

Perspectives of alcohol treatment providers and users on alcohol addiction and its
facilitating factors in Uganda and Belgium

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Abstract

Background: Although conceptualisation of addiction varies with time and culture, literature on intercultural studies between the high and low income countries is scarce. This article uses DSM-5 guidelines on diagnosis of AUD and the COM-B model to explore perspectives on alcohol addiction and its facilitating factors in Uganda and Belgium.

Method: Sixty qualitative interviews (40 with service providers and 20 service users) were administered in four alcohol treatment centres, two in Uganda and two in Belgium.

Interviews were transcribed and analysed thematically using Nvivo software.

Results: While addiction was regarded as a disease enabled by capability factors (affordability and absence of life and social skills) by Belgian respondents, many Ugandans viewed it as a moral or criminal issue; motivated by the varied roles of informal alcohol use amidst weak restrictions. Opportunity-related factors including, acceptability, availability, media influence, cultural/religious beliefs and practices and peer influence were recognised as alcohol addiction facilitating factors in both countries where stigma was equally prevalent.

Recommendations: Interventions in Uganda could explore strengthening legislation and research on utilisation of the well-entrenched religious and cultural institutions to encourage alternatives to alcohol use. In Belgium, promotion of life and social skills, alcohol regulation in educational institutions and other demand reduction strategies seem essential to delay the onset of abuse. In both societies; general reduction of opportunities for access, early intervention, programs for young persons and prevention of stigma through awareness-raising can be explored for mitigation of AUD.

Introduction

The multidimensional nature of addiction

According to Lewis (2015), the concept of addiction has been a battleground of opinions since the time of Aristotle. Perspectives on addiction are culturally dependent and vary by time and space (Egerer, 2013). Hence, an unequivocal definition of addiction is missing (Sulkunen, 2015). Although the use of the term addiction is criticised for individualising problem behaviour and putting treatment before prevention (Sulkunen & Warsell, 2012), its importance in explaining motivation, relapse cues, and behavioural and psychological aspects of dependence cannot be ignored (Sulkunen, 2015). Biological, moral, psychological and sociological theories have been used to explain addiction problems and respond to it, and its scope continues to expand (Lewis, 2015). Interpretations of these theories range from commonly referring to addiction as a condition of being abnormally (compulsively) dependent on some habit/substance (www.thefreedictionary.com) to complex definitions identifying it as a primary chronic disease of brain reward, motivation, memory and related circuitry (Lewis, 2015).

In his systematic review of addiction theories, West (2013) identified over ten groups of models that focus on individual mechanisms underlying addiction, each one addressing just a part of the problem. Besides these individual-focused models, West categorised social network, economic, communication and organisational system theories to describe addiction in terms of an interplay between population-level parameters. From these diverse perspectives on addiction, he concluded that a common perception of a “repeated, powerful motivation to engage in an activity with no survival value, acquired through experience with that activity, despite the harm or risk it causes” (West, 2013, p. 27) stands out.

The COM-B model

Since efforts to find a common definition of addiction stir more controversy than consensus, Sulkunen & Warsell (2012) recommended to tailor interventions around prevailing societal perceptions. A salient feature of current models and theories of addiction is that they are primarily based upon American and European studies (West, 2013), which raises questions regarding their generalizability to other cultures (Chen & Nath 2016). A cross-cultural approach is warranted to understand addiction in non-western countries. West (2013) has suggested the use of the COM-B (Capability, Motivation, Opportunity – Behaviour) model as a potential strategy for understanding mechanisms preceding addiction. According to Michie, Stralen & West (2011), capability, motivation and opportunity are necessary ingredients for any behaviour. Based on the COM-B model, alcohol addiction develops through interactions of these three behavioural factors. Capabilities are innate psychological and physical endowments possessed by individuals, including mental, motor and anatomy skills and facilities required to use alcohol or to resist impulses to drink. Opportunities are social and physical environmental factors that permit or promote alcohol use. Motivation factors describe ‘reflective’ and ‘automatic’ mental processes that energise and direct behaviour processes that promote addiction and recovery. Although the COM-B model offers a framework for developing behaviour change initiatives, it does not describe features and symptoms of addiction in specific terms. Consequently, another framework is necessary to understand manifest symptoms of addiction.

Classification of addiction problems

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) mentions the common usage of the term addiction

“in many countries to describe severe problems related to compulsive and habitual use of substances” (American Psychiatric Association, 2013, p. 519). However, APA prefers to use the term ‘substance use disorder’ for its neutrality and propensity to describe a wide range of features of the disorder; from a mild form to a severe state of chronically relapsing, compulsive substance use. Accordingly, Alcohol Use Disorder (AUD) are considered a cluster of cognitive, behavioural, and physiological symptoms, indicating that the individual continues using alcohol despite significant alcohol-related problems. More specifically, features of AUD include 1) impaired control (use of larger amounts or over a longer period than intended, desire to regulate use, spending a great deal of time obtaining alcohol, craving), 2) social impairment (failure to fulfil obligations, continued use despite social/interpersonal problems), 3) risky use (use in physically hazardous situations, persistent physical and/or psychological problems caused by failure to abstain from alcohol, and continued use despite the difficulties it is causing), and 4) pharmacological criteria (tolerance and withdrawal). The threshold for AUD is established to at least two of any features, occurring at any time in the same 12-month period. In this paper, we will use the term ‘AUD’ to indicate a range of problematic forms of alcohol use, while the word ‘addiction’ shall be used to describe extreme presentations of the disorder.

