Private troubles to public issue: empowering communities to reduce alcohol-related harm in Sabah, Malaysia

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Summary

Alcohol is the number three contributor to the burden of disease worldwide so must remain a priority health promotion issue internationally. Malaysia is a Muslim country and alcohol-related harm was not seen as a priority until recently, because it only affects a minority of the population. Sabah has more than 30 different ethnic groups, and alcohol has a traditional role in the cultural practices of many of these groups. In 2009, the Intervention Group for Alcohol Misuse (IGAM) was formed, under the umbrella of Mercy Malaysia by a group of healthcare workers, academics, members of the Clergy and people who were previously alcohol-dependent concerned about the harmful effects of excessive alcohol consumption. IGAM in collaboration with other bodies have organized public seminars, visited villages and schools, encouraged the formation of a support group and trained healthcare professionals in health promotion intervention. The focus later changed to empowering communities to find solutions to alcohol-related harm in their community in a way which is sensitive to their culture. A standard tool-kit was developed using WHO materials as a guide. Village committees were formed and adapted the toolkit according to their needs. This strategy has been shown to be effective, in that 90% of the 20 committees formed are actively and successfully involved in health promotion to reduce alcohol-related harm in their communities.

Key words: communities, empowerment, alcohol harm, cultural practices
INTRODUCTION

Alcohol consumption has been attributed to more than 200 diseases and injury conditions (Rehm et al., 2010). It directly or indirectly causes a large number of communicable and non-communicable diseases, many serious social ills including violence to women and children, bodily injury resulting from road traffic accidents and even harm to the unborn fetus through fetal alcohol syndrome (Rehm et al., 2009). Worldwide alcohol is documented as the number three contributor or attributes 5.1% to the global burden of disease and injury, as measured in disability-adjusted life years (DALYS) (Mathers et al., 2009), contributing 4.6% of global DALYS and 3.8% of deaths (Rehm et al., 2009). The harm that alcohol causes depends on the volume consumed, pattern of drinking and the quality of alcohol consumed. People consume alcohol because of a variety of factors that has been identified at the individual and societal level. Health promotion programmes which recognize that intervention to reduce alcohol harm need to address both of these levels—behaviour and attitude change at the individual level and social, economic, legal and political change at the societal level—is likely to lead to better outcomes (Van Den Broucke, 2014). In the Malaysian context, this two pronged approach is not yet being systematically adopted to address both the context and the content of the intergenerational transfer of alcohol risk (Campbell and Oei, 2010). Furthermore, most alcohol control programmes in Malaysia are top-down in their inception and delivery and address downstream risks rather than structural contributors to alcohol abuse and harm.

Malaysia is split into two parts; West Malaysia, and East Malaysia on the Island of Borneo. Both government policy and healthcare administration are highly centralized. Central government is situated in West Malaysia and is dominated by the Malay ethnic group. The Malays are muslim and strictly prohibit alcohol consumption. Alcohol use in West Malaysia was almost non-existent until the British Rule. The British colonialists imported beer, wine and hard liquor. The Indian labourers introduced local alcoholic drinks such as tody (from coconut pulp) and samsu (from rice) (Arokiasamy, 1995; Jernigan and Indran, 1999). In East Malaysia, the situation is different. The indigenous non-Muslims have a tradition of brewing and producing their own alcohol from rice, tapioca, pineapple and coconut. This home-made alcohol was traditionally drunk during the harvest festival and social and communal gatherings (Arokiasamy, 1995). In Malaysia only 12.8% of adults currently consume alcohol (Institute for Public Health, 2011), but 23.6% of current drinkers are drinking in a risky way (Mutalip et al., 2014). Alcohol has never been treated as a priority by central government. In West Malaysia drinking was seen as an ethnic Indian problem, which meant that little was done to tackle the problem (Jernigan and Indran, 1999). The government created an excise act in 1976 (The Commissioner of Law Revision, 1976), drink driving law in 1996 and included alcohol in healthy lifestyle campaigning in 2010. Other than this, the government response to alcohol-related harm has been slow and there are few government-sponsored specific treatment facilities for alcohol-related problems.

