



## Research Paper

## A readiness assessment for the prevention of alcohol-related harm in West Africa: A new methodological approach to inform practice and policy



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## ARTICLE INFO

## Keyword:

Alcohol  
Prevention  
Alcohol harm  
Research  
Capacity  
Stakeholder  
Academic-community partnerships  
West Africa

## ABSTRACT

**Objective:** Alcohol-related harm is a growing concern globally and particularly in West Africa. However, tools for assessing the readiness for prevention of alcohol-related harm in low-resource settings have been lacking. We modified the WHO tool, the Readiness Assessment for the Prevention of Child Maltreatment Short Form (RAP-CM), to assess readiness for the prevention of alcohol-related harm across West Africa.

**Methods:** We conducted a cross-sectional survey in the fall of 2020, distributed by the West Africa Alcohol Policy Alliance to their member alliances and stakeholders, predominantly community-based organizations (CBOs) and non-governmental organizations (NGOs), across 7 countries in West Africa ( $N = 140$ ). The survey included modified measures from the RAP-CM short form.

**Results:** In terms of general readiness, the overall adjusted aggregate score for West Africa was 45.0% (ranging from 42.9% in Liberia to 52.7% in Senegal). Of the ten domains assessed (on a 0–10 scale), across all countries, knowledge of alcohol-related harm prevention (8.3) and legislation, mandates, and policies (6.7) received the highest readiness scores. The lowest readiness scores were observed for human and technical resources (2.5), attitudes toward preventing alcohol-related harm (2.7), and the will to address the problem (2.9).

**Conclusions:** Our results demonstrate substantial variability across domains in the readiness to address alcohol-related harm with clear strengths and limitations for future priority setting and capacity building. The barriers to progress include attitudes toward alcohol-related harm prevention, lack of willingness to address the problem, and limited human and technical resources available. These barriers need to be mitigated to address the high burden of alcohol-related harm in the region and to inform both practice and policy.

Leading experts in alcohol research and policy development have acknowledged the limited progress in addressing alcohol-related harm, which represents a growing concern in the global public health community (Jernigan & Trangenstein, 2020; Global Burden of Disease 2016 Alcohol Collaborators, 2018). Alcohol is one of the most commonly used substances globally and contributes to about 5% of deaths and 5% of the global disease burden (World Health Organization, [WHO], 2018a). Of particular concern is the disproportionate burden of alcohol-related harm in Africa, the WHO region with the highest burden of disease and injury attributable to alcohol (World Health Organization, 2018a) and with increased alcohol consumption (Ferreira-Borges, Dias, Babor, Esser & Parry, 2015). A recent study noted that “Sub-Saharan Africa has long

been characterized as a region with weak alcohol policies, high proportion of abstainers and heavy episodic drinkers (among drinkers) and as a target for market expansion by global alcohol producers” (Morojele, Dumbili, Obot & Parry, 2021, p. 403).

Recent research has highlighted that West Africa (non-Muslim majority countries) has some of the highest numbers of age-standardized alcohol-attributable deaths and disability adjusted life years compared to other African regions (i.e., East Africa, Southern Africa, and Central Africa) (Morojele et al., 2021). It may therefore also not be surprising that researchers have pointed out that the West African region has implemented fewer of the World Health Organization (WHO) SAFER priorities (Morojele et al., 2021; World Health Organization, 2018b).

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The WHO SAFER priorities are a set of five evidence-based recommended policies and interventions that include “strengthening restrictions on alcohol availability,” “advancing and enforcing drink driving counter measures,” “facilitating access to screening, brief interventions, and treatment,” “enforcing bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion,” and “raising prices on alcohol through excise taxes and pricing policies” (World Health Organization, 2018b). Additionally, most of the countries in this region do not have a national policy framework to address harmful alcohol, although a few do (World Health Organization, 2018a). It also seems to be the case that in countries with policies, there is insufficient enforcement (Morojele et al., 2021) and limited focus on setting research priorities (Balenger et al., 2021). It is within this context of limited formal infrastructure that we look to community-based organizations (CBOs) and non-governmental organizations (NGOs) to lead the prevention of alcohol-related harm. However, there is a scarcity of research on CBOs and NGOs who address alcohol-related harm in West Africa or in other parts of the continent, to determine their capacity and perceived readiness for prevention. This is a particularly dire situation across Sub-Saharan Africa as the overall alcohol burden remains high and because the region is targeted for market expansion of alcohol products (Morojele et al., 2021).

