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Organizational structure, capacity and reach of organizations involved in alcohol prevention: An assessment of stakeholders across five countries in East Africa

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Abstract

Aims: East African countries, classified as low- and middle-income countries (LMICs), are disproportionately harmed by alcohol consumption, and many countries lack strategies to address and prevent alcohol harm. This study draws on community input from stakeholders involved in alcohol harm prevention in five East African countries to identify organizational structures, capacity and outreach, and strategies for capacity building to address the high burden of alcohol harm more systematically.

Design/Setting/Participants: A cross-sectional survey was distributed from October to December 2020 by the East Africa Alcohol Policy Alliance to their member alliances and stakeholders across five countries in East Africa (i.e., Burundi, Kenya, Rwanda, Tanzania and Uganda). Analyses were based on 171 persons from 171 organizations completing the survey.

Measures: The East Africa Alcohol Policy Alliance Capacity Assessment Survey (EAAPACAS) included organizational size and funding, research capacity, priorities, and perceptions related to alcohol prevention and harm locally and nationally.

Results: The types of organizations, funding structures, and functions dedicated to alcohol prevention vary widely across countries, indicating great diversity and heterogeneity of organizations working on alcohol prevention and advocacy in East Africa. Most organizations rely on volunteer staff. Additionally, 51% reported that they did not know, or could not meet their program goals, with the available operational funds.

Conclusion: These organizations rely primarily on volunteers and face significant barriers to achieving their goals with their current budget, primarily derived from foundations and private donations. Overall, these findings indicate that the infrastructure for alcohol prevention is weak and fragmented in countries where national initiatives are limited or underfunded.

Introduction

Alcohol consumption poses a high risk for an array of non-communicable and infectious diseases and both intentional and unintentional injuries (Rehm et al., 2017), contributing to 5.3% of all deaths and 5% of all disability-adjusted life-years or DALYs (Shield et al., 2020). The World Health Organization (WHO) reported that in 2016 the burden of disease and injury attributed to alcohol, adjusted for age, was disproportionately highest in the African region where alcohol consumption levels vary by country (WHO, 2018a). Regional variations in alcohol-related harm shows that West Africa had the highest DALYs in 2016, whereas East Africa had the second highest number (Morojele et al., 2021). Within East Africa, the alcohol consumption per capita in

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Uganda, Tanzania, Rwanda, and Burundi exceeded the average across the WHO African Region (WHO, 2018a). These findings collectively indicate the need to address alcohol use but also that there is a need to establish an alcohol research agenda for East Africa (Swahn et al., 2023).

To date, epidemiological research on alcohol use and alcohol-related harm across East Africa remains scarce. Francis and colleagues (2014) compiled the most comprehensive systematic review and meta-analysis to date, on the prevalence of alcohol consumption among young people in East Africa. They found that the median prevalence of reported youth drinking was 52% (Francis et al., 2014). Other recent studies on alcohol in East Africa have focused on specific countries and populations, including research on the prevalence of alcohol misuse among adolescent girls and young women in Uganda (Mayanja et al., 2020); alcohol use linked to child physical abuse in slums in Kampala, Uganda (Culbreth et al., 2021; Swahn et al., 2017); sexual-related harm in Kampala, Uganda (Swahn, Balenger, Umenze, Aneja et al., 2022); intimate partner violence and gender-based violence, HIV and sexually transmitted infections (STIs) in Kampala, Uganda (Culbreth et al., 2021; Culbreth et al., 2020; Swahn et al., 2021); the prevalence and key drivers of adult alcohol use in rural Kenya (Takahashi et al., 2017); alcohol use among injured patients in Moshi, Tanzania; alcohol among youth in urban Tanzania (Sommer et al., 2021); and drug use among youth in Rwanda (Kanyoni et al., 2015). Because of this fragmented approach to alcohol research in East Africa, researchers have not yet comprehensively assessed or identified priorities for the prevention of alcohol-related harm in this region although there has been a call for the development of an alcohol research agenda (Swahn et al., 2023). Recent research of stakeholders in the region has assessed readiness to address alcohol-related harm across East Africa. The research noted substantial variability in capacity, knowledge towards alcohol prevention, institutional links, legislative mandates and policies, attitudes towards prevention, willingness to address the problem as well as material, human and informal resources (Swahn, Robow, Balenger et al., 2022).

