ALCOHOLISM AND PUBLIC HEALTH

- *A PRACTICUM REPORT*

Dinnies.V.J.
PGDCHM
2002-2003

for CMC library - Student placement report
SW 24/6/03

TN I would not suggest placing this in the library. (see comments) Perhaps you, CMF and PK would have many more.

400 24/6

Ref : CHC/7/BP/ Date :June 2, 2003

Dr. Abel Rajaratnam,
Head of Departments, RUSHSA,
Christian Medical College,
Vellore

Dear Dr. Abel,

Subject : Placement of Dr. Dennis at Community Health Cell for Practicum as required for the DCHM Course .

Reference: Your letter dated 8th April 2003.

TN
His report is very badly done Perhaps a comment to Abel would be in order after CHF and PK have seen it

We are glad to inform you that Dr.Dennies has completed his practicum for 10th April to 31st May 2003 under the guidance of the senior members of our team.

During this practicum, Dr.Dennies focussed on Community Health and Development approach to prevent alcohol abuse and helped CHC in undertaking a baseline survey in sudhamanagar slum in Bangalore where CHC is involved in partnership with local NGOs. He participated in the other activities and programmes of CHC – such as life skills training, community health orientation programmes, anti tobacco campaign on the occasion of World Tobacco Day on 31st May 2003.

Dr. Dennies gave a presentation of his involvement in the slums to the team of CHC on 2.5.2003.

Dr. Dennies took interest in completing the assignments entrusted to him, and showed fair enthusiasm to learn from the practicum and group discussions.

Dr. Dennies throughout his placement with us, maintained a good inter personnel relationship with the members of our team in CHC.

We wish him all the best in the future.

With regards,

Yours sincerely,
For Community Health Cell,

Thelma Narayan

Dr.Thelma Narayan
Co-Ordinator

"Student's Copy"

ACKNOWLEDGEMENTS

I would like to thank all the faculty members of RUHSA Department of Christian Medical College, Vellore, especially Dr. Rajaratnam Abel, the Head of the Department and Mr. G. Muniraj my course co-ordinator.

I also thank all the faculty members in Community Health Cell in Bangalore. Thanks are due to Dr. Ravi Narayan, Community Health Advisor, CHC, Dr. Thelma Narayan, Co-ordinator, CHC, Dr. B.S. Paresh Kumar ,Fellow –Training , Community Mobilization and Research, who guided me step by step, Mr. Rajendran, Training and Research Assistant, who was of great help to me in the field and all the administrative steff in CHC especially Mr. Gopinathan, Administrative Officer. Special thanks are due to Dr. C.M. Francis who was always ready to help with some very useful tips and hints. I would also like to mention Mr. H.R. Mahadevaswamy, Information Assistant who was of great help to me. Dr. Rajan Patil helped me with the computer processing of collected data.

Lastly I would like to thank the people of Sudhama Nagar. They were very patient and co-operative during my Survey.I would like to mention Mr. Shouri Muthu, Mr. Mariapirakasham and Ms. Kannagi by name.

INTRODUCTION

Post Graduate Diploma in Community Health Management is a one year Academic programme conducted in RUHSA Department of CMC,Vellore. At the end of the course the students are expected to do a Practicum for two months. This is the report of my practicum.

For my Practicum I selected Community Health Cell in Bangalore. Community Health Cell is a nongovernmental organisation, mainly involved in Policy and Advocacy. This organisation was started by Dr.Benjamin Pulimood,Dr.C.M.Francis and Dr.Ravi Narayan. The present co-ordinator is Dr.Thelma Narayan.

During my stay in CHC I was involved in one of the field programmes of CHC. This programme is known as Community Health Approach To Alcoholism(CHATA). This programme is being implemented in five urban slums of Bangalore. I was involved with the project in a place called Sudhama Nagar. Sudhama nagar is an urban slum abutting an upper middle class residential area on the arterial Airport/HAL Road of Bangalore. All the main downtown areas of Bangalore are within a distance of five kilometer. There is a Roman Catholic church and a Hindu temple adjacent to the area. The sprawling Hindustan Aeronautics Limited Campus borders one side of Sudhama Nagar.

As my practicum I undertook a sociodemographic survey of a demarcated area of Sudhama Nagar consisting of 129 households. Along with this survey I also conducted another survey for a haphazard sample population of alcoholics. I was able to administer a prepared schedule to 16 alcoholics. The following report contains the report of that survey.

CONTENTS

Mainly a demographic survey of the slum.
This information may be useful.
Very little to do with goals and objectives.
CM
16/7/03.

JUSTIFICATION

Reproductive and child health is one of the major item in Primary Health Care. Governments all over the world are spending a lot of money for R Ch. But most of the Government programmes do not produce the desired impact. One of the basic reason for this paradox is that the Government programmes do not address the radical causes in the aetiology of R Ch problems.

Alcoholism is fast becoming a major public health issue .The most affected people are from the poorer socioeconomic strata of the society .In urban slums the problem is very acute. Most of the interventions have failed because of different reasons. Some of these are

1) Lack of political commitment
2) The alcohol lobby is very powerful and is able to influence policy
3) The elite classes and elders in the society set bad examples for youth.
4) Usually alcoholics are reluctant to take the problem seriously

One of the best approaches to tackle this problem is to impart life skills to the younger generation.This will enable them to take a sensible decision when they grow up.As citizens they will be fully aware of the consequences of alcohol addiction

In this context it is very important to take alcoholism as a serious public health issue. This problem has serious socioeconomic implications as well. To understand the problem from a community health point of view it is important to study the social canvass of an alcohol addict. This Survey was undertaken in an attempt to understand the social canvass of an alcoholic.

GOALS AND OBJECTIVES

GOAL

To study how Reproductive and Child Health is influenced by the effects of alcoholism as a social problem.

OBJECTIVES

1) To study the social canvass of an addict through post facto explanation
2) To study the effectiveness of deaddiction programmes
3) To study the effect of alcoholism on the family

METHODOLOGY

1) Literature review
2) Case study
3) Administered questionnaire to a haphazard sample to identified families of addicts.
4) Analysis of data.
5) Preperation of report

TIME PLAN	Week-1	Week-2	Week-3	Week-4	Week-5	Week-6	Week-7	Week-8
1)PlanningPracticum With Rusha Faculty	#							
2)Review of literature and contacting local NGOs		#	#					
3)Choosing the universe and enlisting helps		#	#	#				
4)Administering questionnaire			#	#	#	#		
5)Analysis					#	#	#	
6)Report preperation							#	#

ALCOHOL AND HEALTH

The use of alcohol containing beverages has been present throughout recorded history.Its use can be seen in most societies though not in all.It is the only socially acceptable intoxicant in most societies.Certain beverages are specific to certain cultures.Examples being Wine in Mediterranean countries,Palm toddy in certain parts of Africa and India,Sake in Japan and Pulque in Mexico.Feni of Goa and Mahua of tribal belts of Central India can also be mentioned in this context. In India Soma,an alcoholic drink was used in Yagas from Vedic times.Another drink called Sura also is mentioned in Vedic texts.

The process of distillation of fermented sugar to produce alcohol is considered the first chemical industry in the World.This is considered an art.In some societies distillation and consumption of alcohol has religious and spiritual overtones.The process of distillation of alcohol is supposed to have originated in China.The process reached Europe during middle ages through Arabia.Alcohol is not easily denatured.So it can be stored and shipped.During the era of colonisation European powers used alcohol as an instrument of economic and sociocultural domination.

PHARMACOLOGY OF ALCOHOL

Any carbohydrate containing organic material can be used to produce alcohol by fermentation.Fermented sugars yield about 5-15% of alcohol.This is further concenterated through distillation.Distilled beverages can contain anything between 20-55% of alcohol by volume. Ethyl alcohol is the active chemical constituent of all types of alcoholic beverages. It is a colourless,volatile and inflammable liquid.

TOPICAL APPLICATION

When topically applied alcohol has a cooling effect due to evaporation.In higher concenterations it has a rubifacient and mild irritant action.It also has astringent germicidal action in higher concenterations.If injected locally alcohol can produce denaturation of proteins and dehydration.

ORAL ADMINISTRATION

Taken orally alcohol produces a local feeling of warmth and increased salivary secretion.It irritates gastric mucosa and produces increased gastric secretion.But in concenterations higher than 15% alcohol inhibits gastric secretion.The irritation of gastric mucosa can lead to gastritis,nausea and vomiting.Chronic alcoholism leads to gastritis and achlorhydria.
Alcohol consumption leads to impairment of physical co-ordination.It reduces cognition and attention.This in turn increases risk of injury and accidents.Alcohol can affect intention and judgement.This gives rise to violent behaviour and crime.It is estimated that one in five violent crimes are committed under the influenze of alcohol. Very rarely overconsumption of alcohol can lead to a fatal overdose.

Alcohol can potentially affect any organ in the body adversely.The main pathologic conditions resulting from chronic abuse are liver cirrhosis,cancers of upper gastro intestinal tract and liver,cardiomyopathies,gastritis and pancreatitis.Alcoholics are shown to have more susceptibility to infectious diseases in some studies.

ABSORPTION AND EXCRETION

Ethyl alcohol is absorbed as such from stomach, duodenum, and jejunum.It gets distributed throughout the body tissues and diffuses back to blood whenever the blood level falls.In the lung alcohol passes from blood to alveolar air.This is the reason why alcoholics smell of alcohol.Most (90 % to 98 %)of the alcohol is metabolized in the liver.It is oxidized into acetaldehyde.Acetaldehyde is in turn converted to Acetyl Co-enzyme A and is finally oxidized to Carbon Dioxide and water.Non metabolised alcohol is excreted through kidney and lungs.

