Original Articles

Community perspectives on alcohol use among a tribal population in rural southern India

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ABSTRACT

**Background.** Alcohol use is common in many cultures. Excessive use of alcohol adversely impacts individuals, families and communities. Medicine, which uses biomedical models and perspectives, views alcohol dependence as a disease.

**Methods.** We used qualitative methods such as focus group discussions and in-depth interviews to document perspectives on alcohol use among a tribal community in southern India. We recorded traditional norms, changing patterns of use of alcohol and its consequences for individuals, families and the community.

**Results.** Eight focus group discussions and eleven in-depth interviews were conducted. Though consumption of alcohol is part of the local culture, changes in occupation and availability of alcohol has made its consumption a problem. The introduction and easy availability of Indian-made foreign liquor, which is stronger than the locally brewed variety, in government-run outlets has changed the culture of drinking at festivals to drinking more often. This leads to public fights, domestic violence and increasing mortality and morbidity due to road traffic incidents and ill health. The age of initiation into drinking has decreased.

**Conclusion.** The introduction of non-traditional and commercial alcohol use has put a heavy price on tribal and rural people. Community-based interventions targeting young children and adolescents may pay more dividends than pursuing purely medical treatments for problem drinkers.


INTRODUCTION

Alcohol use is common in many cultures and across regions.\(^1\) Harmful consequences of alcohol consumption are well documented. At a personal level, alcohol consumption is causally related to cardiovascular diseases, various cancers, liver diseases and psychiatric ailments. Alcohol consumption affects the family through its psychological impact on growing children, domestic violence and economic instability. Society at large pays for alcohol consumption through burden of alcohol use-related diseases, road traffic injuries and loss of productivity.\(^2\) The impact of consumption of alcohol on national economies is well recognized. The state of Tamil Nadu has a unique situation where it has a monopoly on alcohol sales, the revenue from which is used to fund various welfare schemes of the government. Medicine uses biomedical models and perspectives and views alcohol dependence as a disease, but its understanding of alcohol-related issues is partial and its ability to solve them is limited. Alcohol use (and dependence) are complex societal problems, which need to be viewed through multidisciplinary approaches and solved through intersectoral efforts. Understanding society’s perceptions on alcohol use (and dependence) is necessary to plan and suggest measures to contain its use (and dependence). Research should involve local communities to understand alcohol use (and dependence). We attempted to understand community perspectives on alcohol use (and dependence) among adult men and women in rural tribal hamlets of Jawadhi hills, Tamil Nadu.

METHODS

**Setting**

The Jawadhi hills area, inhabited by about 80 000 people, is located in the Eastern Ghats in Thiruvannamalai and Vellore districts of Tamil Nadu. The hills are segregated by the tributaries of the Palar, Cheyyar and Agharam rivers and are 3600–3800 feet above the sea level. The hilly terrain makes it difficult to access healthcare and other facilities. The overall indicators of health, literacy and development of the population across age groups are poor in comparison to those living in the plains. There are two primary health centres and three higher secondary schools to serve the health and educational needs of the population. There are no colleges or large places of employment.

**Population**

The main inhabitants of Jawadhi hills are the ‘Malayali’ tribes...
(meaning ‘people of the hills’). The participants were permanent residents of the area, classified as tribal on their ration card. The area contained numerous tribal hamlets organized into 11 panchayats. Many hamlets are accessible only by dirt tracts or mud roads. Each hamlet is a cluster of 20–40 houses. Phone coverage is patchy and unreliable, and people often have to trek long distances to reach a motorable road to access healthcare or other facilities. The predominant occupation of the people is subsistence farming and migrant labour.

Discussion guide

The focus group guide was developed on the basis of issues discussed in the literature. The key themes identified were: (i) Is excessive use of alcohol a problem in your community?; (ii) What are the types of alcohol consumed?; (iii) What are the sources of alcohol and its availability?; (iv) What are the patterns of use?; (v) Are there gender differences in use?; (vi) What is the age of initiation into alcohol use?; (vii) What are the common consequences of persistent use?; (viii) How does excessive use impact the family and community?; (ix) Does the community identify people with harmful pattern of use?; (x) What are the sociocultural norms and practices?; (xi) Have there been changes in norms and practices over time?; (xii) What are the possible solutions for those with problem drinking?; (xiii) What are the possible methods to prevent use among young people?; (xiv) What sort of services would the community want to prevent and reduce harmful use?

Data collection

Focus group discussions (FGDs) and in-depth interviews were used to assess the sociocultural models of alcohol use in the community.

