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Short communication

Alcohol use and its consequences in South India: Views from a marginalised tribal population

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ABSTRACT

Background: Alcohol consumption in India is disproportionately higher among poorer and socially marginalised groups, notably Scheduled Tribes (STs). We lack an understanding of STs own views with regard to alcohol, which is important for implementing appropriate interventions.
Methods: This study was undertaken with the Paniyas (a previously enslaved ST) in a rural community in Kerala, South India. The study, nested in a participatory poverty and health assessment (PPHA). PPHA aims to enable marginalized groups to define, describe, analyze, and express their own perceptions through a combination of qualitative methods and participatory approaches (e.g. participatory mapping and ranking exercises). We worked with 5 Paniya colonies between January and June 2008.
Results: Alcohol is viewed as a problem among the Paniyas who reported that consumption is increasing, notably among younger men. Alcohol is easily available in licensed shops and is produced illicitly in some colonies. There is evidence that local employers are using alcohol to attract Paniyas for work. Male alcohol consumption is associated with a range of social and economic consequences that are rooted in historical oppression and social discrimination.
Conclusion: Future research should examine the views of alcohol use among a variety of marginalised groups in developing countries and the different policy options available for these populations. In addition, there is a need for studies that untangle the potential linkages between both historical and current exploitation of marginalized populations and alcohol use.

1. Introduction

In India, while only 21% of men consume alcohol (for women it has been estimated at less than 5%); evidence suggests that more than half of those who consume alcohol are heavy drinkers (Ray et al., 2004). Moreover, drinking is disproportionately higher among poorer and socially marginalised groups, notably Scheduled Tribes (STs), India's indigenous populations (Neufeld et al., 2005; Subramanian et al., 2006). STs tend to have distinct cultural practices, experience high levels of deprivation, face social discrimination, and despite more than 50 years of affirmative action, STs continue to lag behind other social groups (India Ministry of Tribal Affairs, 2004; Xaxa, 2001). Alcohol use is not only associated with a range of health problems (e.g. tuberculosis, HIV, domestic violence), but also contributes to impoverishment due to both diverting income away from family needs and by increasing costs of health care associated with alcohol related problems (Benegal, 2005; Bonu et al., 2005; Gajalakshmi and Peto, 2009). We lack an understanding of STs own views with regard to alcohol, which is important for implementing appropriate interventions, especially among poor and vulnerable populations. Is alcohol a concern among STs? What are the consequences of alcohol use for STs and their communities? Why is alcohol consumed? In this paper, we investigate these questions among a marginalised ST group in a rural community in Kerala state. We conclude with suggestions for future research.

2. Methods

2.1. Setting

This study was undertaken in a Panchayat (lowest territorial unit) in Wayanad district—home to about one third the total ST population of Kerala—as part of a larger action research project. Our census identified 3352 households, of which 30% have ST affiliations. There is a state monopoly in alcohol distribution through the Kerala State Beverages Corporation (KSBC), which runs a wide network of shops that are open 7 days a week. There are also large numbers of licensed toddy[1] shops

[1] Toddy is the secretion obtained by tapping the pods of palm trees and in the unfermented state is not a toxicant. But what is currently available in the toddy shops in Kerala is not the secretion collected from the palm trees but a synthetic concoction highly intoxicating.

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which sell synthetic toddy, often laced with alcohol, as the supply of natural toddy is limited.

We worked exclusively with the Paniya tribe (393 households), who are the poorest and most marginalised group—even compared to other ST (CDS, 2009). The average household income (in 2003–04 prices) is 4911 Rupees per year compared to 8972 for non-Paniya groups. The Paniyas live in colonies (clusters of households in a small geographical area) and are largely landless. The Paniyas have high levels of health needs; the prevalence of underweight, anaemia, and goitre are 60%, 15%, and 11% respectively (Haddad et al., 2010). They were previously enslaved, which may explain observations that they display high levels of resignation and lack the capacity to aspire (Mohindra et al., 2010a). In a nearby Panchayat, a small survey, carried out with 3 Paniya colonies, found that among the 60 males between the ages of 16 and 45, 39 reported consuming alcohol either daily or weekly (Vishnudas, 2010). The global picture is likely comparable in the study site, where the ratio of household alcohol, tobacco, and pan expenditures to total consumption for Paniya households is 14.6% on average, compared to just 2.5% for non-Paniya households.[2] This figure likely represents predominantly alcohol expenditures, since Paniyas tend not to smoke cigarettes and pan is relatively cheap.

2.2. Data collection and analysis

This study is nested in a participatory poverty and health assessment (PPHA). PPHA aims to enable marginalized groups to define, describe, analyze, and express their own perceptions through a combination of qualitative methods and participatory approaches (e.g. participatory mapping and ranking exercises), and can integrate STs cultural worldviews (Mohindra et al., 2010b). A feasibility study was undertaken in April 2006, confirming the appropriateness of the methods. Five (out of 45) colonies were selected for study based on their diversity in terms of size, distance to basic services, and living environment. A participatory process with the community led to the elaboration of a code of research ethics (Mohindra et al., in press). Community consent of each of the colonies was obtained prior to individual consent. PPHA activities were undertaken in the respective colonies of the participants, typically in a common area of the colony compound for the group activities and within the households for individual interviews. All adults (>15 years) living in the 5 colonies were invited to participate in the PPHA, although respondents for individual interviews were selected based on life experiences, which became known to the field team over the 6-month period (January to June 2008). Due to the collective nature of Paniya communities, their work schedules, and their prior negative experiences with non-Paniyas (which has led to high levels of distrust of outsiders), we recruited participants for participatory group actives and focus group discussions using a convenience sample. This approach precluded us from stratifying groups by gender, age, and other important stratifiers, but fostered a culturally appropriate and secure environment to undertake the PPHA activities. We were able, however, to hold several all-female group activities.

