

PREVALENCE AND ASSOCIATED FACTORS OF ALCOHOL USE, ALCOHOL DEPENDENCE AND TREATMENT GAP IN RURAL AREA OF KOLAR

By

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2020 - 2023

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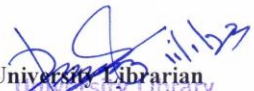
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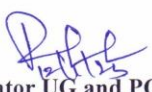
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**Dedicated to My Parents, Brothers, Teachers, Friends,
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Without whom I would have never reached to this stage of
life**



LIST OF ABBREVIATIONS

AUD - Alcohol use disorders

AUDIT – Alcohol Use Disorder Identification Test Questionnaire

APC – Alcohol Per capita Consumption

AMR – Region of the Americas

ASDR - Age-standardized death rates

AAF – Alcohol Attributable Fractions

aPR – Adjusted Prevalence Ratio

ADS – Alcohol Dependent Scale Questionnaire

BAC – Blood Alcohol Concentration

CI – Confidence Interval

CVDs - Cardiovascular diseases

DALY- Disability Adjusted Life Years

EUR – European region

GI – Gastrointestinal

HIV - Human Immunodeficiency Virus

LMICs - Low- And Middle-Income Nations

NFHS – National Family Health Survey

OBC – Other Backward Class

OR – Odds Ratio

PHC - Primary health care

RHTC – Rural Health Training Centre

SEAR – South East Asia Region

SDUMC – Sri Devaraj Urs Medical College

SLI – Standard of Living

SADD – Short Alcohol Dependence Data Questionnaire

SDG – Sustainable Developmental Goals

SC/ST – Scheduled Castes / Scheduled Tribes

USA – United States of America

WHO – World Health Organization

WPR – Western Pacific Region

YLL - Years of Life Lost

YLD - Years of life lived with disability

ABSTRACT

Introduction: Alcohol use disorders cover a wide range of medical issues, from excessive alcohol consumption to alcohol dependency. Alcohol intake is linked to 5.1% of disability adjusted life years, making it the third greatest risk factor for the global disease burden. Alcohol consumption at high levels (10–20 g per day) is linked to an increased risk of heart disease, liver cirrhosis, cancer, and injury.

Objectives: To determine the prevalence of alcohol use, alcohol dependence and its associated factors and to estimate the treatment gap among alcohol use disorder & alcohol dependence.

Materials & Methods: A community based cross sectional study using cluster random sampling technique conducted in Kolar, rural Karnataka. Among the 20 villages in rural Kolar, six villages were randomly selected, respondents aged 18 years and above were approached to complete required sample of 1850. The data was analyzed by using licensed SPSS version 22. Descriptive statistics like frequencies, proportions and confidence intervals were used. Chi-square test applied test the significance difference. Mean and Standard deviation were calculated.

Results: Among the 1850 subjects studied, the mean age in years is 42.5 ± 17

majority were males (53.9%) and were Illiterate (36.9%) and belonged to daily wage workers (32.6%). The prevalence of alcohol consumption among study participants in past 12 months was found to be 9.7%. Prevalence of alcohol dependence among drinkers was found to be 21.7% and only 0.1% of alcohol users had taken treatment for the same.

Conclusion: Alcohol use is an important public health problem in this area, especially due to the high prevalence rate and a larger involvement of adult age group. Prevalence of alcohol use is high, especially among males. Health educational interventions and proper treatment may help in reducing the burden of alcohol use in this area.

Keywords: *Alcohol use disorder, Alcohol dependence, Prevalence, Treatment gap.*

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INTRODUCTION

1. INTRODUCTION

Alcohol use disorders (AUDs) cover a wide range of medical issues, from excessive alcohol consumption to alcohol dependency.^[1] Alcohol is not a typical drug of abuse because it is interwoven into many civilizations' cultures, and causes enormous physical, mental, and social harm on a global scale.^[2]

Alcohol intake is linked to 5.1% of disability adjusted life years (DALYs), making it the third greatest risk factor for the global disease burden.^[2] In 2012, alcohol use was blamed for one in every 20 fatalities worldwide (5.9% of all deaths and injuries).^[2] Up to 70% of alcohol-related fatalities take place in low- and middle-income nations (LMICs), where the illness burden is higher per litre of pure alcohol drunk.^[3]

Between 1980 and 2000, pure alcohol consumption per person in Southeast Asia climbed by more than 50%. Similarly, alcohol consumption per person surged drastically by 106.7% in India during the period between 1994–1996.^[4–6] About 62.5 million people in India in 2005, 17% of those users being dependent users, accounting for 20% to 30% of hospital admissions attributable to alcohol-related issues. The National Household Survey 2004 reported alcohol use in 21% of adult males and <5% among females. The state-wise prevalence rate is highly variable being the lowest (7%) in the western part of Gujarat and the highest (75.0%) in Arunachal Pradesh.^[7] In Southern India, the prevalence of

current alcohol use has varied between 33% and 50%.^[8]

More than 200 preventable health disorders are linked to alcohol, of which more than 30 are brought on entirely by drinking. Alcohol consumption at high levels i.e.; 10 to 20 g per day is linked to an increased risk of heart disease, liver cirrhosis, cancer and injury.^[3,9] Alcohol also makes it more likely for people to get contagious illnesses including the Human Immunodeficiency Virus (HIV) and Tuberculosis.^[3] Alcohol use disorders (AUDs) are the most significant among drinking-specific illnesses and are responsible for half of the harm caused by alcohol.^[9]

Despite the significant cost that AUDs place on society, they continue to be undertreated, even in high-income nations.^[10–15] Globally, the treatment gap for AUDs was calculated to be at 78%.^[13] However, this percentage is thought to be about 95% in LMICs.^[15,16] Primary health care (PHC) is frequently contacted by individuals with AUDs for the physical and mental health effects of their disease, yet primary health care workers hardly ever recognise these disorders.^[10,17] People diagnosed with AUD may choose not to receive treatment or use the service for a variety of reasons, including the accessibility and availability of services.

People could choose not to ask for assistance even when the service is offered.^[16] Evidence suggests that receiving mental health care faces much more obstacles than receiving physical health care. Lack of understanding about the characteristics and treatability of the illness, ignorance of how to obtain

evaluation and treatment, prejudice towards those who have the condition, and expectations of discrimination against those who have a diagnosis are some of the factors that raise the chance of treatment avoidance, delays in care, and termination of service use.^[16,18–20]

It is crucial to investigate the causes of not seeking treatment in order to close the significant treatment gap and enhance help-seeking behaviour among people with AUD.^[10–13]

Alcohol consumption needs to be treated as a social problem and must be tackled at the policy level. Some approaches to addressing this issue include population-based interventions, legislation, tax policy, recommendations for the manufacturing and sale of alcohol, policies on domestic violence, road safety, and occupational safety.^[21]

There is a paucity of data on pattern and associated factors of alcohol use, which may be different in different geographical locations. Such studies will be useful for understanding the problem of alcohol use and for taking specific interventional measures at the community level.

OBJECTIVES OF STUDY

2. OBJECTIVES

Among the individuals aged 18 years and above in the rural field practice area of Sri Devaraj Urs Medical College.

- To determine the prevalence of alcohol use and its associated factors.
- To determine the prevalence of alcohol dependence
- To estimate the treatment gap among alcohol use disorder & alcohol dependence.

REVIEW OF LITERATURE

3. REVIEW OF LITERATURE

3.1 INTRODUCTION

Alcohol abuse is a serious problem in many cultures and societies around the world, having a large morbidity and mortality impact on families and communities. One in ten Indians is moderate to heavy drinker, accounting for almost a third of the country's overall alcohol consumption. This has a detrimental effect on income, education, employment, and marital stability.^[21]

Poor regulatory policies on alcohol, widely prevalent multiple high risks of infectious and noncommunicable diseases, and public health in the nascent stage makes people in developing countries vulnerable to alcohol-related diseases.^[22]

3.2 HISTORY

Along with opium, alcohol was arguably one of the first psychoactive chemicals used by humans. It is now one of the most popular substances consumed for recreational purposes. Homer describes alcohol as "a drug that had the ability of depriving sadness and rage of their sting and eradicating all unpleasant memories" in The Odyssey, which is one documented account that is thought to relate to an opium mixture known as nepenthe. This concoction might be opium and alcohol, which later became known as laudanum.^[23]

Although history is rife with examples of useful and utilitarian uses of alcohol

stretching back to antiquity, today's non-pathological alcohol usage is typically connected with festivities, leisure, and recreational activities. With pictographs from approximately 4000 BCE showing Egyptians using the drug for medical and sustenance as well as for religious and other cultural rituals, it is thought that alcohol was a significant source of income for the Ancient Egyptians. Alcohol usage grew pervasive in many religious and cultural rituals to the point where an imperial edict declaring that "moderate consumption was a religious obligation" was issued among Egyptians. Alcohol was also widely consumed in all facets of ancient Chinese life, and its sale also served as a significant source of revenue for the empire.^[23]

Alcohol, which derives from the Arabic word al-kuhl, came to denote the essence or spirit of something, and its enigmatic attributes were linked in various cultures to transcendental and hence holy experiences.^[23] The inhabitants of ancient Babylon (now Greece) were likewise known to associate alcohol with religion and divinity. Alcohol was continuously consumed in enormous quantities throughout the majority of the known world, with the exception of all but a few Native American and Australian native tribes (for whom alcohol was virtually non-existent before the arrival of Europeans). As the art of brewing gained popularity in 13th-century England, ale developed into a food staple for both kids and adults as well as a valuable item in trade. The renaissance saw a rise in alcohol consumption as well, and beer was a mainstay of the early American economy.^[24]

Alcohol was utilised in the ancient world, as it is today, as an intoxicating in addition to its practical applications. The cult of Dionysus, a religious organisation that believed drunkenness brought followers closer to their god, is one of the earliest accounts of excessive alcohol use. In fact, drinking alcohol, especially wine, was so ingrained in Greek culture that refraining from it was frowned upon. In Athens, drinking wine was regarded as a civic duty.^[24]

Although alcohol played a significant role in Greek life, most Greeks encouraged moderation and condemned excess. The Romans likewise regarded alcohol as being essential to their civilization and valued moderation, just like the Greeks did. However, from the third century BCE, as the Roman Empire grew and subsequently started to crumble, there was a reduction in moderation and an increase in excessive consumption.^[24]

The importance of the Christian religion increased as Roman influence waned. For nearly two thousand years, the expanding influence of the Church affected views regarding drinking and intoxication.^[24]

3.3 VARIOUS PATTERNS OF ALCOHOL CONSUMPTION

3.3.1 ALCOHOL USE DISORDER (AUD)

Alcohol use disorder (AUD) is characterised by a pattern of drinking that is problematic over the course of a year and is characterised by long-term increases in consumption, an inability to control consumption, the onset of tolerance, the experience of withdrawal symptoms, and continued use of alcohol

despite negative effects on one's social life and physical or mental health.^[2] The prevalence of alcohol use varies from 7.7% to 79% according to the study settings and participants in different studies,[Table 1].

Table 1
Prevalence of Alcohol use in similar studies

SL No.	Authors	Study place	Rural/ Urban/ Tribal	Year of Study	Alcohol use prevalence
1	Rose et al., ^[21]	Tamil Nadu, India	Tribal	2021	65%
2	Kumar et al., ^[22]	Puducherry, South India	Rural	2018	79%
3	Ramanan et al., ^[8]	Puducherry, South India	Rural	2016	9.7%
4	Teferra et al., ^[60]	Sodo, Ethiopia	Rural	2015	21%
5	Rathod et al., ^[57]	Madhya Pradesh, India	Rural	2015	23.8%
6	Zewdu et al., ^[2]	Sodo, Ethiopia	Rural	2014	13.9%
7	Katyal et al., ^[65]	Uttar Pradesh, India	Urban	2014	7.7%
8	Pillai et al., ^[1]	Northern Goa, India	Rural/ Urban	2012	14.8%
9	Ganesh Kumar et al., ^[55]	Tamil Nadu, India	Rural	2012	9.4%
10	Sujiv et al., ^[62]	Puducherry, South India	Rural	2012	39.8%
11	Dutta et al., ^[63]	Tamil Nadu, India	Rural	2012	35.7%
12	Kim et al., ^[56]	Tamil Nadu, India	Rural	2011	46.1%
13	Ghosh et al., ^[58]	West Bengal, India	Urban	2009	65.8%
14	Pal et al., ^[59]	New Delhi, India	Urban	2003	44.9%
15	Gupta et al., ^[61]	Mumbai, India	Urban	2003	18.8%

Social Drinking

Men who drink socially or moderately limit their intake to two drinks per day. women only have one drink per day. It speaks of drinking on a single day, not on an average across numerous days.^[28]

Binge drinking

It refers to the consumption of the following number of alcoholic drinks in a period of about 2 hours:

- Men consume five or more alcoholic drinks on a single occasion.
- Women consume four or more drinks for women.^[29]

Harmful drinking pattern

A pattern of alcohol intake that harms a person or society in terms of their physical or mental health. The WHO also recognises this condition.

Hazardous drinking pattern

It is characterised as an amount or pattern of alcohol intake that puts people at risk for negative health outcomes.^[29]

3.3.2 ALCOHOL DEPENDENCE

It is described as a collection of behavioural, cognitive, and physiological symptoms that emerge after prolonged alcohol use and typically include strong urges to drink, trouble with self-control, continued use despite negative effects, preference for drinking over other activities and responsibilities, increased tolerance, and occasionally a physiological withdrawal state.^[29]

Alcohol production and use have been trending up in India over the years.^[22] According to the National Family Health Survey (NFHS) of India, alcohol use by men aged 15 to 54 is at 32%, with alcohol dependence at 9.4%.^[22] Despite the high frequency of alcohol use and the harmful patterns of alcohol intake, there are not many public health initiatives to discourage it. Since alcohol accounts for 20% of all state revenues, it purposely distracts policymakers from this public health crisis.^[22] As a result, it becomes imperative to enhance the secondary level of prevention to limit alcohol's negative impacts on a person's health. Early detection of those who abuse alcohol and effective treatment can serve as a stop-gap measure for the greater problem.^[50,51]

Table 2:
Prevalence of Alcohol dependence in similar studies

SL No .	Authors	Study place	Rural/Urban/Tribal	Year of Study	Alcohol dependence prevalence
1	Rose et al., ^[21]	Tamil Nadu, India	Tribal	2021	24%
2	Kumar et al., ^[22]	Puducherry, South India	Rural	2018	12.4%
3	Ramanan et al., ^[8]	Puducherry, South India	Rural	2016	29.3%
4	Rathod et al., ^[57]	Madhya Pradesh, India	Rural	2015	5.5%
5	Zewdu et al., ^[2]	Sodo, Ethiopia	Rural	2014	1.8%
6	Katyal et al., ^[65]	Uttar Pradesh, India	Urban	2014	9.2%
7	Pillai et al., ^[1]	Northern Goa, India	Rural/Urban	2012	33.7%
8	Ganesh Kumar et al., ^[55]	Tamil Nadu, India	Rural	2012	33.7%
9	Kim et al., ^[56]	Tamil Nadu, India	Rural	2011	4.7%
10	Ghosh et al., ^[58]	West Bengal, India	Urban	2009	14%

3.4 PREVALENCE OF ALCOHOL CONSUMPTION

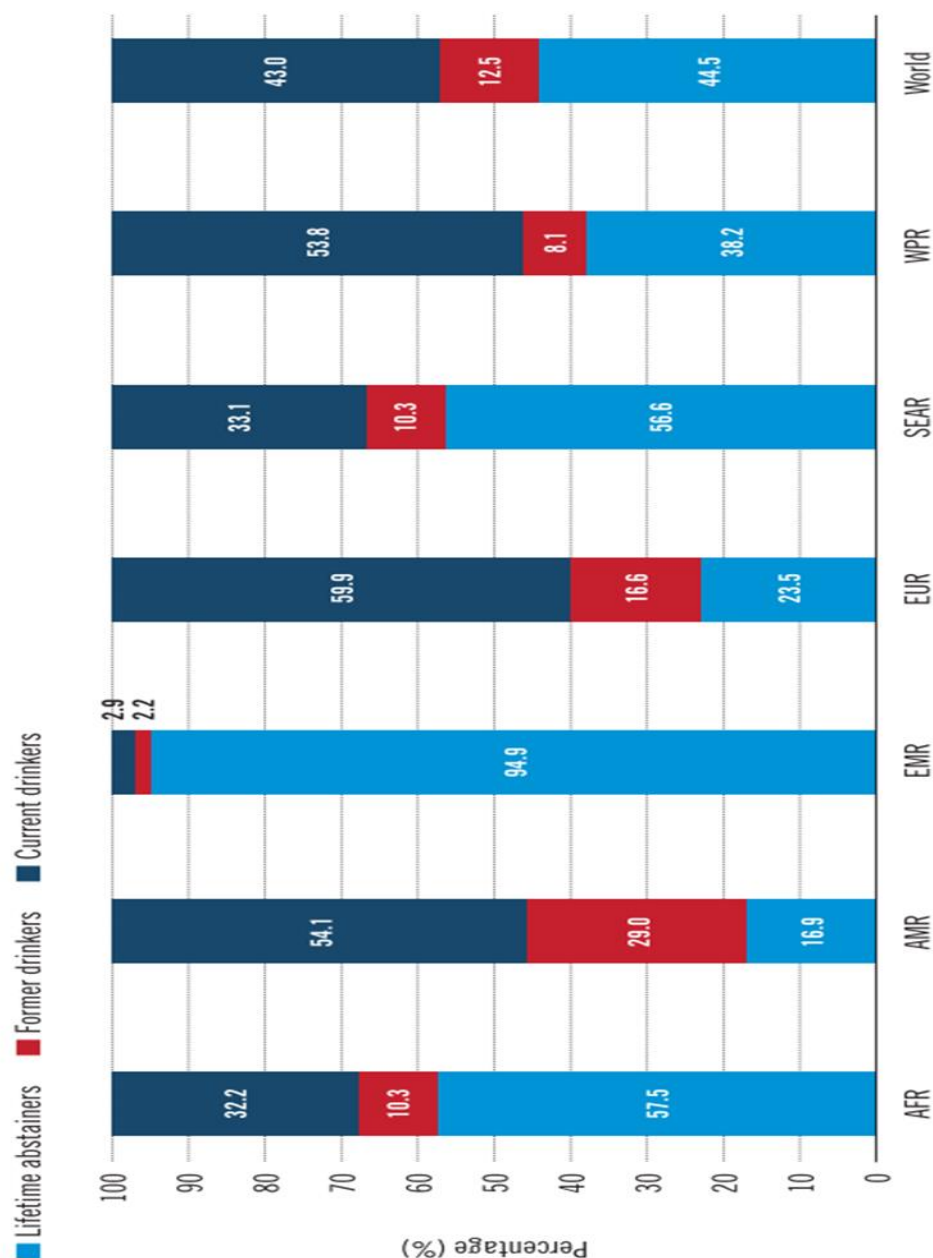
3.4.1 At Global Level and SEAR Level

In 2016, 2.4 billion adults aged 15 and older, or 44.5% of the adult population worldwide, reported never having ingested alcohol. About 43% of the world's population, or around 2.3 billion people, currently drink. Only three WHO regions—the European Region (EUR) (59.9% of current drinkers), the Region of the Americas (AMR) (54.1%), and the Western Pacific Region (WPR)—have populations that consume alcohol above 50%. (53.8%),^[25] [Figure 1].

According to 2016 WHO statistics, the average quantity of pure alcohol used annually by those aged 15 or older in the world is 6.4 litres, or 13.9 grams, per day. However, Per capita alcohol consumption varies greatly between WHO regions and the Member States,^[25] [Figure 2].

Figure 1

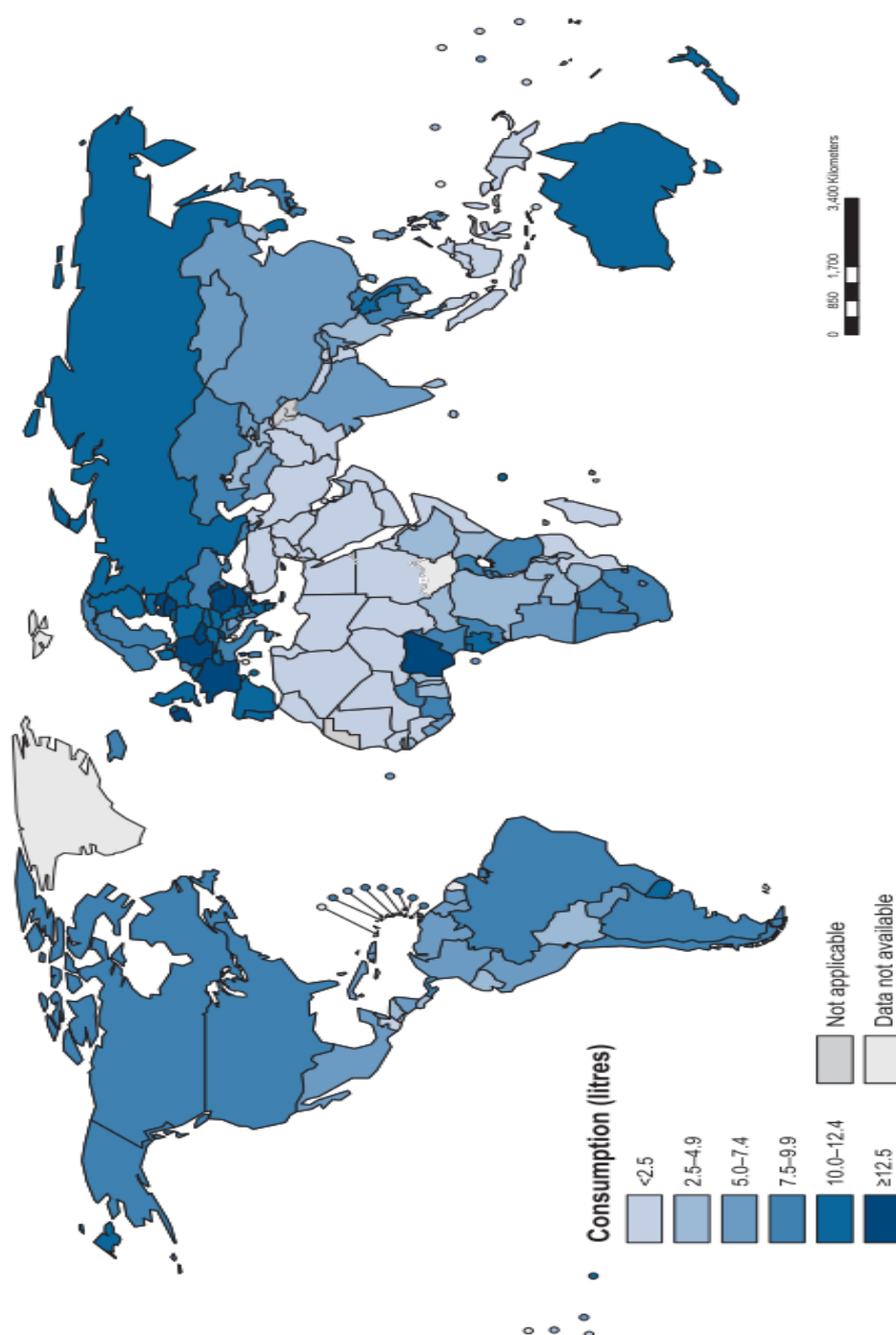
**Percentage of current drinkers, former drinkers and lifetime abstainers
(in %) among the total population (15+ years) by WHO region and
World, 2016^[25]**



Source: WHO. Global Status report on alcohol and health 2018.

Figure 2

Total alcohol per capita consumption (APC) (15+ years; in litres of pure alcohol), 2016^[25]



Source: WHO.Global Status report on alcohol and health 2018.