An FGD is usually used to collect data about a particular topic from a small homogeneous group of people. Several FGDs done till data saturation is achieved usually give the researcher a wealth of information. We recruited participants who were permanent residents of the area over a 3-month period. A combination of tentative lists and snowballing technique were used for recruitment.

We conducted eight FGDs but had some difficulties in conducting FGDs with this population. We experienced this difficulty in the previous work we did with this population. The ‘group’ in the FGD was sometimes a loose group with women leaving in the middle and some joining later, after they had understood the purpose of the discussion. Some participants, particularly women, were reluctant to sign a consent document. We have not included data from participants who did not sign the consent form. However, the responses of participants who did not sign the consent form were very similar to those who did.

Eleven in-depth interviews were conducted, four with women and seven with men. The interviewer asked open-ended questions, probing wherever necessary to obtain data deemed useful by the researcher. The sites for the FGDs and interviews were in the community and were chosen for their ease of access.

The discussions and interviews were carried out by the same researchers, who were fluent in the local language. The moderators of the FGDs ensured that the topics were fully discussed and that all participants were given a chance to express their views. The aims of the investigations were explained at the start of the FGDs. The discussions lasted 45–60 minutes. Demographic details were also collected from the participants. The proceedings were audio-taped and field notes were also taken. The audio-tapes were transcribed verbatim. (These were in Tamil and were translated into English before coding.)

We conducted in-depth interviews among people with harmful alcohol use, an employee of Tamil Nadu State Marketing Corporation (TASMAC), a government retail alcohol outlet and also those with relatives and friends who had a drinking problem.

We triangulated our data from men and women of different age groups, ensuring that key informants such as TASMAC employees, men who regularly drink, alcohol brewers and so on were interviewed. We analysed extensive field notes documented from our interaction with the people in this range of hills. We, the researchers, are part of a team of healthcare workers who provide health and development services to this population. In addition to providing primary and secondary healthcare, we run development programmes for the people, and it was during such programmes that the people started talking to us about the problems of alcohol use in the hills. Over time, as we have been working in this area for the past four decades, we have observed the changing pattern of alcohol consumption and its effects on the people.

Analysis

Data from in-depth interviews and FGDs were deconstructed into themes and coded. Content and narrative analyses were done to explore the effect on families and the wider community. Field notes were used to inform and interpret qualitative data.

Ethical issues

The study protocol was approved by the Institutional Board of the Christian Medical College, Vellore. Informed consent was sought from all participants of the study. The results were discussed with the community.

RESULTS

Fifty people attended the FGD sessions. There were five FGD among women, two among men and one FGD had both men and women. Eleven in-depth interviews were conducted with four women and seven men; these included a village leader, brewers, teetotters, men with a drinking problem and women with spouses who drank alcohol.

Age

Many participants did not know their age. We have experienced this problem during our clinical work in this population; often the patient leaves it to the doctor to record his/her age as ‘deemed appropriate’ by the doctor. Most of the participants were between 25 and 60 years of age.

Education

For a population of 80,000, this area has only three higher secondary schools, all have been started recently. All the participants of the study were adults and had not completed their education. Most of them had attended primary school. There were no professionals.

Occupation

All the participants were engaged in agriculture during some months in the year, as they depend on rains for their living. They also go to neighbouring states of Kerala, Andhra Pradesh, Karnataka and other parts of Tamil Nadu to work as migrant labourers, which is their primary means of livelihood. Sometimes the families migrate, but most often the men go while the women, children and older people stay back in the village. Thus, there were fewer men in the hamlets and we had more women respondents than men.
The verbatim statements are recorded in Table I.

**Availability**

Two types of alcohol are available in the hills—arrack or locally brewed alcohol and 'Indian-made foreign liquor' (IMFL), sold in government-operated retail outlets (TASMAC). Arrack, traditionally brewed in the community, is culturally acceptable in the hills. It is made from the bark of particular trees (‘Soora pattai’, ‘Vellam pattai’), mixed with jaggery, allowed to ferment in a closed pot buried under the ground and distilled. It is brewed by certain families and is sold either by them or by local village grocery shops. It is brewed and stored in homes, and diluted to 50% before selling. It is sold ready for consumption without any mixers.

Three government retail outlets sell IMFL in this area. Almost all types of liquor are available; rum and whiskey are popular. The people in the hills are unfamiliar with the use of mixers to dilute alcohol, and often drink it neat. Some dilute it to 50% as they would arrack. IMFL, though more expensive than arrack, provides a more immediate and greater ‘high’. Sometimes these outlets function like a bar and the shop owner mixes drinks. Adulteration is not uncommon. Alcohol from these outlets is also stocked in grocery shops in interior villages.