As a result of inadequate capacity, information and research are scarce about the organizations involved in alcohol prevention across low-resource settings where the burden of alcohol-related harm remains high and policy development is relatively slow, fragmented, and ineffective (Swahn, Robow, Balenger et al., 2022). It remains unclear who engages in this work and what capacity and resources they have and what their needs may be. These are perhaps simple research questions, but they remain key in terms of implementing evidence-based policies and adapting and using existing tools and strategies, such as those highlighted by WHO in the forms of the SAFER initiatives which stand for "Strengthen restrictions on alcohol availability; Advance and enforce drink driving countermeasures; Facilitate access to screening, brief interventions and treatment; Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion; Raise prices on alcohol through excise taxes and pricing policies" (WHO, 2018b). As such, we conducted a cross-sectional survey to determine the organizational structure, capacity, and reach of organizations engaged in alcohol prevention across five countries in East Africa.

Methods

The East Africa Alcohol Policy Alliance (EAAPA) distributed the online East African Alcohol Policy Alliance Capacity Assessment Survey (EAAPACAS) to its member alliances involved in alcohol harm prevention from October to December 2020. We relied on snowball sampling where EAAPA's member alliances forwarded the survey to contacts in their networks knowledgeable about alcohol policy and alcohol-related issues in their countries. The survey targeted respondents, predominantly from non-governmental organizations (NGOs) and community-based organizations (CBOs), in five East African countries, including Burundi, Kenya, Rwanda, Tanzania, and Uganda. Details about the survey have been presented previously (Balenger et al., 2021; Swahn, Robow, Balenger et al., 2022; Swahn, Balenger, Umenze, Dumbili et al., 2022; Swahn, Robow, Umenze et al., 2022).

To participate in the survey, participants received an invitation to complete the Qualtrics online survey via email or social media (primarily WhatsApp and Facebook). Participants did not receive any compensation for taking the survey. The participant sample is comprised of 171 respondents from 171 organizations. A response rate cannot be computed due to the snowball sampling. The survey was deemed exempt and approved by Georgia State University Institutional Review Board. The survey included questions on perceptions of alcohol-related concerns, risk factors and types of alcohol harm, policies and measures in place to prevent alcohol harm, and research needs, capacity, and priorities. Survey questions were developed by the research team or adapted from the WHO's readiness assessment for the prevention of child maltreatment (WHO, 2013).

The survey had a total of 68 items. The items analyzed in this paper assessed the structure of the organizations (e.g., types of organizations, types of staff, size of the organizations); the sources of funds and key organizational measures such as yearly operational funds, the program goals met with current budget; the scope of programming (main functions, services or programs offered, primary reach, geographic setting, populations served including stakeholders, target populations, and vulnerable populations); leadership (political leaders committed to addressing alcohol-related harm); and agencies mandated with addressing alcohol-related harm. The responses acquired online using the Qualtrics survey tool were downloaded in the form of an Excel spreadsheet and computed as frequency counts by country to obtain descriptive statistics.

Results

The aim of this survey was to identify organizational structures, capacity and outreach, and strategies for capacity building in addressing the burden of alcohol harm among stakeholders involved in alcohol harm prevention in East Africa. In total, 171 participants responded to the survey.

The descriptive characteristics of organizations, the types of staff, sources of funds, yearly operational funds, meeting program goals, main functions, and other factors are outlined in Table 1. The stakeholders included governmental organizations, international organizations, CBOs, research institutes, NGOs, universities, and other/unspecified stakeholders. Countries represented among survey respondents included Kenya, Uganda, Tanzania, Burundi, Rwanda, South Sudan, and other/unspecified countries.

Table 1

Characteristics of Organizations Represented by Stakeholders Participating in the EAAPACAS (n = 171)