Despite this recognition, research on alcohol-related harm, harm reduction initiatives, and evaluated alcohol interventions are largely missing in the literature across sub-Saharan Africa (Francis, Cook, Morojele, & Swahn, 2020). In addition to this scarcity of research, no tools that we know of, have been employed systematically to assess the strengths and weaknesses for the readiness to address alcohol-related harm in this region, representing a critical barrier to progress for both practice and policy. Given recent research highlighting West Africa as the region within Sub-Saharan Africa with the highest number of age-standardized alcohol-attributable deaths (Morojele et al., 2021), development of such a tool is an urgent priority for alcohol research, capacity building, and policy development, particularly in West Africa.

In this study, we modified the Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) tool developed by the WHO (World Health Organization, 2013) to be used in the Readiness Assessment for the Prevention of Alcohol-Related Harm (RAP-ARH) in low-resource settings. The RAP-CM has been implemented successfully in many low- and middle-income countries (e.g., the Middle East, Brazil, Macedonia, Malaysia, Kenya, and South Africa) (Al Eissa et al., 2019; Al Saadoon, Al Numani, Saleheen, Almuneef, & Al-Eissa, 2020; Alkhwari et al., 2020; Almuneef et al., 2014; Shanley et al., 2021; World Health Organization n.d.-a). This tool was developed as a method for assessing how “ready” a country, region, or community may be to implement prevention programs on a larger scale (World Health Organization, 2013). It consists of a ten-dimensional model of readiness and incorporates stakeholders’ attitudes, perceptions, and knowledge of child maltreatment, the availability of data on child maltreatment, the willingness to take action to address child maltreatment, and the legal, policy, human, and technical resources available to prevent child maltreatment (World Health Organization, 2013).

According to the WHO, the goal of this tool and methodology are to identify the key gaps in readiness, establish a baseline to measure or track progress, provide a guide for resource allocation, identify suitable interventions, prompt action, and serve as a teaching tool for stakeholders (World Health Organization, 2013). The RAP-CM is available in a long and short form and has extensive documentation, including the survey measures and a scoring guide, all publicly available on the WHO website.

We believe this tool, if adapted to assess alcohol-related harm, can be valuable for the readiness assessment in countries and communities across Sub-Saharan Africa to mitigate the increased alcohol burden and harm by identifying next steps and leveraging strengths. Moreover, the RAP-CM short form (comprised of 19 survey questions) is an ideal assessment tool because of its ease of use and clear application for the pur-

pose we have intended (World Health Organization n.d.-c). In this study, we present the modified readiness assessment and scores for addressing alcohol-related harm in West Africa overall and at the country-level for seven countries. The assessment highlights the strengths and barriers for priority setting and resource allocation to address alcohol-related harm across West Africa, and it also provides support for applying tools that can inform prevention and policy development.

## Methods

A brief cross-sectional online survey was conducted with stakeholders engaged in the prevention of alcohol-related harm, outreach, and policy development in collaboration with the West Africa Alcohol Policy Alliance (WAAPA) during August and September of 2020. The project is titled the West African Alcohol Policy Alliance Capacity Assessment Survey (WAAPACAS) (Balenger et al., 2021). The goals of the online survey were to assess the stakeholders’ readiness to assess alcohol-related harm, their organizational structure, their operational and strategic priorities, target population, perceptions of best practices and alcohol-related concerns in their local communities, familiarity with WHO SAFER initiative, and research capacity needs. Within the longer survey, we also included a specific readiness assessment tool, described below.

We used a snowball participant recruitment strategy where survey invitations were distributed to those affiliated with WAAPA via email and on social media platforms (i.e., WhatsApp and Facebook) to complete the anonymous Qualtrics online survey. Participants did not receive any compensation for taking the survey, and participants were free to invite others. Among the 140 participants in the survey, most participants worked at either NGOs (56%) or CBOs (24%).

Because of the survey distribution approach, a response rate cannot be computed. We are using data from 140 responses for these analyses. The survey was deemed exempt and approved by the Georgia State University Institutional Review Board (H21075).

