ALCOHOL ABUSE INTERVENTION STRATEGIES FOR RURAL (BUSHMEN) SETTLEMENTS EMBARKING ON CBNRM

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INTRODUCTION

CBNRM and Alcohol Abuse

Alcohol abuse is a prominent risk factor and problem in rural settlements in Botswana. These areas are characterised by low levels of education, poor infrastructure and high unemployment. In Botswana, most Remote Area Dwellers (RADs) are Bushmen (San or Basarwa) who are further marginalised due to their indigenous minority status and difficulties integrating into the cash economy. As seen with indigenous populations throughout the world, alcohol abuse is rampant, and a destructive cultural phenomenon.

The definition of CBNRM as stated in the Government of Botswana's "Draft Community Based Natural Resources Management Policy" of May 12, 2000, is:

> *"a development approach that supports natural resource conservation. The approach alleviates rural poverty by empowering communities to manage resources for long-term social, economic and ecological benefits. CBNRM advances identified national engines of growth such as tourism, wildlife and veld products that rely upon a healthy environment for profits"* (pg 1).

Several NGOs that work towards poverty alleviation and empowerment have facilitated CBNRM as a development and conservation strategy with RADs in Botswana. Roughly 50 rural communities have embarked on CBNRM, and many are initiating small enterprises, joint ventures with safari companies and tourism activities which bring some employment and income. However, alcohol abuse is an increasing risk, especially in Bushmen settlements. Unfortunately, there are no statistics on alcohol abuse specifically in rural areas and among Bushmen. The incidence can only be surmised from anecdotal evidence from people living and working in settlements. The trend seems to be that in areas where residents are earning cash from CBNRM or other livelihood strategies, much of it is going towards alcohol, which is congruent with the overall increase in alcohol use in Botswana (Molamu and Manyeneng 1988).

SNV Netherlands Development Organisation and the CBNRM Support Programme hope that literature research on the background, reasons and attempted solutions for alcohol abuse among marginalised and indigenous peoples will assist NGOs, government and communities in Botswana to tackle the issue. The objective is to come up with concrete strategies that can be applied in CBNRM communities in Botswana (especially those of Bushmen). It is important to note, however, that alcohol abuse cannot be tackled from the outside. The paper will only provide approaches to preventing and minimising alcohol abuse – the desire for change must be within the community itself.

Alcohol Abuse and Alcoholism[1]

The difference between alcohol abusers and alcoholics is generally seen as the difference between *abuse* and *dependence*. Alcoholism has been identified as a medical disease, with roots in genetic, environmental and psycho-social factors. An alcoholic usually has symptoms of withdrawal if they do not drink, and drinks to relieve such symptoms. He or she may have completely given up work or social activities because of alcohol use, is unsuccessful at cutting down on drinking and spends large amounts of time obtaining alcohol, drinking or recovering from the effects of drinking. It is generally agreed that someone who is alcoholic or has a family history of alcoholism should completely abstain from drinking and can never be "cured".

Alcohol abusers on the other hand, may exhibit similar symptoms, but do not show *dependence* on alcohol, or tolerance and withdrawal from alcohol use. They may neglect work or social activities because of drinking, continue drinking even with recurrent health or social problems (fights, marital arguments) and intentionally overuse alcohol. Alcohol abuse can become alcohol dependence. However, some psychologists argue that alcohol abusers can learn to modify their drinking to moderate levels, a process called "controlled drinking".

[1] Diagnostic and Statistical Manual of Mental Disorders, 4th Edition as cited by www.allhealth.com/health/followup/print/0,4197,6717_794,00.html (9/6/00), Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill, www.med.unc.edu/wrkunits/3ctrpgm/alcohol/education/abuse-ism.html (9/6/00)

Alcohol Abuse and Aboriginal People

Alcohol and substance abuse[2] has been recognised as especially prevalent and crippling among aboriginal and indigenous peoples throughout the world. There are several theories that attempt to explain Indigenous substance use patterns. These theories fall into four broad categories:

1. Historical theories claim Indigenous groups were not socially prepared for the potency of alcohol, without codes or patterns of moderate consumption and use was modeled primarily upon the aberrant, uncontrolled consumption of early frontiersmen.
2. Biological/genetic/physiological theories claim Indigenous people are biochemically prone to crave and lose control over alcohol and metabolize it at significantly slower rates.
3. Psycho-social/economic theories purport substance abuse is a coping strategy for forced relocation, broken families, stress, unemployment, poverty, inadequate education, poor health and low self-esteem.
4. Cultural theories allege transitional or bicultural stress and cultural loss precipitates abuse to the more exotic cultural predisposition to seek "visions" in altered states of consciousness.