The PPHA fieldwork was undertaken by a local Non-Governmental Organization (NGO) who had expertise in participatory techniques and experiences working with ST populations. The field team, which included 2 local men from Wayanad (but from a different Panchayat) and 2 women from nearby districts, received additional training prior to beginning fieldwork. They recorded data (producing exact verbatim transcriptions) and field notes in handwritten diaries, which were translated into English and stored confidentially in a data management system. Pseudonyms for colonies and participants have been used to further protect confidentiality. Specific themes were explored based on survey findings and the feasibility study. One of the main themes we examined was well-being of which some questions led to responses of the consequences of alcohol use (How is well-being defined and categorized? What are the main challenges to living a good life? What changes have occurred over time?). A set of limited questions were also posed specific to alcohol (Do colony members have alcohol habits? Is alcohol produced in the colony? Where do men purchase alcohol?).

In this study, analysis is restricted to data related to the study objectives, which comes from 5 participatory mapping exercises (mapping of social resources in their colonies, wealth ranking exercises, and cause and effect analysis, which included tracing causes of key problems and their consequences), 6 focus group discussions (5 mixed gender; 1 exclusively female), and 4 semi-structured interviews (2 females; 2 males) Two authors performed data analysis using a thematic framework analysis (Pope et al., 2000), guided by a vulnerability framework (Alwang et al., 2001; Galea et al., 2005). This multi-disciplinary framework depicts vulnerability as two convergent processes: an elevated exposure to risk and incapacity to reduce the potential deleterious consequences of exposure to that risk. Analysis involved an iterative process, using a structured codebook: coding, thematic framework, descriptive accounts, and interpretative analysis. Following this analysis, we discussed our findings with the colonies, refining our interpretations accordingly. Next, we present our findings specific to the questions posed in this paper.

3. Results

3.1. Consumption patterns

Both male and female participants reported that alcohol consumption was a male activity. In the past, drinking was traditionally done by male elders, but this pattern is changing as younger men are now drinking with prominence (with the exception of one colony where only male elders were reported to consume alcohol). Drinking was also reported to be clustered within families, as one participant noted "fathers and sons drink together." Participants referred to male drinking (especially younger males) as being problematic. Alcohol consumption was reported to be frequent, typically either daily or 4 times a week, depending on availability of earnings.

3.2. Sources of alcohol

Participants cited that alcohol was generally bought in a nearby toddy shop, often located in close proximity to the colonies facilitating access. Some Paniya men also purchase alcohol in the districts 'headquarters (about 20 km away). Alcohol is easily accessible as "government itself provides opportunities" (referring to the outlets of the Kerala State Beverages Corporation, which sells foreign liquor). When asked about *vatu charayam* (illicit liquor), participants mentioned that while it was produced in their colonies in preceding years, this practice has ended. This has been attributed to the greater availability of alcohol elsewhere. In one colony, this production stopped following a campaign launched by a local women's organization. However, in one colony where others reported that illicit liquor was not being made, a 26-year-old woman, Vanaja, reported differently:

> (Vanaja leans over and whispers). "There is illicit liquor business going on in our colony. Many men are involved. It is how they earn a living now. They brew liquor. They sell it and make money. And they drink it. The main man involved in this business was hurt in an accident and could no longer go for work, so he made liquor for a living."

3.3. Social and economic consequences of alcohol consumption

The participants recognized the harmful effects that alcohol has on the community; some observed that alcohol was "ruining" them. When the participants were asked why some households are better off than others in the same colony, the main reason provided was that alcohol was consumed especially among the poorer households, trapping them further into poverty (raised by participants in 4 of the 5 colonies). Alcohol was paid for with wage earnings. "The money earned is spent on liquor. It doesn't reach the family" (Ramesh, 25-year-old man). Income is therefore diverted away from household needs. Valsala, an elderly woman stated the dangers of this type of spending: "Because of this habit there will not be much balance in the hands of men at times of crisis. *Eduthu vakkunna pani pande ilallo*" (We do not have the practice of saving). The Paniyas face high levels of poverty and discrimination that reduces their access to health care. Even though they use public health care services, which are supposedly free, they cannot afford other expenses (e.g. travel). "We have to pay more than 500 Rupees of travel expenditure. How can we afford such a big amount sir?" (Kaylan, 50-year-old male). As an elderly male explained seeking care was difficult because "we are under indebtedness all of

[2] Non-Paniya households in this community include other Scheduled Tribes and those groups falling in India's caste groups, including those at the top of the caste hierarchy (forward castes, which includes Christians), groups at the bottom of the hierarchy (Scheduled Castes), and those who fall in between (other Backward Classes, which includes Muslims).