### Survey modification and adjustments for RAP-ARH

Within the longer WAAPACAS, we included a modified version of the RAP-CM ((World Health Organization, 2013; World Health Organization n.d.-c). The research team closely reviewed all the survey questions in the RAP-CM and replaced any term reflecting child maltreatment with “alcohol-related harm” and made minor editorial changes as needed to create the Readiness Assessment for the Prevention of Alcohol-Related Harm (RAP-ARH). More specifically, we made the following changes. First, we added the term alcohol-related harm to the preamble of the survey and replaced child maltreatment with alcohol-related harm as follows: “The purpose of this first part of the questionnaire is to obtain your view of the capacity of your country to implement evidence-based alcohol prevention programs on a large-scale to address alcohol-related harm. After this section, we have additional questions about your organization, its capacity and priorities for alcohol prevention and policy development.” We also added a definition (as was done in the original tool) for alcohol-related harm, as follows: “For this project, we define alcohol-related harm broadly to include any potential alcohol-related harm to the drinkers as well as harm to others. Alcohol harm may include biological concerns such as HIV transmission, liver damage or cancers, psychological and societal harms including addiction/alcohol use disorders, physical and psychological abuse and violence, injuries, car crashes and other types of harm.”

Second, the research team closely reviewed all the survey questions within the RAP-CM short form and replaced any term reflecting child maltreatment with “alcohol-related harm” and made additional minor editorial changes. As an example, the original question 1 was worded as follows: Compared to other health and social problems, how much of a priority is *child maltreatment prevention* (i.e., taking measures to prevent *child maltreatment* before it occurs)? Our modified survey question read

**Table 1**

Mean dimension and overall adjusted aggregate scores\* of the readiness assessment for prevention of alcohol-related harm (RAP-ARH) using a 10-point scale across 10 domains (D1-D10) by country and for the West African Region (WAAPACAS).

	Burkina Faso	Gambia	Ghana	Liberia	Nigeria	Senegal	Sierra Leone	West Africa
D1: Attitudes towards alcohol-related harm prevention	5.0	2.8	2.9	1.7	2.4	3.7	3.0	2.7
D2: Knowledge of alcohol-related harm prevention	10.0	7.5	8.6	9.0	8.6	8.7	7.8	8.4
D3: Scientific data on alcohol-related harm prevention	5.0	3.3	4.9	2.0	4.7	4.5	3.9	3.9
D4: Current programs and evaluation	2.5	3.1	3.1	2.9	3.1	2.8	3.9	3.0
D5: Legislation, mandates, and policies	7.5	9.0	10.0	7.0	7.6	8.7	8.5	6.7
D6: Will to address the problem	5.0	2.9	3.7	1.4	2.3	4.0	3.6	2.9
D7: Institutional links and resources	5.0	5.2	5.4	5.8	5.8	5.6	6.0	5.8
D8: Material resources	5.0	5.0	6.7	5.0	5.7	5.5	5.6	5.5
D9: Human and technical resources	2.5	3.7	4.4	4.5	4.4	5.1	4.4	2.5
D10: Informal social resources	2.5	4.3	2.8	3.6	3.1	3.9	5.4	4.1
Overall Adjusted Aggregate Score %:	50.0	46.8	52.5	42.9	47.9	52.7	52.1	45.0

\*Scores computed per the WHO RAP-CM short form guidelines and scores for each Domain can range from 0 to 10. The total aggregate score ranges from 0 to 100.

... how much of a priority is *alcohol-related harm prevention* (i.e., taking measures to prevent *alcohol-related harm* before it occurs)?

Third, we made a few modifications to the formatting of the response options to facilitate the online survey distribution. The original RAP-CM short form tool is comprised of 19 survey questions, 14 of which are presented with categorical response options, two with open-ended “write-in” responses, and three where participants are encouraged to write in and list names of programs, names of institutions, and specific partnerships. To simplify the online survey distribution, we modified the two open-ended survey questions where participants were asked to list the consequences of child maltreatment and also the risk factors for child maltreatment. Rather than having participants create their own list, we provided a list of consequences and risk factors for alcohol-related harm so that participants could select all options they thought were applicable. In order to capture risk factors or consequences we had not listed, we provided an “other” category so that participants could write in their own response. We also added a response option to the survey questions asking about the data availability and quality. The four original response options included: such data exist and their quality is good; such data exist, but their quality is low or fair, or you don’t know the quality; no, Don’t know. We added an additional response option that limited data exist, but quality is good, for the two applicable survey questions.

