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# Prevalence, Nature, Context and Impact of Alcohol Use in India: Recommendations for Practice and Research

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Prevalence, Nature, Context and Impact of Alcohol Use in India:

Recommendations for Practice and Research

### **Abstract**

Presently alcohol policy in India takes a moral stand rather than a scientific approach towards understanding and dealing with the problem of alcoholism. To effectively address this social problem in India, public policy must take into account the nature, extent of the problem and the context in which it occurs. This literature review examines the nature, prevalence and impact of alcohol use and misuse in India, within its historical and cultural contexts, as a beginning step to inform policy. Recommendations for practice and future research directions are suggested.

**Key Words:** India; alcohol; alcoholism; policy; culture; historical context; literature review

## Introduction

Alcohol consumption is a culturally defined activity, impacted by the economics and polity of a society at a given point in time. In the year 2000-2001 the recorded alcohol per capita consumption in India was a low 0.82 liters of pure alcohol as compared to the per capita consumption in US (8.51 liters), Canada (8.26 liters) and UK (10.39 liters) for the same period (WHO, 2004). Post 1995, the unrecorded alcohol per capita consumption in India is an estimated 1.7 liters (WHO, 2004). While these figures give the impression that India is largely a dry culture, considerable variations exist in the prevalence of alcohol use and misuse within the country. Class, caste, religion and gender are significant factors that define the patterns and nature of alcohol consumption across India. Further, increasingly, globalization and economic liberalization are affecting changes in the social fabric and organization of the Indian society and is likely to have an impact on drinking patterns and cultures in the country as well.

This article reviews literature on alcohol use in India to identify prevalence, nature, context and impact of alcohol use in India. Current interventions and treatment approaches are examined and future directions for practice and research are discussed.

## Historical presence, use and tolerance of alcohol in India

*“Changes in drinking customs may offer clues to fundamental social changes.”*

David Mandelbaum, *Alcohol and Culture*. 1965

The presence and use of alcohol in ancient India is documented in religious, mythological and medical texts (Benegal, 2005; Mandelbaum, 1965) and finds corroboration in archeological

evidence of distillation instruments found from this era (Allchin, 1979). References to inebriating effects of Soma and Sura are found in the Vedic texts dated back to 2000 B.C (Allchin, 1979). It is inferred that ritualistic and household uses of these concoctions were prevalent in the pre-Vedic<sup>1</sup> and Early Vedic period- 2000 BC- 800 BC approximately (Allchin, 1979; Mandelbaum, 1965).

The first instance of prohibition on the use of alcohol appeared only in 200 BC with the introduction of the Laws of Manu<sup>2</sup> (Mandelbaum, 1965). This prohibition on alcohol consumption was restricted to the priestly class i.e. the elite Brahmins, no restrictions were set on drinking by other strata of society. Mandelbaum (1965) observes that since the time of Manu, drinking has been socially and religiously compartmentalized in India. In fact, even as alcohol was excluded from the worship of high, universalistic gods, local deities and godlings who presided over local illness and misfortunes and whose rituals are carried out mainly by the lower castes continued to receive alcohol as offering. The subsequent advent and spread of Buddhism and Jainism in the 3<sup>rd</sup> century BC further cemented the attribution of religious and moral legitimacy to abstinence (Mandelbaum, 1965).

During the Mughal era (1200-1700 AD), despite the stronger emphasis on prohibition of alcohol use in Islam, drinking was common and alcohol use was not prohibited by the state. In fact some Mughal emperors themselves consumed alcohol and opium (WHO, 2003). Wine was

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<sup>1</sup> The Vedic civilization is the earliest civilization in the history of ancient India associated with the coming of Aryans. The Vedic period refers to the period between 2000 BC- 800 BC approximately and derives its name from the oldest Indian texts known as the Vedas.

<sup>2</sup> The Laws of Manu (Manusmriti) consists of 2,685 verses describing the dharma (or obligations) of persons from various castes and gender. It involves commentary on the conduct of social, political and religious obligations and roles (Doinger, W. & Smith, B., 1991)

also a prominent part of court life, used by courtiers and nobles. Poetry from this period often alludes to the dilemma of drinking wine (WHO, 2003).