PATHOLOGIC CONDITIONS CAUSED BY ALCOHOL

Over the past few decades consumption of alcohol is increasing.The age at which people start drinking is becoming less and less.So from a community health point of view diseases due to chronic abuse of alcohol is likely to increase in the near future.Violent crimes and accidents induced by drunkenness also are likely to increase.Apart from these direct effects, alcoholism can lead to social ills like family disorganization,crime and loss of productivity. Alcohol is incriminated in one out of five violent crimes.

references? CM

USES

Medicinal use of alcohol was very prevalent until the beginning of twentieth century.Before the era of aneasthetics alcohol was widely used as an aneasthetic.Consumption of alcohol in moderate amounts is said to have a beneficial effect on cardiovascular diseases eventhough this is very controversial and is not proved conclusively.The exact mechanism of this action is not known.According to some studies it is resveratrol,a red wine constituent that gives the beneficial effect rather than the alcohol. Alcohol definitely can prevent the build up of plaque in the arteries. Injection of alcohol into nerves is beneficial in certain cases of neuralgias.Topical alcohol acts as an astringent and is used in debilitated patients to prevent bedsores.In a concenteration of 70% W, alcohol is a good antiseptic.

references? CM

Apart from these medicinal uses alcohol has some industrial use as well.In many industries alcohol is used as a solvent.In some countries alcohol mixed with petrol.which is otherwise known as gasohol,is used as an automotive fuel.

It is used as a religious sacrament by Christians.Some of the tribal cults in Africa and South America also drink alcohol as a religious ritual.Alcohol is used as a food stuff in some cultures.In Mediterranean countries alcohol is used as a thirst quencher especially wine.

PSYCHOACTIVE PROPERTIES

Alcohol affects mood and feeling.Earlier alcohol was considered to be a CNS stimulant in small doses. But now it is considered a CNS Depressant irrespective of dose.The oral administration can give rise to symptoms ranging from mild mood alteration to comatose stage.Furthermore consumption of alcohol is considered as a social act.It is often subject to collective influenze.In Modern Society drinking alcohol is often an expression of espirit de corps.

ALCOHOL DEPENDENCE SYNDROME

Experience of loss of control over drinking leading to other psychological and physical sequelae is defined as alcohol dependence syndrome.

It is also known as alcohol dependence,alcoholism,obsessive compulsive drinking etc...

This condition is treated as a mental disorder.

citations relevant to the present study? CM

ALCOHOL AS A PUBLIC HEALTH HAZARD

3.5% of the global disease burden is directly linked to alcoholism.(calculated in DALYs)

Sl.No.	Disease/Addiction	% DALYs
1	Alcoholism	3.5
2	Tobacco	2.6
3	Drug Abuse	0.6
4	Tuberculosis	3.4
5	Reproductive Tract Infections	3.8
6	Malaria	2.6
7	Cancer	5.8
8	Ischemic Heart Disease	3.1
9	Cerebro Vascular Accident	3.2

Source ?

This problem is likely to increase in the near future.The reasons for this are,

1. People start drinking at a comparatively younger age.So there is going to be an increase in the number of cases with after effects of long term abuse.
2. A society undergoing rapid social changes are more likely to come under the adverse effects of alcohol.Most parts in the world are currently undergoing unprecedented sweeping changes.This can lead to an increased level of consumption.
3. After the age of globalisation, local and national Governments are compelled to dance to the tune of International Industrial Interests and are unable to enforce restrictions even if something is against the larger national interests.International trade treaties are dumb on this issue.
4. Multinationals are capable of pulling advertising and marketing coups in third world countries with total disregard to national and public opinions.
5. Liquor sale through internet is capable of overcoming all national restrictions and conventional checks and controls.

THE BUSINESS INTEREST

In a market economy the pricing of a commodity is based on the amount of raw material and labour that goes into the production of that particular commodity.If someone tries to charge more than this, the competition will undercut him pricewise.Alcohol is an exeption to this rule.Alcoholics are prepared to pay much more than what is a fair price for a commodity.This leads to profiteering and makes alcohol industry a lucrative business
proposition.In the context of globalisation this becomes much more worrisome.The multinationals can outsource their raw materials from wherever it is cheaply available,
produce alcohol where labour and other infrastructure facilities are available and market it in countries where profits are lucrative.

THE RESPONSE SO FAR

The negative response of the society to alcohol is not something new.Islam has declared alcohol as haraam(forbidden).In all the major world religions there are sects and denominations who consider alcohol as taboo.Apart from religions, Governments and communities have attempted to control alcoholism in the society. Starting from 1800 there were temperance societies in all the

major European countries.Their concerted effort resulted in the prohibition of alcohol in all major European nations and America at about the turn of twentieth century.All these efforts were initiated by people concerned with society from a moral and ethical point of view.The public health concerns concenterated mainly on the health related problems at an individual level.The main thrust of the public health authorities was in increasing treatment capacity for problems due to chronic abuse.All the efforts of the public health authorities were directed at heavy drinkers.

Apart from prohibition,measures like rationing,prescribed minimum age for drinking,higher penalty for crimes committed under the influenze of alcohol etc...also were tried in the prevention of alcohol abuse.All these measures were rolled back by about 1930.The legal prohibition of alcohol led to the mushrooming of a clandestine industry in almost all the countries where prohibition was enforced.Furthermore the prohibition was considered against the spirit of freedom and egalitarianism prevailing during the period.The temperance movements lost their momentum,once prohibition was enforced in European nations.Similar movements occurred sporadically in other parts of the world also.The Indian freedom movement had prohibition of alcohol as one of its programmes.

THE CURRENT PUBLIC HEALTH APPROACH

A comprehensive approach to alcoholism has many problems. Heavy drinkers and chronic abusers of alcohol constitute only a small percentage of the population. These people as such are responsible for only a small amount of social problems caused by alcohol. Usually a public health problem in a particular society can be studied as an aggregate of problems faced by each and every affected individual. But in the case of alcohol, apart from adverse effects at individual level , the effect at a social level also should be taken into account. These are accidents, crimes like homicide and suicide committed under the influenze of alcohol, traffic accidents caused by drunken driving etc...If the mortality and morbidity due to these factors are clubbed with direct mortality and morbidity due to alcohol the picture becomes much more serious. Apart from this the anguish and mental stress experienced by the family members , friends and colleagues of an alcoholic gives the problem a community mental health dimension also. At the community level any beneficial effect due to alcohol is cancelled out due to the larger number of adverse effects.

In the community health approach drinking at a lower level is more of a threat rather than heavy drinking .So the policy measures in most of the countries addresses the problem at two levels.

1. Reducing the level of consumption in the society.

2. controlling the availability

This model is termed total consumption model in Sweden.Reducing the level of consumption calls for a sincere effort from the Governments and social instituitions.Controlling the availability is being attempted through various legal means like increased taxation,prescribed minimum age limit for drinking,higher penalty for crimes committed under the influenze of alcohol etc...
There are groups who oppose these measures.Their arguments are,

1) The laws do not respect consumer sovereignity and the primacy of individual choice.Their answer to the problem is to domesticate alcohol consumption.
2) Policy measures directed at heavy and problem drinkers is more appropriate rather than measures directed at all drinkers.These groups advocate harm reduction measures for problem drinkers rather than total prohibition.

PREVENTIVE STRATEGIES

Different strategies are advocated for the prevention of problems due to alcohol abuse.These are,

1 Educational strategy
2 Coercive strategy
3 Behaviour modification strategy
4 Isolation strategy
5 Regulatory strategy
6 Collaborative strategy
7 Therapeutic strategy

POLICY CHANGES

Policy changes can be used effectively at three levels

1 Production and marketing
2 Consumption
3 Prevention of health hazards

GLOBAL PERSPECTIVE

Smuggling of alcohol across frontiers have been a lucrative business in frontier towns of all countries were prohibition was enforced. But till recently most of the countries were able to control and dictate alcohol policies within their national borders. But the picture is changing slowly. The last fifteen years of twentieth century saw the unprecedented wave of globalisation. The free market economy advocated by the proponents of globalisation is slowly eroding the power that the nations exercised over their domestic industries including alcohol industry. The national Governments have to follow the norms set by the international trade agreements Which in turn are dictated by International business interests.

In this context it is imperative to have an international policy in the production, consumption and marketing of alcohol.

No links to RCH or women and children Health

Methodology
Choice of Sudhama Nagar

THE SOCIAL CANVASS OF SUDHAMA NAGAR

Table-1 shows the distribution of households in Sudhama Nagar based on the number of years of residence in the area.More than half the households (57.37%) are comparatively new residents.The duration of their residence in the area was less than 10 years.

TABLE-1
Classification of Households in Sudhama Nagar based on Number of years of residence in the area

Sl.No	No.of years of residence	No.of Households	%
1	<5	39	30.23
2	6--10	35	27.14
3	11--15	22	17.05
4	16--20	15	11.63
5	>20	18	13.95
	TOTAL	129	100

GRAPH-1
Number of years of residence in the area

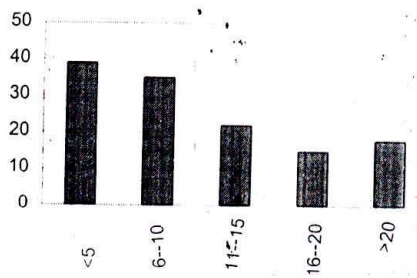


Table-2 shows that 36.43%of the population in Sudhama Nagar are from the state of Karnataka itself.But the majority of the population (61.24%) are migrants from the neighbouring state of Tamil Nadu.Together these two groups form 97.67% of the population in the Sudhama Nagar Slum.