#### Scoring of the RAP-ARH

The approach used to compute the Readiness Assessment RAP-ARH scoring closely followed the RAP-CM Short Version – Scoring system (World Health Organization, n.d.-b). As mentioned previously, this scoring measure will indicate a country’s or region’s preparedness to adopt alcohol harm prevention and policy programs. As used with the RAP-CM scoring, our approach was divided into a 10-dimension model; 1) attitudes toward alcohol-related harm prevention, 2) knowledge of alcohol-related harm prevention, 3) scientific data on alcohol-related harm prevention, 4) current programs and evaluation, 5) legislation, mandates, and policies; 6) will to address the problem, 7) institutional links and resources, 8) material resources; 9) human and technical resources, 10) informal social resources (non-institutional) (World Health Organization, 2013; World Health Organization n.d.-b).

#### Data analysis of the RAP-ARH

The RAP-CM Short Version – Scoring system was used to assess both aggregate and country-specific scoring (World Health Organization, n.d.-b). As outlined in the scoring model, responses to the survey questions were used to produce a score for each of the ten dimensions (ranging from 0 to 10). The score was determined by taking the frequency value from the survey output multiplied by 2, 1, or 0 as identified using the RAP-CM short version scoring guidelines. For any dimen-

sions that required a two-part scoring, a weighted average was taken to receive a score. Additionally, as outlined in the scoring guidelines, we also used the 2.5 multiplier, which gives each dimension a score ranging between 1 and 10. To calculate the overall aggregated readiness score (%), we summed the individual dimensions scores, creating a possible score range between 0 and 100. The dimension scores were mapped in Excel in the form of a radar chart.

A few notations in terms of the specific scoring pertaining to our survey modifications. We added a response option to two survey questions in Dimension 3, as such we adjusted the scoring by summing responses: ‘Yes, such data exist and their quality is good’ and ‘Yes, such data exist, but their quality is low or fair or you do not know the quality’ giving a score of 1. Similarly, per the scoring guidelines for Domain 2, we gave participants a score of 2 if they selected 5 or more risk factors or consequences or a score of 1 if they selected 1–4 of the options we listed, or those that they may have provided in the “other” response.

## Results

In this study, we examined the responses in aggregate ( $N = 140$ ) and disaggregated by country for the seven countries that had at least five survey responses; Sierra Leone ( $N = 33$ ); Nigeria ( $N = 32$ ); Gambia ( $N = 17$ ); Liberia ( $N = 16$ ); Ghana ( $N = 13$ ); Senegal ( $N = 12$ ); Burkina Faso ( $N = 8$ ). The overall readiness score for West Africa was 45.0% (ranging from 42.9% in Liberia to 52.7% in Senegal). The scores for each country and each domain are presented as radar charts (Fig. 1) and in a Table format (Table 1). Table 2 displays the percentage breakdown of responses for each question included in the assessment. Of the 10 dimensions (D1-D10), ranging in scores from 0 to 10, the highest score in this region pertained to D2: knowledge of alcohol-related harm prevention (8.4) and D5: legislation, mandates and policies (6.7). With respect to legislation, mandates and policies, 74.4% of participants across West Africa indicated that yes, there are governmental and non-governmental agencies officially mandated to address alcohol-related harm. However, with respect to whether an official policy that specifically address alcohol-related harm, only 56.8% of participants said yes.

In contrast, the lowest domain scores were observed for D9: Human and technical resources (2.5); D1: Attitudes toward alcohol-related harm prevention (2.7); and D6: The will to address the problem (2.9). Regarding attitudes toward alcohol-related harm prevention, about half of participants (50%) indicated that alcohol-related harm prevention was a low priority in their country, and 69.6% indicated that the measures taken so far to prevent alcohol-related harm in their country had been inadequate. Similarly, with respect to the will to address alcohol-related harm, more than half of the participants 54.5% said no to the question inquiring if there are political leaders who express strong commitment to the issue of alcohol-related harm prevention and are taking effective