The British rule (1858 and 1947 A.D) in India resulted in rapid industrialization accompanied by phenomenal changes within the social and caste structures. Industrialization and urbanization enabled the movement away from traditionally rigid caste-regulated occupations and provided for upward class and caste mobility. Changes in dietary and social practices were adopted by those in the traditionally lower strata to acquire higher social status, a phenomenon known as Sanskritization<sup>3</sup>. Thus a growing middle class embraced the upper-caste norms of vegetarianism and abstinence from alcohol (Benegal, 2005). Meanwhile, during the British colonial rule, manufacturing of alcohol became restricted to licensed government distilleries, leading to the replacement of traditional alcoholic beverages to mass produced factory made products with greater alcohol content (Benegal, 2005). Thus, under the British there was a slow and steady rise in licit alcohol availability and consumption (Mohan, Chopra, Ray & Sethi, 1997) Paradoxically, alcohol came to be regarded by Indians as a British vice and by the elite rulers as an atavistic trait of the poor and socially backward Indians (Benegal, 2005).

With support from Mahatma Gandhi and other national leaders temperance and abstinence was co-opted in the national struggle for Independence for India and from British rule. Drinking became one of the symbol of colonial oppression (Benegal, 2005). Among other things, boycotting and picketing of foreign liquor and alcohol outlets during the non-cooperation movement and civil disobedience movement in the 1920's became a popular form of protest

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<sup>3</sup> Sanskritization is a term coined by the Indian Sociologist M.N. Srinivas. It refers to the process of acculturation (adoption of customs, ritual, ideology and way of life) of the upper castes by those lower in the rungs of the caste hierarchy, or by tribal or other groups.

against the British rule in India. Prohibition thus eventually made its way into the Constitution as a Directive Principles of State Policy of Independent India.

### **Alcohol and State Policy in post- Independence India**

*“The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.”*

Article 47, Directive Principle of State Policy, Constitution of India.

Although alcohol prohibition is encouraged in the Constitution of India, alcohol policy is a state subject. States have full control of alcohol legislation, state excise rates and the production and sale of alcohol (Rahman, 2003). The initial emphasis of the newly independent India on prohibition lasted in most states until the mid- 1960's, by 1970 only the state of Gujarat retained a complete prohibition policy. Currently, at the state level across India, there are three main types of prohibition policy: complete prohibition of production and consumption; partial prohibition -where one or more type of liquor (usually arrack) is prohibited; and dry days where consumption is prohibited on certain days of the week or month (Rahman, 2003). Gujarat continues to remain the only state with a complete prohibition policy.

According to Benegal (2005) most states derive 15-20% of their revenue from taxation on alcohol, given its significant contribution to state treasury, on the face of it, stringency of prohibition policy causes considerable harm to the states exchequers. Hence, since

independence, States have experienced ongoing fluctuations on the degree of prohibition adopted at the policy level. While alcohol remains one of the most important sources of revenue for most states its use attracts considerable social opprobrium (Benegal, 2005; Rahman, 2003). Given the high levels of corruption and inadequate law enforcement the efficacy of prohibition policies have also been called into question. In the state of Gujarat where complete prohibition is in force, the Gujarat Prohibition Department sized close to 8, 39,338.3 liters of liquor in the year 2005 alone. While the rich have continued access to alcohol, the poor resort to illegal brews, with a consequent increase in bootlegging and deaths due to methanol poisoning (Patel, 1998).

Even as social costs continues to fuel social mobilization against the use and sale of alcohol, globalization and economic liberalization ensure increased accessibility and promotion of alcohol through exposure to mass media and increasing disposal income. While, advertisement of alcohol and cigarettes is legally prohibited in India the industry circumvents the ban on advertising through surrogate advertising. Benegal (2005) points to the change in advertising *'from voluptuous pin-ups (targeting the traditional market of middle-aged male consumers) to lifestyle advertisements promoting the connection with good times, aimed clearly at women and youth'* (pp. 1052, para.7).

In other countries, increased taxation has been used to reduce consumption. In India, the impact of such measures is weak as consumers have easy access to undocumented and illicit alcohol and substances. Other regulatory laws pertaining to hours of sale, sale to minors and drunken driving are regularly breached (Benegal, 2005).

To effectively address a social problem, public policy must take into account the nature, extent of the problem and the context in which it occurs. The present alcohol policy in India seems to be based on an ideological stance rather than a comprehensive understanding of the



various dimensions of the problem. The following sections reviews literature on alcohol use in India to gain a better understanding of the nature, prevalence and impact of alcohol use and misuse in India.

### **Types and prevalence of alcohol use in India**

India is a very diverse country with considerable variation in climate, vegetation, natural resources, cultures and traditions. This diversity is also reflected in the types of alcoholic beverages consumed and the cultural meaning associated with alcohol use.

