# COMMUNITY HEALTH APPROACH TO TACKLE ALCOHOL RELATED PROBLEMS (CHATA)

# A DOCUMENTATION

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# 1. Introduction

Alcohol is a substance that has been in use since ancient times. With time however, the consumption of alcohol has shown a steady increase. The recent World Health Organization estimation of the Global Burden of Disease projects that on a global basis, 3.5% of the total loss of disability-adjusted life years (DALYS) is attributable to alcohol. The burden of alcohol not only affects the drinker, but also his significant others, leading to problems in his/her social, economic and health situations. In addition, there is considerable evidence to show the effect of alcohol consumption on health of others in areas such as motor vehicle accident injuries and deaths, violence involved assaults and spouse and child abuse. There is large amount of literature on the association between drinking and forms of victimization such as robbery, rape and aggressive behavior. The effects of alcohol consumption is greater particularly in developing countries where a large part of the family's income is spent on alcohol, aggravated by poor living conditions and malnutrition.

Recently, the phenomenon of globalization has fueled the increase in alcohol consumption. The commercial market interests play a big role in maintaining as well as increasing alcohol consumption. In the recent times, drinking has been synonymous with the process of cosmopolitanism, promoting drinking as an essential part of "the good life".

In India, having a population of nearly a billion people, the prevalence of alcohol use has been difficult to determine. The rough estimates according to the 1999 Global Status Report on Alcohol by the WHO are that use among men varies from 16.7 % - 58.3%, varying with the degree of urbanization as well as by region. The report also points out that the alcohol distribution is administered in a three-tier system in India, consisting of alcohol manufacturers selling liquor through wholesalers to liquor outlets.

The types of liquor sold in the country are of three types namely Indian-Made Foreign Liquor (IMFL), country liquor and illicit liquor. IMFL includes beer, rum, whisky etc while country liquor is that which is made from cheap raw materials such as sugarcane, rice or coarse grains. Illicit liquor is made by unlicensed distilleries and the amount of alcohol and adulteration is unknown. The makers of illicit liquor do not have to pay government revenues and hence provide it at low costs, finding a ready market among the country's poor.

Alcohol use leads to problems of health such as cancer, liver disease, neuropsychiatric disorders, accident related injuries and death. Social problems are also caused such as violence and crime, bad interpersonal relationships at home and the workplace. Excessive drinking leads to loss of money and property. The family of the drinker suffers most. The problems caused within a family due to alcohol use of a member includes loss of money, child abuse, violence and aggression, nutritional deficiencies due to lack of proper food, stress and mental trauma and unwanted pregnancies.

The attempt to control alcohol consumption in the country falls short of its expectations. The Constitution, in article 47, declares, "the State shall endeavor to bring about prohibition of the consumption of intoxicating drinks." It has been seen that there is an increase in

liberalization of production of alcohol and availability, except in a few states. As state governments handle the matter, there is variation in rules of different states. The presence of illicit liquor producers results in people consuming alcohol even if the government has stringent rules on alcohol consumption.

## 2. Community Health Approach to Tackle Alcohol related problems – The Project

The Community Health Cell was involved in the implementation of a program for Women's Health Empowerment program supported by the World Health Organization – SEARO, jointly with the Ministry of Health and Family Welfare of the Government of India. CHC worked in 5 districts of Karnataka from 1999 to 2001. Through the course of the community health work conducted by the Community Health Cell, there was an increasing concern about feedback given by members of urban slums as well as from rural women's groups. In every Women's Health and Empowerment training session conducted, alcohol abuse had been unanimously stated as one of the primary problems faced by the women. It was seen that alcohol use was consistently leading to breakdown of physical, mental and social health of the individuals and families besides worsening economic conditions of the people. There were many requests from the community as well as health workers to create a sustainable community health and development program that addresses this problem.

The Community Health Cell took this as a challenge and formed a NGO network of organizations working with the urban poor in Bangalore city to design a program to tackle this problem. The endeavor was assisted by the Department of Psychiatry at NIMHANS. After several meetings with the partners and visits to suggested slums, a framework for a community health approach was developed. This evolved over time.

The focus of the program was creating a healthy community with the active involvement and participation of the community itself in attending to their needs and addressing public health problems related to abuse of alcohol by the community members. Community based prevention strategies were an important component. The partners for the program namely Navjeevan Mahila Pragathi Kendra, Ragpickers Education and Development Society (REDS), Kanthi Kiranam and NIMHANS, along with CHC ensure the sustainability and effectiveness of the program.

**i. Goal**:

To create a healthy community by addressing community health, public health and development problems, specifically related to reducing alcoholism in the community

**ii. Objectives**:

**a. Long-term**

The long-term objective of the program is to create a healthy community, which attends to the community health needs. The objective includes addressing public health problems and programming for human development by the community members. Non- Governmental Organizations, along with resource groups enable this by building awareness within the community about the ill effects of alcohol consumption and motivating the members to abstain from alcohol use.

**b. Short-term -**

- To identify community and public health problems in the individuals, the family and the community, with the help of the community members and to prioritize these problems
- To conduct action programs to tackle these public health problems with a focus on prevention at all levels
- To initiate human development programs in the community
- To carry out all these activities in the context of comprehensive health care and harmony of the community

**iv. Strategy:**

- To identify community health and public health problems and explore possible solutions through a participatory, interactive approach involving focus group discussions in the community, with the involvement of all the partners in the program
- To evolve programs for general awareness on problems in community and public health, including problems related to abuse of alcohol and "LIFE" programs for children, youth and adults for human development. These programs focus on social skills, life skills, parenting skills and vocational skills
- Prevention of public health problems:
  a. Primary - public health problems
  b. Secondary – health promotion, modifying behaviors and environment, deaddiction treatment
  c. Tertiary – aftercare by the community with the help of experts who provide training and support.

The above-mentioned strategies evolved by mobilizing community resources and ensuring their full partnership in the community action to fulfill the community's needs.

**v. Plan of Action:**

The partners in the program took up specific tasks, through an ongoing process of interaction and collaboration in all activities.

The main activities involved:

- Information dissemination and education
- Alternative group activities
- Value education
- Social skills
- Deaddiction treatment
- Rehabilitation

**vi. Guiding Principles of the Program:**

- The program encourages active participation by the community.
- It helps people to help identify their needs and work with them to find solutions.
- It aims to bring about healthy, self-reliant communities, working with the belief that people becoming empowered will lead to less dependence on outsiders.
- It helps to encourage community life. The aim of a field worker is always to build up life skills and dignity, and never cause offence or humiliation.
- It moves outward to where the people are in the community. It is not clinic or hospital based, but utilizes their specialized services whenever required. It is decided according to the needs of the community rather than the convenience of the service provider.
- It focuses on the next generation – the children and the youth.