3.4.2 Trends in current drinking and abstention

The percentage of drinkers worldwide has dropped from 47.6% to 43%, since 2000, a nearly 5% point drop in each year,^[25][Table 3].

Table 3

Percentage of current drinkers, former drinkers and lifetime abstainers among the total population (15+ years) in SEAR region and in the World, 2016

Year/	Lifetime abstainers		Former Drinkers		Current Drinkers	
Region	SEAR(%)	World(%)	SEAR(%)	World(%)	SEAR(%)	World(%)
2000	59.6	43.9	7.3	8.5	33.2	47.6
2005	60.9	45.5	6.9	9.3	32.2	45.1
2010	59	43.9	7.3	10.6	33.7	45.5
2016	56.6	44.5	10.3	12.5	33.1	43

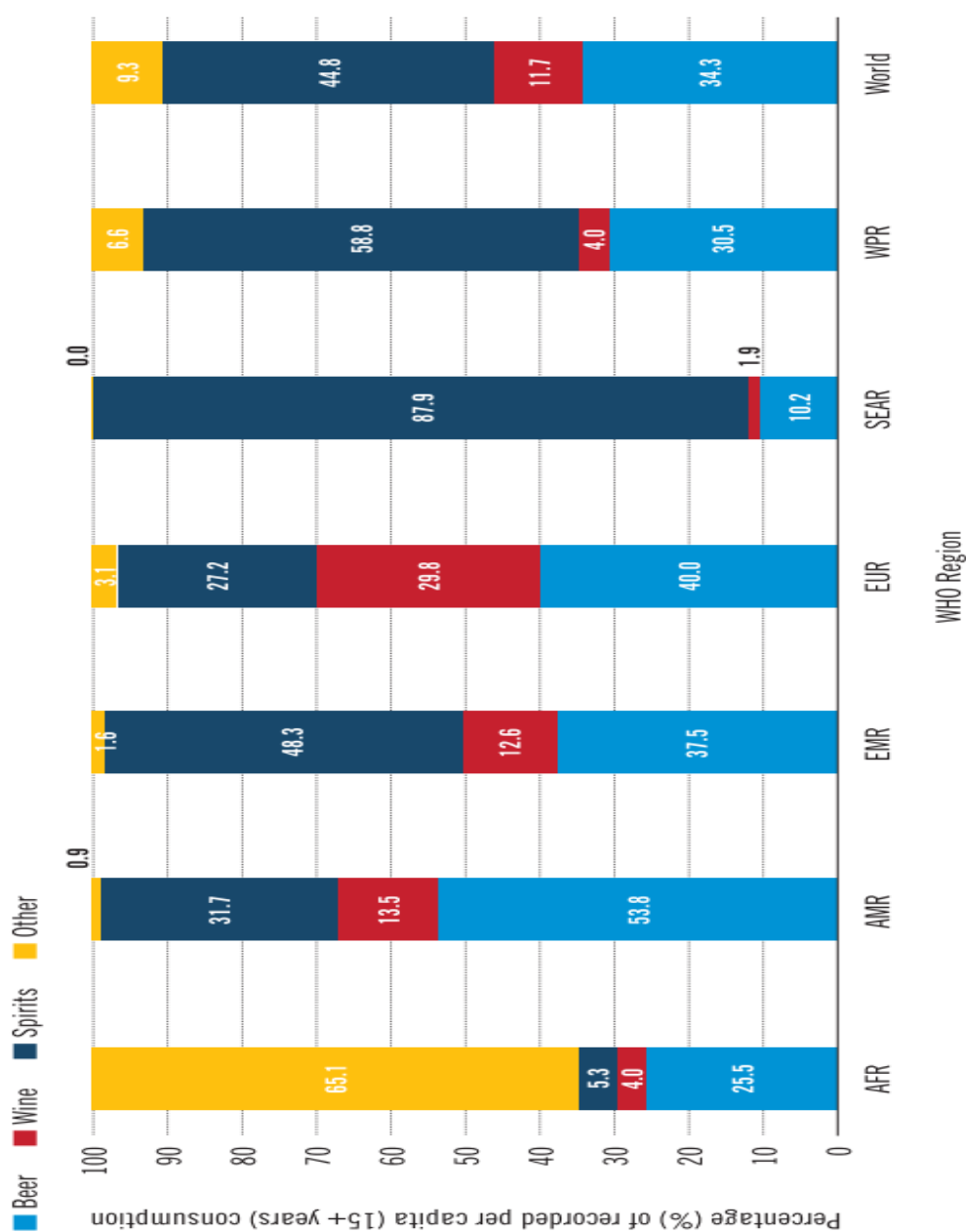
Source: WHO.Global Status report on alcohol and health 2018.

3.4.3 Most consumed beverages

There are regional variations in the types of alcoholic beverages people drink, including beer, wine, spirits, and others (e.g., fortified wines, rice wine or other fermented beverages made of sorghum, millet or maize). In the world, spirits account for 44.8% of all alcohol consumption, and they are also the most popular beverage category in South-East Asia (87.9%),^[25][Figure 3].

Figure 3

Percentage (in %) of recorded alcohol per capita consumption (APC) (15+ years) in the form of beer, wine, spirits and other types of alcoholic beverages by WHO region and the world, 2016



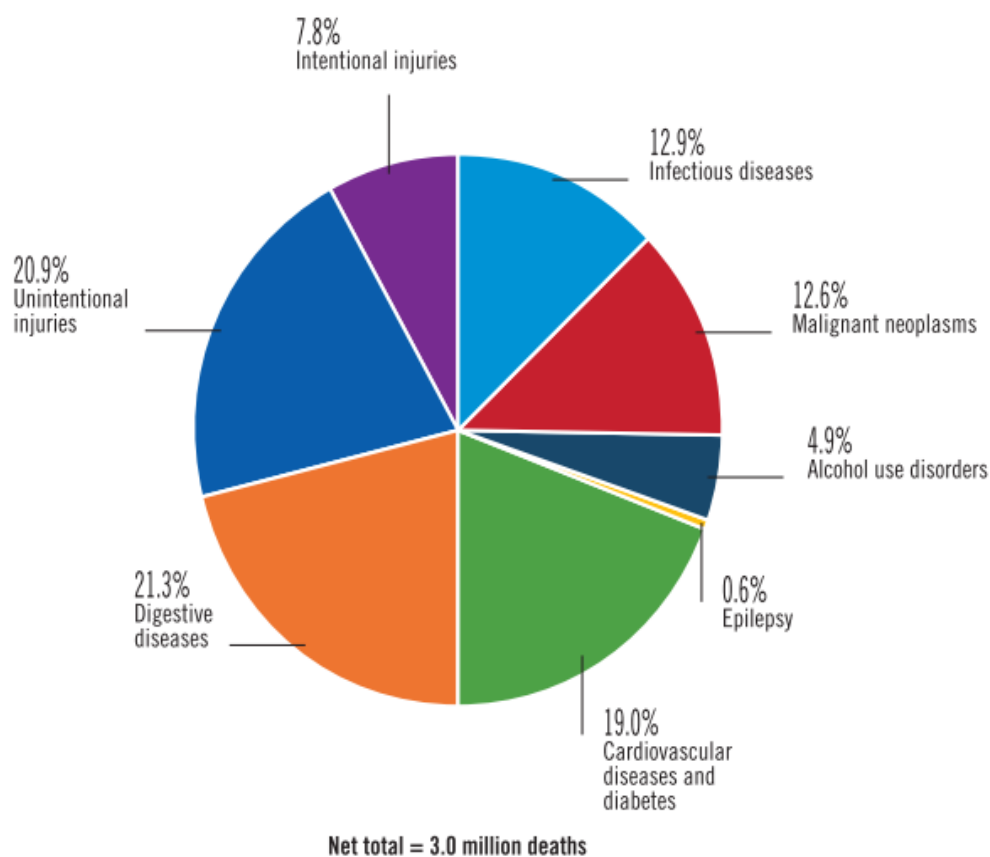
Source: WHO.Global Status report on alcohol and health, 2018.

3.4.4 Alcohol-Attributable Mortality

Globally, the hazardous use of alcohol is estimated to have contributed to 3 million fatalities (4.9% of all deaths) in 2016. Alcohol consumption has a bigger mortality impact than diseases including tuberculosis (2.3%), HIV/AIDS (1.8%), diabetes (2.8%), hypertension (1.6%), digestive ailments (4.5%), traffic accidents (2.5%), and violence (0.8%).^[25]

Figure 4

Percentage of alcohol-attributable deaths, as a percentage of all alcohol-attributable deaths, by broad disease category, 2016



Source: WHO.Global Status report on alcohol and health 2018.

The primary causes of the estimated 3 million alcohol-related deaths in 2016 were digestive disorders, unintentional injuries, cardiovascular diseases (CVDs), and diabetes, which were each individually accountable for 21.3%, 20.9%, and 19.0% of these deaths, respectively,^[25] [Figure 4].

3.4.5 Alcohol-Attributable Morbidity

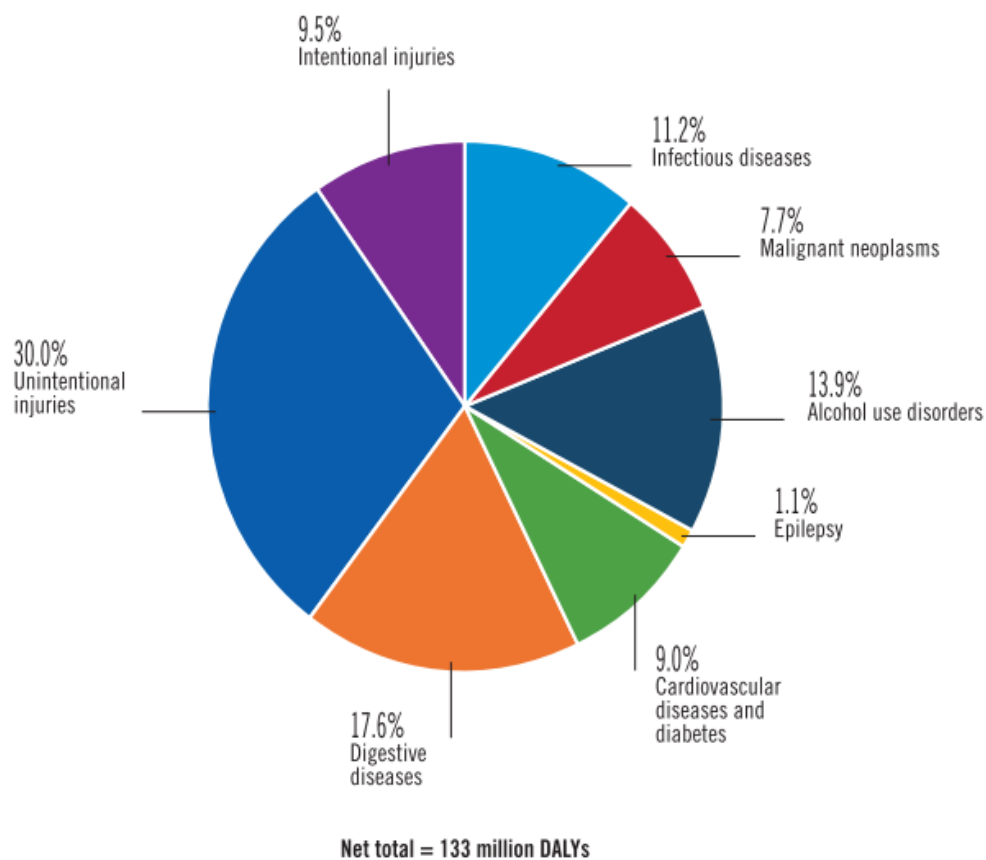
In 2016, alcohol caused 132.6 million DALYs, or 5.1% of all DALYs, contributing to a significant burden of disease and injury. Deconstructed, 107.7 million DALYs (or years of life lost, or YLL), or 5.8% of all YLL, were caused by premature mortality, while 24.9 million DALYs (or years of life lived with disability or YLD), or 3.4% of all YLD, were caused by morbidity.^[25]

The burden of disease and injury brought on by alcohol was mostly borne by unintentional injuries, digestive diseases, and AUDs, which collectively accounted for 30.0%, 17.6%, and 13.9% of all DALYs attributed to alcohol, respectively,^[25] [Figure 5].

From 100% for AUDs to 3% for mortality from ischemic heart disease, alcohol use contributed to certain diseases and injuries' health impacts. Additionally, a worldwide protective effect against alcohol's effects on diabetes and ischemic stroke was seen.^[25]

Figure 5

Distribution of the alcohol-attributable burden of disease, as a percentage of all alcohol-attributable disability-adjusted life years (DALYs), by broad disease category, 2016



Source: WHO.Global Status report on alcohol and health 2018.

3.4.6 Alcohol consumption and its associated factors in various parts of India

Alcohol drinking habits fluctuate across different regions of India, because of the country's many sociocultural groups and varying state regulations.

A cross-sectional survey in India conducted by Rose et al., on 2021 found that significant risk variables for the consumption of hazardous alcohol were discovered to include tobacco usage, higher income, and local alcohol manufacturing.^[21]

Rathod et al., carried out a population-based cross-sectional study in India in 2015 among 3220 adults observed that alcohol use were strongly correlated with depression, high-quality housing, land ownership, living in an urban area, tobacco use, and disability among men who had just drunk alcohol.^[57]

Kim et al., in Tamil Nadu did a cross-sectional study on alcohol use among 2811 men through a household-level census in an urban slum between 2010 and 2011 found that existence of a common mental disorder, manual labour vocations, smoking, drinking before the legal drinking age of 21, and mostly consuming Indian-made foreign liquor were factors linked to alcohol consumption.^[56]

In India, the prevalence of AUDs over 12 months in 2010 was 2.6%, while the prevalence of alcohol dependence was 2.1%. Drunk driving was a factor in 33.1% of all fatal traffic accidents in 2012. According to the National Mental Health Survey of India 2015–16, 9% of adult men have AUDs. Alcohol was determined to be responsible for 5.4% of all cause deaths in India. Alcohol usage was to blame for about 62.9% of all liver cirrhosis-related deaths,^[25]

[Table 4 and Table 5]

Table 4:**Prevalence of alcohol use disorders and alcohol dependence (%), 2016***

	Alcohol use disorders**	Alcohol dependence
Males	9.1	7.0
Females	0.5	0.4
Both sexes	4.9	3.8
WHO South-East Asia Region	3.9	2.9

* 12-month prevalence estimates (15+); **including alcohol dependence and harmful use of alcohol.

Source: WHO.Global Status report on alcohol and health 2018.

Table 5**Age-standardized death rates (ASDR) and alcohol-attributable fractions (AAF), 2016**

	ASDR*		AAF (%)		AAD** (Number)
Liver cirrhosis, males / females	45.8	14.7	60.0	33.3	140 632
Road traffic injuries, males / females	50.3	10.3	33.7	18.3	92 878
Cancer, males / females	107.2	95.3	6.5	0.8	30 958

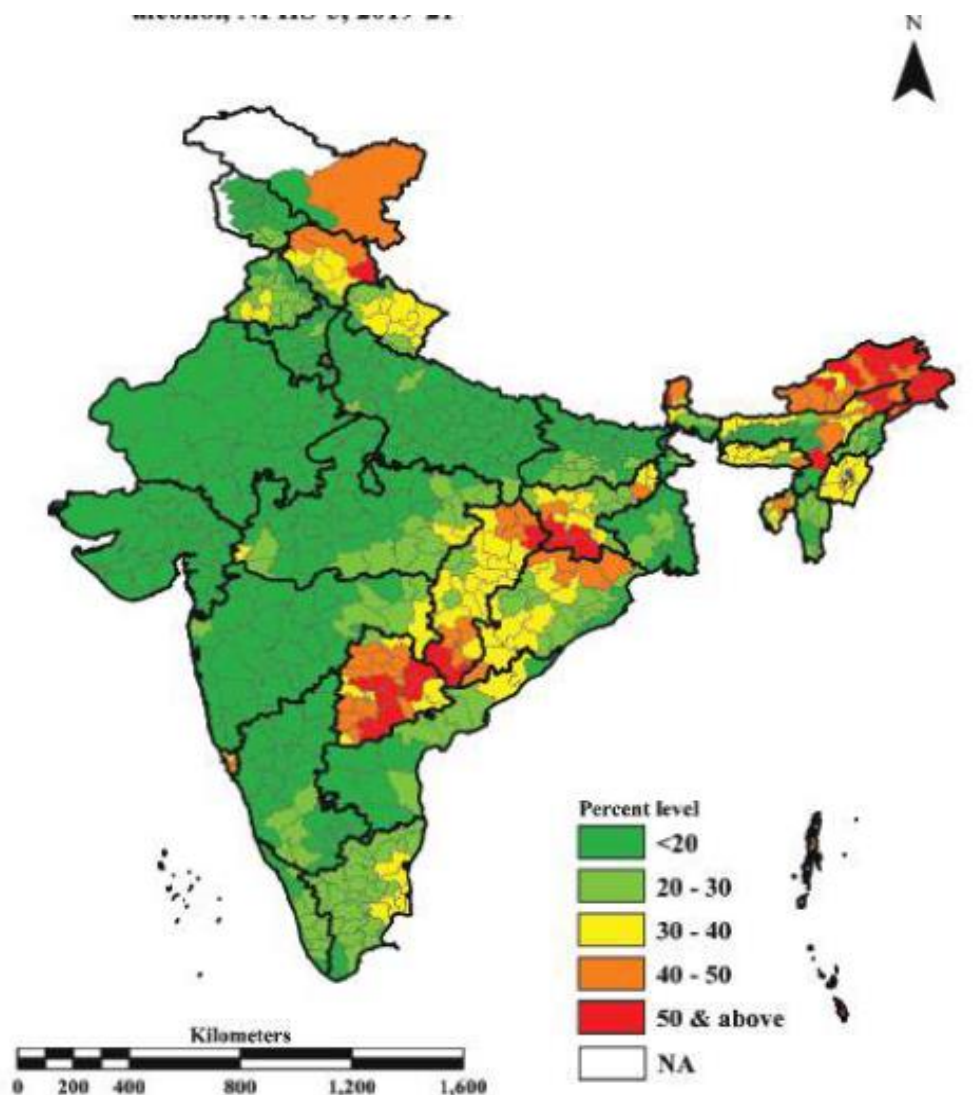
*Per 100 000 population (15+); **alcohol-attributable deaths, both sexes.

Source: WHO.Global Status report on alcohol and health 2018.

The proportion of men who drink alcohol decreased, from 29% to 22%, between NFHS-4 in 2015-2016 and NFHS-5 in 2019-2021. During that period, the proportion of women who drink remained unchanged, ^[26][Figure 6].

Figure 6

Men Aged 50 years and above who consume alcohol, NFHS 5, 2019-2021^[26]



Source: National Family Health Survey (NFHS-5),2019-21

The percentage of women aged 15-49 years who drink alcohol is by far the highest among women in Arunachal Pradesh (18%) and Sikkim (15%). Alcohol use among men is highest in Goa (59%), Arunachal Pradesh (57%), and Telangana (50%) and is the lowest in Lakshadweep (1%).^[26] [Table 6]

Table 6
Percentage of women and men aged 15-49 years who drink alcohol, by
state/union territory, India, 2019-21^[26]

State/union territory	Percentage of women who drink alcohol	Percentage of men who drink alcohol
India	0.7	22.4
North		
Chandigarh	0.1	26.4
Delhi	1.4	27.9
Haryana	0.1	17.9
Himachal Pradesh	0.4	31.9
Jammu & Kashmir	0.2	10.5
Ladakh	3.6	23.7
Punjab	0.1	27.5
Rajasthan	0.1	11.5
Uttarakhand	0.1	32.1
Central		
Chhattisgarh	2.8	35.9
Madhya Pradesh	0.4	20.2
Uttar Pradesh	0.1	16.5
East		
Bihar	0.1	17
Jharkhand	2.6	40.4
Odisha	0.7	38.4
West Bengal	0.7	25.7
Northeast		
<i>Arunachal Pradesh</i>	<i>17.8</i>	<i>56.5</i>

Assam	5.5	26.5
Manipur	1.6	47.9
Meghalaya	1	36.3
Mizoram	1	29.9
Nagaland	1.4	31.1
Sikkim	14.8	36.3
Tripura	4.3	35.9
West		
Dadra & Nagar Haveli and Daman & Diu	0.5	41.8
Goa	4.8	59.1
Gujarat	0.1	5.9
Maharashtra	0.2	17.2
South		
Andaman & Nicobar Islands	2.2	42.1
Andhra Pradesh	0.2	31.2
Karnataka	0.3	23.1
Kerala	0.3	26
Lakshadweep	0.1	0.8
Puducherry	0.2	37.1
Tamil Nadu	0.1	32.8
Telangana	4.9	50

Source: National Family Health Survey (NFHS-5),2019-21

3.4.7 Alcohol consumption in Karnataka

According to NFHS-5, only 1% of women report drinking alcohol, while men are less likely to drink than to use tobacco. Nearly 69% of men who drink alcohol do it at least once a week.^[27]

3.5 MEDICAL CONSEQUENCES OF ALCOHOL USE

The stomach and small intestine absorb alcohol when alcoholic beverages are ingested. To every organ in the body, it is delivered by blood flow. About 95 to 98% of the alcohol consumed is eliminated from the body through the kidneys after being rapidly absorbed by the liver.^[31]

The various medical complications because of alcohol consumption are

Gastrointestinal (GI) complications

Alcohol's direct effects on the stomach's lining can cause acute gastritis and manifest as vomiting, which is typically linked to binge drinking. Damage that occurs repeatedly may result in hyperacidity and peptic ulcer disease. One of the main causes of haemorrhagic gastritis is alcohol. The most frequent side effect of chronic alcohol use is alcoholic liver damage.

