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Review :

Health of the underprivileged children: A close look into a subset of tribal group and street population of India

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Abstract

Child morbidity and mortality are compounded by a wide array of societal factors of

disadvantaged population. Understanding social determinants in tribal and street life in rural and urban setting would excavate the root cause of vulnerability of children towards disease development in at-risk families and highlight the corrective actions required for the two extremities of underprivileged scenario. We have presented the glimpses of 'cause and effect' picture of social determinants of health for the diverse two populations with commonalities of deprivation, which is more pronounced for the street dwellers with the burden of environmental pollution and manmade abuse and crime. Owing to unavailability of standard food, safe water and shelter, and lack of awareness and education, children of such families fall prey to health hazard and disease burden. Understanding the impact of societal factors on children's health and redefining the government plans and policies may ensure betterment of health and improvement of life. Intervention of social pediatrics would be effective with a view to nurturing disadvantaged children's health amidst underprivileged societal factors, lack of facilities for education and healthcare. The outcome of community pediatric investigation would guide for understanding the impact of environmental and epigenetic modifiers on genetic consequences.

Key words:

Social determinants of health, tribal life, street dwellers, health hazards

Introduction

Adivasis (Devanagri: Literally: old inhabitants) is a term used for all the heterogeneous set of ethnic and tribal groups believed to be the aboriginal population of India. In the Indian context, social organization on the basis of caste and other social groups such as tribes represent a form of social stratification. Scheduled Caste (SC; 16.2%) and Scheduled Tribes (ST; 8.2%) and in some cases the Other Backward Castes (OBC) mainly belong to socially disadvantaged groups as they have been identified as poor and living in disadvantaged condition with poverty and deprivation of life-support facilities. This marginalized population even maintains a distance with the civic society, mainly for their illiterate condition. They live in isolated villages or hilltops where the government support including medical facilities are difficult to reach. However, Indian government has implemented number of support systems for betterment of life-course of these socially-excluded people through inter-sectoral coordination. Such percolated implementation has brought in primary health centers at such isolated areas for these classified castes and tribes. Majority of the tribal populations lives in Northeastern (Assam, Manipur, Sikkim, Tripura, Arunachal, Mizoram, Nagaland) and central Indian

(Chhattisgarh, Madhya Pradesh, Orissa, Andhra Pradesh) states and small numbers in almost all the states and Union Territories. Efforts to improve a tribe's educational status have had mixed results owing to the facts that recruitment of qualified teachers and determination of the appropriate language of instruction, and that has plagued many tribal schools by high dropout rates. Tribal Children, suffer from ill-health due to nutritional deficiencies, lack of safe drinking water and sanitary hygiene and poor access to health care. This is reflected in high rates of Infant Mortality Rates (IMR), Child Mortality Rates (CMR) and also low enrolment ratios in schools, high drop-out etc, and thus low level of achievement.1

A street child in India is someone "for whom the street, including unoccupied dwellings,Waste land, etc. has become the habitual abode and/or source of livelihood. Street-kids are of life. Mainly because of family conflict and violence, death of a parent, alcoholism of father, strained relationships with stepparents, parent separation, abuse and so on, children from poor such socio-economic groups leave home and come to live on the streets and take on the full responsibilities of caring for themselves, including working to provide for and protecting themselves. They grow up on the streets, form families with street-dwellers and thus the generation continues living underneath the flyovers along the roadside. There is currently no effective program for estimating the accurate number of street children in India owing to the difficulty in obtaining data because of their floating characters/residences. Street children usually have no proof of identification, demographic certificate and move between places often. Human Rights Watch Project (Human Rights Watch) 1996 reported that annually 50,000 people leave home in India, of which 45% percent are below 16 years with average age of 13 years. Overall, estimate for the total number of street children in India ranges from 400,000-800,000.3, 4 Social determinants of tribal children's health "The conditions in which people are born, grow, live, work, and age, including the health system" are the social determinants defined by WHO.5, 6 Unhealthy antenatal care, insufficient food, lack of safe drinking water, unhygienic sanitary and living system, poor infrastructure for education and healthcare are the key contributors of poor maternal and child care.7, 8