#### **Types of Alcoholic Beverages**

The most common forms of alcoholic beverages are arrack (made from paddy or wheat), toddy (palm wine), country liquor, illicit liquor, Indian Made Foreign Liquor (IMFL)<sup>4</sup>, beer and imported liquor (Bennett, Campillo, Chandrashekar, Gureje, 1998; Navchoo & Buth, 1990; Mohan, Chopra, Ray, Sethi, 2001). Alcohol content in traditional alcoholic beverages such as arrack, toddy, country liquor ranges from 20 to 40 % (WHO, 2004). Alcohol content in illicit liquor is much higher (up to 56%). Illicit liquor production is a serious problem in India. Raw materials used in production of illicit liquor are similar to those used for country liquor, however, illicit liquor is often adulterated using adulterants such as industrial methylated spirit (WHO 2004). Illicit liquor is cheaper than licensed country liquor and therefore popular among the rural and urban poor. In many parts of India, illicit production of liquor and its sale is a cottage industry with each village having one or two units operating illegally (WHO, 2004).

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<sup>4</sup> Indian Made Foreign Liquor consists of alcoholic beverages that were originally formulated in foreign countries but are currently being made in India, such as, whiskey, rum, gin, vodka, beer, wine.

Home production and self- consumption of some alcoholic beverages is also common in certain regions and ethnic communities in India. For instance, in Ladakh, a mountainous region set in the northernmost State in India, certain alcohol (chhang, phaph, gur gur cha) and narcotic (berzeatsink, staspakchek, zimpating) preparations are part of the local diet (Navchoo & Buth, 1990). Arunachal Pradesh, a Northeastern state in India boasts a rice wine called Apong (WHO 2004). Zu and Rohi are locally brewed alcoholic beverages found in the state of Nagaland (WHO 2004). In the Sundarban region in West Bengal, Handia (rice beer) is a traditional drink regarded as food as well as intoxicants by the local adivasis (tribal/indigenous) communities (Chowdhury, Ramakrishna, Chakraborty, Weiss, 2006).

### **Prevalence of alcohol use in India**

Business news reports claim that the Indian market for IMFL is growing at the rate of 8%- 10% a year (Thottam & Hannon, 2009). Sales of IMFL is however likely to account for only a section of the population consumption, namely the middle and the upper middle class consumption. It does not account for traditional or country made liquors consumed primarily by the lower middle class and the urban and rural poor. Further, illicit liquor production, sale and consumption remain unaccounted for.

The dearth of systematic national level epidemiological survey makes it difficult to estimate the prevalence and patterns of alcohol consumption and/or misuse at a country level. The 2003 National Survey for Alcohol and Drug Abuse found that of the 40697 male respondents (across 25 states, covering rural and urban populations) aged 12-60 years, 74.1% reported life-time abstinence and 21.4% reported being current users (used in last 30 days) of alcohol. Of the total-users, 17% were classified as dependant users (based on the International

Classification of Diseases 10) (WHO, 2004). The prevalence rate reported in this study is higher than that in the following secondary two national studies as well as in other regional or community specific epidemiological studies that have been conducted so far.

Neufeld, Peters, Rani, Bonu & Brooner (2005) analyzed data from the nationally representative survey (National Sample Survey) of 471,143 people across the country. They reported that the national prevalence of alcohol use was 4.5%. Men were found to be 9.7 times more likely to report regular use of alcohol than women. Further, members of Scheduled Castes and Scheduled Tribes (historically marginalized communities in India) were significantly more likely to report regular use of alcohol as well as tobacco smoking and chewing.

Similar results were reported by Subramaniam, Nandy, Irving, Gordon & Smith (2005) who analyzed the Indian National Family Health Survey for the period 1998-1999. They too reported that members of the schedule castes, schedule tribes and other backward classes were more likely to consume alcohol than members of other caste groups. Further they found that men with no education were more likely to report alcohol use than those with post-graduate education. These studies hint at class, caste and gender variations in alcohol consumption but reveal little in terms of alcohol related problems.

With the exception of studies mentioned above, almost all other epidemiological studies on alcohol use in India have been very region or community specific and their generalizability to the entire country is questionable (Bennett, Campillo, Chandrashekar, Gureje, 1998). Nonetheless, these studies provide insights into factors determining nature and patterns of alcohol use in India.

### **Factors determining nature and patterns of alcohol use**

**Class, Caste and Ethnicity.**

Chowdhury, Ramakrishna, Chakraborty & Weiss (2006) conducted an ethnographic study to identify alcohol consumption patterns and norms in 2 ethnically and economically diverse Development Blocks<sup>5</sup> in West Bengal, India. One of the development blocks, Sagar, is inhabited mainly of Hindu migrant workers from another state while Gosaba is home to the adivasis i.e. local tribal (indigenous forest people) communities. Sagar is relatively better developed and has a ferry connection to the mainland. Comparatively, Gosaba is close to a tiger reserve with only country boats to connect them with the mainland.

