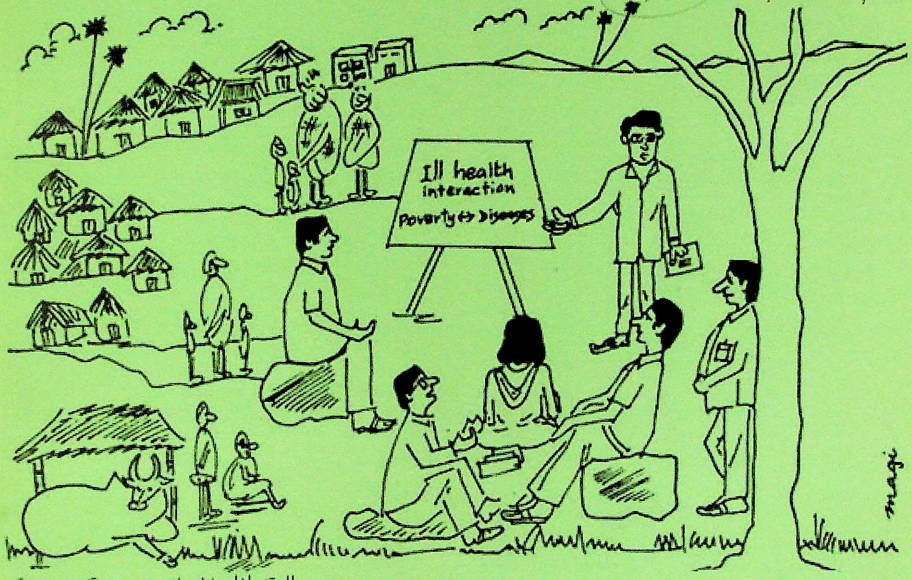
Community Health Learning Programme 2009



Source: Community Health Cell

A Report on the Community Health Learning Experience

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COMMUNITY HEALTH CELL

Community Health Learning Programme

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THE LIVES OF THE URBAN POOR, MIGRATION AND MALARIA

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ACKNOWLEDGEMENT

Participating in the Community Health Learning Programme has given me a valuable chance in meeting with and helping individuals and organisations at the very heart of a community.

I would like to thank my professor Dr. Priyadarshini Maddi for having introduced me to the Community Health Cell, my mentors Dr. Rakhal Gaitonde, Dr. R. Sukanya, and all at the Community Health Cell for their constant support and encouragement towards making my time spent in the programme productive.

My sincere gratitude to Lakshapati sir, Patil sir and Ramadevi of APSA for going the extra mile to make sure my participation in their programmes was comfortable.

Also, heartfelt thanks to all my friends in CHLP for making the experience extra special and I wish them good luck.

Introduction

As an intern in the Community Health Learning Programme I spent time after orientation re-defining my learning objectives. These evolved with our collective experiences as a group as well as some that were personal, which left me feeling I understood 'society' very little.

My initial learning objective was to understand better community participation in disease control programmes. This soon became a need to understand the unheard in society, the 'migrants', 'constructions labourers' and others, to listen and later ponder on what it means to live as they do in the heart of cosmopolitan India. I also tried to gauge the status of their health and their awareness about the same through the various opportunities CHLP and other organisations provided me. I began with a few visits to urban health centres and dispensaries in and around Koramangala, later proceeding to Association for Promoting Social Action (APSA) where I accompanied field staff in their work with communities who live in the streets as well as in registered slums. As a beginning I was encouraged to meet with two families in Koramangala who live on the streets. Additionally I also read some material on the link between migration and Malaria as well as some examples of community participation in control programmes of the same. I found my time as an intern very enriching and self-engaging.

In the report I would like to describe the sights, responses, thoughts and questions that both engaged pre-conceived notions and gave me a peek into migration, the urban poor – their quality of life and their needs, the role of community workers, both in areas that are provided guidance by NGOs and in those where there is no such initiative. Also, I have included brief summaries about the reading I was able to do during the course of the programme.

The First Step

I began by introducing myself to two families who live on the streets in Koramangala. The nail biting first steps led me to individuals and families who were very welcoming and helpful. My preconceived notions that they might be suspicious of me or scared or rude or even dangerous to introduce oneself to was now affirmatively broken. Both families have migrated to Bangalore in search of work, one from West Bengal and the other from Raichur, Karnataka. Below is a brief on my time spent with them.

Family One: Geetha is from Kolkata and has lived in Bangalore for the past three years. They are a family of four- herself, her husband and her two sons. She lives with her husband and younger son in Bangalore. Her son, Babu, is eight years old and does not go to school, as he is unable to speak Kannada. In their village Babu used to go the village high school. Geetha works as a domestic help in the nearby apartment complex and her husband is a construction labourer. They have left their voter's identity card and ration cards at home in Kolkata and have unsuccessfully asked for help – their biggest obstacle being their unfamiliarity with the language. They seek care from a nearby private practitioner and have earlier spent upto Rs.500 on such a visit. They lack supply of potable water and sanitation facilities. They suffered a recent bout of Chicken Pox that they attributed to the nearby sewage.

Family Two: Later I spoke with Lakshmi whose family hails from Raichur. They are a family of ten and have come to Bangalore as labourers who lay the roads. None of the children go to school and they have left behind their voter's ids at home and do not have ration cards. They live under plastic sheets and lack basic water and sanitation facilities. The community is not visited by any social worker – government or private. Lakshmi did not know where the nearest hospital is in the area. Owing to my limited fluency in Kannada I was unable to understand her health problems except for that they suffered from joint pains frequently.