Tribes usually believe in their own myths and culture. They have poor health and high morbidity and mortality due to lack of awareness, inadequate health infrastructure and also their conservative culture and superstitions related to health management. Deficiency of essential components in diet results in overall malnutrition, protein calorie malnutrition and micronutrient deficiencies. Tribal diets are frequently deficient in calcium, vitamin A, vitamin C, Riboflavin and animal protein. High prevalence of genetically transmitted diseases such as sickle cell anaemia , glucose 6 phosphate dehydrogenase (G6PD) deficiency and different forms of thalassaemia and goiter are some of the endemic disorders in some of the tribal areas.9, 10 Waterborne and communicable diseases, gastrointestinal disorders, malaria, TB, wide spectrum of other viral and venereal diseases take huge toll among these marg nalized populations living in inadequately protected and supervised, and directed by responsible adults" as defined by UNICEF.2 They live in nature with all odds of the environmental, societal and political conflicts, and are nurtured by the nature for getting strength to live in all unfavorable conditions and odds disadvantaged areas across the country. Approximately, 7 of every 100 children die during the first year of life. To site an example of lives of tribal population, Raigad district may be suitable for comparison with that of street population of Mumbai. According to the 2011 census, Raigad district has a population of 2,634,200 with a sex ratio of 955 females for every 1000 males and a literacy rate of 83.89% with a density of 368 inhabitants per square kilometer (950/sq mi). The schedule tribes and schedule caste comprise 24.6% of the total Raigad population. Among these are the Mahadev, Koli, Katkari and Thakur.11 Each one of the backward communities

has got its characteristic features and peculiarities in respect of customs and manners. Its population growth rate over the decade 2001-2011 was 19.36%. The tribe of Raigad district is settled in the hilly parts of Karjat, Khalapur, Panvel, Sudhagad and Pen talukas in exclusive hamlets located on high altitudes. Each community is aloof from other castes and as much as possible live by themselves. In bygone days it was their practice to shift the location of the village on the outbreak of an epidemic but this nomadic tendency is now practically obsolete owing to some facilities available in the villages or nearby township. Katkaris, from their customs, to some extent indicate probably a Bhil origin. However, from their appearance, culture, customs and religion it would appear that they are an aboriginal tribe. There are some cultural differences among sub-tribes such as Sons and Dhors of Katkari. Girls are generally married between 12-15 years and boys between 18-25 years. Widow marriage is also allowed. The culture of marriage restriction with mother's sister's daughter and sister's daughter has some control over consanguinity among these isolated communities; however, custom of cross-cousin marriage is still followed. Arranged marriage with mother's brother's (Mama) daughter (consanguinity) as an indication of respect to Mama has been experienced through genetic counseling of suspected genetic disorders among the children born to such parents.

Control of land is a particularly contentious issue, with several large scale residential and industrial projects and special economic zones coming up in Raigad. The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act has also not helped as 12,000 of the 18,000 claims for land filed in Raigad have been rejected. Most of the tribals do not even have ration cards and so do not get subsidized food under the Public Distribution System. Raigad district is not covered by the Mahatma Gandhi National Rural Employment Guarantee Act. As a result, large numbers of farm laborers who are unemployed during the lean summer months migrate to work in brick kilns in neighboring districts. Banks and cooperatives in the area do not provide loans to tide over this seasonal unemployment leaving many with no alternative but to turn to moneylenders and brick-kiln owners, who charge them high interest rates. Unable to pay off these loans, many sell of their land, get caught in a debt trap or work as bonded labor in the brick kilns. Katkari, Koli and Agri communities are engaged in fishing also. Sixty-eight years after independence, the poor and socially marginalized Adivasis continue to be deprived of their right to land, forest, water, education, health, and housing and government benefits.

Healthcare is of concern as government-run primary healthcare centers in the villages are not equipped to treat most illnesses particularly pregnancies and childbirth, leaving the poor to the mercy of private clinics and hospitals which charge hefty fees for their services. Malnutrition and poor health take a huge toll of infant death in areas of tribal population in Maharashtra every year.9 "These have not been dealt with because though crores are spent in the name of tribal development, only a fraction of the amount reaches the beneficiaries" said by a Tribal Welfare Body of Nasik. Among the prime causes of malnutrition are unemployment, landlessness of local people, degradation of forests, deficient healthcare and a defective public distribution system. And all these ills can be ascribed to rampant maladministration. "The allegations of rampant corruption are true. Employment schemes are not functioning well, doctors hardly visit health centers and people in resettlement villages are landless. All in all, the situation is bad," once said by the state's rural development minister.

Issues of health-care facility to these communities are not the limiting factors. There is enormous barrier within these populations of all ages as they find difficulty in language for communication and expression of health problem, lack of knowledge as to where to go for health care, how they will be treated in the community or by the

physicians, what course of treatment will be advised, what will be the effects, how much will be the cost, etc. That is the reason of the tribal villagers live isolated from the community, and that further establish marriages within the close community (? consanguinity) and reproduction of children at-risk with multiplication of recessive mutations. They, both tribal-villagers and urban-street dwellers follow unani treatments, mostly with phytochemicals for any ailment.12 The disease-burden is compounded in due course and takes life at any age.