**Acceptability**

Alcohol has been part of the tribal culture from time immemorial. It is used at religious and cultural ceremonies.

**Pattern of drinking**

The perceived causes of problem drinking identified during FGDs are listed in Table II. The age of initiation is usually in the mid-teens. Boys start drinking often after they were introduced to alcohol by their peers. Some boys are initiated into drinking alcohol by family members during festivals or family functions.

**Gender differences**

It is not culturally acceptable for women to drink. In some interviews strong statements were made: ‘If we find any woman drinking she will be thrown out of the village or killed.’ Drinking among women is not acceptable even during festivals or funerals when alcohol is traditionally served.

**Socio-cultural norms**

Alcohol was always part of the local tribal culture. However, there were cultural norms governing the use of alcohol in this community. Alcohol was brewed by particular families, usually in anticipation of certain cultural events such as festivals. It was also served during weddings and funerals. Young boys are not served alcohol, nor were women allowed to drink. Drinking without any ‘reason’ such as at a festival, or everyday drinking was not common. It was perceived to be ‘manly’ to drink, and men who don’t drink were considered to be miserly and effeminate. Being drunk and using money meant for household use for drinking was not acceptable. These perceptions continue even now.

**Changes over time**

Over time, there have been certain sociocultural changes that caused a shift in this type of drinking:

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**Table II. Perceived causes of problem drinking**

<table>
<thead>
<tr>
<th>Perceived cause</th>
<th>Number of focus groups where the issue was discussed</th>
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<tbody>
<tr>
<td>1. Easy availability of IMFL, which is much stronger than the traditional brew</td>
<td>8</td>
</tr>
<tr>
<td>2. Change in employment patterns that result in availability of money</td>
<td>8</td>
</tr>
<tr>
<td>3. Change from a barter system to money transactions</td>
<td>8</td>
</tr>
<tr>
<td>4. Loss of traditions and changes in culture</td>
<td>8</td>
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</tbody>
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Note: Listed above are the main conclusions of the study and the number of focus group discussions where these conclusions were reached. The four points are the perceptions of the participants related to change in the drinking pattern among the people in the hills. IMFL Indian made foreign liquor
1. Government monopoly on sale of alcohol: The state government controls the sale of alcohol. Home brewing and sale of alcohol by villagers has been made illegal and invites heavy fines and imprisonment. This is monitored by the forest guards and police. Alcohol brewing is now done illicitly, deep in the forest and sales are clandestine. Arrack is sold far away from the place it is brewed, often in the plains, to avoid detection by the police. The people in the hills rely more and more on alcohol from the legal TASMAC outlets. IMFL being more potent and stronger than arrack, and the fact that the local population is used to drinking alcohol without dilution, results in the ingestion of a much larger quantity of alcohol. Consequently, it is now common to see several men under the influence of alcohol in the villages in the evenings.

2. Change in occupation: Traditionally, the people were subsistence farmers and supplemented their income by gathering and selling forest produce. Over time, more and more people started seeking other forms of employment. People started migrating in large numbers, often as families, to neighbouring states as contract labourers. They spend 3–4 months working in textile factories, tea estates or digging bore wells and return in time for the rains and local festivals. At the end of their contract they have large amounts of cash in hand. This experience of having cash in hand rather than farm produce to meet their needs seems to have contributed to the changing pattern in alcohol consumption.

Effects on family and society
Changes have been noticed in relationships within the family and society after the establishment of the TASMAC shops. Whereas drunken brawls were infrequent in the past, they are now common and often escalate into physical violence. There has been a noticeable increase in road traffic accidents causing increased mortality and morbidity, mainly among young men riding two-wheelers while under the influence of alcohol. Feuds erupt among youth of different villages during festivals due to the boys being drunk. Social order such as obedience to the local leader has decreased.

Within families, the responsibility of providing for the children and running the households has shifted to the women, with the men being under the influence of alcohol when they are back in the village after migrant work. Women earn a living by seeking employment for daily wages in the Mahatma Gandhi National Rural Employment Guarantee (MGNREGS) ‘100-day work’ government scheme to provide for children. Women also manage the farming of their own fields and activities that were traditionally done by men (e.g., ploughing the field with oxen). Though there are some reports of wife-beating while under the influence of alcohol, the men mostly seem to leave the women alone, and domestic violence is less than in the plains.

Effect on children
Villages where most children went to school were perceived as having fewer problems with alcohol use. On the other hand, school dropouts were perceived to be the largest group of children consuming alcohol. They were also identified as the ones likely to influence other children to drink. Those who discontinued school were often engaged in manual labour and had cash in hand to spend. Boys who have money are perceived to be independent of parental care and sanctions.