The researchers found that popular alcoholic beverages in both these blocks were country liquor and toddy (palm wine). The consumption of IMFL was restricted to tourists and 'high status male'. Differences were observed in the culture and pattern of drinking among the tribal community and the migrant community. Handia (rice beer) was a household brew among the tribal and mainly made for private consumption as part of the diet. Handia was not considered a hard drink and did not have negative connotations associated with alcohol drinking. Like other tribal communities, alcohol consumption by women was not taboo. Handia was also popular among lower caste men and laborers in Sagar. Among the members of low caste and tribal communities country liquor could be used to barter services (boat/ferry ride) or goods (soil beds, betel leaves). Additionally, consumption of alcohol at religious, funeral, marriage ceremonies are reportedly common. Unlike Gosaba, in Sagar consumption of alcohol was not allowed at home or within the immediate community. Alcohol related problems were identified in both these sites

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<sup>5</sup> A Development Block is an administrative demarcation identifying a rural area in India that is targeted for development activities. A single Development Block may cover several Gram Panchayat i.e. village administrative units.

and punitive community actions were targeted towards those perceived as alcoholic or engaging in disruptive public behavior (brawls, eve teasing etc.).

Mohan, Chopra, Ray, Sethi (1997) who surveyed 12,157 men and women aged 15 + years from three districts (Mandsaur, Barabanki & Thoubal) in Madhya Pradesh a state in Central India also found significant differences in drinking patterns and attitudes among specific castes and ethnic groups. They reported that men from certain land and cattle owning castes groups (Rajputs, Yadavs and Meghvar) had a culture of alcohol consumption and a reputation for entertaining guests. Drinking was reportedly generally done at home by members of these caste groups. This cultural acceptance of alcohol was limited to the men and complete abstinence from alcohol was expected of women among these Hindu castes groups. In contrast the tribal groups in Thoubal district viewed alcohol as a natural product, a gift of god to be utilized for dietary as well as medicinal purposes by men and women.

### **Religion.**

Religion plays an important spiritual and regulatory role in individual and community life in India. The Census of India identifies Hinduism, Islam, Christianity, Sikhism, Buddhism and Jainism as the five major religions in India. In the 2001 Census, 6,639,626 Indians identified themselves as following religions and persuasions other than the five mentioned above. Of the five major religions three, namely, Islam, Buddhism and Jainism explicitly prohibit alcohol consumption. Across studies, Indian Muslims report the highest abstinence rates (Chowdhury, Ramakrishna, Chakraborty & Weiss, 2006; Gupta, Saxena, Pednekar, & Maulik, 2003; Mohan, Chopra, Ray, Sethi 1997; Subramaniam, Nandy, Irving, Gordon, Smith, 2005). Despite the stronghold of religion in the lives of people in India, its role in alcohol consumption had not been adequately explored.

**Gender.**

With the exception of tribal societies, abstinence from alcohol consumption by women is a cultural norm in India. General population studies have consistently found a low consumption rate among Indian women- ranging from 2-5%. Cultural and religious norms, limited accessibility and gendered nature of drinking spaces are likely to explain the low rates of alcohol consumption among women in India (Benegal, Nayak, Murthy, Chandra & Gururaj, 2005). Not much is known about women who do drink.

One study examined patterns and context of alcohol consumption among women in urban and rural Karnataka. Benegal, Nayak, Murthy, Chandra & Gururaj (2005) interviewed 1517 males and 1464 women across eight urban and rural centers in the southern state of Karnataka. Of the women interviewed, 84% reported being life time abstainers and 5.8% reported having at least one drink in the last 12 months. Of the 5.8% women, urban working class women and rural women drinkers comprised 2% while affluent urban women comprised the remaining 4%.

This study highlights the differences in drinking patterns amongst women reporting alcohol consumption. Of the 5.8% women, 46.5% women drinkers reported heavy drinking (6 or more drinks per typical occasion). Further it was reported that a larger proportion of rural women than urban women reported drinking weekly or more often as well as drinking more 5+ drinks per occasion. These researchers also found that poor women in rural and urban communities mainly consumed Arrack (country liquor) or moonshine (illicit liquor) and were more likely to drink at home or at off-license retail outlets. These women also reported that they consumed alcohol for tension reduction and stress relief rather than for pleasure. In comparison, alcohol consumption was significantly lower among women from upper and middle socio-economic groups. These women were younger; more educated and reported drinking less per typical

drinking occasion. They primarily consumed wine, IMFL and beer and drinking occurred largely in socialized circumstances i.e. at restaurants, parties, with spouse, friends and co-workers.