In East Malaysia the two states of Sabah and Sarawak have the highest prevalence of drinkers in Malaysia (Institute for Public Health, 2011), with 18.4% of the population currently consuming alcohol in Sabah. Among the indigenous people of East Malaysia, 37% of drinkers have an alcohol use disorder identification (AUDIT) score of 8 or more, indicating that they are drinking in a risky way (Mutalip et al., 2014). Heavy episodic drinking is the major cause of alcohol-related harm, mainly due to cardiovascular disease and accidents (Roerecke and Rehm, 2010). There are more than 30 different ethnic groups in Sabah (Gov/Sabah, 2014) and in most of these ethnic groups alcohol has a traditional role in their cultural practices (Shoesmith et al., 2011). In these indigenous communities, it has been observed that the men drink heavily, became drunk and often end up with alcohol-related harm. Women bear the burden of this behaviour socially, economically and physically especially via the risk of domestic violence.

In 2009, a group of concerned citizens joined forces and formed the Intervention Group for Alcohol Misuse (IGAM). These included healthcare workers, academics, members of the clergy and people who were previously alcohol-dependent. The formation of this group was driven by the perception of alcohol causing physical, social, economic and psychological harm in their communities and the apparent inaction by the central government. One committee member observed that in her village there were hardly any men over the age of 60, despite the fact that the life expectancy for men in this region is reported to be over 70 years (Department of Statistics (2011)). She reported a comment from an elderly village woman that ‘alcohol kills Kadazan men’. It was also becoming evident that alcohol was no longer consumed only during special occasions. In contrast, alcohol was being used excessively all year round and having a devastating impact on family life. Many spoke about accidents after alcohol intoxication. They felt that this increased consumption was due to better point of sale facilities, more income and easy accessibility to cheap smuggled alcohol. There is very little published data on these observed trends, and at the time the committee formed there was no obvious coordinated activities to reduce harmful use of alcohol in Sabah.
ACTIVITIES AND IMPLEMENTATION

Initial activities of the Central Committee (2009–2013)

IGAM was endorsed by MERCY Malaysia, as one of the committees in Sabah state Chapter. MERCY Malaysia is a medical relief non-profit organization registered under the Societies Act of Malaysia. The committee is made up of a heterogeneous group of interested parties with varying approaches to preventing alcohol-related harm. The Alcoholics Anonymous member and the Church members prefer an abstinence-based approach but not to ban alcohol. Other members, some of whom were low-risk drinkers themselves, prefer a harm reduction approach. This dilemma was largely resolved by using different approaches for different cohorts. An abstinence-based approach was used for young people in the early intervention work. A harm reduction-based approach was used for the health promotion activities with older adults as it was felt that using an abstinence-based approach would be seen as a threat to culture and would create resistance. After much deliberation, discussion and reflection on culture and practices of the target populations, the committee came up with the following objectives for IGAM:

1. To be a support group in creating awareness about alcohol-related problems and provide support for those with alcohol-related problems and their families.
2. To conduct early intervention programs to prevent damage due to alcohol misuse affecting social and emotional development of children.
3. To conduct research on alcohol-related issues in Sabah.
4. To act as an advocacy group to lobby for social, legal, political and economic change to address upstream contributors to alcohol abuse.

IGAM subsequently joined forces with Johor Mental Health Association (who were already doing alcohol-related work), IOGT International, University Malaysia Sabah and Sabah Health Department to accomplish its objectives. The team used WHO materials such as Brief Intervention for Hazardous and Harmful Drinkers (Babor and Higgins-Biddle, 2001), and Resolution of the Sixty-third World Health Assembly (World Health Organisation, 2008) to come up with strategies to reduce alcohol-related harm to the communities. The team organized various activities and production of printed educational material on alcohol in Bahasa Malaysia (the national language), which is understood by almost all communities. Activities included an event in a village (which included discussion groups about drinking), awareness seminars and workshops on brief interventions and motivational interviewing for healthcare staff. The committee members also supported each other in carrying out activities, which were independent of the central committee. One of the committee members set up an Alcohol Anonymous (AA) group in the city. He had previously set up an AA group, but had become discouraged by a poor initial response and had not continued. This time, the encouragement of the central committee helped him persevere through the difficult early stage, and media coverage of IGAM activities helped him recruit members. The committee members from the clergy organized youth events for Christians and created alcohol-related Bible study material. The academic members developed a research interest in alcohol and started alcohol-related research projects and lobbying key players in economic and political decision-making in Sabah. The committee meetings helped to encourage each other and share expertise in carrying out these independent activities.