**vii. Resources:**

1. **Human Resources - The division of responsibilities were as follows:**

   Community Health Cell – primary prevention interventions for alcoholism, including community health approach to this public health problems;

   National Institute of Mental Health and Neuro Sciences (NIMHANS) – treatment counseling

   Local Non- Governmental Organizations such as Navjeevan, Kantikiranam and Ragpickers Education and Development Society (REDS)– mobilizing the community and taking the responsibility for the local action

Bangalore Medical Service Trust and Rotary Blood Bank – life skills training for youth

TTK Hospital, Chennai – training of health workers/ animators and counselors

Local volunteers and the community

**2. Financial Resources:**

Financial support was provided by CHC. Staff time of participating NGO's and NIMHANS was through the respective organizations. The community provided the venues for meetings and field training, their time and labour. There was a lot of volunteerism.

**3. Technical Support:**

CHC, NIMHANS, SKIP, TT Ranganathan Clinical Research Foundation, Dr. Lakshman (MIND)

**viii.Advocacy:**

In addition to the above partners, the community leaders and NGO's were also to be involved in advocacy action including the following with specific reference to alcohol abuse:

- Meet the policy and decision-makers in the state (politicians, secretaries to government, taxation committees and others)
- Promote legislation to reduce drinking
- Scanning advertisements in the media and taking action to ban/reduce/modify the advertisements promoting tobacco, liquor and other addictive substance
- Creating awareness leading to action through campaigns, rallies, street theater etc

**ix. Monitoring:**

A monitoring committee was to be set up among the partners to review and plan. At the end of every month, the monitoring committee was tol review the finished programs critically and analyze the success and failures for future improvements.

## x. Indicators:

| 1. **Health and life skills session for SHG members (women)** | | | |
|---|---|---|---|
| **Input** | **Output** | **Outcome** | **Process** |
| 37 Health, and Self esteem topics will be discussed Every week 100 women participate in each slums | Number of women participants | Improvement in collective action to maintain their health and demand health as the rights | Participatory way |
| **2. Intensive training for volunteers on prevention and management of addiction** | | | |
| All the topics related to alcohol, alcoholism, treatment, rehabilitation and community action will be discussed<br>10 volunteers from each slum i.e 30 persons will get the training | Number of participants Volunteers) | Volunteers increase their knowledge, develop their skills in prevention and management of addiction. | Interactive manner |
| **3. Life skills education for youth** | | | |
| Ten basic life skills will be covered<br>• Decision making<br>• Problem Solving<br>• Communications<br>• Interpersonal relationship<br>• Self awareness<br>• Empathy<br>• Critical thinking<br>• Creative thinking<br>• Stress management<br>• Emotion management<br>150 youngsters will participate | Numbers of persons participating | Young people increase their capacity to deal effectively the needs, demands and challenges of every day life and prevent the risk behaviors | The interactive educational methodology will be followed with group activities |
| **4. Reeducation program for people recovered from addiction**. | | | |
| • Motivation<br>• Treatment for physical and psychological, dependency<br>• Skills development<br>• Re-education on alcoholism and relapse prevention plan<br>• Group therapy<br>• Rehabilitation<br>• 25 chronic people participate from each slum | Numbers of participating | People who have recovered continue to be away from alcoholic drinks | Participatory method |

**xi. Evaluation:**

Three outside evaluators in the field of psychiatry and community development will be appointed to evaluate the program. In addition, through the participatory evaluation process, team group partners assess the efficiency of the methodology and measure the effectiveness and the impact of the program.

## 3. Community Health Approach to Tackle Alcohol related problems – The Process

The problems faced in communities, as expressed by its members initiated the whole process of a comprehensive, community health approach to overcome the alcohol related problems in these slums. The process began with the forming of a network of Non- Governmental Organizations that sat together and brainstormed to form a concrete plan to implement the program. The network of NGOs was formed for the following purposes:

- Providing an opportunity to share information and communicate ideas
- To interact with one another in order to help promote the accomplishment of common goals
- To encourage support for decision making and creative thinking
- Bringing about integration of ideas
- To avoid duplication of effort
- To help create a team spirit amongst organizations, enhancing team building
- To help the members to express their feelings, reactions and ideas openly, through a non-threatening and democratic process thus enhancing self-learning and group learning processes

Once the network was established, the process of creating a program proceeded.
The process took place through the following steps:

1. Brainstorming sessions;
2. Needs assessment done in three slum communities, using surveys and focus group discussions;
3. Analyzing the problems faced by the community due to alcohol and designing a comprehensive plan to tackle alcohol related problems in these slums.

**1. The Brainstorming Phase:**

The brainstorming phase occurred before the inception of the CHATA program, but still continues during each phase of the program. Initially, once the network was formed, the partners in the program met to discuss the various aspects of the program. While brainstorming, some of the points that were kept in mind were:

- Strategies focusing on women to cope with husband's or other family member's alcohol addiction
- Ways to reduce alcohol consumption in affected areas
- Ways of helping the community to address this problem
- Methods to maintain sobriety after treatment
- Discuss the problem of alcohol use at a macro level

The brainstorming took place to decide which locality to focus on and how to go about assessing the need of the community for an intervention plan for alcohol related problems. The specific area for program implementation and its ethnic composition were looked at along with details about the residents' cultures and prevailing traditions. The action plan for intervention, in terms of methodology and process, human and financial resources, and mobilization of funds were discussed at great length. The integration of alcohol consumption control with Primary Health Care and intervention to control alcohol supply at a policy level were also discussed.

Once the need assessment information was obtained, the profiles of the four slums were obtained and presented to the group. The trends of alcohol consumption and possible patterns were determined and discussed. Some members of the NIMHANS de-addiction program as well as members of Alcoholics Anonymous were consulted during this phase to share their experiences as well as views about the feasibility of the program.

In the brainstorming phase, the group went through a process of looking at alcoholism at an individual level, as a disease, to viewing it as a community's problem affecting various aspects of the community's functioning. There was a paradigm shift in the network, from addressing the issue with the aid of the biomedical model to using the community health model. The network believed it best to address community health, public health issues and development issues, with specific focus on alcohol related problems.

**2. The Need Assessment Phase:**

During the need assessment phase, questionnaires were used to obtain data from the communities. These questionnaires included questions about livelihood, economic conditions, and problems faced by the people due to alcohol.