Intercultural studies on (alcohol) addiction

Considering the growing evidence regarding the importance of cultural sensitivity towards predicting treatment process and outcomes (Russell, Davies & Hunter, 2011; Egerer, 2013; Chen & Nath, 2016; Koski-Jännes, Pennonen, & Simmat-Durand, 2016) and the general lack of research in this area (Holma et al., 2011; Fraser, 2016), this study aims at highlighting emic views on alcohol addiction among individuals involved in

alcohol treatment in Uganda and Belgium. Intercultural studies on the intersection between addictive and non-addictive behaviours are important to improve insights on effective prevention and diagnostic/therapeutic strategies and to enhance information exchange on best practices in a world characterized by constant migration, in which addiction has become a global phenomenon (Chen & Nath, 2016).

In this study, two diverse socio-economic contexts are used as case studies to explore similarities and dissimilarities in factors facilitating alcohol addiction. Uganda is an East-African country with a mean age of 15.7 years (Central Intelligence Agency (CIA), 2017), numerous ethnic groups (43 different languages), and a GDP of \$672.81/capita, of which 75% is jointly contributed by the agricultural and service sectors (World Bank, 2017). Uganda is recovering from decades of post-colonial internal conflicts and facing high rates of illiteracy (29%) (Uganda Bureau of Statistics (UBOS), 2010) and disease burden (e.g., the prevalence of HIV/AIDS and malaria is 7.3 and 36.2%, respectively (Uganda AIDS Commission, 2016; Population Secretariat & UNFPA, 2012).

Belgium is a Western-European industrial country with a mean age of 41.4 years and an estimated GDP of \$44,900/capita. The country consists of two major ethnic categories (Flemish (58%) and Walloon (31%)), while 11% is considered to be of 'mixed' or another ethnicity. The country has three official languages (French, Dutch and German) and hosts the European Union headquarters. Belgium is confronted with a rapidly growing multicultural population and faces high youth unemployment rates (23%). The country has a high urban population rate (97%) and the northern part (Flanders) is one of the most densely populated regions in the world (CIA, 2017).

Both Uganda and Belgium are faced with considerable alcohol problems that are associated with high levels of per capita alcohol consumption (9.8 litres in Uganda, 11 litres in Belgium) (World Health Organization (WHO), 2014). Underage drinking is an increasing concern in both countries (Centre de Recherche et d'Information des Consommateurs (CROIC), 2011; Swahn, Palmier & Kasirye, 2013; WHO, 2014). It is estimated that 9.8% of the Ugandan population suffers from Alcohol Use Disorders (AUD) (Kabwama et al., 2016), but despite Uganda's high alcohol-related burden (Graham et al., 2011) research on AUD is almost non-existent and treatment is new and limited to the capital city (Kalema, Vindevogel, Derluyn, Baguma & Vanderplasschen, 2015). Moreover, Uganda lacks a National Alcohol Policy (NAP) (WHO, 2014) and uses an alcohol law (Enguli Act, 1965) which was drafted by the British colonists on the eve of the country's independence. On the other hand, Belgium has a NAP and a long treatment tradition, dating back to the 1960s. Substantial research is available on alcohol abuse and related problems (Vanderplasschen, De Bourdeaudhuij & Van Oost, 2002). Despite several residential and community-based treatment services for persons with AUD and extensive prevention and early intervention efforts (Plettinckx, 2014), heavy episodic drinking (drinking \geq 60 gram of pure alcohol on at least one occasion in the past seven days) among the general (34.3%) and youth population (38%) (WHO, 2011; Hibell et al., 2012) is an important public health concern in Belgium.

Several studies report similar facilitating factors for alcohol addiction in Africa and Western countries, often associating problem drinking with wide availability of alcohol, underage use, and drinking to intoxication (Tumwesigye, 2003; Hibell et al., 2012; Egerer, 2013; & Muhwezi, 2014; WHO, 2014; Gual et al., 2016; Dumbili, 2017). However, explanations of addiction based on biological vulnerability (Egerer, 2013; et

al., 2016; Klingemann, Klingemann, & Moskalewicz, 2017) are more profoundly documented in Western countries, while African studies commonly report on the association of addiction with moral and spiritual choices and influences (Odejide, Oheri, Adelekan, & Ikuesan, 1992; Tumwesigye, 2003).

The expansion of addiction knowledge in low-income countries offers a learning opportunity for policy makers, practitioners and researchers, but is challenged by limited mental health and addiction research in these countries (Razzouk et al., 2010) and lack of collaboration with high income countries. Some recent studies (e.g., Holma et al., 2011; Russell, Davies, & Hunter, 2011; Egerer, 2013; Fraser, 2015; Chen & Nath, 2016; Koski-Jannes et al., 2016) have addressed inter-nation and inter-culture differences, but like most previous explorations, these studies are confined to comparisons among high-income countries and only Chen and Nath (2016) refer to low-income countries. Moreover, none of these studies purposefully explored the opinions of service users themselves, although they are crucial beneficiaries of alcohol policies and treatment interventions. Also, apart from the studies by Fraser and Egerer, the above-mentioned studies are based on perspectives among the general population and use a quantitative design. This information needs to be complemented by in-depth understanding of the factors associated with addiction, as perceived by service users and treatment providers who are confronted with these problems daily (Koski-Jannes et al., 2016).

Aims of the study

Application of models that were generated elsewhere and transferred to other cultural settings have often led to misguided, erroneous and conflicting results (Chen & Nath, 2016). This, this study is hence intended to contribute knowledge towards possible

prevention and treatment measures of AUDs for specific contexts. Since treatment providers and service users are crucial stakeholders in alcohol treatment, this paper applies a qualitative approach to highlight their perceptions of addiction across two different countries/cultures. This study aims at highlighting the conceptualisation in similarities and dissimilarities of alcohol addiction and its facilitating factors in Uganda and Belgium. To achieve this, the COM-B model was selected for its ability to accommodate a wide range of theoretical approaches through which the initial presentation and eventual development of addiction in a particular society can be understood (West, 2013). Since the COM-B model is a general behavioural model, conceptualisation of AUD in the DSM-5 was used to appraise perspectives on the symptomatic presentation of alcohol addiction problems in both societies.