Country	Burundi *n* (%)	Kenya *n* (%)	Rwanda *n* (%)	Tanzania *n* (%)	Uganda *n* (%)	Total *n* (%)
Total	**14 (8.2)**	**42 (24.6)**	**9 (5.3)**	**36 (21.1)**	**41 (24.0)**	**171 (100.0)**
Types of Organizations						
Governmental	7 (50.0)	14 (33.3)	6 (66.7)	27 (75.0)	25 (61.0)	80 (46.8)
International	1 (7.1)	15 (35.7)	0 (0)	2 (5.6)	6 (14.6)	25 (14.6)
Other	2 (14.3)	4 (9.5)	0 (0)	4 (11.1)	2 (4.9)	14 (8.2)
Community-based	0 (0)	6 (14.3)	2 (22.2)	1 (2.8)	2 (4.9)	11 (6.4)
Research Institute	3 (21.4)	2 (4.8)	0 (0)	0 (0)	4 (9.8)	10 (5.9)
NGO	0 (0)	0 (0)	0 (0)	1 (2.8)	1 (2.4)	3 (1.8)
University	0 (0)	0 (0)	0 (0)	1 (2.8)	0 (0)	1 (0.6)
Types of Staff						
Volunteers	4 (28.6)	20 (47.6)	4 (44.4)	21 (58.3)	21 (51.2)	73 (42.7)
Social workers	2 (14.3)	15 (35.7)	2 (22.2)	15 (41.7)	25 (61.0)	60 (35.1)
Administration and finance	3 (21.4)	13 (31.0)	1 (11.1)	15 (41.7)	23 (56.1)	56 (32.8)
Peer educators	1 (7.1)	20 (47.6)	2 (22.2)	13 (36.1)	18 (43.9)	55 (32.16)
Health workers	1 (7.1)	12 (28.6)	1 (11.1)	8 (22.2)	21 (51.2)	43 (25.2)
Psychologists	2 (14.3)	13 (31.0)	1 (11.1)	9 (25.0)	12 (29.3)	38 (22.2)
Researchers	1 (7.1)	6 (14.3)	1 (11.1)	9 (25.0)	19 (46.3)	38 (22.2)
Development workers	1 (7.1)	9 (21.4)	1 (11.1)	4 (11.1)	9 (22.0)	26 (15.2)
Medical workers	1 (7.1)	6 (14.3)	0 (0)	5 (13.9)	10 (24.4)	22 (12.9)
Medical practitioners	1 (7.1)	5 (11.9)	0 (0)	6 (16.7)	10 (24.4)	22 (12.9)
Other	1 (7.1)	3 (7.1)	0 (0)	1 (2.8)	5 (12.2)	10 (5.8)
Sources of Funds for the Organization						
Foundations	1 (7.1)	9 (21.4)	0 (0)	9 (25.0)	15 (36.6)	37 (21.6)
Membership fees	2 (14.3)	7 (16.7)	3 (33.3)	9 (25.0)	9 (22.0)	30 (17.5)
Public donations	1 (7.1)	8 (19.1)	1 (11.1)	4 (11.1)	14 (34.2)	28 (16.4)
Private donations	2 (14.3)	6 (14.3)	3 (33.3)	3 (8.3)	12 (29.3)	26 (15.2)
Fees for services	2 (14.3)	8 (19.1)	0 (0)	6 (16.7)	7 (17.1)	23 (13.5)
International	3 (21.4)	3 (7.1)	0 (0)	5 (13.9)	7 (17.1)	19 (11.1)
Consulting fees	0 (0)	7 (16.7)	1 (11.1)	2 (5.6)	8 (19.5)	18 (10.5)
National	1 (7.1)	6 (14.3)	0 (0)	4 (11.1)	6 (14.6)	17 (9.9)
Sales	1 (7.1)	1 (2.4)	1 (11.1)	2 (5.6)	9 (22.0)	14 (8.2)
Other	0 (0)	4 (9.5)	0 (0)	4 (11.1)	2 (4.9)	10 (5.8)
Local	0 (0)	1 (2.4)	0 (0)	2 (5.6)	0 (0)	3 (1.8)
Primary Reach of the Organization						
Community	4 (28.6)	22 (52.4)	4 (44.4)	17 (47.2)	23 (56.1)	71 (41.5)
National	6 (42.9)	13 (31.0)	3 (33.3)	14 (38.9)	21 (51.2)	59 (34.5)
District	3 (21.4)	15 (35.7)	3 (33.3)	15 (41.7)	16 (39.0)	52 (30.4)
Regional	3 (21.4)	9 (21.4)	1 (11.1)	17 (47.2)	16 (39.0)	47 (27.5)
Individuals	1 (7.1)	13 (31.0)	4 (44.4)	6 (16.7)	12 (29.3)	36 (21.1)
International	2 (14.3)	5 (11.9)	1 (11.1)	4 (11.1)	8 (19.5)	20 (11.7)
Geographic Setting						
Urban	5 (35.7)	20 (47.6)	4 (44.4)	19 (52.8)	24 (58.5)	74 (43.3)
Both	2 (14.3)	8 (19.1)	0 (0)	3 (8.3)	5 (12.2)	19 (11.1)
Rural	0 (0)	1 (2.4)	0 (0)	1 (2.8)	0 (0)	2 (1.17)
Stakeholders/Population Served by the Organization						
Communities	4 (28.6)	24 (57.1)	4 (44.4)	19 (52.8)	25 (61.0)	78 (45.6)
Primary/Secondary school	3 (21.4)	22 (52.4)	4 (44.4)	18 (50.0)	21 (51.2)	70 (40.9)
Tertiary/Vocational institutions	2 (14.3)	18 (42.9)	0 (0)	6 (16.7)	20 (48.8)	46 (26.9)
Stakeholders/Population Served by the Organization (continued)						