(Scott 1992: 4)

Indigenous peoples themselves have most often attributed the high rates of alcohol abuse among their communities to its use as a coping strategy. Those who have been asked to rate the causes of abuse listed the following (from most important to least important):

- lost cultural identity
- poverty and unemployment
- lack of social opportunities
- low education levels
- availability of the intoxicant
- lack of recreational opportunities
- peer group pressure, and
- family pressure. (NNADAP undated: 2)

The role of alcohol among the Bushmen is no exception. Several studies have made reference to the increasing consumption of alcohol in Basarwa settlements as adaptive and abusive (Guenther 1996, Macdonald *et al* 1998, Mogwe 1992, Molamu and Macdonald 1996, Shostak 1990). Batswana and Afrikaner pastoralists settled in increasing numbers throughout the 19th and turn of the century, overtaking water points and hunting grounds for cattle and goats. Basarwa became impoverished farm labourers, particularly in Ghanzi District (Childers 1976 as cited by Good 1999, Guenther 1996). The change from a semi-nomadic to sedentary lifestyle has meant that Bushmen are now living in permanent and constant contact with larger groups of people. Conflicts arise, and individuals can no longer simply move away to avoid them (Van der Jagt, pers. comm.). The relatively sudden and complete loss of access to land, water and resources and relegation to a distinct and displaced minority has been a pattern across the world for indigenous peoples.

> *"The chronic insecurity associated with these conditions has contributed to excessive alcohol consumption and abuse by Basarwa. Drinking is no longer primarily for pleasure. Many Basarwa use alcohol, usually excessively, as an analgesic for both existential and physical pain"* (Macdonald and Molamu 1998).

Patterns of Drinking

In order to devise intervention strategies for alcohol abuse among rural and marginalised populations in Botswana, it is important to form a picture of the "why" and "how" people drink. The previous section explains the underlying cultural phenomenon of alcohol abuse among marginalised groups. To become more specific, what is the immediate motivation for drinking? What are the circumstances of a person's drinking?

Traditionally, alcohol could be produced by the Bushmen from a variety of wild fruits, berries and honey available in the Kalahari. Drinking was used to promote social cohesion and in rituals and events (for instance, marriages and trance dances), and as such, was only an occasional activity. A further natural limitation to the amount of alcohol that was produced was the lack of potable water. Before the drilling of boreholes and wells, fresh water and grain for brewing beer were only occasionally available (Macdonald and Molamu 1998).

[2] Substance abuse can include illicit drugs (i.e. marijuana, heroin) in addition to alcohol.

Nowadays, drinking in rural settlements primarily takes place in informal settings – particularly shebeens. Shebeen "queens" home-brew beer and sell it by the cup. They are often willing to extend credit, as they know this will attract the customer (Parsons 1996). There are three main types of alcohol consumed in rural settlements:

1. *Nyola*: a home-brewed alcohol prepared from a commercial beer powder, usually based on sorghum.
2. *Bojalwa* and *Khadi*: home-brews based on a mash of sorghum, wild berries, oranges or maize etc. Yeast, black tobacco, or other substances are added to give it "strength", and the alcohol content can vary widely.
3. Commercial packaged alcohol: *Chibuku* or "shake-shake", canned beers such as "Castle" or "Black Label" and "Lion" or various brands of vodka or whiskey, referred to as "hot stuff". (Molamu and Macdonald 1996)

The first two options are the cheapest and most often consumed by Basarwa. However, the home-brews are rarely produced by Basarwa themselves. Other ethnic groups such as the Baherero and Bakgalagadi dominate the beer-brewing and selling, generally because few Basarwa have the available money and grain necessary for production. Furthermore, the culture of sharing and reciprocity among Bushmen is likely to discourage the practice of Basarwa selling alcohol to other Basarwa (Macdonald and Molamu 1998).