The questionnaire followed the following guidelines:

**ABOUT THE SLUM**

- Name of the slum
- Location of slum
- Years of existence
- Number of houses in the slum
- Languages spoken by people in the slum
- Origin of the people in the slum (migrants from within or outside the state)

- The nature of the occupation of the majority of men and the women
- The wages paid per day to the men and women
- Who the land occupied belongs to – BMP/BDA/KSCB/ private owners
- Is the slum recognized? Yes/No. If yes, under BMP/BDA/KSCB

**i. BASIC NEEDS**

**a. Water**

- How is the water demand of the community met?
- Does the community face difficulty in obtaining/ accessing water?
- If so, what are the difficulties?

**b. Sanitation**

- Is there a drainage system in place? What is its condition? If poor, why?
- Where do most people go for toilet?
- The number of households that have a toilet
- What facility is available for others and how adequate are they?
- If there is a public toilet, do people use it and what is its condition?
- Does the slum have a proper road?

**c. Housing and Electricity (observe, ask and write)**

- The number of
  a) *Pucca* houses (RCC roof)
  b) Semi *pucca* houses (Tiled and sheet)
  c) *Kutcha* houses (thatched)

- The number of houses that have electricity connection
- The number of people who have an authorized electricity connection
- What changes have taken place with regard to these facilities in the past five years?
- Has the situation improved or deteriorated?
- The people's ideas and thoughts about how the situation can be improved
- The cooking medium used by the majority of the people

**d. Public Distribution System**

- Is there a Public Distribution System in the slum?
- Who accesses it?
- What are the reasons for people not accessing it?
- Is there a fair price shop in the slum?
- What items are usually available?
- How are the prices?
- Does everyone get the same quantity for the same prices?

- Has the situation changed in the past 5-10 years?

## ii. EDUCATIONAL FACILITIES AND LITERACY STATUS

- What educational facilities are available in the slum, non-formal as well as formal?
- If no facility is available within the slum, then where is the nearest facility available?
- Where do most children attend school? Government or private schools? If private, why?
- How many people can read and write in the slum?
- Are all the children of school going age attending school?
- If some children are not attending school, then what are the reasons for this?

### a. Anganwadi/Balwadi

- Is there an anganwadi/balwadi center in the slum?
- If no, why? If yes, who runs it and what services are offered?
- Since when are these centers in existence?
- What are the duties of the teacher and the aayah and how regular are they?
- Who attends these centers? What are the reasons for children not attending?
- What changes have taken place in the lives of the children after the center has been started?
- The number of children/pregnant and lactating mothers who make use of these facilities
- What are the reasons for some not availing of the facilities?

## iii. HEALTH STATUS AND HEALTH FACILITIES, SOCIAL SITUATION

- What are the common health problems that are faced by the people during the past year?
- What health care facilities are available in or near the slum?
- Where do people seek help and why?
- Is there a Government health center in the slum? How does it function?
- Where is the nearest Government health center?
- What services does it offer to the people?
- How are the fees for these following services?
  a) Consultation
  b) Consultation and medicine
  c) Investigation facilities
  d) If referred, where and how much is charged?

**a. IPP8/UFWC/SJCSRY**

- Are there any women's sangha/men's sangha/youth association being run in the slum?
- Who is running these sanghas and what facilities do they offer to the people of the slum?
- Is there a link worker/SHE club member from this slum?
- What services do they offer to the people?
- Have you used the services of family welfare centers or maternity homes? If so, what has been your experience?
- Are there members of Community Development Society formed by SJSRY?
- What program does SJSRY carry out in the slum?
- Who does it benefit and how does it benefit the people of the slum?
- What changes have taken place during the past 5-10 years with regard to the health problems of people and health services available, including in the voluntary and private sector and why?

**b. Peace and Harmony**

A discussion must be initiated to understand the extent to which people can live in peace and harmony with each other in the slum.

- When did the last disturbance take place in the slum and why?
- How did it affect the people?
- How was it resolved?
- Is there a perception that it is likely to occur again?
- How can these disharmonies be prevented?

**c. Social Problems**

- How many liquor shops are present within the slum?
- How many people are there who indulge in the following:
  a) Alcohol consumption
  b) Tobacco and drug use
  c) Infidelity and commercial sex
- Why are they involved in these?
- What can be done about it?
- How many people are involved in home-based income generation programs?
- How are the people distributed amongst political parties?
- What is the role of the local politician in slum development?

**d. Leisure Time Activities**

- What are the different kinds of recreational facilities in the slum?
- What do men do for recreation?
- What do the women and children do for recreation?

- How do the unemployed/seasonally unemployed spend their day?
- What alternate leisure activities could be introduced for each group?

**e. Social Situation**

- How many people are unemployed?
- How many are on seasonal employment?
- Are there any income generation activities?
- How many children (below age 16) are there in each house?
- What family planning methods are used?
- How many liquor shops are there in the slum?
- Is liquor brewed in the slum? If so, in how many places?
- How many people in the slum use alcohol on a daily basis?
- What are the three main reasons why people consume alcohol?
- Do people use drugs in the slum?
- If so, which group and what kind of drugs are used?
- What problems are associated with drug use?
- Has the alcohol problem in the slum increased/decreased/remained same in the last 10 years?
- If change has occurred, what are the reasons for change?
- Are there any nearby facilities for treating persons with drug and alcohol problems?
- Are these services satisfactory?
- How many people in each household use tobacco?
- Are people aware of the health consequences of tobacco, alcohol and drug use?
- How can these problems be prevented?
- How common is domestic violence among families?
- What are the outcomes?
- How common is suicide in the slum?
- What are the possible reasons for this?
- Are there any commercial sex workers living in the slum?
- How many of the males visit commercial sex workers?
- How common are sexual liaisons among inhabitants of the slum?
- How common is premarital sex among males?
- How common is premarital sex among females?
- Are there instances of homosexuality?
- How much is the awareness of sexually transmitted diseases?
- What types of protection do people use?

Along with the above-mentioned guidelines, a map of the locality, including geographical and observable behavioral details was made for each slum.