I also visited two urban health centres and one urban health dispensary.

Audogodi Health Centre: At the Audogodi Health Centre (HC) I spoke to the nurse about the general activities conducted by her and the services available. At the HC routine ANC and PNC checkups, blood investigations (Hb, sugar, VDLR), urine (routine) are referred and immunizations are carried out. Blood and urine investigations are carried out in the nearby Wilson Garden and Siddiah hospitals. The nurse goes on house visits and conducts awareness meetings on sanitation and the national programmes at the nearby schools, sabhas and temples.

Some of the camps carried out by the HC are:

1. School Health.
2. Outreach immunization.
3. Encouraging male participation.
4. Adolescent programmes.
5. Audiovisuals

The fixed programmes in the HC are:

1. ANC and PNC, Monday and Friday
2. Immunisation, Thursday
3. IUD-OP-_CC, daily
4. Well Woman Clinic, Tuesday

Charges:

1. Lab- Rs. 100
2. OPD- Rs.5
3. Anti Rabies injection- Rs.100

The HC is a well-made building with a large compound.

Audogodi Dispensary: The Audogodi Dispensary has a dental as well as a formal clinic and a DOTS center. Apart from the DOTS center, the consultation room and the dental clinic (run by the Bangalore Dental Science College) it also has an additional room with one stretcher and a common bathroom. There is a chart of available medicines and the count of various ailments reported at this dispensary. From the information on the chart I inferred that the area suffers from high incidence of Diarrhea and Enteritis (more than 70 cases), skin diseases, urinary tract infections, dog bites and other respiratory diseases. Mosquito borne diseases is not a problem in this area of Bangalore and the most prevalent cases based on the experience of the medical officer present were Diabetes, Hypertension, fevers owing to urinary tract infections and wounds.

Madiwala Health Centre and Dispensary: The Madiwala Health Centre and Dispensary also has a DOTS centre and a birth and death registration office.

Interaction with Street and Slum Communities

CHLP directed me towards meeting organisations and people involved in related work. I was asked to visit APSA and in doing so was given the opportunity to observe and learn from the very roots of the organisation.

APSA works broadly with the urban poor in Bangalore and works to engage and empower the community towards availing facilities they are rightfully entitled to, thereby helping them climb the first steps in being self-sufficient and protected from exploitation. They run 'Dream School'- a bridging school to re-introduce children from varied backgrounds such as child labourers, school dropouts, children who have been rescued from distress and migrant children to mainstream schools as well as give them opportunities in vocational training that will eventually ensure them a safer future.

After my first visit I was introduced to the director of APSA – Mr. Lakshapati and the chief field coordinator – Mr.Ishwara Patil. Together I was able to chart a plan of action that would enable me to visit communities, interact and observe focus group discussions (conducted by APSA field coordinators and social researchers from the Indian Institute for Social and Economic Change) and community resource mapping along with members of the community.

Focus Group Discussions

They were conducted in the following areas that lie along the length of Old Madras Road and immediately behind the APSA premises. These were conducted with women and children separately and in one instance men also attended the discussions. All the discussions conducted covered broadly the following – Child Rights, Gender, Alcohol and Development.

1. Ibutipura
2. Batralli
3. T C Pallya
4. Pai Layout

Ibutipura Women and children

Groups: Women (10) – some participants were from the self-help groups and some were not. Their husbands later joined some of the women. Participants among the adults were drivers, construction workers, domestic help and housewives. Children (4th, 6^{th} and 9^{th} standards) from the nearby school also participated.

As this was the first focus group discussion that I had attended, I paid greater attention to the methodology rather than the group's response to most questions.

Child Rights

- Questions asked and discussions thereafter pertained to identifying resources that are accessed by children in the locality and their perceptions on children and their rights.
- The group was asked about the quality of the resources for their children.
- The children specific schemes provided to them, how many avail of them and how aware they are of the schemes they are entitled to.
- Awareness and participation of parents in government forums such as the SDMC.
- The discussion tried to gauge the prevalence of child marriage, child labour, and cases of missing children in the locality and understand the health of the children in the area.

Reactions to the Above Discussion

- Quality of the mid day meal is poor.
- Most parents do not avail of educational schemes for their children although there was a general understanding that schemes are specifically available for girl students and on the basis of caste.
- One mother was disturbed by the fact that the education schemes that she was aware of were directed to girls only.

Alcohol and Ghutka

- Questions in this section broadly covered the availability of alcohol in the locality (shops), preferences (illicit liquor or otherwise), problems related to alcoholism – domestic violence and addictions and their direct or indirect influence on children.

Reactions to the Above discussion

- Most participants (both women and children) were very open to the discussion.
- A few of the women responded – "Only those who drink will know where to get it." This could either be her discomfort in discussing the topic or due to her weaning interest to take part in the same.
- All were in agreement that violence owing to alcohol was common in the community and also that Ghutka usage is widely prevalent.
- On questioned about wine shops in the locality one response was interesting. One participant mentioned " a border area" that separated broadly the area where the Tamil speaking families live from that in which the Kannada speaking families live, as a result of which they were unable to let us know of the wine shops on the other side of the road. Does this imply very little interaction between the two sides of the locality?
- As the women have little control over the family income some expressed an inability to control their husband's alcoholism.