These activities were carried out between 2009 and 2013. The committee discussed the observed outcome after each activity. A return to the village that the committee visited showed a positive response. Those villagers who attended the activities said that they had reduced their drinking to a certain extent. The feedback from the awareness seminars was generally disappointing. Although the events were well attended, the respondents gave good feedback after the events and they received good press coverage, there appeared to be very little observed outcome. This may have been because the seminars were mainly didactic in nature, with little opportunity for reflection. The people attending the events were mainly concerned individuals from other NGOs, rather than people with alcohol problems. The committee decided that a different approach was needed. The village visit appeared to be effective, but was impossible to replicate on a large scale. The committee decided that the best way of approaching the problem was to stimulate the formation of other committees in each community, through workshops. These committees would be supported by the central committee, but would act largely independently in attempting to reduce alcohol-related harm in their respective communities.

Forming village level committees 2013–2014

Various evidence-based materials were used by the committee to come up with a set of power-point presentations, reading materials and posters. All these materials are in the national language. These evidence-based materials were collected to form an ‘alcohol intervention tool-kit’. There were nine topics in the power-point presentation simplified so that it can be presented in around 15–20 minutes. The content of the alcohol intervention tool-kit is shown in Table 1.
The first workshop was held in late 2012 with an objective to encourage and support the community to reduce alcohol-related harm. Representatives from eight different villages were invited to this workshop. Each village was represented by a minimum of four people, one of whom was a healthcare professional and one a respected member of the community or a village leader. These four were to form the working committee and were trained using the alcohol intervention tool-kit. There was also a brainstorming session to help them think about how alcohol-related harm could be reduced in their communities. They were then asked to create a brief proposal (Table 2) and were given a small budget to run an alcohol-related event. The budget was five Malaysian Ringgit (RM 5.00 equivalent to USD 1.2) per head for light refreshment. It was anticipated that ~30 would attend each event so each village committee was given a total of RM 150.00 (USD 47.00). The working committee were then asked to go back to their respective villages, adapt the tool-kit using their local knowledge and cultural beliefs and run a programme to reduce alcohol-related harm. All working committees are required to write a report after organizing the workshop. An after event report template was given to ease report writing (less than one page).

After this first workshop, further workshops have been held every 6 months to follow up the progress of the village committees and introduce new committees. During subsequent workshops, new groups of people from different villages are invited to participate. The old committees from

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**Table 1: Content of alcohol intervention tool-kit**

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<td><strong>Objectives</strong></td>
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| II. | Reading materials in Bahasa Malaysia with the following titles:
| | *Bahan-bahan bacaan dalam Bahasa Malaysia dengan tajuk seperti berikut:* |
| | 3. Prevent Alcohol Misuse: Early Intervention Programme Module |
| III. | Brochures in English with the following topics:
| | *Risalah dalam Bahasa Malaysia dengan tajuk seperti berikut:* |
| | 1. What is your level of drinking? |
| | 2. Alcohol use disorder identification test (AUDIT) |
| IV. | Poster with the following topics:
| | 1. Healthy without alcohol |
| | 2. AUDIT |
| | 3. Alcohol harm |

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**Table 2: Proposal: community programme to reduce alcohol-related harm**

| Name of activity | : |
| Date of activity | : |
| Venue | : |
| Objectives | 1. |
| Justification for budget required: | 2. |
previous workshops share their experiences with new committees. They also share their adaptation of the alcohol intervention tool-kit to suit their respective village. Examples of activities in separate villages are organizing alcohol awareness events, implementing time limits on sales of locally brewed alcohol, preventing persons under 18 years old from buying alcohol, limiting alcohol service during celebrations, organizing sporting events and organizing activities that help young people to have less time without activities. After the sharing from the previous groups, the participants are divided into two groups. One group is the newly formed committees and the second group are those who have attended the previous workshop and done work in their respective villages. The new group are introduced to the alcohol intervention tool-kit. The second group is facilitated to talk in detail about their activities. They discuss what worked, the problems they face during the activities and brainstorm possible solutions.

