Society for Community Health Awareness Research and Action

HUNTER'S HUNT

Community health learning programme (CHLP) 2015

Shanaz Begum.C

Knowledge is not what is memorized,
Knowledge is what benefits.

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1.0 Acknowledgement

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And a lovely thanks to my fellow travelers, their present made the CHLP journey memorable and great opportunity to learn from each of them.

1.1 HUNTERS HUNT

The tittle “hunters hunt” itself can say what I mean, I see most people who come to SOCHARA will hunt it. Even I’m one among other hunters in search of practical knowledge which was lacking in me, but I was searching only mental health practical knowledge in clinical set up with narrow view. As days went on, now I realized that I’m in the right path of hunt. I see most of them are fed up with their job and the way they are working. I always feel they are service oriented people where heart and mind doesn’t match. And most importantly SOCHARA is not been advertised/ no publicity at all, I felt it’s hunted by likeminded people. I’m very astonished by seeing the fellow travelers all over the county and abroad too come to learn and share their experiences.

I’m a fresh MSc psychology post graduate student, and in one month, I got into SOCHARA. When I was studying my post-graduation in psychology at Bangalore University, we had an internship for a month and joined Victoria hospital psychiatry dept. Bangalore. From then, we got to know Mohan Sir who is very helpful and he is the one who showed the way to SOCHARA. After completing MSc in Psychology we went back seeking a job which offers training in psychology field. As a psychology student, I lack practical experience and I’m bored of just listening to theory even though I’m punctual to college I forget a lot so, I was in hunt of practice exposure learning by doing. He showed the path to CHLP which I was exactly hunting for. Now the path continued. I came to SOCHARA without knowing much about it. After reaching SOCHARA, I met Kumar sir and Joseph Anna who offered tea by thinking that we came for the meeting which held in SOCHARA. Then we asked for Dr .Thelma and Kumar asked to meet Chander. Chander Sir and Mohamed Sir gave their time to explain all about SOCHARA but I’m blank and had no idea about field. I just kept asking him ‘What is the field, what is the field?’ He said, well you will understand once you get into it and gave time to think and called for immediate interview but I couldn’t attend immediately because it was the month of Ramzan. So later I attended the interview and it was my 1st interview where I didn’t know what to speak and I was a bit terrified. Later I felt the interview was to find out what I’m willing for and they gave me the space to express myself with my English, which I was not confident about. Still, I remember Dr.Thelma appreciated for speaking/trying in English by saying “ your English is good” I was surprised to

hear from the lady who speaks so fluent English and made a positive comment but I know my English was not so good, but still positive strokes works a lot in learning. I was approved to be a part of SOCHARA and the joy was so much that I couldn't give another interview attentively on the same day. I should say I was flying in the air. It is my privilege to be a part of SOCHARA and I'm very thankful for selecting an inexperienced person. Now my journey continues….

Some of the things which surprised me at SOCHARA in the beginnings the free space to learn and exchange ideas between fellows and between mentors and mentees and no sir/ madam tags for teaching facilitators. Many times they force us to call by their name. It helps in breaking down hierarchy, which I never found in any of my formal education system just came across hierarchy, favoritism, discrimination and so on by only some teachers. But in SOCHARA doctors, engineers, social workers from different background, places with different disciplines are our friends. We sit together, we learn together, we eat together. Actually, I had fun together even though I took time to get along with others.

The first day of SOCHARA there was self-introduction of all who are new to SOCHARA and who are known to SOCHARA. This is the first system where I saw this kind of introduction system every time even a single fellow came to see or know about SOCHARA. It actually helps in to start communication further with new person and creating a network.

The way each of us, including mentors introduced themselves is very simple in manner. I never found anywhere before. I'm glad to join SOCHARA to understand the other professionals and their behaviors. It helps to break down my stereotype and filled confidence in me to speak, to understand, to learn from each individual.

When my journey started, I started to learn about health. Later I felt I'm learning health in a holistic way which I never thought of. I perceived health i a form of medical model but not in social model. This is where the individuals first perception changes. Then to learn health I was taught about all the multi disciplines - history, psychology, sociology, biology, politics, economy, epidemiology etc. at the end of the day I use feel I'm carrying a mountain inside my head. I use to fell I'm filled with bundle of knowledge never before. Consciously or unconsciously I use to think about it sometimes because I had to see one problem in different angle which is huge

change in my perception makes me feel it's becoming hard to digest. I'm always surprised to know hard reality of life and become an active learner. And I reflect on my education system after spending 15 years being as a student in my own country I'm not aware of my country's reality. I know it's very sad to say but it is also one reality among other realities.

Till month, we are 5 members 3 full time fellows and 2 interns. Just After 2 weeks I started of my SOCHARA journey, mosquitos gave the practical exam to experience, so I got chickungunya. The things which I was learning about vector borne diseases I experienced it. After a month I got an opportunity to meet all my fellow travelers who are back from field. I got scared to see 20. Many times I felt like quitting due to lack of confidence but still I decided to continue because SOCHARA accepted me "as me". Even I wanted to keep my words and trust which I promised at the time of joining. I did lot of internal and external alteration/ changes in self. Finally I succeeded.

Mostly the reflection was hard time for me may be because it made my lazy brain to work. Now the reflection part I feel is an informal daily test of yesterday's knowledge to know how much one has learned and understood from his or her own perspective and it is a revision of yesterday to remind what we learnt. Each of us varies in our capturing capacity. The reflections helps in pushing our knowledge to long term memory.

Now I would like to share my learning after joining SOCHARA.

1.2 My Learning Objectives:

In the journey of SOCHARA I wanted to learn about general health and to know more about community mental health.

*The challenges faced by the people with mental illness and their caretakers from the community.

*Impacts on adolescents (abuse children, street children, and neglected children), challenges and coping strategies.

* l wanted to know about older adults who are on street despite having the children , what's the reason to became helplessness and their mental status.

*And most importantly why the mental illness is not easily recognized as an illness by the larger society.

2.0 Collective Sessions

2.1 Health Definition:

The WHO defines health is a state of complete Physical, mental, social and spiritual wellbeing and not merely absence of diseases or infirmity".

Above definition is after all I learned in my formal education. After coming to SOCHARA I got know health is a broader term which cannot be restricted definition. It also includes other factors like economic, politics; environment and culture which also determine health. Health varies individual to individual for some health it is joy, peace, no diseases, cleanness, food etc. this are the some aspect I heard in field from people.

2.2 Mental Health:

"There is no health without mental health"

According to WHO mental health " a state of well-being in which the individual realized his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Mental health is a burning problem, the women's are more affected due to many reasons Mr Keshav Desiraju during dissemination meeting states that *'poor -> sick -> female is scariest in India'*. There is lot of stigma attach to mental health and even its very neglected or least bothered area in India due to stigma people avoid going to mental healthcare facilities. Around 5-15% of Indian population are suffering from common mental illness and 1-1.5% are suffering from severe mental disorders. We are lack in resources have 42 mental hospital in India with only 20000 beds for the care and only 2 psychiatrics for 10 lacks population and we have only 4000 psychiatric in a country. So there are psychiatric departments in territory sectors where they can feel free to get the treatment. But the base rehabilitation works better because people needed care, love, and affection and regular environment to feel better than institutional isolation. Dr. Janardhan from NIMHANS during class mentioned that research says 70% of disability can be curable with in society. So there is lot of need

to bring a change in the infield of mental health through working from community level.

2.3 Community health:

"Community health is a process of enabling and empowering people, to exercise collectively their responsibility, to their own health and to demand health as their right". The process of building people by using various strategies to demand health as their right collectively.

2.4 My Understanding of Alma Ata Declaration:

The international conference 1978 on primary health care the Alma Ata declaration "health for all' by 2000 held in Kazakhstan. The health is a fundamental right of all human beings based on equity principle where poor also approach the health care which fulfils all the 4A's(Accessible, Available, Affordable and Acceptable) and qualities The social determinants (preventative promote) and bio- medical (curative and rehabilitative services) fulfilling the 8 major elements are needed for health. The government is also responsible for the health of their people. The primary health care is key to attain the target of comprehensive primary health care. The people participation and collective planning to implement health is necessary for sustainability. The intersectional collaboration of different sectors for development of health system of the community by overall socially, politically, culturally and economically. AYUSH is important for the integrated, functional and supportive referral system. The scientific method, technology and locally available resources are appropriate used. The budget should be spent more on health (on 8 major elements along with recitation) t which makes the people healthy than on armaments. So, in late 70's the shift occurred from comprehensive approach to selective approach on cost effective targeting high risk group which destroyed the comprehensive health care system.

Till now we are struggling to reach health for the all which was need to be fulfilled by 2000. The present government is investing 1.9 percent GDP on health government is investing 1.9% of the GDP which has been shown to be highly inadequate for the needs of the people, thereby undervaluing health.

"Health is wealth of the people and people are wealth of country"

2.5 Globalization

The globalization is commonly heard and studied at formal education. Never had an idea that it has such a negative impact on my country in the name of development. As classes progresses I understood that how much the globalization affected the poor families. Since in India most of the population are agriculturist with their own traditional style cultivation. When globalization introduced most of our poor farmers suffered in the name of development. The food crops were replaced by cash crops and loans were allotted for pesticides and "hybrid" seeds for which they offer. The pesticides have spoiled the lands original fertility and make farmer dependent on pesticides forever. And others problems like dependency on technology, life style changes and so on.

"Globalization made poor people poorer and rich people richer"

2.6 Community health axioms:

Axioms help us understand the foundation of community health, which have emerged after long years of work with the community by SOCHARA. Community axioms are holistic bottom up approach to community "health enabling and empowerment of the community to take collective action to demand health as a right". So enhances the togetherness of the community. Focuses more on development of social aspect. And health care to be more community friendly, its break the hierarchy and give the authority to the people to know to the information and make the decision. And also promotes the appropriate uses of technology and uses of locally available resources. The axioms ill bring a change to reach the dream of "health for all".

2.6.1 Example from field

FEDINA involve the people in meeting as per the people convent to support the union to make people aware of their rights and enable them withstand by injustice (axiom5). And this organization has series of meetings where the organization has a detailed information about the issues and try to find the solution with the involvement of community (axiom 2). The organization selects 2 people from area through election as representative \ leaders whenever the activities not available these leaders carry on the process with in the area (axiom 4). The BBMP protest for

mid-day meals and for decent pension for elderly people the people are participated from different sectors as union to show solidary (axiom 6)

2.7Communitization and community health building:

Communitization is a word initiated by National Rural Health Mission (NRHM). Communitization is a process of involving the community actively to participate at all levels of health planning, managing, monitoring and evaluating. It's a bottom up approach to know what people want rather than just giving just what authority feels. It's a process of empowering people to make decision as a community what they feel as right to maintain their health. It involves all the members of community from children to adults.

To engage the community in the process of communitization one has to build a good rapport and built trust. Building communities is a lengthy process. To bring change in the community one needs to understand what people see as a problem and involve them in solving the problem in their own way because communities are the best knowledgeable people to solve their problem. The readymade implementation may have consequences or the rules and regulations without community participation may have consequences or it doesn't might applicable to community as a beneficiaries

Communitization is nothing but the Chinese poem

"Go to the people

Live among them

Learn from them

Love them

Start with what they know

Built on what they have

But of the best leaders

When their task is done

The people will remark

We have done it ourselves"

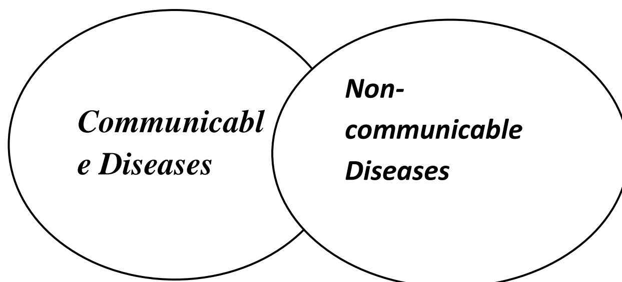
2.8 Health system and health care system:

Health system is an umbrella which addresses the social determinants of health and health care system which falls under umbrella which restricted to bio-medical model. India has 4 tire of health care system are primary, secondary, territory and 4th tire is home based medicine. So only focus on health care system doesn't increases in quality of life because biomedical model plays a role on illness which is Curative and rehabilitative care. The health system plays a role on wellness starts from individual, family, community through prevention, promotion, people participation and action. Preventative and promotive measures are cost effective and sustainable along with curative and rehabilitation care is necessary in out breaks, disasters etc.

Health is a fundamental right of the human being. Each individual is as equal rights to demand health as a right. But actually health become a commodity and health care system become a business, it means health is for people who have the capabilities to pay and our health system are not poor friendly. And surprisingly in India 20% 0f population has 80% of wealth and 80% of population has 20% of wealth so this percentage shows the highly emergency of equitable wealth distribution system e.g. through high taxations richer and less tax for poor to reduce inequality.

2.9 Social determinants and Diseases and disease burden:

2.9.1 Types of diseases



India has double burden of diseases both communicable and non-communicable diseases. Most of the countries are able to control the communicable diseases by improving life style of the people and development of infrastructure. As my

experience in the field in Bangalore city slums which is called to be a "silicon city" the ground reality was different as I went to the field I was surprise to see the lack of social determinants. The big drains are open, no safe drinking water to the community, no job facilities for people (unemployment) and laborers are exploited (injustice), corrupted PDS system, small places to survive which are tightly pack to and the garbage disposal in front of the health care or no proper garbage dumping place and this people are evicted from different place. So this is quite obvious to increase the communicable diseases in the space less community and spread the diseases. And no proper government health care system. And there is lack of stigma on non-communicable diseases epically comes to mental health. So the more investment on preventive and promotive measures reduces the burden of the diseases. The life style diseases are emerging due changes in life style like nature of work/ sedentary work, lack of physical activity, change in food pattern (more junk food) etc.

2.10 Epidemiology

Epidemiology is a "study of distribution and determinants of health related states/ events and applying of this study to prevent diseases and promote health" by John Emlast

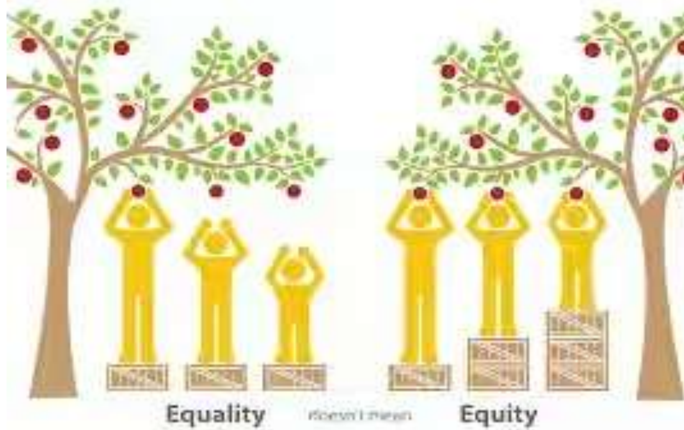
Epidemiology helps to understand in out breaks based on distribution like person, place and time. Determinants are biological, chemical, physical, environmental, social and behavioral.