In addition to the above-mentioned questionnaire, focus group discussions were also conducted during the need assessment phase. The guidelines used for this includes:

- How many liquor shops are there in the slum or in its vicinity?
- What is the distance from your house to the nearest liquor shop?
- In how many places is liquor brewed in the slum?
- On an average how many persons in the household use alcohol?
- How many people in the slum are daily drinkers?
- How many women are consuming liquor?
- How many people consume alcohol only on weekends/holidays/festivals?
- Are there any restrictions or prescriptions in your community/religion/caste regarding drinking? If so, give details
- What benefits do the people feel about consuming alcohol
  a) To feel more comfortable, sociable, less shy, confident
  b) To relax, forget worries or tension
  c) To feel good, improve the mood
  d) To reduce fatigue and tiredness
  e) To increase sexual desire/performance
  f) To concentrate better, to improve mental functioning
  g) Others
- Approximately how much does a family spend on alcohol per week?
- What problems are faced by the family due to alcohol use by one member
  a) Marital discord
  b) Extramarital relationships
  c) Domestic violence – wife beating or child beating
  d) Physical assault against others
  e) Snatching of savings
  f) Excessive spending
  g) Not gainfully employed or attending work
  h) Abusive
  i) Neglect of self
  j) Lying on the street
  k) Loss of respect
  l) Neglect of children

- What are the health problems due to alcoholism?
- Has the alcohol problem in the slum increased/decreased/remained the same since the previous year?
- In what way do you feel your community can tackle this problem?
- Last year, how many people do you know who died due to alcohol related problems? For example, suicide, physical assaults/fights, accidents, health problems
- How many people in the slum were admitted to the hospital?
- Last year, how many women died because of their husbands'/relations' habit of alcohol consumption?

- Do you know any persons who have tried to give up alcohol?

**3. Analysis and Designing a Comprehensive Plan to Tackle Alcohol related problems:**

Once the information from the need assessment reports were presented by the local NGOs conducting the surveys, the network decided to choose three areas to implement the program - one big area and two small areas. The possibility of implementing the program in a rural area was also discussed, but dismissed due to the difficulties in accessing the area as well as the community. Finally, it was decided that three urban areas would be focused on.

Among the discussions, partners from NIMHANS expressed that the disease model would be a failure in this case, as it looks at the individual alone. The members from NIMHANS also emphasized the importance of follow up of the patients after completion of their treatment. The high chance of relapse was also discussed and it was decided that the community should be involved not only to implement the program, but also to monitor the possibility of relapse in the patients. It was then decided to have group meetings to monitor relapse of the patients.

Keeping in mind the situation in the slums and the existing problems within the community, the network believed that integrating the CHATA program with other programs, mainly focusing on health and development would be beneficial. It was believed that the program would be successful if the local people are organized into groups, facilitating the implementation of the program. The program was to bring about intervention with various groups such as children, youth, women and men's groups. The responsibility of the program would lie with the community as well as the local non-governmental organizations.

As various groups were being worked with, different activities were formulated for each of these groups. All the activities have the underlying objective of building awareness on the issue of alcohol and its related problems. In addition, all the groups would have sessions focusing on health.
For prevention of use of alcohol, the network felt it pertinent to work with children and youth. It was decided that sessions must be conducted with children, in schools or within the community and youth groups. Alternative activities such as sports and other recreational activities were also formulated. Similarly, self-help groups were formed that would deal with various health issues as well as function as a savings group. The alcohol users must be organized into a group, which would be motivated with the help of Alcoholics Anonymous group members to obtain treatment for their addiction. The wives of these alcoholics would also be organized into a group and sessions would be conducted on enhancing their coping skills.

The group debated the importance of Life Skills Education. It was then decided that the Life Skills Education, once it is incorporated into everyday lives of the community members would help the community.

## 4. Profile of Slums under Purview of Program

Three slums were considered for the CHATA program. They are the Sudhamanagar slum, Victoria Layout and Ragigudda slum areas. A brief profile of each slum is given below:

### a. Sudhamanagar Slum:

The slum is situated near HAL, Bangalore. The houses are built on 11/2 acre of land that belongs to HAL. There were 139 families with a total population of 700 people. The majority of the population belong to Schedule Castes (90%) and of these, about 80% follow Christianity. The majority of the men in the slum are construction workers and the women are domestic servants. The literacy rate among men is 18% and among women is 12%. 90% of the children attend the corporation school. There is one preschool run by Navjeevan Mahila Pragathi Kendra. All houses have electricity and drinking water is supplied every alternate day. The people of this slum have organized themselves and formed an association called the Ambedkar Welfare Society. Among the women, there are 7 self-help groups. Among the major problems faced by the community are alcoholism, unemployment, illiteracy and environmental problems related to water and sanitation. In 2003, the Rotary Club of Bangalore, on the request of CHC, addressed the issue of sanitation and supported the community to build 41 individual toilets. The community members are exposed to environmental pollution because of burning of garbage in the dumping ground near the slum.

### b. Ragigudda Slum:

The slum was established in 1970 and is located in J.P. Nagar. The land the slum occupies belongs to KSRTC, BDA and private owners. There are currently 1400 houses built on rocky and uneven land. The residents are from Andhra Pradesh, Tamil Nadu and Karnataka, speaking Telugu, Kannada, Tamil and Urdu. The majority of the men in the community are construction workers whereas the women are employed as housemaids, or maybe be vegetable or flower vendors. A few women are also employed in garment factories. The average family consists of five members, a few living in joint families. Water is supplied to the slum via two borewells and a few families have BWSSB water connections. The BWSSB supplies water on alternate days. There are open drains within the slum are the public toilets are inadequate for the people. Women were most affected by this as the men used the open space adjacent to the slum. About 200 families have their own toilets. About 500 families live in semi-pucca houses whereas the rest live in mud homes with thatched roofs. One out of ten families have access to television connection.

There are two schools in the vicinity; one is run by the government and the other by a private trust. Most children attend schools. World Vision and Kanti Kiran, voluntary organizations work within the community and focus on women and child development in the slum.

The most prevalent ailments are cough, cold, fever, asthma and jaundice. There is a health center in the vicinity of the community, run by the the Bangalore Mahanagara Palika with initial support from the India Population Project -IPPVIII. There are 4-5 private clinics nearby run by MBBS doctors. There are nearly 20 wine shops around the slum. Many residents of the slum are involved in illicit arrack sales. The majority of the male community members consume alcohol whereas a small proportion of women also do. Most men smoke and a few women chew tobacco. Youth and children inhale toluene, a chemical used in correction fluids. Suicide is prevalent, as it is seen as the solution for failed love affairs and family problems.

Income generation activities are available through self-help groups. For recreation, residents turn to television and gambling. There is great unemployment among the youth. Sex workers also operate from the slum, but not within the slum.

**c. Rajendranagar Slum:**

The Rajendranagar slum is located in Koramangala on 20 acres of land, housing 5000 households. There have been two major fires in the area since 1972, which destroyed many houses. The majorities of the people are dalits and belong to backward communities. The majority of the people are Hindus, while Christians and Muslims are minorities. The literacy levels in the community are low, particularly among the women. The slum dwellers are mostly first or second-generation migrants from Tamil Nadu or Andhra Pradesh. A small proportion of people have migrated from Gulbarga, Bellary and Kolar in Karnataka recently.