Cancer

Alcohol was found to significantly increase the incidence of malignancies of the pharynx, oral cavity, oesophagus, and larynx in a study conducted by Bangardi et al.^[32] A woman's risk of breast cancer increases by 1.4 times with just 1.5 drinks per day. Four drinks a day increase the risk of oral and oesophageal cancers by roughly three times, and the risk of rectal cancers by 1.5 times, for both sexes.^[31]

Changes in the genitourinary system

In the short term, low dosages of ethanol can cause a decline in men's erectile function in addition to increasing sexual urge. A significant minority of chronic

alcoholic males have irreversible testicular atrophy and shrinkage of seminiferous tubules even in the absence of liver damage, leading to a decrease in ejaculate volume and a low sperm count.^[33] According to a study by Chandra et al., alcohol addiction is disproportionately strongly associated with high-risk sexual behaviour and HIV infection.^[34]

Muscular changes

Acute alcoholic myopathy, which can cause skeletal muscle weakness in up to two-thirds of alcoholics, may become better with abstinence but is not completely cured. Lower bone density is one of the skeletal system's effects of alcohol use.^[33] According to a study by Venkat et al., people with chronic drinking experience lower bone density and avascular necrosis of the femoral head.^[35]

Neurological complications

Blackouts, hazy vision, poor memory, and slower reaction times are some of the short-term symptoms of alcohol intake that can be alleviated after quitting drinking.^[31] Chronic alcohol usage has been linked to the development of alcoholic tremors, myopathy, Wernicke's encephalopathy, and cerebellar degeneration, according to research by Peng et al.^[36]

Psychiatric complications

Alcohol consumption has long been used as a treatment for depression and anxiety. While initially helping to some extent, alcohol starts to deplete the neurotransmitter serotonin in the brain, which causes depression and anxiety. As

a result, the need to drink more to treat depression grows. Chronic use can increase the likelihood of suicidal thoughts, personality disorders, and risky behaviours.^[36] In a general hospital in India, alcohol-related issues accounted for 17.6% of mental emergencies.^[37]

Teferra et al., has conducted a cross-sectional community-based survey in Ethiopia in 2015 with 1500 adults found that male gender, increasing age, having experienced one or maybe more stressful life events, and severe psychological distress were all factors independently associated with hazardous alcohol use.^[60]

Ramanan et al., in India did a cross-sectional study in 850 homes chosen from 19 villages with two Primary Health Centres^[8] reported that one-third of drinkers started drinking before the age of 20, and half of the alcohol users did so to relieve stress, pain, or fatigue.^[8]

3.6 SOCIAL CONSEQUENCES OF ALCOHOL USE

Alcohol usage has an impact on not only the individual but also on his family members in some way. The children of alcoholic fathers will have strained relationships with their family members, which can affect their psychological well-being. The person intoxicated may engage in domestic violence with his family members; may deplete the family's savings, which can have a negative impact on the education of his children. In a study conducted by Gururaj et al.,

in Bangalore, it was discovered that alcohol users were 2.5 times more likely to emotionally abuse their spouse, 23.3% of users physically attacked their spouse, and 7.8% of users physically assaulted their spouse inflicting injuries.^[38]

In research by Markowitz et al., 20% of women reported experiencing domestic violence, and they identified their husbands' drinking habits as the main contributing factor.^[39]

Ramanan et al., in India observed in their study that about half of the alcohol users among the study population reported having problems with both their neighbours and family.^[8]

A population survey conducted by Pillai et al., found that alcohol related outcomes can increase the sexual risk, intimate partner violence and alcohol dependence.^[1]

3.7 LEGAL PROBLEMS BECAUSE OF ALCOHOL CONSUMPTION

Several legal issues are associated with alcohol consumption. Sexual and physical assault, rape, the exploitation of women in commercial sex work, and murder are crimes that are committed after drinking. The Prohibition Act, Gambling Act, Psychotropic Substance Act, and Excise Act are the four principal acts that cover the many offences associated with alcohol drinking, according to the National Crime Records Bureau of India. However, because these offences are categorised as small offences, they frequently go

unrecognised or may be neglected, which is the main reason why the public annoyance caused by alcohol consumption remains unnoticed.^[38]

3.7.1 ALCOHOL POLICY IN INDIA

Alcohol policy is a state matter, despite the fact that the Indian Constitution encourages the restriction of alcohol usage. Alcohol-related laws, excise taxes, and the manufacture, distribution, and sale of alcohol are completely under state jurisdiction. Alcohol prohibition persisted in India until the middle of the 1960s. By 1970, only the state of Gujarat had a complete alcohol prohibition policy.^[38] Since April 4, 2016, drinking is completely prohibited in Bihar. However, a year after the ban, commerce in illegal alcohol grew along the borders because neighboring states do not have an alcohol ban. Additionally, it appears that illicit drug trafficking is occurring as more people turn to other substances for addiction.^[31]

Manipur is another contentious "Dry State," where alcohol consumption has been banned since 1991, although scheduled castes (SCs) and scheduled tribes (STs) have been permitted to produce their traditional alcoholic beverages. The government of Manipur removed the prohibition on alcohol in select districts in 2002. Manipur is presently referred to as the "Wettest Dry State." The government is now attempting to repeal the Prohibition Act due to rising illicit alcohol use, methanol poisoning mortality, and substance abuse.^[31] The primary

factor hindering states' policy on alcohol prohibition is that it brings in roughly 15% to 20% of their total revenue from alcohol taxes, which is a sizable sum for the state coffers.^[31]

The wealthy continue to have access to alcoholic beverages in places like Gujarat where total prohibition is in effect, but the lower classes and the impoverished turn to illegal alcohol production, which is associated with an increase in fatalities from methanol poisoning.^[31]

Increased taxes on alcoholic beverages have been utilized in nations like the United States of America (USA) to cut down on drinking. These precautions won't be effective in India because there is easy access to illegal alcohol and drugs for drinkers. Other rules governing the use of alcohol, such as those governing sale hours, driving while intoxicated, and sales to minors, are frequently broken. The legal drinking age is the age at which a person can purchase alcohol.^[31] The legal age in different states in India is given in Table 7.

Table 7

Legal age of drinking in various states in the country

Legal drinking age	State/Union Territory
Illegal (Complete ban on alcohol use)	Bihar, Gujarat, Lakshadweep, Nagaland and partial prohibition in Manipur
18	Goa, Haryana, Himachal Pradesh, Jammu and Kashmir, Puducherry and Sikkim
21	Andaman and Nicobar, Arunachal Pradesh, Andhra Pradesh, Uttar Pradesh, Assam, Jharkhand, Karnataka, Tamil Nadu and Telangana
25	Chandigarh, Daman and Diu, Delhi and Punjab.

3.7.2 DRUNKEN DRIVING (*Section 185 in The Motor Vehicle Act, 1988*)

There is a slow and progressive loss of driving ability because of the increase in reaction time, overconfidence, diminished muscle coordination, impaired attention, and lower auditory and visual acuity that occurs when a person drinks alcohol. This is referred to as drunken driving. In India, inebriated driving is prohibited by law. The 0.03% Blood Alcohol Concentration (BAC) level is the upper limit. According to the Motor Vehicle Act, anyone whose BAC levels are determined to be above this limit is charged with a first offence and faces a maximum penalty of 6 months to 4 years in prison as well as a fine of around INR 2,000 to 10,000.^[31]

3.7.3 ALCOHOL ADVERTISEMENTS

Alcohol advertising was outlawed in India by the Cable Television Network (Regulation) Amendment Bill. Nevertheless, private channels frequently allow alcohol businesses to advertise using dummy products, such as brand names for soda, water, or music. But as the target group switches from viewing television to using mobile devices, alcohol businesses are also spending money on online video marketing. ^[31]

3.8 ALCOHOL AND SUSTAINABLE DEVELOPMENT GOALS 2030

HEALTH TARGETS

There are three key interconnected processes via which alcohol consumption causes health and social harms: three ways: 1) through intoxication - the euphoric effects of alcohol hours after drinking; 2) through the onset of alcohol dependence, which results in the drinker's diminished ability to control their drinking and frequently involves alcohol-induced mental problems such as depression or psychoses; and 3) the damaging effects of alcohol on various organs and tissues in the body of the consumer leads to liver disease, heart disease, or cancer. ^[30]

Strengthening the prevention and treatment of substance addiction, including drug abuse and problematic alcohol use, is the SDG health objective 3.5. ^[25] It covers two indicators. They are

3.5.1. Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders.

3.5.2. Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol.^[25]

3.9 FACTORS THAT HAVE AN IMPACT ON HEALTH

CONSEQUENCES

Alcohol intake and the likelihood that certain illnesses and injuries would occur are both influenced by several different factors.

Social vulnerability factors - degree of development, culture, drinking setting, and production, distribution, and controls of alcohol

Individual vulnerability factors - age, gender, familial circumstances, and sociodemographic characteristics.^[25]

3.10 TREATMENT GAP IN ALCOHOL USE DISORDERS

Prior estimates imply that more than 56% of those with depression and 78% of those with alcohol use and dependence have not received care, illustrating the wide disparity between those who require mental health care and those who actually receive it globally.^[16] In low-income nations, 52.6% of those with depression received therapy in the previous 12 months, but only 20.5% of those with depression received treatment that was at least minimally appropriate, according to research of 21 countries using the World Health Organization (WHO) Mental Health Surveys.^[40] Untreated mental illness has been linked to

several negative outcomes, including early mortality, poverty, unemployment, homelessness, co-occurring substance misuse and addiction, poor physical health, and suicide, according to studies.^[16] Recently, several actions have been done to close the treatment gap in mental health care.^[41–43] The disparity is still wide, particularly in low- and middle-income nations (LMICs).^[13,44] In order to establish policies and plans to lower these barriers to mental health care, it may be helpful to understand the reasons why persons with mental disorders discontinue or refuse treatment. There are several things that are thought to prevent people from receiving mental health treatment, including lack of perceived need, stigma, not knowing where to turn for help, thinking that the issue will go away on its own, wanting to handle the issue on one's own, inability to pay for treatment costs, uncertainty about the treatment's efficacy, and a lack of services.^[45–49]

In a study conducted at Ethiopia by Zewdu et al., reported that alcohol users never sought treatment for their alcohol dependence due to a high level of internalised stigma.^[2]

From September 2012 to December 2012, Dutta et al. conducted a cross-sectional study in the Tiruvallur district of Tamil Nadu found that the study participants failure to seek alcoholism treatment is due to family issues.^[63]

The two most common excuses given by study participants not seeking treatment for alcohol use in a community-based study in India conducted by Pal et al., is that “ashamed to admit issues” and “treatment does not help” which

were given in proportions of 26.5% and 22.8% respectively.^[59]

3.11 ALCOHOL USE DISORDER IDENTIFICATION TEST (AUDIT) QUESTIONNAIRE

A standardised tool for screening people who use alcohol harmfully is the WHO Alcohol Use Disorder Identification Test, which is recommended for use in primary health care facilities.^[52] Peripheral health professionals can utilise the assessment to identify alcohol users who need specialised psychiatric care at the community level. The Global Information System on Alcohol and Health advises utilising the AUDIT instrument to report dependence prevalence at the country level.^[22]

The objective of the instrument was specifically not to identify "alcoholism" or alcohol dependency, as was stated in the original publication on the development of the tool, but rather to identify patients before they established reliance on alcohol by focusing on hazardous alcohol consumption.^[53] Although alcohol use measures were adopted as the instrument's "reference standards," using just these measures as a screening or diagnostic tool was rejected for the following reasons: 1) neither alcohol intake nor the frequency of intoxication are sole determinants of harm; 2) the validity of patients' self-reports of drinking was satisfactory; however, other symptoms (such as blackouts) were also important; and 3) the amount of alcohol needed to cause many medical conditions is much lower than the amount needed to cause other symptoms. As

a result, in addition to inquiries concerning alcohol consumption, the AUDIT also probes patients about typical issues brought on by alcohol as well as typical signs of alcohol dependence, and the answers are factored into the patient's overall score.^[54] The AUDIT, which consists of 10 questions about recent alcohol use, signs of alcohol dependency, and alcohol-related issues, is described in the table below,[Table 8].

Table 8
Domains and Item Content of the AUDIT

Domains	Question Number	Item Content
Hazardous Alcohol Use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence Symptoms	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful Alcohol Use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

Source: WHO, The Alcohol Use Disorder Identification Test, Guidelines for use in primary care

MATERIALS AND METHODS

4. MATERIALS AND METHODS

4.1 STUDY SETTING:

This study was undertaken in rural areas of the Kolar district. It is situated in the southern part of Karnataka state at a distance of about kilometres from Bengaluru. It occupies an area of about 4012 sq. km. and comprises a population of 15,36,401 with a sex ratio of 976 females per 1000 males.^[65]

Figure 7
Map of Karnataka showing Kolar district



The district includes six Taluks namely Mulbagal, Kolar, Malur, Srinivasapura

and Kolar Gold Fields (KGF). The effective literacy of the district was 74.33% and female literacy of 66.56%.^[65] Most of the people speak Kannada and a notable proportion also speak Telugu in the regions bordered by Andhra Pradesh and Tamil in KGF. This study was conducted among all individuals from the 6 villages aged 18 years and above living for at least a minimum of 12 months duration in Devarayasamudra, a Rural Health Training Centre (RHTC), Department of Community Medicine, Sri Devaraj Urs Medical College. Under RHTC there are three subcentres – Devarayasamudra, Kothamangala and Keeluholalli. The rural field practice area has a population of 11638 which is spread over 20 villages according to the 2020 (November) Community Need Assessment (CNA) survey of RHTC

4.2 STUDY POPULATION:

All persons aged 18 years and above residing in the selected areas of rural field practice area of the Department of Community Medicine, Sri Devaraj Urs Medical College, Tamaka, Kolar.

4.3 INCLUSION CRITERIA:

- Person aged 18 years and above whoever gives consent.
- Person aged 18 years and above who were residing in areas of the rural health training centre for at least one year.

4.4 EXCLUSION CRITERIA:

- Person aged 18 years and above who had not available during the second visit.

4.5 STUDY DESIGN:

Community-based cross-sectional study.

4.6 STUDY DURATION:

The study was conducted from 1st February 2021 to 30th June 2022.

4.7 METHODS OF COLLECTION OF DATA INCLUDING SAMPLING PROCEDURE:

4.7.1 Sample Size:

$$\begin{aligned}\text{Calculation: } & \frac{Z_{\alpha}^2(p)(1-p)(DE)}{d^2} \\ &= \frac{(1.96)^2(9.4)(90.6)(2)}{(1.88)^2} \\ n &= 1850.\end{aligned}$$

Z_{α} = Standard normal variate at α 5%.

p = Expected proportion in population based on prevalence study conducted by Ganesh Kumar et al. ^[54]

d = Relative precision of 20% i.e., 1.88.

DE = Design effect of 2.

4.8 BRIEF PROCEDURE:

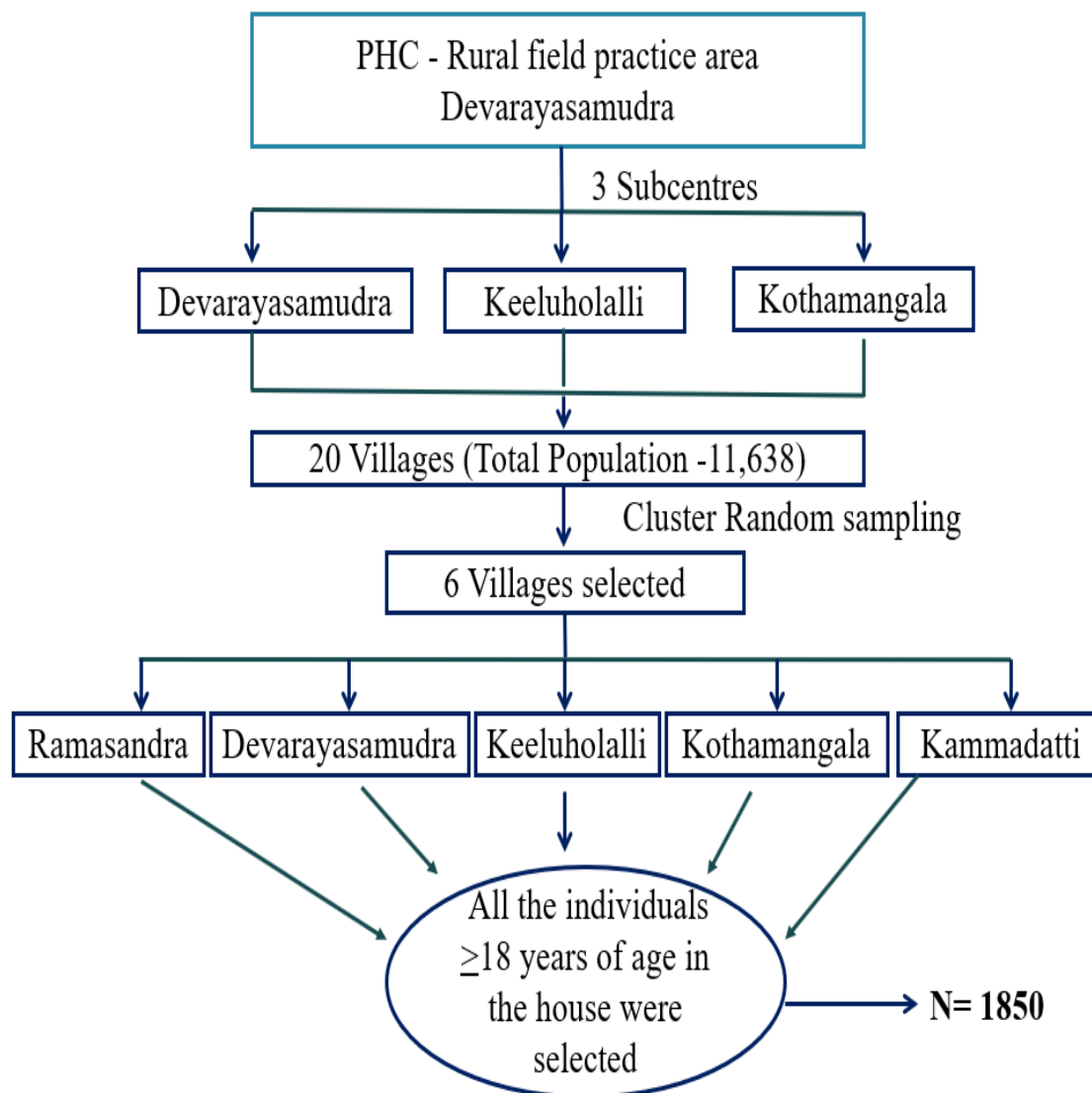
4.8.1 Sampling:

The sample size of 1850 was calculated by using a prevalence of alcohol use 9.4% and relative precision of 20% (1.88), with a design effect of 2, Cluster sampling design will be used for identifying the villages. Among the 20 villages (clusters), 6 villages (clusters) namely Ramsandra, Devarayasamudra, Kammadatti, Keeluholalli, Kothamangala had been randomly selected from the rural field practice area the of Dept. of Community Medicine, SDUMC, Kolar. Among the selected villages (clusters), all the households were included in the sample. In the house, individuals who are aged 18 years and above were included in the study. If the house is locked during the initial visit, one more visit was done on next day before dropping that house from the study.

In the selected houses, written informed consent was obtained from the participants. A pre-tested, validated, semi-structured questionnaire was used to collect information on basic socio-demographic details from all the household members aged 18 years and above. Then, the AUDIT questionnaire was used to assess the alcohol consumption, drinking behaviours, and alcohol-related problems in rural persons aged 18 years and above in that house. If the AUDIT score is ≥ 16 , a question regarding the treatment gap was assessed.

Figure 8

Flow diagram of Sampling



4.9 STUDY TOOL:

4.9.1 Pretested semi-structured questionnaire: was used to collect socio-demographic details, it was administered by interview method. The questionnaire was prepared in English, validated, pilot-tested and later translated to Kannada language. The variables collected by interview were basic demographic details namely age, sex, marital status, address, religion, education, occupation, type of family and socio-economic status which included the total income of working members in the family and the number of individuals in the house. Smoking history and tobacco chewing were recorded.

4.9.2 The Alcohol Use Disorders Identification Test (AUDIT): For capturing information on alcohol use WHO, The Alcohol Use Disorders Identification Test (AUDIT) questionnaire was used. The questionnaire was translated in to local language (Kannada) and back-translated to English. The variability after the back translation was checked and corrected.

The AUDIT questionnaire is a 10-item screening tool used to assess alcohol consumption, drinking behaviours, and alcohol-related problems. Participants were encouraged to answer the AUDIT questions in terms of standard drinks. Scores for each question ranged from 0 to 4, with a maximum score of 40.

- A score of 8 or more was considered to indicate hazardous or harmful alcohol use
- A score of 13 or more in women, and 15 or more in men, was likely to

indicate alcohol dependence.

4.9.3 For assessing the Treatment gap: Participants with an AUDIT score ≥ 16 , a single question was asked, “Did you seek any help for these problems?” Follow-up questions were then asked about the time, type, source and usefulness of the help sought.

4.10 PILOT STUDY:

A pilot test was conducted among 20 residents of Nadupalli village, Tamaka, Kolar before the initiation of the study and the questionnaire was found to be feasible.

4.11 STATISTICAL ANALYSIS:

The data collected were coded and entered into Microsoft Excel version 2019. Data analysis was carried out using SPSS version 22. Qualitative data were represented as frequencies, proportions and the chi-square test was the test of significance used for comparison. Quantitative data were represented as mean and the standard deviation. Binary logistic regression to find associated risk factors for alcohol use disorder and treatment gap. A prevalence ratio with a 95% confidence interval was computed to find the strength of association among various demographic variables with the outcome measures namely alcohol use, alcohol dependence and treatment gap. $p < 0.05$ was considered statistically significant.

4.12 ETHICAL CONSIDERATIONS

This study is approved by the institutional ethical review committee of Sri Devaraj Urs Academy of Higher education and Research, Kolar. (No.SDUMC/KLR/IEC/575/2020-21)

4.12.1 Autonomy

- Participants in the study were given a participant information sheet that explained the study and invited them to participate willingly.
- The participants were requested to provide a written informed consent form if they were willing to participate in the study.

4.12.2 Confidentiality

- The data was collected from the participants using a self-administered questionnaire, which was kept confidential.
- The collected data was accessible only to the study team. The data was entered and stored in a password-protected Excel sheet for analysis.

4.12.3 Benevolence

- The participants who were found to have harmful alcohol use and alcohol dependence were informed regarding the same and advised to seek medical support.

RESULTS

5. RESULTS

A Community based cross-sectional study was conducted in Devarayasamudra, PHC, a rural field practice area of the Department of Community Medicine, SDUMC. A total of 1850 people were interviewed from the six villages (Keeluholali, Devarayasamudra, Kothmangala, Mallapanahali, Ramsandra, and Kammadatti). The results are as follows:

Table 9
Distribution of study participants according to Age (n=1850)

Age (in years)	Frequency (%)	Percentage (%)
18-32	650	35.2%
33-46	531	28.7%
47-60	376	20.3%
≥61	293	15.8%
Total	1850	100%

From the above table, it is observed that, among the 1850 participants, 35.2% of them were between the age group of 18-32 years, 531 (28.7%) were in the 33-46 years age group, while 376 (20.3%) belonged to the age group of 47-60 years and participants ≥ 61 years were the least, accounting for 293 (15.8%). The mean ($\pm$ Standard Deviation) age of participants was 42.5 ± 17 (Table 9).

Table 10
Distribution of study participants according to Gender (n=1850)

Gender	Frequency (n)	Percentage (%)
Male	998	53.9%
Female	852	46.1%
Total	1850	100%

It was noted from the above table that, out of 1850 participants, 998 (53.9%) of them were males, whereas 852 (46.1%) were females. It was observed that male participants were relatively more compared to female participants (Table 10).

Table 11
Distribution of study participants according to Religion (n=1850)

Religion	Frequency (n)	Percentage (%)
Hindu	1835	99.2%
Muslim	13	0.7%
Christian	2	0.1%
Total	1850	100%

From the above table, it is found that, among 1850 participants, majority of them 1835 (99.2%) belonged to the religion Hindu, 13 followed by (0.7%) Muslims and 2 (0.1%) of them were Christians (Table 11).

Table 12

Distribution of study participants according to Caste (n=1850)

Caste	Frequency (n)	Percentage (%)
General	251	13.6%
OBC	369	19.9%
SC/ST	1230	66.5%
Total	1850	100%

From the table, it is observed that, of 1850 participants, majority of them 1230 (66.5%) belonged to SC/ST caste, 369 (19.9%) were in the OBC, and 251 (13.6%) belonged to the General caste (Table 12).

Table 13

Distribution of study participants according to Education (n=1850)

Education	Frequency (n)	Percentage (%)
Illiterate	683	36.9%
Primary and Secondary School	419	22.6%
PUC	372	20.1%
Degree	376	20.3%
Total	1850	100%

In the above table, the education profile of the study subjects was detailed after the interview and most of the study subjects were literate (63%). Among those literate participants, 22.6% of them had primary schooling, 20.1% went till PUC, 20.3% were degree holders and 36.9% were illiterates (Table 13).

Table 14

Distribution of study participants according to Occupation (n=1850)

Occupation	Frequency (n)	Percentage (%)
Daily Wage	603	32.6%
Self Employed	417	22.5%
Professional	234	12.6%
Student	161	8.7%
Homemaker	435	23.5%
Total	1850	100%

From the above table, it is found that, of 1850 participants, 603 (32.6%) were daily wage workers, 435 (23.5%) of the female participants were homemakers, 417 (22.5%) participants were self-employed, 234 (12.6%) were Professionals and only 161 (8.7%) participants are doing their studies (Table 14).