2.11Values

2.11.1 Ethics:

The practice of ethics are very important to deal with living beings. After coming to SOCHARA I learnt about values the ethics is one among them. In collective session we were taught research ethics and life ethics and we practiced at field. For e.g.: one of my participant was not interested in filling the questionnaire forcing her just for sake of data collection I didn't felt ethical. ***"Ethics cannot be taught, only can be caught" by Dr. Ravi Narayan***.

2.11.2 Equity, equality and social justice:



"Reaching the unreached" the equity word is quite soothing when it comes to practice its very difficult, because the other side people doesn't give up. So equity and equality are not same. Equity to reach the unreached the upper classes people need to be sensitized and the poor needed to be empowered to demand their rights.

"Equity brings equality".

2.12 Paradigm shift:

The paradigm shift is from health care system to social model beyond the doctor, patient relationship addresses social determinants and also social action. The community health seven shift.

- A shift in focus from Individual model to community model
- A shift in dimension from Physical and pathological to border psychological, cultural, economic and political, ecological dimension.
- A shift in technology from Drug and vaccines to education and social process.
- A shift in types of services Social marketing and service provision to enabling, empowerment and autonomy building process and initiatives.
- A shift in attitude of people from patient to people and/or passive beneficiaries to people and communities as active participant.
- A shift in research from molecular biology, pharmaco-therapeutics and clinical epidemiology to social-epidemiology, social determinants, health system and social policy research.
- A shift in structure from institutional based (hospital and health centric) work to community based and led approach.

2.13 Social Vaccine:

Social vaccine new term as per my understanding any action from the society which addresses social determinants and social inequities of health and promotion of health than just getting health care facilities. The society takes over the autonomy over health and decides what they want through collectively (involving all the individual despite of caste, class, religion, gender, race etc.) the social vaccine is cost effective long run model because the action point was coming from the community.

2.14 Floor Mopper to tap turner off:

After being 10 month at SOCHARA I understood the role of tap turner off. To be a tap turner off once should bring a change in self, family and in community. The shift from just treating illness to promoting wellness. It means understanding the problem and solving the problem from root causes using low cost effective model by involvement of people. The turning the tap is challenging factor with stands against us as a tap turners.

3.0 Field Experience:

3.1 Organization Details

FEDINA: (Foundation for Educational Innovation in Asia)

I was placed in FEDINA after the collective sessions and I had opportunity to experience the actual reality of the life and understand reality in a multidimensional view point in field. The field experience gave me clear picture about the health determinants. The organization, which works for marginalized people through making union and empower the people and demand for the laborer rights. As we the laborers are exploited by not paying their wages which affect the health other aspects of life.

3.2 FEDINA Vision:

We believe that the most effective way to fight oppression is to enable the vulnerable people to become **actors** in their own **emancipation**.

3.3 Area of Operation

FEDINA's network extends all over **South India**, especially in Karnataka, Tamil Nadu, Pondicherry, Kerala and Andhra Pradesh States.

3.4 Main Objective:

Empowering the marginalized-Dalit, Women, Informal Sector workers, Slum Dwellers, Tribal.

3.5 Priorities:

1. Unionizations & Collective Bargaining

2. Employment Guarantee

3. Land Rights

4. Women Rights

5. Dalit's Rights

6. Gov't Welfare Activities

7. Own priorities

3.6 Meetings:

3.6.1 Area Meeting:

The area meeting held weekly once. With the community people most of people participate who joined union. Sometimes the activist will present and sometimes people will discuss the issues.

3.6.2 Team Meeting:

In teaming meeting once in a month, the program coordinator and activist works in different areas on particular sector will discuss about issues. If there is any major problem it will be addressed in the staff meeting.

3.6.3 Executive Committee Meeting:

The Executive committee meeting held once in a month, there were 2 representative from the community will attend the meeting at FEDINA with program coordinator and activists.

3.6.4 Staff Meeting:

The staff meeting held once in a month whole FEDINA staff will be gather at this meeting. Picks up the major issues from different unions groups to discuss about and to take collective actions as a union, major announcements are made in this meeting and administrator sector issues also brought into the meeting.

3.6.5 Central Team Meeting:

The central team meeting held twice in a month with the programme coordinator, associate coordinator and Executive trusty. For the smooth functions of the organization and the unions. The management level decision will be taken (confidential thing and project implementation).

3.6.6 General Body Meeting:

The general body meeting held once in a year. The union leaders are selected from community for each FEDINA's working area.

3.6.7 Collective Meeting:

The collective meeting held once in 3 months the days depends of meeting depends on funds. We attended for a week where all the networks where FEDINA in south India is working will gather and present the situation of their issues on which they are working, the challenges they facing and overcoming of issues as union. The presentation will be form the grassroots community union leader.

3.6.8 My Experience of Collective Session Meeting of FEDINA:

The seminar on unionization in the informal sector (cooperation between CHDT, France and FEDINA, India) on 5 Oct to 11 Oct 2015. The unionization meeting gave me huge knowledge in short period of time. The meeting was language friendly, people were sitting in a circle as a group and one person was translating with in their groups, the experience shared by particular person on stage working as union.

Session 1: Attended Seminar on unionization in the informal sector. Beedi workers attempt to unionize and for collective bargaining at Davangere. The beedi workers struggle for increase in wages and wages on time, good quality of raw materials, apposed for unnecessary beedi rejection and demanding more beedies with less raw materials. And all the workers need to get registered and works card should be issued for all the beedie works to gain benefits, not for their relatives or friends.

Session 2: Efforts in organizing sanitary workers in Pondicherry. There are 9000 women workers are from Dalit committee all are become members of union who are facing multi- contract system and treated as bounded labor. Their demand for single contractor (single contractor->subcontractors->works), treat them as labors, fixed wages by labor dept. Provisional fund, holiday, bonus and protective gear should be provided.

Session 3: Struggle of NREGA (national rural employment guarantee act) workers at Kolavige Haadi, HD Kote. All the government acts are at national level the implementation is very poor or needy families are not getting benefited. The tribal

people facing the issues with job like lack of job opportunities and job security, and lack of awareness about NREGA and implementation also becoming difficult because political and police forces are becoming a barrier. So people are scared to fight against them and this is a challenge to bring people together and fight against issues.

Session 4: Efforts in organizing migrant workers at CPWD Bangalore. CPWD is a central government project where all the workers are from north- east belt. Issues facing by this workers are they don't have housing, drinking water and sanitation facilities they are living under the flyover. Discrimination of wages according to the states and gender. No safety provided gears for the workers. And contracts started migrating the workers from place to another which is a challenge issue to form a union. High political threat, if workers share their problems with the union they were thrown out of the job. The workers who are working for the government project facing lots of issues but no one addressing. It shows that policy are only remains on white sheet with black ink rather than implementation.

Session 5: Efforts in organizing Devadasi women in Tirupathi and lobbying on farming rules in the act. Devadasi (sex slaves of God) are the girl’s child dedicated on the name of God when they attend puberty. This are women's from Dalit families, uneducated who are indulge in sex work (some time force to have sex) and the men have right to treat however they want also subjected for physical and emotional abuses. On the name of religion they were exploited e.g. on moon day the girls were made to stand undressed and men will come and select this women's on their body posture and pay some money, and in other places this women's were made to dance undressed. This women's and children's don't have property rights nor parental rights for father. Thorough unionization process the main aim is to abolish Devadasi system; women can fight for their rights and lobbying on framing rules on the act. Through unionization some of the women's are stepping for success.

Session 6: Struggle of women tea plantations workers in Munnar. All the 11000 workers are unionized and recognized by the company. The trade union were exploiting the workers when they demand the workers’ demands for bonus saying the company is in loss. Workers got united blocked the national highway for 5 during protest and they kept political parties and trade union and family members (men's) aside. In the process of protest they had captured a minister until they get confirmation of their demands will be met like bonus, increasing wages, better houses and medical facilities.

Session 7: Struggle of domestic workers situation in India. The domestic workers also called as *"ghost force"* which is unrecognized as workers and no statics are there. Approximately 2.5 million domestic workers in India. This domestic workers are poor and don't have bargaining power with agencies or owners.

There are 3 types of workers
1 Full time: The worker work in a single home for fixed time.
2. Part time: The worker work in multiple houses for fixed time.
3. Living worker: These workers live in benefits provided by owners.

Very few States has the policies for domestic workers are Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Kerala and Jharkhand.
Issues of domestic workers are no Job security and social security, lots of physical, verbal and sexual harassment, lots of caste issues from house entry to use of wash rooms which affect their health, child labor and child trafficking, No weekend holidays and maternity leave, No identification as workers, over time work and less wages, police harassment and struggle for removal of tag " *theft by servant* " which is particularly and only for domestic workers this kind of rules not found in any other sectors. And their demand is to address all the issues. Helpline should be provided for domestic workers.

The discussion of future plans (short term plans for 1 year) and actions from all sectors were presented.
The action plans were like

1. Strengthening the union.
2. More members' registration for unions.
3. Leadership training for members
4. Consecutively Meetings according to the plan.
5. Networking or lobbying the unions
6. Sector wise re- constituting
7. Co-operation and welfare societies

So the collective meeting gave me bundle of knowledge at one place from different sectors. Hearing to the people who are working at grass root level gave me understanding that people perceive many problems through the help of community or as unions they really with stand against the problem. I also felt that standing

against culture is quite difficult like Devadasi culture the community accepted it blindly. So the strong will is needed to make them understand and bring a change.

3.7 Stepped **into the ground reality** (Field work Kormangala)

The field work gave the actual picture of Bangalore city which is called to be as “garden city” or “silicon city” and many people have many dreams to make more and more. But there are 1200 slums in Bangalore and garbage become a major issue in Bangalore. The poor people are evicted from many diffident areas and dumped into openly drained areas. In the name of developmental greed to construct malls, roads, bridges, buildings. We are putting poor voices in all sorts’ threat.

I spent my time in my field in Kormangala slum according to the 2011 censes the population is 38316, 9719 households, family size: 3.94.

Physical aspect

The kormangala slum is one of the Bangalore slum. The slum was sub divided into 8 areas under it. We worked in Ambedkar Nagar and L.R. Nagar. The houses are

very close to each other, there were good electric and good transportation facilities. The lanes are small, the roads are very muddy when it rain not able to walk on the road and the drinking water get contaminated with drainage water. So the people have to waste the water for hours to get clean water. They don’t have any proper place to dispose garbage the community throw garbage in front of the health center. The combination of different communities in this slum are Hindus, Muslims and Christians, they speak Tamil, Kannada and Urdu. And so on all this people are from lower economic background. This people are evicted from different slums and placed in kormangala slum. Most of the women work as domestic worker in national games village apartments and men’s were coolie workers. There is lots of violence in the community in youths they were unemployed. As I was in the field the youth was murdered and placed under the mud just for mobile or money issues. The alcohol are mostly consumed by men and even violence is also there in the community. But

the family doesn't disclose when we ask about the consumption of alcohol as part of survey the community people most of them hesitate to answer might be because we were strangers. And there is a service provided by church for de-addiction for alcoholics. And there is lot of dogs which bites but still people are living with them.

Leaders:

Harish was the MLA, Lokesh and Gopal Krishna were counselors. And there are many informal leaders in an area. There are informal leaders for lanes who have money and other power.

Existing groups and institutions:

There were many organizations working in koramangala slum as I witness like FEDINA (Foundation for Educational Innovation in Asia), REDS (Rage picker Education and Development Scheme) APSA (association for promoting social action), Agni Raksha NGO for burnt people and CHRIST college this institution with the slum community etc. the people who are familiar with NGO'S had lot of expectation from NGO's and others didn't like to respond to us. And there is an one health care center which was run by BBMP government Anganwadi's, private and government schools, youth center and all religious institution like Mosque, Mandir and church etc.

Visits in Koramangala:

The health center is open Monday to Saturday from 9:00 am -2:00 pm. There are 2 general practitioners and a specialist visiting the health care center, 1 nurse, social worker, and housekeeping staff. The PHC charges 5₹ and receipt is also given and the only diagnosis for common diseases. If there is an emergency they refer to other government hospital. There was no delivery services were provided because of lack of technology but they provide immunization to children and prenatal care is given. There are list of 30 medicines which will provided for free in health care. The health care was also supported by St. Philomena and Ashirwad (as charity) this money is used to buy the shortage medicine in health care. Each month at least one camp held in health care. Their target to diagnosis 35 people per day but now the patient may increase up to 100 sometimes. The most commonly seen problems are respiratory problems, gastrointestinal infection and dog bitten cases. Now the HC is deciding

not to charge 5₹ also but not yet declare. This information is provided by Dr. Anil the general practitioner (or resident doctor) of health care center.

The outer view of health care:

The entrance gate to HC was very pathetic. The garbage was fully scattered both the side of entrance. When it rains it becomes very difficult to walk in. There is no responsibility of any one neither government nor people and this people don't get any garbage vehicle In front of the houses. All will throw the garbage in front of health care.

People’s perception: presently people who are visited said that present doctors are good. But the 4A’s are absent to approach the health care. Depending on the situation and medicinal effect people prefer the clinics also.

The survey results at Koramangala:

I did home visit in kormangala as per the instructions from FEDINA mentor to know whether elderly people are using government hospital or not, and why they are not using. In survey we found out that most of the elderly woman whom we interacted are using PHC services and getting their medicine for free of cost diabetic and calcium tables. And Adults and children are using both facilities government and private depending on severity of diseases, and availability of facilities. At present the people who uses the PHC services are satisfied and the doctor also very social with patients. The people who uses only private clinic has bad experience in government hospital very long back and they found that tablets was not suit for their body.

The change in doctor and arrival of new doctors who is social which is the helping people in getting the health care facilities.

Visit to Anganwadi:

There were no children in Anganwadi due to continuous raining and there is huge crack on the wall and fear of building collapses. The doctor's visits 3months once. The posters were many on wall and weight scale. But there were no separate kitchen for cooking, no safety from electric stove and toilet for children. To shift the Anganwadi the governments not ready to pay advance amount.