The slum does not have any basic sanitation facilities and this has led to physical and mental health of the residents. The residents commonly suffer from asthma, diarrhea, ulcers, fever, common cold and cough, heart diseases and mental illnesses. Wife beating is common among the households and a number of women have been abandoned by their husbands. There are a significant number of widows also in the community. Girls are engaged in child labor and the trend seems to be increasing. There is a high percentage of alcohol and tobacco use amongst the men. One of the main reasons cited for this is the absence of recreational activities and facilities.

**d. Victoria Layout:**

The Victoria Layout slum covers 4 acres of land housing 180 families with a total population of 1080 people. The major religion followed in the slum is Hinduism, followed closely by Islam, the Christians forming a minority. The total literacy rate in the community is 35%. The majority of the homes are kutcha houses with few pucca houses. Nearly 50% of the men are corporation workers while others work as coolies, carpenters, painters or domestic workers. About 5% of the men have their own businesses. The women are usually domestic servants. Inspite of there being 5 schools (Government and private) within a 2km radius of the slum, the enrolment in these schools is low. There are 5 private clinics in the vicinity of the slum. The common health problems faced by the community members are common cold, fever, malaria,

vomiting, tuberculosis, skin problems and heart problems. The community does not face any problems with respect to availability of water. There are 20 public taps and 2 borewells in the slum. About 80% of the people have private toilet facilities while the other 20% use public toilets within the community. All homes have electricity connections. The Government fair price shop is 2km away from the slum. There is an arrack shop within the slum and several in the vicinity.
The social problems faced by the community are due to improper drainage system, alcoholism, low literacy rates, familial conflicts and environmental pollution.

## 5. Situation in the Slums

The problem situation in three slums, namely Sudhamanagar, Victoria Layout and Ragugudda slum due to alcohol consumption, assessed through observation, questionnaires and focus group discussions have been divided into three categories:

a. **Health Problems**

It was found that health problems among men are increasing due to alcohol consumption. These problems included pulmonary tuberculosis, stomach ailments, poor eyesight, anemia, cancer, hypertension and diabetes. There was an increase in health problems of women and children due to nutritional deficiencies; the increase in money spent on alcohol leading to decrease in the amount of food available for consumption. It was also found that there was a marked increase in poverty in families due to alcohol abuse. There was also an increase in child sex abuse and sexual harassment. Domestic violence was on the rise making wife beating and child battering common. This led to physical as well as mental trauma. It was also noted that there were many unwanted pregnancies due to the failure of men to use contraceptives. The many misconceptions and myths about alcohol and little knowledge about addiction and treatment services within the community fueled these problems. In addition, many people found it difficult to get the deaddiction services due to the time taken to complete the course of treatment.

b. **Social Problems**

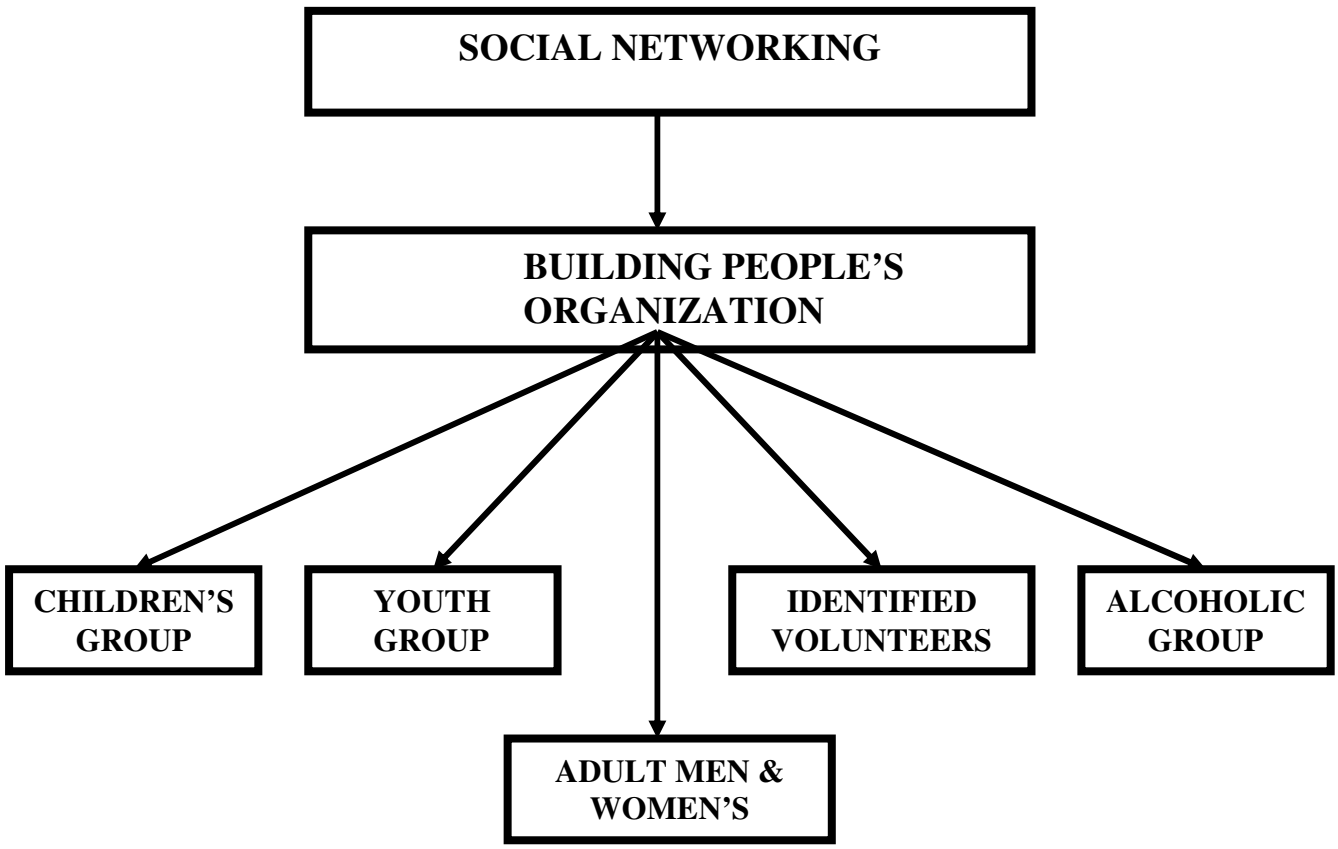
The social problems endured due to alcohol consumption are numerous. Low self-esteem was detected among women and children. The numbers of woman-headed households were increasing as were the number of broken families. Suicides and suicidal tendencies among community members became common. The social interactions of people consuming alcohol were poor, many indulging in antisocial activities, mainly to fulfill the need for liquor. There was no availability of recreational facilities within the slum area, causing idleness and boredom, which leads to increased consumption of alcohol. Violence within and outside the home was frequent in the slum. Alcohol caused poverty made child labor unavoidable in some families. Consequently, the rate of dropout of children from school was also increasing. The burden of debt and related problems were high in the slums. Adding to all these problems, there were retail shops of IMFL and bars located in the vicinity of the slum.