Table 15

Distribution of study participants according to Marital status (n=1850)

Marital status	Frequency (n)	Percentage (%)
Unmarried	266	14.4%
Married	1584	85.6%
Total	1850	100%

From the above table most of the study participants were married 1584 (85.6%) and 266 (14.4%) of them are unmarried (Table 15).

Table 16
Distribution of study participants according to Type of family (n=1850)

Type of family	Frequency (n)	Percentage (%)
Nuclear family	1208	65.3%
Joint family	545	29.5%
Three generation family	97	5.2%
Total	1850	100%

According to the above table, the majority of the participants 1208 (65.3%) were from the nuclear family, while 545 (29.5%) belonged to the joint family and only 97 (5.2%) of the participants were coming from three-generation family (Table 16).

Table 17

**Distribution of study participants according to Modified BG Prasad
classification of Socio-Economic Status 2021 (n=1850)**

Socioeconomic status	Frequency (n)	Percentage (%)
Upper class	94	5.1%
Upper middle class	440	23.8%
Middle class	694	37.5%
Lower middle class	556	30.1%
Lower class	66	3.6%
Total	1850	100%

According to the above table, the majority of the study subjects belonged to the middle class 37.5%, and almost one-fourth of the study subjects 30.1% belonged to the lower middle class, followed by 23.8% belonging to the upper middle class, 5.1% to upper class and 3.6 % to lower class respectively (Table 17).

Table 18

**Distribution of study participants according to No of Family members
(n=1850)**

Number of Family members	Frequency (n)	Percentage (%)
≤ 5	998	53.9%
≥ 6	852	46.1%
Total	1850	100%

From the above table, it is observed that the majority of the participants 998 (53.9%) belonged to families with less than 5 members and 852 (46.1%) belonged to families with more than 6 members (Table 18).

Table 19

**Distribution of study participants according to Chewing of Tobacco
(n=1850)**

Tobacco chewing	Frequency (n)	Percentage (%)
Present	210	11.4%
Absent	1640	88.6%
Total	1850	100%

It was found that about 210 (11.4%) of participants reported using as smokeless tobacco (Table 19).

Table 20

**Distribution of study participants according to Smoking of Tobacco
(n=1850)**

Tobacco Smoking	Frequency (n)	Percentage (%)
Present	101	5.5%
Absent	1749	94.5%
Total	1850	100%

From the above table, it is found that, about 101 (5.5%) of participants reported to use as smoking tobacco (Table 20).

Table 21
Sociodemographic characteristics of alcohol users

Participants characteristics	AUDIT category	
	Alcohol users Frequency (%) (n=180)	Non alcoholics Frequency (%) (n=1670)
Age		
18-32	18(3%)	632(97%)
33-46	62(12%)	469(88%)
47-60	54(14%)	322(86%)
≥61	46(16%)	247(84%)
Gender		
Male	163(16%)	835(84%)
Female	17(2%)	835(98%)
Religion		
Hindu	180(10%)	1835(90%)
Muslim	0	13(0.7%)
Christian	0	02(0.1%)
Caste		
General	22(16%)	229(84%)
OBC	41(11%)	328(89%)
SC/ST	117(10%)	1113(90%)
Education		
Illiterate	95(14%)	588(86%)
Primary & Secondary School	38(9%)	381(91%)
PUC	35(9%)	337(91%)
Degree	12(3%)	364(97%)
Occupation		
Daily Wage	100(17%)	503(83%)
Self Employed	57(14%)	360(86%)
Professional	18(8%)	216(92%)
Student	01(1%)	160(99%)
Homemaker	04(1%)	431(99%)
Type of Family		
Joint	53(10%)	492(90%)

Nuclear	121(10%)	1087(90%)
Three generation	06(6%)	94(94%)
Socioeconomic status		
Upper class	04(4%)	90(96%)
Upper middle class	41(9%)	399(91%)
Middle class	74(11%)	620(89%)
Lower middle class	58(10%)	498(90%)
Lower class	03(5%)	63(95%)
Marital status		
Married	11(4%)	255(96%)
Unmarried	169(11%)	1415(89%)
Number of family members		
≤5 members	105(11%)	893(89%)
≥6 members	75(9%)	777(91%)
Tobacco chewing		
Present	53(25%)	157(75%)
Absent	127(8%)	1513(92%)
Smoking history		
Present	49(47%)	55(53%)
Absent	131(8%)	1615(92%)

From the above table sociodemographic characteristics of the alcohol users and non-alcohol users are described (Table 21). Among alcohol users (180), majority (62) of the study participants belonged to 33-46 years, 163 participants were males, 117 participants belonged to scheduled caste or scheduled tribe and whole 180 participants were Hindu by religion. Majority of alcohol users were illiterates (95), daily wage workers (100) and unmarried (169). Majority of participants (121) belonged to nuclear family and 74 participants belongs to middle class according to modified B G Prasad socioeconomic classification. Among 180 alcohol users, 53 participants use tobacco in the form of chewing form and 49 participants use tobacco in smoking form.

Frequency distribution of responses of participants to different questions in the AUDIT Questionnaire (Table 22-26)

Table 22

Frequency of alcohol consumption among the study participants based on AUDIT Questionnaire(n=1850)

AUDIT Q1): How often do you have a drink containing alcohol?	Frequency (n)	Percentage (%)
Never	1670	90.2%
Monthly or less	11	0.6%
2 to 4 times a month	74	4.0%
2 to 3 times a week	57	3.1%
4 or more times a week	38	2.1%
Total	1850	100%

From the above table, it is observed that, of 1850 participants, 1670 participants never consumed alcohol in the past 12 months and the prevalence of alcohol consumption among study participants in the past 12 months was found to be 9.7% (180 study participants). The frequency of alcohol consumption among study participants by 2 to 4 times in a month was 74 (4%). About 57 (3.1%) participants are using alcohol 2 to 3 times a week and 38 (2.1%) were consuming alcohol 4 or more times in week (Table 22).

Table 23
Number of drinks consumed on a typical day by the study
participants(n=180)

AUDIT Q2): How many drinks containing alcohol do you have on a typical day when you are drinking?	Frequency (n)	Percentage (%)
1 or 2	20	11.1%
3 or 4	49	27.2%
5 or 6	79	43.9%
7, 8, or 9	23	12.8%
10 or more	9	5.0%
Total	180	100%

From the above table, it is observed that among 180 participants who consume alcohol in the past 12 months majority of the participants 79 (43.9%) had 5 or 6 drinks containing alcohol on a typical day followed by, 49 (27.2%) participants had 3 or 4 drinks 23 (12.8%) participants 7-9 drinks and only 9 (5%) participants had 10 or more drinks on a typical day (Table 23).

Table 24
Response of study participants on patterns of alcohol consumption to
AUDIT Q3-Q8 (n=180)

AUDIT (Q3-Q8): Patterns of alcohol use	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Total
Q3: How often do you have six or more drinks on one occasion?	20 (11.1%)	67 (37.2%)	51 (28.3%)	32 (17.8%)	10 (5.6%)	180 (100%)
Q4: How often during the last year have you found that you were not able to stop drinking once you had started?	20 (11.1%)	96 (53.3%)	47 (26.1%)	9 (5%)	8 (4.4%)	180 (100%)
Q5: How often during the last year have you failed to do what was normally expected from you because of drinking?	20 (11.1%)	112 (62.2%)	29 (16.1%)	16 (8.9%)	3 (1.7%)	180 (100%)
Q6: How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	20 (11.1%)	113 (62.8%)	36 (20%)	8 (4.4%)	3 (1.7%)	180 (100%)
Q7: How often during the last year have you had a feeling of guilt or remorse after drinking?	20 (11.1%)	117 (65%)	36 (20%)	5 (2.8%)	2 (1.1%)	180 (100%)
Q8: How often during the last year have you been unable to remember what happened the night before because you had been drinking?	20 (11.1%)	112 (62.2%)	36 (20%)	7 (3.9%)	5 (2.8%)	180 (100%)

From the above table, it is found that 20 alcohol users (11.1%) never had six or more drinks on one occasion. 67 (37.2%) alcohol users had six or more drinks

on one occasion less than monthly followed by 51 (28.3%) alcohol users monthly, 32 (17.8%) alcohol users weekly and 10 (5.6%) alcohol users daily or almost daily.

It was observed that 20 (11.1%) alcohol users never had difficulty in stop drinking in the last year. 96 (53.3%) alcohol users find difficulty in stop drinking less than monthly followed by 47 (26.1%) alcohol users monthly, 9 (5%) alcohol users weekly and 8 (4.4%) alcohol users daily or almost daily.

It was observed that, 20 (11.1%) alcohol users never fail to perform the duties that were ordinarily placed upon them over the past year as a result of drinking. 112 (62.2%) fail to perform the duties that were ordinarily placed upon them over the past year as a result of drinking less than monthly, followed by 29 (16.1%) monthly, 16 (8.9%) weekly, 3 (1.7%) daily or almost daily.

It was found that 20 (11.1%) alcohol users never required the first drink in the morning over the past year to get themselves going after a heavy drinking session. 113 (62.8%) alcohol users require a first drink in the morning over the past year to get themselves going after a heavy drinking session less than monthly followed by 36 (20%) alcohol users required a first drink in morning monthly, 8 (4.4%) alcohol users weekly and 3 (1.7%) alcohol users daily or almost daily.

It was observed that, among 180 alcohol users who consume alcohol in the past 12 months, 117 (65%) alcohol users sense regret or guilt after drinking in the past year less than monthly, followed by 36 (20%) alcohol users monthly, 5

(2.8%) alcohol users weekly and 2 (1.1%) alcohol users daily or almost daily.

Among 180 alcohol users who consume alcohol in the past 12 months, 112 (62.2%) alcohol users had difficulty less than monthly in recalling what happened the night before because of drinking in the last year followed by 36 (20%) alcohol users monthly, 7 (3.9%) alcohol users weekly and 5 (2.8%) alcohol users daily or almost daily. 20 alcohol users never had difficulty in recalling what happened the night before because of drinking in the past year (Table 24).

Table 25

Participant-reported incidents of causing injury to self/others after alcohol consumption(n=180)

AUDIT Q9): Have you or someone else been injured as a result of your drinking?	Frequency (n)	Percentage (%)
No	160	88.9%
Yes, but not in the last year	15	8.3%
Yes, during the last year	5	2.8%
Total	180	100%

Based on the above table, among 180 alcoholics, 20 (11.1%) participants had injured someone else as a result of drinking, in this only 5 (2.8%) participants injured someone else as a result of drinking during the last year (Table 25).

Table 26

**Participant-reported instances of receiving advice to reduce alcohol
consumption(n=180)**

AUDIT Q10): Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down??	Frequency (n)	Percentage (%)
No	167	92.8%
Yes, but not in the last year	8	4.4%
Yes, during the last year	5	2.8%
Total	180	100%

From the above table, among 180 alcoholics, 13 (7.2%) participants got suggestions from a relative or friend or a doctor to cut down their alcohol consumption, in this only 5 (2.8%) participants got suggestions to cut down alcohol consumption during the last year (Table 26).

Treatment gap Questionnaire

It is found that among the 180 alcohol users only 2 individuals (0.1%) had taken treatment for alcohol consumption in the past 12 months.

Table 27

**Participants involved in alcohol consumption according to AUDIT category
(n = 180)**

AUDIT score	Frequency (n)	Percentage (%)
1-7 (within harmless zone)	20	11.1%
8-15 (hazardous drinking)	121	67.2%
16-19 (Severe alcohol problem)	23	12.8%
20-40 (alcohol dependent)	16	8.9%
Total	180	100%

The above table shows patterns among alcohol users (n=180). In this study, 39 (21.7%) individuals among alcohol users require special alcohol de-addiction care with an AUDIT score >16. The majority of the alcohol users 121 (67.2 %) had hazardous alcohol usage (AUDIT score 8-15) while 20 (11.1%) had low-risk alcohol usage. (AUDIT score 1-7) (Table 27).

Table 28
Association of alcohol consumption and socio-demographic characteristics

Participants characteristics	AUDIT category		Chi-square/df/ P-value	Odds ratio (95% CI)	Adjusted odds ratio (95% CI)
	Yes	No			
Sex					
Male	163(16%)	835(84%)	$\chi^2=107.5$ df =1 P=0.000	1	1
Female	17(2%)	835(98%)		0.104(0.062-0.173)	0.133(0.076-0.234)
Caste					
General	22(16%)	229(84%)	$\chi^2=5.149$ df =2 P=0.161	1	1
OBC	41(11%)	328(89%)		1.301(0.755-2.243)	1.26(0.672-2.393)
SC/ST	117(10%)	1113(90%)		1.094(0.679-1.763)	1.003(0.570-1.765)
Education					
Illiterate	95(14%)	588(86%)	$\chi^2=32.136$ df =3 P=0.000	1	1
Primary & Secondary School	38(9%)	381(91%)		0.617(0.414-0.919)	0.604(0.380-0.961)
PUC	35(9%)	337(91%)		0.642(0.426-0.968)	0.688(0.409-1.157)
Degree	12(3%)	364(97%)		0.204(0.11-0.377)	0.243(0.111-0.532)
Occupation					
Daily Wage	100(17%)	503(83%)	$\chi^2=94.3$ df =4 P=0.000	1	1
Self Employed	57(14%)	360(86%)		0.796(0.559-1.132)	0.923(0.606-1.405)
Professional	18(8%)	216(92%)		0.419(0.247-0.709)	1.037(0.531-2.029)
Student	01(1%)	160(99%)		0.031(0.004-0.227)	0.076(0.009-0.605)
Homemaker	04(1%)	431(99%)		0.046(0.017-0.127)	0.118(0.041-0.343)

Type of Family					
Joint family	53(10%)	492(90%)	$\chi^2=1.500$ df =2 P=0.472	1	1
Nuclear family	121(10%)	1087(90%)		1.033(0.735-1.451)	1.160(0.755-1.782)
Three generation family	06(6%)	94(94%)		0.611(0.255-1.466)	0.754(0.287-1.983)
Socio- Economic classification					
Upper class	04(4%)	90(96%)	$\chi^2=6.312$ df =4 P=0.177	1	1
Upper middle class	41(9%)	399(91%)		2.309(0.807-6.622)	1.817(0.594-5.562)
Middle class	74(11%)	620(89%)		2.688(0.958-7.518)	1.675(0.556-5.049)
Lower middle class	58(10%)	498(90%)		2.617(0.928-7.407)	1.685(0.549-5.170)
Lower class	03(5%)	63(95%)		1.071(0.231-4.95)	0.870(0.172-4.409)
Marital Status					
Married	11(4%)	255(96%)	$\chi^2=11.07$ df =1 P=0.001	1	1
Unmarried	169(11%)	1415(89%)		2.77(1.483-5.181)	1.077(0.533-2.175)
Number of Family members					
≤5 members	105(11%)	893(89%)	$\chi^2=1.545$ df =1 P=0.214	1	1
≥6 members	75(9%)	777(91%)		0.821(0.601-1.121)	0.868(0.589-1.280)
Tobacco chewing					
Present	53(25%)	157(75%)	$\chi^2=64.86$ df =1 P=0.000	1	1
Absent	127(8%)	1513(92%)		0.248(0.173-0.356)	0.222(0.139-0.354)
Smoking history					
Present	49(47%)	55(53%)	$\chi^2=175.3$ df =1 P=0.000	1	1
Absent	131(8%)	1615(92%)		0.091(0.059-0.139)	0.240(0.148-0.387)

From the above table, it was found that there is a significant association between alcohol consumption and gender. The odds of alcohol consumption were found to be significantly higher among male participants. This association was found to be statistically significant even after adjusting for other variables.

The odds of consumption of alcohol were found to be 1.301(0.755-2.243) (95% CI 0.755-2.243) times among participants of OBC compared to participants from general caste. Similarly, the odds of alcohol consumption among participants from SC/ST category 1.094 times (95% CI 0.679 – 1.763) that compared to general caste. Caste was found not found to be significantly associated with alcohol consumption when adjusted for other variables.

Education level was found to be significantly associated with among the participants. It was found that illiterate participants had higher odds of alcohol consumption compared to other categories. After adjusting for other variables, it was found that illiterate participants had significantly higher odds of alcohol consumption when compared to participants with primary and secondary school education and graduation.

It was also found alcohol consumption was significantly higher among daily wage laborers when compared to professionals. However, no significant difference existed between daily wage laborers and self-employed participants. No statistically significant association existed between alcohol consumption and socio-economic status. After adjusting for other variables, it was found that profession was not associated with alcohol consumption. However,

Socioeconomic class was not found to be significantly associated with alcohol consumption after adjusting for other variables.

It was found that unmarried participants had 2.77 times odds (95% CI 1.483 - 5.181) of being an alcoholic compared to married participants. However no significant association existed between alcohol use and number of members in the participants family.

After adjusting for other variables, marital status was not found to be significantly associated with alcohol consumption.

There existed a significant association of alcohol consumption with tobacco chewing. Participants who chewed tobacco had 4.03 times odds of alcohol consumption compared to those who did not use tobacco. Similarly, it was found that participants who had history of smoking have higher odds of alcohol consumption when compared to those who did not smoke. Tobacco chewing and smoking were found to be significantly associated with alcohol consumption, even after adjusting for other variables (Table 28).

DISCUSSION

6. DISCUSSION

A total of 1850 people from six villages have taken part in the Community based cross-sectional study. The objectives of the study were to estimate the prevalence of alcohol use, alcohol dependence and their associated factors. The study also aimed to estimate the treatment gap among participants who had alcohol use disorder & alcohol dependence. A predesigned, pretested, semi-structured questionnaire which included sociodemographic details and Alcohol-Use Disorders Identification Test (AUDIT) questionnaire was used for interviewing.

6.1 PREVALENCE OF ALCOHOL CONSUMPTION

The problem of alcohol consumption in India has widely attracted the attention of the public, policy-makers, researchers, and workers.^[58] Taxes from alcohol production and sales are the major sources of revenue in most states and have been cited as a reason for permitting the sale of alcohol.^[58] During the past four decades, several field surveys of general psychiatric morbidity and alcohol consumption have been carried out in different parts of the country.

It was observed in the present study that out of 1850 participants, 1670 participants never consumed alcohol in the past 12 months and the prevalence of alcohol consumption among study participants in the past 12 months was found to be 9.7% (180 individuals). Overall, the prevalence of alcohol use was

found to be 9.4% and the prevalence of hazardous or harmful use of alcohol was 3.7% (based on the cut-off value of ≥ 8 on AUDIT) in the study conducted by Kumar et al., in Tamil Nadu.^[55]

A cross-sectional study undertaken by Girish et al., in four distinct geographic settings of Bangalore district in India, observed that prevalence of alcohol consumption was 13%.^[6] Of the 2811 men screened for alcohol use, 588 (20.9%) were reported as drinkers in the study conducted by Kim et al., in an urban slum of southern India.^[56]

A cross-sectional study conducted by Verenkar et al., (2018) in Goa, India among the medical students noticed the proportion of alcohol consumers among the study participants was found to be 39.4%.^[67] The prevalence of alcoholism among the study participants was 35.7% in the study conducted by Dutta et al., in a rural population at Kuthampakkam village, in Poonamallee block of Tiruvallur district in Tamil Nadu, India^[63]

A study in rural Tamil Nadu among the general population found a prevalence of 9.4% whereas a study in rural Vellore by John et al., found a prevalence of 24.6% among males and none among females.^{[55], [70]}

A community-based, cross-sectional study conducted by Ghosh et al., in Kolkata, India revealed that 65.8% (150/228) were current consumers of alcohol.^[58] A cross-sectional study was conducted by Rose et al., among adult male and permanent residents of Jawadhi hills in Kattumailur, and a total of 1200 men were interviewed. A large proportion of men (65%) had a history of

alcohol consumption in the last one year using one-year, of whom a quarter showed hazardous use (29%).^[21]

The huge variations can be attributed to the different types of instruments used, methodologies adopted and the different definitions of alcohol use and interestingly, very few have been done in different populations using similar methodology.

6.2 ALCOHOL USE AND ASSOCIATED FACTORS

6.2.1 Age:

The mean ($\pm$ Standard Deviation) age of all participants in the current study was 42.5 ± 17 . It was observed that, among the 1850 participants, 35.2% of the study participants were between the age group of 18-32 years, 531 (28.7%) were in the 33-46 years age group, while 376 (20.3%) belonged to the age group of 47-60 years and participants ≥ 61 years were the least, accounting for 293 (15.8%). Among the alcohol users (180), 62 alcohol users belonged to the age group of 33-46 years of age group, 54 belonged to 47-60 years of age group, 46 belonged to more than 61 years of age and 18 belonged to 18-32 years of age group.

In a study conducted by Dutta et al., in participants with a mean age of 37.20 years, it was observed that 51.43% of study participants aged less than 30 years and 31.15% of participants aged more than 30 years consumed alcohol.^[63] In the study conducted by Kim et al., it was observed that the mean age of the

study participants was 36.2 years and 5.8% of study participants in 18-24 years, 24.1% of them in 25-32 years, 35.5% of them in 33-45 years and 34.5% of them was ≥ 46 years use alcohol.^[56] The mean age of the respondents was 43 years in the study conducted by Vignesh et al., in Chennai but it included only male participants.^[64] In the study conducted by Rathod et al., it was observed that the mean age of the study participants was 40.2 years and 15.8% participants were in 18–29 age group, 12.8% in 30-49 years and 11.6% was ≥ 50 years^[57]

6.2.2 Gender

In the study male participants (53.9%) were relatively more compared to female participants (46.1%). Among alcohol users 163 were male alcohol users and 17 were females. The odds of alcohol consumption were found to be significantly higher among male participants, even after adjusting for other variables. Similar findings were observed in a cross-sectional study undertaken in four distinct geographic settings of Bangalore district in India by Girish et al., in which proportions consuming alcohol were greater in males compared to females.^[6] Prevalence of hazardous alcohol consumption was 59.6% among males compared to 35.8% among females in the cross-sectional study conducted by Verenkar et al., (2018) in Goa, India.^[67] In the study conducted by Rathod et al., it was observed that the 23.8% of males and 0.6% of females are alcohol consumers.^[57] The cross-sectional study conducted by Teferra et al., in a rural Ethiopian district involving 1,500 participants were interviewed, of whom 49.5

% were males and the remaining 50.5% were females among this 31.8% males and 10.4% females are alcohol users.^[60]

According to National Family Health Survey-5 (NFHS-5), conducted on 2019-2021 in India found that the prevalence of alcohol use among men was found to be 22% and 1% among the women.^[26]

The meta-analysis by Reddy and Chandrashekar revealed a 10-fold difference in rates between men and women (men 11.9 /1000 population and women 1.7/1000 population).^[71]

6.2.3 Religion

The majority of the study participants 1835 (99.2%) were Hindus, 13 (0.7%) Muslims and 2 (0.1%) of them were Christians. Among alcohol users in the current study, all the participants belonged to Hindu by religion (180). A cross-sectional study was conducted by Verenkar et al., (2018) in Goa, India in which 73% were Hindus, and 25% were Christians. They noticed that alcohol consumption was higher among Christian religion (48.1%).^[67] In the study conducted by Rathod et al., it was observed that 89.8% were Hindus and the remaining 9.2% were non-Hindus and also noticed that nearly 14.7% of Hindus had consumed alcohol in the past 12 months.^[57] Recent consumption of alcohol was far higher among Hindus (14.7%) than Muslims (1.2%), a finding which is consistent with national patterns.^[68] It should be noted, though, that while religious affiliation is predictive of whether an adult drinks alcohol or not,

religious affiliation was not associated with the intensity of consumption among male drinkers. In the study conducted by Kim et al., it was observed that prevalence of alcohol users are more from Hindu religion (88.6%).^[56] According to NFHS-5 survey conducted in India during the period 2019-2021 revealed that alcohol users men belonged to Christian religion(36%) had consumed more when compared to other religions.^[26] In the study conducted by Luitel et al., in Nepal, it was observed that 80.3% were Hindus and the remaining 19.7% were non-Hindus.^[16]

6.2.4 Education

Among the participants, 22.6% of them had primary and secondary schooling, 20.1% went till PUC, 20.3% were degree holders and almost one-fifth of the total study participants remaining (36.9%) were illiterate. Among alcohol users majority were illiterates (95), 38 participants had done primary and secondary schooling, 35 participants had higher secondary education and 12 participants were degree holders. It was found that illiterate participants had higher odds of alcohol consumption compared to other categories.