APL/BPL/Labour Cards and Schemes

- The BPL system is being implemented well in the locality.
- The quality of rations is good.
- The store is good. However they do not get supplies over three days from the day the rations are bought to the store.
- Those among the participants who work in construction are unaware of 'Labour Cards' and its use.
- Some participants were aware of schemes like the 'Bhagyalakshmi Scheme' but chose not to avail of them.

Utilities

- The water supply in the locality is governed by politics.
- The local leader from the congress ensured them water supply, but the present leader who is from the BJP has not, the common excuse being that there is 'repair work' in progress.

Police

- It was made clear to the group that having gone to a police station implied both going for one's own purpose as well as going on behalf of or accompanying someone.

- There is a common perception that one must go to a police station only in an instance of crime.
- There is no reporting owing to fear of approaching the police.
- Also those who have approached them have had experiences of shabby treatment where the police have responded saying. "People from rented houses don't deserve..."

Gender

- The response was that the husbands take decisions as they earn more than their wives.
- Wives only inform their husbands and do not discuss issues with their husbands.
- In the instance of the FDG, it was interesting to observe the men in the group (husbands whose wives were also present) encouraged the women (not necessarily the wife herself) to speak, take part and ask questions.
- Most of the children felt their father was superior to their mother due to his role in decision-making. Some of their responses were that, the father is the head of the family, they are big, they are elder to them, and you must listen to them or else get beaten up.
- Some of the children agreed that in the locality girls are sent to government schools while the boys are sent to private schools. They said that it is because girls will get married and leave the family, hence the little importance to their education.
- All the girls agreed that this view is discriminatory.

FGD Co-Ordinators Response to the Children

- The opportunity to interact with the children was used to also create awareness amongst them. In the context of gender roles in a family the FDG was taken advantage to emphasize that respect for elders was good but respecting their role and that of their mother's is also a possibility and is also good to consider.

Groups in the Locality

- Sanghas are formed in the locality (by whom?) but their activities are not followed up on.

Migrants in the Community

- The adult participants had mentioned that there has been an influx of people from Bihar who work mainly as construction labourers.
- The children listed out the following – Assam, Bihar, Orissa, Kerala and Tamil Nadu on the basis of their classmates in school.

HIV- AIDS

- Adults as well as the children had nil awareness on HIV-AIDS
- Some of the women reacted negatively, which is suggestive of the issue being a taboo to discuss.
- It is important to note that while the children had heard of HIV-AIDS, their knowledge of how it spreads is very poor.
- The children believed that taking old medicines and mosquito bites cause HIV-AIDS.
- Some (very few) of the children said it spreads through blood.

Treatment Seeking

- Everyone visits the private clinic in times of complications.
- They go to the nearby government hospital for pregnancy related issues and immunization.
- The services of the government hospital is good, they are treated well and are not asked to pay.
- Some of the participants said that a lot of money is spent on 'Birth Registrations', mostly due to change of name at a later stage.
- They were unaware that birth registration in the first 25 days is free (token system).
- Some cases of infant mortality have occurred in the locality.

Batralli, Anganwadi

Groups Present: Children (11) – in the age group of 11 to 13 years.
Women (11) – Included the anganwadi helper and mothers of some of the children present.

Child Rights

- Both groups (children as well as the women) are aware of 'who' a child is with respect to the definition based on the age of an individual.
- They are aware that children are entitled to basic rights but are unable to give examples of 'what' these rights are.

School

- The children are unaware of what they are entitled to as students of a government school. Schools have toilet facilities with separate sections for boys and girls. They also have a playground and a community hall. They do not have library facilities, either in a building or mobile. Some of the mothers said that in the English medium schools the mandatory books have not been given and there is no playground in the school.
- They have not heard of the School Development and Monitoring Committee (SDMC) and do not know the functions of the same. Some of the women have attended meetings at their children's school where they were asked to sign papers. However, they are unaware of the presence and purpose of the SDMC and are not clear as to whether the meetings they had attended were pertaining to the same.

Midday Meal

- Children were happy with the quality of the meal.
- The mothers were very unhappy with the meal given in the school. They said the quality of the rice used is very poor and there is no source of clean drinking water within the premises. Some mothers also said that children do not complain and bring the food home so as not to offend the teacher.

Teachers

- Children expressed satisfaction with their teachers.
- The mothers were very dissatisfied with the teachers and feel that there is an overall lack of interest to teach among the teachers and they are careless.
- Some of the women have observed a teacher talking on the phone during class hours while the children are ignored.
- Some of the mothers felt helpless to complain as they feel nothing will happen if they singularly complain.

- They also expressed concern over the roads their children must take to reach school. The roads are major highways without pedestrian crossings or police patrols with traffic that is mainly of trucks and intercity buses. As they fear for the safety of their children they personally drop and pick them up from school.

Child Marriage

It is prevalent in the community. While the children are aware of one such case involving a child in the age group of seven to eight years, the women were aware of three to four instances. The children and women are aware that child marriages should not be the norm and reasons for the same. Some women are also aware that it is an illegal practice.

Child Labour

There are a few children who work in the area. Both groups elicited the various jobs the children are engaged in, construction workers, bus cleaners, garage workers, as workers in restaurants and as domestic help. It was interesting to not that the children listed all of the above mentioned work.

Children's Health

They have had instances of water borne illness such as Typhoid and Jaundice. All those present in the discussion were immunized against Polio. None of the participants of the discussion prescribe to home remedies. They go to Patil Hospital first and choose to go to the government hospital later. They are happy with the treatment at both hospitals.