c. **Economic Problems**

The increase in rate of alcohol consumption also led to an increase in absenteeism from work. Due to low productivity and lowered efficiency, more people were losing their jobs. As the people were already unskilled laborers, there were no regular or permanent job opportunities available to them. The people who had jobs earned little and most of their earnings were going towards buying liquor, which led to many families often surviving without the bare necessities such as food and shelter. This also led the wife and children of a drinker to work, often taking up dangerous jobs for low wages. In addition, there was a high degree of depression and stress on the wives of alcoholics. The eligibility to get loans in cases of emergencies was decreasing.

## 6. Activities

The broad activities of the Community Health Approach to Tackle Alcohol related problems are as follows:



**Children's Group:**

The program works with the children's groups to:

- Create awareness through entertainment at schools in and around the slums with the aid of the teachers
- Initiate and sustain sports and game activities in the slum area, especially during the holidays to develop healthy habits
- Provide health and science education, including discussions about familial and societal problems due to alcohol
- Have discussions with respect to values
- Provide training for teachers

**Youth Group:**

The youth groups are provided the following:

- Sports, games and recreational activities, creating awareness about relaxing in a healthy way
- Life skills education, with special emphasis on resisting peer pressure to use substances
- Technical skills training for income generation
- Education about addiction, creating awareness about social and economic consequences of alcohol consumption
- Health education
- Science and value education for everyday life, promoting voluntary and social work in the neighborhood
- Initiating youth clubs

**Identified Volunteers:**

The volunteers identified were provided with the following training:

- Health workers training
- Intensive training on prevention and management of addiction
- Trainer training program on life skills

**Adult Men and Women's Groups:**

The adult men and women's groups dealt with:

- Parenting skills
- Violence in the family as well as community
- Coping skills and developing a helpline to solve problems
- Development of social skills and self-esteem
- Health education
- Income generation activities and vocational training
- Leisure time activities

**Alcoholic's Group:**

The chronic alcoholic's group was provided with:

- Motivation through ex-alcoholics or Alcoholics Anonymous group members
- Treatment through acupuncture or allopathy
- Aftercare and rehabilitation

The training is mainly done by NIMHANS, wherein people with problems related to alcohol are identified with the help of the community and local NGOs. Then, deaddiction programs are discussed with the person and his/her family. Once treatment is given, follow-up is done. Groups like Alcoholics Anonymous are involved and individual counseling is also provided in the community. Mainly the community and local NGOs provide aftercare by providing support for those who participated in the deaddiction program through counseling, alternate activities and recreation facilities.

**Training Sessions:**

The training sessions were preceded by sessions with women, adolescent girls and youth groups during which the aims and objectives of the CHATA program were explained to them.

The sessions undertaken by the CHATA program are:

1. Life Skills Training Sessions
2. Health Sessions
3. Vocational Training
4. Recreational Activities

Life Skills Training:

The life skills approach is an interactive educational methodology that not only focuses on transmitting knowledge but also aims at shaping attitudes and developing interpersonal skills. The main aim of this approach is to enhance young people's ability to take responsibility for making healthier choices and resisting negative pressures and avoiding risk behavior. The objectives of the sessions conducted are:

- To provide youth with necessary skills to resist social(peer) pressure to smoke and drink
- To help the youth to develop greater self-esteem, self-awareness, self-responsibility, self-mastering and self-confidence
- To develop their positive social skills, critical thinking and decision-making skills
- To enable youth to effectively cope with social anxiety
- To increase their knowledge on the immediate consequences of smoking and drinking alcohol and training them to protect themselves from substance abuse, violence and harmful influences
- To empower them to take charge of their lives as well as the society's future and face the challenges of everyday life

- To encourage community support and action to control alcohol related problems within the slum
- To enhance cognitive and behavioral compliancy to reduce and prevent a variety of health risks and behavior

Life skills are behaviors that enable individuals to adopt and deal effectively with the demands and challenges of life. The content of the life skills training session increases the ability

- Make decisions
- Solve problems
- Think critically and creatively
- Communicate
- Listening skills
- Build empathy
- Be assertive and negotiate
- Cope with emotion and stress
- Build self awareness
- Select life's goals
- Get along with others
- Gain self confidence
- Cope with conflicts
- Resist peer pressure
- Build relationships with members of the opposite sex
- Understand and make choices about alcohol use and abuse, tobacco and health related problems
- Understand human sexuality and HIV/AIDS and other sexually transmitted diseases

The teaching method for these sessions contained gender sensitive, interactive and participatory approaches. The most common teaching methods include working in groups, brainstorming, story telling, role playing, debating and audio-visual activity.

Evaluation of the sessions was conducted through a questionnaire with the following questions:

- Which session did you find the most relevant for your fieldwork and how?
- Which are the sessions you found not very useful and why?
- Comment about
  a. Food
  b. Venue
  c. Background materials
- What other topics you feel useful for future training?
- Any suggestions for improvement

Health Sessions for the Women –

The majority of the women in Sudhamanagar are part of self-help groups organized by the Navjeevan Mahila Pragati Kendra. These groups meet regularly and have a good money

savings system. Once the self-help groups became strong, the health sessions were conducted. The women for the most part discussed their most pressing problems. The topics of discussion included practices to obtain good health, proper nutrition, especially for children, reproductive health, anemia, chronic headaches, obesity, hypertension etc. Among these many sessions, the women expressed their concerns of the use of alcohol in their husbands. The women feared the effects of alcohol on their families and scorned the presence of many liquor shops in the vicinity of their homes. From this concern arose the sessions on alcohol and alcohol related problems. Regular health sessions are conducted with the women including issues of stress management and feelings of depression. The women are helped to make informed decisions and sessions are specifically conducted with the wives of alcoholics. It was through the women's groups sessions that the idea of forming a group of alcoholics came about, with the encouragement and support from their wives.

Vocational Training –

As part of the CHATA program, in collaboration with the organization SKIP, vocational training was provided to both young boys and girls. The place of training was the Loyola ITI on Bannerghatta Road. The youth themselves identified areas in which to get training. These included driving, motor mechanics and car servicing. Among the girls, the identified need was to take up a computer course. The project helped young men of the community obtain their drivers licenses with the aid of SKIP and Loyola ITI in order to enable them to obtain a suitable job and hence be financially independent.

