SOCHARA

Blooming Where it has Planted

Report of the CHLP

Shanthi D Souza

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Chapter I

[This is the report of Community Health Learning Programme fellowship. It has the mentioning of learning that took place in different aspects. It consists the learning that took from the classroom sessions, field experience, inner learning and the small study conducted during the programme.

A word of acknowledgment to Dr. Thelma, Mr. Chander , Dr. Yuvaraj, Mr. Karthik, all the SOCHARA team and my batch mates for helping me to have a foundation for my professional life.]

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Chapter I

Introduction:

C.E.M Joad a writer says when we think freely, think new and live a life, which is just, and giving respect to others makes the person to be civilized. This is also makes me to be special in life and value my life for a cause.

We may have many capacities and strengths in life but to bring out we need confidence, grace of God support of others, and an opportunity. This is what I feel; I got it in this one year being with SOCHARA.

The idea of joining SOCHARA sowed by the inspiration and guidance of Mrs. Lavanya alumni. It took few days to sink into the inspiration. Later decide to get into the cause of “Health for All”.

Sitting back I recalled the past work place where the incidents of discrimination in the schools for the reason they were born with HIV/AIDS, children who were labourers experiencing very little attention with regard to the nutrition and health, poor health systems in the backward districts of Northern Karnataka and epidemics of Malaria in Mangalore. This helped to get impressed to work for a cause of health.

A year spent in working with community where people were undergoing various diseases like communicable and non-communicable disease, can be prevented if the prior majors were taken. Therefore, to get experience and skill this fellowship programme was the best opportunity for me.

Since my childhood, I had the interest to be in the medical field but could not fulfil this desire. Now the opportunity came to the doorstep and I do not wanted to lose the opportunity. Therefore, I decided to join this fellowship programme.

To sprout a seed it needs the fertile ground with manure and water. The seed of desire sowed in me got the place to sprout in SOCHARA from December 2012 to December 2013. Now when I think back of the past one year I feel I have gained a lot and it helped me to prepare myself for this cause.

The main objectives were as follows:

- To learn and develop the skills required while working in health.
- To learn the public health systems in India, and the existing gaps in addressing health.
- To learn health as a right of all especially, of those who are neglected in the society like street children, people in the slum areas, people with mental health.
- To learn the status of the people, their problems in assessing the health facilities and their priorities in life

Based on my objectives I divide my learning into a few categories. They are

- Participatory Learning
- Learning in the field
- Self discovery
- Other experience in SOCHARA
- Research

1) Participatory Learning:

It was something new experience being in SOHARA. The experts would teach us from their many years of working experience. It did not remain only in transmission of knowledge from experts to the learner rather it was a participatory learning were both the expert and the learning were in the same scale of learning. It was an active learning wherein the learner also was given the chance to share the experience, which is comparatively very small. Yet the feeling was created that all are equal. The knowledge was given from the place where the learner stands in the particular topic.

I would like to give my reflection on the new topics that I have learnt here.

a. Community:

Previously my opinion regarding the community was that community is the place where people live together. However, the new insight that I got from Mr. Sam Joseph was that the community does not exist at all. It has to be built. The new definition that I learnt of community is that “Community is a set of interested individuals who share common understanding”. We have to build community around the purpose. So we cannot mobilize community rather individuals. Therefore, when they come together under a single purpose it becomes the community.

It is true when I look into my practical field experience. People who are with same problem will come together and it will unite until they get what their requirement. If we mobilize, the community people may gather but after a while, they will be not be interested and may say something wrong or negative and slowly they will go from that group and make the people who are with enthusiasm to lose their interested. Therefore, the group with the interest and with same issues will work together until they succeed in their demand.

b. Primary Health Care:

The Alma Ata conference, 6-12 September 1978, USSR, provided two further focus - one was the principle (and slogan) of Health For All 2000, with the obvious inference in respect of equality and equity, whilst the other was the primacy given to the primary care setting. It also incorporated a commitment to community participation and inter-sectoral action.

Before Alma-Ata, primary health care was regarded as synonymous with “basic health services”, “first contact care”, “easily accessible care”, “services provided by generalists” etc. The conference defined it, as “Primary health care is an approach ad has adopted primary health care through primary health centres. It is the essential health care based on practical, scientifically sound and socially accepted methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.”

The primary health care is equally valid for all countries from the most developed to the least developed. Primary health care is the key suggested to attain the target ‘health for all by 2000’.

PHC is not only primary medical or curative care, nor is it a package of low-cost medical interventions for the poor and marginalised. On the contrary, it calls for the integration of health services into the process of community development, a process that requires political commitment, inter- sectoral collaboration, and multidisciplinary involvement for success.

Every individual and community is responsible to participate in planning and implementation of the health care. It is their right as well as duty. The technology used must be accessible to individuals and families in the community. Unless there is involvement of people, it will not work fruitfully.
The main central function and focus is overall social and economic development of the community. The focus of the primary medical care had to take a shift to primary care.

The shift was like from

- Illness to health
- Cure to prevention and care
- Treatment to health promotion

- Episodic care to continuous care
- Specific problem care to comprehensive care
- Specialist to general practitioner
- Physician to other personal groups
- Single handed to team

Primary health care addresses the main health problems in the community. It is a promotive, preventive, curative and rehabilitative service for all who are in need. It has to include the education on health problems, methods prevent the diseases and controlling the prevailing diseases, promotion of nutrition and food, supply of portable drinking water, chid and maternal health care, basic sanitation, immunization, controlling the epidemic disease, proper treatment, and provision of essential drugs.

Health depends more on living conditions than on health care services. It also includes, in addition to the health sector, all related sectors and aspects of national and community development, in particular: agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors and demands the coordinated efforts of those sectors.

It requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control in making full use of all available resources. This is possible through appropriate education. It is sustainable by integrated, functional and supportive referral systems, and progressive improvement of comprehensive health care for all and by giving priority to those who most need. It also relies on local and referral levels, on health workers including physicians, nurses, midwives, community workers. Traditional practitioners are required in the health system. They must also be encouraged for teamwork, which will lead to achieve the goal of health.

A policy on the PHC Approach was therefore adopted by a Special Faculty Assembly in August 1994, which committed the Faculty to the following set of principles with respect to its education, research, and clinical service, and its engagement with communities:

1. Promoting **equity** in health care
2. Displaying **bio-psychosocial-cultural sensitivity** towards the patient
3. **Evidence-based** and cost-effective health care
4. **Health promotion** by means of information, education, communication, advocacy, participation and partnership
5. Treating patients at the **appropriate level of care**
6. **Multidisciplinary** health care
7. **Inter-sectoral collaboration** within society
8. **Community involvement** in asserting their rights and interests
9. Continual **monitoring and evaluation** of the effectiveness, efficiency and equity of health services

   Everything that is done in promoting health including reduction of poverty, unemployment, promoting education, sanitation and other basic needs are all helping for better health. These are actually contributing health care including the medical care. For good health the supply of portable drinking water, balanced diet, shelter, environment is contributing .All is coming under primary health care.

c. Health Indicators:

Studying the health indicators helped to know the various statics, which is required while working in the public health. It was useful while we read certain numbers makes to update self when we see some numbers, which represents certain figures. It makes us know what it exactly indicates.

d. Social determinants of health:

"I become sick because of my poverty, well; I become poor due to my sickness". The sickness determined with various other related causes. The social status, education, income, food security, gender, culture, environment, sanitation facility and place of shelter etc are a few which determinates of the health of the person. Therefore, the focus must be on these determinants, which will promote the health.