3.8 Lingrajpuram:

This slum is divided in to 3 blocks Lingrajpuram A, B & j block. We spent most of the time in B and A block. The roads are good in B block but the roads are muddy in A bock. Most of them have own houses. The people are from lower cast (SC/ST). Women's goes for housekeeping or domestic work and men have own business like vegetable, sofa making shops and even coli workers. The people are uneducated are very low education. The roads, sanitation, electricity and water facilities are good. Most of them were migrated from north Karnataka in B and A block there were mixture of different communities. B block had an Anganwadi, 2 government schools. Religious institutions like mosque, temple and church. And FEDINA meeting hall. We spent most of the time with elderly population and conducted a survey the use of health care system by elderly adults and the perception based on some questions. The results are given below

Home Visit in Lingrajpuram 'B' block & 'A' block. Lingrajpuram is a recognized slum. Collected 50 peoples data by interact with elderly people and 2 Handicapped people. Most of them are females, are widows, less educated. The people are migrated from north Karnataka living from past 30-35years in the area. All of them have own houses whom we met. The people are from lower cast (SC&ST). Women's goes for house picking or domestic work and men have own business like vegetable, sofa making shops and even coolie workers. The people are uneducated are very low education. The roads, sanitation, electricity and water facilities are good.

Most of the senior citizens are highly dependent financially on family and lacking family support like no proper care, love and belongingness and starvation for food. The pension is helping them to take care of themselves for medicine, travelling etc. And of them are leaving with daughter and some of them living with sons and very few are living independently.

The health related issues commonly seen are diabetic, joint pain, feeling of

loneliness, stress and become emotional when they talk about the family and worried about the children future who are widows and whose husbands are not taking care of them well.

The government health facilities (PHC) are very far from the slum which is in Cox town and no proper transport facilities are in cheap to seek health facilities this people have to pay for auto which taxes more than private clinic. The people are highly unsatisfied with the service provided in PHC and the behavior of staff also very bad and make to wait for long hours or telling them to come on next day or refer to boring which is even more farer. In PHC they don't provide free medicine to elderly people who has to get free medicine for a diabetic and joint pain. And for general public also they don't provide medicine. So, majority of the people prefer private clinics, some of them go to 7th day charity in church where the doctor come twice in a month and they check for Blood pressure, sugar and provide free medicine. In starting they have pay 10₹ for card and for sugar test 15₹ need to pay each time. And who has no money and no strength to go to hospital they do self-medication take the tables from pharmacy are else bare the pain to themselves.

Visited Lingrajpuram Anganwadi:

There were 20 children were in Anganwadi and 30 were in the record. The Anganwadi had good facilities of separate kitchen, toilet and good space to play. But there was no weight scale, no chart or boards. The doctor visits once in a month to Anganwadi. The Anganwadi provides the supplementary food to pregnant lady, lactation mother and for malnourish child. For malnourish child they provide 3 days egg and 3 days milk until the child become normal. There were 3 malnourish children were recorded with in 1000 population.

Reflection:

The tiles inside the Anganwadi might not be safe because children may slip and fall if there was water falls on floor or while walking. There were lot of violence physical and verbal violence was inflicted on innocent children very badly, beating is not the solution, since children are good exploring learners.so they can provide or engage children through other activities. The teacher and Aiya was not trained properly to handles the children's. So I feel there is need of teachers who understand and handles children's without harming/hurting. Since childhood is a crucial period of life, good environment helps in becoming better individual.

3.9 Protest at BBMP

This is first protest which I joined with FEDINA 1 Oct 2015 was world senior citizens day held at town hall. FEDINA organized a rally demanding elder's rights as the organization is working with marginalized groups including elders. Thought there was law in national level it was not implemented in gross route level , so it was demand for mid- day meals , free diabetic medication and pension for above the age of 60. After 5 hours of struggle the authority agree to restart mid-day meals which was stopped 2years before and reimbursement of pending pension within a month. After two months also they government was Negotiation with other NGO's for mid-day meals. So, the 2nd protest on March 10 was held after lot of effort the BBMP Government allotted 4 corers for mid-day meal.

To reflect personally the elderly people are the citizen who worked for the country with small wages and built our country. Now it's government responsibility to take of them. At protest I found that people are participated enthustically but the sun and other health issues making them exhausted.

3.10 Meeting with drivers of remix Cement Company.

Interacted with 3 members who had been to FEDINA. The workers have to work for 24 hours the salary is 16000. The company doesn't provide any workers I'd card for worker as proof. The owner didn't pay the full salary instead of that he use pay the amount which is needed for present less than their pays and promise them to get the own vehicle to them and the workers trust went wrong and the company cheated them. The six workers joined union and they were immediately fired out from job and without clearing the pays up to 1 lack balance needed to get paid by company. At present this workers are jobless and their debts are increasing and they are selling or keeping the gold ornaments at bankers to meet the needs of family. The bosses threatened the workers verbally and made them to wait for long hours in rain and paid the amount in installments and still they need to get 2 months pays. There are many people are suffering from same problem due to the fear of unemployment they suppressing the suffering. This company also has their own bank they give loan to workers and also make profit through interests.

Reflection: The workers are cheated when are employed and suffers when they are unemployment. And due to immediate fire out from job the debts were increasing and the living conditions are automatically goes down.

3.11Domlur building visit:

Construction Building visit in Domlur. To form the workers union. The male workers were paid 300 and 250 for female workers the actual pay for both male and female is 500. When we asked them to demand for it he said that the person who brings him here is his relative and they can't ask for it. Initially when they brought here they informed about the pays which is very less due to unemployment the workers agreed for the pays and migrated people are from Andre Pradesh and other states people also were there. Every week this workers only get 1000₹ at the end of the month the remaining payments will cleared. There is no holiday was given on Sundays. The residence was given with in the building. Finally the workers are agreed to join the union.

Reflection:

This is the first visit to the building through FEDINA. This visit gave me idea about the struggle and negotiation they have to make before entering to the building. Later the trust and rapport building they have to build up and start empowering them to fight for the rights. I got to know the process of building union and the problems faced by them.

3.12Rajendranagar (koramangala) slum:

2nd field work in Rajendranagar is part of kormangala slum. The houses are very close to each other, there were good electric and good transportation facilities. The lanes are small, the roads are good. There was poor water facilities people. When there is power the people who have motors they just fill water and who doesn't have motors they have water problem and get water only when the power cuts the water comes to through pies where they have dug holes.

The combination of different communities in this slum are Muslims, Hindus, and Christians, but majority are Muslim population in the slum, they speak Tamil, Kannada and Urdu. And so on all this people are from lower economic background. This people are evicted from different slums and placed in kormangala slum. Most of the women work as domestic worker men's were coli workers.

There is lots of violence in the community among youths and also in the community. The women's in the vigilance committee meeting reported that there is lots of raging and teasing, girls were not safe and the mothers felt they are helpless. And I even personally felt that due environment/ continuous expose to violence. The most of the adolescents were also violent and they fought a lot for simple reasons among themselves and bulling was quite common among themselves.

Formal leaders were Ramlinga Reddy was MLA and Sampath was counselors.

3.13 The survey in D.J Halli on waste management:

The D.J Halli is slum in Bangalore. Did survey on waste management project collaboration with Baptist hospital, SOCHARA, GRACE and BBMP. The 2 days survey targeting 200 household to understand the community waste disposal and their behavior with the help of questionnaire. I cover totally 44 houses in 2days. Where I initially found out few people are afraid to give the data and few are doubtful and fed up by giving data one lady said that she was "fed-up by sing the papers". Then had to negotiate/ convince with the people to give the data about their waste management. The garbage dump behind the Baptist urban health center. The people who are living surrounded the garbage dump area they see garbage as problem but mostly not the other people who are living far and they keep the houses and surrounding clean. The people said they dump the garbage because vehicle doesn't comes in front of the house, if small trolley comes to take garbage they ask money so many people will just dump the garbage on empty land and few said they throw in the vehicle when they comes to collect the garbage from dump yard. Few said they throw the garbage at night because in day time nearby residency prevent them not to throw the garbage. Most of the people didn't had the information about garbage segregation and few had and they were doing. As we ask the people to join hands with to facilitate cleaning up the surroundings some are scared and said others are there and few said if they are working for us surely we will join. As we went inside I found out very small lanes where two people also not able to walk comfortably and many homes with very few toilets. In one building there is 2 toilets for 6 houses and in lane I heard there are only 2 toilets for 13 households and sometimes 1tiolet get filled. And even there are households who doesn't have toilet facilities at all.

Community people doesn't know who the counsellor is, when we went said the survey for garbage management, they ask about the counsellor and they said that from their side they sent letters and complains went but nothing was happening. I felt it was just blame game happening from people to politicians or vice versa.

Reflection:

The community doesn’t have information about garbage segregation. Due to some lanes are small they vehicle/ trolley cannot go and no other facilities in the community to throw garbage they are helpless to proper waste management. So if any organization takes initiative and starts awareness about garbage and the creative way to reuse waste, it will be very helpful to the community. Since people are poor if any low cost model need to plan to help the community keeping in mind that the space is less in the homes. Helping them use and reuse of waste brings the huge change the community. We need community participation and take their responsibility to keep the environment clean. The creative method of recycling helps in some kind of saving.

“We know waste is actually not a waste it’s a resource to reuse”

Inauguration of the project, community based waste management:

After the 180 homes survey the integration for project took place. Where the counsellor is been invited for inauguration of the project and doctors from Baptist hospital, people from SOCHARA, people from GRACE and few people from community participated. The counsellor was on time and gave the brief introduction about how the D.J Halli was and what all he did for improved in his period. The counselor was aware of slum condition of slum and had good statists of peoples living condition. He agreed for all demand to fulfill raised by Baptist hospital after the survey. As a politician the work he had done need to be enlighten, He was self-parsing too much. And in inauguration there was very less community participation and the demonstration of segregation of waste was down and people are sitting on chairs. In front row male were sitting and in back row female where they are not able to see demonstration.

Reflection:

The actual key the people were not present in the inauguration. Without peoples participant it was just a floor mopping act. The inauguration was happening in the community hall in 1st floor and outside there was a fight going on within the community just ahead due to blockage of drains. To bring a change in the community mobilizing the community is highly needed with awareness.

3.14 Real life stories

I'm happy now:

The family with four children 2 male and 2 female. The female adolescent girl of 14 year was completed 9th standard was back to happy life recently. Once upon time her father was an alcoholic and also use to do violence at home on wife and abuses the children's. The children's were scared when he consumes alcohol and she use to hide in room. And she asks herself why me? Always worried about their future and their respect. She started comparison with other families to her family, from other children to herself. The thoughts were always ruined in her mind "what might people think about me because of violence". Sometimes he runs away from home for many days and her mother brings her back thinking that he is the family dignity. Now her father left consuming alcohol, she was so free to talk with others and even with father. The fear of talking behind due to violence was died when father left alcohol. Now she was happy with her family by sharing and caring. The changes in person brought light into the lives of his family members.

I'm not the same give me chance:

There was a girl 13 years old completed 8th standard and from last one year she is staying at home. Her parents made her and her sister quit the school because her elder sister had fell in love with a guy. Now the elder sister is working at garment factory but the younger sister, though a very enthusiastic learner is forced to say at home. I felt her dreams are fading away because of the way her family has reacted that is the problem. This shows the patriarchy in our society.

Missing my father:

There was a girl aged 14 years had 4 brothers and one elderly sister and mom. The elderly sister got married and she is living with other family members. Her 3 brothers were alcoholic use to do frequent violence at home. When they drunk their ill-

treatment, there abuses made her get suicidal thoughts, thoughts of running from home, and other emotional feelings in her. Most of the time she use to think about father and cry, the absence of father in life from past 14 years brought the negative impact on family. And now she has a trust her friends spent time with them and also she feels that once she gets married she will can live happily.

I didn't committed crime than just being born as a girl:

The girl was 11 years old studying in 5th standard in nearby government school. She has one brother and one sister. The father was stone worker and mother was domestic worker. Her father was alcoholic and fights a lot at home. Many times he hit the child purposefully and even she was wounded and he doesn't care. Her farther looks after well for her brother and dislikes the girl child, once he took her and left in Dargha and came back. Due to her good luck she met her uncle who was staying there and she returned back to home safely but she is unsafe at home. And he points her not as her daughter ***"tu kon ki dhad ni ki bachi".*** And whenever she wears a good cloths he always abuses. Even though her mother divorced him he continued to stay in home by troubling the family.

I'm not an object, for package of violence (most of father's family members inflict violence)

The family with 4 daughters and one son. The women was working in hotels and men was Chola maker and also alcoholic, he never use to take care of family expenses, he use to take money from wife to consume alcohol. If he doesn't get money he takes the things from home sell it to consume alcohol. And abuses children very badly while having food, because he was not able to eat he also use to beat the children very badly on lungs when her mother is absent for silly reasons, he also threaten the children by saying that he gives the complaint and dies if they say to quite alcohol. And the men's family supports the men to beat and sometimes they will also abuse the children. The mothers and her family taking care of children and helping in their growth. But the girl doesn't discloses her discomfort to her mother because her mother cries.

We need freedom:

This is the story of twins they had other siblings. The twins were 17 years old. Both completed 10th standard. And one was going to college and another one was at home

due to back logs. Their mother is domestic worker and father doesn't works, but sits and manages home but instructing what to do and what not to do, he is a strict man, never set children to live the as they like to minimal and he also use to alcohol. Now the father is forcing the girl the go for domestic work which she doesn't like and scolds her for not earning and she has a dream to become a nurse, but there no way to archive her dream. And another girl who is completed 1st P.U.C (pre university course) had no hope to continue her studies her studies, it's all dependent on father because of father oppression she wanted to work in office. The twins were very innocents, suppress a lots of things with in them. And they are become the victims of exploitation.

The story of the girl without parents:

This was the stories of the 11year happy, charming girl her mom died when she is small and her father left her mom but the child doesn't know about father she has been told that her father also died. Now her grandmother (mother's mother) is taking care of her, things are fair enough in her life. But most of the times she become the victim of physical violence from her aunt. Which hinders her normal happy childhood. And the neighbors empathize with the girl. And she cried out when people says or reminds her mother and her aunt violence on her.

The story of the girl, the mother with mental illness (stigma):

There were 2 daughter for a mother and she was suffering from mental illness. The women become mentally ill when his husband left her and married another lady. One daughter was left in hostel (Madrasa) and another one is staying at home with her mother. Most of people recognize the child with her mother's mental status not from her own identity, which affects her personal growth and gives an idea how society perceive as mentally ill patients and the negative role of the society to in child life.

The political oppression:

There was small family living in slum with 2daughters. One got married and another was affected by pulse polio she was not able to walk and she was getting pension of 1200 per month. Father was senior citizen taking care of her and mother was to go for work. Once the government gave the wheel chair too physically disabled she is also received the chair with inauguration function and photographs while distribution of wheel chairs. Later very shortly the wheel new wheel chair replaced by very old/ nonfunctional one by saying that they misplaced the wheel chair the

new was not hers. This shows the extreme oppression for poor people by political parties.