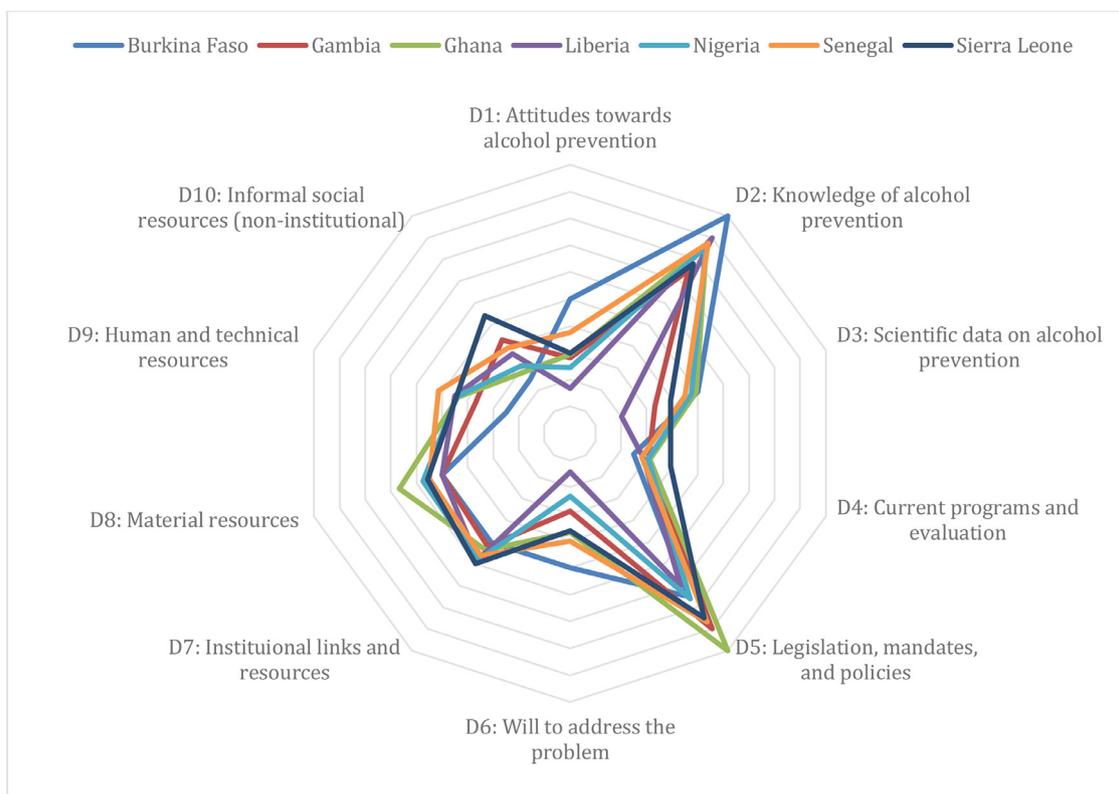


Fig. 1. Mean dimension scores from the readiness assessment for prevention of alcohol-related harm (RAP-ARH) using a 10-point scale (0–10) across 10 domains (D1–D10) in 7 countries (WAAPACAS).

measures to address the problem. Additionally, 57% indicated that communication regarding alcohol-related harm prevention had been weak in their country.

## Discussion

In this study, we sought to determine the readiness for preventing alcohol-related harm in West Africa by modifying an existing tool that has been developed by the WHO and used to assess readiness for the prevention of child maltreatment (RAP-CM) in low- and middle-income countries and communities (World Health Organization, 2013; World Health Organization n.d.-c). Our findings, based on the modified tool we refer to as the RAP-ARH, demonstrate a high perceived knowledge of alcohol-related harm and strong legislative mandates and policies across West Africa, although variations between countries were noted.

Importantly, our findings also noted weaknesses in several areas that are cause for great concern as they will hinder progress in addressing alcohol-related harm. Participants' responses indicated that human and technical resources are sorely lacking, that there is limited willingness to address the problem (alcohol-related harm), that minimal programs are available, and finally, that there is limited data. These concerns, when taken together, reflect major gaps in capacity and represent significant obstacles to progress in alcohol-related harm reduction.

A critical barrier in addressing these gaps have been the few alcohol policy reviews (Odejide, 2006) and assessments of alcohol use and related problems specifically in Sub-Saharan Africa (Obot, 2006). Previous research in related disciplines has noted the limited research output from West Africa, which may be at least partially due to limited data and limited human and technical resources (Defor, Kwamie & Agyepong, 2017; Ezeanolue et al., 2018; Sam-Agudu et al., 2016). Strengthening the research environment in West Africa should be an urgent priority as it is critically important for the prevention of alcohol-related harm

and can also improve more broadly the systems to address local public health challenges across the region.