Methods

Respondents

This paper is based on 60 in-depth qualitative interviews that were administered among AUD treatment service users and treatment providers in four AUD treatment centres in Uganda and Belgium (see table 1). Selected treatment providers are persons closely involved in service users' therapeutic processes, such as counsellors, psychologists, medical staff and social workers (Koski-Jannes et al., 2016) and one administrator/program co-ordinator in each centre, to understand the treatment philosophy and background of the participating organisations. Only staff members who had worked for at least one year in the service were eligible for participation. Inclusion criteria for service users were: a) been diagnosed with alcohol dependence as primary substance of abuse; b) been in treatment for at least two months; and c) being in a stable psychological and physical state at the time of the interview. Administrators of the programs selected the respondents, based on these eligibility criteria. To represent the multidisciplinary composition of the treatment staff in the selected services, a greater number of treatment providers was selected than the number of service users.

Using purposive sampling, 40 AUD treatment providers and 20 service users were recruited from two alcohol treatment centres in Kampala (Uganda) and two services near Ghent (Belgium). The four selected centres differ in terms of type of facilities, program, nature of clients and staff. They all apply a bio-psycho-social treatment model with varying intensity, but offer comparable long-term residential treatment programs during one to three months. In Uganda, the study sites were the national psychiatric hospital, consisting of a 25-bed alcohol and drug treatment ward, and a small-scale non-governmental organisation with a bed capacity of 15 clients. In Belgium, respondents were recruited at alcohol treatment units in two psychiatric hospitals, with a bed capacity

of 30 and 50 persons respectively. Fifteen respondents (ten treatment providers and five service users) were interviewed at each site. Overall, 41 (68%) male respondents and 19 (32%) female respondents were recruited. Interviewed service providers (25men and 15 females) had varied professional background: 12 were nurses, nine psychologists, eight counsellors, four social workers, two pastoral workers, two psychiatric clinical officers, two psychiatrists and one physiotherapist. Service users were four females (all from Belgium), and 16 males. Apart from five Ugandan respondents who were students in higher education, the other participating service users (15) were university/college graduates (see Table 1). Major disparities were observed among and between users and providers of alcohol treatment in both countries. For example, Ugandan service providers were on average 36.2 years and had 5 years of work experience in alcohol treatment, while Belgian service providers were older (52 years on average) and more experienced (8.7 years of work experience). The Ugandan sample of service users had a mean age of 24.5 years and had been dependent on alcohol for – on average – six years, while participating services users in Belgium had a mean age of 37.5 years and were dependent on alcohol for 20.3 years.

Although this sample is too small to adequately represent the characteristics of service users in both countries, some limitations should be noted. In the Ugandan sample, the absence of female service users is attributable to the low participation rate (<10%) of women in alcohol treatment. Also, the high number of school-going respondents may not surprise, given the young average age of the population (UBOS, 2014). The overrepresentation of highly educated alcohol users depicts an affluent group that can afford treatment.

Data collection

Data were collected using open-ended interviews that generally lasted 60 to 90 minutes. Interviews were administered in the participating treatment facilities. The interview guide was piloted among seven persons (five treatment providers and two service users) in the two countries. Feedback was incorporated in the final draft of the interview schedule that was, along with the research protocol, approved by the ethical board of the two supervising universities (blinded) and the Ugandan National Council of Science and Technology. Participants did not receive any incentive for participation in the study. Identified respondents were informed about the study and its ethical implications, offered written informed consent to which they kept a copy and with their permission, interviews were recorded with an audio device. To mitigate interviewer bias due to proximity to the own culture, the interviews in Belgium were conducted by the first author (Ugandan nationality), while those in Uganda were administered by a Belgian female master student in special needs education. Respondents had the option to be interviewed in English or their local language; all respondents agreed to be interviewed in English.

Data Analysis

Collected data were analysed using thematic analysis methodology. Thematic analysis was chosen as it enables scrutiny of conceptual similarities and discovery of patterns of themes, which are frequently talked about by respondents (Braun & Clarke, 2006). Themes were inductively generated around the research questions, i.e. perceptions towards alcohol use, alcohol addiction and its facilitating factors. All interviews were transcribed verbatim by members of the research team, including Ugandan and Belgian research assistants. The first author then read all the transcriptions to familiarise himself

with the collected data and noted down initial ideas and patterns. These ideas formed the initial codes that were clustered, based on patterns emerging from the data using NVivo 11 computer software. Repeated patterns as seen by similarities in meaning and implications were then grouped to form themes. These were presented to the research team that discussed, defined and, where necessary, (re)named the themes (see table 2). Finally, the codings on perceptions regarding alcohol use were merged with codings regarding facilitating factors due to the observed close relation between the two topics (see figure 1). The COM-B model was then used to identify ((dis)similar and distinct) facilitating factors of alcohol addiction among respondents from both countries (see figure 2). According to West (2013), the COM-B model provides one potentially helpful way for generating a high-level analysis of ongoing behaviour patterns, as well as a way for deducing the changes required to alter these patterns. It can be applied at the level of populations, subpopulations, social groups and individuals. Perspectives on the conceptualisation of AUD were assessed against the DSM-5 symptoms of AUD (see figure 3), which was chosen because of its wide use in clinical and educational settings in Belgium as well as Uganda. To strengthen the reliability and validity of the study findings, the results were discussed by all members of the research panel (co-authors) and with some staff members at each study site.