Once upon a time happiness was there:

There was a widow women aged 62 years old with 2male and 1female children all were married. She has her house but boys are occupied and says her to stay at daughters homes. And she goes for work earns 600 even thought she was not able to work to meet her daily expenses and also she gets pension. To save money or hesitation of keep asking food for children she drunks tea to reduce hunger and only one meal she eats. She is sufferings from health issues chest pain, diabetics, joint pain and so on. So she prefers free health care from charity rust but none of the government hospital are nearby and meeting the needs of elderly people. Her previous life with husband was good when she was went back to her old memories the tears rolled out. And she was house wife before now become a domestic worker when she lost her energy. To live the same life now it was just a dream.

The blame game

The man aged 86 years has 6 children 2female and 4 male. He and his wife was living with boy children and all were married. He had diabetics but he couldn't go for hospital even though he is suffering because he is financially dependent on children and he doesn't gets any pension. But he helps the sons in the business and they pay how much they feel the money wasn't meet her expenses. When he ask money for tablets each of them say they get it for him but sometimes they get for few days and sometimes they don't get it. Later the blame game happens among themselves. But between them this has to suffer.

The Tears:

The house was beautiful with garnets all around the walls. The women was laying down with tears due to dis-easiness in health, she was around 65-70 widow with 2male and 1 female children. The women was suffering from fever. The neighbor was a son and he was sitting involved in his work. But he didn't turning to her mother to take her hospital. This lady didn't had much strength to walk and see a doctor neither had money in her hand. The pension also stopped from past 2-3 months. Which made her life miserable.

Just a Wish of death:

The women she was 80 plus, lost everything in life (from inter to intra) was living. Her back bone was bent, the poor eyesight, she doesn't had energy help herself. And only the pension was her income to care of herself. When she speaks the tears always rolls and hands shows the upward direction. She was alive with the only wish of death.

The elderly people was more dependent on pension even though the amount was not so big. So once upon time were a productive assets to the country but who is responsible for them? No one, just they, their silent tears and painful hearts.

The stubborn people:

Daily early morning people comes to bus stop as routine. In spite being a knowledgeable people they were so stubborn to follow the rules. There was a traffic police with his informal dress daily comes to BTM bus stop to clear the traffic jam and always he keep shouting at the people to stand in bus stop the and at same time directing the vehicles to move faster, But people are not cooperative. People are still doesn't follow when he is absent on bus stop. Once the lady was fighting back to him who is actually helping us by clearing traffic jam and get busses. Unless they fine for something the things are not going to change. So people participation and cooperation helps the police productive for rest of the day.

Me and my Dadi:

The family was separated after the twins was born and the 2 daughters was shared by 2 families, one for mother and another for father. The daughter was with mother was got married and the daughter growing under father and grandmother was still studying and her father was alcoholic and she was subjected to violence when she goes to protect her grandmother many times grandmother asked granddaughter to go back to her mother because she is not able to carry the huge responsibility of granddaughter due to age related issue, but her granddaughter is not getting convinced with this idea and she is not ready to go. The grandmother was poor lady around 70-75yrs who is actually looking after her granddaughter with the help of her daughters and also she work at home, peeling the garlic with her granddaughter and also grandmother work as daiye. And she is not getting even her pension from past 2-3 months, but all the money she earns goes for rent and other expenditure and they eat the food if neighbor gives when they cook more or their relatives looks after it, but they rarely cooks at home. When I ask her to go to tailoring class buy a machine and start her business. *She replied me didi there is no money to eat you are taking*

about buying a sewing machine. Her reply gave me a shock and made me think from her perceptive

Your words kills more than diseases:

In my survey I met a boy who is just around 13-14yrs. He was suffering from diabetics (sugar) which cures only with the cost of death. The boy needs to take daily siring for the diseases and he was unconsciously always made aware of the people that he is a diseases person/ not normal. So, the diseases doesn't kills, but people's words does. Rather than being empathetic, the people they just hurt without their knowledge by speaking without thinking. The just support/ empathy for a person heels might not physical, but it heels mentally.

4.0 VISITS AND MEETINGS

In SOCHARA apart from classes, we had field visits and meetings which enhance our knowledge.

4.1 Sanitation work shop:

"Community Culture and tackling the sanitation problem though a sustainable community health approach". After joining SOCHARA this was my 1st work shop at SOCHARA about sanitation on 23&24 July 2015. The shocking thing for me was even though toilets were constructed they are not functioning as toilet but people are using the toilet as store rooms, puja rooms etc. So I realized that building the toilet is not a solution but making people understand the important of toilet can help in sustainable toilet. Even I was not aware of the consequences of not having toilets, it's really remarkable work to make people understand and bring community action.

The proper garbage plan is necessary to recycling and healthy environmental. And the water management through weeds plants was presented by Janell. The weed plans removes chemical toxins and purifies water which is safe to use and fishes are income for people. The appropriate technology with low cost helps in maintain clean water and earn an income.

4.2 Reflection on Alumni-Mentor meeting 0n 7 & 8 December 2015

The alumni mentors meeting brought all the segregated family together and helped us to know the old and new family members to build a network. The meeting with inspiring people who dedicated their life to community health

to reach health for all which was and motivating the youth to move ahead in their life journey. The experience which was shared by the mentor and alumni threw light to think in different direction and brought a linkage to self-experience. I felt that human resources bring an immense change in the world when they are trained in a proper and positive way. This meeting gave the essence that learning, understanding, knowing etc. is important with the practical implementation in life. Each member of SOCHARA is directly or indirectly moving in the way to achieve 'Health for All' without any boundaries of discrimination. Each one's approach to the dream is in unique, fighting with the battles coming in the way. The satisfaction of life is not only the money, luxuries life, but it is joy, happiness. When others are happy, the community celebrations.

4.3 Meeting with alumni to understand on Child trafficking

The child trafficking is become common in India. The Indian children are not safe. They are under some or other harassment. The children who become victims of trafficking will have a huge impact on their overall health and they have a long term effect on their wellbeing. Trafficking "spoils the huge dreams of little eyes". As per the current scenario, harassment take place within four walls. Children's voices are unheard by trust worthy individuals until they see the consequences. .

4.4 EP Menon Meeting:

The informal chat under the trees with a 78 year old young man at chitra kala parishadth . He shared two stories: One was about his journey and another one was about his motivation to a youngster. The meeting gave the message that to bring change, it doesn't matter how many people are involved. It matters how much change can start from a single person. He is a simple man with big networks. He also taught us that if you see something question "Why? How? "Why not". And we saw Indian paintings at Chitra Kala Parishth, which communicated the Indian tradition. The lines were communicating about the picture.

4.5 Ground Level Panel discussion

In this ground level panel, we heard the voice of people who are marginalized and oppressed and struggling to get the justice not as

charity on any one’s mercy but as a right. The government is turning a blind eye and ignoring the larger population of the country who are living in poverty. The authority forgets their duties once they get into their seats that they are by the people for the people and of the people. I felt most of the time the policies and people’s needs doesn’t matches. Because the authority doesn’t know the actual suffering of the people and never wants to approach and see what works better for the people. This leads to lots of other problems where again the poor families have to suffer.

4.6 APD (Association of People with Disability):

The APD is” ray of hope for children with disability.” APD is working with children with disabilities and bringing up their strengths by providing the education and skills training. They also helping them to become fully functional individuals. The most important aspect I like in APD is the education will be provided for both children with disability and children without any disabilities. The normal children are the siblings of the children’s with disability this kind of education helps to understand the difficulties of the disable once. And brings closeness among siblings and helps to break down the misunderstanding and stigma. And also helps to shine and fight against the world.

4.7 Little Things Matter

The talk was on “the impact of toxins on the developing brain” by Dr Bruce. The little itself talks that little toxins also has negative impact on the people especially

on children's. But the money has been invested more on curative than preventive and promotive measures. So state is doing the job of floor moppers even though it can turn off the tap. So it shows that there is nothing called safe limit. So what I feel is rather making fool for the people in the name of safe limits of toxins "its better not to use than harming people.

4.8 NIHMANS Wellness Clinic:

We all know mental health has lot of stigma and it is ignored. The NIMHANS wellness clinic is most unique clinic which spreading its wings by bringing awareness in rural and urban areas by using various methods to approach people with the use of technology. To prevent the illness and promote well-being. This clinic is more people friendly and people get help all the time. And most importantly the clinic are targeting for young adults to prevent suicides' among youngsters who are more prone to sudden decision which are life threatening.

4.9 GRACE: (Grass Root Action on Community Empowerment)

The grace institutions work with the collaboration with BBMP and other waste pickers. In Bangalore city the garbage is become a huge problem. So this organization is motivating people to segregate the dry waste and wet waste separately. This helps in recycling the dry waste, if they encourage any creative methods it will encourage people to understand and co-operate with them. But still the waste picker conditions are very bad as they strain in the waste. So it is very important to take care of health.

4.10 Inaugural Health in Slums Symposium

The aim of the symposium was to bring together the organizations, research, educational institutions and students working with slum communities facilitating the exchange of ideas and experiences and stimulating collaboration. Thus, it allow the development of a health in slum network of partners that works together to maximize their efforts, and enhance the lives of slum communities in Bangalore.

The symposium was organized by Zuyd University of applied science, collaborating with other organization and institutions in Bangalore Baptist hospital on 30 April 2016. The major focus of symposium is health in slums. The symposium gives an insight into the sufferings of the people in different slums in Bangalore. I saw many like-minded people, doctors and other professionals who are dedicated to work in slums and NGOs are bringing change with the use of appropriate technology and low cost model. The symposium would be much better

if we had audience from other streams and community people for more arguments and clarification.

4.12 Workshop orientation to psychotherapies:

The 2 days' work shop at NIMHANS wellness clinic gave me the idea of how psychotherapy is conducted. They showed 6 case videos with 5 psychotherapy (narrative psychotherapy, cognitive psychotherapy, integrated therapy and emotional therapy and psychodynamic therapy). Though the video language was complex after each therapy we had discussion for clarification which helps in understanding better.

4.11 FRLHT: (Foundation for Revitalisation of Local Health Tradition)

The visit to FRLHT was a unique experience with nature. The campus was surrounded by medicinal plants. The university named Trans Disciplinary University and Institute of Ayurveda and Integrated Medicine. It identifies and encourages the local health traditional healers and encourages them to work after the certification.   We are losing our tradition which is fourth tier of health care system which is which full fills 4's (Acceptable, Access able, Affordable and Available). So there is need for motivation retain the culture.

4.13 Raipur for MFC Meeting:

MITANIN PROGRAM

The visit SHRC on 18 Feb 1026 (state health resource center) and the areas where mitanin works. Mitanin refers to ‘’best friend’’ one mitanin for 100-200 households called ‘para’. Totally 70000 mitanins are working in Chhattisgarh and 1025 mitanins are working in Raipur. The mitanins are selected from the community and by the community people. The mitanin programme is working successfully in rural areas. The mitanins of rural area are from same community, uneducated but trained by SHRC and in urban area the mitanins are educated, from same community and they also get training from SHRC. The both rural and urban mitanins tested after the training and before the training. The mitanins are paid in incentive based and the incentive is also for particular work e.g. for institutional delivery, T.B, contraceptive, recording the work in mitanin panchi etc. and she doesn’t get paid for home visits, extra time spent with people/community etc. The mitanins will be given 5 books based on that the mitanins give information to the community and each book is depicted with pictures which helps in understanding for the mitanin and for the people or community. The visual images have more impact on people just than words. The books are:

1. Swasth hamara adhikar

2. Mitanin tod, mod goar (talk between us)

3. Mitanin ki dawa peti

4. A. Nawajathi bachoo ki dekh bali (baby care for 40 days)b.

5. Phal nay wali bemari

And mitinan panchi to record the whole work done by mitanins. The expected to work for an hour/ two per days.

Reflections on visit to area:

The mitanins are dedicated to their work even though they paid for particular work, incentive based pay, and delay payment for 2-3 month. They are likeminded people whose intention is to serve community. The mitanins are serving as doctors, counselor, friends and family members to the community. The main gadgets are the information with pictures in books and the wall paintings on the house wall of community. The paintings will help remind the people of community to do the thing in correct way. The visiting the mithanin helped me connect whenever I hear or learn about them.

4.14 MFC (medico friends circle).

The MFC meeting was on 19-2- 16 and; 20-2- 2016. The meeting was started by self-introduction. The people from senior level also introduced themselves in simple manner. The topic to discuss in meeting was on urban health. Under urban health the sub topics like landscape, migration, urban women and health, policy challenges, diverse perceptive, clinical theory, city health care assessment and current issues were discussed. After each session people clarified their doubts, debate took place, and suggestions and experienced were shared. Every time a person used to moderate the

time and reminded the limit of questions, answer and arguments on topic. It was inspiration for me that the people are talking from their experience and bring the new ideas to the stage to think on that. People did not have enough time to discuss on the topic. Seeing and meeting new people helps in building rapport and network with each other. The discussions outside the meeting was more interactive It was more about the sharing of personal experiences and the work, their interest and suggestions on our area of interest. People were friendlier once we started interacting with them. We felt as if we knew each other from past. And there doesn't have any barrier of younger/elder, male/female, states, classes, educational back grounds and so on. The people with bundle of knowledge and experiences are ready to hear and learn from every one rather than just speaking by themselves. I felt there was equal opportunity for everyone who raised their hands to speak and share ideas. The preparation in SOCHARA for MFC was very useful. It helped in connecting to the issues what they are addressing about and sometimes it became difficult to get some points may be due to long hours of sitting, my capacity of paying attention and lack of knowledge about the issue. We had in between songs entertainment, tea break for refreshments. I personally felt this meetings helps in bring people together, understand about the problem, building networks and working on the goal of "Health for All".

4.15 SOCHARA Silver Jubilee on 15 & 16 April 2016:

I’m glad to be a fellow of the jubilee year of SOCHARA. It was 2 days great celebration for us. With organic food, songs, kalajathas and with meaning full panel discussion Tamil Nadu floods, rural challenges of agriculture and sanitation and communitazation on health system. The after noun sessions had 4 parallel work shop. Some of the quotation I captured which are very meaning full to me.

“Thousands of farmer died due to pesticides and lacks of people are in threat”

“Our choices kills farmer”

“We can work in miracle if there is solidarity”

“We are surplus in production and lack in distribution”

Community participation become “buzz word to fuzz word”

The two work shop I attended in 2days on environmental determents of health. Where we had discussion but video was more meaning full to me that it say everything was linked in chain if one is affected another will also affect. How to involve the disable people in the process of communitization. The discussion went about polices and the process to involve the disable people in process of communitization.