### OUTCOMES AND CHALLENGES

By May 2014, four workshops (Table 3) had been held. These had been attended by 185 participants, and 20 working village level committees formed. The village committees are considered to have contributed in reducing alcohol-related harm if they managed to run the workshop and formulate activities that engaged the communities to activities that lead to less drinking. The village committees also shared their observations in respective villages if there was reduction in alcohol consumption. Out of the 20 working village level committees, 18 reported success while 2 did not manage to organize the workshop at their village level.

#### Success stories

Out of the 18 village committees, most ran a workshop to reduce harm due to alcohol. Limited brief intervention was performed during these workshops. The sharing among the village committees about this strategy appears to be effective and encouraging although there are challenges.

One village created alcohol-related bylaws. They prohibited alcohol to be sold and drunk by persons under 18 years of age. If caught the village head will penalize them using customary law. This entails the offender to pay ‘sogit’; a fine used in the area of customary law. Two village committees made banners on alcohol harm and placed them at strategic area during festivals where alcohol is served. Employing people to serve alcohol at the table was also prohibited. Anyone who wants to drink alcohol has to get up to go to the bar and get their own drink. Three other village committees organized regular sporting activities for the communities to participate. Alcohol is not allowed after the sporting activities.

The working committees that are relatively successful are observed to be those with good leadership. They are able to get the cooperation of the communities, organize activities that are well attended and showed evidence of improvement in promoting alcohol-related harm awareness and reducing excessive alcohol consumption.

#### Obstacles

Two village committees failed to organize anything. Although four representatives attended the workshop organized by the central committee, some decided not to get involved once they were back in their own village. This made organizing difficult for those left in the committee. Some committees reported a lack of enthusiasm in their community and a lack of cooperation from the village leaders. Some had a small number of participations during events organized in their village. Some felt that they were not confident enough to speak or give the talks listed in the alcohol intervention tool-kit. Almost all the working committees voiced that the amount of financial assistance from the central committee is not enough.

#### Recommended solutions

The problems faced by all of the working committees were discussed, and possible solutions were suggested. The first issue was the failure to organize anything, the suggested solution was to only invite villagers that are really committed and if possible people in leadership positions in their communities. On the issue of lack of participants, the working committees suggested a few other activities to be held concurrently with the workshop. They found that the communities tend to avoid attending if they hear that it is an alcohol workshop. The suggested activities were medical screening, sporting activities and lucky draws. Lucky draws normally draw people for any event in Sabah. The need for confident speakers was acknowledged and training was added to the agenda to be examined. To help facilitate this, the central committee continues to modify the alcohol intervention tool-kit. The aim is to make it as user-friendly as possible. At the same time, at every workshop a few village level committee members
are given the opportunity to be a speaker. The central committee has also started to deliver talks if requested. The inadequate budget to run the programme is another issue that needs to be addressed.

**DISCUSSION**

The WHO is committed to reduce the global burden of disease caused by the harmful use of alcohol. The Sixty-third World Health Assembly in 2010 approved a resolution to endorse a global strategy to reduce the harmful use of alcohol. This strategy represents a unique consensus, developed through a long and intense collaboration among all WHO Member States on ways to tackle harmful use of alcohol at all levels. It contains extensive and detailed evidence-based policies, interventions and guides for global, regional as well as national action to reduce alcohol-related harm. Community action is one of the 10 target areas for policy options and interventions available for national action. The WHO states that communities can use their local knowledge and expertise in adopting effective approaches to prevent and reduce harmful use of alcohol by changing collective rather than individual behaviour while being sensitive to cultural norms, beliefs and value systems. There are seven policy and interventions suggested in this area (WHO, 2010).