Being the health worker the role must be **turning of the tap rather than mobbing the floor**. To attain the health as a right for all there must be the **approach of equity** without neglecting anyone in the society. Where social and economic development exists there will be health among the people. It will be true the words said by **Karan Singh** an Indian politician in a conference about population control, **"Development is the best contraceptive"**. Therefore, for anything to attain or to control the development will play the major role.

e. Right to Health:

Health is the right of all the individuals born on this earth. Right to health is an affirmation for a standard of adequate living for health and wellbeing. Public health practice is heavily burdened by the problem of inadvertent discrimination in the society. The discrimination is much in the country and it is one of the main reasons for the people in assessing the health system. The discrimination is based on colour, race, caste, poverty etc... To have the right to health the focus must be on the issue of discrimination. Therefore, it should be addressed.

f. Epidemiology:

Epidemiology is the study of the distribution and determinants of disease or health events in human population and the application of that knowledge to improve health. It helps in knowing the condition of health and the various risk factors influencing health. The epidemiology traits must be understood very well. The three are Agent, Host factor and Environmental factors. The agent remains the same whereas the host and environment can be changed to prevent from diseases.

g. Integrated Health System: India is the country where the health was taken from old even before the allopathic medicine was introduced. So, the integration of various medicine will promote health among the people. In the rural areas, assessing the health system is also major problem. The tradition medicine that was followed by our ancestors needs recognition and encouragement keeping in mind the health of the people. The concept that the people bear in mind only the allopathic medicine is curing the diseases must be changed and the integration will help in this process.

h. NRHM:

This is a major step by the UPA government in promoting the health of the mother and child. This is a mission to reduce the mortality and address the morbidity of women and children in the rural areas of the nation. This helps the women to easily assess the health care facilities and in an equitable manner. Yet there are gaps in the implementation, pooling resources, and economically. To have the success of this programme the community participation, capacity

building, flexible planning and monitoring the progress is needed. Only then, there will be success and good result. Communization is the main key in reaching out to the people in the health system.

2. Learning from the field work:

As per the individual interest to work with children who are discriminated of their rights in the society, the basic study on United Nation Convention on child rights done. The brief summary was prepared on the child rights. The summary is below;

a. Child Rights:

Child is the human being below the age of 18 as per the legal law of the country who has the right to live, survive, develop participate and of protection. In 1923 the founder of Save the Children, Eglantyne Jebb summarized the rights of children. Later in 1924, her declaration adopted by the League of Nations and it became the Declaration of Geneva.

After the World War II the United Nations focused on preparing the Universal Declaration of Human Rights in 1948 due to the atrocities in the country, which includes the rights of the child, was insufficient and the special needs of the children documented separately.

In 1959, the UN General Assembly adopted the second Declaration of the Rights of the Child. This consists of ten principles to work best for the child. It found that it was only the legal statement. The UN General Assembly adopted the UNCRC in 1989, after thirty years of 1959 Declaration. On 2 September 1990, UNCRC entered into force as international law. The UNCRC works to bring about a world in which every child attains the right to survival, protection, development and participation

Objective of UNCRC:

The UNCRC objective was to protect the child from all sorts of discrimination, neglect and abuse. It is the principal children's treaty, covering a full range of civil, political, economic, social and cultural rights. It gives right for children in peacetime as well as during armed conflict, and provides for the implementation of the rights. The Convention serves as a useful tool for civil society and individual people, working to protect and promote children's rights. In many ways, it is an innovative instrument.

What it says?

The UNCRC focuses on giving the special care, protection of children. It recognizes that children have the human rights too. It consists of 54 articles and two optional protocols. It mainly focuses on right to survival, health care, education, legal, civil and social survival, develop to the fullest, protection from harmful influences, abuse and exploitation, and participate fully in the family culturally and social life. All children have the same rights.
Almost every country has agreed to these rights. All rights related to each other, and all are equally important. Sometimes, we have to think about rights in terms of what the best is for children in a situation, and what is critical to life and protection from harm. As the person grows, everyone has more responsibility to make choices and exercise the rights.

It says that the child has the freedom to live exercise what it likes without harming the other persons feeling. They have the right to be with their parents and even to have the contact with both the parents if they are living separate. They have the right to make their own decision for their life. There has to be no discrimination between the boy and girl.
They have the freedom to share their views, information, and receive the information through reading, writing, talking and drawing by giving respect to others. They can form their own associations; follow the religion that they like.

The parents have the responsibility to take care of their child and protect them from discrimination, child labours, use of drugs and other social problems. They are to guide and direct them to grow, learn and use their rights properly. They have no freedom to take the child away from their families.

It is the responsibility of the government to social services, legal, health and educational systems. They are to provide unique identity, name that recognizes the person as the part of the nation and their nationality. They are to allow them to be with parents if they are in other countries.

They are to be protected illegally sending to the other countries. The convention has optional protocol on the sale of children, child prostitution, and child pornography has the provision that concerns abduction for financial gain.

Ground reality

Present situation it does protect the child yet the ground realities are not as per the convention. When we glance at Indian reality, where there are more than one-third of their populations below 18 years who are highest in the strength we find that

- Only 35% of births are registered, affecting name and nationality
- One out of 16 children die before they attain the age of one, and one out of 11 die before they are 5 years old
- 35% of the developing world's low-birth-weight babies are born in India.
- 40% of child malnutrition in the developing world is in India
- The declining number of girls in the 0-6 age group is cause for alarm. For every 1,000 boys there are only 927 females, even less in some places
- Out of every 100 children, 19 continue to be out of school
- Of every 100 children who enrolment, 70 drop out by the time they reach the secondary level.
- Of every 100 children who drop out of school, 66 are girls.
- 65% of girls in India are married by the age of 18 and become mothers soon after
- India is home to the highest number of child labourers in the world

  India has the world's largest number of sexually abused children, with a child below, 16 raped every 155th minute, a child below 10 every 13th hour, and at least one in every 10 children sexually abused at any point in time.

b. Child Welfare Committee:

Child Welfare Committee is the committee, which works for the issues related to children. The committee consists of five people who have contributed in the children's right.

CWC functions at different level concerning children. They are to rescue the children, hearings and rehabilitation.

Rescue:

The committee has the responsibility to rescue the children from various problems. To have easy access to the protection of children Child line started in 1997 at the Police Campus office in Bangalore. When a child is in danger or in problem, anyone can call to 1098 and express the situation. The committee has to go immediately to rescue the child.

Hearing:

It is the responsibility of CWC to have the hearing of the child after the rescue. They are to hearing the child with lot of compassion and make a plan for that child. They are to find out regarding the child's family through home visits and see whether the child can be reunited to the family. If they find the home is not a safe place then the child can shift to any other rehabilitation institution either governmental or non-governmental where the needs of the child's are met.

Rehabilitation:

The child is to rehabilitate in other institution where the child is safe and secure. There the rights of the child need to uphold. The Committee has the right and responsibility to give permission to the institution to keep the minors and the institution has the responsibility to report to Committee regarding the whereabouts of the child and its plans. They will see that the child gets education and all other rights.

The CWC can hold the institution responsible if the rights of the child violated. They even withdraw the permission of the institution to run.

Some of the Challenges:

- The people responsible wait for the hearing to start for a long time.
- People are not given adequate shelter facilities especially to those parents who travel for a long distance to meet their child.
- Sometime the children are reunited but they are not in the safe place.
- When the hearing takes place people come as their parents but they are not their parents, actually s they go back to the same trade again. E.g. child labour, child prostitution etc.
- There are many run away cases because they do not find a friendly place to be in the governmental homes.
- Children who are in the shelter home fail to get the needed plans and training to be on their own feet.
- There are children who sent out once they reach the age of 16. No follow-ups done and they end up in the wrong places.
- The delayed committee meeting really disturbs the parents and children and makes to feel anxious about various things as if they have to focus on the other members in the family. Therefore, they give up coming for the hearing and the case postponed for some other day. This affects the child in all levels. This creates the feeling of insecurity, neglected, etc.

c. Interview with Mrs. Branda:

To have a background of the contribution of Mrs. Branda made in the child right promotion this interview conducted on 25/02/2013. She was formerly working with Bosco for the children. Then they initiated the camps for the children rescued from the streets, hazardous work place etc. and kept them in Raichur for a month and later sent to their own homes back. Presently it works in the name of SAATHI in Raichur. She also contributed her share in starting the child helpline. Now she has the Organization "Global Concerns India" which works for the women and children in Bangalore.

There was a discussion on the role of the CWC. Her team started the present child helpline in 1997 with the name called Makala Sahayavani in the Police campus Office in Bangalore.

The Juvenile Justice Act 1986 was too rigid and limited in its role and functions. The children who are suffering not rescued from the field for the reason that the law does not provide with necessary provisions. Therefore, they went beyond the law and beyond the Child Welfare department in order to have better effect on the protection of children the problem discussed and the new amended act came into force in 2000 and she was a part of this meeting. In this meet, the possible extended plans were included in rescuing the children. It took place in the year 1998-99. The bench of Magistrate selected from the NGOs with different background of studies. They are to respect the child and made to feel that the child feels comfortable and secure in their presence and shares the pain freely.