4.16 Communication class:

Communication class was By Mr. Magimai. The class started based on needs even though he had prepared some of his notes. He said that 55% communication through nonverbal communication, 38% through modulation and 7% communication through words. He talk about FIG (focus, involvement, goal)tree for better understanding of our communication need to have focus with confident, involvement with dedication, gesture and position and clarity over the Goal and regular feedback helps in improving communication skills. The 5 gate ways are essential in communication and it should need to be keep sharpening. He also talk about the techniques to build self-confidence.

This class helped me in gaining confident to communicate and thought me keep focus on your work to achieve the goal. He used the all aids while communicating, which had a greater impact on me and I was able to catch the things and importance and role of social media to share knowledge.

4.17 Qualitative research technique in social sciences:

Qualitative research technique in social sciences was in Kristu Jayanthi college Social science qualitative research technique was discuss were observation, in-depth interview, focus group discussion, case studies, ethnographic research, phenomenology and grounded theory. To get the appropriate results both qualitative and quantitative research are needed. The qualitative research was very useful it helped in my field while doing research. So the hard work of Kristu Jayanthi College was remarkable. Each and every thing was systematically organized and the engagement of students and their enthuasim made the event successful. It gave the message proper planning and hard work gives the best results.

5.0 PERSONAL LEARNINGS AT SOCHARA

5.1 Turning point at SOCHARA:

SOCHARA promotes individual specific learning and creates an environment which makes such a learning possible with the help of mentors and fellow travelers.

Motivation:

I got lots of motivation from my fellow travelers and my sochara team

Confident:

My confident to speak in class was build up by this sentence *"there is nothing wrong and right answer".* The team work and field work gave me confident to learn and share knowledge.

Communication skills:

Thinking the language is barrier is not a solution, but learning and developing is a solution. So I felt SOCHARA created friendly environment to learn languages it was a good opportunity to be a multi lingual.

Critical thinking:

The journal club session and recap session has to more reflective. But initially I wasn't understood even though I studied many times in my formal education until I started it. So being critical to things helps in learning more and gives the better understanding I different dimension or show the different path way to think and reflect on best way.

Community psychology:

I was just studying the theory in my college days. Without practical knowledge the theory losses the connection and my only focus was on illness rather than wellness. So at SOCHARA I learned community psychology going to the community working with them cleared a concept that community (majority also need to focus) for prevention of illness and promotion of wellbeing.

Self-realization:

In the field I realized my self, which area I'm fit for to work in my future.

Open mind:

Going to the community with open mind will helps in understand community in better way. The stereotype and prejudice keeps us away learning many things because we keep judging based on our knowledge.

Acceptance:

Acceptance for people bring closer or sense of belongingness which creates the friendly environment to learn, understand and bring a change in a best way.

Importance of TINA:

There is no alternative for reading and writing. So it should be must to enhance the knowledge. And volunteer work need to be done to be active in work.

Self-time:

In spite of busy schedule the person to give self- time to think and reflect. Its helps in more productive functioning.

"We learnt by doing"

5.2 Likings at SOCHARA

Multidisciplinary:

This is the 1st organization which is multidisciplinary people will selected from different back ground. I had an opportunity to talk with different professional and get new insights. And their way of seeing the things.

Concept of co-learner:

We at sochara doesn't have any hierarchy as teacher and students. So all believe each one as co-learner. The concept of co-learners create a friendly environment to learn. When I reflect the co-learner concept it gave me the essence that "*there is nothing called high level knowledge and low level knowledge as such everything is important"*.

Sharing's of field:

The sharing of fellows after field takes us to their place sitting at SOCHARA. Apart from this enrich the knowledge and helps us in understanding the person's ability, their observations, learnings, challenges and uniqueness approach to their field work. It helps me connecting to my field experience.

Recap session:

Recap session is the reflection of yesterday's test knowledge to know how much one is learned and understood from his or her own perceptive and its revision of yesterday to remind what we learnt, each of us varies in their capturing capacity

Self-introduction:

Self-introduction each time when new members arrives helps me to connect with them and it helps me to approach them easily.

Networking:

The sochara has huge networks. After coming to sochara I understood the importance of building networks. Keep connected with people helps in active learner for life long.

Visits:

The visits to different organization helps in connecting to the collective session. And helps in get better understanding of both visit and class room sessions.

Other activities in class:

The other activities in class like use of audio, visual helps us remember some concepts for long time.

Team work:

Team work helps in understanding oneself better to work in team and self-role and engagement of self. It also helps in understanding the others ability to work as group.

Role play:

Role plays puts the actual self to role self and gave the strong feeling the other people feels at the same position. It is a process of sensitization to feel others role.

I, we, and you:

The change starts from individual. Then can join hands with, we and you. So self-change will help in bring the changes of others. When we are in groups if I become we the progress of the community starts.

We are in Action

6.0Research

A study on impact of physical domestic violence on emotional and behavioral health of adolescent girls

Protocol of the proposed research with

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6.1 Abstract:

A study on impact of physical domestic violence on adolescent girls emotional and behavioral health. For the study I used age group 10-18yrs. And used mixed method to collect data for above sample, the SDQ (strength and difficulties questionnaire) for quantitive data and in-depth interview for qualitative data. The quantitive data supports qualitative data or vice versa which shows children are suffering from emotional and behavioral problems (internal and external problems). There 22 participants for quantitive data collection from 22, 8 participants were selected for in-depth interview by purposive sampling. The studies shows that mostly the

domestic violence caused due to the use of alcohol by father/brothers. Most of the adolescents were become the victims of physical domestic violence. The qualitative data shows that the domestic violence also had a negative impact in emotional and behavioral health problems. The SDQ data shows that 68.2% of the adolescents falls under abnormal category in emotional scale. 63.6% of the adolescents fall under abnormal category in behavioral scale. The 50.0% of adolescents are falling under normal category in hyperactivity. The 54.5 % of adolescents are falling under borderline category in peer problem and the 100% adolescents are falling under normal category under pro-social behavior. The studies shows that the majority of the adolescents falling under abnormal category in emotional and conduct problems. In peer problem the majority of the adolescent are falling under borderline category. Majority of the adolescents are in hyperactivity are falling under normal category and all adolescents in pro-social scale are falling under normal category. So the results shows that's majority of the adolescents in emotional and conduct falling in abnormal category.

6.2 INTRODUCTION

India has world`s largest youth population, 356 million 10-24 years old [1]. Most of the Indian youth stay with the family. The domestic violence is also more predominant across the globe and especially in developing countries [2]. The BBC news reports that about once every five minutes an incident of domestic violence reported in India (date). The NFHS-3 data shows 15-19 years women has experience 20.7 % physical violence and mostly in lower income families .

As studies report that short and long term intimate partner violence has negative impact on adolescent emotional and behavioral wellbeing. Young children and adolescent are more vulnerable to abuse. The children and adolescents were directly become victims of intimate partner abuse are at the dangerous risk. Adolescents intervenes to stop the violence, thereby putting themselves at greater risk [7]. So, it's important to address the mental health issues due to domestic violence may be because the community may not be aware of that, the continuous physical domestic violence may lead mental health problems. The study is to explore the physical domestic violence impact on adolescent girl's emotional and behavioral health.

Physical violence

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; aggressive hair pulling; slapping; punching; hitting; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts. (3)

ADOLESCENTS:

Defining terms. The World Health Organization (WHO) defines adolescents as those people between 10 and 19 years of age. Adolescents is often divided into early (10–13 years), middle (14–16 years) and late (17–19years) Adolescents (4)

Emotion:

"An emotion is a complex psychological state that involves three distinct components: a *subjective experience*, a *physiological response*, and a *behavioral* or *expressive response*."[5]
(Hockenbury & Hockenbury, 2007)

BEHAVIOUR: **Behavior** the actions by which an organism adjusts to its environment. [6]

6.3 Review of literature

Studies shows that long and short term exposure to intimate partner violence are more likely to exhibit behavioral and physical health problems including chronic somatic complaints, depression, anxiety and violence towards peers. They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution and commit sexual assault crimes, Children who are exposed to intimate partner violence have increased difficulties with learning and school functioning. Symptoms of trauma including sleep difficulties, hyper-vigilance, poor concentration and distractibility which interfere with a child's ability to focus and to complete academic tasks in a school setting. Children who grow up with violence in the home learn early and powerful lessons about the use of violence in interpersonal relationships. (7) (pdf book download)

In meta-analysis of studies that examined the relationship between domestic violence exposure in childhood and adolescent internalizing and externalizing behaviors, indicating moderate associations between exposure and both outcome. Including low self-esteem, social withdrawal, depression, anxiety and aggression (violence& delinquency). [8]

Adolescent females who witnessed parental violence were significantly more depressed and aggressive than females from non-violent homes, whereas no similar interactions were found. (9)

Domestic violence has greater impact on the family. Mother are unable to care for their children properly. Often they transmit to them their own feelings of low self-esteem, helplessness, and inadequacy. (10)

Adolescents who experience the domestic violence are twice likely to have mental health problems. Urban people are more vulnerable to emotional and behavioral

problems. Physical and sexual abuse were independent risk for common mental disorders in both the gender. (11)

The main causes of behavioral problems (conduct disorders) are alcoholism, mental illness, and domestic violence. (12). In addition another studies shows family factor associated with aggression are family conflict, negative parenting behavior, disturbances in family organization, and marital conflicts among parents. However, the prolonged exposure to conflicts can have consequences and add to the work of development of conduct problems in adolescence. (14)

There is a significant correlation between domestic violence and suicidal ideation which has been found in developing countries among 15-25 year of women. The childhood physical, sexual and emotional abuse lead to higher risk of female suicide. (13)

The area in which there is probably the greatest amount of information on problems associated with witnessing violence is in the area of children's behavioral and emotional functioning. Generally, studies using the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) and similar measures have found child witnesses of domestic violence to exhibit more aggressive and antisocial (often called ""externalized"" behaviors) as well as fearful and inhibited behaviors (""internalized"" behaviors), and to show lower social competence than other children. Children who witnessed violence were also found to show more anxiety, self-esteem, depression, anger, and temperament problems than children who did not witness violence at home. (21)

6.4 METHODOLOGY

This chapter deals with the aim, objectives, hypothesis, design of the study, sample selection, procedure, details description of data collection tools, data collection procedure and data analysis of the study.

6.4.1 PROBLEM:

To study the impact of physical domestic violence on adolescent girls emotional and behavioral health and their coping strategies

6.4.2 OBJECTIVES:

1. To assess the emotional and behavioural health problem of adolescent girls due to physical domestic violence
2. To assess the coping strategies of adolescent experiencing and witnessed the physical domestic violence

6.4.3 VARIABLES:

Independent variable: Physical domestic violence

Dependent variable: emotional and behavioral problems and coping mechanisms.

6.4.4 Operational definition:

Emotion: "An emotion is a complex psychological state that involves three distinct components: a *subjective experience*, a *physiological response*, and a *behavioral* or *expressive response*."[5] (Hockenbury & Hockenbury, 2007).

Behavior The actions by which an organism adjusts to its environment. [6]

Conduct problems:

Conduct disorder is a repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated. The child or adolescent usually exhibits these behavior patterns in a variety of settings—at home, at school, and in social situations—and they cause significant impairment in his or her social, academic, and family functioning.[14]

Hyperactivity:

Hyperactivity means having increased movement, impulsive actions, and a shorter attention span, and being easily distracted.[15]

Peer problems:

Being rejected or neglected by peers, lacking in friendships, and exhibiting behavior characteristic of poor social skills predict a number of negative long-term out comes [16]

Pro-social Behavior:

"A broad range of actions intended to benefit one or more people other than oneself - behaviors such as helping, comforting, sharing and cooperation." [17]

Coping mechanism:

Coping mechanism “refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events”.[18]

6.4.5 RESERCH DESIGN:

Cross sectional study design was adopted. It aim to finding out the impact of physical domestic violence on adolescent girl’s emotional and behavioral health. The in-depth interview was conducted to conformation of the emotional and behavioral problems and the strength and difficulties questioner was being used to assess the emotional and behavior status of the adolescents.

6.4.6 STUDY AREA:

The study area was Kormangala Bangalore slum sub division Ambedkarnagar and Rajendranagar and L.R Nagar.

6.4.7 SAMPLE:

Sample of twenty two adolescent girls who were willing to be respondents for the SDQ survey was included. Of the 22 girls, 8 of them purposively selected aged 10-

19 who are experienced physical domestic violence and were willing to participate in in-depth interviews

6.4.8 Tools:

For quantitative: The SDQ questionnaire was selected to know the status of the adolescents, in externalized and internalized behavior.

Questionnaire measures

The SDQ is a brief questionnaire that can be administered to the parents and teachers of 4- to 16-year-olds and to 11- to 16-year-olds themselves (Goodman, **1997**, **1999**; **Goodman** ***et al*****, 1998**). Besides covering common areas of emotional and behavioral difficulties, it also enquires whether the informant thinks that the child has a problem in these areas and, if so, asks about resultant distress and social impairment. Further information on the SDQ and copies of the questionnaire in over 40 languages can be obtained free from http:\www. sdqinfo.com. Computerized algorithms exist for predicting psychiatric disorder by bringing together information on symptoms and impact from SDQs completed by multiple informants (**Goodman** ***et al*****, 2000*****b***). The algorithm makes separate predictions for three groups of disorders, namely conduct—oppositional disorders, hyperactivity—inattention disorders, and anxiety—depressive disorders. Each is predicted to be unlikely, possible or probable. Predictions of these three groups of disorders are combined to generate an overall prediction about the presence or absence of any psychiatric disorder.

Scoring

Consists of 25 items comprise 5 scales of 5 items. It is usually easiest to score all 5 scales. 'Somewhat true' is always scored as 1, but the scoring of 'Not True' and 'Certainly True' varies with the item, as shown below scale by scale. For each of the 5 scales the score can range from 0 to 10 if all items were completed. These scores can be scaled up pro-rata if at least 3 items were completed, e.g. a score of 4 based on 3 completed items can be scaled up to a score of 7 (6.67 rounded up) for 5 items.

Reliability:

Type:		Rating	Statistics	Min	Max	Average
Test-Retest-# days:	14	Acceptable	Pearson correlation	0.52	0.75	0.72

Validity:

Multiple studies (including those cited below under "USE IN OTHERCOUNTRIES") have examined the relation between the SDQ and Child Behavior Checklist (CBCL). Goodman & Scott (1999) studied the predictive validity of SDQ and CBCL using ROC curves. Both measures discriminated well between high- and low-risk samples, with no significant differences between the measures in terms of predictive validity, assessed using area under the curve.
They found high correlations between the CBCL and SDQ: Total (r=.87), Externalizing to Conduct (r=.84), Hyperactivity/Inattention (r=.71), Internalizing/Emotional (r=.74), and Social/Peer (r=.59).