Some reasons given by Basarwa for their drinking do not differ from mainstream drinkers. Many started drinking as youths because of peer pressure, to "get girls" or to celebrate and relax . However, other reasons given are particular to the impoverished, particularly, to stave off hunger, "to keep going" or forget about unemployment or pain (Macdonald and Molamu 1998, Parsons 1996). Macdonald (1997) found that drinkers have preferences for different types of alcohol and make rational choices based on a detailed knowledge of the effects (makes one lose or gain appetite, results in upset stomach). Some informants attributed different types of alcohol to self-medication, that either heal the body or help one avoid sickness. Even if misguided, these choices indicate personal harm-reduction strategies.

There is a positive correlation between available cash and drinking habits, which has particular relevance for CBNRM and other rural development initiatives that seek to increase employment and income. Macdonald's (1997) interviews revealed that 10 out of 23 informants said that if they had more available money then they would drink more often. It is generally known that at the end of the month, when wages are paid, "binge" drinking takes place. That is why credit is an important part of the strategy of streetvendors and shebeens – during the middle of the month, few people have cash available, but at the end of the month they will return with their money to buy more beer. It has been said that in areas with some access to towns, at the end of the month when the Drought Relief Programme Officer arrives with paychecks, a beer truck will literally follow him or her. In one settlement with 150 regular drinkers, an informant said that adults will spend their 90 Pula of Drought Relief income on alcohol in two days (Molamu and Macdonald 1996). Similarly, it has been reported by several newspapers that Basarwa who have been relocated from Xade settlement within Central Kalahari Game Reserve to New Xade have spent most of their compensation money on alcohol (Macdonald and Molamu 1998).

> *"many a Khwe never has that much money on their pocket before. So the first few weeks or months were a time of feasting and indulging in excessive alcohol consumption, as outside traders selling all kinds of brews soon appeared on the scene. It is foreseeable that alcoholism, like in all Bushmen resettlement sites of the country, will soon become a major problem"* (Erni 1997: 9).

Alcohol Abuse as a Problem

Why is alcohol use and abuse a problem? Liver disease, incidence of rape, accidental injuries, neglected children, poor job performance, spreading of STDs and physical fights are all consequences from alcohol abuse and use. Problems among Basarwa and marginalised populations do not differ drastically. In November 1996 the Basarwa Alcohol Abuse Action Research Project held an alcohol research and information workshop at Kuru Development Trust in D'Kar in which Bushmen from 8 settlements participated. During the workshop, participants were asked to list the health-, social- and economic-related harm that comes from alcohol abuse. Their responses included:

- harm to the individual: malnourishment, "TB defaulters", muscle weakness, loss of self-esteem, loss of dignity, loss of job, debts, no "life plan";
- harm to the family: malnourished children, conflicts, lack of health care, misuse of family resources, no role models for children, delinquency, shortage of money, no school fees, child abuse; and
- harm to the community: spread of TB and STDs, polluted environment, lack of community cohesion, no participation in development, poor education performance, poverty and unwanted pregnancies. (Macdonald and Malila 1996)

The majority of respondents in Macdonald's (1997) study said that they had problems related to their drinking. Many felt that drinking had exacerbated or caused their Tuberculosis, while others said that they had few health problems besides hangovers. Eleven people admitted financial problems stemming from buying alcohol, and a similar number said they had arguments and fights through drinking. This is an indication of a recognition of the problem. It is also interesting to note that 18 of the 23 drinkers had stopped drinking at one time or another. However, all had resumed. The problem, as always with alcohol treatment, is the prevention of relapse.

In regards to CBNRM and rural development strategies, alcohol abuse has several repercussions. Why invest in the economic and social development of a community if there is premature death, widespread TB and malnourishment? Surely these issues are more pressing and basic than development of a community-based tourism enterprise or crafts co-operative. Furthermore, if such employment-generating projects are initiated, will there be enough employable and interested individuals to take part? Will those individuals use their increased income to invest in their housing, education, food and quality of life? Part of the issue is that many of these communities are so isolated that very few commodities, besides alcohol, are available for people to spend their money on. Furniture, tools, housing materials and clothing are all scarce. Alcohol is a cheap source of enjoyment and socialising to spend one's money on.

Alcohol abuse among the Basarwa and remote communities is not a simple problem that can be solved with simple solutions. The drinking itself stems from a complex cultural, social, psychological and environmental context, and its primary consequences (fighting, poor health, unreliability, unwanted pregnancies) spurn secondary consequences (loss of job, spread of TB, malnourished children, dropping out of school). Furthermore, these primary and secondary consequences of uncontrolled drinking very soon become the *causes* of the drinking, or a way to justify the alcohol abuse. This cycle is very difficult to break, and if a drinker does manage to stop, relapse is always on the horizon.