Country	Burundi *n* (%)	Kenya *n* (%)	Rwanda *n* (%)	Tanzania *n* (%)	Uganda *n* (%)	Total *n* (%)
Service providers	2 (14.3)	13 (31.0)	1 (11.1)	10 (27.8)	18 (43.9)	45 (26.3)
Local councils	3 (21.4)	7 (16.7)	3 (33.3)	13 (36.1)	15 (36.6)	41 (24.0)
Policy makers	2 (14.3)	9 (21.4)	2 (22.2)	7 (19.4)	18 (43.9)	39 (22.8)
Other	0 (0)	0 (0)	1 (11.1)	0 (0)	3 (7.3)	4 (2.3)
Target Populations Served						
Youth	3 (21.4)	25 (59.5)	4 (44.4)	16 (44.4)	26 (63.4)	76 (44.4)
Women	2 (14.3)	22 (52.4)	4 (44.4)	18 (50.0)	23 (56.1)	71 (41.5)
Children	1 (7.1)	21 (50.0)	4 (44.4)	16 (44.4)	21 (51.2)	64 (37.4)
Families	2 (14.3)	23 (54.7)	4 (44.4)	10 (27.8)	23 (56.1)	62 (36.3)
Men	2 (14.3)	21 (50.00	3 (33.3)	12 (33.3)	20 (48.8)	60 (35.1)
Not specific	3 (21.4)	1 (2.4)	0 (0)	4 (11.1)	3 (7.3)	12 (7.0)
Vulnerable/Key Populations Served						
Street children	2 (14.3)	15 (35.7)	4 (44.4)	11 (30.6)	15 (36.6)	48 (28.1)
HIV positive	1 (7.1)	16 (38.1)	3 (33.3)	11 (30.6)	15 (36.6)	48 (28.1)
Slums	2 (14.3)	18 (42.9)	3 (33.3)	5 (13.9)	17 (41.5)	46 (26.9)
Violence Victims	1 (7.1)	13 (31.0)	4 (44.4)	15 41.7)	11 (26.8)	45 (26.3)
Orphans	2 (14.3)	15 (35.7)	3 (33.3)	9 (25.0)	14 (34.2)	43 (25.2)
Prostitutes	0 (0)	12 (28.6)	4 (44.4)	10 (27.8)	13 (31.7)	39 (22.8)
IV drug users	0 (0)	14 (33.3)	0 (0)	8 (22.2)	8 (19.5)	31 (18.1)
Child laborers	1 (7.1)	6 (14.3)	0 (0)	5 (13.9)	14 (34.2)	28 (16.4)
Human traffic victims	0 (0)	4 (22.2)	0 (0)	4 (11.1)	10 (24.4)	18 (10.5)
Truck drivers	1 (7.1)	5 (11.9)	0 (0)	4 (11.1)	2 (12.2)	16 (9.4)
None	2 (14.3)	4 (9.5)	0 (0)	3 (8.33)	6 (14.6)	16 (9.4)
Refugees	1 (7.1)	2 (4.8)	1 (11.1)	2 (5.6)	5 (12.2)	12 (7.0)
Fishers	0 (0)	4 (9.5)	0 (0)	3 (8.3)	4 (9.8)	11 (6.4)
Others	1 (7.1)	5 (11.9)	0 (0)	0 (0)	3 (7.3)	9 (5.3)
Agencies Mandated with Addressing Alcohol-Related Harm						
Yes	4 (28.6)	2 (4.8)	2 (2.2)	5 (13.9)	2 (4.9)	15 (8.8)
Ministry of Health Budget has a Dedicated Budget for Alcohol-Related Harm						
Yes	2 (14.3)	17 (40.5)	1 (11.1)	12 (33.3)	13 (31.7)	45 (26.3)
Other Government Units have Budget dedicated for Alcohol-Related Harm						
Yes	2 (14.3)	7 (16.7)	1 (11.1)	13 (36.1)	16 (39.0)	39 (22.81)
Political Leaders Committed to Addressing Alcohol-Related Harm						
Yes	5 (35.7)	8 (19.1)	1 (11.1)	6 (16.7)	7 (17.1)	30 (17.5)

The staff were primarily volunteers, social workers, administration and finance officers and peer educators. The average size of organizations counted 11 to 25 people, paid or unpaid as seen in Figure 1.