Keys and norms

For qualitative:

The in-depth interview method was selected to conform about the problems.

The in-depth interview guide was developed with the help of review of literature

In-depth interview guide

Recorder

Writing material

SI. NO	Objectives	Methods	Tool of data collection
1.	To assess the emotional and behavioural problem of adolescent girls who witnessed and experienced the physical domestic violence	In-depth interview	Strength and difficulties questionnaire were used to collect data. And in-depth interviews was conducted with adolescent girl in Koramangala slum area Bangalore.
2.	To assess the coping strategies of adolescent girls who witness and experience the physical domestic violence	In-depth interview	

Inclusion criteria for strength and difficulties questionnaire:

Any adolescent girls aged between 10-19yrs, who are willing to participate in the study are included.

Exclusion criteria for strength and difficulties questionnaire:

The adolescent girls below the age of 11 and above the age of 19 are excluded and the adolescents who are not willing to participate in the study.

Inclusion criteria for in- depth interview:

The adolescent girls aged between 10-19yrs, who were witnessing/ becoming a victim of domestic violence and also willing to participate in the study are included

Exclusion criteria for in-depth interview:

The adolescent girls who are not expose to physical domestic violence.

The adolescent girls who are not willing to participate in the study are excluded.

Below the age of 11 and above the age of 19 are excluded.

6.4.9 Data Analysis:

The quantative data was scored with the help of keys and norms. And it was analyzed using the epinfo software.

Total difficulties score: This is generated by summing scores from all the scales except the pro-social scale. The resultant score ranges from 0 to 40, and is counted as missing of one of the 4 component scores is missing. 5 scales of 5 items. It is usually easiest to score all 5 scales. 'Somewhat true' is always scored as 1, but the scoring of 'Not True' is scored as '0' except for 5 items(item number- 7, 11, 14, 21 and 25) and 'Certainly True' as 2 expect the 5 items mention in bracket above, varies with the item, as shown below scale by scale. 5 scales gives 5 problem areas and overall the total difficulties can be check.

The data collected through interviews was analyzed manually using the principles of thematic analysis.

6.5 Findings:

Table 6.5.1 showing the brief details of Participant's:

Caste	Medium	School/ college	Age classification
19 Muslims	13 Urdu medium	16 government	Early 11
2 ST	5 English medium	6 private	Middle 8
1 Christian	4 Kannada medium		Late 3

Table 1 showing the brief details of participants, the data was collect with help of psychological questionnaire in Koramangala slum (Amdednagar and L.R Nagar) Bangalore. In Rajendra Nagar slum the Muslim population was in majority. So as shown in the table the 19 Muslim female out of 22 were participated. 2 schedule cast and 1 Christian adolescent were participated. 13 girls were studying in Urdu medium, 5 in English medium and 4 in Kannada medium. Majority were going to government school 16 out of 22 and 6 were going in private school. In study 11 girls from early adolescents 8 from middle adolescent and 3 from late adolescent.

Brief details of in-depth interview participant:

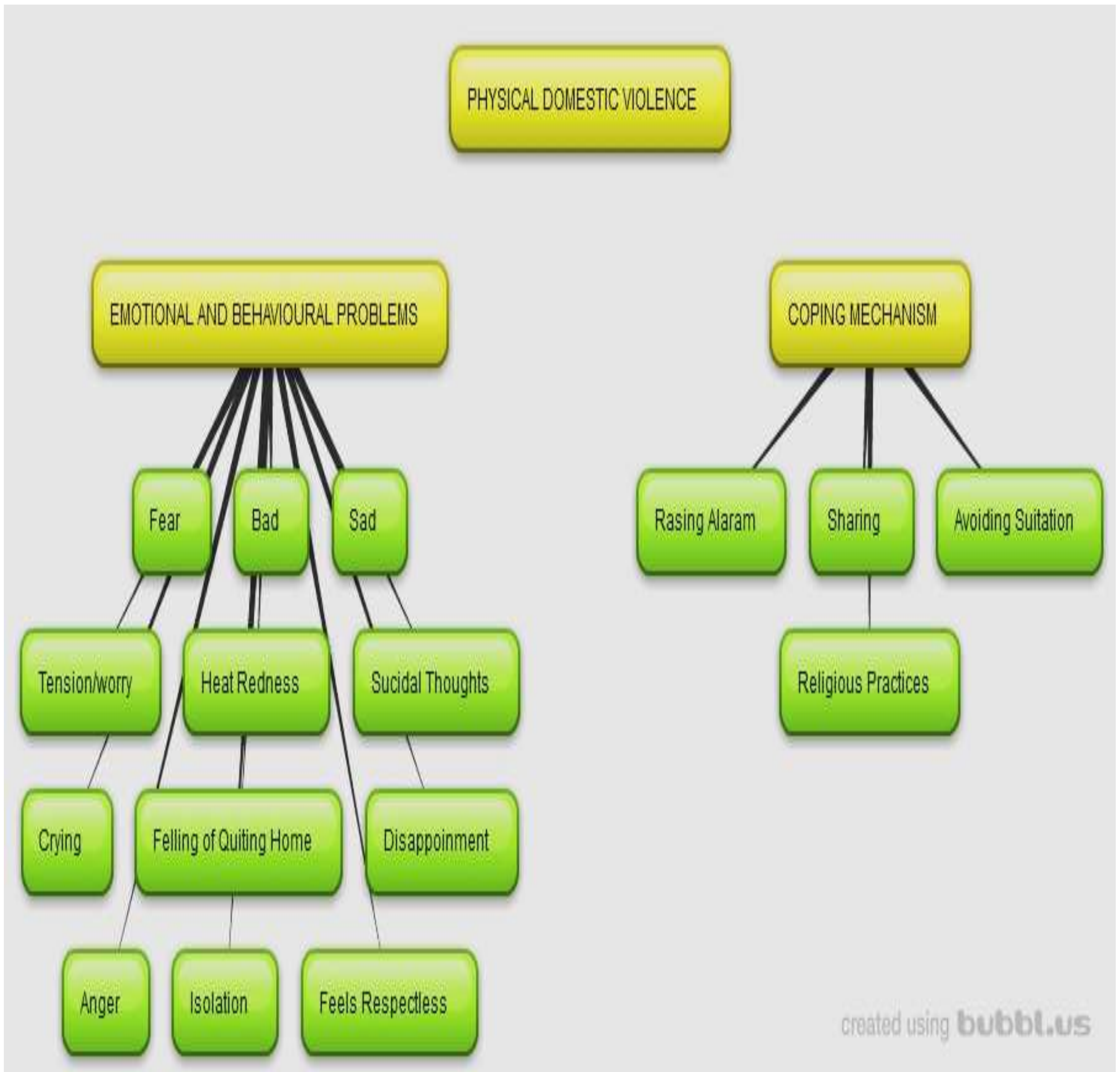
Table 6.5.2 showing the demographic details of in-depth interview Participant's

SI. NO	Age	Caste	medium	class
1	14yrs	Muslim	English	9th
2	11yrs	Muslim	Urdu	5th
3	15yrs	Muslim	English	9th
4	17yrs	Schedule tribe	Kannada	11th
5	17yrs	Schedule tribe	Kannada	10th
7	10yrs	Muslim	Urdu	4th
8	12yrs	Muslim	English	7th

Table 2 showing the demographic details of in-depth interview Participant's. off 22, 8 girls were selected for in-depth interview who was undergoing frequent violence reported by self or by other children/ their friends.

Findings of In-depth Interview

Emotional, Behavioral Problem and Coping Mechanism



From the Qualitative data collection (in-depth interview) the adolescents were discussed different emotional, behavioral problems and different coping mechanisms

Physical violence

Out of 8 adolescents 6 adolescents were reported that they are victims of both verbal abuse and physical violence. And two girls said that they are only victims of verbal abuse. Few said they will get hurt when they go in between to settle down the fights, some girls said that their father's hold and beats purposely when they go for settle down the fights.

"I'll get hurt than to I control, because I have to save mom" (p3, 15yrs). "In fight he hit me, opened my head lot of blood came out" (p2, 11yrs). "If we say something he comes, hits on lungs and holds hairs and hits from scoop" (p8, 12yrs). "Tu konki dhad ni ki bachi" (p2, 11yrs).

Due to domestic violence 4 girls reported that they face some physical problems like loss of appetite, late night sleep, sleep disturbance, and abdominal pain.

"Now 12:30, 1:00, 2:00, 3:00 have to sleep, because they fight we don't get neither feel hunger, morning I wake up I feel stomach ache I can't bare" (p3, 15yrs).

"If we say eat he doesn't eat, if we eat he fights" (p8, 12yrs).

Emotional and behavioral problems;

Fear: adolescents were told that when father/brother consumes alcohol and comes home the adolescents had fear of both physical abuse and verbal violence at home and also on themselves. Due to the fear of violence and ill treatment from the father/ brother. Due to the fear of violence girls speak less or *avoid* speaking and stay away from him. When the father/ brothers were drunk. One adolescent also said she get scared when boys tease her/ speak loudly.

"Dar kabibi rahthai" (p3, 15yrs). "I feel like anything" (p7, 10yrs). "He always fights I don't like to speak with him" (p1, 14yrs). "If we don't care he will be on his own, why we need to care him" (p3, 15yrs).

Disappointment;

Half of the adolescents reported that they also get disappointed and get the feeling of quitting home, when they witness the violence at home. One girl said she will get disappointed when siblings fight with her. And another girl reported she fell disappointed when friends doesn't speak with her.

"Daily same, disappointingly I go somewhere" (p8, 12yrs).

Anger: out of 8 girls 5 girls reported that they get anger when they see their father/ brother consumed alcohol. And they also said that they get anger and, one girl reported she feel shame when people gathers in front of their home while violence were happening. Few girls said that they express the anger by avoiding/ hitting or disobeying to father. And when people gather in front of people they express the anger by scolding them.

"I'll get angry didi when they drink heavily, we beat them from brooms, slippers" (p6, 14yrs). "He do such things I feel like beating" (p7, 10yrs).

Heat redness:

Because of domestic violence 3 girls reported that they don't like father and one girl said that she doesn't like to live with father, when he comes home she feels that he should have gone somewhere else rather coming home.

"I don't like to live with father, "nakoch nako" (p6, 14yrs).

Worry and tension:

The 2 girls reported that they worry/ think about their mom and violence when they were in school. One girl said it also affect in her studies and lose concentration on study. And another girl reported that she check at home before entering that her father was quite or talking she gets tension when he was fights.

"I left home and I'm in school, what might have happening, he hitting or what' "if they take lesson also ill not able to understand, if they teach well also I don't understand" (p1, 14yrs). "When I return I see in home whether father drunk or not if he was shooting then I get tension" (p3, 15yrs).

Crying:

1 adolescents were reported that when there was violence she cries and goes to settle down the fight. And another 2 adolescents were said that they cry at school when they are by thinking about the violence.

"I'll think about dad much, if father was alive this much doesn't had happen" (p6, 14yrs)

Bad/sad:

The girl feels bad when she goes out people looks at her. And even she said she feel sad when her father comes home and fights.

"Why he came like that I feel bad", "if I go out people looks at me like anything, why did I came I feel sad" (p3, 15yrs).

Perception of loss of respect:

The 2 adolescents also reported that when people sees she feels like lost respect, also think about what respect they are going to have in future and feels uncomfortable.

"What respect will have when we grow up I feel uncomfortable" (p1, 14yrs).

"What happening 'chi' everyone are standing and seeing, feel like lost respect" (p3, 15yrs).

Isolation:

The 2 adolescents reported that after fight they don't speak with others, they doesn't feel like going out due to fear of teasing because her father consumes alcohol and one girl said that whenever she speaks with others she feels that they might be thinking something about her because there is a violence in her home. And also they reported when they is no violence they are happily talk with others.

"When public sees I don't feel like going out, I just feel like staying at home" (p3, 15yrs).

Suicidal thoughts:

One girl also reported that because violence she get suicidal thought to consume something and die.

"Once I thought to consume something and die". (p6 14yrs,)

Coping mechanism:

Sharing:

The girls reported that they share about violence with friends, few said that they also share with mothers/relatives. 2 girl said that they never with mother and one girl said she doesn't share because her mom cries.

"Everything ill share with my mom, whatever happens ill share with friends" (p3, 15yrs). "One friend use to be there, in their home also violence happens and in our home also violence happens, so we both shares".

"I don't share with mom because she cries" (p8, 12yrs).

Avoiding:

The adolescents said that they avoid the violence situation by going somewhere, hiding in room etc.

"I go and hide in room and sleep" (p1, 14yrs).

Raising an alarm:

The 2 adolescents reported that they call their relatives whom his father scared off/ someone who guides him when the violence happens at home.one girl said that she does noise to alert.

"How I can go out, to whom should I tell my mother is getting hit, then I use to do loud noise" (p1, 14yrs).

Religious Practices:

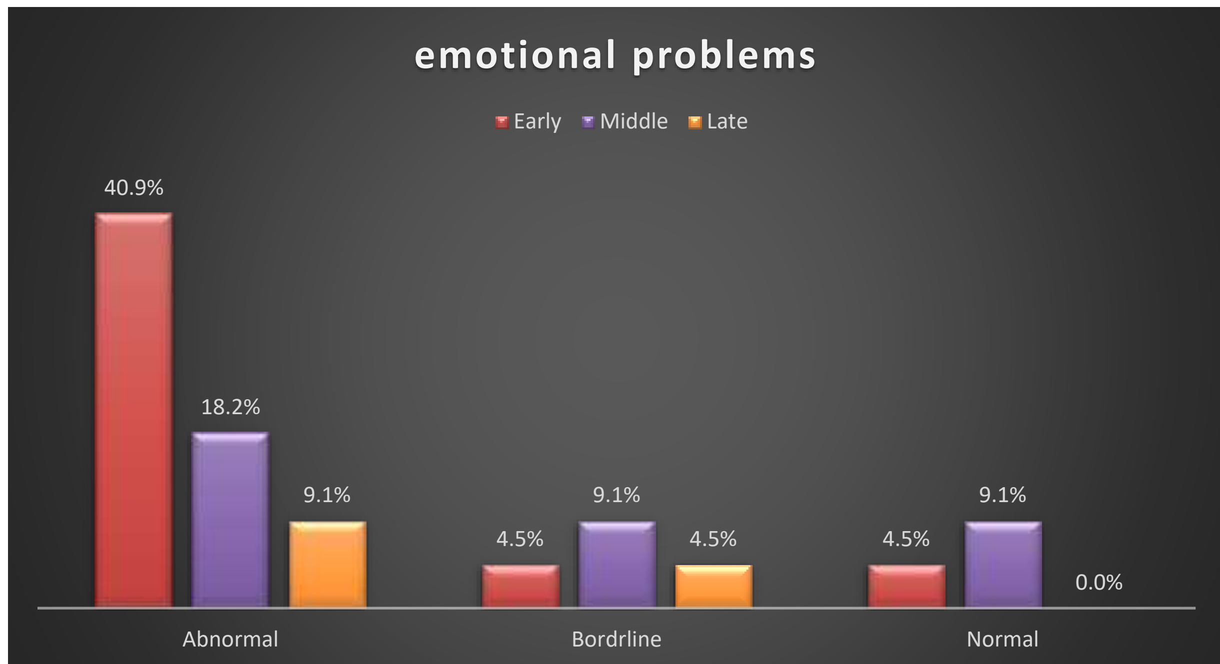
The 3 girls reported were reported that they offer prayer, not to happen violence at home.