Since the police were contributing the large share in the rescuing, they prepared the manual for a child friendly police, in which the training given to the police in handling the children. This is a major contribution for the child rights by her.

However, in reality it was not happening as it was supposed to be. Therefore, she even had filed case against the CWC in which she won the case.

As for her, there are certain drawbacks in the functioning of CWC wherein the registration of the child takes place but the further actions not taken like;

- Doing the home visits
- Real focus on the children is lacking.
- Based on the capacity of children training are not given.
- Once they reach 18 years, sometimes they leave from shelter home, which has damaged the life of the girls.
- Real growth of the child is not taken care.

d. Visit to Makala Jeevodaya:

The visit paid to Makala Jeevodaya along with Mr.Chander and Karthik to introduce and to plan for the fieldwork. Sr. Mercita in charge of the organization said the children are available in the evening time and requested to help them in their studies, since the exams are nearing she suggested that the group therapies could be done during their holidays.

Therefore, the evening time was with children in teaching Mathematics, English. It was good to be with the children and to help them not only academically but also to help them in dealing with each other and regarding the maintenance of the hygiene.

The basic understanding of the background of the children:

- Children are denied of their rights in the families.
- They did not have two meals a day when they were in their families.
- They were not sent to school rather they were made to work, beg, look after their younger ones.
- Due to the behaviour of the parents, HIV/AIDS the children are with family stigma.
- They lacked the security in their families.
- Some children were abused by their family members
- For some children, the family people and relatives even planned to kill them.

Due to the psychological, physical, mental pressure and the denial in the past,

- They have lost the interest in studies and even they find very difficult to cope with their studies, with each other.
- Some have become violent and fight with each for the little thing that goes wrong with them.
- Their cleanliness level is also not good though Sister supervises them.
- Give the guidelines regarding self-caring, which will improve their personal health.

e. Meeting on Urban Health with Women's Voice:

There was a meeting held on the issue of urban health in the community, by K.K.N.S on 26-02-2013 for which we were a part of. Mr. Chander, Dr. Mahesh, Mr. Madhu and nearly 20 voices from the community were present. It was an interactive session.

During the meeting

- ✓ Concept of health,
- ✓ hazards in maintaining health,
- ✓ concept of NUHM, and
- ✓ Their suggestion for the NUHM, were the few points of discussion.

The following are the suggestion by the community people.

- ➢ Idea of starting new hospitals to give up and strengthening of the existing government hospitals
- ➢ Increase the daily wages of the people, so that can have the secure life in the present situation.
- ➢ Provide free medicine
- ➢ Discourage the concept contract labour in the hospitals.
- ➢ Removal of User's fees
- ➢ Construction of the toilets in the slum areas
- ➢ Provide clean portable drinking water.
- ➢ Keep clean the environment and waste management.
- ➢ Maintenance of the govt. hospitals and its cleanliness

By the sharing from the people in community, it is clear that in Bangalore the poor are, denied of their basic rights of accessing the health facilities in the PHCs and other public hospitals. They too have no proper sanitation; portable drinking water and management of removing waste in the surrounding areas where they reside is not taken care due to which there is increase of diseases.

They also face lot of problems from the community representative, doctors in the hospitals, nurses and other officials. They feel fed up of the government health facilities. Due to certain discriminations, they prefer to go to the private hospitals where they avail the facilities though it too costly. On the other hand, they are unaware of the silent discriminations on them by taking a lot of amount.

f. JAAK meeting:

The JAAK BU meeting attended on 28.02.2013.Dr.Sadhana, Dr. Harshavardhana, Dr.Nirmala- Dr. Ganga Laxmi, Mrs. Nazima Begam, and Mrs. Sudha were the guest of honour of the day. The main purpose of the programme was to keep the demands of people before the officials in order consider them in NUHM programme.

This meeting helped to know more about the present scenario in the urban areas. It increased the awareness of people who live in Economically Weaker Areas. The interactions with the people and listening to the cases came to know that the people are, deprived in the PHC and other referral

hospitals. In their areas waste removal not done. Whole day some people of community go to remove waste in other areas but in the night, they live in the area where they again surrounded with waste. This has contributed in the increase of diseases. It is also very painful to listen to the cases of the people who feel denied of their basic right for health. There is need for more people to intervene in urban areas in promotion of the basic facilities for the poor people.

The people who are working at the grass root level feel community participation and constantly enquiring about the PHC is must for better functioning of PHC. The people are, made to pay bribes in the government hospitals that need action.

g. Learning Primary Health Centre:

To learn the PHC Beguru PHC visited. The main objective of learning was to know the present health system in the ground level and its reality in reaching out the people.
This visit helped to know the basic information about the PHC and the various programmes takes place in the PHC. Presently it does not work well for the reason that, there is no medical officer in the hospital. Yet the services like

- Delivery 24/7
- Sputum test
- Medical treatment for the common sickness like fiver, cold and cough
- Diagnosis of Malaria

The Doctor visits the PHC weekly twice on Tuesday and Friday from Bommanahalli PHC. He does check up of the patients.

Observation about the PHC:

- Many people do come to the PHC for treatment for the reason that it is very close by.
- People feel the health system that they have is their own.
- The feeling that it is for people exists among the people.
- The major share in the promotion of the health is, contributed by the PHC. Therefore, the people have the confidence especially those people who are elderly in that area.
- They have trust in the medicine that has given in the PHC because it is bought every year.
- In spite of the absence of doctor, the basic treatment is taken care.

Limitations of the PHC:

- The cleanliness of the PHC is poor in spite of the presence of the sufficient staffs. The drainage system is, not taken care and the waste is burnt in front of the PHC.
- Since they suffer from the shortage of water, they refer the patient to other governmental hospitals.
- The wastewater is, left in the open space. There is no proper closing of the water flowing pits. As a result, there is increase of mosquitoes.
- Due to the insufficient water, the delivery cases referred to other government hospitals. Therefore, the women with labour and the relatives face the consequences.
- Sometimes dealing with the patient is harsh from the part of staff. They are yet times scolded and made to come to the PHC over and again without any treatment.
- The staffs lack in punctuality and they leave the PHC before the time like around 1 O'clock or two.
- There is no provision for the patient to use the toilets due to the scarcity of water.

Interaction with Nurse:

There was an interaction with nurse to know challenges that; they do face in the PHC. They are happy being a government employee yet they too have certain challenges.

- Lack of security in the nights,
- water problem,
- Night shifts where only two people are involved and there is no presence of the permanent staff.
- Insecurity of the job. They are contracted nurses under NRHM.
- She feels that the area is very dangerous and risk involved because they are alone at night and there is a possibility of anyone arriving in the midnight and it would harm them.
- Due to the absence of the doctor, they feel risky in conducting the delivery. She admits saying that she is not so competent for the same.
- Now after the training for the period of one month and doing the delivery practically has helped her in gaining the confidence.

From their viewpoint, it is difficult for the nurse where she has to work without any security and for low salary. Since only nurses appointed under NRHM, they are to take shift day and night. So, it is difficult for them. Since there is no proper supply of water, it is causing them problems. They also lack the co-operation from the group D workers who fail to do their responsibility especially in the maintaining the cleanliness of PHC.

Views of people in the Community:

To know more about the PHC from the viewpoint of the community the home of the locality were, visited. Community people had something good to say of the 7-10 years back experience. Nevertheless, later they were not very happy with PHC. They feel that, the PHC is not promoting health care rather

- They are asking them to pay towards the treatment.
- Doctor prescribes the medicine from the medical stores, which is nearby, and run by the relative of the doctor.
- Poor feel neglected in PHC.
- The patients feel that they have to wait if the time is over.
- PHC is, not opened on time and the doctor does not come on time and on the fixed days.
- They are not happy with the maintenance and cleanliness.
- They feel that the information with regard to the arrival of the doctor is, not given clearly.
- They go to the medical store for the minor aliment and for major they go to clinic with the feeling that they can avail better treatment; in clinics with the same cost that is collected in PHC.
- The people need the education regarding cleanliness, sanitation, health promotion.