Alcohol, Ghutka and Illicit Liquor

- The children who took part in the discussion were very open to discussing the issue.
- Both groups are aware of liquor shops in the community and the preference is for bottled liquor.
- Ghutka is also commonly used in the area. Children identified with 'Pan Parag' when issues related to Ghutka usage were discussed.
- Both groups said that illicit liquor was available in the locality earlier but is unavailable now.
- Usage of both alcohol and Ghutka is more among the men. Children are aware that Ghutka usage will cause Cancer and that alcoholism contributes to domestic violence, some of the children also know of such cases in the area. The children were of the opinion that alcohol would affect one's Kidneys, lead to blood loss and heart trouble.
- Children are also aware that people can overcome these addictions.
- Women in the discussion spoke more on the issue of domestic violence owing to alcoholism and did not bring to attention health related problems owing to the same. The police have conducted door-to-door campaigns urging people to give up the habit. There has not been any other de addiction camp apart from this in the area and most people who have given up the habit have done so on their own will and not as a result of outside intervention.
- Some women have enrolled their children with the help of the local social worker into hostels in order to protect them from domestic violence owing to alcoholism.

APL and BPL Cards

- Both groups possess and are aware of the role and purpose of the cards.
- Most families own a BPL card.
- Both groups agreed that the quality of rations is poor and they have been cheated off the exact quantity owed to them, according to the children by half a Kg. Women are aware of

the units owed to them by the ration shop (1 person = 4Kg). They claim that there are families who get more than twenty kilos of rations in the area.

- Pension Cards – nobody in the locality has pension cards. Some had mentioned that those who did were not getting the amount that is due to them.

Children and Women's Groups

- Bosco and Kids – newly formed for the children, is only for boys.
- Girls do not have groups of their own.
- Sthree Shakti – Is very popular in the locality and most in number.
- Teachers Sangha – Sthree Shakti and the Teachers Sangha have organised immunization programmes and doctors visits
- Ujeevani and Shishu Mandir are some of the other groups, which were discussed about.

Utilities

- Toilet and water facilities are of major concern to both groups. Both groups felt embarrassed about discussing the issue.
- None of the houses in the locality have indoor bathrooms.
- Everyone has to use the banks of the lake, which all the women agreed was dangerous. There have been reports of accidents involving children there.
- There have been instances where the sewage and drinking water have mixed leading to water borne illnesses among the children.
- Water supply is usually at night and there is no payment for the supply.
- The locality has direct electricity supply.
- There are garbage collection dumps.
- They do not have a bore well in the area.

Police and Local Governance

- The police station is 11km away in Hoskote.
- The children were of the opinion that the police take bribes. Some of the children have visited a police station.
- Everybody is aware of their local leaders, Iranna and Nagesh Reddy (MP)
- Women are aware of the election process.

Domestic Relations

- Most of the children felt strongly that their father at home takes decisions.
- The children's response was that their father 's income buys the household food and that he is responsible for their school fees, books and for decisions on marriage.
- The mother of the family helps out in doing their homework.
- The children feel they do not get discriminated with respect to education.

HIV

- Children are not aware of what HIV and AIDS are.
- Women were not aware either but agreed that having awareness about it would be helpful to them.

Pai Layout Residents

Conducted by the Institute for Social and Economic Change (ISEC)

A few observations:

- Seven members have 'Pension Cards' and 90% of the community has voters' ids.
- Local leaders of any political party have never addressed their needs.
- Some members have lost employment owing to health problems and accidents. In the case of accidents, APSA has helped the community file cases and garner help from the legal system.
- All the children go to the nearby 'Tent School'
- Parents expressed a lack of accountability in the functioning of the school.
- They face water and sanitation problems.
- Some groups in the layout do not pay rent for the land they occupy while some others do.
- This group in Pai Layout has moved within the locality 2-3 times.
- A government health worker has never visited them.
- Some of the issues they would like to address are,
    1. Organising Sanghas for both men and women.
    2. Open savings accounts in a bank.
    3. Gain access to drinking water.
    4. Be given a permanent place of stay with facilities for a decent way of life (house, water, toilets).
    5. A good school for their children.
- Problems they feel hinder the organisation of a Sangha in the community,
    1. Lack of money.
    2. Lack of permanent residence.
    3. Threats from landlords.

Observations - Methodology

- Always maintain respect for persons who are being discussed – no finger pointing.
- There were attempts to include everybody in the discussion by the more confident women, men and the coordinator conducting the FGD.
- Participant's answers to questions were tactfully used to understand their opinion on an issue as well.
- Questions that seem ambiguous are explained through instances and examples.
- Always emphasize the context. In this case all questions pertained to Ibutipura/Batralli/Pai Layout as a whole and not just the street they live in and the few houses to their right and left.
- The group assembled must be representative of all households in the locality.
- The importance of finding a suitable place and time of the day.
- Maintain focus on point of discussion.

Observations – Learnings from the discussions attended - General

- Focus group discussions are an excellent tool to gain an overall understanding of the utilities, needs, awareness and beliefs of the community. Also, it provides a platform to build rapport and expand the work of the organization in the community keeping in mind 'their' needs.
- The definition of 'Migration' and what defines a 'Migrant' became clearer. It became apparent that within the limits of the city most families who are not from Karnataka have lived in Bangalore for over fifteen to twenty years and gave assimilated into the local population. Therefore, I found it difficult to categorize them. In the end I realized that in

many different ways we are all migrants. My experiences therefore focused on learning more about the urban poor.