In the study conducted by Rathod et al., it was observed that educational attainment was low, as 28% of adults never attended school and another 23% started but did not complete primary school (23%).^[57] A study conducted by Katyal et al., found that among study participants 16.7% of illiterates, 10.4% graduates, 2.1% professionals, 7.3% and 28.1% participants who had primary

school education and high school education were alcohol users.^[66] In the cross-sectional study conducted by Teferra et al., in rural Ethiopian district, the level of literacy was not statistically associated with alcohol use.^[60] In the study conducted by Luitel et al., in Nepal it was observed that among the study participants, 17.2% of illiterates, 24.4% participants who had primary education, 39.1% participants who had secondary education, 5.7% of graduates are alcohol users.^[16] A population-based conducted by Pillai et al., in India observed that Men with lower education were more likely to report a risky usual quantity of alcohol (60g/drinking day).^[1] In the study conducted by Kim et al., it was observed that a higher level of education serves as a protective factor.^[56] In the current study, household representatives of men who are better educated might have under-reported alcohol consumption since they felt that it was a socially desirable response.

6.2.5 Occupation

It was found that, of 1850 participants, 603 (32.6%) were daily wage workers, 435 (23.5%) of the female participants were homemakers, 417 (22.5%) participants were self-employed, 234 (12.6%) were Professionals and only 161 (8.7%) participants are doing their studies. Among alcohol users (180), majority were daily wage workers (100), 57 participants were self-employed, 18 were professionals, 4 participants were homemakers and one was student. It was also found alcohol consumption was significantly higher among daily wage

labourers when compared to professionals. However, no significant difference existed between daily wage labourers and self-employed participants. Similar observation was seen in the study conducted by Teferra et al.,^[60]

6.2.6 Marital status

Most of the study participants were married 1584 (85.6%) and 266 (14.4%) of them are unmarried. Among alcohol users (180) 169 were not married and rest were married (11). It was found in the present study that unmarried participants had 2.77 times the odds (95% CI 1.483 - 5.181) of being an alcoholic compared to married participants. However, it was not significant when adjusted for other variables. In the study conducted by Dutta et al., it was observed that nearly 87.9% of the study participants were married and among them 35.5% were alcohol users.^[63] The marital status was not significantly associated with alcohol use in the present study and a similar observation was seen in the study conducted by Teferra et al.,^[60] In the study conducted by Vignesh et al., in Chennai, India it was noticed that 90% of the respondents were married.^[64] In a study conducted by Kim et al., around 87.2% of study participants who were married consume alcohol when compared to unmarried (10.7%).^[56]

In contrast to our study findings, AUDIT scores, in the study conducted by Rathod et al.,^[57] 65% lower for drinkers who were widowed, divorced, separated or deserted compared to those who were married. It was observed

6.2.7 Type of family

It was found that the majority of the participants 1208 (65.3%) were from the nuclear family, while 545 (29.5%) belonged to the joint family and only 97 (5.2%) of the participants were coming from a three-generation family. In the study conducted by Vignesh et al., in Chennai, India it was noticed that 90% belonged to nuclear families and 9% were joint families.^[64]

6.2.8 Socio-Economic Status

Majority of participants who consumed alcohol (41.1%) were in middle class and lower middle class (32.2%). No statistically significant association existed between alcohol consumption and socio-economic status even after adjusting for other variables. This is probably because of the low sample size representing lower and upper socioeconomic class.

6.2.9 Number of Family members

The majority of the participants 998 (53.9%) belonged to families with less than 5 members. However, no significant association existed between alcohol use and the number of members in the participants family. In the study conducted by Vignesh et al., in Chennai, India it was noticed that 61% of the participants belonged to families with less than 5 members and no significant association was found between the number of family members and drinking alcohol.^[64]

6.2.10 Tobacco use

About 210 (11.4%) of participants reported tobacco chewing while 5.5% of participants are reported smoking tobacco. Among 180 alcohol users, 53 participants use tobacco in the form of chewing form and 49 participants use tobacco in smoking form. There existed a significant association between alcohol consumption with tobacco chewing. Participants who chewed tobacco had 4.03 times the odds of alcohol consumption compared to those who did not use tobacco. Similarly, it was found that participants who had a history of smoking have higher odds of alcohol consumption when compared to those who did not smoke. A similar observation was seen in the study conducted by Rathod et al., in which AUDIT scores were positively associated with tobacco use among the study participants.^[57] In the study conducted by Kim et al., it was observed that a history of smoking was identified as a risk factor for drinking alcohol.^[56]

6.3 ALCOHOL USE PATTERNS

Among the alcohol users (180) the frequency of alcohol use as per AUDIT in the past 12 months was 74 (4%) who are consuming alcohol 2 to 4 times a month. About 57 (3.1%) are using alcohol 2 to 3 times a week and 38 (2.1%) were consuming alcohol 4 or more times a week. A cross-sectional study undertaken by Girish et al., in four distinct geographic settings of Bangalore district in India, observed that nearly 85% of users consumed alcohol more than

once in a month: one-third consuming every day or every alternate day and one-third consuming once or twice a week.^[6]

majority of the participants 79 (43.9%) had 5 or 6 drinks containing alcohol on a typical day followed by 49 (27.2%) participants who had 3 or 4 drinks 23 (12.8%) participants 7-9 drinks and only 9 (5%) participants had 10 or more drinks on a typical day. It was found that 20 (11.1%) never had six or more drinks on one occasion. 37.2% of individuals had six or more drinks on one occasion less than monthly followed by 51 (28.3%) individuals monthly, 32 (17.8%) individuals weekly and 10 (5.6%) individuals daily or almost daily.

A cross-sectional study undertaken by Girish et al. in four distinct geographic settings of Bangalore district in India observed that more than four-fifths (83%) of the users consumed less than five drinks per session and of the heavy alcohol users (17%), three-fourths (13%) drank frequently.^[6]

A population-based conducted by Pillai et al., in India observed that 26 % drank less than once a month, while 21 % reported four or more drinking episodes per week. The majority of drinkers (72 %) consumed less than four drinks (40 g) on a typical drinking day, while 14.8 % had six drinks or more (60 g). Over one-fourth of male drinkers (29 %) reported Heavy Episodic Drinking monthly or more frequently and 7 % reported getting drunk at least weekly.^[1]

It was observed that 20 (11.1%) participants never had difficulty in stop drinking last year. 96 (53.3%) participants find difficulty in stop drinking less than monthly followed by 47 (26.1%) participants monthly, 9 (5%) participants

weekly and 8 (4.4%) participants daily or almost daily.

The policy implication of these findings is that a community-level focus on health promotion programmes (eg, working with local non-governmental organisations and village health workers) may be necessary and conducted in addition to population-level programmes (eg, through legislation or taxation) in changing alcohol consumption patterns.

6.4 PREVALENCE OF ALCOHOL DEPENDENCE

We measured alcohol use with the AUDIT tool, which had been validated elsewhere in India, and demonstrated here a high value for internal consistency.^{[28],[72]}

In this study, 39 (21.7%) individuals among alcohol users require special alcohol de-addiction care with an AUDIT score >16. The majority of the alcohol users 121 (67.2 %) had hazardous alcohol usage (AUDIT score 8-15) while 20 (11.1%) had low-risk alcohol usage (AUDIT score 1-7). In contrast, a population based study conducted by Pillai et al., in India observed that while the majority of alcohol users had low-risk usage (72%) based on their usual quantity of consumption; however, 43% of drinkers reported heavy episodic drinking during the past year.^[1] A cross-sectional study was conducted by Verenkar et al., (2018) in Goa, India in which around 82.2% of those reporting alcohol use were light drinkers (AUDIT Score <8) while 17.8% were classified as heavy drinkers (AUDIT score >8) and the prevalence of Alcohol dependence was 20.9%.^[67]

In the study conducted by Kim et al., it was noticed that 19% (15.3%–22.6%) of men were hazardous drinkers, 7.7% (4.4%–11.1%) were high-risk drinkers and 4.7% (3.1%– 6.3%) were dependent drinkers. Combined, an estimated 31.4% (27.5%–35.2%) of all men were hazardous drinkers.^[56]

In the study conducted by Vignesh et al., in Chennai showed that more than half of the population had either a medium level of alcohol dependence (40%) or high-level alcohol dependence on SADD (46%). More than half of them (65%) had a substantial level of alcohol dependence and 3% of them had a severe level of alcohol dependence on ADS.^[64]

In the study conducted by Rathod et al, it was noticed that 33.2% of the recently consumed alcohol persons had an AUDIT score which was consistent with hazardous alcohol consumption behaviour (AUDIT score 8–15), 3.3% with harmful behaviour (AUDIT score 16–19) and 5.5% with dependent behaviour (AUDIT score ≥ 20).^[57]

Many forms of excessive drinking cause substantial risk or harm to the individual. These include high-level drinking each day, repeated episodes of drinking to intoxication, and drinking that makes a person alcohol-dependent. Therefore, the identification of drinkers with various types and degrees of at-risk alcohol consumption has a great potential to reduce all types of alcohol-related harms.^[63]

6.6 TREATMENT GAP AMONG ALCOHOL USERS

It is found that among the 180 alcohol users only 2 individuals (0.1%) had taken treatment for alcohol consumption in the past 12 months. In the study conducted by Dutta et al., it was observed that only 4.5% of adult males had taken treatment for alcohol related symptoms.^[63] In the study conducted by Luitel et al., in Nepal, it was observed that only 5.1% of the alcohol user disorders had taken treatment for alcohol related symptoms.^[16]

Of the adults with AUD, in the study conducted by Rathod et al., it was mentioned that only 2.8% had sought treatment for problems with drinking in the past 12 months, primarily from traditional healers.^[57] Treatment-seeking by those with problems with alcohol in India is an infrequent occurrence,^{[59],[73–75]} and is partially due to the lack of public treatment services and the inaccessibility of private services.^[73] Yet recognition that problems with alcohol are medical in nature is rare,^[59,76] and most likely contributes to both the low supply of and demand for treatment services.

Various factors could be considered in this study to impede mental health treatment including lack of perceived need, stigma, not knowing where to go for treatment, belief that the problem will resolve itself, desire to deal with the problem oneself, inability to afford treatment expenses, doubt regarding the effectiveness of the treatment, and lack of services. These results warrant immediate efforts to address barriers to AUD treatment.

The results of this study may be useful for policymakers and mental health

professionals in developing a strategy to minimize barriers to care and the treatment gap. Given the need for, and the low level of uptake of, services, it may be useful to consider the role of community health workers in implementing screening and brief intervention programmes.

SUMMARY

7. SUMMARY

This is a community based, cross sectional study carried out in rural area of Kolar district, to determine the prevalence of alcohol use, alcohol dependence and its associated factors and to estimate the treatment gap among alcohol use disorder & alcohol dependence. The Alcohol Use Disorder Identification Test (AUDIT) questionnaire was used to study a total of 1850 study participants from the six selected villages from the rural field practice area of Dept. of Community Medicine, SDUMC, Kolar.

Among the study participants, majority were male(53.9%) and were in the age group of 18-32 years (35.2%). More than three fourth of them (85.6%) were married. About 99.2% of study participants were Hindu by religion and 66.5% belonged to SC/ST caste. Most of the study participants were Illiterates (36.9%) and Daily wage labourers (32.6%). More than half of the study participants belonged to nuclear family (65.3%) and 37.5% belonged to middle class according to Modified BG Prasad classification 2021. Around 11.4% study participants consume tobacco in chewing form and 5.5% of them consume tobacco in smoke form.

The prevalence of alcohol consumption among study participants in the past 12 months was found to be 9.7% (180 participants) and the prevalence of alcohol dependence among the alcohol users (AUDIT score >15) was found to be

21.7% (39 participants). The majority of the alcoholics 121 (67.2%) belonged to hazardous drinking (AUDIT score 8-15) followed by 20 (11.1%) belonged to low-risk zone (AUDIT score 1-7).

It was found that among the 180 alcohol users, only 2 individuals (0.1%) had taken treatment for alcohol consumption in the past 12 months.

CONCLUSION

8. CONCLUSION

The prevalence of alcohol consumption among the study participants in the past 12 months was found to be 9.7%. Alcohol dependence was present in 21.7% of people, according to the AUDIT tool. Alcohol usage was significantly higher among men, illiterates, daily wage workers, unmarried individuals, and tobacco users. Only 0.1% of the 180 alcohol consumers studied reported receiving treatment. The treatment gap is therefore greater in the current study area.

The results of this study have implications for the development and execution of alcohol therapies in this rural environment. Along with enhancing the integration of alcohol treatment services into conventional primary health care, interventions aimed at modifying public perceptions of alcohol use disorders, the treatment they receive, and the locations where they are provided must be formulated and put into action.

RECOMMENDATIONS

9. RECOMMENDATIONS

- The current study highlights that despite a 9.7% prevalence of alcohol use in the study population, with 21.7% alcohol dependence among users, only 0.1% among them sought medical care. Hence, we recommend that public health initiatives to reduce hazardous drinking should be combined with a stepped care approach for alcohol use disorder, including screening all people who present to primary care, brief intervention for hazardous drinking, and referral of severe alcohol dependency cases.
- The study also identified that community-based screening for alcohol use and dependence is feasible and thus can be incorporated in routine primary health care services. This would help in identifying cases at an early stage and averting the problem's subsequent effects.
- The current study recognized the association between gender, education and tobacco use with alcohol use disorder. However, it is recommended that a longitudinal study can be undertaken to study the temporal relationships between alcohol dependency and various factors, such as sociodemographic characteristics, environmental factors, behavioural factors, and attributes related to the workplace. An understanding of the changing trends in alcohol use will help guide the health promotion among the targeted population, and

further support the expansion of programmes for screening and brief intervention, and more intensive programmatic interventions. Qualitative research is crucial for understanding care barriers, the impact of stigma on AUDs, and the relationship between seeking help and stigma.

STRENGTHS

10. STRENGTHS

- A sizable sample size of 1850 in 6 villages of Kolar district, was gathered for this community-based study, which had a good response rate.
- Cluster sampling was adopted because it makes it easier to investigate large populations, especially when the samples were representative of 20 villages.
- The survey was translated into the regional language of Kannada and then back into English. After back translation, the variability was observed in the translated questionnaire and reframed. Final version was piloted before use.

LIMITATIONS

11. LIMITATIONS

- The AUDIT is a screening tool, and while a clinical diagnosis would have been ideal, it was not practical for a community-based study. When utilizing an instrument that has not been validated for usage in a particular setting, measurement bias is yet another limitation.
- Confounding variables that may influence the association between various factors and alcohol use including alcohol usage in the family and childhood environment were not considered in the study.
- Since this is a cross-sectional study the temporal association between the factors and alcohol use or alcohol dependence could not be established.
- In this study, the alcohol content of beverages was not taken into consideration, hence the per capita consumption of alcohol could not be calculated.
- Social desirability and recall bias may be present in self-report surveys used in an interview format, which may have an impact on prevalence estimates.

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ANNEXURE

ANNEXURE I
Questionnaire
Proforma for data acquisition

Form No.:
Village Name:

- 1) Name/ ಹೆಸರು
- 2) Address/ ವಿಳಾಸ
- 3) Socio-demographic details/ಸಾಮಾಜಿಕ-ಜನಸಂಖ್ಯಾ ವಿವರಗಳು

Age/ ವಯಸ್ಸು (In completed years)					
Gender/ ಲಿಂಗ	MALE/ ಪುರುಷ	FEMALE/ ಹೆಣ್ಣು	TRANSGENDER/ ಮಂಗಳಮುಖಿ		
Religion/ ಧರ್ಮ	HINDU/ ಹಿಂದು		MUSLIM/ ಮುಸ್ಲಿಂ	CHRISTIAN/ ಕ್ರಿಶ್ಚಿಯನ್	
Caste / ಜಾತಿ	GENERAL/ ಸಾಮಾನ್ಯ ಜಾತಿ		OBC/ಬ.ಬಿ.ಸಿ	SC/ST ಪರಿಶಿಷ್ಟ ಜಾತಿ/ ಪಂಗಡ	
Education / ಶಿಕ್ಷಣ	ILLITERATE/ ಅನಕ್ಷರಸ್ಥ	PRIMARY OR SECONDARY SCHOOL/ ಪ್ರಾಥಮಿಕ ಶಾಲೆ		PUC/ ಪಿ.ಯು. ಸಿ	DEGREE/ಪದವಿ
Occupation/ ಉದ್ಯೋಗ	DAILY WAGE/ ದಿನಗೂಲಿ ಕೆಲಸಗಾರ	SELF EMPLOYED/ ಸ್ವಯಂ ಉದ್ಯೋಗಿ	PROFESSIONAL/ ವೃತ್ತಿಪರ	STUDENT/ ವಿದ್ಯಾರ್ಥಿ	HOMEMAKER/ ಗೃಹಿಣಿ
Marital status/ ವೈವಾಹಿಕ ಸ್ಥಿತಿ	SINGLE/ ಅವಿವಾಹಿತ		MARRIED/ ವಿವಾಹಿತ	DIVORCED/ ವಿಚ್ಛೇದನ	
Type of Family / ಕುಟುಂಬದ ಪ್ರಕಾರ	JOINT/ ಜಂಟಿ ಕುಟುಂಬ		NUCLEAR/ ವಿಭಕ್ತ ಕುಟುಂಬ	THREE GENERATION/ ಮೂರು ತಲೆಮಾರಿನ ಕುಟುಂಬ	
Total monthly family income/ಒಟ್ಟು ಮಾಸಿಕ ಕುಟುಂಬದ ಆದಾಯ					
Number of family members /ಕುಟುಂಬದ ಸದಸ್ಯರ ಸಂಖ್ಯೆ					

ಟುಂಬ ನದಸ್ಯರ ಸಂಖ್ಯೆ				
Smoking history/ಧೂಮಪಾನದ ಇತಿಹಾಸ	YES/ಹೌದು	NO/ಅಲ್ಲ	CIGARETTES/ ಸಿಗರೇಟ್	BEEDI/ ಬೀಡಿ
Tobacco chewing/ ತಂಬಾಕು ಜಗಿಯುವುದು	YES/ಹೌದು		NO/ಅಲ್ಲ	

ANNEXURE II

AUDIT Questionnaire

1. How often do you have a drink containing alcohol? (0) Never [<i>Skip to Qs 9-10</i>] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week 	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily <i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i>	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
Record total of specific items here 	

ANNEXURE III- ಆಡಿಟ್ ಪ್ರಶ್ನಾವಳಿ

1. ಮಧ್ಯಪಾನವನ್ನು ನೀವು ಎಷ್ಟು ಬಾರಿ ತೆಗೆದುಕೊಳ್ಳುತ್ತೀರಾ ? (0) ಎಂದಿಗೂ ಇಲ್ಲ [9-10 ಪ್ರಶ್ನೆಗಳಿಗೆ ತೆರಳಿ] (1) ತಿಂಗಳಿಗೊಮ್ಮೆ ಅಥವಾ ಕಡಿಮೆ (2) ತಿಂಗಳಿಗೆ 2 ರಿಂದ 4 ಬಾರಿ (3) ವಾರಕ್ಕೆ 2 ರಿಂದ 3 ಬಾರಿ (4) ವಾರದಲ್ಲಿ 4 ಅಥವಾ ಹೆಚ್ಚಿನ ಬಾರಿ	6. ನಿಮಗೆ ಮುಂಜಾನೆ ಎದ್ದ ಕೂಡಲೇ ಮಧ್ಯಪಾನವನ್ನು ಸೇವನೆ ಮಾಡಲು ಎಂದಾದರೂ ಅನಿಸಿತ್ತಾ ? (0) ಎಂದಿಗೂ ಇಲ್ಲ (1) ಮಾಸಿಕಕ್ಕಿಂತ ಕಡಿಮೆ (2) ತಿಂಗಳಿಗೊಮ್ಮೆ (3) ವಾರಕ್ಕೊಮ್ಮೆ (4) ಪ್ರತಿದಿನ ಅಥವಾ ವಾರದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಅಧಿಕ ದಿನ
2. ನೀವು ಕುಡಿಯುವಾಗ ಒಂದು ಸಾಮಾನ್ಯ ದಿನದಲ್ಲಿ ಎಷ್ಟು ಮಧ್ಯವನ್ನು ಸೇವಿಸುತ್ತೀರಾ ? (0) 1 ಅಥವಾ 2 ಪೆಗ್ (1) 3 ಅಥವಾ 4 ಪೆಗ್ (2) 5 ಅಥವಾ 6 ಪೆಗ್ (3) 7, 8, ಅಥವಾ 9 ಪೆಗ್ (4) 10 ಅಥವಾ ಹೆಚ್ಚಿನ ಪೆಗ್	7. ಕಳೆದ ವರ್ಷದಲ್ಲಿ ನೀವು ಎಷ್ಟು ಬಾರಿ ಕುಡಿದ ನಂತರ ನಿಮಗೆ ನೀವೇ ಅಪರಾಧ ಮಾಡಿದ್ದೀನಿ ಅಂತ ಅಥವಾ ಪಶ್ಚಾತ್ತಾಪವನ್ನು ಅನುಭವಿಸಿದ್ದೀರಿ? (0) ಎಂದಿಗೂ ಇಲ್ಲ (1) ಮಾಸಿಕಕ್ಕಿಂತ ಕಡಿಮೆ (2) ತಿಂಗಳಿಗೊಮ್ಮೆ (3) ವಾರಕ್ಕೊಮ್ಮೆ (4) ಪ್ರತಿದಿನ ಅಥವಾ ವಾರದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಅಧಿಕ ದಿನ
3. ಒಂದು ಸಂದರ್ಭದಲ್ಲಿ ನೀವು ಆರು ಅಥವಾ ಇನ್ನು ಅಧಿಕ ಪ್ರಮಾಣದ ಮಧ್ಯವನ್ನು ಸೇವಿಸಿದ್ದೀರಾ ? (0) ಎಂದಿಗೂ ಇಲ್ಲ (1) ಮಾಸಿಕಕ್ಕಿಂತ ಕಡಿಮೆ (2) ತಿಂಗಳಿಗೊಮ್ಮೆ (3) ವಾರಕ್ಕೊಮ್ಮೆ (4) ಪ್ರತಿದಿನ ಅಥವಾ ವಾರದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಅಧಿಕ ದಿನ 2 ಮತ್ತು 3 = 0 ಪ್ರಶ್ನೆಗಳಿಗೆ ಒಟ್ಟು ಸ್ಕೋರ್ 0 ಇದ್ದರೆ 9 ಮತ್ತು 10 ಪ್ರಶ್ನೆಗಳಿಗೆ ತೆರಳಿ	8. ಕಳೆದ ವರ್ಷದಲ್ಲಿ ಎಷ್ಟು ಬಾರಿ ನೀವು ಕುಡಿಯುತ್ತಿದ್ದ ಕಾರಣ ಹಿಂದಿನ ರಾತ್ರಿ ಏನಾಯಿತು ಎಂದು ನೆನಪಿಟ್ಟುಕೊಳ್ಳಲು ನಿಮಗೆ ಸಾಧ್ಯವಾಗಲಿಲ್ಲ? (0) ಎಂದಿಗೂ ಇಲ್ಲ (1) ಮಾಸಿಕಕ್ಕಿಂತ ಕಡಿಮೆ (2) ತಿಂಗಳಿಗೊಮ್ಮೆ (3) ವಾರಕ್ಕೊಮ್ಮೆ (4) ಪ್ರತಿದಿನ ಅಥವಾ ವಾರದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಅಧಿಕ ದಿನ
4. ನೀವು ಮಧ್ಯವನ್ನು ಪ್ರಾರಂಭಿಸಿದ ನಂತರ ಕುಡಿಯುವುದನ್ನು ನಿಲ್ಲಿಸಲು ನಿಮಗೆ ಸಾಧ್ಯವಾಗಲಿಲ್ಲ ಎಂದು ಕಳೆದ ವರ್ಷದಲ್ಲಿ ಎಷ್ಟು ಬಾರಿ ನೀವು ಕಂಡುಕೊಂಡಿದ್ದೀರಿ? (0) ಎಂದಿಗೂ ಇಲ್ಲ (1) ಮಾಸಿಕಕ್ಕಿಂತ ಕಡಿಮೆ (2) ತಿಂಗಳಿಗೊಮ್ಮೆ (3) ವಾರಕ್ಕೊಮ್ಮೆ (4) ಪ್ರತಿದಿನ ಅಥವಾ ವಾರದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಅಧಿಕ ದಿನ	9. ನಿಮ್ಮ ಕುಡಿಯುವಿಕೆಯಿಂದ ನೀವು ಅಥವಾ ಬೇರೆಯವರು ಗಾಯಗೊಂಡಿದ್ದೀರಾ? (0) ಇಲ್ಲ (2) ಹೌದು, ಆದರೆ ಕಳೆದ ವರ್ಷದಲ್ಲಿ ಅಲ್ಲ (4) ಹೌದು, ಕಳೆದ ವರ್ಷದಲ್ಲಿ
5. ಕುಡಿಯುವ ಕಾರಣದಿಂದಾಗಿ ನಿಮ್ಮಿಂದ ಸಾಮಾನ್ಯವಾಗಿ ನಿರೀಕ್ಷಿಸಿದ್ದನ್ನು ಮಾಡಲು ಕಳೆದ ವರ್ಷದಲ್ಲಿ ನೀವು ಎಷ್ಟು ಬಾರಿ ವಿಫಲರಾಗಿದ್ದೀರಿ? (0) ಎಂದಿಗೂ ಇಲ್ಲ (1) ಮಾಸಿಕಕ್ಕಿಂತ ಕಡಿಮೆ (2) ತಿಂಗಳಿಗೊಮ್ಮೆ (3) ವಾರಕ್ಕೊಮ್ಮೆ (4) ಪ್ರತಿದಿನ ಅಥವಾ ವಾರದಲ್ಲಿ ಒಂದಕ್ಕಿಂತ ಅಧಿಕ ದಿನ	10. ಸಂಬಂಧಿ ಅಥವಾ ಸ್ನೇಹಿತ ಅಥವಾ ವೈದ್ಯರು ಅಥವಾ ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತರು ನಿಮ್ಮ ಕುಡಿಯುವಿಕೆಯ ಬಗ್ಗೆ ಕಾಳಜಿ ವಹಿಸಿದ್ದಾರೆಯೇ ಅಥವಾ ಕುಡಿತವನ್ನು ಬಿಡಲು ಸೂಚಿಸಿದ್ದಾರೆ ? (0) ಇಲ್ಲ (2) ಹೌದು, ಆದರೆ ಕಳೆದ ವರ್ಷದಲ್ಲಿ ಅಲ್ಲ (4) ಹೌದು, ಕಳೆದ ವರ್ಷದಲ್ಲಿ
ನಿರ್ದಿಷ್ಟ ವಸ್ತುಗಳ ಒಟ್ಟು ಮೊತ್ತವನ್ನು ಇಲ್ಲಿ ದಾಖಲಿಸಿ	