Dialogue with Mr.Venkatraj the health Inspector of Beguru PHC:

- His responsibility is to visit the community, give health education with regard to the cleanliness of the area, water, sanitation and surrounding.
- He checks out the cleanliness of the public tanks and spray of medicine during the incidence of diseases.
- He organizes various awareness programmes under the National Health Programmes from District health Office Funds.
- He also focuses on the IEC Programmes (Information, Education, and Communication) in the area through poster, literature, flipchart, and palm lets.
- Lavani programmes through mono act, drama, street play etc.

- Health education in all the institutions covered under their PHC.

Observations:

- He does contribute to the cleanliness of the surroundings.
- People do have positive feelings towards his work.
- In spite of the lack of good health, he contributes his share in the promotion of health.
- He conducts the health education in the schools.
- The focus on the sanitation facility not promoted.
- The focus on community education for health, cleanliness has not reached to people in a satisfactory level and they still require it.

Interaction with Mrs. Shanthamma LHV:

There was interaction with the local LHV Mrs.Shanthamma. She mainly focuses on the visit to the community, identifying TB patients, follow up, educating the mothers about ANC, PNC, and Family Planning. She also supervises the Sub-centre, Anganwadies, utilization of funds of the PHC, welfare programmes for community and PHC etc. She has the role in focusing on the promotion of health education in both Government and Private Schools on all diseases and cleanliness.

Learning:

- It gave the idea with regard to the work that the LHV do in Karnataka.
- She acts like the ASHA in the community who is more people oriented and does for the welfare of people.
- Interested in promotion of health
- Sees the better functioning of PHC
- She acknowledges that, doctors and the group D workers are taking amount from people who come for treatment.
- With her sharing, it found that health committee had taken action on medical officers when they failed in their responsibility.
- She is interested in making sanitation facility for the anganwadi children.
- Due to the lack of funds for travel expenses from PHC, she feels difficult.
- Since the PHC comes under urban area, they do not have the ASHA workers.

Visit to the local Anganwadi:

Beguru Anganwadi is having 40 children. On the day of our visit, there were only 18 children and others were absent. When there is supply of water parents do not send their kids.
The anganwadi has the contribution from the community. They have contributed chairs, play articles, and sometimes the vegetables etc. They have a committee that meets every month and discusses on better functioning.

The following programmes conducted in the Anganwadi:

- Kishori Programme – two girls who are with low weight selected from the area and given the food from ICDS for about six months. At the hobli level, there are 39 anganwadies and the beneficiaries of this scheme are, brought together and given health education every month.
- Nutrition Education
- Mothers Meeting
- Quarterly Health checks up.
- Mahithi seve on immunization, nutrition food for pregnant women, and taking care of newborn babies given

- Distribution of Food under ICDS Programme

As per the observation, the following problems occur in the Anganwadi:

- Water problem
- No sanitation facility for the kids and they either have to go to their homes for needs or use the open space.
- They lack enough place for the outdoor games.
- No compound walls
- When there is supply of water both the Anganwadi worker and helper go home locking the door and making, the children sleep.
- They make the children sit quietly when worker is doing her work without teaching them anything.

Doubts:

??? Though the anganwadies get the amount for food, yet they give same food everyday without any vegetables in it. Aren't they given any menu for the providing of the food?

??? Since they are in the Community hall, they wait for the local Co-operator to provide them with sanitation facility. Don't they have any provision for construction of toilets under Anganwadi?

- **Visit to Singsandra PHC:**

We visited Singsnadra PHC and interacted with Mr. Subhash the administrator. There are 30 staffs working. Three are under the Punchayats so there are three ASHA Workers among 10 sub centres. They treat for the following diseases. They are:

- TB
- Leprosy
- Malaria
- Cataract
- Immunization, ANC and PNC
- Delivery 24/7
- They also conduct the eye and dental check up in the PHC and problems with eyes identified and referred to Private eye Hospital for follow up.

Observation:

- There are many people coming to the PHC for treatment.
- The treatment is very good as per the opinion of the people.
- The community people do contribute in the better functioning of PHC.
- Nearly 200-250 patients treated in the PHC every day.
- Under the NRHM Programme, only normal deliveries conducted and complicated cases are, referred to other hospitals.
- The Medical Officers attend the delivery in case it takes place during the day and not otherwise.
- The cleanliness of the surrounding not maintained well.
- They also face water problem.
- They have drug shortage during which they buy from other PHCs where there is less usage.
- They also promote health education.

Doubts:

Is it the doctors should be attending the delivery cases if it takes place during the night under the NRHM Programme?

Visit to the Community:

Along with the Sub centre, Mrs. Saroja the ANM visited the community. We paid visit to the houses of TB patient to distribute the DOTs and supervise their regular intake of DOTs. The visit also paid to the families of newborn babies during which the awareness given with regard to caring of babies and immunization. In order to recognize the pregnant women all the suspected houses visited and informed them about schemes available.

My Learning:

- ✓ Youth are more prone to TB in this area.
- ✓ TB is spread in the work place
- ✓ The immunity system is low among the people.
- ✓ They are migrants from other places.
- ✓ They come here in search of the jobs.
- ✓ My assumption is that since they come from the rural areas and due to existence of poverty, they earn and support the family gradually they fail to take good food for themselves.
- ✓ They live in congested areas where more people and less space.

Talk on "health of oneself and of family":

There was a talk for the domestic workers group on the topic of "Health of oneself and of family". There were 35 women present for the meeting.
There was a short interaction with regard to taking care of themselves and their family. Mainly the following points were touched upon:

- The definition of health
- Taking nutritious and balanced food that keeps the immunity good.
- Discussed on the food that gives vitamin, protein, calcium etc
- Maintain cleanliness of their body especially during menstrual period.
- Social determinants of health
- Points to take care of children in the families

Medical Pluralism:

There was a small interaction with people to learn about medical pluralism.

- People in this area when they are sick for a few days they do the home remedies.
- Some people get medicine directly from the chemist store.
- Once the disease is on the increase then they go to the government hospitals for treatment because the hospitals at their door step.
- They also go to the Ayurvedic doctor for treatment.
- When there is some bone damage, they go to the bonesetter in area behind Lalbugh.
- In times of mental health related problem, they still believe that some evil spirits on their body and they take to the temple priest and now they have come to know about this now they refer them to the counsellor who comes to APSA from BNI.

History of APSA organization:

The Association for Promoting Social Action (APSA) started in the year 1981 in Hyderabad with a vision of rehabilitating homeless children. As they started to work there they found many children migrating from Hyderabad to Bangalore due to poverty, running away from the homes etc. so to

protect these children Mr. Lakshapathi came down to Bangalore. When they came to Bangalore the place, where the current APSA office exists there was lake and nothing else around.

They started the Namma mane hostel with 10/10 feet. They had three children who were taking shelter in the hostel. They had financial crisis to run the organization, the Bangalore branch.
Mr. Lakshapathi in order to feed these children, he started to sell the groundnuts in Lalbagh park during the day. In addition, with the money that he earned would buy rice and vegetables and would feed these children.

Later Mr. Ram Kumar joined Mr. Lakshapathi in the same work and both did the same work. As the organization grew, they got the grants from National Child Labour Project from the central government. Gradually they started the network with other funding agencies national as well foreign funds like

- Norway- FOURT Funding Organization
- Central Government Project 1098
- ADD

Presently with that, they run the organization and they have many projects like

- Dream school
- Nammamane hostel
- Skill Training Centre
- Child line etc

The staff structure of the organization is as follows:
Founding Members Mr. Lakshapathi

1. Executive Director Mr. Lakshapathi
2. The Associate Director Mr. Ram Kumar
3. Director Mrs. Sheela
4. Coordinators- 12
5. Assistance Coordinator
6. Staff
7. Field Activist
8. Community organizer--- Presently it is cancelled
9. Promoter--- Presently it is cancelled

Anganwadi Supervised by APSA; My Observation:

- ✓ The anganwadi workers are used for other works too where they cannot fully focus on the development of children alone.
- ✓ Only one person has to give attention to the 25 children.
- ✓ They also have to see to the distribution food to the pregnant and lactating mothers.
- ✓ Sometimes the children are taken back home without having informed to the worker or helper. They have to run behind them to look the children where they are.
- ✓ They have to maintain the various documents may it be of food distribution, health check up details, weight and height details, immunization details etc…
- ✓ Comparing to the other anganwadi in Jai Bhuvaneshwari this is better and has better facilities and the documentation is good.