The above study suggests that there is much to understand about factors that influence abstinence as well as alcohol consumption among women. Not only are women understudied, some women (women in prostitution, women working in dance bars) do not even receive a mention in the literature.

Summing up, current literature suggests that class, ethnicity, gender and region significantly define the alcohol consumption patterns and culture in India. However, the current picture is fragmented and incomplete. More extensive research is needed for a holistic understanding of the nature of alcohol use and abuse in India.

India has had very strong grassroots movements to address the problematic alcohol consumption. The following section examines what is known about the impact of alcohol abuse on the lives of individuals, families and communities in India.

### **Impact of alcohol use**

Alcohol abuse has significant individual, familial and social costs. Long term and/or chronic alcohol use has been associated with liver cirrhosis, liver disease, lip, oral cavity and pharynx cancers and heart disease (WHO, 2004). Additionally, intoxication increases risk for road traffic accidents, poisoning and intentional and unintentional injury. Globally alcohol causes 3.2% of all deaths or 1.8 million deaths annually and accounts for 4.0% of disease burden (WHO 2007). This section examines what is known about the impact of alcohol on the health and lives of individuals and families in India

### **Health, Injury and Violence.**

Cancela, Ramdas, Fayette, Thomas, Muwonge, Chapuis, Thara et. al. (2009) interviewed 32,347 participants to evaluate the role of alcohol drinking and patterns of consumption in oral cancer incidence and mortality in 13 panchayats<sup>6</sup> in Trivandrum district in Kerala. They found that incidence of oral cancer increased by 49% among current drinkers and 90% among past drinkers than among never drinkers. Current and past drinkers in this study were also more likely to be tobacco smokers and betel- quid chewers than never drinkers. Further, it was reported that the risk of dying from oral cavity cancer was significantly increased among alcoholics in this study. Other studies in India have found alcohol consumption to be a risk factor in for cardiovascular diseases (Kusuma, Babu & Naidu 2009) and oral submucous fibrosis (Hashibe, Sankaranarayanan, Thomas, Kuruvilla & Matthews 2002).

Alcohol use has also significantly associated with injury. India has one of the most stringent Blood Alcohol Content (BAC) count allowed for drivers yet in a study by the National Institute of Mental Health and Neurosciences, India it was found that in the city of Bangalore alone, 18-25% of the road injuries are attributable to driving under the influence of alcohol (NIMHANS, 2007).

Benegal, Gururaj, Murthy, Taly, Kiran, Chandrashekar., R & Chandrashekar, H. (2007) sampled 658 injury cases reported to the Emergency Department (ED) of the largest and most reputed general hospital in Bangalore. The injuries represented more than half (54.5%) of all cases seen at the ED during the study period. A high proportion of injuries were found to be alcohol related. It was found that 23.7% of all subjects presenting for treatment of injuries had consumed alcohol prior to the injury occurrence. Of these, 17.9% had BAC readings of .03 and over, which is the legal limit for driving in India. 77.5% patients who reported alcohol use prior

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<sup>6</sup> Panchayat is the municipal administrative unit in a village in India.



to the current injury were also significantly more likely to have had repeated admissions to the ED in the past. Further, subjects who had drunk prior to injury were significantly more likely to drink five or more drinks per sitting, more than 3-4 times a week than subjects without alcohol use prior to injury.

An important gender difference related to indirect alcohol related injury was observed in this study. Of those reported injuries indirectly related to alcohol (use by others) 57% were female and 59% male. Injuries indirectly related to alcohol among women included injuries due to burns, hanging, poisoning and assault. The researchers point out that in the Indian context, a large proportion of burn injuries are not accidental burns but assault and homicidal attempts on women by male relatives. In a family where a woman is already being harassed for dowry, birth of a girl child or lack of male child/ren, alcohol abuse by the husband is likely to intensify physical, emotional and financial abuse (Benegal, Gururaj, Murthy, Taly, Kiran, Chandrashekar., R & Chandrashekar, H. 2007)

A number of studies on domestic violence suggest that while alcohol abuse by the spouse may not be the primary cause of domestic violence, it increases women's vulnerability to violence perpetrated by her spouse or partner. Varma, Chandra, Thomas & Carey (2007) interviewed 203 women attending an antenatal clinic in a public hospital in Bangalore to assess the prevalence of intimate partner violence and sexual coercion and its mental health consequences among pregnant women. 30 of 203 women in this study reported experiencing physical and psychological violence. Further, of these 30 women 15 reported ongoing violence during pregnancy. Prevalence of alcohol use was found to be much higher among spouses of abused women (82%) compared to spouses of non abused women (18%). This study found that

harmful use of alcohol use was a significant predictor of the presence as well as severity of violence.