ANNEXURE IV

Treatment Gap Questionnaire

1. Did u seek any help for these problems?

Yes / No

2. If Yes,

a) Period of visit.....

b) Type of health care visited – 1. PHC, 2. Private Hospital, 3. Quack, 4. De addiction centre, 5. Ayush care, 6. Tertiary care hospital.

c) Do you think alcohol use and alcohol dependence can be completely prevented- Yes/ No.

d) Do you think that Ayush care like Ayurveda, Siddha and Unani can cure alcohol related problems Yes / No.

e) Usefulness of help sought -.....

ಚಿಕಿತ್ಸೆ ಗ್ಯಾಪ್ ಪ್ರಶ್ನಾವಳಿ

1. ಈ ಸಮಸ್ಯೆಗಳಿಗೆ ನೀವು ಯಾವುದೇ ಸಹಾಯವನ್ನು ಹುಡುಕಿದ್ದೀರಾ?

ಹೌದು / ಇಲ್ಲ.

2. ಹೌದು ಎಂದಾದರೆ,

a. ಭೇಟಿಯ ಅವಧಿ

b. ಭೇಟಿ ನೀಡಿದ ಆರೋಗ್ಯ ಕೇಂದ್ರ ಪ್ರಕಾರ - 1. ಪಿಎಚ್‌ಸಿ, 2. ಖಾಸಗಿ ಆಸ್ಪತ್ರೆ, 3. ಕ್ವಾಕ್, 4. ಡಿ ಅಡಿಕ್ಷನ್ ಸೆಂಟರ್, 5. ಆಯುಷ್ ಕೇರ್, 6. ತೃತೀಯ ಆರೈಕೆ ಆಸ್ಪತ್ರೆ.

c. ಆಲ್ಕೋಹಾಲ್ ಬಳಕೆ ಮತ್ತು ಆಲ್ಕೋಹಾಲ್ ಅವಲಂಬನೆಯನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ತಡೆಯಬಹುದು ಎಂದು ನೀವು ಭಾವಿಸುತ್ತೀರಾ- ಹೌದು/ ಇಲ್ಲ.

d. ಆಯುಷ್, ಸಿದ್ಧ ಮತ್ತು ಯುನಾನಿಯಂತಹ ಆಯುಷ್ ಕಾಳಜಿಯು ಆಲ್ಕೋಹಾಲ್ ಸಂಬಂಧಿತ ಸಮಸ್ಯೆಗಳನ್ನು ಸರಿಪಡಿಸಬಹುದು ಎಂದು ನೀವು ಭಾವಿಸುತ್ತೀರಾ- ಹೌದು / ಇಲ್ಲ.

ಸಹಾಯದ ಉಪಯುಕ್ತತೆಯನ್ನು ಹುಡುಕಲಾಗಿದೆ -.....

ANNEXURE V

Information Sheet

Title: Prevalence and Associated Factors of Alcohol Use, Alcohol Dependence and Treatment Gap in Rural Area of Kolar.

My name is **Dr. Ramees M Sali**, Post graduate student in the Department of Community Medicine, Sri Devaraj Urs Medical College, Kolar. I am carrying out a study on Prevalence and Associated Factors of Alcohol Use, Alcohol Dependence and Treatment Gap in Rural Area of Kolar. The study protocol has been reviewed by the Institutional Ethical Committee and has been started only after obtaining their formal approval.

Some questions will be asked to you and you are at liberty to refuse to answer any questions that is asked and you may end this interview at any time you want to. However, your honest answer to these questions will help us to understand your current socio-demographic profile and level of alcohol use. We would greatly appreciate your participation in the study by way of responding to the questionnaire. The interview will take about ten to fifteen minutes. Participation in this study is free of cost for you. This study is not only beneficial to you but also to the community at large. The results gathered from this study will be useful in estimating the prevalence of alcohol use and associated factors.

All the information collected from you will be strictly confidential and will not be disclosed to any outsider unless compelled by law. This information collected will be used only for research.

There is no compulsion to participate in this study. You will be no way affected if you don't wish to participate in this study. You are required to sign only if you voluntarily agree to participate in this study. This document will be stored in the safe locker in the Department of Community Medicine, Sri Devaraj Urs Medical College and a copy is being given to you for information.

For any further clarification you are free to contact the Principal Investigator,

Dr. Ramees M Sali - Department of Community Medicine, Sri Devaraj Urs Medical College, Kolar whose mobile phone number is **9746040253**.

ANNEXURE VI

ಮಾಹಿತಿ ಹಾಳೆ

ಶೀರ್ಷಿಕೆ: ಕೋಲಾರದ ಗ್ರಾಮೀಣ ಪ್ರದೇಶದಲ್ಲಿ ಆಲ್ಕೋಹಾಲ್ ಬಳಕೆ, ಮದ್ಯದ ಅವಲಂಬನೆ ಮತ್ತು ಚಿಕಿತ್ಸೆಯ ಅಂತರದ ಹರಡುವಿಕೆ ಮತ್ತು ಸಂಬಂಧಿತ ಅಂಶಗಳು.

ನನ್ನ ಹೆಸರು ಡಾ.ರಮೀಸ್ ಎಮ್ ಸಾಲಿ, ಕೋಲಾರದ ಶ್ರೀ ದೇವರಾಜ್ ಉರ್ಸ್ ವೈದ್ಯಕೀಯ ಕಾಲೇಜಿನ ಸಮುದಾಯ ವೈದ್ಯಕೀಯ ವಿಭಾಗದಲ್ಲಿ ಸ್ನಾತಕೋತ್ತರ ವಿದ್ಯಾರ್ಥಿ. ಕೋಲಾರದ ಗ್ರಾಮೀಣ ಪ್ರದೇಶದಲ್ಲಿ ಆಲ್ಕೋಹಾಲ್ ಬಳಕೆ, ಆಲ್ಕೋಹಾಲ್ ಅವಲಂಬನೆ ಮತ್ತು ಚಿಕಿತ್ಸೆಯ ಅಂತರದ ಹರಡುವಿಕೆ ಮತ್ತು ಸಂಬಂಧಿತ ಅಂಶಗಳ ಕುರಿತು ನಾನು ಅಧ್ಯಯನ ನಡೆಸುತ್ತಿದ್ದೇನೆ. ಅಧ್ಯಯನದ ಪ್ರೋಟೋಕಾಲ್ ಅನ್ನು ಸಾಂಸ್ಥಿಕ ನೈತಿಕ ಸಮಿತಿಯು ಪರಿಶೀಲಿಸಿದೆ ಮತ್ತು ಅವರ ಔಪಚಾರಿಕ ಅನುಮೋದನೆಯನ್ನು ಪಡೆದ ನಂತರವೇ ಆರಂಭಿಸಲಾಗಿದೆ.

ಕೆಲವು ಪ್ರಶ್ನೆಗಳನ್ನು ನಿಮ್ಮನ್ನು ಕೇಳಲಾಗುತ್ತದೆ ಮತ್ತು ನಾವು ಕೇಳುವ ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳಿಗೆ ಉತ್ತರಿಸಲು ನೀವು ನಿರಾಕರಿಸಬಹುದು ಮತ್ತು ನೀವು ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಈ ಸಂದರ್ಶನವನ್ನು ಕೊನೆಗೊಳಿಸಬಹುದು. ಆದಾಗ್ಯೂ, ಈ ಪ್ರಶ್ನೆಗಳಿಗೆ ನಿಮ್ಮ ಪ್ರಾಮಾಣಿಕ ಉತ್ತರವು ನಿಮ್ಮ ಪ್ರಸ್ತುತ ಸಾಮಾಜಿಕ-ಜನಸಂಖ್ಯಾ ಪ್ರೊಫೈಲ್ ಮತ್ತು ಆಲ್ಕೋಹಾಲ್ ಬಳಕೆಯ ಮಟ್ಟವನ್ನು ಅರ್ಥಮಾಡಿಕೊಳ್ಳಲು ನಮಗೆ ಸಹಾಯ ಮಾಡುತ್ತದೆ. ಪ್ರಶ್ನೆಗಳಿಗೆ ಪ್ರತಿಕ್ರಿಯಿಸುವ ಮೂಲಕ ಅಧ್ಯಯನದಲ್ಲಿ ನಿಮ್ಮ ಭಾಗವಹಿಸುವಿಕೆಯನ್ನು ನಾವು ಬಹಳವಾಗಿ ಪ್ರಶಂಸಿಸುತ್ತೇವೆ. ಸಂದರ್ಶನವು ಸುಮಾರು ಹತ್ತು ಹದಿನೈದು ನಿಮಿಷಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳುತ್ತದೆ.

ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದು ನಿಮಗೆ ಉಚಿತ. ಈ ಅಧ್ಯಯನವು ನಿಮಗೆ ಮಾತ್ರವಲ್ಲದೆ ಸಮುದಾಯಕ್ಕೂ ಪ್ರಯೋಜನಕಾರಿಯಾಗಿದೆ. ಈ ಅಧ್ಯಯನದಿಂದ ಸಂಗ್ರಹಿಸಿದ ಫಲಿತಾಂಶಗಳು ಆಲ್ಕೋಹಾಲ್ ಬಳಕೆ ಮತ್ತು ಸಂಬಂಧಿತ ಅಂಶಗಳ ಅಂದಾಜು ಮಾಡಲು ಉಪಯುಕ್ತವಾಗಿದೆ.

ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಿದ ಎಲ್ಲಾ ಮಾಹಿತಿಯು ಕಟ್ಟುನಿಟ್ಟಾಗಿ ಗೌಪ್ಯವಾಗಿರುತ್ತದೆ ಮತ್ತು ಕಾನೂನಿನಿಂದ ಒತ್ತಾಯಿಸದ ಹೊರತು ಯಾವುದೇ ಹೊರಗಿನವರಿಗೆ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ. ಸಂಗ್ರಹಿಸಿದ ಈ ಮಾಹಿತಿಯನ್ನು ಸಂಶೋಧನೆಗೆ ಮಾತ್ರ ಬಳಸಲಾಗುತ್ತದೆ.

ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಯಾವುದೇ ಒತ್ತಾಯವಿಲ್ಲ. ನೀವು ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಬಯಸದಿದ್ದರೆ ನಿಮಗೆ ಯಾವುದೇ ರೀತಿಯಲ್ಲಿ ಪರಿಣಾಮ ಬೀರುವುದಿಲ್ಲ. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನೀವು ಸ್ವಯಂಪ್ರೇರಣೆಯಿಂದ ಒಪ್ಪಿಕೊಂಡರೆ ಮಾತ್ರ ನೀವು ಸಹಿ ಮಾಡಬೇಕಾಗುತ್ತದೆ. ಈ ಡಾಕ್ಯುಮೆಂಟ್ ಅನ್ನು ಶ್ರೀ ದೇವರಾಜ್ ಉರ್ಸ್ ಮೆಡಿಕಲ್ ಕಾಲೇಜಿನ ಸಮುದಾಯ ಔಷಧ ವಿಭಾಗದಲ್ಲಿರುವ ಸುರಕ್ಷಿತ ಲಾಕರ್‌ನಲ್ಲಿ ಸಂಗ್ರಹಿಸಲಾಗುವುದು ಮತ್ತು ಪ್ರತಿಯನ್ನು ನಿಮಗೆ ಮಾಹಿತಿಗಾಗಿ ನೀಡಲಾಗುತ್ತದೆ.

ಯಾವುದೇ ಹೆಚ್ಚಿನ ಸ್ಪಷ್ಟೀಕರಣಕ್ಕಾಗಿ ನೀವು ಪ್ರಧಾನ ತನಿಖಾಧಿಕಾರಿಯನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು,

ಡಾ. ರಮೀಸ್ ಎಂ ಸಾಲಿ - ಸಮುದಾಯ ಔಷಧ ವಿಭಾಗ, ಶ್ರೀ ದೇವರಾಜ್ ಉರ್ಸ್ ವೈದ್ಯಕೀಯ ಕಾಲೇಜು, ಕೋಲಾರ ಅವರ ಮೊಬೈಲ್ ಫೋನ್ ಸಂಖ್ಯೆ 9746040253.

ANNEXURE VII

Informed Consent

Sl. No:

Title of the Study: Prevalence and Associated Factors of Alcohol Use, Alcohol Dependence and Treatment Gap in Rural Area of Kolar.

I, the undersigned, agree to participate in this study and disclosure of my personal information and as outlined in this consent form.

I have been read out/explained in my local language i.e., in kannada and understand the purpose of this study and the confidential nature of the information that will be collected and disclosed during the study. I have had the opportunity to ask questions regarding the various aspects of this study and my questions have been answered to my full satisfaction. The information collected will be used only for research.

I understand that I remain free to withdraw from this study at any time. Participation in this study is under my sole discretion and does not involve any cost to me.

Subject's name and signature /thumb impression

Name and signature of witness

1.

2.

Name and signature of interviewer:

Name and signature of Principal Investigator: **Dr. Ramees M Sali**

Contact No: **9746040253**

Date:

Email: rameesmsali001@gmail.com

ANNEXURE VIII

ತಿಳಿಸಿದ ಒಪ್ಪಿಗೆ

ಎಸ್‌ಎಲ್ ಇಲ್ಲ:

ಅಧ್ಯಯನದ ಶೀರ್ಷಿಕೆ - ಕೋಲಾರದ ಗ್ರಾಮೀಣ ಪ್ರದೇಶದಲ್ಲಿ ಆಲ್ಕೊಹಾಲ್ ಬಳಕೆ, ಆಲ್ಕೊಹಾಲ್ ಅವಲಂಬನೆ ಮತ್ತು ಚಿಕಿತ್ಸೆಯ ಅಂತರದ ಹರಡುವಿಕೆ ಮತ್ತು ಸಂಬಂಧಿತ ಅಂಶಗಳು.

ನಾನು, ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಒಪ್ಪುತ್ತೇನೆ ಮತ್ತು ನನ್ನ ವೈಯಕ್ತಿಕ ಮಾಹಿತಿಯನ್ನು ಬಹಿರಂಗಪಡಿಸುತ್ತೇನೆ ಮತ್ತು ಈ ಒಪ್ಪಿಗೆ ನಮೂನೆಯಲ್ಲಿ ವಿವರಿಸಿದಂತೆ

ನನ್ನ ಸ್ಥಳೀಯ ಭಾಷೆಯಲ್ಲಿ ಅಂದರೆ ಕನ್ನಡದಲ್ಲಿ ನಾನು ಓದಿದ್ದೇನೆ/ವಿವರಿಸಿದ್ದಾರೆ ಮತ್ತು ಈ ಅಧ್ಯಯನದ ಉದ್ದೇಶ ಮತ್ತು ಅಧ್ಯಯನದ ಸಮಯದಲ್ಲಿ ಸಂಗ್ರಹಿಸುವ ಮತ್ತು ಬಹಿರಂಗಪಡಿಸುವ ಮಾಹಿತಿಯ ಗೌಪ್ಯ ಸ್ವರೂಪವನ್ನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ. ಈ ಅಧ್ಯಯನದ ವಿವಿಧ ಅಂಶಗಳಿಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ನನಗೆ ಅವಕಾಶ ಸಿಕ್ಕಿದೆ ಮತ್ತು ನನ್ನ ಪ್ರಶ್ನೆಗಳಿಗೆ ನನ್ನ ಸಂಪೂರ್ಣ ತೃಪ್ತಿಗೆ ಉತ್ತರ ನೀಡಲಾಗಿದೆ. ಸಂಗ್ರಹಿಸಿದ ಮಾಹಿತಿಯನ್ನು ಸಂಶೋಧನೆಗೆ ಮಾತ್ರ ಬಳಸಲಾಗುತ್ತದೆ.

ನಾನು ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಈ ಅಧ್ಯಯನದಿಂದ ಹಿಂತೆಗೆದುಕೊಳ್ಳಲು ಮುಕ್ತನಾಗಿರುತ್ತೇನೆ ಎಂದು ನಾನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದು ನನ್ನ ಸ್ವಂತ ವಿವೇಚನೆಯಲ್ಲಿದೆ ಮತ್ತು ನನಗೆ ಯಾವುದೇ ವೆಚ್ಚವನ್ನು ಒಳಗೊಂಡಿರುವುದಿಲ್ಲ.

ವಿಷಯದ ಹೆಸರು ಮತ್ತು ಸಹಿ /ಹೆಬ್ಬರಳಿನ ಗುರುತು

ಸಾಕ್ಷಿಯ ಹೆಸರು ಮತ್ತು ಸಹಿ

1.

2.

ಸಂದರ್ಶಕರ ಹೆಸರು ಮತ್ತು ಸಹಿ:

ಪ್ರಧಾನ ತನಿಖಾಧಿಕಾರಿಯ ಹೆಸರು ಮತ್ತು ಸಹಿ: ಡಾ.ರಮೀಸ್ ಎಮ್ ಸಾಲಿ

ಸಂಪರ್ಕ ಸಂಖ್ಯೆ: 9746040253

ದಿನಾಂಕ:

ಇಮೇಲ್: rameesmsali001@gmail.com

ANNEXURE IX

OPERATIONAL DEFINITIONS OF VARIABLES UNDER STUDY

Age: The completed age of study participants in years at the time of the interview was considered.

Education: Formal education was recorded as stated by the subject.

- **Primary:** Study participants with education up to VII standard.
- **Secondary:** Study participants with education between VIIIth and Xth standard.
- **PUC:** Study participants with education up to Pre-University (up to XII standard).
- **Degree:** Study participants with university level of education.

Occupation:

- **Daily wage:** Study participants who works for wages or salary.
- **Self-employed:** Participants does not work for a specific employer who pays them a consistent salary or wage.
- **Professional:** It relates to a participants work, especially work that requires special training.
- **Student:** Participants who is studying at a university or other place of higher education.
- **Homemaker:** Participant who spends their time looking after a

home and doing housework rather than being employed outside the home.

Marital status:

- **Single:** Participant who is not married.
- **Married:** Participant who stay with their partner.
- **Divorced:** Participants who is separated after marriage from their partner.

Type of family

- **Nuclear family:** one which is composed of the husband, the wife, the minor children and direct dependent.
- **Joint family:** composed of two or more couple and their children, including older persons related to them.
- **Three-generation family:** Representatives from three generations residing there among the households.

Total monthly family income: It is the combined total income received by all members of a family.

Number of family members: Total number of family members in a house.

Socio-economic status: The modified BG Prasad socioeconomic scale was used to classify socioeconomic status of study participants.

Modified BG Prasad socioeconomic status classification, 2021

Socioeconomic classification	Social class	Per capita monthly Income	
		In 1961	2021
Upper	Class I	≥ 100	Rs 7863 and above
Upper middle	Class II	50-99	Rs 3931-7862
Middle	Class III	30-49	Rs 2359-3930
Lower Middle	Class IV	15-29	Rs 1179-2358
Lower	Class V	< 15	Rs 1179 and below

BG Prasad's classification was based on per capita monthly income. It was introduced with the base of Consumer Price Index (CPI) of 1960 as 100. Which was modified in the year 1982 and 2001, by adding linking factors.

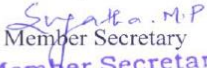
New income value = multiplication factor $\times$ old income value $\times 4.63 \times 4.93$.

Multiplication factor = Current index value/ Base index value
linking factors were 4.93 and 4.63.