While our tool outlines key strengths and limitations, we also need to acknowledge the limitations of our survey methodology when interpreting our findings. First, the sample size of respondents ( $N = 140$ ) may limit the generalizability of the results, and this concern may be compounded when examining findings by country. Second, some bias most likely exists in who chose to respond to the survey, since those most interested in alcohol-related programs and prevention were invited to take the survey. The WAAPA disseminated the survey to their engaged alliances and stakeholders. Accordingly, those organizations not affiliated with the alcohol policy alliances may not have been invited to participate. Moreover, the intent of the survey was to assess the capacity of stakeholders who are most familiar and engaged in alcohol-related harm prevention. As such, the approach and survey distribution did not target governments or its representatives specifically.

Despite these limitations, the findings from this survey and readiness assessment identify key themes, strengths, and limitations in the field of alcohol-related harm prevention. However, this assessment was not designed to imply precision in the findings in the region or for a specific country, but instead serve to identify broad issues for further discussion and research with the goal of strengthening the readiness for the prevention of alcohol-related harm. To our knowledge, this is the first effort to understand the readiness across domains for preventing alcohol-related harm in a low-resource setting. As a first step, it demonstrates the feasibility of a new methodological approach and the utility of a modified, easy-to-use tool in alcohol-related harm research and capacity building that may be delivered in community settings and also online as we did in this study. To our knowledge, none of the previously published RAP-CM short forms had been implemented online.

We conducted this study with the goal of modifying an existing tool to assess the readiness for the prevention of alcohol-related harm

**Table 2**  
Responses to readiness and capacity assessment for prevention of alcohol-related harm in West Africa and by country (WAAPACAS).

	West Africa(%)**	Gambia (%)	Ghana(%)	Liberia(%)	Nigeria(%)	Senegal(%)	SierraLeone (%)
Dimension 1: Attitudes towards alcohol-related harm							
How much of a priority is alcohol-related harm prevention?							
High Priority	23.7	12.5	27.3	20.0	23.3	37.5	24.2
Moderate Priority	25.4	43.8	18.2	6.7	16.7	25.0	36.4
Low Priority	50.0	43.8	54.5	73.3	60.0	37.5	36.4
Do you think that measures taken so far to prevent alcohol-related harm in your country have been adequate?							
Adequate	5.4	6.3	9.1	0	10.3	12.5	0
Neither adequate nor inadequate	25.0	31.3	27.3	20.0	13.8	25.0	34.4
Inadequate	69.6	62.5	63.6	80.0	75.9	62.5	65.6
Dimension 3: Scientific data on prevention of alcohol-related harm							
Are there data on the magnitude and distribution of alcohol use in your country? If so, how good is the quality of these data?							
Yes, limited data exist, and their quality is good	17.5	9.1	14.3	0	25.0	20.0	27.8
Yes, such data exist, and their quality is good	2.5	0	0	0	8.3	0	0
Yes, such data exist, but their quality is low or fair or you do not know the quality	46.3	54.5	85.7	42.9	50.0	40.0	22.2
No	33.8	36.4	0	57.1	16.7	40.0	50.0
Are there data on the magnitude and distribution of alcohol-related harm in your country? If so, how good is the quality of these data?							
Yes, limited data exist and their quality is good	11.7	0	16.7	0	13.6	20.0	20.0
Yes, such data exist and their quality is good	2.6	0	0	0	9.1	0	0
Yes, such data exist, but their quality is low or fair or you do not know the quality	46.8	60.0	50.0	38.5	45.5	60.0	40.0
No	39.0	40.0	33.3	61.5	31.8	20.0	40.0
Dimension 5: Legislation, mandates, and policies							
Are there any governmental or non governmental agencies officially mandated to address alcohol-related harm prevention in your country?							
Yes	74.4	100.0	100	40.0	60.9	80.0	83.3
No	25.6	0	0	60.0	39.1	20.0	16.7
Is there an official policy –or are there official policies- specifically addressing alcohol-related harm in your country?							
Yes	56.8	60.0	100	40.0	44.0	66.7	56.0
No	43.8	40.0	0	60.0	56.0	33.3	44.0
Dimension 6: Will to address the problem							
Are there political leaders who express strong commitment to the issue of alcohol-related harm and are taking effective measures to address the problem?							
Yes	23.2	18.8	30.0	14.3	24.0	20.0	25.0
Not Clear	22.2	31.3	30.0	21.4	12.0	20.0	25.0
No	54.5	50.0	40.0	64.3	64.0	60.0	50.0
How intensive have communication efforts been concerning alcohol-related harm in your country?							
Intensive	5.1	6.7	14.3	0	3.7	28.6	0
Moderate	37.8	33.3	28.6	7.1	25.9	42.9	70.4
Weak	57.1	60.0	57.1	92.9	70.4	28.6	29.6
Dimension 8: Material resources							
Does the Ministry of Health (or equivalent) in your country have a dedicated budget for alcohol-related harm prevention?							
Yes	11.5	0	33.3	0	15.8	20.0	7.7
No	88.5	100	66.7	100	84.2	80.0	92.3

