Baskerville, N. B., & Paraje, G. (2022). Prices, taxes and alcohol use: A systematic umbrella review. *Addiction, 117*(12),   3004–3023. https://doi.org/https://doi.org/10.1111/add.15966

Gupta, S., & Harvey, W. S. (2022). The Highs and Lows of Interviewing Legal Elites. *International Journal of Qualitative Methods, 21*, 16094069221078733. https://doi.org/10.1177/16094069221078733

Hoe, C., Weiger, C., Minosa, M. K. R., Alonso, F., Koon, A. D., & Cohen, J. E. (2022). Strategies to expand corporate autonomy by the tobacco , alcohol and sugar-sweetened beverage industry : A scoping review of reviews. *Globalization   and   Health, 18*(1),   17. https://doi.org/10.1186/s12992-022-00811-x

Jernigan, D. H., & Babor, T. F. (2015). The concentration of the global alcohol industry and its penetration in the African   region.   *Addiction,   110*(4),   551-560. https://doi.org/10.1111/add.12468

Jernigan, D. H., & Trangenstein, P. J. (2020). What's next for WHO's global strategy to reduce the harmful use of alcohol?. *Bulletin   of   the   World   Health Organization*, *98*(3),   222–223. https://doi.org/10.2471/BLT.19.241737

Juma, P. A., Mapa-tassou, C., Mohamed, S. F., Mwagomba, B. L. M., Ndinda, C., Oluwasanu, M., Mbanya, J., Nkhata, M. J., Asiki, G., & Kyobutungi, C. (2018). Multi-sectoral action in non-communicable disease prevention policy development in five African countries. *BMC   Public   Health,   18*(1),   953. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5826-6

Manirakiza, A. V. C., Rubagumya, F., & Ngendahayo, L. (2020). Burundi cancer care needs: a call to action. *The Oncologist,   25*(12),   1055–1059. https://doi.org/10.1634/theoncologist.2020-0410

Manthey, J., Shield, K. D., Rylett, M., Hasan, O. S. M., Probst, C., & Rehm, J. (2019). Global alcohol exposure between 1990 and 2017 and forecasts until 2030: A modelling study. *The Lancet, 393*(10190), 2493–2502. https://doi.org/10.1016/S0140-6736(18)32744-2

McCambridge, J., Mialon, M., & Hawkins, B. (2018). Alcohol industry involvement in policymaking: A systematic review. *Addiction, 113*(9), 1571–1584. https://doi.org/10.1111/add.14216

Milsom, P., Smith, R., Modisenyane, S. M., & Walls, H. (2022). Does international trade and investment liberalization facilitate corporate power in nutrition and alcohol policymaking ? Applying an integrated political economy and power analysis approach to a case study of South Africa. *Globalization and Health*, *18*(1), 32. https://doi.org/10.1186/s12992-022-00814-8

Mitchell, G., & McCambridge, J. (2022). The ubiquitous experience of alcohol industry involvement in science : Findings from a qualitative interview study. *Journal of Studies on Alcohol and Drugs*, *83*(2), 260–266.

Morojele, N. K., Dumbili, E. W., Obot, I. S., & Parry, C. D. H. (2021). Alcohol consumption, harms and policy developments in sub-Saharan Africa: The case for stronger national and regional responses. *Drug and Alcohol   Review,   40*(3),   402–419. https://doi.org/10.1111/dar.13247

Murray, C. J. L., Aravkin, A. Y., Zheng, P., Abbafati, C., Abbas, K. M., Abbasi-Kangevari, M., Abd-Allah, F., Abdelalim, A., Abdollahi, M., Abdollahpour, I., Abegaz, K. H., Abolhassani, H., Aboyans, V., Abreu, L. G., Abrigo, M. R. M., Abualhasan, A., Abu-Raddad, L. J., Abushouk, A. I., Adabi, M. (2020). Global burden of 87 risk factors in 204 countries and territories, 1990-2019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet, 396*(10258), 1223–1249. https://doi.org/10.1016/S0140-6736(20)30752-2

Mwagomba, B. L., Nkhata, M. J., Baldacchino, A., Wisdom, J., & Ngwira, B. (2018). Alcohol policies in Malawi: Inclusion of WHO 'best buy' interventions and use of multi-sectoral action. *BMC Public Health, 18*(1), 957. https://doi.org/10.1186/s12889-018-5833-7

Parry, C. (2010). Alcohol policy in South Africa: A review of policy development processes between 1994 and 2009.   *Addiction,   105*(8),   1340–1345. https://doi.org/10.1111/j.1360-0443.2010.03003.x

Rekve, D., Banatvala, N., Karpati, A., Tarlton, D., Westerman, L., Sperkova, K., Casswell, S., Duennbier, M., Rojhani, A., Bakke, Ø., Monteiro, M., Linou, N., Kulikov, A., & Poznyak, V. B. (2019). Prioritising action on alcohol for health and development. *BMJ, 367*, 1–4. https://doi.org/10.1136/bmj.l6162