TABLE-2
Classification of Households in Sudhama Nagar based on the State of Origin

Sl.No	State of Origin	No.	%
1	Tamil Nadu	79	61.24
2	Karnataka	47	36.43
3	Andhra Pradesh	2	1.56
4	Madhya Pradesh	1	0.77
	TOTAL	129	100

GRAPH-2
Original State from which People migrated

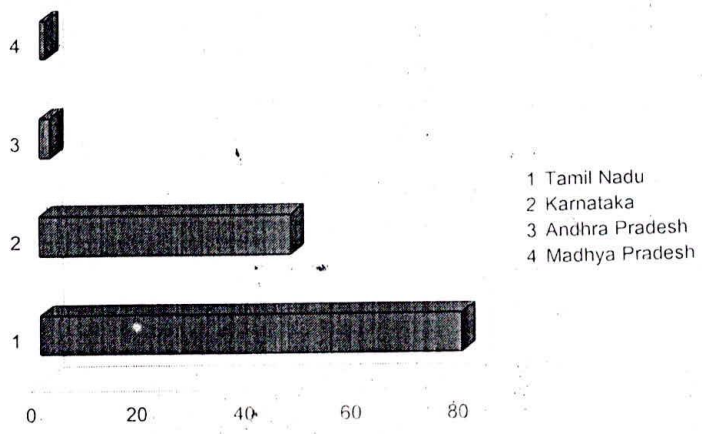


Table-3 shows the distribution of households in Sudhama Nagar based on their District of Origin.Most of the people of Karnataka Origin are native to Bangalore(31.01%).But the people of Tamil origin have migrated from different parts of Tamil Nadu.Majority of the people of Tamil Origin have migrated from the districts of Tiru Annamalai(28.69%),Villupuram(10.85%),Vellore(6.21%),and Madurai(3.89%).Another interesting feature was that nearly all the people of Karnataka origin in Sudhama Nagar spoke Tamil.

TABLE-3
Classification of Households in Sudhama Nagar based on the District of Origin

Sl.No	District of Origin		No.	%
1	Bangalore	(Karnataka)	40	31.01
2	Tiru Annamalai	(T.N)	37	28.69
3	Villupuram	(T.N.)	14	10.85
4	Vellore	(T.N.)	8	6.21
5	Madurai	(T.N.)	5	3.89
6	Gulbarga	(Karnataka)	4	3.12
7	Chennai	(T.N.)	3	2.33
8	Salem	(T.N.)	2	1.56
9	Kadalur	(T.N.)	2	1.56
10	Kolar	(Karnataka)	2	1.56
11	Kuppam	(A.P)	1	0.77
12	Gudallur	(T.N.)	1	0.77
13	Dharmapuri	(T.N.)	1	0.77
14	Neyveli	(T.N.)	1	0.77
15	Avur	(T.N.)	1	0.77
16	Nellore	(A.P)	1	0.77
17	Mysore	(Karnataka)	1	0.77
18	Tirunelveli	(T.N.)	1	0.77
19	Chidambaram	(T.N.)	1	0.77
20	Kanjipuram	(T.N.)	1	0.77
21	Krishnagiri	(T.N.)	1	0.77
22	Kanpur	(M.P)	1	0.77
	TOTAL		129	100

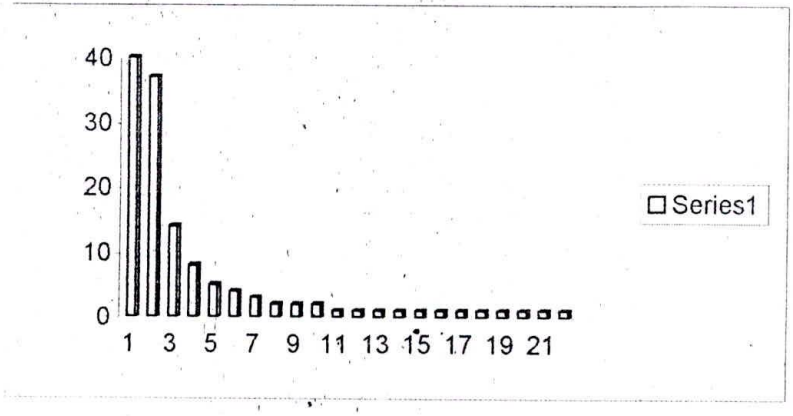
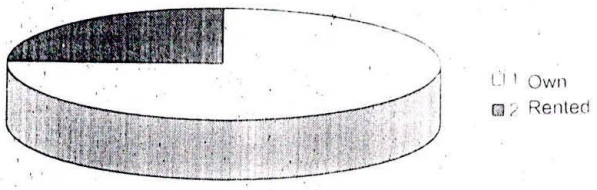


Table-4 shows that more than three fourths of the families had their own houses.The rest of them were staying in rented houses.

TABLE-4
Classification of Households in Sudhama Nagar based on the type ownership of The House

Sl.No	Type of Ownership	No	%
1	Rented	32	24.81
2	Own	97	75.19
	TOTAL	129	100

GRAPH-3
Type of ownership of house

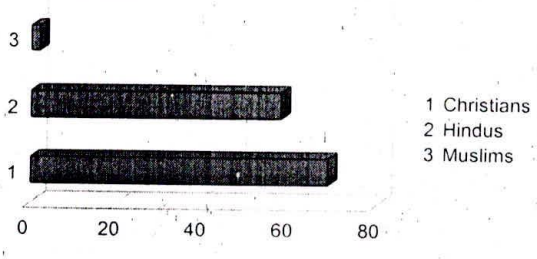


Christians and Hindus together form 98.44% of the population.There are only two Muslim families in the area.

TABLE-5
Classification of Households in Sudhama Nagar based on the Religious Faith

Sl.No	Religion	No	%
1	Christian	69	53.48
2	Hindu	58	44.96
3	Muslim	2	1.56
	TOTAL	129	100

GRAPH-4
Religions



Roman Catholics are the majority denomination among Christians forming 92.75% of Christian community while people belonging to scheduled castes formed the majority among the Hindu popu lation(93.11%)

TABLE-6
Classification of Households in Sudhama Nagar based on the Castes/Denominations

Sl.No.	Caste/Denomination	No.	%
1	Roman Catholic	64	49.61
2	Scheduled Castes	54	41.86
3	Pentacostal Church	3	2.33
4	Muslim	2	1.56
5	Vokkaliga	2	1.56
6	Mudaliar	1	0.77
7	Gounder	1	0.77
8	Church of South India	1	0.77
9	Baptist Church	1	0.77
	TOTAL	129	100

TABLE-7
Classification of Christian Households in Sudhama Nagar based on the Religious Denominations

Sl.No	Denomination	No.	%
1	Roman Catholic	64	92.75
2	Pentacostal	3	4.35
3	Church of South India	1	1.45
4	Baptist Church	1	1.45
	TOTAL	69	100

TABLE-8
Classification of Hindu Households in Sudhama Nagar based on the Castes

Sl.No.	Castes	No.	%
1	Scheduled Castes	54	93.11
2	Vokkaliga	2	3.45
3	Mudaliar	1	1.72
4	Gounder	1	1.72
	TOTAL	58	100

Households with three,four or five members formed nearly 70% of the total number of households.There was no one living alone.The largest family had 16 members.

TABLE-9
Classification of Households in Sudhama Nagar based on the Number of members in the Family

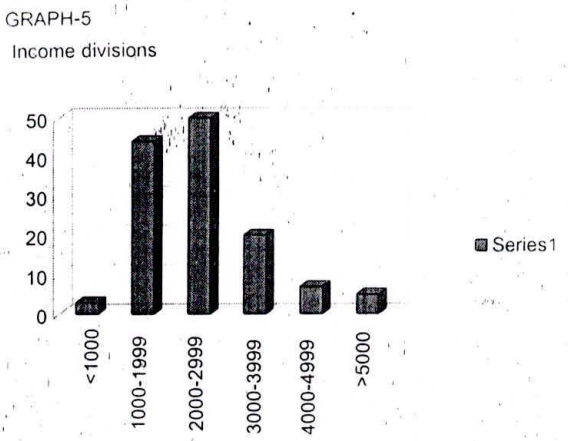
Sl.No.	No.of Members	No.	%
1	2 m	5	3.88
2	3 m	16	12.41
3	4 m	27	20.93
4	5 m	36	27.91
5	6 m	24	18.61
6	7 m	12	9.20
7	8 m	2	1.60
8	9 m	2	1.60
9	10 m	1	0.77
10	11 m	3	2.32
11	16 m	1	0.77
	TOTAL	129	100

In India people are reluctant to divulge their true incomes.Usually people tend to understate their incomes.So the actual monthly income can be higher than what is stated during the interview. Anyway the people living in an urban slum are generally poor.Nearly 90% of the people gave their monthly income as being between Rs 1000 - Rs 4000.

TABLE-10
Classification of Households in Sudhama Nagar based on the Total Monthly Household Income (Rs)

Sl.No.	Monthly Income in Rupees	No.	%
1	<1000	3	2.32
2	1000--1999	44	34.11
3	2000--2999	50	38.76
4	3000--3999	20	15.5
5	4000--4999	7	5.43
6	>5000	5	3.88
	TOTAL	129	100

GRAPH-5



The public distribution system in Karnataka has given two types of ration cards to the public. 1)BPL Card(Below Poverty Line Card.This card is coloured yellow and is colloquially known as the "Yellow Card" ;This card entitles the holder to buy provisions at concessional rates.Families with a monthly income of less than Rs 1500/-are eligible for this card.)

2)APL Card (Above Poverty Line Card).This card is coloured blue.This is given to families with a monthly income of more than Rs 1500/-

Some of the households did not have neither yellow card nor blue card.This problem was more prevalent among new migrants to the area.