Parker, Fernandes & Weiss (2003) conducted focus group discussions with women, men, youth and community leaders in a slum in Mumbai to identify the needs of the community for a community based mental health program. Alcoholism emerged as a major problem in the community. Participants reported that alcohol was distilled locally, was readily available and imbibed by 60% to 70% of the male population in the community. Domestic violence was identified as a rampant problem and closely associated with alcohol abuse by men. In addition to physical abuse women reported that their husbands regularly harassed them for money to repay credit taken for alcohol or for further alcohol consumption.

Similar findings were reported by Stanley (2008) who interviewed 75 wives of men enrolled in a de-addiction center in the city of Tiruchirappalli in South India. Like the previous studies, women in this study reported regular psychological, physical and financial abuse. 43.3% women reported that alcohol was consumed by their spouse at all times of the day. 30 % reported that their husbands had borrowed money and 13.3% reported that property was sold to meet the drinking expenditure. Of the sample 96.7% reported being verbally abused and 90% reported being physically abused. 50% of these women also reported physical abuse of children.

These studies indicate that alcohol abuse and woman and child abuse co-occur but do not explore the role of alcohol in domestic violence perpetuation or the nature of injuries caused by violence involving alcohol abuse. While it is unclear whether alcohol use triggers or intensifies violence, the studies suggest that women with alcoholic husbands are at increased risk for injury, victimization and impoverishment.

### **Poverty and Impoverishment.**

According to the Planning Commission of India in the year 2004-2005 an estimated 27.5% of the Indian population was living below poverty line. Given that health care in India largely involves out of pocket expenditures, alcohol related health problems can become a major source of impoverishment particularly among the rural and urban poor. Saxena, Sharma and Maulik (2003) compared two groups of families (families with at least one family member consuming alcohol and families with no member consuming alcohol) in an urban slum community in Delhi. While the families in both the groups ( $n = 197$ ) were similar in socio-demographic, families with at least one member who consumed alcohol spent a larger fraction of their income on alcohol and were in debt to a greater extent. These families also had fewer financial resources for food, education and purchase of daily living consumer goods. Further, higher number of illness or injury in the previous 1 year was reported by these families than the non-drinking families. In this study families with drinkers were also less likely to seek health services due to limited resources.

Similar findings were reported by Bonu, Rani, Peters, Jha and Nguyen (2005) who analyzed data from the 52<sup>nd</sup> round of the National Sample Survey, a representative nationwide survey of 120942 households across India. They found that the likelihood of borrowing and distress selling and the proportion of total expenditure met through such borrowing or selling, during hospitalization was greater among individuals who used tobacco and alcohol than from non-users. Approximately 16% of the total borrowings/ distress selling of assets during hospitalization was attributed to tobacco or alcohol use. These researchers point out the need to include strategies for control of alcohol and tobacco consumption into the larger framework of poverty reduction.

The preliminary studies discussed in this section suggest that alcohol abuse and dependence has significant impact not just for those addicted but also for those connected to the addicted person's life. This impact is even starker for those living in poverty.

### **Interventions and Treatments**

Treatment for alcohol/drug problems in India is offered mostly in public mental health institutions, psychiatric departments of government hospitals, private psychiatric clinics and substance abuse treatment centers (Chakradhar, K. 2009). According to the Ministry of Social Justice & Empowerment's website, through the Scheme of Prevention of Alcoholism and Substance (Drug) Abuse, the ministry currently funds 41 Counseling Centers and 401 Treatment –cum- Rehabilitation Centers. Further the website states that through this scheme the central government provides financial support to NGOs and employers for following preventive, curative, research and training activities and program (Ministry of Social Justice and Empowerment, GOI, 2008)

In addition these initiatives on the part of the Central government, there are independently / privately funded organizations and initiatives that provide services for alcohol and drug addiction. These services range from traditional ayurvedic treatment to Alcoholic Anonymous interventions.