- ✓ Here the children do not have much safety because it is on the roadside and children they run out every now and then without the notice of staff.
- ✓ They are given better food.
- ✓ The worker is paid Rs.5000/- and helper is given Rs. 2500/-.
- ✓ They are with an anxiety because the new government has declared to give milk to the children in anganwadi and this may cause further problems from parents because they may demand to give that milk to homes. In the past when this project was run they had faced many problems and this is the experience of helper as she seen this before 15 years.

National Domestic workers Day:

We participated in the rally of the domestic workers on 'National Domestic workers Day'. It was good to be a part of the same through which came to know the networking in various organizations. The unity was showing they are all one for a cause with seeing the caste, colour, religion. This is really contributing for the unity. The rally and the demand that they placed before the group was really a concrete one and it is out of their experience they were their voice.

3. Self Discovery:

This is another unique experience and it learning of self. Various exercises like Johari Window, Giving constructive feedbacks, Solving conflicts, and life skills were taught and learnt through various classes and being in the team and working in a team. All this has helped me to discover myself.

- Made me confident
- Helped me to be emotionally strong
- To keep Confidentiality
- To be satisfied
- To respect and value the other who is unique
- to resolve the conflicts
- Made me to be passionate and committed to the work

4. Experience in SOCHARA:

It was good and wonderful to be in SOHARA and it has given a base for my professional life. The interactive session made me to consider each and everyone's unique experience as something great that contributes in the development of the society. The friendly atmosphere for learning was a really appreciating.

My Suggestions:

- To have the change of place for field work for three period in different part of India
- To encourage the fellows to be in network with each other after the completion of the fellowship programme.
- To help the fellows in job placement across India.

Chapter II:

"A study on substance abuse among street children between the ages of 6-18 years in Bangalore slums."

Introduction:

Today the world is developing rampantly with new innovations. Developmental activities have been more in urban areas. In rural areas focus is mainly on agriculture. Due to various circumstances like lack of support for agriculture, low income generation, drought, natural calamities, poor services and facilities people living in rural areas have started migrating towards the urban areas.

The structural inequality that exists has caused people to move towards the cities. With the idea of development people have started to migrate from the rural areas to urban areas/cities looking for profitable jobs. The competition that exists in the society has made the people to take up the work that is of less income generating.

Low income generation and high cost expenditure have made them to take shelter in the slums. In the process due to financial instability and poverty people dwell in the slums and unhygienic areas where they really lack basic needs and get into jobs which are available. This also has led children to be on the streets and to be deprived of their basic rights as children.

The United Nation Convention on Child Rights describes every human being below the legal age of 18 considered to be a child. Child will be enjoying their childhood with love, care, encouragement from the family and will be learning in the school. As children they have the right for survival, health care, education, legal, civil and social survival, develop to the fullest, protection from harmful influences, abuse and exploitation, and freedom to participate fully in the family in the cultural and social life.

In spite of many rights, laws in the world and in country, the child is experiencing violence, exploitation, abuse, addiction, child labour, harassment, and feeling of desertion and so on,and it is on the increase. There are a number of children who have been deserted for various reasons and have made the street as their home.

Magnitude of the problem:

A study conducted in Surat slum in 1993 on street children among 300 children found 135 (45%) that were using substances. They mainly used smoking tobacco, chewable tobacco, snuff, injected drugs and inhalant.

A survey conducted by National Commission for Protection of Child Rights (NCPCR), reported that nearly 4000 children are addicted to inhalants alone below the age group of 15years. 35.1% street kids are addicted to substance abuse nationwide. .

A survey conducted by FXB India Suraksha in October 2012 amongst 120 street children in the railway station of Jaipur reported that half of the children were addicted to whiteners, cough syrups, and other medicines to get a high.

In order to avoid harassment from the police kids are compelled to take refuge in the crime rings. Eventually to cope with life's difficulties they get into substance abuse. More than 35 per cent of street kids reported to be using inhalants (solutions), 21 per cent were smoking, 16 per cent were hooked to cannabis and12 per cent to alcohol.

In all these studies majority of children are street children, working children and trafficked children**..**

Rationale:

The children who are on the street get into various activities like drug abuse, prostitution, criminal activities, theft and so on. The number of children who are landing up in the street has been on the rise in India. It was recorded that 60,000 children live on the streets of Bangalore and this number is on the increase daily .Daily about 60 children add to this number. Since children are more vulnerable it is required to address their problem. If the issues are not addressed in their younger age there would be an increase in drug abuse, prostitution, crimes, theft, mental illness, cancer, Tuberculosis, suicidal cases, rapes and so on.

With these points in mind in the public and community health point of view it should be addressed. Though various studies have been conducted on the magnitude of problem and use of particular drugs not many studies are available on the reasons for drug abuse amongst the street children of Bangalore.

There is a rise in the addiction of various substances among adults living in the slum areas. In order to reduce the usage of substances measures have to be taken before the children get into the habit by looking at the reason how they are initiated into the habit and the causative factors to be addressed.

Definition of Variables:

a. **street children:**

According to UNICEF there are following categories of street children.

i. **Children of the street:** children who work and live on the streets in the urban areas by themselves and they don't have any contact with their families and they lack the care, love and affection from their parents and family. They find the street as their home.

ii. **Children on the street:** children who come under this category are who work for their livelihood on the street as rag pickers, shoeshine boys, sellers, in the small shops and as beggars. They are in touch with their family and they go at night to their families. They spend a lot of time in the street so they lack emotional and psychological support from their families.

iii. **Deserted children:** children of this category are who may be run away from the family, due to problematic parents, abuse from the family, alcoholism, poverty and exploitation etc. These children have cut off their relationship from their families. They are more vulnerable and may involve in the theft, crime, and prostitution for their livelihood.

Taking into consideration the above categories the street child is the one who:

- Lives in the park, bus stand, on the street, public places and railway stations.
- Sleeps in the street, temple and old and demolished buildings.
- Works in the street for low income, as rag pickers, shoeshine, sellers, in the small shop, and as beggars.
- Gather where the public and police won't disturb.
- They are money minded, involve in crime, theft and beating.
- They get less parental care and protection.

"Street children vary from cities and regions. Age wise 40% of the street children are between 11-15 years while another 33% are between 6-10 years of age... A study found that majority (89.8%) of children live on the street with their parents/family."

The UNICEF estimates that in 2003, there were 100 million street children in the world. In 1994,

UNICEF estimated that India had 11 million street children. These street children were mainly in the cities like Bombay, Madras, Kanpur, Bangalore, Hyderabad and Delhi. As per the Indian embassy estimation 314,700 street children are in the above five cities and 100,000 street children in Delhi.

As per the United Nations High Commissioner for Human Rights, India has the highest number of street children in the world. The numbers of children who work and live the urban streets is nearly 20million.

Why do they come to street?
They come due to various reasons like poverty, migration, lack of capacity to learn, pressure from the family and so on.

Outlook by the environment: The street children are not accepted in the society and they are overlooked.

Role of family: the children in the street are neglected by their families. They get less social, psychological and emotional support from the families. They are also least bothered of their families for the reason that their needs and priorities are different than that of the other families.

Role of NGO's: they are helped by the NGO's in the rehabilitation.

b. Substance abuse:

"Substance is any chemical that, upon consumption, leads to changes in the functioning of human mind and more specifically leads to a state of intoxication."Substances can be like alcoholic beverages, cannabis (Ganja), Inhalants or Volatile solvents (fluid, white fluid, whitener, petrol, iodex) and tobacco products (cigarettes, chewable tobacco, bidi, Gukta).

c. Abuse:
Abuse is continued use of substance of any form, having negative impact, resulting in the physical, social and legal harm to the person.

d. Addiction:

Addiction is a Habitual psychological or physiologic dependence on a substance or practice that is beyond voluntary control.

The dictionary gives the following meaning:
"The condition of being abnormally dependent on some habit, especially compulsive dependency on narcotic drugs."

The effects of substance abuse are:
- ✓ It will result in the failure to fulfill their daily roles.
- ✓ The recreational, occupational activities get reduced.
- ✓ It will lead in spending a lot of time in obtain the substance.
- ✓ It will increase the problems of physical, psychological.
- ✓ It causes the family functioning etc.