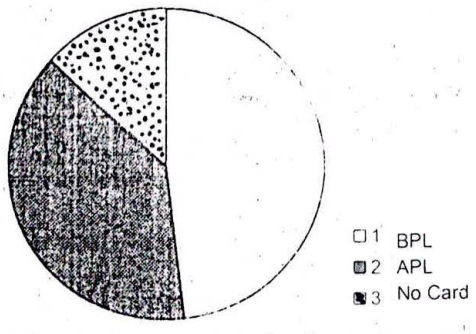
BPL- Below Poverty line card
APL- Above Poverty line card

TABLE-11
Classification of Households in Sudhama Nagar based on the type of Ration Card owned by them

Sl.No.	Type of Card	No	%
1	BPL	62	48.06
2	APL	50	38.76
3	No Card	17	13.18
	TOTAL	129	100

Legend : BPL- Below Poverty line card
APL- Above Poverty line card

GRAPH-6
Type of ration Card



Majority of the households in Sudhama Nagar did not have any savings.80% of the people who had some savings were involved in Self Help Groups rather than any conventional saving schemes. Very few people opted for saving schemes like bank accounts or Post Office Savings.This was especially true of people belonging to lower income groups.More than 85% of the people who opted to deposit their money with SHG groups belonged to lower income earning groups .

TABLE-12
Classification of Households in Sudhama Nagar based on the involvement in Saving Schemes

Sl.No	Savings	No	%
1	Yes	51	39.53
2	No	78	60.47
	TOTAL	129	100

TABLE-13
Classification of Households involved in Saving schemes with respect to the type of savings

Sl.No	Type of Saving	No	%
1	Self Help Group	41	80.39
2	Bank	4	7.84
3	Post Office	4	7.84
4	Others	2	3.93
	TOTAL	51	100

TABLE-14
Comparison of income levels of Households and the Type of Savings they have

	Type of savings				
	SHG	Bank	Post Office	Others	TOTAL
Income					
1000-1999	17	....	....	1	18
2000-2999	19	2	1	....	22
3000-3999	4	....	1	1	6
4000-4999	1	1	1	....	3
>5000	....	1	1	....	2
TOTAL	41	4	4	2	51

There is no marked sex difference in the number of people.The Male : Female ratio is nearly one.More than 60% of the population were below the age of 25.Nearly 90% of the population were below the age of 40.

TABLE-15
Total number of people in Sudhama Nagar based on Sex

Sl.No.	Sex	No.	%
1	Male	336	50.3
2	Female	332	49.7
	TOTAL	668	100

TABLE-16
Age Distribution of people in Sudhama Nagar

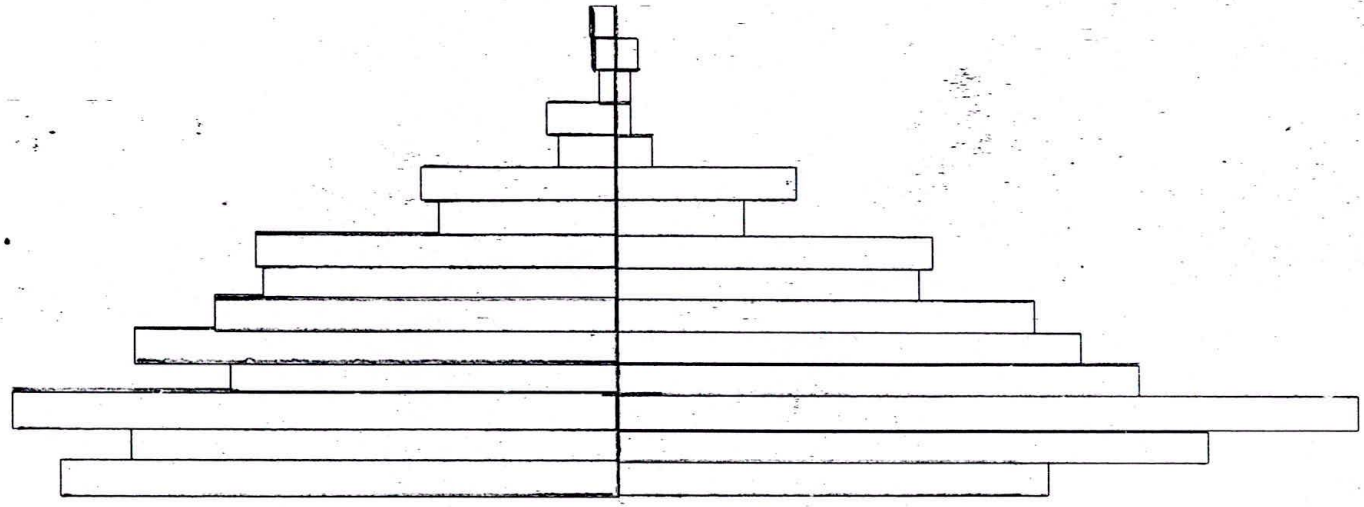
Sl.No.	Age Group	No.	%
1	0--5	78	11.68
2	6--10	86	12.87
3	11--15	107	16.03
4	16--20	73	10.93
5	21-25	76	11.38
6	26-30	65	9.74
7	31-35	52	7.78
8	36-40	54	8.08
9	41-45	24	3.59
10	46-50	30	4.49
11	51-55	8	1.18
12	56-60	7	1.05
13	61-65	2	0.3
14	66-70	4	0.6
15	>70	2	0.3
	TOTAL	668	100

The Age-Sex Pyramid for the population of Sudhama Nagar drawn for a class interval of 5 yrs is a more or less regular pyramid barring the lowest 3 segments.

TABLE-17

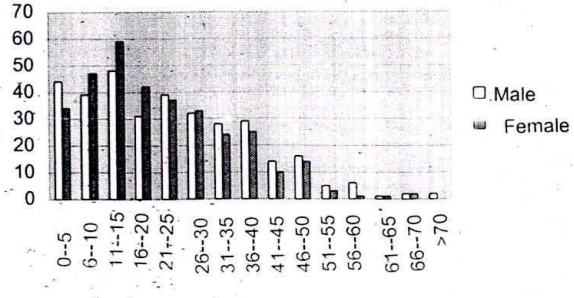
Age Sex Pyramid of the population of Sudhama Nagar

Age Group	Male %	Female %
>70	0.60%	0.00%
66--70	0.60%	0.60%
61--65	0.30%	0.30%
56--60	1.79%	0.30%
51--55	1.49%	0.90%
46--50	4.76%	4.22%
41--45	4.17%	3.01%
36--40	8.63%	7.53%
31--35	8.33%	7.23%
26--30	9.52%	9.94%
21--25	11.61%	11.15%
16--20	9.23%	12.65%
11--15	14.29%	17.77%
6--10	11.59%	14.16%
0--5	13.09%	10.24%



GRAPH-7

Age and Sex distribution of population



The number of people above the age of 50 yrs is very few for both sexes. While there are no females above the age of 70 yrs there are two males above the age of 70.

TABLE-18
Male/ Female Distribution of the people of Sudhama Nagar in Different Age Groups

Sl.No	Age Group	Male	Female	TOTAL
1	0--5	44	34	78
2	6--10	39	47	86
3	11--15	48	59	107
4	16--20	31	42	73
5	21--25	39	37	76
6	26--30	32	33	65
7	31--35	28	24	52
8	36--40	29	25	54
9	41--45	14	10	24
10	46--50	16	14	30
11	51--55	5	3	8
12	56--60	6	1	7
13	61--65	1	1	2
14	66--70	2	2	4
15	>70	2	0	2
TOTAL		336	332	668

TABLE-19
Age Distribution of Male population in Sudhama Nagar

Sl.No	Age Group	No.	%
1	0--5	44	13.09
2	6--10	39	11.59
3	11--15	48	14.29
4	16--20	31	9.23
5	21--25	39	11.61
6	26--30	32	9.52
7	31--35	28	8.33
8	36--40	29	8.63
9	41--45	14	4.17
10	46--50	16	4.76
11	51--55	5	1.49
12	56--60	6	1.79
13	61--65	1	0.3
14	66--70	2	0.6
15	>70	2	0.6
TOTAL		336	100

TABLE-20
Age Distribution of Female Population of Sudhama Nagar

Sl.No.	Age Group	No.	%
1	0--5	34	10.24
2	6--10	47	14.16
3	11--15	59	17.77
4	16--20	42	12.65
5	21--25	37	11.15
6	26--30	33	9.94
7	31--35	24	7.23
8	36--40	25	7.53
9	41--45	10	3.01
10	46--50	14	4.22
11	51--55	3	0.9
12	56--60	1	0.3
13	61--65	1	0.3
14	66--70	2	0.6
15	>70	0	0
TOTAL		332	100

TABLE-21
Classification of people of Sudham Nagar
based on the Marital status

Sl.No	Marital status	No.	%
1	Married	277	92.34
2	Widow/Widower	19	6.33
3	Seperated/Divorced	4	1.33
	TOTAL	300	100

TABLE-22
Sex distribution of people of Sudhama Nagar
based on the Marital Status

Sl.No	Marital status	Male	Female	TOTAL
1	Married	137	140	277
2	Widowed	3	16	19
3	Seperated	....	4	4
	TOTAL	140	160	300

Only 2.4% of the population in Sudhama Nagar had above High School level education. There were 2 degree holders and two diploma holders.12 people had gone for higher secondary education.25.9% of the people had no formal education.Both the degree holders were females.In most other levels of education males were more than females in number.Females outnumbered males among people with no formal education.

age? 78 children 0-5 yrs. CM

TABLE-23
Classification of people of Sudhama Nagar
based on the Education

Sl.No	Education	No.	%
1	No Education	173	25.9
2	Kinder Garten	16	2.4
3	Primary	87	13.02
4	Upper Primary	187	27.99
5	High School	189	28.29
6	Higher Secondary	12	1.8
7	Diploma	2	0.3
8	Degree	2	0.3
	TOTAL	663	100

TABLE-24
Sexwise Distribution of people of Sudhama Nagar
based on the Level of Education

Sl.No	Education	Male	Female	TOTAL
1	No education	84	89	173
2	Kinder Garten	9	7	16
3	Primary	38	49	87
4	Upper Primary	95	92	187
5	High School	101	88	189
6	Higher Secondary	8	4	12
7	Diploma	1	1	2
8	Degree	0	2	2
	TOTAL	336	332	668

TABLE-25
Classification of Employed People of Sudhama Nagar based on the type of Job

Sl.No.	Type of Job	No.	%
1	Type-1	69	29.87
2	Type-2	10	4.33
3	Type-3	33	14.29
4	Type-4	119	51.51
	TOTAL	231	100

Type of Jobs

Type-1
Jobs with a monthly salary

Type-2
Self Employed with a High Income >Rs 2000

Type-3
Self Employed with a Low Income <Rs 2000

Type-4
Jobs with daily Wages

Break up of individual jobs is given in subsequent tables

For the sake of convenience the jobs were classified into four types.