Results

Respondents' perceptions on facilitating factors for alcohol addiction indicate that all three components of the COM-B model are present, but vary in manifestation between Uganda and Belgium. While aspects of affordability (mainly in Belgium) and alcohol use for medical reasons (Uganda) feature capability and motivation factors respectively, opportunity-related factors were frequently mentioned in both countries, including acceptability, availability, media influence, cultural/religious beliefs and practices, peer influence and lack of restrictions. As in the DSM-5, respondents associated alcohol addiction with the frequency and volumes consumed and related negative consequences. Stigma against people with AUD was noted in both societies, despite different conceptualisations of alcohol addiction.

Similarities in perspectives on facilitating factors for alcohol addiction in Uganda and Belgium

Capability-related factors: In both countries, alcohol addiction was associated with drinking due to failure in utilising alternative stress management strategies in an environment where alcohol is increasingly affordable. A Belgian nurse stated: "We can afford everything. Now everybody has wine in his home, but 30, 40, 50 years ago, only the rich ... drank wine." A similar example was given by a Ugandan student who attributed affordability to cheap, sachet-packed alcoholic beverages that are widely available in Uganda.

"I had to substitute from Uganda waragi [a spirit brand] to much cheaper [alcohol] ... Now, all this alcohol is a 1/5 of a dollar. It was so easy to keep the sachets and put it in your pocket. So, I would pick up four and put them in my pocket with about two cigarettes, take a walk, and drink ... So, by the

time I get home, I was already drunk. I always park up and walk away.”

(User, Uganda).

Responses from both countries showed that not knowing how to cope with stressful situations fuelled addictive behaviours. All service users mentioned stressful events and situations as triggers for their heavy drinking. For one participant, her divorce triggered excessive alcohol use: “The real problem started after my divorce ... I had serious problems at work with concentration and stress. ... I used alcohol as medicine to keep calm. Gradually, it took over and I lost control completely” (User, Belgium). Similarly, a Ugandan teenage user associated the onset of his addiction to the death of his parents: “I lost both of my parents. I lost my dad in 2007, when I was 15. And I lost my mum, beginning of 2008. So, I couldn’t handle it”.

Opportunity-related factors: Respondents narrated that stressful life events would not be a major reason for alcohol use, if it was not for the abundant opportunities that come in the form of wide availability and accessibility, promoted by peers and media influence. Generally, alcohol is reportedly entrenched in the day to day lives of people, extensively used for social functions and considered a ‘normal drink’. One counsellor from Uganda explained that alcohol has hospitality functions and visitors are served alcohol ‘like a cup of tea’. “Everybody drinks ... Not everyone drinks a lot of alcohol, but at parties there is always alcohol, you can buy it in every shop” narrated a Belgian psychologist. “You have a lot of products” added a Belgian nurse. Peer influence was equally reported by respondents from both countries. Users gave examples where friends would take them regularly for ‘boozing episodes’ and laughed at them whenever they refused such offers: “If you don’t have money, we buy for you”, or “I will wait for you”. These

sentiments were expressed by Ugandan service users, adding that their peers also gave them advice on cheaper liquor brands whenever they lacked money.

Motivation-related factors: The above-mentioned factors reinforce the existing pro-alcohol culture in both countries by minimising the perception of danger and influence the motivation of users, along with pain relieving expectations. Service users as well as providers observed an overall low societal risk perception towards the harmful effects of alcohol in Belgium and Uganda: *“A lot of people don’t think that alcohol can be dangerous and they say ‘oh it’s fun and it’s nice to drink a bit’... And it is nice, but... they don’t always see what could go wrong”* stated a Belgian psychologist. Also, the notion that alcohol abuse functioned as coping mechanism was stressed by several professionals, as evident from the following quotation:

“Then you look at the economic stress and alcohol alternatives. How do people deal with stress? It [alcohol] is an alternative way of coping with stress. They do not have any alternatives to deal with the stress. It is indeed therapy for them. So how do they adjust without anything?” (Psychologist, Uganda).

Dissimilarities in perspectives on facilitating factors for alcohol addiction in Uganda and Belgium

Some dissimilarities were noticeable at the level of capability and opportunity factors. Belgium respondents considered a combination of underdeveloped personal skills (such as low self-esteem and relational skills) and need for conformity as common facilitating

factors for alcohol addiction. A Belgian service user explained how his alcohol consumption was triggered by the need to behave in a more extravert way.

“I used to be very shy, ... never answer any questions in group. But once... two girlfriends came to my studio and we opened a bottle of wine, and immediately I felt the fear was gone. I went to the lessons I didn't do before. There was some wine leftover, which I drank the next day at noon and studying in the evening was easier. It was like comfort to read in my courses. So, all the tension I was feeling reduced with one glass at noon and one glass in the evening’ (User, Belgium)

The majority of Ugandan respondents regarded the easy accessibility as the main facilitating reason for alcohol addiction. Although accessibility was repeatedly mentioned as a cause of alcohol addiction, it is manifested differently in the two cultural settings. Accessibility in Uganda is enabled by the presence of alcohol factories in the community, omnipresence of alcohol in the form of sachets, homemade alcohol (with high alcohol volumes as high as 60%) and further compounded by the absence of restrictions. In Belgium, alcohol is easily accessible, which – in combination with the low threshold for sale to minors (16 years) – can promote the early onset of alcohol use. Cultural practices and religious beliefs that promote alcohol use were frequently observed in Uganda, such as children’s introduction to alcohol at a tender age and the glorification of alcohol use by (especially) male members of society. Some Ugandan respondents further reported that alcohol is at times used as medicine.

From participants’ responses, it can be noted that the line between facilitating factors for alcohol use and addiction is thin and ambiguous. Respondents’ reports on facilitating factors in both societies were similar on many occasions, but differed in emphasis on

specific aspects. The interplay between culture, media, underage use and peer influence was commonly cited by respondents from Belgium and Uganda. While informal production and use of alcohol for medical purposes, religious and customary functions was overemphasised in Uganda, lack of life skills and conformity related factors were more pronounced among Belgian respondents.