❖ General Objective:
To understand the substances used and the reasons for initiating amongst street children.

❖ Specific Objectives:

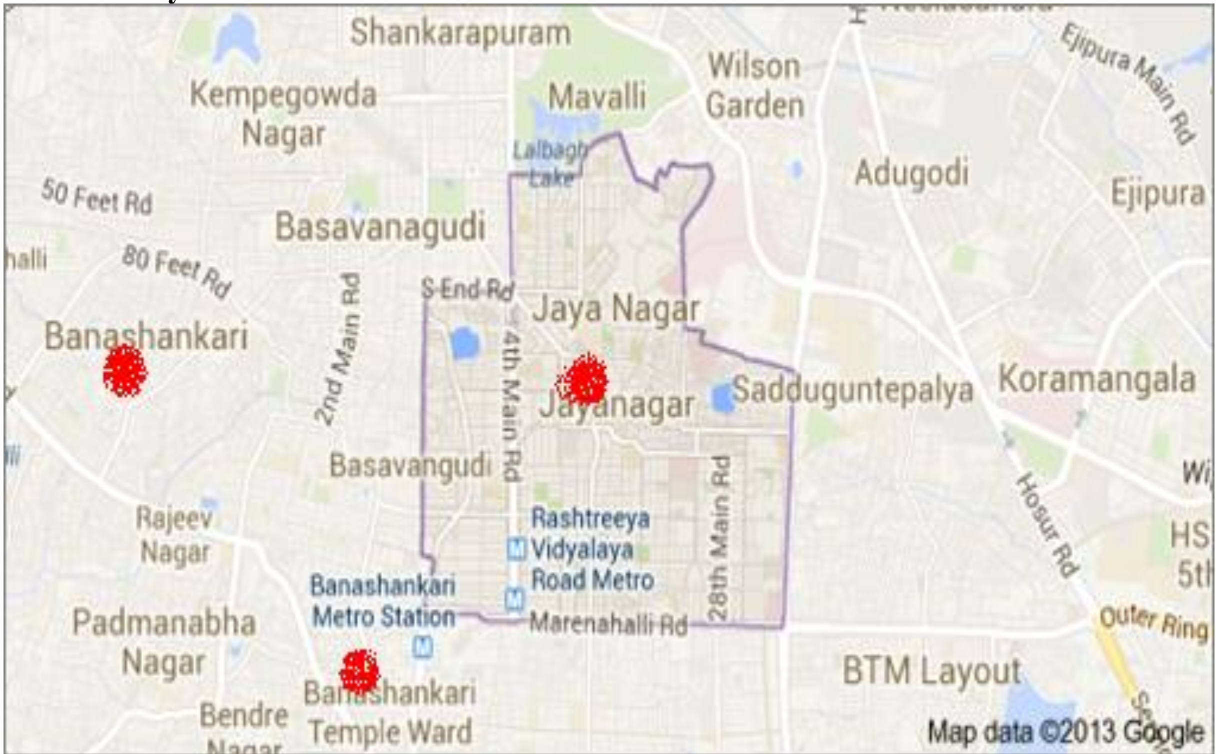
- To identify the nature of substances used by the street children.
- To know the quantity of daily use.
- To know how they were influenced to initiate the habit.
- To know the present reason for consuming it.

❖ Methodology:

Cross sectional study design was used. Both quantitative and qualitative data were collected in the study to understand the substance abuse among the street children in Bangalore slums. 22 children below the age of 18 years in the areas of Banshankari and Jayanagar were interviewed. The study period was between August and September 2013.
Sampling Method: The snow ball sampling technique was used to find the respondents and with help of a schedule the data was collected.
The inclusion criteria was mainly

- Children between the ages of 6-18.
- Children who is consuming the substances of any form.
- Children who are of the street, on the street and deserted.
- Children who gave the consent.

Data analysis:, Nvivo, SPSS, graphs and tables prepared in Microsoft Excel were used.
Ethical Issues: Informed verbal consent was taken from the respondents and participants were assured about the confidentiality. Respondents were given an option to change the name at the time of the interview. Further names of the respondents have been changed for the purpose of report and names have been assigned by the researcher. Measures have been taken for protection of data collected.
Area of study:



Results:

Socio- demography:

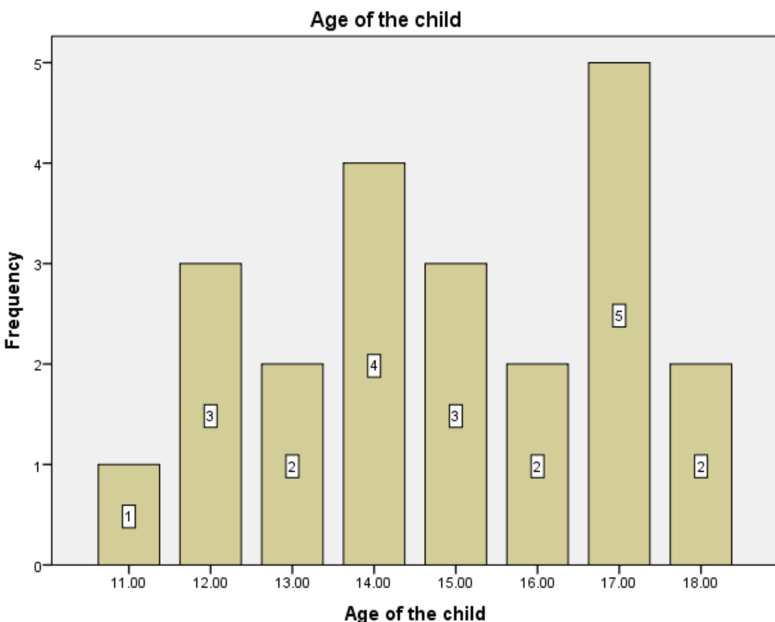


Figure : Age of the Respondents

The respondents were from the age of eleven up to the age of eighteen, among them 5 respondents were of 17, and one was of eleven year old who was youngest among them (FigureNo.1). The respondent included two girls and 20 boys.

Table : Educational qualification of the respondents

Qualification	Frequency	Percent
Never attended	1	4.5
1-5	15	68.2
6-10	6	27.3
Total	**22**	**100.0**

In the respondents group the children had completed different level of education and were drop out from schools. 15 respondents had completed their schooling between 1-5 standard which was 68.2% (Table No.1).

Table : Type of Work

Type of work	Frequency	Per cent
Rag picker	9	40.9
Seller	3	13.6
Helpers in Garage	2	9.1
Not working	2	9.1

BBMP waste collection	1	4.5
Daily wage work	1	4.5
Painting	1	4.5
Shoe cleaner	1	4.5
Tiles work	1	4.5
Welding	1	4.5
Total	**22**	**100.0**

Majority (40.9%) of the respondents are rag pickers, followed by sellers with 13.6%. They are all working in Bangalore areas.

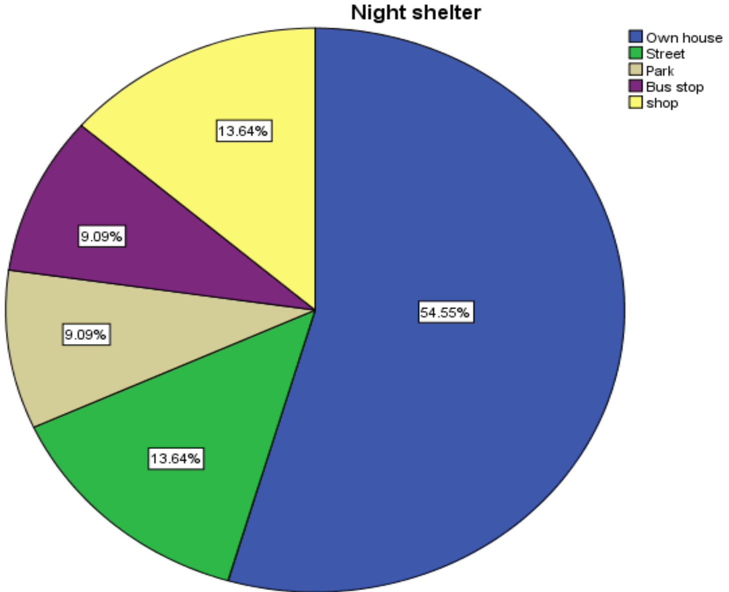


Figure : Night Shelter at the time of interaction in 2013.