Type-1 Table- 25A

These were jobs with a monthly salary.Most of these jobs need skilled or semiskilled people,eventhough some jobs like office boy or hospital attendent require no special skills.Most of the working women came under this category ,many of them working as housemaids.

Type-2 Table-25B

This type of jobs are done by self employed people.They get a comparatively higher income.These people form the better off section of the population.

Type-3 Table-25C

These people are also self employed.But their earning potential is lower compared to type-2 jobs.Jobs like Autorickshaw driver,Fruit vendor,Vegetable vendor etc....fall under this category.

Type-4 Table-25D

This group comprises of people working for daily wages.Most of them do not get regular employment.In a month they can hope to get work for a maximum of 20 days,if lucky.So they are only partially employed.An interesting category among these is what is known as token coolies.There are certain big industrial establishments near Sudhama Nagar area. These factories have formed pools of casual labourers.Out of these pools only a few will get work on any given day.Others will go home once they know that there is no hope of work that day.All these workers are given I D Discs.These Discs are locally known as Tokens Sometimes as they leave the workers will pass these tokens to others who are prepared to wait for the job.This is done for a small consideration.So if the proxy worker gets the job he has to share the wages with the real owner of the so called token. These coolies are not given most of the benefits due to the regular workers in the factories.

TABLE-25A

Classification of People of Sudhama Nagar with Jobs with a monthly Salary(Type-1Jobs)

Sl.No.	Job	No
1	Acid Company Worker	1
2	Anganwadi Teacher	1
3	Assistant in Studio	1
4	Ayah in Nursery	1
5	Driver	8
6	Factory Worker	2
7	Garment Factory	3
8	Gas Supply Company	1
9	Help in courier	1
10	Help in shop	1
11	Help in Xerox Shop	1
12	Hospital Attender	1
13	Hotel Worker	2
14	Housemaid	26
15	Officeboy	1
16	Office Clerk	2
17	Office Clerk-Government	1
18	Peon in School	1
19	Petrol Pump Assistant	1
20	Salesgirl in Shop	1
21	Salesman in Shop	3
22	Security Guard	3
23	Supervisor in Company	1
24	Sweeper in Office	2
25	Tailoring Teacher	1
26	Workshop Mechanic	2
	TOTAL	69

TABLE-25B

Classification of Self Employed people of Sudhama Nagar with a Higher monthly Income

Sl.No	Employment	No
1	Contractor	3
2	Hotel Owner	1
3	Incense Stick Making	1
4	Juice Vendor	1
5	Shopkeeper	1
6	Tailor	3
	TOTAL	10

TABLE-25C

Classification of Self Employed people in Sudhama nagar with a Lower Monthly Income

Sl.No	Employment	No
1	Auto Driver	1
2	Auto Mechanic	2
3	Barber	1
4	Electrician	4
5	Firewood Vendor	1
6	Fruit Vendor	4
7	Furniture Maker	1
8	Old Bottle Collector	1
9	Old Paper Collector	1
10	Plumber	2
11	Tailor-Part Time	1
12	Vegetable Vendor	11
13	Vegetable/Fruit Vendor	3
	TOTAL	33

TABLE-25D
Classification of people of Sudhama Nagar doing Jobs with Daily Wages

Sl.No	Job	No
1	Cargo Work	1
2	Casual Work	2
3	Coolie-Construction	2
4	Coolie	84
5	Helper in Minilorry	1
6	Mason	10
7	Painter	10
8	Token Coolie in HAL	4
9	Part Time Job in P&T	1
10	Part Time Job in Private Co	1
11	Wire Bending	1
12	Wood Worker	2
	TOTAL	119

TABLE-26
Classification of People in Sudhama nagar with Chronic Diseases

Sl.No	Disease	No
1	Asthma	7
2	Diabetes	5
3	Knee Pain	5
4	Migraine	4
5	Ulcer	4
6	Blood Pressure	3
7	Chest Pain	3
8	Dropsy	2
9	Ophthalmologic Complaint	2
10	Stroke	2
11	Joint Pain	1
12	Cerebral Palsy	1
13	Scaly Skin	1
14	Hypothyroidism	1
15	Uterus Complaint	1
16	Heart Disease	1
17	Piles	1
18	6-Fingers	1
19	Leg Deformity-H/O Trauma	1
20	H/O Accident&Head Injury	1
21	Cleft Palate	1
22	Renal Stone	1
23	Epilepsy	1
24	Throat Pain	1
	TOTAL	51

TABLE-27
Classification of Households in Sudhama Nagar based on the Type of Family

Sl.No.	Type of Family	No.	%
1	Nuclear	95	73.64
2	Extended	23	17.83
3	Joint	11	8.53
	TOTAL	129	100.00

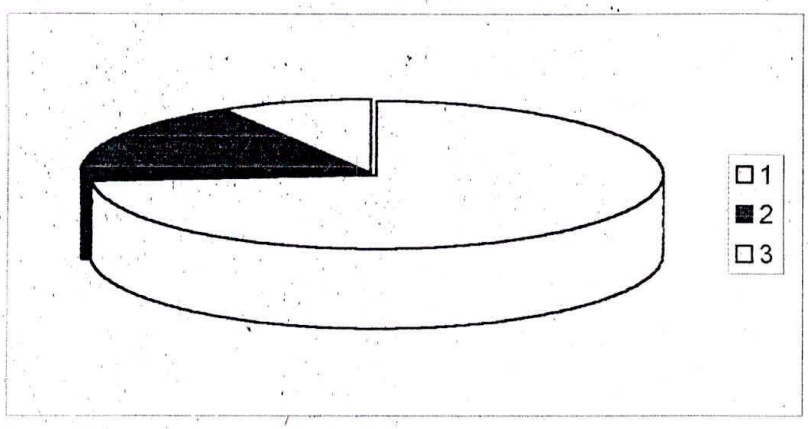


TABLE-28
Classification of Households in Sudhama nagar based on the Highest level of Education achieved by any one member of the Family

Sl.No	Level of Education in the family(Highest)	No	%
1	No Education	3	2.32
2	5-STD	7	5.42
3	6-STD	7	5.42
4	7-STD	13	10.07
5	8-STD	20	15.51
6	10-STD	54	41.86
7	12-STD	9	6.97
8	Degree	2	1.56
9	Diploma	2	1.56
10	9-STD	12	9.31
	TOTAL	129	100.00

Selection gate 16 ? CM

Only tables
No introduction summary or discussion !!
No profile generated of Problem drinkers or families
No RCH issues sveted as objective

ALCOHOL SURVEY

TABLE-1

Majority of the sample population of alcoholics whom I interviewed were below the age of 50 years, and all of them were working men.

TABLE -1
Classification of Sample population based on Age Group

Sl.No.	Age Group	No.	%
1	20--29	3	18.75
2	30--39	6	37.5
3	40--49	6	37.5
4	>50	1	6.25
	TOTAL	16	100

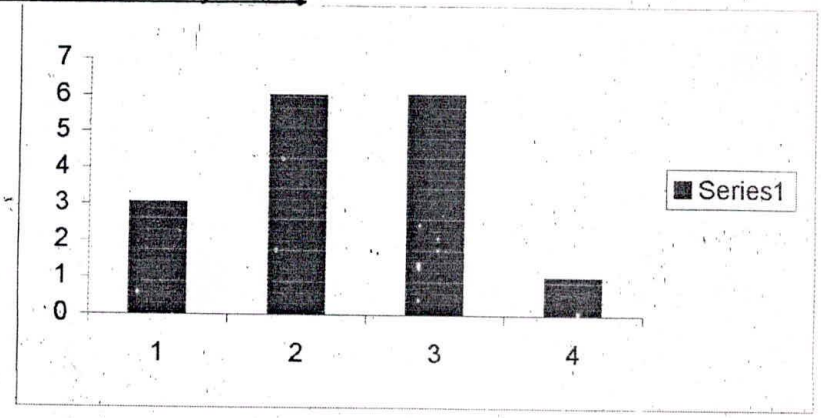


TABLE-2

More than 55%of the sample population were residing in the area for less than 10 years. This tallies well with the general demographic trend where 57.37% of the population are of less than 10 years residence in the area.