One intervention model that finds mention in literature on alcohol treatment is the community based rural rehabilitation camps. Community-Based Rehabilitation (CBR) model was introduced by the World Health Organization in 1976 in the field of physical disabilities, especially for implementation in low-income countries with scarce resources (Chakradhar, K. 2009). This model essentially involves mobilizing social capital within the community to meet

the needs of members of the community without costs to the client. The responsibility for the intervention is shared by the professionals and the members of the community, with the community providing the physical infrastructure and aftercare help (Chakradhar, K. 2009). In India the CBR camp approach has been used to provide a wide range of community based services including eye camps, immunization camps, family planning camps and camps for substance abuse. Raj, Chavan & Bala (2005) evaluated the effectiveness of the camp approach for the treatment of alcohol and drug dependence for 46 patients from villages near the city of Chandigarh in North India. At six months follow up 22.2% patients were found to be totally abstinent and 50% patients reported 50%-75% reduction in intake of alcohol and drugs. The researchers noted in 95% cases the patient and his family were in agreement regarding alcohol intake improvement observed. The drop- out rate in this study was 16.3% reportedly lower than drop-out rates for hospital based treatments. Findings from other studies suggest that the camp approach could be a useful model in de-stigmatizing alcoholism in rural communities and providing effective intervention (Chakradhar, 2009).

Currently, there is a dearth of information as to the number of organizations addressing alcohol misuse, the nature of services provided and their impact. There is an urgent need for stocktaking of available services for persons with addiction to alcohol.

### **Recommendations for Social Work Practice**

A multifaceted problem such as alcohol abuse requires a multi-pronged and multi-system approach to intervention (Benegal, 2005). As with most social problems, prevention, detection and treatment are key areas for intervention in addressing alcohol abuse. Social work

professionals can make significant contributions by initiating and testing best practice options in each of these areas.

Preventive initiatives usually involve raising awareness through education regarding the problem and capacity building for action. Preventive efforts not only create awareness but can also help to de-stigmatize the problem and individuals affected by alcohol misuse. Schools, colleges, religious organizations, community based and development organizations (such as youth and women's organization) are key community institutions that need to be enrolled in the efforts to address alcohol problems within a given community. Social workers can be instrumental in community mobilization for social change. As change agents social workers can identify, motivate, train and assist stakeholders to draw on community assets for initiating, planning and implementing community specific preventive and treatment strategies.

Educational and awareness raising initiatives must be complimented by adequate detection and treatment efforts. Professionals likely to come in contact with those affected by alcohol abuse including health care providers, development workers, women's organizations, police and traffic police require capacity building to ensure detection and appropriate referrals are made. A review of websites of organizations<sup>7</sup> offering alcohol treatment and de-addiction services indicate that some have adopted the Alcohol Use Disorders Identification Test (AUDIT)<sup>8</sup> for screening and assessment. However the extent of its usage in assessment and screening across treatment facilities in India is unknown. Training of health care professionals and social service providers in the use of standardized assessment measures is essential for practice as well

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<sup>7</sup> List websites of organizations

<sup>8</sup> AUDIT was developed by the World Health Organization and has been tested for cross-national standardization.<sup>8</sup>

as research. Social work professionals are an integral part of many systems including schools, hospitals and law enforcement and can be instrumental in facilitating networking and collaborations between various stakeholders in the community. Additionally social workers can significantly contribute to planning, co-coordinating and implementation of training and capacity building of professionals.

Literature on treatment approaches currently in use in India is sparse. A review of websites of organizations reflect a variety of approaches including detoxification units, yoga, psychotherapy, counseling, brief therapies, residential and non-residential programs, community based rehabilitations camps and programs involving one or more family members. However the efficacy of these treatment approaches for the particular client population remains to be demonstrated. The current situation warrants the urgent need for social workers to conduct practice evaluation research in order to identify best practices in addressing alcohol related problems.

### **Implications for Research and Policy**

Presently it appears that while the majority of the Indian populace is abstinent, among those who do drink there are high rates of problematic and harmful drinking (Benegal, Nayak, Murthy, Chandra & Gururaj, 2005; D' Costa, Nazareth, Naik. Vaidya, Levy, Patel, & King, 2007; Rahman, 2003). Systematic and streamlined research on countrywide prevalence, context and impact of alcohol abuse is needed in order to formulate effective policies and implement appropriate interventions. Further, a thorough investigation of the nature, type and effectiveness of alcohol interventions currently in use is essential.

Given that the current alcohol policies are not only inadequate but also harmful (causing increase in illegal activities and endangering lives) alternatives need to be explored. Such alternatives must take into account the factors that help the majority of the Indian population abstain or observe temperance in alcohol consumption as well as factors that increase vulnerability to alcohol abuse and dependence within individual communities. Presently alcohol policy takes a moral stand rather than a scientific approach towards understanding and dealing with the problem of alcoholism, possibly compounding the problem. A better understanding of the nature, extent and cause of the problem would help design policies and interventions that are closer to target in affecting these areas and creating social change.