- Most families I was able to meet are form North Karnataka and Tamil Nadu. Some of the individuals who participated in the FGDs and those who we spoke to individually had mentioned that more recently there has also been an influx of people from Bihar in the same locality.
- The families belong to two broad categories. 'Street families', who live on the road under plastic sheets on land that is not officially under the slum development board and 'Slum families', who live in concrete and brick colonies that are officially registered with the slum board.
- The opportunity for better livelihood options in Bangalore spreads through word of mouth.
- Travel expenses are covered by loans.
- The reasons cited by the families for migration were many. Some of the most common reasons cited are the following – Higher wages for the same kind of work in Bangalore compared to their home towns and the failure of agriculture on their land owing to lack of irrigation facilities.

Learnings Specific to Issues

Land

- Is a constant source of worry to those families who live on the street.
- Some live on railway land. This gives them a degree of immunity against evictions by private contractors and local leaders.
- Others on the street but not on railway land reported paying a monthly rent to a local leader.
- Families who reside in registered colonies are more secure on matters of shelter.
- Most communities have developed on land that belongs to the lake authority.
- While certain sections of the colony are registered, owing to expansion of the community certain sections are left out, for purposes such as voter's id. Also, this also poses safety risks as these expansions occur on unsafe ground and in close proximity to the lake.

Governance

- In Pai Layout, T C Palya and Ibutipura, owing to the work of APSA all families have Voter's ID, Ration Cards, Labour Cards and Pension Cards.
- With regards to the community's interaction with their local leaders, all members of the community practice their franchise but there remains a lack of interest on the part of the leaders after election season.
- For instance in Pai Layout, the local leader 'Cement Nagarajan' is a mere signature on Pension Cards. Such needs (signatures and stamps) are the only instances of 'interaction' between the community and their elected local representative.
- In T C Palya, the local leader is an active land mafia member. Hence APSA coordinators maintain a healthy distance and have introduced only a few members of this community to him so as to reduce the risk of eviction, as they do not have the security of government land.

Health

- A health worker has visited none of the communities.

- Maternal Health – Most mothers are prompt with regard to their checkup however chose to deliver at home with the help of a midwife (an elderly woman).
- Most illnesses are owing to 'water borne' diseases like Jaundice and Cholera and respiratory problems.
- There have been cases of the entire community falling ill during a particular rainy season such as an instance in Pai Layout. As the cases were not recorded and were described as being fever, vomiting, diarrhea, body aches and chills I presume it might be owing to both water borne as well as mosquito borne illness.
- All areas visited lacked access to basic geriatric care and de-addiction opportunities.
- The only immunization mentioned was that of 'Polio'. None other was mentioned during the FGDs.

Treatment Seeking

- Most on the street visited the hospital when their children were taken ill whereas this seemed not the case when an adult felt ill, in which case care would be sought if it hindered their ability to work.
- Private clinics were everybody's first option. Some also go to the local pharmacist for a diagnosis of their problem.
- During the FDG in Pai Layout I asked them if it was absolutely necessary to get an injection on a visit to the hospital. One participant explained that it is for the doctor to decide on its necessity. Though it is not representative of what everybody in the group thought of the question it was good to know that the issue which I had previously read to be a trend might not be so anymore.
- All participants were of the opinion that home remedies are inferior to allopathic medicines in this time and age. The common response was that they do not alleviate illness today as they did in yester years.
- The community living in T C Palya believes that the sacrifice of a chicken and the use of its blood is a good remedy to overcome illness. One of the children had mentioned that initially someone who is ill is taken to the hospital and if the illness worsens they would sacrifice a chicken.
- Snakes, dogs and mosquitoes are a major nuisance.

Preventive Measures

All communities use mosquito coils. None mentioned the use of bed nets. Some individuals complained of irritation to the eyes and skin owing to the use of coils (allergies).

School

- All areas have a government primary school.
- Mid-day Meals, while most children said they liked the meal, adults were unanimously dissatisfied with the quality of the meal.
- Some of the schools lacked drinking water facilities.
- Most schools have separate toilet facilities. However, the school at Batralli lacked such a facility. Children need to use the banks of the lake, which poses a serious safety threat and has resulted in accidents.

- Both parents and children are unaware of the School Development Monitoring Committee. Those who have attended meets at the school are unaware of whether they were in relation to SDMC. This was due to the absence of an explanatory session with the parents and also because some of the parents are illiterate and hence unaware of what it is that they are made to sign.
- Scholarships and books are given sporadically in all schools. There is not much awareness on the scholarships children are entitled to.
- Teaching is poor.

Housing

- In Pai Layout and T C Palya shelter is made of plastic sheets and some rods.
- In Batralli and Ibutipura housing colonies were made of concrete and bricks.

Electricity and Water

- Families who live on the street buy water that costs a minimum of Rs.200 per month.
- Families who live in the slums have good infrastructure such as bore wells and tanks. However very few are in working condition. For instance in Ibutipura they have around six bore wells among which only one works. Hence water is available only in the evenings and is insufficient for their daily needs. The registered communities have had instances of sewage and drinking water mixing.