(continued on next page)

Table 2 (continued)

	West Africa(%)**	Gambia (%)	Ghana(%)	Liberia(%)	Nigeria(%)	Senegal(%)	SierraLeone (%)
Are there dedicated budgets in other parts of government (e.g. other ministries, departments, etc.) in your country?							
Yes	10.2	0	33.3	0	13.6	0	14.3
No	89.8	100	66.7	100	86.4	100	85.7
Dimension 9: Human and Technical Resources							
Do you think the number of professionals specializing in alcohol-related harm is adequate for large-scale implementation of alcohol-related harm prevention							
Yes	16.1	14.3	14.3	25.0	18.5	25.0	9.1
No	83.9	85.7	85.7	75.0	81.5	75.0	90.9
How widely available are undergraduate or postgraduate educational institutions which devote some of the curriculum to alcohol related harm prevention?							
Widely available	7.5	0	0	9.1	12.5	0	8.0
Some or a few	43.8	33.3	60.0	36.4	33.3	80.0	52.0
None	48.8	66.7	40.0	54.5	54.2	20.0	40.0
Dimension 10: Informal Social Resources							
What level of citizens' participation is there typically in efforts to address various health and social problems in your country?							
High	13.2	14.3	0	7.7	12.0	28.6	16.0
Moderate	41.8	50.0	33.3	30.8	32.0	0	64.0
Low	45.1	35.7	66.7	61.5	56.0	71.4	20.0
How good at getting things done through their joint efforts are the people living in your country?							
Good	26.1	35.7	20.0	30.8	16.0	40.0	28.0
Moderate	40.9	21.4	40.0	38.5	36.0	20.0	64.0
Poor	33.0	42.9	40.0	30.8	48.0	40.0	8.0

\*Note that Dimensions 2, 4, 7 were not asked as categorical response questions and are presented in separate charts.

\*\*Overall numbers represent all participants including those with countries with small cell sizes not presented in the table.

in West Africa, a region with high burden of alcohol-related harm, scarce research, and weak alcohol policies. Recent research has reported that most of the countries in West Africa, 16 out of 19, have specifically raised prices on alcohol through excise taxes and pricing policies (Morojele et al., 2021) which clearly has strengthened the alcohol policy environment. However, the West African region appears to have implemented fewer of the WHO SAFER priorities, such as strengthening restrictions on alcohol availability, advancing and enforcing drink driving countermeasures, enforcing bans or adding comprehensive restrictions on alcohol advertising, sponsorship and promotions (Morojele et al., 2021) as recommended by the WHO (World Health Organization, 2018b). As such, there are clear opportunities to strengthen policies and to address alcohol-related harm in the region. Our tool and findings add context for the specific strategies and next steps in the prevention of alcohol-related harm in West Africa, which in turn can support the WHO SAFER priorities.

To conclude, we find that this modified tool (RAP-ARH) has been helpful in identifying the domains most in need of attention by stakeholders to make progress in the prevention of alcohol-related harm in a region that has been understudied, but that bears a very high burden of alcohol-related harm (Morojele et al., 2021). Our readiness assessment for the prevention of alcohol-related harm outlines clear priorities for next steps to determine the best strategies for building capacity within West Africa and to mitigate the harm caused by alcohol. Moreover, the findings point to the urgent attention needed to focus on developing human and technical resources, shifting attitudes towards

the prevention of alcohol-related harm, and strengthen the willingness to address alcohol-related harm as these domains scored the lowest in terms of readiness in the region and will serve as significant obstacles for progress.

#### Declarations of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

#### Ethical principles

The authors have no conflicts of interest to disclose. The material has not been published in whole or in part elsewhere. The paper is not currently being considered for publication elsewhere. All authors have been personally and actively involved in substantive work leading to the report, and will hold themselves jointly and individually responsible for its content. All relevant ethical safeguards have been met in relation to patient or subject protection. The research has complied with the World Medical Association Declaration of Helsinki.

#### Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.drugpo.2022.103650.

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