Initiation into alcohol use at a young age was also said to be influenced by children being sent to shops to buy alcohol for their father and uncles, children having money to spend and availability of alcohol.

Effects on health
Alcohol consumption is perceived by the people to be detrimental to health. People say it causes stomach pain, vomiting, blood vomiting, bloated stomach and a decreased life span. However, there is poor awareness of any allopathic medical treatment available to treat this condition. They prefer treatment facilities in the hills rather than travelling to the plains.

Community efforts to curb availability
The ill-effects of consuming IMFL have been noticed by the people and some successful attempts have been made to stop the opening of new outlets. Some hamlets, led by strong community leaders have been successful in not allowing TASMAC shops to be opened in their village. However, in one village, a TASMAC outlet has been opened next to a school hostel and places of worship, despite protests from the local people and non-governmental organizations (NGOs) working in that area.

Members of self-help groups were considered less likely to indulge in hazardous use as they were engaged in constructive work and were educated about the effects of problem drinking and were subject to peer pressure. The government ban on local brewing and frequent raids by the police and forest guards made local liquor more expensive as it was manufactured deep within the forest. The non-availability of water in the forest due to the near-drought conditions, presence of elephants (who have developed a taste for alcohol) and heavy fines placed by the forest guards on discovery of this activity have made brewing a dangerous and secretive activity.

Establishment of alcohol outlets in some villages has been stopped by the presence of strong oorans (village leaders) who can influence the people to boycott sales and protest the presence of the shop in the village. Protests by women and people without the support of the traditional leaders have not been very effective.

The community did not seem to perceive medical intervention as a need and were not aware of the availability of medical detoxification. There was some skepticism about whether men who were problem drinkers would volunteer for treatment. The people preferred medical help at local centres in the hills as travel to the plains was uneconomical and difficult.

DISCUSSION
The strength of our study is the focus on community perspective by conducting a large number of FGDs across a cross-section of the local population. Its limitations include the fact that traditional qualitative methods were difficult to follow in tribal communities. People, especially women, were reluctant to sign the informed consent form, and hence some interviews could not be included in the analysis. Though we have a rapport with this community, a few participants left the FGDs early while others joined the session midway. The analysis of the data collected by FGDs and key informant interviews was along the lines of an explanatory model leading to the development of a perceptual framework.

We documented traditional norms, patterns of use of alcohol, its consequences for individuals, the families and the community. We also recorded changes in the sources and procurement of alcohol, its impact on the local culture and people. There was a shift in patterns of drinking and there are problems related to young people now being addicted to IMFL that is easily available and affordable. These detrimental effects on young men, families and society have been reported by other studies as well. Changes in occupation and terms of employment, and from a barter system to cash transactions have had a major impact on the community.
and its traditional way of life. Established in 1983, the TASMAC has monopolized the wholesale distribution of IMFL and since 2003 it has also monopolized the retail vending of IMFL. Since inception, this Tamil Nadu state government-owned company has registered steady growth in sales and revenue. Opening of TASMAC outlets supplying IMFL have wrought havoc on the local culture and altered consumption patterns to the detriment of the community. The negative impact of alcohol use has been documented in other tribal populations in India.

The dependence of governments on income generated by alcohol focuses only on budgets and revenue. The rapid expansion and aggressive marketing strategies, particularly among tribal communities, have a major impact on traditions and cultures. Policy decisions related to location of outlets, dry days, restriction on the hours of sale, increasing prices, enforcing drink driving laws and enforcing age limits go a long way in preventing problem drinking. However, India lacks such a rational alcohol policy. Education about problem drinking and the ill-effects of alcohol in schools, self-help groups and communities and enhancing life-skills are helpful. Awareness and community initiatives against alcohol use are not well augmented by law enforcement in India.

Conclusions
This tribal community has a good insight into the problems caused by alcohol consumption among their families and society. They attribute the rising prevalence of problem drinking to easy availability of IMFL, which is much stronger than the traditional brew, change in employment patterns resulting in having cash in hand and changes in the culture of drinking in this area, which has made it easier for younger men and boys to drink. Traditional cultures pay a heavy price with the introduction of non-traditional and commercial alcohol. The people in this society report increasing mortality and morbidity related to alcohol use, breakdown of families and societal structures and increasing burden on women to support the family. While government budgets need to be balanced, they should also recognize the long-term implications of policies related to alcohol. The results of the analysis also suggest that community-based interventions targeting young children and adolescents may pay more dividends than pursuing purely medical treatments for problem drinkers.

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