Alcohol and Ghutka – Prevalence and Addiction

- There was no inhibition to talk about the issue.
- Children and adults perceived the ill effects of alcohol and Ghutka abuse very differently. However, both groups acknowledged that alcohol abuse was the leading cause of domestic violence.
- Women admitted to very little power over the family's income, which they felt to be the sole reason in being unable to control their husband's addiction.
- In Batralli, women of certain households have enrolled their children in hostels with the help of a social worker in order to protect them from domestic violence.
- Children view alcoholism from a scientific point of view and most responses dealt with which organs of the body alcohol affects.
- Batralli and Ibutipura had problems relating to illicit liquor use previously but do not have this problem now. Access to alcohol and Ghutka is very easy in the locality and known to all.
- De-addiction in all areas was a result of the individual's decision to do so and not due to any intervention. The communities do not have intervention programmes in their area.

Gender Relations

- In all discussions the father was always quoted to be the superior.
- Reasons for his superiority were many, for instance, he takes care of the school fees, books, takes you out, decides on issues pertaining to marriage
- 'Mothers look after the kitchen' was a common answer among the children.
- Among the adults, the women described themselves as being their husband's informant. They do not have the liberty to discuss the issue and partake in decision-making.

Observations – Responses

- When discussing the issue of alcohol, one participant showed her disdain in talking about it and said, "Only those who drink will know where to buy alcohol."
- When the topic of HIV/AIDS was introduced one of the response among the women was, "It is not present in people like us."
- When the children at Ibutipura were asked how one gets infected with HIV these were some of the responses, "You get it by ingesting old tablets", "You can infected by being bitten by a mosquito".
- A father in Pai Layout on being asked why the school his daughter attends is not improved said, "We are poor. Our children go to school that is attended by children of other poor families. Since all of us poor nobody cares." (Accountability only to the rich?)
- When he was asked about what he would like for the future he said, "We live for today and my concern is whether I can survive today. I do not think about the future."

Lecture at NIAS

There are two schools of thought regarding the definition of "Who is poor?"
1. Caused due to calamities that is both natural and man-made such as floods and political strife (Jeffrey Sachs)
2. Caused due to the power struggles and red tape within society that discourage the socioeconomic growth of the poor.

Prof.Banerjee proposes that the poor are well aware of their situation and limitations. They choose to be where they are despite being aware of the opportunities in society. His study is yet to be complete and the presentation was on his reflections from the data collected thus far. The field area was Udaipur and parts of interior West Bengal.

Definitions of the poor - Very Poor (less than a dollar a day)

Poor (two dollars a day) and the middle class (between two and four dollars). The definition of the poor as given by the World Bank and India's Planning Commission is the same.

The data collected covered food, assets and migration.

Food
They continue to spend on high cost low calorie food. They do not spend enough on food despite having the ability to. (What if that is the only option available?)

Assets
Their sources of income are multiple and 95% of all those interviewed have land but lack business assets and savings accounts. Most poor people are self-employed with small businesses. The businesses run by the poor and the middle class are the same. In terms of numbers, the poor run more businesses and the notion that most businesses are run by the middle class is questionable. The difference is that the middle class are mostly salaried workers and begin business to keep members of the family (wives starting tailoring units) occupied whereas the poor begin the same venture as they do not have jobs and not out of choice. All families spend heavily on health care. The number of visits to a hospital per person is once in two months. However, despite these frequent visits

people in the communities studied die very early. It was suggested that this could be because of the indiscriminate use of steroid injections and unethical prescriptions that could lead to resistance at a later more desperate stage in life. People also insist on injections and drips. The worth of the doctor depends on its use.

Migration in Search of Work

Is extremely common but for very short periods of time, the maximum being for eighteen weeks. Migration in this case is without the family. It is the largest source of income with most families living on the earnings of four months for the rest of the year. Interestingly, owing to the hardships of being a migrant worker people choose not to stay back and earn more. If growth continues in the metropolitan cities, migration will reduce whereas if it is in the middle tier towns and cities, migration will increase. There will soon be migration of entire families in this case, which will positively affect education opportunities of their children.

Conclusion

People are aware of opportunities but choose not to take them owing to reasons of convenience. While the poor begin business owing to a lack of jobs the middle class begin the same to "keep themselves busy". In this context the poor despite a general lack of resources are more entrepreneurial. Therefore they are neither victims of powers outside their control nor are they held back by power struggles.

Inward Learning

The experience as a whole has allowed me a peek into the working of an organization with communities that are both permanent as well as those that are nomadic. Participating in field activities helped me explore parts of Bangalore city that are lesser known and communities that are invisible to the common eye. I had first hand experience of the rapport shared by the organization with the community. The activities that I was able to observe showed me the means to interact with people so as to gain an understanding of their lives as well as well discuss and share awareness on issues in a sensitive and non-offensive manner. In interacting with families on the road I was forced to face my fears. At first I was unsure on how I must approach individuals and introduce myself. My fellow interns helped me with a few pointers they had learnt from experience. I spoke with the woman of the family first and introduced myself as a student, I was pleasantly surprised by their willingness to talk to me without fear of who I might be. All families were very hospitable and the memory of sitting on a road in the heart of Bangalore city will remain a very special one for me. On reflection I came to realise that my 'fear' was a result of growing up in an environment that shunned street families as those who are dangerous and better left alone. Challenging this mindset helped me learn to cope with people's views that were in conflict with mine. The CHLP has helped me face inner and outer conflicts with greater maturity and responsibility. I remind myself to pay greater attention to detail and be more proactive towards charting my learning. Though it was hard to maintain, my daily dairy now makes for a good read into all that I was part of during my time with CHLP.