Figure 1

The Size of the Organizations Represented in the EAAPACAS

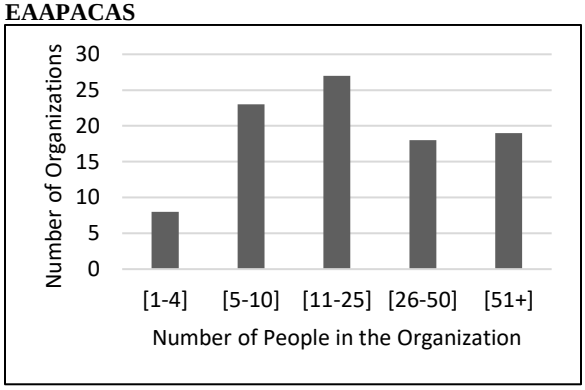
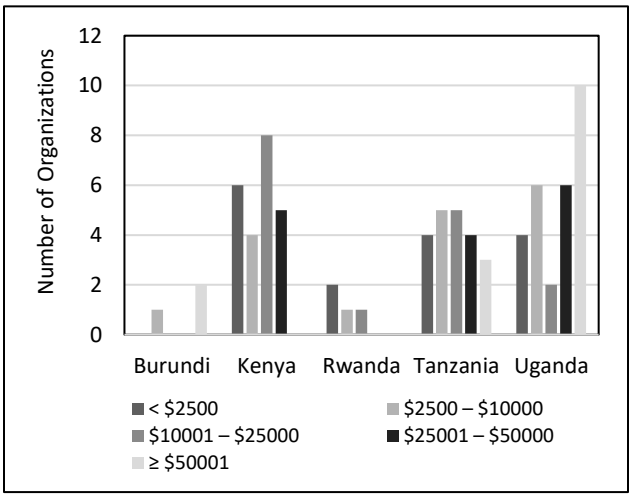


Figure 2

The Yearly Operational Funds per Organization, in U.S. Dollars, by EAAPA country

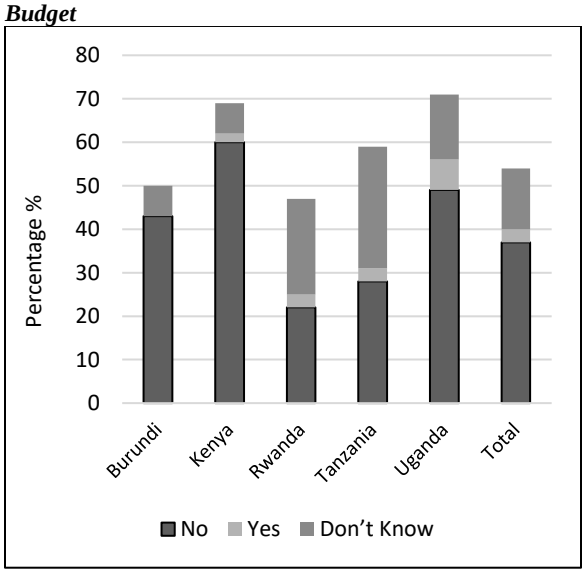


Respondents reported that 22% of the funding came from foundations, 18% from membership fees, 16% and 15% from public and private donations respectively (Table 1). The overall yearly operational funds available to organizations in Uganda were higher than that of other countries that participated (Figure 2). Tanzania had the second-highest yearly operational funds for its organizations.

Thirty-seven percent of the organizations reported that they were not able to meet their program goals with their current budget, 3% met their goals, and 14% did not know whether the goals had been met (Figure 3).