"I read Duwa's before going to school" (p3, 15yrs). "I'll offer Namaz daily" (p8, 12yrs).

Tables and graphs

Table 6.5.3 showing the emotional problems among adolescents

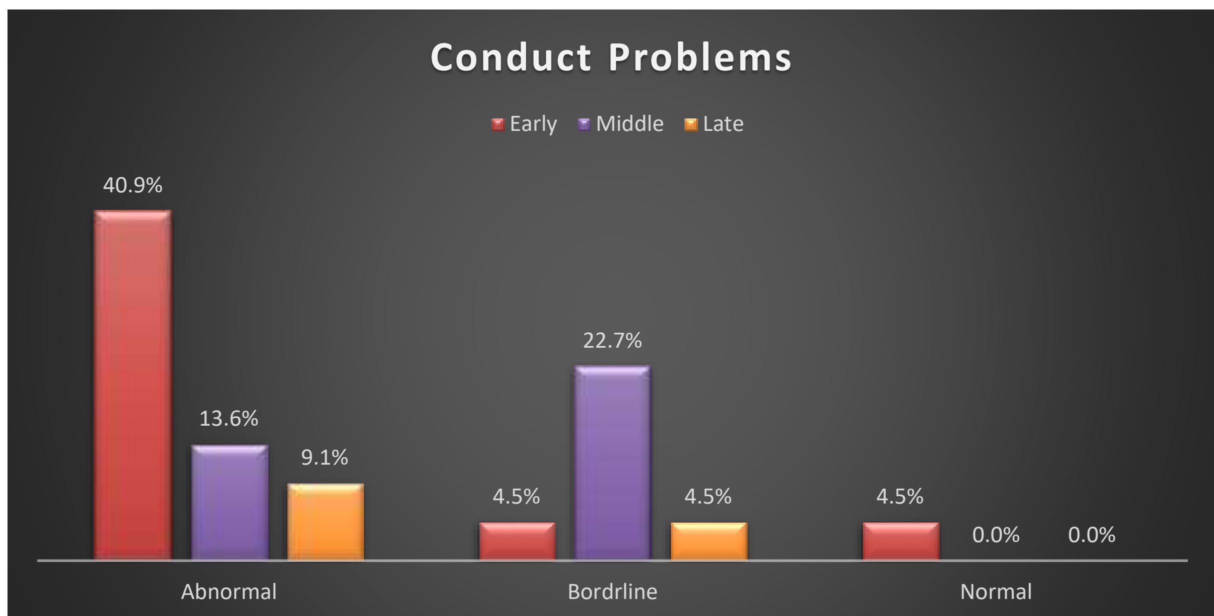
Emotional problems			
Age	Abnormal	Borderline	Normal
Early	9	1	1
Middle	4	2	2
Late	2	1	



The above table 6.5.3 showing the emotional problems among adolescents. In emotional domain out of 22. In early adolescents the 9(40.9%) children's were abnormal, 1(4.5%) in borderline and 1(4.5%) falls under normal. In middle adolescent 4 (18.2%) were in abnormal, 2(9.1%) were in borderline and 2(9.1%) were in normal. In late adolescent 2(9.1%) were in abnormal and 1(4.5%) in borderline. The majority of the adolescents falling under abnormal category in emotional scale.

Table 6.5.4 showing the conduct problems among adolescents

Conduct Problems			
Age	Abnormal	Borderline	Normal
Early	9	1	1
Middle	3	5	0
Late	2	1	



The table 6.5.4 showing the conduct problems among adolescents. In early adolescents 9 (40.9%) of them were in abnormal, 1(4.5%) of them were in border line and 1(4.5%) in normal. In late adolescent 2(9.1%) were in abnormal, 1(4.5%) in borderline. And in middle adolescent 3(13.6%) in abnormal, 5(22.7%) in borderline. The majority of the adolescents falling under abnormal category in conduct scale.

Table 6.5.5 showing the hyperactivity among adolescents

Hyperactive			
Age	Abnormal	Borderline	Normal
Early	4	2	5
Middle	3	1	4
Late	0	1	2

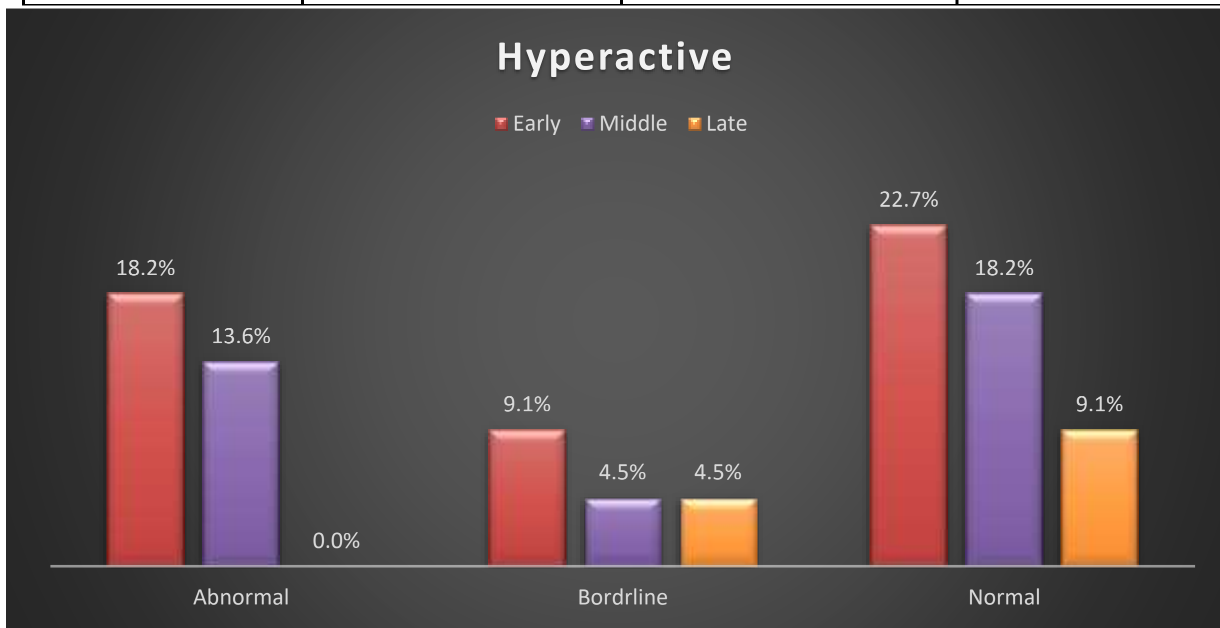


Table 6.5.5 showing the hyperactive among adolescents. In early adolescents the 4(18.2%) children's were abnormal, 2(9.1%) in borderline and 5(22.7%) falls under normal. In middle adolescent 3 (13.6%) were in abnormal, 1(4.5%) were in borderline and 4(18.2%) were in normal. In late adolescent 0 were in abnormal, 1(4.5%) in borderline and 2(9.1%) in normal. In hyper activity majority of the adolescents falling under normal category and also graph showing that hyperactivity decreases as age increases.

Table 6.5.6 showing the peer problems among adolescents

Peer Problem			
Age	Abnormal	Borderline	Normal
Early	5	5	1
Middle	1	6	1
Late	1	1	1

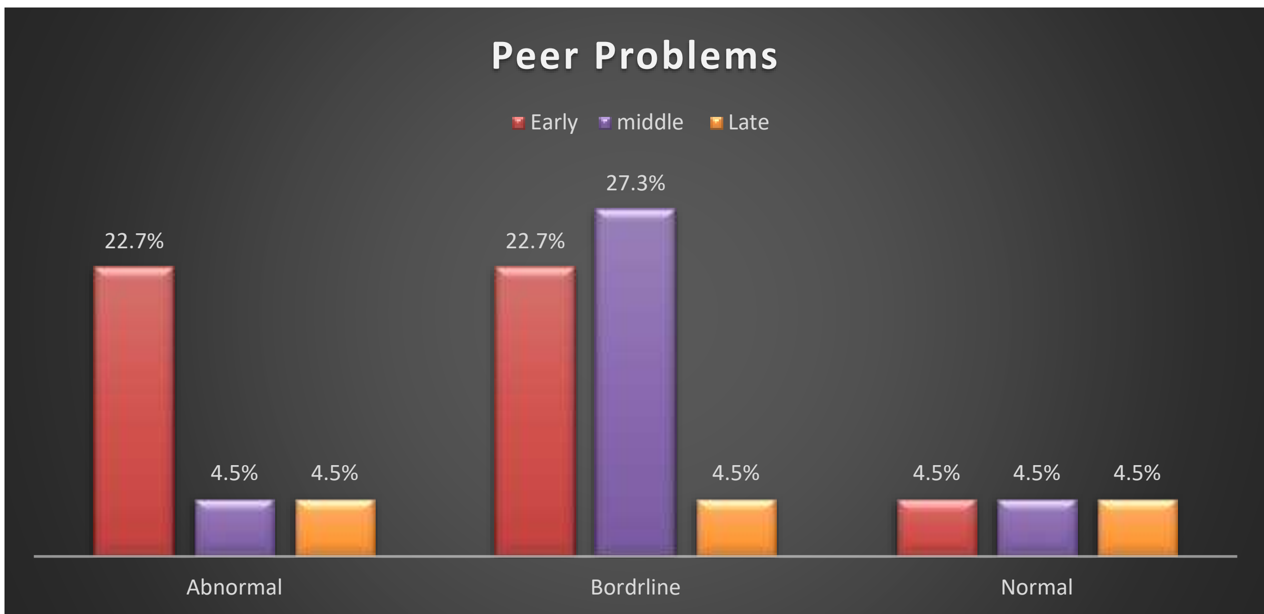


Table 6.5.6 showing the peer problems among adolescents. In early adolescents the 5(22.7%) children's were abnormal, 5(22.7%) in borderline and 1(4.5%) falls under normal. In middle adolescent 1(4.5%) were in abnormal, 6(27.3%) were in borderline and 1(4.5%) were in normal. In late adolescent 1(4.5%) were in abnormal, 1(4.5%) in borderline and 1(4.5%) in normal. The majority of the adolescents falling under border line category in peer problem.

Table 6.5.7 showing the Pro Social behavior among adolescents

Pro Social behavior			
Age	Abnormal	Borderline	Normal
Early	0	0	11
Middle	0	0	8
late	3	1	4

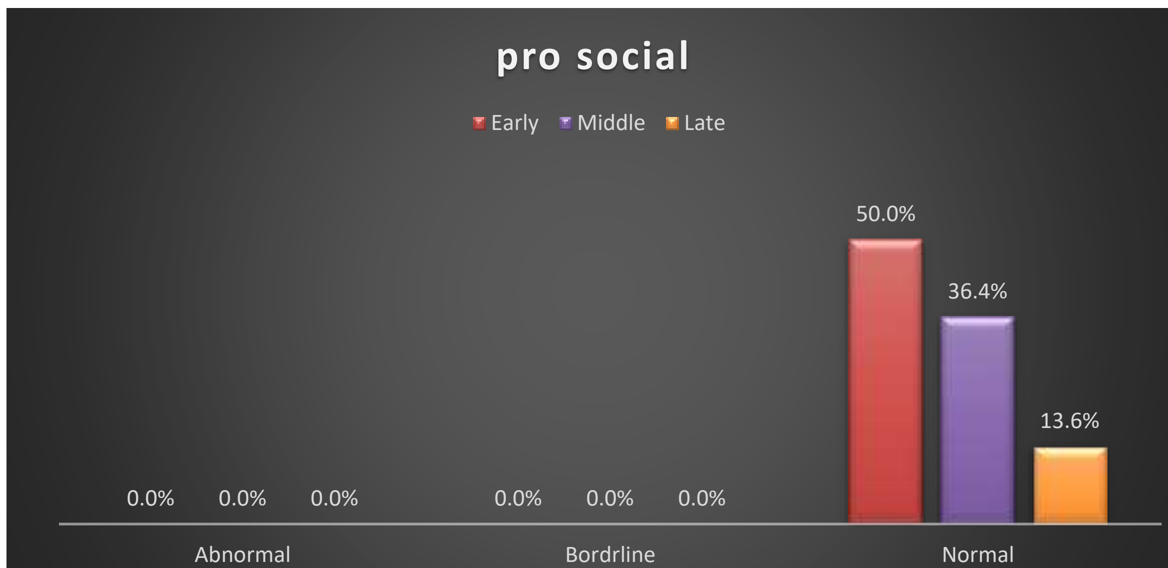


Table 6.5.7 showing the pro-social behavior among adolescents. In early adolescents 11(50.0%) of them are normal, in middle adolescents 8(36.4%) were in normal, in late adolescents 4(13.6%) were in normal. In pro-social behavior all the adolescents fall under normal category. It indicates that all adolescents are good in helping behavior and sharing with others.