Outward Learning

Communities on the street differ starkly from those who live in registered housing colonies in distribution, shelter, employment, awareness and access. Families living on the street are often found alone or in small pockets along main roads and railway lines. They are mostly construction labourers from other parts of the state and the country. Some of the families had come to Bangalore

through the NREGA and have not returned home, instead they have found work and decided to stay. Whereas, most families who reside in registered colonies work as teachers in government schools, domestic help, drivers and as other skilled workers. They have better access to water and sanitation facilities compared to families on the street who have to buy water as well as lack access to sanitation facilities owing to a lack of public facilities. In field visits with APSA I saw valuable infrastructure that was in disuse. While there are certain myths in health that both communities believe in, all families were aware of and utilized their nearest health facility. Owing to their size and the fact that most members were family or friends, families on the street had a stronger sense of camaraderie than those who resided in colonies. In colonies, self- help groups played a crucial role in keeping the community together with the concerned NGO in working towards overall development. In both areas women played a dominant role in interacting with the NGO.

Looking Forward

From time spent in CHC and APSA I realised I would like to take part in initiatives that address the issue of implementation. I need to pay closer attention to time management and learn to better present my thoughts both orally as well as in writing. Practicality and the need to be so has been emphasized through out the programme and is a skill I hope to implement in learning and working.

Reading

I. Beyond Biomedicine: The Challenges of Socio-Epidemiological Research, Dr. Ravi Narayan, CHC, Bangalore, Sir Dorabji Tata Symposium Series

- Introduces the social paradigm i.e. a shift from a merely biomedical perspective to include Socio-Epidemiology in the control and prevention of Malaria.
- Programmes must look into knowledge, attitude and practices of the community and personnel in the control programme like doctors and other health care providers.
- Close attention to the following factors – migration, health impact studies on development work, economics of Malaria (for instance the expense of using DDT and medicines), the skill, competence and efficiency within the public health system, relevance of specific control measures in the context of the way of life of the specific community, include participation of sociologists and anthropologists in disease prevention and control programmes.
- Research on new initiatives must be in the context of the 'need'.

II. The Contextual Determinants of Malaria, Determinants of Malaria in South Asia, Vinod Prakash Sharma

- "Sustainable Malaria control requires a primary attack on poverty, health system reforms, emphasis on community based approaches and investments in research and development."
- This chapter studies the following broadly, FORESTS, GEM MINING, DEFORESTATION, POPULATION MIGRATION, IRRIGATION, URBAN AREAS, INDUSTRIAL AREAS, INTERNATIONAL BORDER MALARIA AND SOCIOECONOMIC DETERMINANTS.
- Forests – There exists perennial malarial transmission owing to deforestation for resettlement, agriculture, industries and the presence of streams. Tribals are most affected by forest Malaria and hence are the most vulnerable population in this context.
- Gem Mining and Dam Construction – Facilitates the migration of non-immune populations to work in malarious areas as well as migration of people from malaria endemic regions.

- Deforestation – Many examples enumerate on how deforestation and agricultural activities help in the spread of Malaria owing to breeding areas that can be destroyed and kept in check by the community. As different mosquitoes occupy different habitats, persons infected owing to visits to the forest act as carriers.
- Population Migration – The reason for migration being work and usually from areas with high transmission. The chapter also mentions the gender bias in migration, i.e. men tend to travel longer distances than women, hence facilitating transmission in the host population.
- Irrigation – Leads to the spread of Malaria owing to increase in ground water levels coupled with the lack of drainage in farms. Additionally due to the migration of labour from malaria endemic regions.
- Urban Areas – Malaria presence owing to artificial storage areas and the adaptability of certain species of mosquitoes to breed in the new environment (Anopheles stephensi). For the poor, reasons are poor sanitation and the rationing of water.
- Industrial Areas – Examples showing the connection between construction of industries and the prevalence of Malaria.
- International Border – This is a relatively new ecotype and has resulted in the development of numerous resistant strains. Facilitates transmission owing to lack of treatment facilities, unscrupulous medical personnel, substandard medicines and unchecked movement.
- Socioeconomic Determinants – Broadly , population movement (for work and political strife) to urban areas with deplorable living conditions, malnutrition, medical expenses, lack of access to medical facilities, practices such as plastering of mud walls over DDT sprayed walls, insufficient and improper use of insecticides and anti-malarial tablets, difficulties in sustaining community participation.
- Examples of cost effective control in industrial areas and agricultural practices that can control malaria have also been enumerated.

III. The Contextual Determinants of Malaria, Determinants of Malaria in South Asia, Population Migration and Malaria, Janice Longstreth and Anatole Kondrachine

- The extent of Malaria within a population depends "on whether the receiving location is in the developing/ developed world."
- Covers the two basic types of migration – unidirectional and circular as well as the reasons for migration.
- Explores the consequences for the receiving population especially since the major population movements are to the developed countries where immunity is low. Immigrants in developed countries live in substandard conditions and do not consider treatment owing to problems such as language barriers and fear of deportation.
- Land use – For the purpose of agriculture which involves the introduction of non-immune persons, new hosts and the possibility of drug resistance.
- Urban Construction – Provide various breeding opportunities such as excavation pits. Helps increase malarial transmission owing to migration.
- As cities grow rapidly with inadequate or completely absent housing, the exposure to mosquitoes and increased breeding sites increases the risk of transmission.
- Resettlement and development projects bring in labour, resulting in the formation of squatters that lack cohesion owing to cultural and economic factors resulting in overcrowding, lack of sanitation and hence ill health. This is explained in the context of Ethiopian highlanders who were infected owing to their migration to the plains for irrigation projects. Infection remains in the plains due to the nomadic movement of the pastoral tribes.