Perspectives on the conceptualisation of alcohol addiction in Uganda and Belgium

Respondents from both countries described alcohol addiction as ‘dependence’ and listed a combination of interrelated factors, such as the frequency of use/daily drinking, volumes consumed, preoccupation with the substance and related negative consequences. Alcohol-related negative consequences such as reduced socio-economic functioning and preoccupation with alcohol use were mentioned as typical characteristics of addiction by both Ugandan and Belgian respondents. Several respondents stated that treatment is regarded to be for the most severe cases only. *“They [society] think you have to be a drunk lying on the street to come here. When they think about our place, they think of the worst possible scenarios”*, stated a psychologist in a Belgian hospital. This perception is also illustrated by the following quotation of a Belgian service user:

“I was brought ... because I had some problems with my stomach and the liver due to excessive use of alcohol. At this point, you realize that your life becomes one big lie. You are lying to yourself, to your children, your family, your lawyer. You start to invent things. Generally, let’s say that alcohol is the main issue in your life and all the rest becomes less important.” (User, Belgium)

As far as volumes are concerned, respondents mentioned that although dependence is illustrated by the high quantities consumed, it is the potency of alcohol that matters most. Consequently, users in both countries reported switching to cheaper spirits, regardless of the brand. To avail highly potent alcohol in the needed frequency, Ugandan service users reported that they manipulate alcohol to make it stronger or make their own alcohol to quench the craving in face of depleted financial resources. One service user testified: *“I mix Bond 7 with hot water such that it speeds up very fast the brain”*.

Regarding the views on persons with alcohol addiction, respondents from both countries agreed that problem users are often blamed for being weak and are seen as a shame. *“Stigmatization of addiction is common due to its association with and the location of alcohol treatment in psychiatry”* said a Belgian nurse. Most of the Belgian respondents emphasized that addiction is an inheritable, and incurable disease of the brain. A Belgian user narrated: *“Both of my grandparents are alcoholics and my father is the only child, but my mother has two brothers and one sister. One brother is misusing alcohol and the other is an alcoholic who stopped”*. The view of alcoholism as a disease was also expressed by medical professionals in Uganda. However, other Ugandan participants associated addiction with lower social class and linked it to social ‘evil’ such as crime and spread of diseases, as expressed by a service user:

“We are like social rejects. When people know that you either drink or smoke weed ... they, ... think it made you crazy. They can't easily trust you with anything. You can't fit into society, freely. ... Most people perceive us as criminals...They also believe that drug and alcohol abusers are the major causes of HIV”. (User, Uganda)

Another Ugandan service user emphasized similar societal judgments by explaining that most people perceive persons with addiction problems as individuals who get involved in crimes such as theft and rape.

In a nutshell, respondents from both countries associated addiction to deterioration in a person's physical, social and emotional life and stated that addiction is associated with stigma by the society. Perspectives of Ugandan respondents differed from these of Belgian respondents as they rather emphasized spiritual and moral factors in relation to addiction, while their Belgian counterparts associated addiction with inheritable and disease aspects.

Discussion

Inspired by the varying conceptualisations of addiction across cultures, this study explored the perspectives of Ugandan and Belgian alcohol treatment providers and service users towards addiction and its facilitating factors in both countries. Addiction is explained by a variety of interconnected socio-economic features. Overall, wide availability and absence of restrictions (Uganda) and affordability and insufficient coping skills in adversity (Belgium) stand out as major facilitators of alcohol addiction in the respective countries. The role of social and cultural habits, promotional activities by the alcohol industry, early exposure to alcohol, peer influence and social/economic hardship was acknowledged in both societies. While many Ugandan respondents viewed addiction as a moral or criminal issue, most of their Belgian counterparts explained it as a disease.

The similarities found in respondents' perceptions of facilitating factors for alcohol addiction mirror the description by Michie, Stralen & West (2011) of opportunity and motivational factors, but these are manifested in varying ways in the two contexts. As reported earlier by Tumwesigye (2003) and Hibell and colleagues (2012), alcohol is considered as a usual drink in both societies and is imbedded in social and cultural traditions. According to Rantala and Sulkunen (2012), addictive behaviours develop from culturally defined and regulated pleasures. Cultural norms and functions determine acceptability of alcohol and range from total abstinence over ritual consumption to use for personal pleasure and conviviality (Sulkunen, 2015). According to Rukundo, Kibanja, & Steffens (2017) alcohol industry creates a 'non-addictive and relatively harmless alcohol impression'. Consequently, perspectives of alcohol as an ordinary drink and medicine raise concerns, since epidemiologists point at alcohol as one of the

major causes of the global burden of disease, disability and death in high as well as low-income countries (Babor, et al., 2010).

Michie and colleagues (2011) and Surujlal and Keyser (2014) explained that behaviour is motivated by the anticipation of pleasure or satisfaction and relief from craving. The general pro-drinking culture ignites automatic motivational cues (conditioned by drives, emotions and habits) and biases reflective processes (e.g. conscious cost-benefit analysis (Heyman, 2009; Petraitis et al., 1995), there by escalating use and hampering recovery from alcohol addiction. Since addiction is related to repeated association, reinforcement, and modelling (Caprara, Regalia, & Bandura, 2002; Giovazolias & Themeli, 2014) media images glamorising alcohol and associating it with modernity and fun (Sznitman & Romer, 2014) seem to fuel AUDs in both Uganda and Belgium. Many Ugandans also testified to consume alcohol as a kind of self-medication to cope with psychological pain, which was recently reported by the WHO (2013).