Recreational Activities –

The recreational activities were initiated with the dual purpose of provide alternative activities for the unemployed youth of the community as well as a medium for promoting awareness about alcohol and related issues. With the help of local NGOs the CHATA program has been able to provide sports equipment and other games equipment to the community members.

The trainers and health workers of the CHATA network who conduct the above mentioned sessions are given training as well. Their sessions deal with the same issues with the addition of how to conduct sessions and counsel alcohol users. The main objectives of training the trainers are

- To help the trainers of CHATA network to understand the learn the principles and to learn the basic methods for effective counseling assistance to persons and families coping with addiction
- To develop more resource personnel in the field to support and aftercare to families affected by addiction

The trainers training curriculum includes sessions on motivation, addiction related problems, developing empathy, managing lapse and relapse, assertiveness training, managing negative emotions, formulating intervention plans and its evaluation methods, obtaining feedback.

The trainers learn from these sessions and are empowered by them, enabling them to be more effective while working with the community. Various types of media are used in training the trainers so as to leave an impact of the issues dealt with.

**7. Techniques and Therapies Used:**

**Alcoholics Anonymous Method –**

The Alcoholics Anonymous method involves a voluntary self-help group, coming together to assist one another with their drinking problems. It follows the abstinence model, and encourages the member to seek spiritual help by understanding oneself and giving in to the power of God. The members share their experiences and problems, giving each other strength and hope to resolve their drinking problems. The only requirement for membership is the desire to stop drinking.

The Alcoholics Anonymous method envisions change through twelve steps. They are:

1. The members admitting that they have become powerless due to alcohol and accepting that their lives have become unmanageable due to alcohol.
2. The members come to believe that a power greater than themselves can restore them to sanity.
3. The members make a decision to turn their will over to the care of God as they understand him.
4. The members make a search and fearless inventory of themselves.
5. The members admit to God, to themselves and to another human being the exact nature of their wrongs.
6. The members are entirely ready to have God remove all the defects of their character.
7. The members humbly ask God to remove their shortcomings.
8. The members make a list of all persons they have harmed and become willing to make amends to all of them.
9. The members make amends to such people whenever possible, except when doing so will injure them or others.
10. The members continue to take a personal inventory.
11. The members seek, with the help of prayer and meditation, to improve their conscious contact with God.
12. Having a spiritual awakening as a result of these steps, the members try to carry this message to other alcoholics.

**Al-Anon Method –**

The Al-Anon is a self-help group for the spouses, relatives and friends of alcoholics. It is essentially a group of men and women whose lives have been affected by the compulsive drinking of a family member. The purpose of the group is to offer comfort, hope and friendship to the family and friends of alcoholics. Al-Anon work is based on the above-

mentioned twelve step method. Through this method, the members learn constructive ways of dealing with the difficulties alcoholism creates.

**Group Therapy Techniques –**

Group therapy is one of the most effective methods of treatment for addiction. Groups tend to have a sense of belonging as they share the same problems. This provides the members an opportunity to share freely and identify with others of the group. The group therapy also helps clients in understanding their own attitudes about their problem and the defenses they use against giving up substance use while relating to others in similar situations. The group members learn to be interdependent, hence building a better social network. This also helps the chemically dependent to work through their feelings of isolation. Group therapy provides a congenial atmosphere to powerfully confront denial and form new responses and new skills. In addition, sharing of insights, offering suggestions and support gives an individual the feeling of helping another, leading to enhanced self-esteem. Listening and sharing are two essential components of group therapy. All participants are treated equally irrespective of their substance use status, level of dependency or nature of problems.

**Individual Counseling –**

Counseling is a process of assistance to an individual who needs it. The process aims at enabling the individual to learn and pursue realistic solutions to their problems. Counseling takes place over a period of time. Three main components of counseling are listening, processing and providing adequate and sensible feedback.

**Media:**

Street Plays –

The most used media were street plays and skits. The street plays dealt with issues of alcoholism and depicted stories of families affected by alcohol. The plays were conducted with the help of Kendriya Sadan, which provided a specialized team to conduct street plays. The plays illustrated the agony of the family members and the problems faced by the wife and children of the drinker. In addition, they also depicted the stages of alcoholism of the drinker, beginning with casual social drinking, leading to increased tolerance and then the desperation to consume liquor at any costs. The interest among the community members for the plays was good and the response and affects were also good. The women of the slums, especially the wives of the alcoholics responded well to the themes in the play and related to them. The plays left a good impact on the audience, according to members of the community and local animators.

Movies –

Various documentaries and films were screened within the communities with the themes of “ill effects of alcohol consumption” to create awareness among the people.

## 8. Stakeholder Perspectives

There are various stakeholders in the comprehensive approach used to tackle alcohol related problems in the slums. The stakeholders are at various levels namely the beneficiaries of the intervention ie the alcohol users and their wives, the health workers, trainers, and the program planners.

A case study:

MR. A was an alcoholic who is the father of six children and has an unemployed wife. He worked as a waste paper seller and had the habit of using alcohol. He became overly dependent on alcohol when he started consuming alcohol whenever he was feeling upset about something. Slowly, he became unable to work and became a full time drinker, his choice of drink being brandy. There was easy availability of alcohol in and around his slum (Sudhamanagar) from the many liquor shops. The repercussions of this were felt by his family and six children. He spent all his earnings on alcohol. During this time, his wife became a part of a self-help group in the slum. As part of the CHATA program, health workers spoke at great lengths to the women about alcohol use and its effects using the various media mentioned above. Through his wife, he was admitted to NIMHANS for treatment. Mr. A abstained from drinking during his period of stay in the hospital and shortly after his return home. However, when he had rough times again, he resumed his drinking and very soon went back to his initial drinking ways. He was again sent to NIMHANS for treatment and again stopped drinking briefly. He came home and started to work again. In the meantime, his elder children had also started working to look after the family. Shortly after coming home, he relapsed again "due to family problems" and was admitted again to NIMHANS for deaddiction. Currently, he claims not to have consumed alcohol for the one month that he has been back home after treatment at NIMHANS.

According to him, the treatment at NIMHANS is systematic, beginning with five days of heavy medical treatment, followed by a progressive reduction in the number of medicines administered until just one tablet is given. The routine at NIMHANS also included regular exercise, group meetings of the patients and individual meetings with the doctors. His medicine has been changed recently. He says that with the previous medicine, he could not control his urge to drink. The new medicine is successful in doing this, according to him. He now claims that he is completely clean from his alcohol addiction and has recently resumed work again.