Similarly reforestation activities in Brazil created opportunities amongst the non-immune migratory population.

- The chapter also highlights the link between occupation and Malaria. E.g. Migration of nearly 60% of the population from the non-malarious hills to a malarious delta – Naya river valley in Columbia.
- The prevention and control of Malaria in developing countries depends on how efficiently control programmes function and the immunity of the urban population to the new virulent and drug resistant strains that are introduced by immigrants.

IV. Exposed and Vulnerable: Tribals and Malaria in Bihar, Malaria in India – Reflections, Responses and the search for alternatives, Voluntary Health Association of India, New Delhi Society for Community Health Awareness, Research and Action, Bangalore P A Chako S J and Prabir Chatterjee

- The article covers the occurrence and the public health system's response to the occurrence of Malaria amongst two tribal groups – the Malto and the Santals in south Bihar.
- Malaria, especially Cerebral Malaria has had an extremely debilitating effect in the Malto tribals. Their communities are located in a hilly belt and are not visited by health workers or sprayers. Irrational practice among insufficiently trained personnel is rampant. This has resulted in resistance in the community. The Malto tribals use herbal medicines for the treatment of malarial fever and studies were being carried out by the Jeevodaya Dispensary run by the Paharia Seva Samiti on the preventive aspects of the herbal medicines. Kala Azar is also surfacing amongst the Malto tribe.
- The Santals are the third largest tribe in India. "Raban- rua" (cold fever) is how Malaria is identified in Santali. Cerebral Malaria is referred to as "Bai" or "Mirgi" and is considered to be different from "Raban-rua". "Pila" refers to the enlarged spleen, is confused with Kala Azar, which is also common in the community.
- The article brings out the cultural issues that need to be considered on confronting Malaria in tribal communities. For instance DDT spraying is stopped by the Santals as it smells bad and "Diku" (the non tribals) do not pay heed to sensitive tribal practices such as leaving ones shoes outside the house before entering the house.
- Inadequacies in the health system, i.e. delayed functioning of labs, inadequate supply of medicines for the population at risk and the inadequate supply of medical equipment. With regard to preventive measures the lack of pesticide supply and the supply of expired pesticides have been some of the stumbling blocks.
- Medications that are available and the manner in which they are prescribed have also been detailed.
- Interestingly, the tribal form of governance has a worthy mention in the article which aides in better understanding the sociological aspects to be considered when interacting with the community in the context of Malaria.

V. Health of the Urban Poor, Prepared for the second national health assembly – Bhopal, Madhya Pradesh

- "Studies conducted by NIN in Jabalpur and Calcutta showed a higher prevalence of malnutrition among children in urban areas than the rural population."
- Determinants of ill urban health area a result of poverty, malnutrition, overcrowding, lack of water and sanitation, inadequate housing and insecure tenure of land.

- The Jawaharlal Nehru Urban Renewal Mission aims at addressing and tackling issues of sanitation housing to name a few but is prey to lobbyists and has imposed pre-conditions for states to avail of the mission.

VI. Malaria and Migrant Labourers: Lessons from a South Indian Experience

- This article enumerates on the steady rise in Malaria in Vellore, South India and the possible role of the migrant diversity in the town complimenting the spread of the disease. This is studied with the help of a case study that involves migrant construction workers, who came to work in the CMCH campus, living in very poor conditions, had complained of fever and were diagnosed with Malaria and Anemia.
- Treatment had to end abruptly as they were sent back without notice to the authorities. The facets discussed in the context of Malaria and migrants include,
    1. Access to health care and their complete helplessness
    2. They lived in conditions that were conducive to mosquito breeding
- Malaria Transmission: Owing to the lack of health centres and access to health centres leading to incomplete medicine regimes, migrants bring in Chloroquine resistant falciparum injections to the existing community. Chloroquine resistant P.falciparum is common in the areas from which the migrants come from.
- Social and Ethical Issues: Migrants are completely dependent on the employer to seek treatment. Stigma of an infectious disease may lead to them being moved out.
  Will migration for sustenance be stopped in order to control infection?
- Control on Migration Malaria – Violation of Human rights?: Screening for disease must be the responsibility of the employer and bound by law. According to the National Malaria Control Programme for Migrant Malaria, migrants must be encouraged to use bed nets, allow spraying and use mosquito repellants. However, owing to the multiple marginalizations of migrant families it remains to be seen as to whether they have the means that is both inclusive and accessible. The socio-political scenario must also be tackled in the context of Malaria keeping in mind that migrants are a high risk and vulnerable group.

VII. Malaria Control in Tribal Areas: Issues and Problems, Malaria in India: Reflections, Responses and the search for alternatives.

- Malaria is a major problem in under five and pregnant women in Ganjam District (Orissa).
- The lack of information on treatment, guidelines to follow, lack of supply of drugs, lack of trained personnel for injectable Chloroquine, lab facilities that are not upgraded and not easily accessible.

VIII. ICMR Bulletin – The Epidemiology of Malaria in Orissa, June-July, 2006

Orissa – 50% of Malaria deaths in the country.

- Population Characteristics – 22.3% tribal.
- They live in the forests, forest-fringe and foothill areas. This leads to operational problems leading to difficulties in accessibility.
- Population movements are due to the non-availability of work.
- Population movement led to the development of slums where there is an absence of spraying, treatment of water receptacles along with movement of non-immune individuals.
- Socio-economic characteristics

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