In terms of differences in perspectives, primarily opportunities (high availability and absence of restrictions) and capabilities (affordability and lack of coping skills in case of adverse events) appear to facilitate addiction in Uganda and Belgium, respectively. Most Ugandan respondents cited external influences such as the abundant supply of highly toxic products and absence of alcohol regulation as main facilitating factors (see also Dumbili, 2014; WHO, 2014; Rukundo, Kibanja, & Steffens, 2017). On the other hand, Belgian respondents emphasized affordability (CROIC, 2011) and internal factors. Alcohol is used to boost personal confidence and relational skills (Niemz, Griffiths, & Banyard, 2005; Chen & Nath, 2016; Perkins).

Differences in perspectives between both societies become clearer when respondents were asked about the conceptualisation of the term ‘alcohol addiction’ in each country. Unlike Belgians respondents, several Ugandan participants mentioned religion as a key factor in alcoholism, confirming earlier studies in Africa that related mental health to spiritual, supernatural or moral forces (Odejide et. al., 1992; WHO, 2013). This may not surprise, since religion plays a significant role in shaping day-to-day events in Sub-Saharan countries (Lunn, 2009). Moreover, the entire Ugandan population affiliates to religions (Uganda Religion Stats, 2014). Moralising and criminalising addiction may hamper the role of professional treatment and promote stigma and discrimination. The predominance of a disease perspective among Belgian respondents has as well been reported in similar studies in Western European countries like France (Egerer, 2013), Spain (Gual et al., 2016) and Poland (Klingemann, Klingemann, & Moskalewicz, 2017). Ugandan respondents with a medical background (e.g. psychiatrists) expressed similar perspectives, which can as well be attributed to the educational curriculum in western societies. However, although the conceptualisation of addiction as a disease is widespread, it can be criticized for placing responsibility on the individual and for its controversial incurable claims, hence stigmatizing millions of people and denting hope for full recovery (Gual et al., 2016; Klingemann, et. al).

A common understanding of aspects that are considered useful to mental health is a step towards agreeable interventions (Sweeney et. al, 2015). In this study, like in previous studies by Redfield & Brodie (2002) and Holma and colleagues (2011), people with addiction problems are depicted as consuming high volumes of alcohol, accompanied by negative social-economic consequences. These characteristics resonate well with the symptoms of alcohol use disorder (AUD) as classified in the DSM-5 . However, associating addiction only with severe negative consequences is likely to inhibit the

detection of early problematic use that is characterised by impaired cognitive control, impulsivity, and high reward sensitivity (Iacono, Malone, & McGue, 2008).

A combination of interventions to reduce opportunities and motivational factors and to enhance resistance capabilities for alcohol use can be explored to prevent alcohol addiction in Uganda and Belgium. Enhancement of young people's capabilities for peer resistance and increasing their stress management skills are global concerns (Rukundo, Kibanja, & Steffens, 2017).

Regarding opportunities, the strong peer influence as evident from the study findings along with the rampant availability of alcohol including areas in and around educational institutions calls for school/college-based interventions in both societies (Suneel, 2015; Urwin & McNaney, 2015). The legal drinking age in Uganda and Belgium is 18 and 16 years respectively, but all service users started to drink long before that age indicating persistence in underage drinking concerns. Consequently, the enactment of protective policies is needed to restrict opportunities of alcohol production and consumption, which is expected to protect many individuals from starting use (Babor, et al., West, 2013). In Uganda, further studies analysing the impact of cultural and spiritual beliefs on treatment programs and stigma among service users are necessary, since culture, religion and spirituality are regarded to be strong influences on the addiction process (Tumwesigye, 2013; Kalema, Vanderplassen, Vindevogel & Derluyn, 2016).

As far as Motivation based interventions are concerned, several respondents associated alcohol addiction with emotional distress (Rukundo, Kibanja, & Steffens, 2017), which argues for measures to protect young people against extreme socio-economic pressures and offering various sources of relief to complement the traditional psychosocial/recreational support (Heyman, 2009). Also, engaging people in

meaningful economic activities may reduce their motivation towards alcohol use. In Belgium; measures regarding price control can be explored for demand reduction strategy, given its ability to protect vulnerable populations from alcohol ab(use) and to decrease underage drinking.

To mitigate the stigma and other limitations of the disease model, more research is needed on management of treatment so as to respond to users' unique needs, (Iacono, Malone, & McGue, 2008; Fraser, 2016), while paying attention to emerging intermediate positions that see addiction as a societal problem (Kalema, Vanderplasschen, Vindevogel, Derluyn, & Baguma, 2017; Klingemann, Klingemann, & Moskalewicz, 2017). Manipulating alcoholic beverages or making own alcohol is a central feature of alcohol misuse in Uganda and can be adapted as one of the core characteristics of AUD upon treatment entry.

Limitations of the study

Although this is a paper on a cross-cultural study, referencing is biased towards literature from high-income countries given its wider prevalence, while literature from low-income countries is scanty. The study sample was limited to four residential treatment facilities, excluding outpatient and other community-based services with other treatment philosophies. As only 20 (highly educated) service users were interviewed, the range of perspectives and experiences among service users was limited. Socio-demographic differences can account for the disparity in views of respondents from the two countries. Likewise, understanding of concepts relating to alcohol use' differs between the two countries due to divergence in the way alcohol units are measured. Moreover, variations noted in this study could reflect policies, media representations and institutional

traditions, and not necessarily societal views. Finally, the fact that respondents were selected by the management of the participating facilities and did not answer the interview questions in their native language to an external interviewer, may have caused socially desirable answers and missing of useful information. Yet, all interviews were administered in separate rooms and confidentiality was assured to all respondents. It is recommended to include a more diverse sample in future studies, since no female users from Uganda nor users from lower socio-economic classes were included in this study.