TABLE-2
Classification of Sample population based on number of years of residence in the area

Sl.No.	No. of years of residence in the area	No	%
1	0--5	3	18.75
2	6--10	6	37.5
3	11--15	4	25
4	16--20	0	0
5	21--25	3	18.75
	TOTAL	16	100

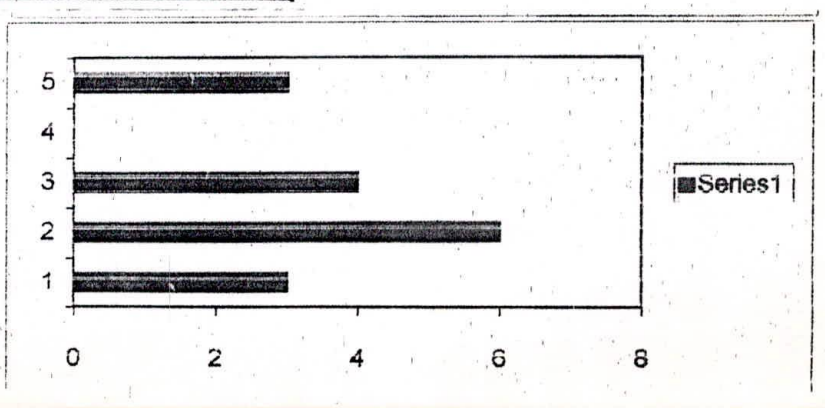


TABLE-3

Most of the sample population had own houses.(68.75%)

TABLE-3

Classification of sample population based on the type of ownership of house

Sl.No.	Type of ownership of the house	No	%
1	Own	11	68.75
2	Rented	5	31.25
	TOTAL	16	100

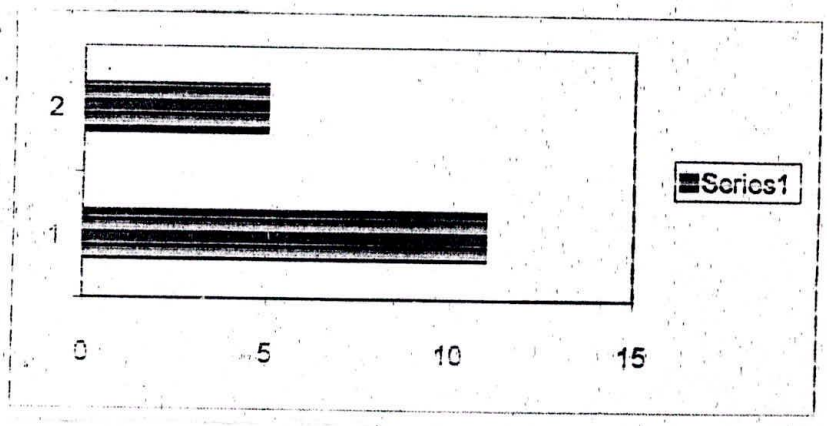


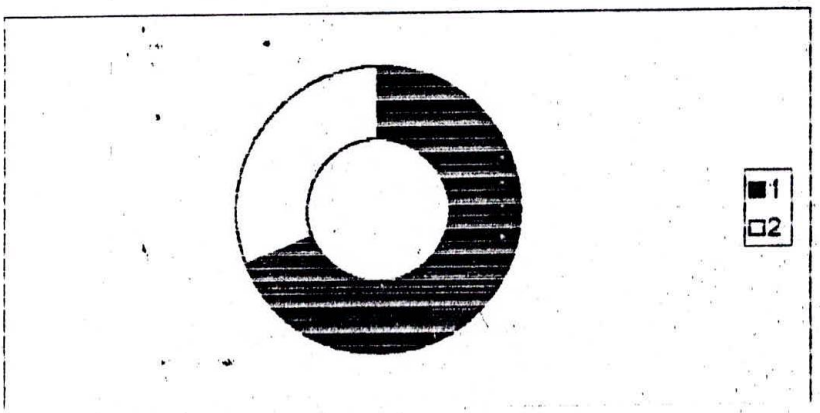
TABLE-4

These tables show a marked difference with the general sociodemographic trend. In the general population majority of the people are migrants from Tamil Nadu.But in the sample population, majority of the people (62.50%)are native to Bangalore.

TABLE-4

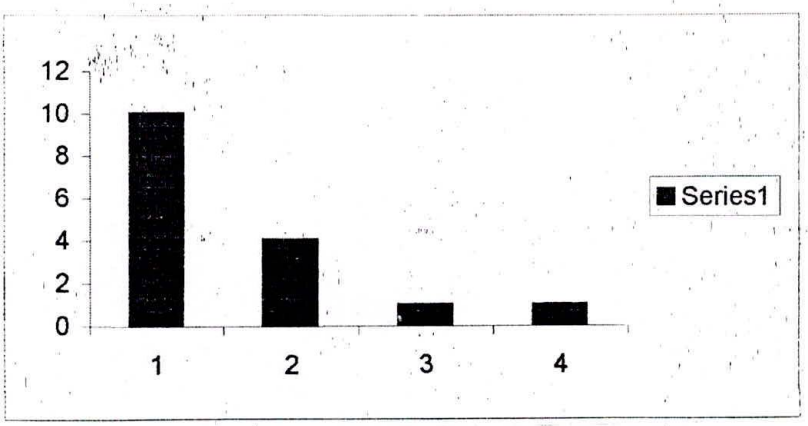
Classification of Sample population based on their state of origin

Sl.No.	State of orgin	No.	%
1	Karnataka	10	62.5
2	Tamil Nadu	6	37.5
	TOTAL	16	100



Classification of Sample population
based on their native District

Sl No	Native District	No	%
1	Bangalore	10	62.5
2	Tiru Annamalai	4	25
3	Vellore	1	6.25
4	Villupuram	1	6.25
	TOTAL	16	100



Religionwise the population was evenly distributed between Hindus and Christians.Caste/Denomination wise the sample population consisted of majority Castes/Denominations.

TABLE-6
Classification of Sample population
based on their respective religions

Sl.No.	Religion	No.	%
1	Christian	8	50
2	Hindu	8	50
	TOTAL	16	100

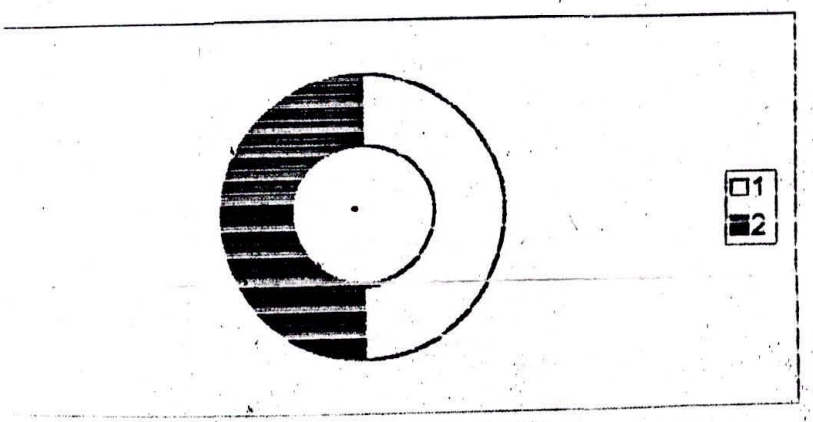
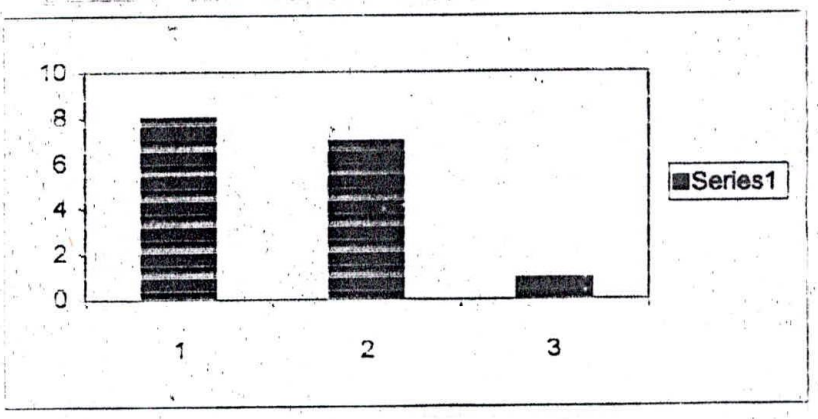


TABLE-7
Classification of Sample population
based on caste/denomination

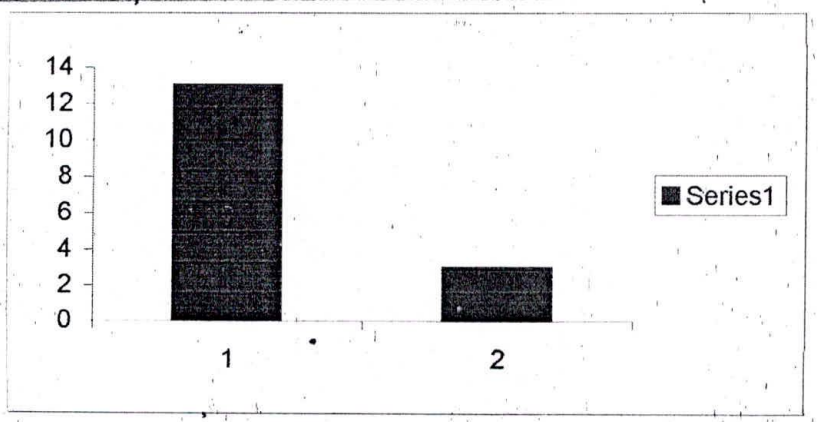
Sl.No.	Caste/Denomination	No.	%
1	Roman Catholic	8	50
2	Scheduled Castes	7	43.75
3	Vokkaliga	1	6.25
	TOTAL	16	100



All the people in the sample population had Ration Cards.81.25% of them had BPL Cards while the rest of them had APL Cards.