Table 6.5.8 showing the total difficulties score

SI.NO	Emotional	Conduct	Hyperactive	Peer Problem	Total difficulties score	Status	Pro-social
1	6	5	5	3	19	Borderline	6
2	5	5	3	5	18	Borderline	7
3	8	4	6	5	23	Abnormal	9
4	6	5	3	8	22	Abnormal	9
5	8	5	5	5	23	Abnormal	7
6	7	5	7	5	24	Abnormal	6
7	8	5	5	5	23	Abnormal	10
8	6	4	5	6	21	Abnormal	9
9	8	3	7	2	20	Abnormal	7
10	9	6	7	6	28	Abnormal	10
11	3	4	6	4	17	Borderline	7
12	8	7	5	4	24	Abnormal	8
13	9	4	7	5	25	Abnormal	10
14	6	6	5	6	23	Abnormal	6
15	7	4	10	4	25	Abnormal	8
16	9	6	6	3	24	Abnormal	10
17	7	4	4	5	20	Abnormal	10
18	4	4	7	5	20	Abnormal	9
19	9	9	5	5	28	Abnormal	10
20	9	8	6	7	30	Abnormal	10
21	9	6	5	6	26	Abnormal	10
22	10	8	6	6	30	Abnormal	8

Table 6.5.8 showing the total difficulties score obtained by calculating all the 4 (emotional, behavioral, hyperactive and peer problem) except pro-social scale. The table shows that the majority of adolescents, out of 22, 19 adolescents were falling under abnormal category and 3 were in borderline category. So it indicates that majority of the adolescents were facing some or the other problems. And all the adolescents were normal in pro-social behavior, it means helping behavior is good among adolescents.

6.6 Discussion:

The aim of the experiment to a study the impact of physical domestic violence on adolescent girl's emotional and behavioral health. Using mixed for quantitive data collection the strength and difficulties questionnaire were used and in-depth interview guide for qualitative data. The experiment was administered to 10-19 years adolescents who hails from Bangalore slums.

The key findings in present study using mixed method. The studies shows that mostly the domestic violence caused due to the use of alcohol by father/brothers. Most of the adolescents were become the victims of physical domestic violence. The domestic violence also had a negative impact in emotional and behavioral health problems. The data shows that 68.2% of the adolescents falls under abnormal category in emotional scale. 63.6% of the adolescents fall under abnormal category in behavioral scale. The adolescents also has coping mechanism (sharing the problems with others…) and it also found that all the adolescents were normal under pro-social (helping behavior) scale.

The review of literature also supports the current study. Using child behavior checklist the Similar measures have found child witnesses of domestic violence to exhibit more aggressive and antisocial (often called ""externalized"" behaviors) as well as fearful and inhibited behaviors (""internalized"" behaviors), and to show lower social competence than other children. Children who witnessed violence were also found to show more anxiety, self-esteem, depression, anger, and temperament problems at home. Overall, these studies indicate a consistent finding that child witnesses of domestic violence exhibit a host of behavioral and emotional problems (21). So the current studies also have more/ less similar findings. (But there was no studies carried out the to measure the child status using SDQ due to domestic violence)

6.6 Limitations:

There was time limit to conduct a study the study was conducted within a month. The study area was also new to me so, in order to build a rapport and understand the adolescent's environment took time to extract information on physical domestic violence. The exam for school children become a major constrain for study. It would had been better if could had involved the adolescents boys for better results and

problems to compare among girls and boys. The study was done with small sample so findings cannot be generalized.

6.8 Scope of the study:

The further study can be conduct including adolescent's boys to understand the problem better and there by FEDINA even though my organization priority was adolescents, can think necessary steps to be taken to bring awareness among parents in vigilance committee to help the adolescents.

6.9 Suggestion for further study:

The research can be carried including boys and girls to better understanding of the problems faced by both genders. The research can be done on whole family struggle due to domestic violence to understand the impact on each family members.

6.10 Conclusion:

The study was to find out the emotional and behavioral problems among adolescents girls due to domestic violence and their coping mechanism in koramangala slum Bangalore. The study also found out that the most of the in-depth interview participants were victims of domestic violence. The major findings of the study was that the adolescents were facing many emotional and behavioral due to domestic violence problems like anger, fear, isolation, sad/bad, worry, loss of concentration, crying, feeling loss of respect, hate redness, disappointment, suicidal feeling. The both quantitative and qualitative data shows that majority of the adolescents are undergoing in emotional and behavioral problems. And it also shows they are overcoming with the problems through coping mechanism was religious practices, sharing the problems with trust worthy person, avoiding situation and rising alarm. So the alcohol was a major cause of domestic violence.

6.11 Ethical issues

Risk & Benefits

No physical risk for the participants in the study. Since the study was done without the knowledge/ in the absence of the father around. But there will be emotional trigger for the participants.

- No immediate benefits for the respondent.
- Study will help to identify the behavioural & emotional health issues and address this mental health issues in community.

Consent

Oral or written informed consent will be obtained from adolescence after explaining the intention of the study.
Participant information sheet will be provided in local language.
Every respondent will be free to withdraw anytime during the study and this right will be informed to each and every respondent.

- **Confidentiality**

  The data will be kept confidential and anonymity will be maintained during sharing of the data with internal and external agencies.
- If there is any serious issues the confidentiality will be broken down without harming the participant to a local NGO.

- **Dissemination**

A final report will be prepared and shared with SOCHARA and FEDINA.
A presentation will be made on the same and presented to the community at FEDINA office in BANGALORE.
The results will also be shared with the respondents.
The final draft will be published in an peer review journal after obtaining permission\ from the community, FEDINA and SOCHARA supervisor

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Annexure-A

In-depth interview to know emotional and behavioral changes

Questions

1. List out the happy moments of your life.
2. List out the sad moments of your life.
3. What is your family routine?
4. How often domestic violence happens?
5. What do you think the cause of domestic violence?
6. How often you become a victim of the violence?
7. What/how do you feel when there is a violence?
8. What are the thoughts comes to you are mind when you witness/ become victim of violence?
9. How is your relationship with your family?
10. How is your relationship with your friends?
11. What are current problems you are facing?
12. How do you cope with the situation?
13. What do you think about your future?

Psychological questionnaire

P 4-17

FOLLOW-UP

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of your child's behaviour **over the last month**.

Child's Name ....

Male/Female……………… Date of Birth

SI no	Questions	Not true	Somewhat true	certainly true
1	I try to be nice to other people			
2	I am restless, overactive, cannot stay still for long			
3	I get a lot of headache, stomach-aches or sickness			
4	I usually share with others			
5	I get very angry			
6	I am usually on my own			
7	I usually do as I am told			
8	I worry a lot			
9	I am helpful is someone is hurt, upset or feeling ill			
10	I am constantly fidgeting or squirming			
11	I have one goof friend or more			
12	I fight a lot			
13	I am often unhappy, down-hearted or tearful.			
14	Other people my age generally like me			
15	I am easily distracted			
16	I am nervous in new situations, easily loses			

	confidence			
17	I am kind to younger children			
18	I am often accused of lying or cheating			
19	Other children or young people pick on me			
20	I often volunteer to help others			
21	I think before I do things			
22	I take things that are not mine			
23	I get on better with adults than with people my age			
24	I have many fears, easily scared			
25	I finish the work I am doing			
26	I face domestic violence			

Scoring the Strengths & Difficulties Questionnaire for age 4-17

The 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. 'Somewhat True' is always scored as 1, but the scoring of 'Not True' and 'Certainly True' varies with the item, as shown below scale by scale. For each of the 5 scales the score can range from 0 to 10 if all items were completed. These scores can be scaled up pro-rata if at least 3 items were completed, e.g. a score of 4 based on 3 completed items can be scaled up to a score of 7 (6.67 rounded up) for 5 items.

Table 1: Scoring symptom scores on the SDQ for 4-17 year olds

<u>**Emotional problems scale**</u>	Not True	Somewhat True	Certainly True
ITEM 3: Often complains of headaches… *(I get a lot of headaches…)*	0	1	**2**
ITEM 8: Many worries… (*I worry a lot)*	0	1	**2**
ITEM 13: Often unhappy, downhearted… (*I am often unhappy….)*	0	1	**2**

ITEM 16: Nervous or clingy in new situations… (*I am nervous in new situations…)*	0	1	**2**
ITEM 24: Many fears, easily scared *(I have many fears…)*	0	1	**2**
Conduct problems Scale			
ITEM 5: Often has temper tantrums or hot tempers (*I get very angry)*	0	1	**2**
ITEM 7: Generally obedient… *(I usually do as I am told)*	**2**	1	0
ITEM 12: Often fights with other children… *(I fight a lot)*	0	1	**2**
ITEM 18: Often lies or cheats *(I am often accused of lying or cheating)*	0	1	**2**
ITEM 22: Steals from home, school or elsewhere *(I take things that are not mine)*	0	1	**2**
Hyperactivity scale			
ITEM 2: Restless, overactive… *(I am restless…)*	0	1	**2**
ITEM 10: Constantly fidgeting or squirming *(I am constantly fidgeting….)*	0	1	**2**
ITEM 15: Easily distracted, concentration wanders *(I am easily distracted)*	0	1	**2**
ITEM 21: Thinks things out before acting *(I think before I do things)*	**2**	1	0
ITEM 25: Sees tasks through to the end… *(I finish the work I am doing)*	**2**	1	0
Peer problems scale			
ITEM 6: Rather solitary, tends to play alone *(I am usually on my own)*	0	1	**2**
ITEM 11: Has at least one good friend *(I have one goof friend or more)*	**2**	1	0
ITEM 14: Generally liked by other children *(Other people my age generally like me)*	**2**	1	0
ITEM 19: Picked on or bullied by other children… *(Other children or young people pick on me)*	0	1	**2**

ITEM 23: Gets on better with adults than with other children *(I get on better with adults than with people my age)*	0	1	**2**
Pro-social scale			
ITEM 1: Considerate of other people's feelings *(I try to be nice to other people)*	0	1	**2**
ITEM 4: Shares readily with other children… *(I usually share with others)*	0	1	**2**
ITEM 9: Helpful if someone is hurt… *(I am helpful is someone is hurt…)*	0	1	**2**
ITEM 17: Kind to younger children *(I am kind to younger children)*	0	1	**2**
ITEM 20: Often volunteers to help others… *(I often volunteer to help others)*	0	1	**2**

Total difficulties score: This is generated by summing scores from all the scales except the pro-social scale. The resultant score ranges from 0 to 40, and is counted as missing of one of the 4 component scores is missing.

'Externalizing' and 'internalizing' scores: The externalizing score ranges from 0 to 20 and is the sum of the conduct and hyperactivity scales. The internalizing score ranges from 0 to 20 and is the sum of the emotional and peer problems scales. Using these two amalgamated scales may be preferable to using the four separate scales in community samples, whereas using the four separate scales may add more value in high-risk samples *(see Goodman & Goodman. 2009 Strengths and difficulties questionnaire as a dimensional measure of child mental health. J Am Acad Child Adolescent Psychiatry 48(4), 400-403).*

Cut-points for SDQ scores: original three-band solution and newer four-band solution

Although SDQ scores can be used as continuous variables, it is sometimes convenient to categories scores. The initial bandings presented for the SDQ scores were 'normal', 'borderline' and 'abnormal'. These bandings were defined based on a population-based UK survey, attempting to choose cut points such that 80% of children scored 'normal', 10% 'borderline' and 10% 'abnormal'.

More recently a four-fold classification has been created based on an even larger UK community sample. This four-fold classification differs from the original in that it (1) divided the top 'abnormal' category into two groups, each containing around 5% of the population, (2) renamed the four categories (80% 'close to average', 10% 'slightly raised, 5% 'high' and 5% 'very high' for all scales except pro-social, which is 80% 'close to average', 10% 'slightly lowered', 5% 'low' and 5% 'very low'), and (3) changed the cut-points for some scales, to better reflect the proportion of children in each category in the larger dataset.

Table 3: Categorising SDQ scores for 4-17 year olds

	Original three-band categorisation			**Newer four-band categorisation**			
	Normal	Borderline	Abnormal	Close to average	Slightly raised (/slightly lowered)	High (/Low)	Very high (very low)
Parent completed SDQ							
Total difficulties score	0-13	14-16	17-40	0-13	14-16	17-19	20-40
Emotional problems score	0-3	4	5-10	0-3	4	5-6	7-10
Conduct problems score	0-2	3	4-10	0-2	3	4-5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10

Peer problems score	0-2	3	4-10	0-2	3	4	5-10
Pro-social score	6-10	5	0-4	8-10	7	6	0-5
Impact score	0	1	2-10	0	1	2	3-10
Teacher completed SDQ							
Total difficulties score	0-11	12-15	16-40	0-11	12-15	16-18	19-40
Emotional problems score	0-4	5	6-10	0-3	4	5	6-10
Conduct problems score	0-2	3	4-10	0-2	3	4	5-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-3	4	5-10	0-2	3-4	5	6-10
Pro-social score	6-10	5	0-4	6-10	5	4	0-3
Impact score	0	1	2-6	0	1	2	3-6
Self-completed SDQ							
Total difficulties score	0-15	16-19	20-40	0-14	15-17	18-19	20-40
Emotional problems score	0-5	6	7-10	0-4	5	6	7-10
Conduct problems score	0-3	4	5-10	0-3	4	5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6	7	8-10
Peer problems score	0-3	4-5	6-10	0-2	3	4	5-10
Pro-social score	6-10	5	0-4	7-10	6	5	0-4
Impact score	0	1	2-10	0	1	2	3-10

Note that both these systems only provide a rough-and-ready way of screening for disorders; combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect.

Annexure-B

PARTICIPANT INFORMATION SHEET

A Study on Impact of physical domestic violence on adolescence emotional and behavioural health In Bangalore Slum (area unknown)

Dear participant,

SOCHARA is an independent organization situated at Bangalore facilitates a Community Health Learning Program through SCHOOL OF PUBLIC HEALTH EQUITY AND ACTION (SOPEHA). In this learning program fellows learn “community based “approach for community health awareness and action.

Principal Investigator **MS.Shanaz begum.c** is a fellow of community health learning program and as a part of his fellowship learning purposes he is expected to conduct a field study. She has chosen to conduct a study on **a study on impact of physical domestic violence on adolescence emotional and behavioural health in Bangalore slums under the FEDINA organization** the purpose of this study is for learning as well as for initiating action wherever necessary. You may inform to persons whose contact details are given below for any adverse effect in connection with the study.

S J Chander
Programme Officer
SCHOOL OF PUBLIC HEALTH EQUITY AND ACTION (SOPHEA)
No. 359, 1st Main, 1st Block, Koramangala,
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Annexure-C

<u>Consent Form</u>

The principal investigator Ms.Shanaz Begum.c, a fellow of community health learning programme (CHLP) of SOCHARA, Bangalore has informed me about objective of the study “A study on impact on domestic violence on adolescence emotional and behavioural aspects in Bangalore” and also informed about the risks and benefits that involved in this study. She said study is for learning purpose, the findings will help FEDINA organisation whenever necessary. She assured me that all data collected from me will be kept confidential. She will not quite my name of what said anywhere without my consent. She took consent both for interview and photographs for the study purposes.

Name:

Date:

Place:

SOCHARA Silver Jubliee Celebration

Thank y☺u