The above figure shows the place of shelter for the respondents at night. 54.55% take shelter in their own houses but day time was spent on the streets other respondents take shelter in the places like street, park, bus stop and in the shop where they work.

Table : Age while initiated into Substance use

Age(in years) (mean¾10.27 $\pm$ 2.12**years)**	**Frequency**	**Percent**
6	1	4.5
8	3	13.6
9	4	18.2
10	6	27.3
11	3	13.6
12	2	9.1
13	1	4.5
15	2	9.1
Total	**22**	**100.0**

In the respondents group the initiation into the substance use begins at the younger age from 6 years. Children from 8 to 11 years are at high risk of initiation. Initiation at the age of 10 alone has 27.3%(Table 3). Respondents who have initiated into, at the early age they are addicted to various type of

substances.

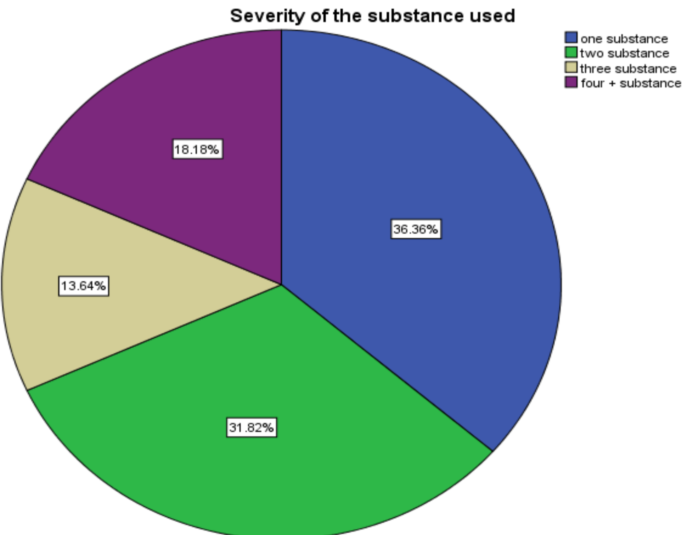


Figure : Number of Substances Consumed by the respondents

The severity of substance used among the respondents shows that the addiction to multiple substances is high. 64% of the respondents are addicted to two or more substance which is a large number.18.2% of the respondents are using 4 and more substance (shown in Figure 3).

Table : Consumption of various Substances

Substance	Frequency(n¾22)	Percent
Chewing Tobacco	17.0	77.3
Smoking	16.0	72.7
Alcohol	7.0	31.8
Inhalation	7.0	31.8
Cannabis	1.0	4.5

The respondents are consuming substances like tobacco products both chewing and smoking, alcohol, inhalation (whitener) and Cannabis (Ganja). 77.3% of the respondents are chewing tobacco and 72.7% of them are smoking which is high in the respondents group followed by other substances.

Reasons for getting into the substance use:

In the study among the 22 respondents the main cause of influence to get into the habit of substance consumption were like

- Peer influence
- Individual curiosity
- Parental influence
- Media influence
- Lack of parental guidance
- Influence from the siblings

From the interaction it was found that the respondents are drop out in their early classes and are child labours. As they are smaller in age majority of them have no responsibilities in contributing the burden of the family. The earnings are for their own expanses. So they feel it as their earnings and can spend it as they wish.

1. **Peer Influence:**

Peer pressure was one of the influencing factors which made the street children to get into the use of various substances. 21 respondents had got the substance products from their friends with the idea of having an experiment, to have a recognition as an adult, pressure from the group to be included in the group of friends and by seeing the elder friends of the area with whom they would spend a lot of time after work or during the free time. Krishna is a sixteen year old boy he got influenced by his friends and he says in his words "*I work from 9am- 5pm. Later I come and join my friends group. While I was in my 10th year I started with my friends using substance like gutkha. Presently I use substances in the form of like chewing substance, smoking and alcohol…"*

Mahesh a fourteen year old boy who is an orphan says *"When I return from the work I join the friends group of the area. So gradually seeing, my friends smoking cigarettes and beedies I too started smoking beedies. It began with one as an experiment and now I smoke 10 beedies a day. I started in my 10th year. It helps me to forget my tension and pain that I undergo….."*

2. **Parental Influence:**

Respondents were influenced by their parents to get into the habit of consuming the substance. Four among the respondents shared that they were influenced from their parents who were consuming alcohol and smoking tobacco. Three among them had tasted hiding from the packet used by their father.

Krishna an eighteen year old boy had started consuming the alcohol for the past nine years. He says that *"Seeing my father taking alcohol I increased the curiosity and sometimes my father would consume alcohol in the house. So I would taste it without his knowledge. Gradually it became a habit."* Another boy named Kumar a 15 year old boy says "*I had seen my father taking alcohol and beedi. Seeing him I started the curiosity in me. Then I started to take beedi from the packet that was used by my father. I started with occasional use and now I feel I cannot incase I don't take. I take it regularly for the past seven years……"*

3. **Media Influence:**

In the respondents group some had the influence from the actors smoking which was seen in the TV. They assumed that the actors are without any effect of it and that contributes in having fame. So the seed of curiosity was sown in them. With the intension of experiment started and has become a habit which they feel it is impossible to give up. Imthyaz 17 years old boy says *"I was curious to smoke the cigarette by seeing the heroes smoking in the movies and I thought it really makes them great. So I started it as a style but now it's impossible to quit for me."*

4. **Individual Curiosity:**

This is another cause of getting initiated into the habit among the respondents. But there are various factors which created a desire to have an experiment. The main were like seeing their friends enjoying, parents consuming, media showing and with the self desire to have experiment.
It was started with trial and gradually they were carried away by it. Ten among the respondents had this curiosity to check how it works. Now it has become like a habit which they feel hard to give up in them. Salman a 12 year old boy says as following about his initiation into the habit, *"In the evening hours after work I would come and play the games in the local ground. There the adults also would play other games and since I am a small boy they would give some amount and would ask me to get the gutkha. Because they are elder than me I would go and buy.*

Gradually I cultivated a curiosity to taste the same. So when they threw the packet after the use I used to tastes once everyone left. They also would give me some tips for buying so with that amount I bought some more packets and tasted it. Sometimes I even kept back a packet and used it.
Then I developed the tasted and now I take minimum 15 packets per day and Volatile Solvent like whitener three or more times a day which I learnt from my friends being in their group".

5. **Lack of Parental Guidance:**

In the respondents group this also was a cause for initiation. Three among them had this also a cause due to poverty where the parents are mainly focusing on the livelihood, economic condition of the family. The respondent's parents are daily wage workers due to which the income depends on the day's work. This makes them to pay less concentration on the behavior of the children. Along with this there were reasons like loss of parents and being away from their parents. This has lack of attention from their parents on their children. Sixteen year old Shankar says, *"I take 14 cigarettes per day, alcohol depends. I do it without the knowledge of my parents. They are busy with their work, since they trust me they don't inquire about my habits."*

Another boy named Rebel says, *"I consume cigarette and gutkha for the past one year. I got into the habit by the influence peers group. My parents don't bother about me in this regard. Since I don't work I get money from my parents."*

6. **Influence by Siblings:**

This is also a reason for the initiation into the habit. Respondents say that in order to cover the mistake like taking tobacco products brother gave the products to taste it. This is experienced by one from the respondents group. It made him develop the thirst for having it daily. Nameez who is 12 year old boy says, *"I had the curiosity of tasting the tobacco but I hadn't money and I knew my brother used to eat gutkha. He was afraid that I would tell it at home so my brother gave me some packets to have a taste. Later he shared with everyday and now I feel I cannot skip it. I get irritated when it is not taken."*

Current reason for consuming:

The data was gathered to know the current reason for consuming it. The respondents had various reasons. Some had multiple reasons. These are the reasons gathered,

- **To get rid of Psychological pain:**

The respondents undergo the sadness of the previous incidents like the loss of loved ones, insult from the public, police personnel, the tension faced being on the street are causing them to use the substance. Ganesh says, *"I working as a rag picker for the past four years. The work and the stay in the park really disturb me and to forget the pain and the tension, I got into the habit of chewing tobacco and smoking. It helps me to forget the sadness, pain….In case I don't use I get tensioned."*

- **To forget Physical pain:**

The respondents feel the kind of work they perform makes them to feel tired at the end of the day. The works they do like rag picking, selling, helping in the garage, wielding and daily wage work which causing the physical pain with work. In order to reduce and forget the bodily pain uses the substances daily in different forms. Mola says, *"It helps me to forget the tension, pain and tiredness after the day's work….to show that I am an adult started chewing tobacco with his friends who are elder to me. Now I feel in case I don't use it then it makes me to feel low and sad."*

- **To forget the daily responsibility:**

Carrying out daily responsibility in the family is one of the duties for some respondents besides their daily work. The respondents who are married have their family, which is another burden for them being smaller in age. So the respondents share, consuming substance makes them to forget the worries of the family and makes them to be free. Dasharatha says in his words, *"I take it to forget the tension and pain of being in the street. Since I have additional responsibility to take care of my wife and child*

I consume substance like smoking, alcohol, gutkha which helps me to forget it."