Conclusion

While Belgian respondents regarded alcohol addiction as a disease facilitated by capability-related factors, Ugandan participants rather attributed it to motivational aspects and associated addiction with moral breakdown. Respondents from both countries emphasized repeatedly the role of available opportunities to access alcohol. Respondents in both countries associated AUD with excessive use and negative alcohol-related consequences, while the aspect of manipulating and manufacturing alcohol was unique to the Ugandan context. Based on this study, interventions in Uganda could explore possibilities for strengthening regulation and utilisation of well-established and highly influential religious and cultural institutions to reduce access to alcohol. In Belgium, human development approaches such as life and social skills training programs seem necessary to further prevent and delay the onset of AUD. In both societies, awareness raising, early intervention, programs for children and adolescents and alcohol regulation in educational institutions are essential components for the prevention of addiction. Ultimately, more cross-cultural research is necessary on the implications of addiction perspectives on treatment and recovery opportunities in high- and low-income societies.

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Declaration of interest

David Kalema works with an alcohol and drugs rehabilitation centre in Kampala, Uganda. Others have no interest. The authors alone are responsible for the content and writing of the paper.

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Table 1: Characteristics of the study respondents

	Uganda		Belgium		Overall
	Providers n (%)	Users n (%)	Providers n (%)	Users n (%)	
Sex					
Male	13 (21%)	10 (17%)	12 (20%)	6 (10%)	41 (68%)
Females	7 (12%)	0 (0%)	8 (13%)	4 (7%)	19 (32%)
Age Range					
Below 20	0 (0%)	2 (3%)	0 (0%)	0 (0%)	2 (3%)
21 - 30	6 (10%)	4 (7%)	3 (5%)	0 (0%)	13 (2%)
31 – 40	7 (12%)	3 (5%)	6 (10%)	4 (7%)	20 (33%)
41 – 50	7 (12%)	1 (2%)	6 (10%)	4 (7%)	18 (30%)
51 - 60	0 (0%)	0 (0%)	5 (8%)	1 (2%)	6 (10%)
60 and above	0 (0%)	0 (0%)	1 (2%)	0 (0%)	1 (2%)
Experience at work (Years)*					
1 - 5	12	N. A	10	N. A	22
6 – 10	7	N. A	3	N. A	10
11 – 15	0	N. A	2	N. A	2
16 – 20	1	N. A	1	N. A	2
21 and above	0	N. A	4	N. A	4
Range of years at work					

Average duration alcohol use*					
Below 5	N. A	0	N. A	0	0
6 - 10	N. A	5	N. A	0	5
11 – 15	N. A	2	N. A	1	3
16 – 20	N. A	3	N. A	3	6
21 - 25	N. A	0	N. A	5	5
25 and above	N. A	0	N. A	1	1
Education					
Postgraduates (Masters, PhD...)	4 (6%)	0 (0%)	8 (13%)	0 (0%)	12 (19%)
University Bachelors' Degree holders	6 (10%)	2 (5%)	11 (18%)	8 (13%)	28 (47%)
College Diploma/Certificate holders	10 (17%)	3 (5%)	1 (2%)	2 (3%)	13 (22%)
Students (higher learning)	0 (0%)	5 (8%)	0 (0%)	0 (0%)	7 (12%)

* mean (years); NA=not applicable

Table 2: Interview Analysis; Theme, Nodes, sub-nodes and quote identification

Interview question	Theme (Perceptions)	Nodes	Node pervasiveness	
			Uga	Bel
		<i>Acceptability Availability</i>	6	9
		<i>Formal alcohol</i>	3	0
		<i>Informal</i>	2	0
		<i>Promotion (Role of mass media)</i>	1	1
		<i>Low risk perception (Effects)</i>	2	2
		<i>Medicinal purpose and others.</i>	2	0
		<i>Cultural/Religious (beliefs and practices)</i>	8	5
			<i>Frequency of use/ Volumes consumed</i>	1
	<i>Preoccupation with alcohol</i>		3	2
	<i>Related negative consequences</i>		2	4
	<i>Making own alcohol</i>		2	3
	<i>Mixtures vs cheap spirits (Bel)</i>			
		<i>Alcoholism as a disease</i>	1	3

Interview question	Theme (Perceptions)	Nodes	Node pervasiveness	
			Uga	Bel
do clients give for alcohol /addiction? <i>To Service Users (Only)</i>		<i>Association with wrongdoing</i>	5	3
According to your experience, <ul style="list-style-type: none"> • What do you regard as proper use as compared to alcohol abuse/addiction? • When does use turn into abuse? • Why did you continue to use alcohol in spite of the its negative effects 		<i>Peers and underage</i>	3	3
		<i>Stress (full events)/lifestyle and Inadequate life skills</i>	3	6
		<i>Absence of restriction</i>	3	0
		<i>Affordability</i>	3	1

Figure 1: Thematic map for perceptions on Alcohol use disorders and facilitating factors