The WHO has also developed alcohol manuals as guidelines for use in the primary care setting. The AUDIT and brief intervention for hazardous and harmful drinking are such manuals (Babor et al., 2001; Babor and Higgins-Biddle, 2001). These two manuals were used as the main health promotion tools in the workshops. The manuals were adapted to suit individuals as well as communities and were presented in the alcohol intervention tool-kit. The adaptations are in line with the needs of the Sabah population with unique and divergent ethnic groups. They have differences in their cultural beliefs and practices making it difficult to implement a standard approach. The alcohol intervention tool-kit made it easier for the respective individuals and communities to adapt rather than starting the development of tools from scratch. Health promotion as defined during the Ottawa Charter in 1986 is the process of enabling people to gain control over the determinants of health and thereby improve their health and well-being. In order to achieve this, the Charter deliberated on multi-strategy approaches that include policy changes, environment, community, individuals and the health services (WHO, 1986). These multi-strategy approaches were reinforced and further detailed in subsequent International forums for health promotion as exemplified in the Bangkok Charter and the Jakarta Declaration (WHO, 1997; WHO, 2006).

The methods that we have been using focus on empowering the communities and individuals to tackle alcohol-related harm. Alcohol related problems are normally private, hidden in families and not talked about. Our approach has turned these private issues into public issues for the health system, governments, scientific bodies and the population. Alcohol has been used traditionally and brewed by most indigenous groups in Sabah. Any programmes or activities that appear to be against alcohol have to be handled with sensitivity. The activities must not be seen as anti-alcohol or as an advocacy push to stop the use of alcohol altogether otherwise these communities will not participate in the activity. In a study in rural Sabah, one of the main reasons for drinking was ‘maintaining culture and traditions’ (Shoesmith et al., 2011). Maintaining culture is important to most people in Sabah, where there is a general feeling that the traditional cultures are under threat. Alcohol is seen as part of the culture by many communities and a program that is ‘anti-alcohol’, rather than ‘anti-alcohol related harm’ could be seen as a threat to culture. This makes it difficult to introduce programmes or activities that stop the use of alcohol altogether. Thus harm minimization, rather than prohibition, becomes a key ingredient in health promotion programmes designed to increase individual and population health. Different strategies are used for children and young people, to promote total abstinence from alcohol consumption.

There have been published trials and reports on community action to reduce alcohol-related harm. Many showed that community-based bottom-up prevention measures are effective in curtailing drinking and alcohol-related problems (Perry et al., 1996; Holder et al., 2000; Wagenaar et al., 2000; Midford et al., 2005). A recent cluster randomized controlled trial showed that community action leads to a reduction in self-reported average weekly consumption and experience of alcohol-related verbal abuse (Shakeshaft et al., 2014), but did not show a significant reduction in risky alcohol consumption and harm.

The community action described here shows encouraging results, with minimal implementation cost. The use of the alcohol intervention tool-kit raises awareness on the harmful use of alcohol thus making the intervention easy to execute but also offers flexibility to cater for culturally nuanced needs. Documentation of this intervention scientifically is important because communities often want locally based evidence rather than relying on findings from far afield (Babor, 2010).

**CONCLUSION**

The intervention implemented showed that collaboration, support from various organizations and involvement of
the community appear to help reduce alcohol harm. Furthermore, the intervention reinforced the established health promotion gold standard of good practice, established nearly three decades ago in the Ottawa Charter, namely the use of flexible, integrated and comprehensive multisectoral and multilevel strategies and methods to ‘provide the best answer to the complex realities that impact on people’s health’ and their quality of life (Van Den Broucke, 2014, p. 599). Our intervention has been multilevel, in that a central committee has empowered village level committees at the same time as advocating for policy at a higher level. The central committee act as a vehicle through which people from diverse backgrounds could work together and support each other, despite different values and worldviews. There remain many limitations and challenges to implement this intervention systematically across Sabah. More development work is needed especially to address structural contributors to alcohol abuse and targeting the agencies that have a vested interest in maintaining unsafe levels of alcohol consumption. The programme also needs to be evaluated. Evaluation of the intervention is obviously essential to determine whether it works using a variety of consumption, health, well-being and social indicators, to help improve program delivery and to provide evidence for continuing support of the program. It will also help to determine whether the programme is appropriate for the target population, identify any problems with implementation and concerns that need to be resolved. A small study has been started to evaluate the effectiveness of this intervention using quasi-experimental design.

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