- **For life enjoyment and passing the time:**

Majority (16 among 22) of the respondents use it for enjoyment. They feel use of substance makes them to pass the time when they are in the friends circle. Krishna explains in his words about his reason of consuming substance. *"I work from 9am- 5pm. Later I come and join the friends group. When I chew tobacco (gutka) I feel comfortable, satisfactory and mind gets free. In case I don't use I feel low. We must enjoy as long as we are alive and must not bother about tomorrow."*

- **Other Reasons:**

The are other reasons for consuming substance like to get a taste of food, for the smooth digestion, to avoid from the situation of getting lost. They feel without it they feel irritated and for which they feel impossible to give up. Prabhabakar says about his reason. *"I started smoking cigarette and chewing tobacco (gutkha) everyday and ganja rarely……. I feel happy ….when I take. If not taken I feel indigestion, tension and pain in the body."* Irfan says that it helps him in the process of digestion, "I*n case I don't take then I become blank, low within and get disinterested in the work. So to avoid this I smoke daily after food."*

Discussion:

As the objectives of study was to know the use of substance among the street children, causes of initiation and current reason for intake, the review of the literature was done and formed the interview schedule. To have the better information it was discussed with the guide, staffs and the expertise at the ground level workers from APSA. Once it was ready as pilot study five children were interviewed. Based on their responses the interview schedule was rearranged. Then the researcher visited the children along with a staff from APSA and volunteers from community to identify the respondents. When the first respondent was interviewed, there were some challenges from the part of the respondents for the fear that the information might be revealed to others in spite of the verbal consent and assurance of maintaining confidentiality.

It was found that the substance abuse is on the increase mainly in the urban areas. There still exists the child labor and being away from the families, which contributes in the experiment of various substances, lacks proper guidance and supervision. The poor socio-economic condition of the families also makes the parents fall back in paying full attention to the children. So there is poverty and difficulty to survive in the developing cities like Bangalore for the family.
The various reasons for substance abuse mentioned by the respondents in this study are peer influence, parental influence, media influence, influence by the siblings, lack of parental guidance and individual curiosity for experiment and the present causes for continuing the use found to be like to forget the physical and psychological pain, to forget the responsibility, and for passing the time.

By the type of work done by them has also contributed in using substance in order to forget the physical pain, harassment at the work place and due to lack of knowledge with regard to savings, which makes them to spend in the group and share substance among the friends.
In comparison to the night shelter, the respondents living away from their houses are consuming multiple substances for the reason of peer influence, lack of parental guidance, curiosity to try different substance seeing the other people and the friends in the group. So it is like a chain which goes on and on.
The previous studies done in Mumbai in 2008, and literature review done by NIMHANS in 2013 shows the same causes for consuming substances like peer influence(62.1%), experiment (36.3%) and to boost self-confidence(28.7%) . In addition, there are few other reasons found by the researchers that explained above in the chart.

The study has some limitation of not including the girls in the equal number. It has the respondents from the area of APSA intervention.

In order to reduce the substance use among street children the researcher recommends the following measures.

- To impart education regarding the impact of substances
- To involve all the children in Hasiru Sangha run by APSA.
- To provide children with health education

Bibliography

(n.d.). Retrieved August 17, 2013, from Dictionary.com: http://dictionary.reference.com/browse/addiction

Agrawal, R. (1999). *Street Children- A Socio-Psychological Study.* Delhi: SHIPRA Publications.

Ali, S. I. (2012, October 25). *The Times of India - Jaipur*. Retrieved August 14, 2013, from http://articles.timesofindia.indiatimes.com/2012-10-25/jaipur/34729371_1_railway-station-substance-abuse-rail-station

BREADS. (2012, February 22). *BREADS: Continuous Support for Street Children*. Retrieved August 14, 2013, from http://www.help-alliance.com/en/projects/asia/india/breads-117/

Child Line 1098 Night & day. (2013, August 07). Retrieved August 14, 2013, from http://www.childlineindia.org.in/street-children-india.htm

Child Line 1098 Night & Day. (2013, August 07). Retrieved August 13, 2013, from http://www.childlineindia.org.in/children-affected-by-substance-abuse.htm

Concerned Working Children and CARD. *Children whom the world tries to forget- Situational Analysis of street Children in the city of BAngalore.* Bangalore.

Lal, R. (2013). *Screening and brief Intervention for Drug use: Resource Guide.*

MNT Medical News Today. (n.d.). Retrieved August 17, 2013, from http://www.medicalnewstoday.com/info/addiction/

Murthy, P., Manjunath, N., Subodh, B. N., Chand, P. K., & Benegal, V. (2010, January). Retrieved August 02, 2013, from www.indianjpsychiatry.org: http://www.nimhans.kar.nic.in/cam/CAM/IndianJPsychiatry527189-1011864_024838.pdf

Raza, D. (2013, July 17). Retrieved August 17, 2013, from First Post.India: http://www.firstpost.com/india/35-of-delhis-street-kids-are-dealing-with-substance-abuse-survey-962495.html

SiliconIndia. (2013, July Wednesday, 17). *News*. Retrieved August 12, 2013, from http://www.siliconindia.com/news/general/Substance-Abuse-on-the-Rise-Children-Addicted-To-Inhalants-as-Drugs-nid-150803-cid-1.html

UNICEF. (2009, November 29). *Convention on the rights of the child*. Retrieved February 2013, from www.unicef.org: http://www.unicef.org/crc/index_30177.html

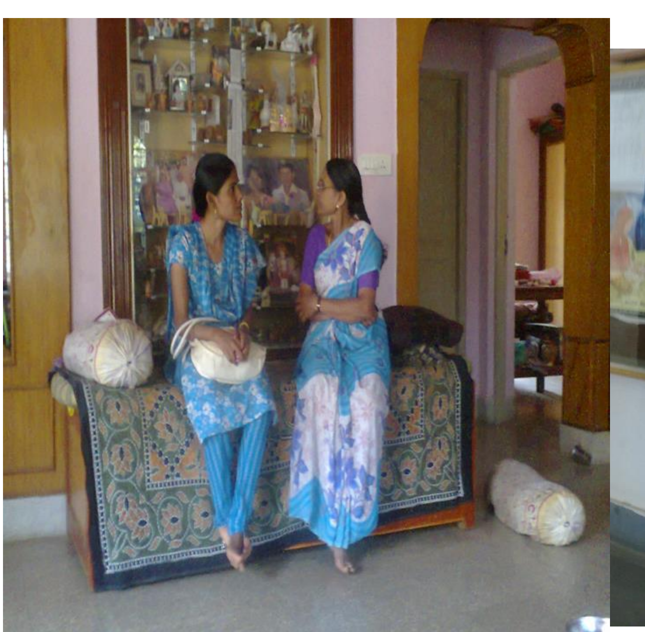
Vivek Benegal, K. B. (1993). Drug Abuse Among Street Children in Bangalore. Bangalore,

Karnataka, India.

W.S.K.Phillips. (1994). *Street Children in India.* Jaipur and New Delhi: Rawat Publications.

Children at Makala Jeevodaya with Dr.Joe and other SOCHARA Team

Mrs. Branda CWC ex-member
Mr. Chander addressing the people on NUHM



Realities in Beguru PHC

Interaction with community people during home visits in Beguru

Talk on “Health of Self and family”

Summer Camp for the Children in APSA

Hasiru Sangha Meeting in APSA

Domestic Workers Rally