## Glossary

**Arrack:** Arrack, Arrack is a distilled beverage, obtained from paddy or wheat. Jaggery, sugar or sugarcane is added to either of these two cereals and boiled with water. This is allowed to ferment, after which it is distilled. This beverage contains about 50- 60 per cent of alcohol (WHO, 2003).

**Ayurvedic:** Ayurveda is a traditional system of Indian medicine. Ayurvedic medicine is an organized system of traditional health care, both preventive and curative, that is widely practiced in parts of Asia. (Britannica, n.d.)

**Berzeatsink:** Local narcotic preparation in Ladakh, India. It is made by roasting roots of depgul over a fire. The roasted roots are mixed with tobacco and powdered. Either smoked with tobacco or taken with milk, the preparation is claimed to stimulate and activate a person (Navchoo & Buth, 1990).

**Caste:** A system of rigid social stratification characterized by heredity status, endogamy, and social barriers sanctioned by customs, law and religion. (Merriam- Webster Dictionary n.d.)

**Chhang:** A local beer and an important part of everyday life of an average Ladakhi. Chang is sold commercially and also prepared at home (Navchoo & Buth, 1990).

**Dace Bar:** The term **dance bar** is used in India to refer to bars in which adult entertainment in the form of dances by women are performed for male patrons in exchange for cash (Wikipedia , n.d.). Common clients of these bars tend to be men from low income groups.

**Dowry:** refers to money, goods, property given to the groom's family by the bride or bride's family at the time of marriage. Demands for dowry may continue to be made by the husband or the husband's family years into marriage.

**Gur gur cha:** This is a local salt tea in Ladakh, India. It is specially prepared in an indigenous instrument known as a "gur gur." (Navchoo & Buth, 1990)

**Laws of Manu:** The Laws of Manu (Manusmriti) consists of 2,685 verses describing the dharma (or obligations) of persons from various castes and gender. It involves commentary on the conduct of social, political and religious obligations and roles (Doinger, W. & Smith, B., 1991)

**Panchayats:** Panchayat is the municipal administrative unit in a village in India.

**Phaph:** Indigenous alcoholic drink in Ladakh, India made from wheat flour, powdered twigs of burnak and an assortment of roots and fruits (Navchoo & Buth, 1990).

**Sanskritization:** Sanskritization is a term coined by the Indian Sociologist M.N. Srinivas. It refers to the process of acculturation (adoption of customs, ritual, ideology and way of life) of the upper castes by those lower in the rungs of the caste hierarchy, or by tribal or other groups

**Staspakchek:** A local narcotic preparation in Ladakh, India. Prepared from dried leaves of staspak (Navchoo & Buth, 1990).

**Soma and Sura:** The Hindu mythological descriptions of the time around 2000 BC present accounts of soma and Sura, used by various groups in the society for their tranquillizing and euphoriant effects. Soma was considered to be an alcoholic beverage for the upper classes of humans and the Gods. Many pleasant as well as life-enhancing effects were described of the use of Soma. On the other hand, the lower classes of human society, especially the warriors, were described to consume Sura as a relief for their physical hardships. Descriptions of the use of alcohol by society continued to be available for the period of the Indus Valley Civilization (1500 BC) and the Vedas (1800 BC) (WHO, 2003).

**Toddy:** Toddy is obtained from the flowers of a coconut or palm tree. A white liquid, with a sweetish taste, oozes out of these flowers. When consumed fresh, this juice has no intoxicating effect. This liquid is collected and allowed to ferment. At times, yeast is added to hasten the process. The fermented juice has an alcohol content of approximately 5-10 per cent (WHO, 2003)

**Tribals: Tribals or adivasis is an** umbrella term for a heterogeneous set of ethnic and tribal groups. Recognized by the Indian government as "Scheduled Tribes" in the Fifth Schedule of the Constitution of India, adivasis are a historically marginalized section of Indian society. (Wikipedia, n.d.)

**Vedic:** The Vedic civilization is the earliest civilization in the history of ancient India associated with the coming of Aryans. The Vedic period refers to the period between 2000 BC- 800 BC approximately and derives its name from the oldest Indian texts known as the Vedas.

**Zimpating:** Local narcotics preparation in Ladakh, India. Made from young twigs and mature fruits of zama. The mixture preparation is kept for 3-4 days and then taken after meals. It is reported to cause delirious conditions if taken in excess (Navchoo & Buth, 1990).

**Zu and Rohi:** Zu and Rohi are locally processed alcoholic liquors found in Nagaland. The alcohol concentration ranges from ten to twenty per cent (WHO, 2004).

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