TABLE-8
Classification of the sample population
based on the type of ration card they possessed

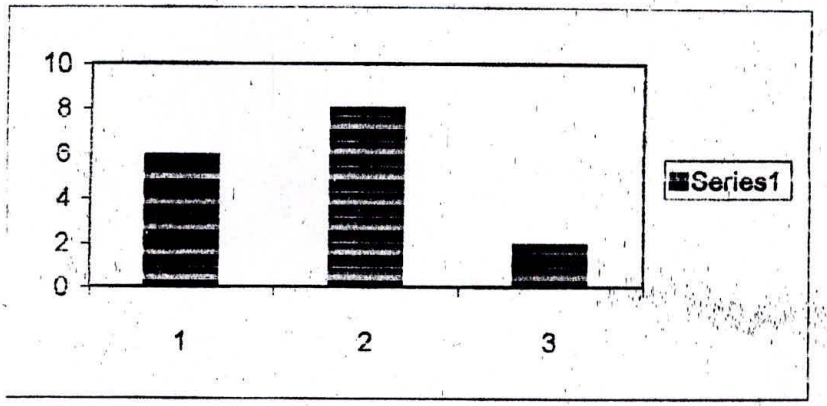
Sl.No.	Type of ration card	No	%
1	BPL	13	81.25
2	APL	3	18.75
	TOTAL	16	100



Most of the sample population consisted of people from lower income groups.None of them had a monthly income higher than Rs 4000/-while 87.5% of the sample population had monthly incomes of less than Rs 3000/.

TABLE-9
Classification of Sample Population
based on the Monthly income

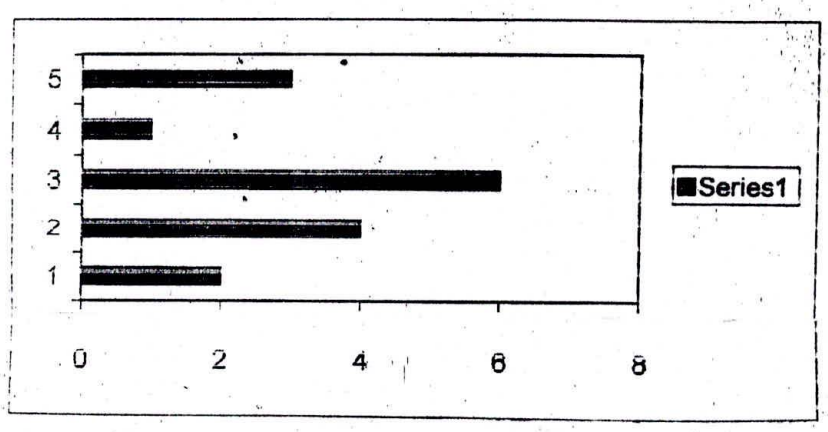
Sl.No.	Monthly income(Rs)	No.	%
1	1000--1999	6	37.5
2	2000--2999	8	50
3	3000-3999	2	12.5
	TOTAL	16	100



Three fourth of the sample population belonged to households with five or less than fivemembers.The maximum number of household members in the sample population was seven

TABLE-10
Classification of Sample Population
based on the Number of members in the Family

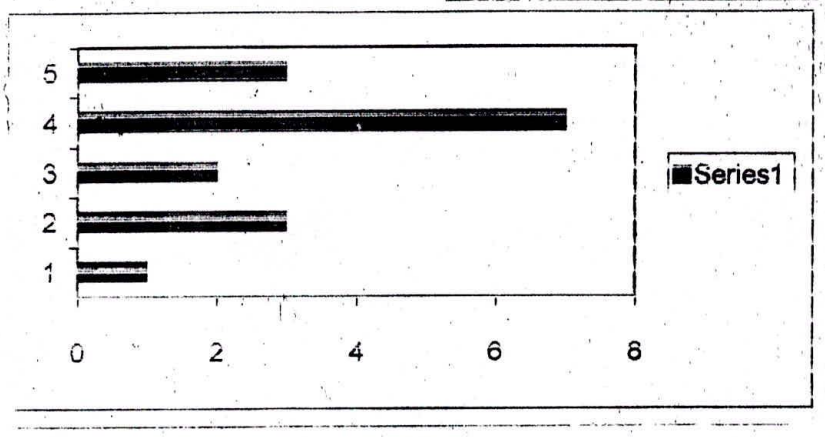
Sl.No.	Number of members in the family	No	%
1	3 m	2	12.5
2	4 m	4	25
3	5 m	6	37.5
4	6 m	1	6.25
5	7 m	3	18.75
	TOTAL	16	100



Most of the sample population consisted of Heads of their respective Households.

TABLE-11
Classification of Sample Population
based on the Number of dependents

Sl.No.	Number of Dependents	No	%
1	1 d	1	6.25
2	2 d	3	18.75
3	3 d	2	12.5
4	4 d	7	43.75
5	6 d	3	18.75
	TOTAL	16	100



Majority of the sample population had only less than fifth standard education(62.50%).The man with the highest education in the sample population had 9th standard education.

TABLE-12
Classification of the Sample Population
based on their Level of Education

Sl No	Education	No	%
1	No Education	7	43.75
2	5-STD	3	18.75
3	6-STD	1	6.25
4	7-STD	2	12.5
5	8-STD	2	12.5
6	9-STD	1	6.25
		16	100

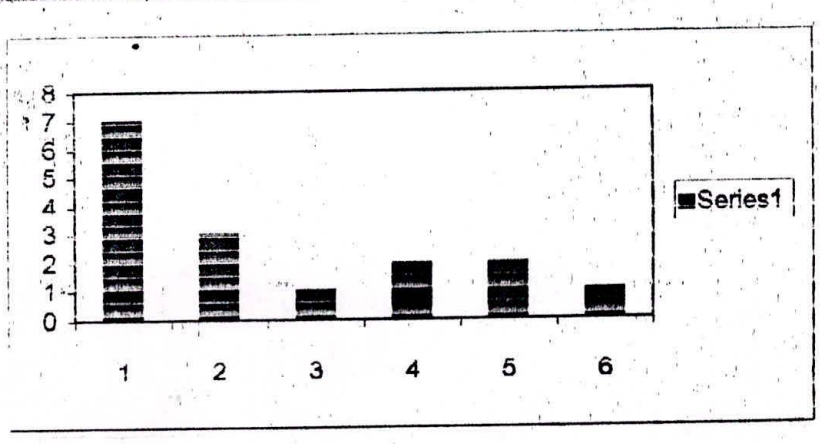


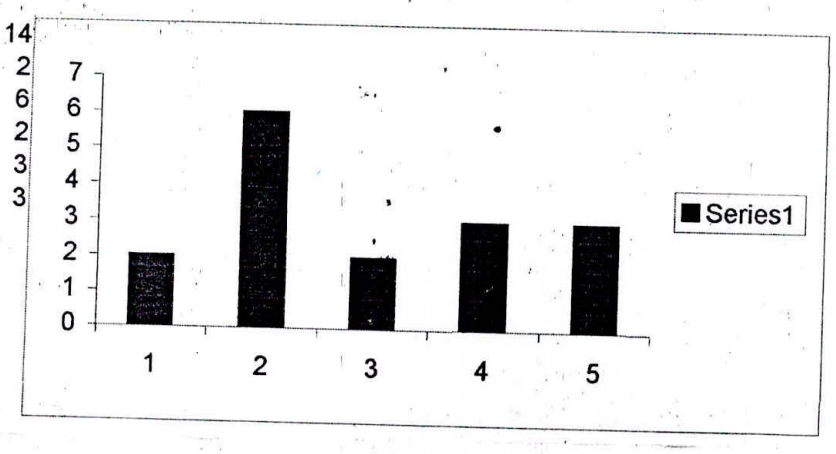
TABLE-13 shows the type of alcoholic beverages preferred by the sample population.68.75%of the sample population preferred either Brandy or Whisky.62.50% of the sample population had high frequency of alcohol consumption ranging from 3-5 times a week to several times a day.

TABLE-13
Classification of the Sample population
based on the type of Alcoholic beverages they preferred
to drink

Brand	Brandy	Whisky	Rum	Beer	TOTAL
Brandy	6	—	1	—	7
Whisky	—	5	—	2	7
Rum	—	—	1	—	1
Beer	—	—	—	1	1
TOTAL	6	5	2	3	16

TABLE-14
Classification of the sample population
based on the frequency of drinking

Sl.No.	Frequency	No	%
1	Several times daily	2	12.5
2	Daily or 6 days a week	6	37.5
3	3--5 days a week	2	12.5
4	2--3 times a month	3	18.75
5	Less often	3	18.75
	TOTAL	16	100



Most of the sample population preferred to drink in a bar (75%).Only one of them drank while at home.