ANNEXURE X

Institutional Ethics Committee Certificate

	SRI DEVARAJ URS ACADEMY OF HIGHER EDUCATION & RESEARCH	
	SRI DEVARAJ URS MEDICAL COLLEGE Tamaka, Kolar	
	INSTITUTIONAL ETHICS COMMITTEE	

Members 1. Dr. D.E.Gangadhar Rao, (Chairman) Prof. & HOD of Zoology, Govt. Women's College, Kolar, 2. Dr. Sujatha.M.P., (Member Secretary), Assoc. Prof. of Anesthesia, SDUMC, 3. Mr. Gopinath Paper Reporter, Samyukth Karnataka 4. Mr. G. K. Varada Reddy Advocate, Kolar 5. Mr. Nagesh Sharma Priest, Sanskrit Scholar and School Teacher 6. Dr. Hariprasad, Assoc. Prof Department of Orthopedics, SDUMC 7. Dr. Mahendra.M , Asst. Prof. of Community Medicine, SDUMC 8. Dr. Harish Asst. Prof. of Pharmacology, SDUMC 9. Dr. Vinay Kulkarni Lecturer, Dept. of Anatomy, SDUMC 10. Dr. Ruth Sneha Chandrakumar Asst. Prof. of Psychiatry, SDUMC 11. Dr. Shiva Kumar C S Asst. Prof. Dept. of Clinical Nutrition and Diabetics, SDUMC 12. Dr. Munilakshmi U Asst. Prof. of Biochemistry, SDUMC	No. SDUMC/KLR/IEC/575/2020-21 Date: 24-12-2020 PRIOR PERMISSION TO START OF STUDY The Institutional Ethics Committee of Sri Devaraj Urs Medical College, Tamaka, Kolar has examined and unanimously approved the synopsis entitled “Prevalence and associated factors of alcohol use, alcohol dependence and treatment gap in rural area of kolar” being investigated by DR. RAMEES M SALI , Dr. Naresh Kumar S J in the Department of Community Medicine at Sri Devaraj Urs Medical College, Tamaka, Kolar. Permission is granted by the Ethics Committee to start the study.  Member Secretary Member Secretary Institutional Ethics Committee Sri Devaraj Urs Medical College Tamaka, Kolar.  Chairman CHAIRMAN Institutional Ethics Committee Sri Devaraj Urs Medical College, Tamaka, Kolar
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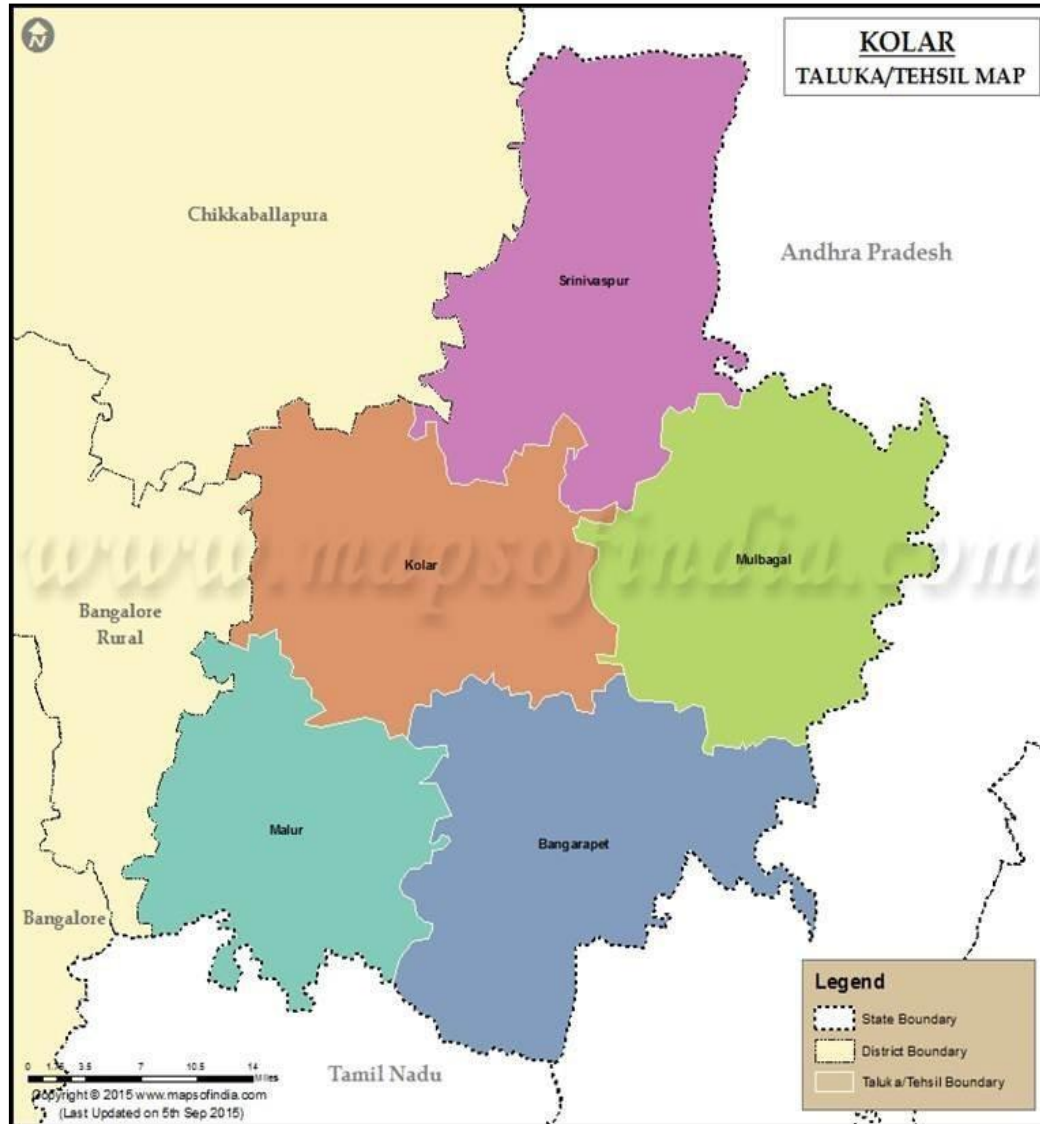
ANNEXURE XI

GANTT CHART

STEP	ACTIVITY	TIME PERIOD										
		2020			2021			2022				
		Sept& Oct	Oct	Dec	Jan	Feb to Mar	April to Dec	Jan to June	July to Aug	Aug to Sep	Sep to Nov	Dec
1	Topic search, selection & synopsis writing											
2	Synopsis submission											
3	Approval by IEC*											
4	Proforma Preparation and validation											
5	Pilot project											
6	Review of literature											
7	Data collection											
8	Data analysis											
9	Dissertation writing											
10	Submission of dissertation											

ANNEXURE XII

MAP SHOWING KARNATAKA STATE AND KOLAR DISTRICT IN KARNATAKA



ANNEXURE XIII
DATA ACQUISITION IMAGES



Investigator while interviewing the study participants in the community



ANNEXURE XIII- MASTER CHART

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLY INCOME	Per capita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
1	30	2	1	3	2	5	2	2	1200	1714	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
2	47	2	1	3	3	1	2	2	1200	1714	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
3	70	1	1	3	2	1	2	2	1200	1714	4	2	2	2	2	2	1	1	0	0	1	0	0	0	7	1	2					
4	21	1	1	3	2	1	1	2	1200	1714	4	2	2	1	2	1	2	1	1	2	0	1	0	0	10	1	2					
5	35	1	1	3	2	1	2	2	1200	1714	4	2	2	2	2	2	1	1	1	1	1	2	0	0	11	1	2					
6	40	2	1	3	1	1	2	2	1200	1714	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
7	47	1	1	3	2	1	2	2	1200	1714	4	2	1	1	2	1	1	2	1	1	2	2	0	0	12	1	2					
8	18	2	1	3	3	4	1	2	7000	1167	5	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
9	38	2	1	3	2	1	1	2	7000	1167	5	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
10	19	2	1	3	3	4	1	2	7000	1167	5	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
11	80	2	1	3	2	1	1	2	7000	1167	5	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
12	40	2	1	3	2	1	1	2	7000	1167	5	2	1	2	2	1	1	1	2	1	2	2	0	0	12	1	2					
13	29	1	1	3	4	3	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
14	22	2	1	3	4	2	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
15	45	2	1	3	2	1	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
16	50	2	1	3	2	2	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
17	28	2	1	3	4	4	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
18	22	2	1	3	1	5	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
19	20	1	1	3	4	4	1	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
20	19	1	1	3	4	2	1	2	5000	1250	4	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
21	60	1	1	3	1	2	2	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
22	64	2	1	3	2	1	2	2	4000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
23	19	1	1	3	2	4	1	2	6000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
24	36	2	1	2	2	5	2	2	6000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
25	42	1	1	4	2	2	2	2	6000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
26	68	2	1	2	3	5	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
27	29	1	1	3	3	1	1	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
28	55	2	1	3	3	5	2	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
29	30	2	1	2	2	5	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
30	76	1	1	2	3	1	2	2	1000	2000	4	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
31	48	1	1	3	1	2	2	2	2000	2000	4	1	2	2	1	1	1	0	0	0	0	1	0	1	5	1	2					
32	23	1	1	3	4	3	2	2	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
33	40	2	1	3	4	3	2	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
34	40	2	1	3	4	2	2	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
35	74	1	1	3	4	3	2	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
36	22	1	1	3	4	4	1	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
37	52	2	1	3	3	5	2	2	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
38	75	2	1	3	2	5	2	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
39	40	1	1	3	1	2	2	1	2000	2000	4	2	2	2	2	1	1	0	1	0	2	2	0	0	9	1	2					
40	28	1	1	3	4	3	1	2	2000	2000	4	1	2	2	4	2	2	2	1	0	1	1	2	0	15	1	2					
41	19	1	1	4	3	4	1	2	4000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
42	32	2	1	3	1	1	2	2	1500	3750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
43	76	1	1	3	1	1	2	2	1500	3750	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
44	25	1	1	3	4	1	2	2	1200	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
45	35	2	1	3	2	5	2	2	1200	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
46	21	2	1	4	2	5	2	2	2500	4167	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
47	35	1	1	3	1	1	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

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48	29	2	1	3	4	3	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
49	38	2	1	3	2	1	2	2	1400	3500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
50	46	1	1	2	1	1	2	2	1400	3500	3	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
51	68	1	1	4	2	2	2	2	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
52	30	1	1	4	1	2	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
53	54	2	1	3	1	2	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
54	60	1	1	4	1	1	2	2	7000	1750	4	1	2	2	2	2	1	1	0	1	2	1	0	0	10	1	2					
55	68	2	1	4	3	1	2	2	5000	2500	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
56	78	2	1	4	3	5	2	2	5000	2500	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
57	23	2	1	4	4	2	1	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
58	60	2	1	4	3	3	2	2	7000	2333	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
59	26	2	1	4	4	3	1	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
60	50	2	1	4	3	3	2	2	20,00	4,00	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
61	23	2	1	4	4	2	2	2	20,00	4,00	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
62	30	1	1	4	1	2	2	2	15,00	3,75	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
63	28	2	1	4	4	5	2	2	1500	3750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
64	18	1	1	4	3	4	1	2	1000	2000	4	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
65	66	1	1	4	1	1	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
66	50	2	1	4	3	5	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
67	37	1	1	4	2	1	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
68	33	2	1	4	3	5	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
69	27	2	1	4	4	2	1	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
70	28	2	1	3	3	1	1	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
71	25	2	1	3	4	4	1	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
72	26	1	1	3	4	1	1	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLY INCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
73	20	2	1	1	3	4	1	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
74	45	2	1	3	2	5	2	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
75	35	2	1	3	3	5	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
76	45	1	1	3	3	2	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
77	26	1	1	3	4	4	1	1	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
78	47	2	1	3	3	2	2	1	1000	2500	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
79	58	1	1	3	4	3	2	1	2000	4000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
80	21	1	1	3	4	4	1	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
81	62	1	1	4	2	1	2	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
82	62	2	1	4	1	5	2	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
83	25	2	1	4	3	5	2	1	2000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
84	68	1	1	4	4	3	2	2	8000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
85	19	2	1	4	4	4	1	2	8000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
86	25	2	1	4	4	5	2	2	1200	2400	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
87	38	1	1	4	4	3	2	2	1200	2400	3	1	1	2	2	1	1	1	0	1	2	1	0	0	9	1	2					
88	80	2	1	4	1	1	2	2	4000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
89	35	2	1	4	2	1	2	2	4000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
90	62	2	1	4	2	5	2	2	6000	1200	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
91	70	1	1	4	3	1	2	2	6000	1200	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
92	27	1	1	4	3	2	1	2	6000	1200	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
93	22	2	1	4	3	5	1	2	6000	1200	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
94	79	2	1	4	3	5	2	2	2700	6750	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
95	48	2	1	4	3	3	2	2	2700	6750	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
96	26	1	1	4	3	2	1	2	2700	6750	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
97	22	2	1	4	4	3	1	2	2700	6750	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

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98	50	2	1	4	3	5	2	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
99	60	1	1	4	4	2	2	2	1500	3000	3	1	1	2	2	2	3	1	1	2	1	1	0	0	13	1	2					
100	25	2	1	4	3	2	1	2	2500	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
101	26	2	1	4	3	2	2	2	2500	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
102	32	1	1	4	1	2	2	2	2500	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
103	77	2	1	4	1	5	2	2	2500	5000	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
104	31	2	1	4	2	5	2	2	1100	2750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
105	45	1	1	4	4	1	2	2	1100	2750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
106	21	2	1	4	3	3	1	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
107	66	2	1	4	3	5	2	2	1000	3333	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
108	27	2	1	4	4	5	2	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
109	69	1	1	4	2	5	2	2	1000	3333	3	1	1	2	3	1	1	1	1	0	2	0	0	0	9	1	2					
110	29	1	1	4	3	1	1	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
111	25	2	1	4	3	1	2	2	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
112	45	1	1	4	3	2	2	2	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
113	76	2	1	4	1	5	2	2	1600	4000	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
114	24	1	1	4	4	3	1	2	1200	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
115	26	2	1	3	4	4	1	2	2000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
116	45	1	1	3	3	1	2	2	2000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
117	19	1	1	3	4	4	1	2	2000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
118	38	2	1	3	3	5	2	2	2000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
119	39	1	1	3	3	2	2	2	2000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
120	40	1	1	3	1	1	2	1	1200	4000	2	2	2	1	2	3	2	1	1	2	2	1	0	0	14	1	2					
121	35	2	1	3	3	1	2	1	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
122	85	1	1	3	1	1	2	1	1000	1667	4	2	1	1	3	2	2	1	1	1	1	1	0	0	12	1	2					