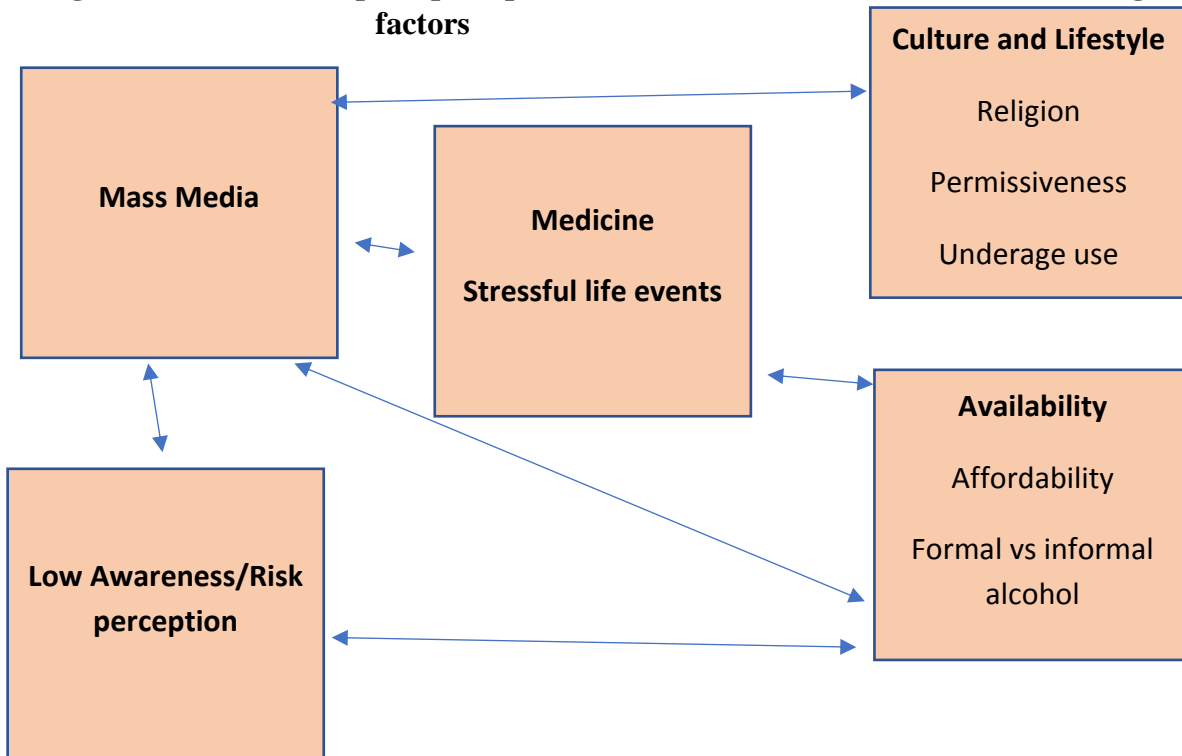


Figure 2: Classification of the facilitating factors of addiction using the com-B Model

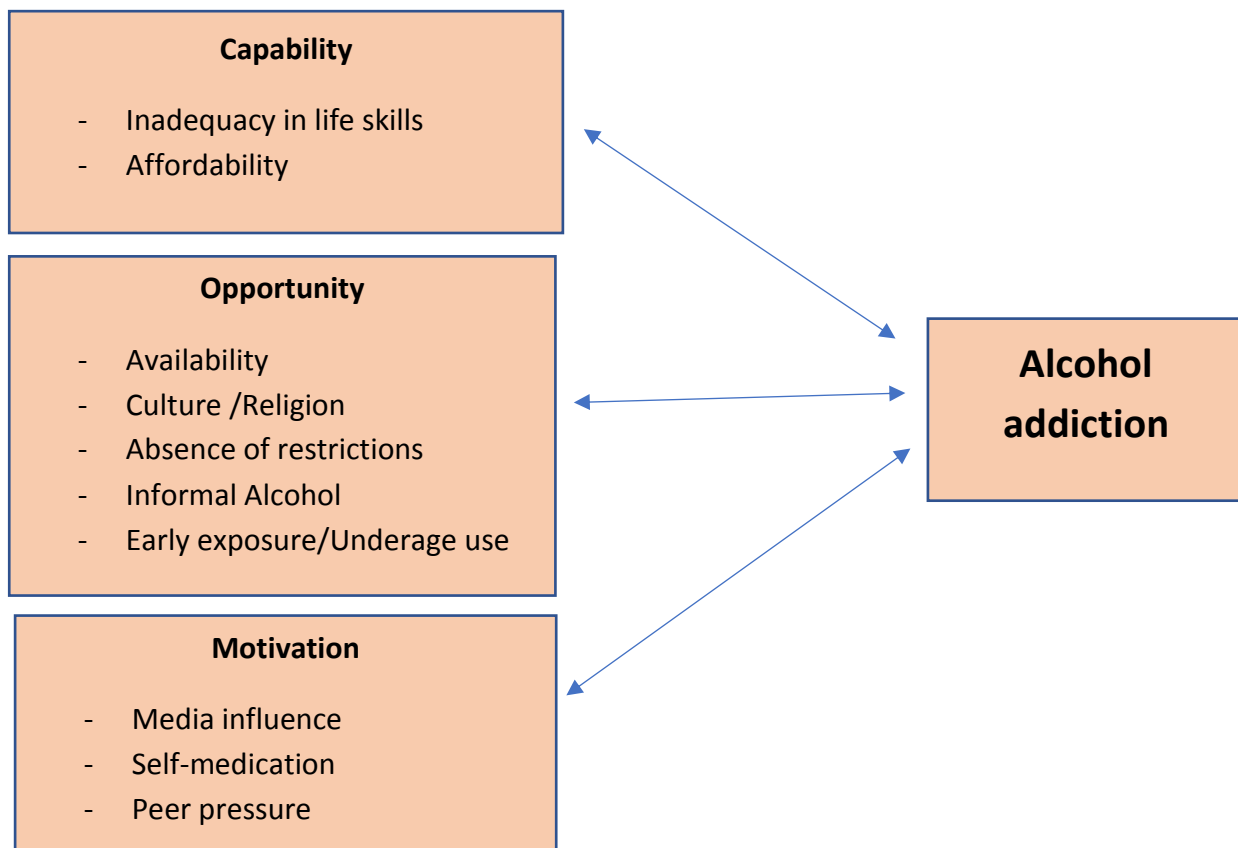


Figure 3: Thematic Map for perceptions towards Addiction