STRATEGIES

From this discussion of the causes and subsequent results of alcohol abuse, it is evident that intervention strategies need to be holistic in approach. The Royal Commission on Aboriginal Peoples identified three dimensions of community health that need to be changed to improve well-being of Aborigines:

1. poverty and social assistance
2. shelter, water and sanitation facilities, both community and individual infrastructure
3. environmental conditions, including pollution and land and habitat degeneration.

(NNADAP undated: 1)

From this, it could be inferred that rural development strategies could help to mitigate the incidence of alcohol abuse by providing people with employment, skills and self-esteem. There is evidence that communities involved in meaningful and self-determined projects are less likely to abuse alcohol. However, it is recommended that income generated from such projects be reinvested in community development, not distributed to individuals (Thoma pers. comm.). It is true that without cash, it is more difficult for people to drink. In Macdonald's study, four of the 23 informants had stopped drinking at one time or another because of lack of money. However, they all resumed drinking once their income was restored.

Formal employment usually results in an income, and it has been argued that individual cash earnings (particularly from employment) are vital for cash-poor communities (Van der Jagt *et al.* 2000). School fees need to be paid, paraffin or candles bought, food supplemented and tobacco smoked. It is

perhaps important to work on strategies that incorporate the earning of money by individuals as a given.

Control Mechanisms

Nevertheless, control mechanisms to curb alcohol abuse have been popular among Basarwa and other indigenous peoples. Government regulations on the minimum drinking age and price increases can reduce alcohol-related fatalities and consumption. However, on First Nations reserves in Canada, "dry reserve" policies have generally not been effective. This has been linked to the lack of enforcement or community mediation/policing (NNADAP undated: 32). There have been similar failures in Ghanzi and Kgalagadi district, where informal policies to block all licenses for bottlestores and bars in settlements had almost no impact on the actual sale and drinking of alcohol (Van der Jagt pers. comm., Rozemeijer pers. comm.)

Even so, many Bushmen feel that the government has been too lax in its regulation of bottle stores and licensing. Several communities have tried to get stores closed or applications for licenses rescinded with no success (Molamu and Macdonald 1996). It is likely that the proliferation of bottle stores has exacerbated the problem of alcohol abuse, even if it did not cause the problem. Bushmen are not the only ones who believe in restricting the sale of alcohol. When asked what they thought was the best way to prevent or control alcohol abuse, respondents of an alcohol use survey most strongly supported licensing fewer bars, or that bars be closed early (Molamu and Manyeneng 1988).

However, government is not likely to tighten its control over this sector. In 1986 the Botswana government accepted the recommendations of the Presidential Commission on Economic Opportunities to remove restrictive regulations in order to allow Batswana to engage in all forms of informal commercial activities (Molamu and Manyeneng 1988: 86). Shebeens were accepted as an important livelihood strategy for many households, even if it is based on the unhealthy consumption of alcohol by others.

> *"For instance, in both the urban squatter and the rural areas, traditional beer brewing is the biggest informal, income-generating employment opportunity. An estimated 5 000 households, and a high proportion of these female-headed, depend upon beer brewing for their subsistence.* (Egner and Klausen 1980 as cited by Molamu and Manyeneng 1988: 4)"

Individual Bushmen who have referred to themselves as alcoholics have said that certain churches (Pentecostal, The Prophet) have helped them overcome their abuse. These churches seem to be fundamentalist in doctrine and focus on guilt and worshipping (Thoma pers. comm.). However, in a survey of Batswana who abstained from alcohol, only 6.9% said that religion had any influence on their drinking behaviour.

Community-Based Strategies and Harm Reduction

Though abstinence is preferred in many cases, this paper will focus on suggesting strategies for prevention and harm reduction interventions. The feasibility for the Botswana country context is stressed. Examples will be drawn from work with indigenous groups in other countries as well as in Botswana.

In 1995 the Basarwa Alcohol Abuse Action Research Project was initiated at the University of Botswana with three principal researchers and assistants. Its objective was to perform active research about why and how Basarwa drink and come up with harm reduction and intervention strategies. Several papers were written (which have been drawn on heavily here) and research was performed primarily in Ghanzi district. The project was not finalised clearly because the three main researchers all left for other positions in 1998. However, the process of applied research on alcohol abuse among Basarwa was begun.