Figure 3

Goals Met by the EAAPA Organizations with their Current Budget



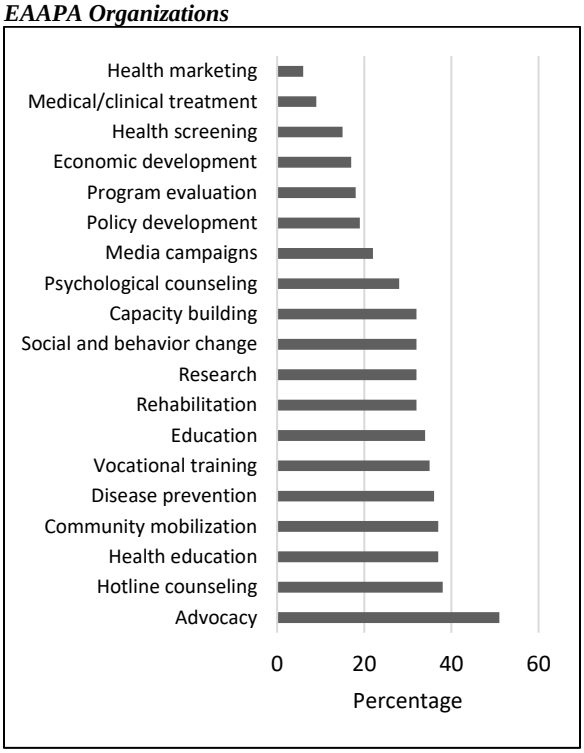
Advocacy, hotline counseling, health education, and community mobilization were the main functions of the organizations according to the respondents, depicted in Figure 4.

The community was the primary reach of the organizations, followed by the national, district, regional, individual, and international levels. Forty-three percent of the programs were implemented in urban areas, whereas 1% were in rural settings, and 11% in both. The organizations served more communities, primary/secondary schools, tertiary/vocational schools than policymakers, and targeted more youth, women, and children than men. Among these populations served were vulnerable people, predominantly street children, HIV-positive individuals, people living in slums, violence victims, and orphans (see Table 1).

Only 9% of all the agencies were mandated with addressing alcohol-related harm across the five countries surveyed. Twenty-six percent responded that their Ministry of Health had a budget dedicated to alcohol-related harm, whereas 23% responded that the budget came from other government units. In 18% of cases, political leaders were committed to addressing alcohol-related harm (see Table 1).

Figure 4

The Main Functions, Services or Programs Offered by the EAAPA Organizations



Discussion

This study engaged stakeholders to identify the organizational structure, capacity, and reach of organizations involved in alcohol prevention. The cross-sectional survey was distributed across five countries in East Africa. Although most organizations represented government units, funding mainly came from external sources such as foundations and donations. Also, respondents indicated that their infrastructure was weak with half indicating that they were not able to meet program goals with their current operational budget. Moreover, many of the organizations relied primarily on volunteers.

Taken as a whole, our findings across East Africa demonstrate weak infrastructure and a fragmented approach to addressing alcohol-related harm. Our findings indicate that alcohol prevention efforts are primarily delegated to NGOs and CBOs. These findings illustrate the challenges for comprehensive alcohol prevention initiatives, strategies, and policy development within low-resource settings which need to be factored into plans seeking to address alcohol harm more broadly. Previous research already underscores weak human and technical resources for alcohol-related harm prevention in East Africa and the need for a research agenda (Swahn et al., 2023; Swahn, Robow, Balenger et al., 2022).

It is also clear that most of the organizations target youth and women, while some also target specific key populations such as street children, orphans, victims of violence, and those living with HIV. Most studies to date on alcohol and related harm in East Africa are focused on specific populations, such

as adolescent girls and young women in Uganda (Mayanja et al., 2020), injury patients in Tanzania (Staton et al., 2020), or among youth in urban Tanzania (Sommer et al., 2021) or urban Uganda (Swahn et al., 2017), to name a few. Our findings and the current literature reinforce the need to assess drinking and alcohol harm by using national and repeated surveys. Although NGOs and CBOs ensure alcohol prevention efforts, government leadership and engagement in supporting national surveys are needed.

We acknowledge several limitations of our study. First, the sample size (n = 171) and snowball sampling limit the generalizability of our findings. Stakeholders who were involved in alcohol harm prevention but were unknown to the East African Alcohol Policy Alliance or its affiliates were likely not reached for inclusion in this study. In addition, the sample sizes for each country were too small to examine the organizational structure, capacity, and reach at the country level. However, the strength of the study is the presentation of the organizational structure, needs, and reach of key stakeholders, NGOs, and CBOs, in a region where national alcohol prevention strategies remain relatively scarce and where capacity building is urgently needed.

Conclusion

This study collected input from organizations engaged in alcohol prevention in East Africa regarding their operations, reach, and functions. In a setting where alcohol prevention efforts are mostly delegated to NGOs and CBOs, it is important to understand the infrastructure and capacity needed to address alcohol-related harm more systematically. The fact that many organizations rely on volunteers and private funds is important to consider in any plans requiring substantial mobilization or multi-year efforts for sustained impact. We urge decision-makers, researchers, and other stakeholders to consider these findings when developing capacity-strengthening programs to address alcohol-related harm in communities across East Africa.

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