TABLE-15
Classification of the sample population based on the place where they prefer to drink

Place	Bar	House	Others	TOTAL
Bar	12	1	–	13
House	–	–	–	–
Others	–	–	3	3
TOTAL	12	1	3	16

TABLE-16
Classification of the Sample population based on the previous attempts made to stop the habit

Sl.No	Made attempt	No	%
1	Yes	9	56.25
2	No	7	43.75
	TOTAL	16	100

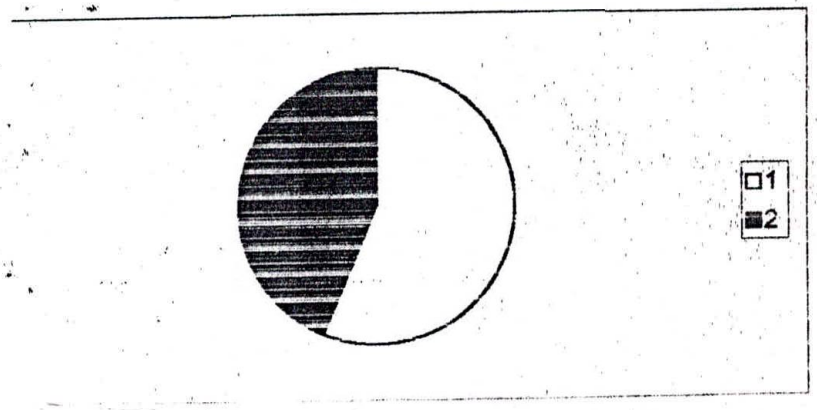


TABLE-17
Number of people from Sample Population who had familiy problems with wife

Sl.No	Problem/No problem	No	%
1	Problem with wife	11	68.75
2	No problem with wife	5	31.25
	TOTAL	16	100

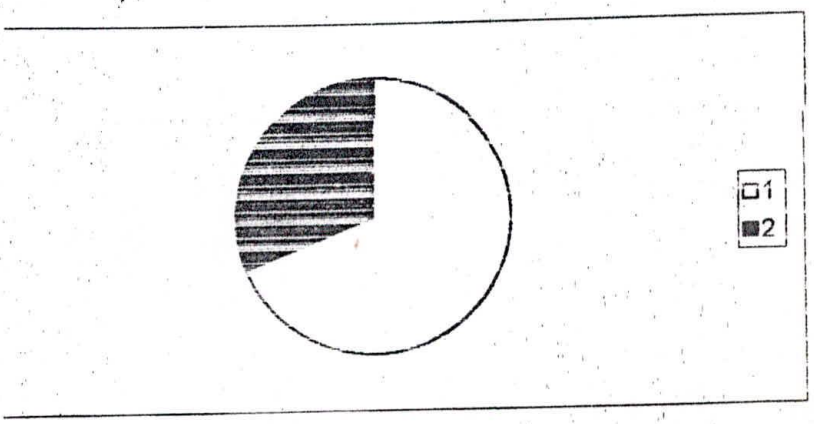
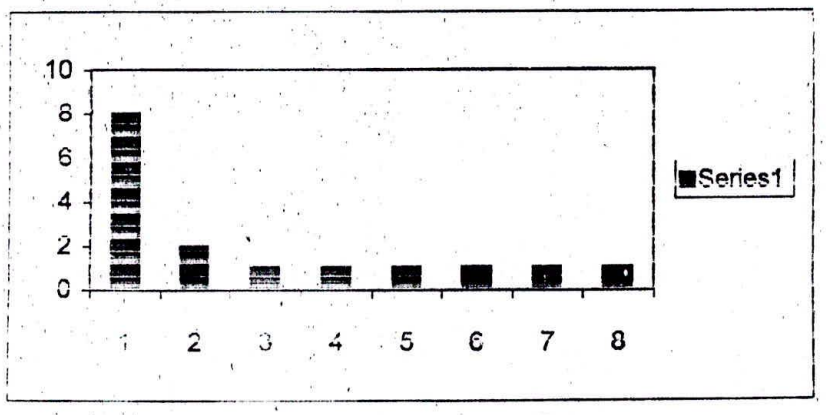


TABLE-18
Classification of the Sample population based on their Employment

Sl.No	Employment	No	%
1	Coolie	8	50
2	Mason	2	12.5
3	Contractor	1	6.25
4	Factory Worker	1	6.25
5	Old paper collection	1	6.25
6	Street Vendor	1	6.25
7	Token Coolie	1	6.25
8	Vegetable Vendor	1	6.25
		16	100



Discussion?
Conclusions?

Appendix 1

Life skills and Alcohol Prevention Programme

Life skills approach is an interactive educational methodology that not only focus on transmitting knowledge but also aims at shaping attitudes and developing interpersonal skills.

Goal: - The main goal of the life skills approach is to enhance young people's ability to take responsibility for making healthier choices, resisting negative pressures and avoiding risk behaviour.

Objectives: -

1. Provide youth with necessary skills social (peer) pressure to smoke and drink.
2. Help them to develop greater self-esteem, self-awareness, self-responsibility, self-mastery and self-confidence.
3. Developing their positive social skills, critical thinking and decision making skills.
4. Enable youth to effectively cope with social anxiety.
5. Increase their knowledge on the immediate consequences of smoking and drinking alcohol and training them to protect themselves from substance abuse, violence and other harmful influences.
6. Empowering them to take charge of themselves and our planet's future.
7. Enhance cognitive and behavioural compliancy to reduce and prevent a variety of health risks and behaviour.

What are the Life skills to be evolved in the interactive session?

Life skills are behaviour patterns that enable individuals to adopt and deal effectively with the demands and challenges of life. The content of the life skills, which will increase the ability to

- make decision
- solve problems
- think critically and creatively
- communicate
- listening skills
- build empathy
- be assertive and negotiating
- cope with emotion and stress
- be self aware

- goal setting
- getting along with others
- gaining self confidence
- coping with conflict and other sessions like;
- types of group pressure; how to say "No"?
- relationship with members of opposite sex
- alcohol use and abuse
- tobacco and health related problems
- HIV-AIDS/STDs – human sexuality

This curriculum will be called "Learning to Live and Learning to Love"

Methodology: -

The teaching methods are youth oriented, gender sensitive, interactive and participatory. The most common teaching methods include working in groups, brainstorming, story telling, role-plays, debating and participation in discussions and audio-visual sessions.

Resource Persons:

1. Dr. Lakshman -Honorary
2. Dr. Sekar Sheshadri-Honorary
3. Dr. Mani Kaliath-Honorary
4. Mr. Rajendran-Main resource person
5. Mr. Chander-respective field expert
6. Dr. Rajkumar- respective field expert
7. Mr. Prahlad- respective field expert

Duration and Timing

Tentatively every Sunday and one and half hours to two hours (It will be finalized after discussions with the groups). The session will start on 21st July 2002 onwards.

Target One:

1. Sudhama Nagar (HAL)
2. Ragigudda Slum
3. L.R.Nagar (Koramangala)

Education and Monitoring

Dr. Lakshman and Dr. Mani will visit the areas and do the assessment work. Participatory evolution will be arranged at the end of the programme.

Appendix 2

A brief note on CHC's innovative experiment in tackling Alcohol Abuse

Community Health Cell (CHC) is a non-governmental Organisation with a group of resource professionals working in the area of community and public health, research, training and advocacy for the past two decades. CHC is the functional Unit of the Society for Community Health Awareness, Research and Action (SOCHARA).

Aims and Objectives of CHC

- To create awareness regarding the principles and practice of Community Health among all people involved and interested in health and related sectors.
- To promote and support community health action through voluntary as well as governmental initiatives.
- To undertake research in Community Health policy issues, particularly:
    - Community health care strategies,
    - Health personnel training strategies,
    - Integration of medical and health systems.
- To evolve educational strategies that will enhance the knowledge, skill and attitudes of persons involved in Community Health and Development.
- To dialogue and participate with health planners, decision makers and implementers to enable the formulation and implementation of community oriented health policies.
- To establish a library, documentation and interactive information center in Community Health.

CHC consists of a small core team of 18 people, including health and social science professionals, office and library team, research and training assistants, supported by a large informal network of professional associates and friends.

CHC supports community health action through

- Information and advisory services.
- Training and interactive discussions
- Participatory reflections and reviews
- Research and evaluation
- Peer group support
- Networking and solidarity
- Policy research, advocacy and action.

CHC has developed a rich and diverse web of interaction among person and groups involved in community Health in India & specifically in Karnataka. These include:

- Individuals in search of greater social relevance in health work
- Coordinating agencies in health in the voluntary sector
- Community health and development projects in rural areas, urban slums and tribal regions.
- Networking and issue raising health groups
- Development projects, networks and development training centers
- Government agencies and ministries at Central and State level
- National and international agencies supporting health action

To undertake research in community Health policy issues, particularly:

During 1999 – 2001 CHC was involved in the implementations of a World Health Organisation – South Asia Regional Office supported and Govt. of India sponsored project of Women's Health and Empowerment in 5 districts of Karnataka and a few slums in Bangalore.

During the implementation of this WHO-SEARO supported programmed, the importance of effectively tackling alcohol abuse" was often emphasized because alcohol abuse was identified as one of the major problems being faced by the community. CHC was requested to help in addressing this alarming trend.

CHC accepted this request and formed an NGO network with the assistance of the NIMHANS, Department of Psychiatry. A series of study, reflection, consultation and brain storming sessions at NIMHANS and CHC in this regard was conducted. As a result, of which a framework of community prevention plan using community health and development approach was developed with the participation of the community.

The focus now lies in creating a healthy community with the active involvement and participation of the community itself in attending to their needs and addressing public health problems like abuse of alcohol by members of the community. CHC believes that this can be made sustainable and effective with the collaborative effort of the community and other partners. The partners comprise of three NGOs and NIMHANS.

1. Sudhamanagar
2. L.RL. Nagar, Kormangala
3. Ragigudda Slum

The specific aim of this exploratory experimental programme is to tackle alcohol related problems in a broader community/public health and health promotional framework.

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Appendix-3

GOALS AND OBJECTIVES OF COMMUNITY HEALTH CELL

Community health cell (CHC) is an NGO working in the field of Primary health care at a policy and advocacy level. CHC works in association with other NGOs and Government and private health care organisations. It was established with the following objectives.

1. To create awareness – Especially among policy makers and public.
2. To promote action- Both voluntary and Government.
3. To Promote research- In community health, In health personnel and in Integration of different systems.
4. To promote changes in educational strategy to make medical education more appropriate and focused.
5. To conduct policy dialogues with appropriate authorities
6. To provide library services and documentation.