Here, a community-based approach to prevention and intervention is suggested. It melds a methodology from the US called "Communities That Care" with strategies from the Basarwa Alcohol Abuse Action Research Project. It requires that communities be mobilised to actively address alcohol abuse issues.

Community-Based Prevention and Intervention

The "Communities That Care" drug reduction strategy developed in the United States has been held up as a model community-based intervention. The "Communities That Care" approach uses community mobilisation strategy to reduce risk factors and increase protective factors against drug (and alcohol) abuse, particularly by adolescents. The mobilisation consists of four phases:

1. community key leader recruitment and orientation
2. community advisory board formation
3. risk and resource assessment by the community board to identify priority risk factors
4. action planning and implementation of family, school and community interventions which have been developed by the community and which reduce risk factors and enhance protective factors.

The general prevention principles that form the core of "Communities That Care" are:

- interventions should focus on known risk and protective factors
- interventions should target risk and protective factors which are appropriate for different levels of development
- prevention of abuse should start early, including major components that are delivered before drug use occurs
- interventions should reach people at high risk
- interventions should address multiple risk factors across multiple domains – individual, family, school, peer group and community.

(NNADAP undated: 34)

The limitations of this strategy for the rural Botswana context is that many of the adolescents or teenagers are not in school, or if they are pursuing studies beyond primary they are boarding in a larger town – away from their community. Also, the low education level of community leaders may be a constraining factor – though there are many specific rural outreach techniques for illiterate communities.

For example, the Basarwa Alcohol Abuse Action Research Project used slides and a "storyboard" technique learned in Australia to present the findings of their research back to the community. The pictures represented alcohol consumption patterns and motivations, and was effective for the community which was largely illiterate and visually and symbolically oriented. It was also interactive, allowing participants to place themselves and their circumstances within the 'story' (Macdonald *et al.* 1998).

To generate this type of information a "Consequences of Alcohol Use" self-completion chart could be used with the community advisory board. The chart helps people map out the different types of harm (health, social and economic) to the individual, family and community. The chart can be filled out individually and then discussed in a group.

Consequences of Alcohol Use Self-Completion Chart

Level of Harm	**TYPE OF HARM**		
	Health eg. physical and mental	**Social** eg. relationships between people, violence, criminal activities	**Economic** eg. debt, level of productivity
Individual			
Family			
Community			

From (Macdonald and Malila 1996: Appendix 2)

This chart can be used as a starting point to identify community priority areas and then interventions which address different levels of risk and abuse (individual, family, community). Following this, workshops can be held (facilitated by an outside expert on counselling and abuse) for peer intervention. These can be relatively short, and are not supposed to train someone to be able to treat alcohol abuse. However, the sessions can be a day of information on how to recognise the signs of

abuse, what the medical consequences are, and how to help someone who is abusing alcohol. These skills, of course, must be culturally appropriate. Such a workshop was held at Kuru Development Trust in October of 1998 with about 20 participants (Macdonald and Malila 1996).

It has been shown that education itself is not enough for behavioural change. Education generally increases a persons short-term knowledge and attitude change, rather than long-term behavioural change (NNADAP undated). More success is found in "resistance skills" and assertion and negotiation skills training. The training gives young people and ex-alcohol abusers the tools to recognise, handle and avoid situations where they will experience pressure to drink (Ibid.). This is especially important to reduce the possibility of relapse among ex-abusers.

Treatment has not been touched upon here. Treatment of alcohol abuse and alcoholism usually requires in-patient stays in rehabilitation centres or hospitals, detoxification and intensive case-management and therapy. Countries such as Canada and Australia, with large indigenous populations and the requisite funding, have specific treatment centres and programmes for native Indians and Aborigines. These use traditional rituals as well as mainstream medical therapies to treat an abuser. It may not be possible to treat an alcoholic or alcohol abuser (one who needs medical assistance for tremors, withdrawal etc.) in a community in Botswana. However, an ex-abuser can be given the skills and support needed after having quit drinking. Again, this would be assertion training, social skills training and recognising high-risk situations. A community support group could provide a modest form of support for an ex-abuser, and seek to create forms of entertainment and relaxation that do not revolve around drinking.