Mr. A feels fortunate that he has lost his drinking habit. He is sure that he will not resume his habit, as he is able to control his urges to drink more now. According to Mr. A, the CHATA program has definitely been a success in his case as he has finally lost his drinking habit. When asked about his two relapses, he took the onus of these upon himself and said that his inability to control his urges to drink caused him to relapse. He did not find fault with the program. However, he mentioned that there were no follow up group sessions taken for the persons who had returned from the hospital after the de-addiction treatment.

As mentioned above, the repercussions of Mr. A's drinking habit were felt by his wife and children. It was pertinent to get his family's perspective on the issue. Mrs. A felt happy that her husband has been rid of his drinking habits. She was also happy that his eating habits have improved after the treatment and that he has resumed work. She says that the family is much happier as there is no tension of loss of money or fights within the family. The couple is looking forward to their second daughter's wedding. The family hopes that Mr. A does not start consuming alcohol again, but is not entirely certain that he will not. Though Mrs. A is part of a self-help group that has regular health sessions, there were no sessions conducted solely with the wives of alcoholics.

Another stakeholder group in the CHATA program is the health workers who train and counsel the local community through various sessions. These trainers undergo training sessions themselves before they start working with the community. A discussion was conducted with three health workers working in the area of Sudhamanagar. The three health workers are part of the staff of Navjeevan Center and work closely with the self-help groups and the youth groups. The area has 20 strong and cooperative self-help groups that focus on saving money. The groups conduct health meetings twice a month. It is through these self-help groups that the issue of alcohol related problems was first brought to the community. As part of the health meetings, alcohol related problems were also discussed, along with skits and street plays about problems faced by a family having an alcoholic member. The play had a great impact on the women who decided to continue working with this issue. It is said that there was an increase in the enrolment into the various self-help groups after the play was staged. The health workers took the initiative to conduct home visits. The interest of the health workers in the health situation of the community members led to the members being more enthusiastic in their approach to the health workers, the sessions they conducted as well as the issues being discussed.

The life skills education sessions that were conducted, according to the health workers, has increased their own decision-making capacities as well as that of the women and youth in the community. The trainers reported that there is an increase in the self-esteems and belief in self of the community members. This is also said to increase the interest of the community in the work of the health workers. Once the health workers and trainers gained the trust of the community, the implementation of the CHATA program became easier. The wives of alcoholics who urged their husbands to form a group then strengthened the work done by the health workers. This group became the primary focus of the work and they were sent for the de-addiction program at NIMHANS.

The group has since finished their course of treatment and returned to the community. The problem however is that more than half of them have had at least one relapse since the treatment. The relapse rate makes the health workers say that the program is "only an 80% success." The health workers are however very happy with the training sessions conducted by the partners of the CHATA program. They believe that the resource personnel who have come so far to conduct the sessions have been excellent and have been able to initiate thinking within the various groups and encourage them to tackle the problems they face in everyday life. They are of the opinion that the CHATA program has brought about awareness within the community about the issue of alcohol, empowering them to tackle the problem. Along with de-addiction of alcoholics, one of the aims of the CHATA program is prevention of the use of alcohol. For this purpose, the youth

groups are targeted. Along with life skills training, the CHATA program has helped the youth in obtaining vocational training and gaining awareness about addiction to various substances. Many of the youth in the slum, according to the health workers, are unemployed and this increases their chances of substance use. The youth are therefore provided with recreational activities with the help of local NGOs. According to the health workers, the youth have become more sensible about alcohol use due to the various activities of the program. They feel that the program is doing well and this will continue as long as the interest of the local NGO in this issue remains constant.

## 9. Looking Ahead

The CHATA program will continue within the slum with the help of the local community members and the trainers. There will be continued focus on developmental and health issues in the slum. One of the activities to be taken up in the slum in the near future is the formation of an entrepreneurship-income generation group, with the help of the local NGO Navjeevan, the Rotary Club of Bangalore and the Association for Women Entrepreneurship of Karnataka (AWEK). The self-help groups plan to get actively involved in this process and are looking forward to it.

The health workers are also hoping that they can initiate more alcoholics into the treatment program at NIMHANS. In addition, they hope that they can effectively monitor and prevent the relapse rate of the alcoholics who have undergone the de-addiction treatment.

The local NGO's and the community will need to take increasing responsibility in the CHATA intervention.

## 10. Key Observations and Suggestions

- The CHATA program is going on smoothly in the Sudhamanagar community with the help of the trainers and the community members. However, there is a large percent of relapse cases. It is of course natural for addicts to have episodes of relapse. The rate of relapse might be lowered in forming a core monitoring group within the community which does constant follow up of the patients undergoing and those who have undergone the de-addiction treatment. The role of this group could be to monitor the addicts group so as to immediately detect a case of relapse. Follow up is essential in de-addiction cases and most institutions are not successful in doing this. Consequently, if the community itself has members who are trained and work for the purpose of doing continuous follow-up sessions with the alcoholics, the relapse rate may be controlled.

- Though the program is being implemented well currently, its sustainability is a matter to be thought about and it involves further planning. One of the issues that came up while speaking to the health workers was their concern that the there might be a lag in the program

if the interest of the local NGO on the issue of alcohol dwindles. The health workers fear that changes in the leadership or policy of the NGO might affect the program and hence the community. They have a valid point and possible ways of preventing this must be thought of. As it is impossible to prevent changes within the NGO, the CHATA program might benefit from empowering the local community to a level where they themselves can sustain the program. As the initial training sessions for the trainers have been conducted, they are likely to have a concrete understanding of their roles within the community. With the help of the trainers, the program can attempt to organize people who are interested in the issue to take it forward. There seems to be 20 strong self-help groups and the understanding of the observer was that they cooperate with one another and work together. Hence, it might be easy to organize the women of the community to take the program forward. Once the program ands its responsibility essentially lies in the hands of the community, changes within the local NGOs may not have a huge impact on the implementation of the program.

- Follow-up while the patients are undergoing the de-addiction treatment in the hospital is also suggested. A follow-up of the patient's treatment progress and medications administered would help. Often during the course of treatment, the patient may give clues about the possibilities of relapses as well as the progress made by the patient during the treatment. In addition, the medications administered can be checked and the doctor consulted as to why certain medicines are prescribed. This continuous follow-up would also enhance the therapy sessions by the health workers in the community that would follow the treatment. Only an individual who is knowledgeable of de-addiction treatments or psychiatry, however can do this type of follow-up. One of the partners from NIMHANS would be ideal, but the time constraints and availability would be drawbacks in implementing this.

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