Room, R., Laslett, A.-M., Miller, M., Waleewong, O., Assanangkornchai, S., Beccaria, F., Benegal, V., Borges, G., Gmel, G., Graham, K., Hao, W., Mäkelä, P., Morojele, N., Hanh, H. T. M., Obot, I., O'Brien, P., Pinsky, I., Sornpaisarn, B., & Stockwell, T. (2022). Research agendas for alcohol policymaking in the wider world. *International Journal of Alcohol and Drug Research,   10*(1),   34–44. https://doi.org/10.7895/ijadr.353

Rumgay, H., Shield, K., Charvat, H., Ferrari, P., Sornpaisarn, B., Obot, I., Islami, F., Lemmens, V. E. P. P., Rehm, J., & Soerjomataram, I. (2021). Global burden of cancer in 2020 attributable to alcohol consumption: a population-based study. *The Lancet. Oncology*, *22*(8), 1071–1080.   https://doi.org/10.1016/S1470-2045(21)00279-5

Sanchez, Z. M., Carvalho, A., Sacramento, C., D'Alva, F., Rita, I., Pinheiro, S., Soares de Barros, E. M., Gil, V. S., Costa Alegre, M. C., Ancia, A., Monteiro, M. G., Opoko, C. A., & Tello, J. E. (2022). Development of alcohol

control law, Sao Tome and Principe. *Bulletin of the World Health Organization*, *100*(10), 628–635. https://doi.org/10.2471/BLT.22.288590

Savell, E., Fooks, G., & Gilmore, A. B. (2015). How does the alcohol industry attempt to influence marketing regulations? A systematic review. *Addiction*, *111*(1), 18–32. https://doi.org/10.1111/add.13048

Smith, L. A., & Foxcroft, D. R. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: Systematic review of prospective cohort studies. *BMC Public Health, 9*(1), 51. https://doi.org/10.1186/1471-2458-9-51

Swahn, M. H., Robow, Z., Balenger, A., Staton, C. A., Kasirye, R., Francis, J. M., Komba, S., & Siema, P. (2022). Preventing alcohol-related harm in East Africa : Stakeholder perceptions of readiness across five countries. *International Journal of Environmental Research and Public Health*, *19*(22), 14979 https://doi.org/10.3390/ijerph192214979

Trangenstein, P. J., Morojele, N. K., Lombard, C., Jernigan, D. H., & Parry, C. D. H. (2018). Heavy drinking and contextual risk factors among adults in South Africa: Findings from the International Alcohol Control study. *Substance Abuse: Treatment, Prevention, and Policy, 13*(1), 43. https://doi.org/10.1186/s13011-018-0182-1

U.S. Department of State. (2021). *2021 Report on International Religious Freedom: Burundi.* https://www.state.gov/reports/2021-report-on-international-religious-freedom/burundi/

Ulucanlar, S., Lauber, K., Fabbri, A., Hawkins, B., Mialon, M., Hancock, L., Tangcharoensathien, V., & Gilmore, A. B. (2023). Corporate political activity: Taxonomies and model of corporate influence on public policy. *International Journal of Health Policy and Management, 12*(1) 1–22. https://doi.org/10.34172/ijhpm.2023.7292

United Nations Development Program (UNDP). (2022). *Human development insights*. https://hdr.undp.org/data-center/country-insights#/ranks

Walls, H., Cook, S., Matzopoulos, R., & London, L. (2020). Advancing alcohol research in low-income and middle-income countries: a global alcohol environment framework. *BMJ Global Health, 5*(4), e001958. https://doi.org/10.1136/bmjgh-2019-001958

World Health Organization (WHO). (2019). *SAFER: Strengthen restrictions on alcohol availability*. https://www.who.int/initiatives/SAFER/alcohol-availability

World Health Organization (WHO). (2018a). *Global status report on alcohol and health 2018*. https://www.who.int/publications/i/item/9789241565639

World Health Organization (WHO). (2018b). *Policy in action: A tool for measuring alcohol policy implementation.* https://iris.who.int/bitstream/handle/10665/349924/9789289056700-eng.pdf?sequence=3

World Health Organization (WHO). (2018c). *The SAFER initiative: A world free from alcohol related harm.* https://www.who.int/initiatives/SAFER

World Health Organization (WHO). (2017). *'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases*. https://apps.who.int/iris/bitstream/handle/10665/259232/WHO-NMH-NVI-17.9-eng.pdf

World Health Organization (WHO). (2016). *Burundi: Alcohol consumption: Levels and patterns*. https://cdn.who.int/media/docs/default-source/country-profiles/substances-abuse/bdi.pdf?sfvrsn=c7db42a2_3&download=true

World Health Organization (WHO). (2010). *Global strategy to reduce the harmful use of alcohol* (Issue May). https://iris.who.int/bitstream/handle/10665/3087/A63_R13-en.pdf?sequence=1

World Bank. (2023). The World Bank in Burundi. https://www.worldbank.org/en/country/burundi/overview