CBNRM Strategies – Avoidance

How do these strategies work in relation to CBNRM? It would be possible for a community Trust to initiate the formation of an alcohol abuse action committee which would work as the "Community Advisory Board" as described in the "Community That Cares" approach. This committee would obviously need facilitation and assistance from outside experts in health and assertion skills training. Community clinics and NGOs could provide the linkages to resources for short term workshops of this type. The committee could also organise more social and cultural events to provide recreational opportunities for youth. It is most important that a committee feels dedication and motivation to combat alcohol abuse in the community – an outside facilitator can only provide skills and a starting point for the committee to begin action.

Harm-reduction strategies more specific to income and alcohol abuse can also be initiated by the Trust Board or advisory board. In northern Kgalagadi district, the Nqwaa Khobee Xeya Trust was registered in 1998, representing three communities. In February 1999, before the Trust had tendered out its first hunting and photographic tourism offer, a one-day "Expenditure and Reinvestment workshop" was held to help the communities plan what they would do with the income and benefits from a joint venture with a safari operator. Would they reinvest the money? In what sort of project? Will households get cash disbursements? Will it be enough money to make an impact on the lives of individuals? This type of planning can help communities to look at what sort of benefits are most needed in the community and will most improve the lives of its residents (Van der Jagt *et al.* 2000).

Two suggestions from that workshop have particular importance for avoidance of alcohol abuse. First, residents suggested income from a joint venture should be used for provision of services and goods to the community. For instance, a Trust general dealership could be started which would offer food, household utensils, tools and building materials (corrugated iron, cement, wood). A Trust vehicle could also bring requested items (furniture, radios etc.) in from Hukuntsi or other towns if making a trip, and residents would pay a transport fee. One of the three communities, Ngwatle, is especially small and with limited streetvendors. It was suggested that when money is brought to this community, for payment of joint venture dividends or sale of crafts, a "mobile shop" could follow and offer basic goods at the same time. Essentially, the Trust would act as a service provider for hard-to-find items. If households receive cash disbursements, or people earn an income from employment created, they would have a place to spend it other than at a shebeen.

Second, a banking/savings mechanism was proposed. Safe boxes would be housed by the Nqwaa Khobee Xeya Trust, in which residents could deposit money. It was undecided whether loans should be given, or if people should be able to simply withdraw their money whenever they chose. At Kuru Development Trust in D'kar, a Savings and Loan Programme has been in place for more than one and

a half years. Communities and individuals that accept funding and project support from Kuru commit themselves to the Savings and Loan Programme. They are not obligated to do so, but are highly encouraged, as it also acts as an education on living within a cash economy. People who are part of the programme save about 5% of their income or salary with the project, and after a period of one or two years, depending on the amount saved, they are eligible for a loan. All project recipients must agree with the granting of the loan, and the individual's savings act as collateral. If the borrower pays his or her instalments back, then he or she will be eligible to receive a loan higher than the amount of their collateral. So far, most people have used the money to buy cattle or to upgrade or build housing. Individuals are also allowed to withdraw money from their savings at any time, but generally should not take out more than 50% (Bausch, pers. comm.).

CONCLUSIONS

There are differences in how a community may want to combat alcohol abuse. The community-based prevention and intervention strategies ("Communities That Care", peer education, assertion skills training) directly address the risk factors and consequences of alcohol abuse through communication and skills training. The avoidance strategies (savings and loans, provision of services, participatory planning) do not deal with alcohol abuse itself, but seek to provide alternatives to alcohol. Prevention and intervention requires very intensive facilitation and substantial outside support, but can address alcohol abuse throughout the community and open up the subject for recognition and discussion. As yet, these types of strategies have not been tried in Botswana. The avoidance strategies still require facilitation, but are not quite as involved – again, they do not tackle the issue of substance abuse itself.

Ideally, these two types of strategies would be initiated in combination. A community could mobilise to stimulate recognition of the problem and work on prevention and harm reduction among its members. At the same time, avoidance strategies would be established by the Trust to help create an enabling environment for residents to reduce their drinking. However, it must be remembered that both types of strategies are somewhat symptomatic. Socio-economic empowerment, improvement of esteem and outlook through education, employment and self-determining activities will remain the basis for rural development. It is hoped that donors and government will see the importance of alcohol abuse intervention and its relation to CBNRM and rural empowerment.

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