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123	86	2	1	3	1	1	2	1	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
124	45	1	1	3	4	1	2	1	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
125	37	2	1	3	2	1	2	2	1000	1667	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
126	42	1	1	3	3	2	2	2	1000	1667	4	1	2	1	3	3	2	1	1	1	1	1	0	0	13	1	2					
127	19	2	1	3	3	4	1	2	1000	1667	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
128	20	1	1	3	4	4	1	2	1000	1667	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
129	81	1	1	3	2	1	2	2	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
130	70	1	1	3	1	2	2	1	5000	1000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
131	56	2	1	3	1	2	2	1	5000	1000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
132	32	1	1	3	3	2	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
133	27	2	1	3	4	3	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
134	30	1	1	3	4	3	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
135	48	1	1	3	2	2	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
136	26	2	1	3	4	3	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
137	42	2	1	3	4	3	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
138	42	2	1	3	3	5	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
139	34	2	1	3	4	3	2	1	3000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
140	20	2	1	3	3	5	2	1	5000	1000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
141	29	1	1	3	4	2	2	1	5000	1000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
142	38	1	1	3	2	3	2	1	5000	1000	1	2	2	2	2	3	2	0	1	1	2	2	0	0	13	1	2					
143	23	2	1	2	4	3	2	1	5000	1000	1	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
144	29	2	1	2	3	3	2	1	5000	1000	1	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
145	36	1	1	2	2	1	2	1	5000	7142	2	2	2	1	1	1	2	1	2	1	1	1	0	0	10	1	2					
146	60	2	1	2	1	5	2	1	5000	7142	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
147	70	1	1	2	1	2	2	1	5000	7142	2	2	2	2	2	2	3	1	1	2	0	0	0	0	11	1	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
148	58	2	1	2	3	5	2	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
149	60	1	1	2	3	1	2	2	6000	3000	3	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
150	68	1	1	2	3	2	1	2	3000	3000	3	1	2	1	2	2	1	0	1	1	0	1	0	0	8	1	2					
151	28	2	1	2	3	5	2	2	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
152	38	1	1	2	3	4	2	2	6000	3000	3	1	1	1	1	1	0	1	0	1	2	1	0	0	7	1	2					
153	38	2	1	2	3	3	2	2	2000	1000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
154	68	1	1	2	3	3	2	2	2000	1000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
155	28	2	1	3	3	3	2	2	3000	500	5	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
156	30	1	1	3	4	3	2	2	3000	500	5	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
157	48	2	1	3	3	2	2	2	2000	6667	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
158	21	1	1	3	4	3	1	2	2000	6667	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
159	80	2	1	3	3	2	2	2	2000	6667	2	1	1	2	2	2	1	1	1	0	0	2	0	0	9	1	2					
160	86	1	1	3	3	1	2	1	3000	750	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
161	65	1	1	3	3	2	2	2	3000	750	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
162	57	2	1	3	3	2	2	2	3000	750	5	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
163	60	2	1	3	1	5	2	2	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
164	45	1	1	3	1	1	2	2	1800	4500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
165	39	2	1	3	2	5	2	2	1800	4500	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
166	19	2	1	2	2	3	1	2	1800	4500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
167	19	2	1	3	4	4	1	1	1000	1429	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
168	22	1	1	3	4	4	1	1	1000	1429	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
169	50	1	1	3	2	1	2	1	1000	1429	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
170	40	2	1	3	2	1	2	1	1000	1429	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
171	75	1	1	3	1	2	2	1	1000	1429	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
172	65	2	1	3	1	2	2	1	1000	1429	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
173	34	2	1	3	4	3	2	1	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
174	40	1	1	3	4	3	2	1	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
175	66	2	1	3	2	5	2	1	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
176	83	1	1	3	4	3	2	1	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
177	24	2	1	3	4	4	1	1	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
178	42	1	1	3	2	2	2	1	1200	3000	3	1	2	1	3	2	2	2	1	1	1	3	0	0	15	1	2					
179	38	2	1	3	3	2	2	2	1200	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
180	20	2	1	3	4	4	1	2	2600	6500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
181	60	1	1	3	1	1	2	2	6000	2000	4	1	1	1	3	2	1	0	1	1	0	2	2	0	12	1	2					
182	68	1	1	4	3	1	2	2	6000	2000	4	1	1	2	2	1	0	1	0	0	0	1	0	0	5	1	2					
183	40	2	1	3	2	5	2	2	6000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
184	60	1	1	2	1	1	2	2	1000	1667	4	2	2	2	2	1	1	1	1	1	1	1	0	0	9	1	2					
185	21	2	1	3	4	5	1	1	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
186	55	2	1	3	1	3	2	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
187	70	2	1	3	1	5	2	2	1000	1667	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
188	18	1	1	3	3	4	1	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
189	40	2	1	3	1	1	2	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
190	76	1	1	3	3	1	2	2	6000	3000	3	1	2	2	2	0	0	0	0	0	0	0	0	0	2	1	2					
191	62	2	1	3	3	5	2	2	6000	3000	3	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
192	38	2	1	3	3	1	1	2	6000	3000	3	1	1	2	1	0	1	0	0	1	0	1	0	0	4	1	2					
193	45	1	1	4	1	2	2	2	2000	5000	2	1	2	1	2	1	1	3	2	1	0	1	0	0	11	1	2					
194	38	2	1	4	1	2	2	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
195	20	2	1	4	2	2	1	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
196	80	1	1	4	1	1	2	1	1600	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
197	37	2	1	4	1	5	2	1	1600	3000	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
198	40	1	1	4	3	1	2	1	16000	3000	3	1	1	1	3	4	2	2	3	2	3	2	2	0	23	1	1	3 years	6	1	2	was very usefult after the treatment
199	22	1	1	4	4	3	1	1	15000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
200	39	1	1	3	3	5	2	2	15000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
201	55	1	1	3	2	1	2	2	15000	5000	2	1	2	2	2	2	1	1	1	1	1	1	0	0	10	1	2					
202	45	1	1	3	3	1	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
203	40	2	1	3	3	5	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
204	55	2	1	3	1	5	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
205	65	1	1	1	3	1	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
206	21	1	1	3	4	3	1	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
207	30	1	1	1	3	2	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
208	60	2	1	1	1	5	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
209	65	2	1	4	1	1	2	1	20000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
210	32	1	1	4	2	1	2	1	20000	5000	2	1	2	2	2	1	1	0	1	1	0	0	0	0	7	1	2					
211	27	2	1	4	2	5	2	1	20000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
212	70	1	1	4	1	1	2	1	20000	5000	2	1	2	2	2	1	1	1	1	0	1	0	0	0	7	1	2					
213	40	1	1	3	3	2	2	2	15000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
214	48	1	1	4	1	1	2	2	12000	2400	3	1	2	2	2	1	2	1	0	0	1	0	1	0	8	1	2					
215	50	1	1	4	1	1	2	2	12000	2400	3	1	2	1	2	2	3	2	1	1	1	0	1	0	13	1	2					
216	18	1	1	3	3	4	1	2	15000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
217	19	1	1	3	4	4	1	2	15000	3000	3	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
218	38	2	1	3	2	2	2	2	15000	3000	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
219	40	2	1	4	3	1	2	1	1200	2400	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
220	20	1	1	4	4	3	1	2	1200	2400	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
221	19	1	1	4	4	3	1	2	1200	2400	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
222	35	1	1	3	2	1	2	1	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
223	40	1	1	3	2	1	2	1	2500	3125	3	2	2	2	2	2	2	1	1	1	2	0	2	0	13	1	2					
224	45	2	1	3	1	2	2	1	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
225	80	1	1	3	1	1	2	1	2500	3125	3	2	1	2	3	2	1	1	1	1	1	1	0	0	11	1	2					
226	65	1	1	3	1	2	2	1	2500	3125	3	2	1	2	1	2	1	1	1	0	0	0	0	0	6	1	2					
227	27	2	1	2	3	2	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
228	31	1	1	3	3	3	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
229	40	2	1	3	3	2	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
230	59	1	1	3	3	2	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
231	58	1	1	3	4	3	2	2	2500	3125	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
232	30	2	1	3	3	2	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
233	68	1	1	2	3	2	2	2	1000	2500	3	1	2	1	4	3	3	2	3	1	1	1	2	2	22	1	2					
234	40	1	1	2	3	2	2	1	1000	2500	3	1	2	2	2	2	3	1	1	0	2	1	0	0	12	1	2					
235	60	2	1	4	3	5	2	2	6000	3000	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
236	19	2	1	3	4	4	1	2	1200	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
237	18	2	1	3	3	2	2	2	1200	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
238	36	2	1	3	3	2	2	2	1200	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
239	45	1	1	4	1	1	2	2	1200	3000	3	1	1	2	2	1	1	2	1	1	1	1	0	0	10	1	2					
240	40	1	1	3	1	2	2	2	2200	3667	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
241	68	1	1	3	1	5	2	2	2200	3667	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
242	44	1	1	3	3	2	2	1	2200	3667	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
243	68	1	1	3	2	1	2	2	2200	3667	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
244	30	2	1	3	2	5	2	1	2200	3667	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
245	40	2	1	4	3	5	2	2	7000	2333	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
246	57	1	1	3	3	1	2	2	7000	2333	4	1	1	1	2	1	2	1	1	1	1	1	0	0	10	1	2					
247	18	1	1	3	3	4	1	2	7000	2333	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
248	20	1	1	3	4	4	1	1	1500	2500	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
249	22	2	1	3	4	5	2	1	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
250	20	1	3	4	4	1	1	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
251	85	1	1	3	1	1	2	1	2000	5000	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
252	75	2	1	3	1	5	2	1	2000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
253	42	1	1	3	2	5	2	2	2000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
254	50	1	1	3	4	3	2	2	2000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
255	28	1	1	3	3	2	1	1	2000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
256	36	1	1	2	3	2	2	2	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
257	38	1	1	2	4	3	2	2	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
258	65	2	1	3	3	3	2	2	6000	1500	4	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
259	68	1	1	3	3	4	2	1	1000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
260	64	2	1	2	1	5	2	2	6000	6000	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
261	18	2	1	3	4	5	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
262	27	1	1	3	3	2	2	2	2500	3125	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
263	26	2	1	3	3	1	2	2	1000	1429	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
264	34	1	1	3	3	1	2	2	1000	1429	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
265	55	2	1	4	3	1	2	2	1000	1429	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
266	36	1	1	4	3	2	2	2	1000	1429	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
267	32	2	1	4	3	5	2	2	1000	1429	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
268	80	2	1	3	1	5	2	2	1000	1429	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
269	23	1	1	3	4	3	2	2	1800	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
270	38	2	1	3	4	2	2	2	1500	2500	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
271	48	1	1	3	3	2	2	2	1500	2500	3	1	1	2	3	2	1	1	2	2	2	2	2	0	17	1	2					
272	75	1	1	4	3	1	2	2	1500	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
273	20	1	1	3	4	4	1	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
274	38	2	1	3	3	1	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
275	46	1	1	2	3	2	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
276	26	1	1	3	4	2	1	1	2000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
277	21	2	1	3	4	3	1	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
278	19	1	1	3	3	2	1	1	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
279	60	2	1	3	1	5	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
280	70	1	1	3	1	1	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
281	35	1	1	3	4	3	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
282	27	2	1	3	3	3	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
283	27	2	1	3	3	5	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
284	36	1	1	3	3	3	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
285	30	2	1	3	1	1	2	1	2000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
286	42	1	1	3	1	2	2	1	2000	3333	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
287	30	2	1	3	1	1	2	1	2000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
288	48	1	1	3	2	3	2	1	2000	3333	3	2	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
289	48	2	1	3	1	2	2	1	2000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
290	39	2	1	3	2	5	2	1	6000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
291	36	1	1	3	2	2	2	1	6000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
292	23	2	1	3	1	1	1	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
293	35	1	1	3	1	1	2	1	2000	3333	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be entered into care	alcohol related problems	Usefulness- help
294	47	2	1	3	1	2	2	1	2000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
295	35	1	1	4	3	3	2	1	3000	7500	2	1	1	2	3	2	1	2	2	1	1	1	0	0	13	1	2					
296	29	2	1	3	2	5	2	1	3000	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
297	60	2	1	4	1	5	2	1	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
298	76	1	1	4	1	1	2	1	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
299	35	1	1	4	1	3	2	1	5000	1250	4	1	1	2	2	1	2	1	1	1	1	1	0	0	10	1	2					
300	30	2	1	4	4	3	2	1	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
301	45	1	1	3	3	3	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
302	23	1	1	3	4	3	1	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
303	45	2	1	3	2	5	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
304	21	1	1	3	4	3	1	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
305	60	1	1	3	1	1	2	2	1000	2500	3	1	1	2	2	3	1	1	1	1	1	2	0	0	12	1	2					
306	62	1	1	3	1	1	2	2	1000	2500	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
307	68	2	1	4	1	1	2	2	1000	2500	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
308	68	1	1	3	3	1	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
309	18	1	1	3	4	4	1	2	1000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
310	65	1	1	4	1	1	2	1	2000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
311	41	1	1	3	3	1	2	2	1000	2500	3	1	1	2	2	2	2	1	1	1	1	1	0	0	11	1	2					
312	62	2	1	3	3	2	2	2	1500	7500	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
313	18	2	1	4	3	4	1	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
314	37	2	1	3	3	2	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
315	39	1	1	3	4	2	2	2	1400	4667	2	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
316	29	1	1	3	3	2	2	2	1400	4667	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
317	32	1	1	3	2	2	2	2	1400	4667	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
318	31	1	1	3	3	2	2	2	1500	3000	3	1	2	2	2	2	2	2	1	1	1	1	0	0	12	1	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLY INCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
319	29	2	1	3	4	4	1	2	1000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
320	60	2	1	3	2	2	2	2	3200	8000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
321	24	2	1	3	4	3	2	2	3200	8000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
322	29	2	1	3	3	2	2	2	1400	3500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
323	49	1	1	3	2	2	2	2	3200	8000	1	1	2	2	1	1	1	0	1	0	1	0	0	0	5	1	2					
324	40	1	1	3	3	2	2	2	3200	8000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
325	42	1	1	3	3	2	2	1	1400	3500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
326	22	2	1	3	4	5	2	2	1200	2400	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
327	56	2	1	3	3	1	2	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
328	38	1	1	3	1	5	2	1	2000	6667	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
329	19	1	1	3	4	4	1	1	2000	6667	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
330	45	1	1	3	1	2	2	1	2000	6667	2	1	2	1	2	2	1	1	0	1	1	1	0	0	9	1	2					
331	50	2	1	3	1	1	2	1	2500	8333	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
332	60	1	1	3	2	1	2	1	2500	8333	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
333	22	1	1	3	4	3	1	1	2500	8333	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
334	27	1	1	3	4	3	2	2	1400	2800	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
335	50	2	1	3	3	1	2	2	1000	2000	4	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
336	60	1	1	3	3	2	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
337	80	1	1	3	1	1	2	2	2400	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
338	85	1	1	2	3	2	2	2	2400	6000	2	1	1	2	2	1	1	1	1	1	1	1	0	0	9	1	2					
339	22	2	1	2	3	5	2	2	2500	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
340	28	1	1	2	4	3	2	2	2500	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
341	46	1	1	2	2	2	2	2	2000	5000	2	1	2	2	1	0	1	0	0	1	0	0	0	0	3	1	2					
342	18	1	1	3	3	4	1	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
343	21	2	1	2	4	5	2	2	1400	2800	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLY INCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
344	28	2	1	2	3	5	2	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
345	29	1	1	3	4	3	2	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
346	80	2	1	2	3	3	1	2	2400	6000	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
347	23	2	1	3	3	1	2	2	1500	1500	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
348	20	1	1	3	4	4	1	2	1500	1500	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
349	23	1	1	4	4	3	2	2	1500	1500	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
350	25	1	1	3	3	1	2	2	1500	1500	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
351	72	2	1	3	2	1	2	2	1500	1500	4	2	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
352	68	1	1	3	4	1	2	2	1500	1500	4	2	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
353	19	1	1	4	3	4	2	2	2500	4167	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
354	28	2	1	4	3	5	2	1	2500	4167	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
355	28	1	1	4	4	3	1	1	2500	4167	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
356	35	2	1	4	2	5	2	1	2500	4167	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
357	19	1	1	3	4	4	1	1	1700	2833	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
358	45	1	1	4	1	2	2	1	2500	4167	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
359	27	2	1	4	2	2	2	1	2500	4167	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
360	23	2	1	3	4	5	2	1	1800	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
361	45	1	1	3	1	2	2	1	1800	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
362	20	1	1	4	4	4	1	1	1800	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
363	45	2	1	3	1	2	2	1	1800	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
364	30	1	1	3	1	2	2	1	1800	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
365	40	1	1	3	1	5	2	1	2100	4200	2	2	2	2	2	2	1	1	1	2	1	2	2	1	15	1	2					
366	21	2	1	3	1	2	2	1	2100	4200	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
367	19	2	1	3	4	5	1	1	2100	4200	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
368	45	1	1	3	1	2	2	1	2100	4200	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
369	50	1	1	3	3	1	2	2	1600	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
370	20	1	1	2	3	4	1	2	2000	6667	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
371	40	2	1	3	3	5	2	2	2000	6667	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
372	55	1	1	3	4	3	2	2	2000	6667	2	1	2	2	3	1	2	2	2	2	1	1	2	0	16	1	2					
373	68	1	1	3	3	2	2	2	1500	1875	4	2	1	2	2	2	1	1	2	2	1	0	0	0	11	1	2					
374	22	1	1	3	3	2	2	2	1500	1875	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
375	24	2	1	3	3	5	2	2	1500	1875	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
376	32	1	1	2	3	2	2	2	1500	1875	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
377	38	2	1	3	3	1	2	2	1500	1875	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
378	68	2	1	3	3	1	2	2	1500	1875	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
379	80	1	1	3	4	3	1	1	3000	5000	2	2	2	2	3	2	1	1	1	1	1	1	0	0	11	1	2					
380	73	1	1	3	1	2	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
381	61	1	1	3	4	3	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
382	54	1	1	3	3	1	2	2	3000	1500	4	1	1	2	3	2	2	1	1	1	1	1	0	0	12	1	2					
383	48	2	1	3	3	1	2	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
384	30	1	1	4	4	2	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
385	45	2	1	4	1	5	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
386	49	1	1	4	1	3	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
387	24	2	1	4	4	3	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
388	80	1	1	2	1	2	2	2	6000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
389	52	2	1	2	3	5	2	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
390	24	1	1	4	4	3	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
391	36	2	1	4	2	5	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
392	46	1	1	4	1	2	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
393	20	2	1	4	4	3	1	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
394	21	2	1	4	2	5	2	1	3000	6000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
395	30	1	1	2	3	1	2	2	3000	1000	5	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
396	58	2	1	3	3	1	2	2	3000	1000	5	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
397	57	1	1	3	3	2	2	2	3000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
398	62	1	1	3	3	2	2	2	1300	2167	4	1	2	2	2	2	1	0	1	2	1	1	0	0	10	1	2					
399	30	1	1	3	4	2	2	1	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
400	21	2	1	3	2	4	2	1	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
401	19	1	1	4	3	3	1	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
402	45	1	1	3	2	2	1	1	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
403	35	2	1	4	2	4	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
404	23	2	1	4	2	1	1	1	9000	2250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
405	38	1	1	4	1	2	2	1	9000	2250	4	1	2	2	2	1	1	1	0	0	1	1	0	0	7	1	2					
406	32	2	1	4	1	1	2	1	9000	2250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
407	22	2	1	4	3	4	1	1	9000	2250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
408	26	2	1	3	3	4	2	2	1500	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
409	68	1	1	4	3	1	2	2	1500	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
410	62	1	1	3	1	1	2	2	1500	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
411	32	1	1	4	4	3	2	2	1500	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
412	70	2	1	3	1	1	2	1	1200	2000	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
413	45	1	1	2	4	3	2	2	1200	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
414	68	2	1	3	1	1	2	2	1200	2000	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
415	30	1	1	4	3	2	2	2	1200	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
416	24	2	1	3	4	3	2	2	1200	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
417	82	2	1	3	3	1	2	2	1200	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
418	30	1	1	3	4	3	2	2	1500	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
419	88	1	1	3	3	2	2	2	1500	3000	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
420	40	1	1	4	3	2	2	2	5000	1667	4	1	2	2	1	0	1	0	0	0	1	0	0	0	3	1	2					
421	48	2	1	4	3	2	2	2	5000	1667	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
422	32	1	1	3	4	3	2	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
423	22	2	1	3	4	3	1	1	5000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
424	18	1	1	3	3	3	1	2	3000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
425	30	2	1	3	3	2	2	2	3000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
426	50	2	1	3	3	1	2	2	3000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
427	35	2	3	4	4	4	2	2	2000	4000	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
428	42	1	1	3	4	3	2	2	2000	4000	2	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
429	53	1	1	3	3	2	2	2	5000	1250	4	1	2	2	2	2	1	2	0	1	2	3	0	0	13	1	2					
430	22	1	1	4	4	3	1	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
431	60	1	1	3	2	2	2	2	1500	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
432	28	1	1	1	4	2	2	2	1500	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
433	29	1	1	3	2	1	2	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
434	52	2	1	3	3	2	2	2	1500	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
435	18	2	1	4	3	3	1	2	1000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
436	21	1	1	4	4	3	2	2	1000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
437	45	2	1	4	3	4	2	2	1000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
438	48	1	1	2	3	2	2	2	1000	4000	2	1	2	1	3	2	1	2	2	2	1	1	0	0	14	1	2					
439	80	2	1	4	1	4	2	1	1000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
440	26	2	1	4	4	3	2	1	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
441	26	1	1	4	4	3	2	1	1000	3333	3	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
442	22	1	1	4	4	3	1	1	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
443	18	2	1	3	1	4	2	1	1100	1833	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
444	32	2	1	3	2	4	2	1	1100	1833	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
445	39	1	1	3	2	2	2	1	1100	1833	4	1	2	2	2	2	1	1	0	0	1	1	0	0	8	1	2					
446	28	2	1	3	4	4	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
447	60	2	1	3	1	4	2	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
448	43	2	1	3	4	3	1	1	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
449	21	2	1	3	4	3	1	1	1700	4250	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
450	23	2	1	3	4	3	1	1	1700	4250	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
451	45	2	1	3	2	4	2	1	1700	4250	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
452	27	2	1	4	3	3	2	2	1500	2500	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
453	47	2	1	2	1	1	2	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
454	28	1	1	4	3	4	1	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
455	28	1	1	4	4	3	2	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
456	38	1	1	3	3	1	2	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
457	65	2	1	2	1	1	2	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
458	67	1	1	2	3	1	2	2	1000	1667	4	2	1	2	2	2	2	1	1	0	1	1	0	0	10	1	2					
459	45	1	1	4	2	2	2	1	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
460	26	2	1	4	2	4	2	2	7000	1750	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
461	35	1	1	4	2	2	2	1	7000	1750	4	1	2	1	2	2	2	1	0	1	1	1	0	0	10	1	2					
462	42	1	1	4	1	1	2	2	4000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
463	37	2	1	4	1	1	2	2	4000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
464	21	2	1	4	3	4	1	2	1200	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
465	28	1	1	4	3	3	2	2	1200	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
466	50	2	1	4	1	4	2	2	1200	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
467	29	2	1	3	3	2	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
468	38	1	1	3	3	2	2	2	1000	2000	4	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be entered into care	alcohol related problems	Usefulness- help
469	32	1	1	4	3	2	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
470	61	1	1	3	3	2	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
471	56	2	1	3	3	1	2	2	1000	2000	4	1	1	2	2	2	1	1	1	1	1	1	0	0	10	1	2					
472	30	2	1	3	3	2	2	2	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
473	39	2	1	3	3	4	2	2	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
474	68	1	1	3	3	2	2	1	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
475	23	1	1	3	4	3	1	2	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
476	35	1	1	3	3	2	2	2	7000	1750	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
477	24	2	1	2	3	4	2	2	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
478	37	1	1	3	3	2	2	2	3000	5000	2	2	2	2	1	0	0	1	0	1	1	0	0	0	4	1	2					
479	22	2	1	3	3	1	2	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
480	45	1	1	3	3	1	2	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
481	74	1	1	4	3	2	2	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
482	60	2	1	3	2	1	2	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
483	18	1	1	3	3	4	1	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
484	22	1	1	3	3	1	1	2	3000	1500	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
485	38	2	1	3	2	4	2	2	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
486	42	1	1	3	2	2	2	2	6000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
487	80	1	1	4	1	2	2	1	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
488	38	2	1	4	1	4	2	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
489	29	1	1	2	4	3	2	2	2800	9333	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
490	22	2	1	2	4	4	2	2	2800	9333	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
491	20	2	1	3	3	4	2	2	7000	2333	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
492	55	2	1	3	3	2	2	2	7000	2333	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
493	29	1	1	2	3	2	2	2	1300	2167	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
494	40	1	1	3	3	1	2	2	1300	2167	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
495	33	1	1	3	3	3	2	2	1300	2167	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
496	64	1	1	2	3	1	2	2	1400	3500	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
497	29	1	1	2	2	2	2	2	3000	5000	2	2	2	2	1	1	0	1	0	0	0	0	0	0	4	1	2					
498	28	2	1	3	3	4	2	2	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
499	29	1	1	2	3	2	2	2	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
500	34	1	1	2	2	2	2	2	3000	5000	2	2	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
501	58	2	1	2	2	1	2	2	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
502	68	1	1	2	2	1	2	2	3000	5000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
503	22	2	1	2	4	5	2	2	3200	8000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
504	30	1	1	2	4	3	2	2	3200	8000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
505	29	2	1	2	3	5	2	2	1800	2571	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
506	38	1	1	2	2	1	2	2	1800	2571	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
507	53	1	1	2	3	2	2	2	1800	2571	3	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
508	62	1	1	4	1	1	2	2	4000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
509	71	2	1	4	1	1	2	2	4000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
510	26	2	1	3	2	5	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
511	33	1	1	3	2	2	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
512	70	2	1	4	1	5	2	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
513	47	1	1	4	1	2	2	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
514	35	2	1	4	1	2	2	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
515	24	2	1	4	4	3	1	2	5000	1250	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
516	21	1	1	4	3	2	1	2	6000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
517	44	2	1	3	2	2	2	2	6000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
518	19	2	1	3	3	4	1	2	5000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
519	48	2	1	2	3	5	2	2	3000	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
520	57	1	1	2	3	1	2	2	3000	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
521	27	2	1	3	4	3	2	2	3000	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
522	29	1	1	2	4	3	2	2	3000	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
523	55	1	1	3	3	2	2	2	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
524	40	2	1	3	3	2	2	2	1600	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
525	30	1	1	2	3	1	2	2	8000	2667	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
526	29	1	1	2	3	1	2	2	8000	2667	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
527	28	2	1	2	2	1	2	2	8000	2667	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
528	60	2	1	4	1	5	2	2	2000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
529	70	1	1	4	1	2	2	1	1800	6000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
530	70	2	1	4	1	5	2	2	1000	1000	5	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
531	60	2	1	4	1	5	2	2	3000	1000	5	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
532	22	2	1	2	3	5	2	1	5000	7142	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
533	35	1	1	4	2	2	2	2	2000	4000	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
534	36	1	1	4	2	1	2	2	6000	3000	3	1	2	2	4	2	3	0	0	0	2	0	2	2	15	1	2					
535	32	2	1	4	1	5	2	2	6000	3000	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
536	70	1	1	4	1	1	2	2	2000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
537	30	1	1	2	2	1	2	2	7500	3750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
538	26	2	1	2	2	1	1	2	7500	1500	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
539	50	2	1	2	1	1	2	2	1000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
540	50	1	1	2	2	1	2	2	3000	6000	2	2	1	2	4	2	3	0	0	0	0	0	0	0	9	1	2					
541	55	1	1	2	1	2	2	1	5000	7142	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
542	48	2	1	2	1	5	2	1	5000	7142	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
543	26	1	1	2	2	2	2	1	5000	7142	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLY INCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be entered into care	alcohol related problems	Usefulness- help
544	25	1	1	2	3	2	1	1	5000	7142	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
545	65	2	1	3	1	5	2	2	1000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
546	19	1	1	3	3	2	1	2	8000	8000	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
547	50	1	1	3	2	2	2	2	1500	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
548	40	2	1	3	2	5	2	2	1500	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
549	65	2	1	4	1	5	2	2	5000	1667	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
550	70	1	1	4	1	2	2	2	5000	1667	4	1	2	2	4	2	3	0	0	0	0	0	0	0	9	1	2					
551	40	2	1	4	1	5	2	2	5000	1667	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
552	65	2	1	4	1	5	2	2	2000	1000	5	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
553	40	1	1	2	4	2	2	2	1500	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
554	38	2	1	2	2	5	2	2	1500	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
555	58	1	1	3	1	2	2	2	1000	2000	4	2	1	2	4	3	3	0	0	0	0	0	2	0	12	1	2					
556	46	1	1	3	1	2	2	2	1000	3333	3	1	2	2	3	1	1	0	0	0	0	0	0	0	5	1	2					
557	21	1	1	3	4	4	1	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
558	40	2	1	3	1	5	2	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
559	35	2	1	3	2	5	2	2	1000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
560	42	1	1	3	4	2	2	2	1000	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
561	55	2	1	3	1	5	2	2	1000	2000	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
562	30	1	1	3	2	1	2	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
563	26	2	1	3	2	5	2	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
564	60	2	1	3	1	2	2	1	1200	2000	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
565	75	1	1	3	1	2	2	1	1200	2000	4	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
566	36	1	1	3	2	2	2	1	1200	2000	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
567	30	2	1	3	1	5	2	1	1200	2000	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
568	66	1	1	4	1	1	2	2	9000	3000	3	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
569	22	1	1	4	2	1	1	2	9000	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
570	54	2	1	4	1	2	2	2	9000	3000	3	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
571	65	2	1	1	2	5	2	2	2000	2000	4	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
572	72	2	1	1	4	5	2	2	1000	1000	5	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
573	82	1	1	1	4	3	2	2	3333	1111	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
574	27	1	1	2	4	3	1	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
575	20	1	1	1	4	4	1	1	6000	1000	1	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
576	68	2	1	1	4	3	1	2	8500	1700	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
577	74	2	1	1	2	5	1	2	8500	1700	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
578	57	2	1	1	4	5	1	2	8500	1700	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
579	93	2	1	1	1	5	2	2	8500	1700	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
580	70	2	1	1	2	3	2	2	8500	1700	1	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
581	28	2	1	2	2	5	2	2	1200	2000	4	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
582	52	1	1	2	2	5	2	2	1000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
583	38	1	1	2	4	2	2	2	1000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
584	22	2	1	2	3	5	2	1	1000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
585	68	1	1	1	3	2	2	3	1500	7500	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
586	62	2	1	1	2	5	2	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
587	83	1	1	1	3	2	2	2	2000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
588	43	1	1	1	2	2	2	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
589	40	2	1	1	2	1	2	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
590	20	2	1	1	4	4	1	2	1000	3333	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
591	24	2	1	1	4	5	2	2	1500	3750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
592	31	1	1	1	4	3	2	2	1500	3750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
593	63	2	1	1	1	5	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					

Participants	AGE	GENDER	RELIGION	CASTE	EDUCATION	OCCUPATION	MARITAL STATUS	TYPE OF FAMILY	MONTHLYINCOME	Percapita Income	SOCIAL CLASS	NO OF FM	TOB CHE	SMOKE	Audit 1	Audit 2	Audit 3	Audit 4	Audit 5	Audit 6.	Audit 7	Audit 8	Audit 9	Audit 10	TOTAL SCORE	AUDIT CATEGORY	Treatment gap?	Period of visit	Type of health care visited	use and alcohol dependence can be	alcohol related	Usefulness- help
594	45	2	1	2	2	5	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
595	48	1	1	2	1	2	2	2	1000	2000	4	1	2	2	2	2	1	4	0	0	0	0	0	0	9	1	2					
596	35	2	1	2	2	2	2	2	1000	2000	4	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
597	45	2	1	4	1	1	2	2	1000	2000	4	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
598	62	2	1	1	1	5	2	2	1500	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
599	32	1	1	2	4	2	2	2	1000	5000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
600	22	2	1	2	4	3	2	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
601	75	2	1	2	2	5	2	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
602	59	2	1	2	4	3	2	2	1500	3000	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
603	75	1	1	2	1	2	2	3	8000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
604	50	2	1	2	1	1	2	3	8000	4000	2	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
605	30	1	1	2	3	1	2	3	1000	3333	3	1	2	2	2	2	3	2	1	0	0	0	0	0	10	1	2					
606	22	2	1	2	4	3	1	3	1500	3750	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
607	80	1	1	2	1	2	2	3	1500	3750	3	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2					
608	80	1	1	1	4	3	2	2	4000	5714	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
609	78	2	1	1	3	5	2	2	4000	5714	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
610	56	1	1	1	4	3	2	2	4000	5714	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
611	49	2	1	1	4	3	2	2	4000	5714	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
612	27	2	1	1	4	5	2	2	4500	5625	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
613	50	1	1	1	4	3	2	2	4500	5625	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
614	46	2	1	1	4	5	2	2	4500	5625	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
615	25	1	1	1	4	2	1	2	4500	5625	2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
616	57	1	1	1	3	2	2	2	1000	2500	3	1	2	2	2	0	0	1	0	0	1	0	0	0	4	1	2					
617	50	2	1	1	3	2	2	2	1000	2500	3	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					
618	70	2	1	1	2	5	2	2	1000	1667	4	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2					