Baseline surveys were conducted by ICMR institutions for health, nutrition, morbidity and mortality profiles in various tribes with special focus on primitive tribes of Madhya Pradesh and Andaman & Nicobar Islands. Prevalence of genu valgum was 51% and of dental fluorosis was 74%. High prevalence of Hepatitis B was detected among tribes of Andaman & Nicobar Islands.

Genetic diversity among the tribes is also being studied by ICMR. Prevalence of various types of haemoglobinopathies is being studied and operational research for instituting prevention and control strategies is being undertaken by ICMR in 10th plan.10

A large proportion of ST, SC and OBC are not availing any treatment even for diarrhea and malaria. The same pattern is discernible in the case of maternity care as well. The proportion of SC and ST women who have not availed any antenatal care leads to high IMR and CMR.3, 8 The health status and utilization patterns of medical facility of such groups give another indication of their social exclusion as well as an idea of the linkages between poverty and health. Specific behavioral practices in child birth or early child care are closely linked to the social and cultural background, which shows their roots of social, political and cultural behavior. There are hindrances like physical access to seeking care in health institutions and remoteness of certain areas and forest cover. Mostly non-existent and non-functional health infrastructure deters people from approaching to institutional care and also procedural hassles and delays discourage them to approach for institutional care. Widespread ignorance and lack of awareness on health issues influence prevalent beliefs, myths and misconceptions. There exists lack of structured exposure and discussion on these issues and it would be very difficult to convince and motivate these isolated people. Today with increasing knowledge and understanding through intensive facilitation, there is greater acceptance towards institutional care and services. The exclusion of tribal homogenous society is linked to their socio-economic profiles and care-seeking ability in monetary terms too.13, 14

Social determinants of street-children's health

The street children adopt strategies to cope with the harsh realities of their lives by developing a tough exterior and strong independence attitude. The unfavorable and non-protective surroundings lead these children to engage in unusual behaviors and activities, develop aggressive characters and understand 'take & give' equation. Majority of these children choose maladaptive strategies, such as drinking alcohol, using drugs, and visiting prostitutes to combat with frustrations, stress, conflicts and abuse from the socio-environment as a whole. Street children in India are frequently exposed to abuse, hostility and extortion, being deprived of social status and protection, being physically threatened and intimidated by adults, and being unsecured by the police and general public. Under a government-sponsored program called "Operation Beggar," street children in Bombay were rounded up and given into what was essentially indebted servitude.15 The street children face all types of abuse such as general abuse and neglect, health abuse, verbal abuse, physical abuse, psychological abuse, and sexual abuse with verbal and psychological abuse as the most. In reality, street children are not entirely on their own as they have a leader for specific territory who assigns the job in exchange of financial share, and also reports to the leaders of several such

territories. The street children understand such niche of the leadership system and become leader one day (Indian movies: Traffic signal; Salaam Bombay).

Living and working conditions of street-dwellers are beyond the definitions of child development. They live with lack of and poor awareness about hygiene, and unavailability of shelter, ad libitum food, safe drinking water, sanitary hygiene and access to health care service because of poverty. Patel16 reported that in Mumbai alone, 50,000 children are illegally employed by 11,750 hotels, restaurants, canteens, tea shops, eating places and construction sites. Since the street children are not protected, often they are exploited by the employers with no or low pay, abuse and sometimes physical torture, which finally builds crime in their mind. They are also engaged in stealing, pick-pocketing, drug-peddling, prostitution and also booked for murder. They are illiterate and do not want to go to school.

Begging is one of the most serious social issues in India. In spite of its rapid economic growth, India remains a poverty-driven country, which is also leading to the growth of beggars in the country. They beg being physical handicapped and unable to work or because they are old or blind. They live far below the poverty line and begging is the only way to meet their daily needs. From infants to old are engaged in begging at traffic signals, temples and any other popular and crowded areas. In some cases, the entire family is involved in begging. The family members of such beggars keep on increasing with early marriage and birth at premature age. Children of such families do not go to school but only beg. Poverty and lack of education and awareness are responsible situation for begging for earning the livelihood. Though street-children find a "mother-figure", who cares for them when they are ill and is interested in their well-being, they are vulnerable for ill-health and infection, and victims of morbidity and mortality. Street-kids are dependent on non-nutritious and unsafe food and water, and many of them are dependent on leftovers from small restaurants or hotels, food stalls, or garbage bins. Lack of water for drinking, sanitation, bathing and washing also contributes to poor health. Lack of restroom facilities, protective shelter and clothes further aggravates their vulnerability towards enormous clinical complications without having facilities of medical care. They are not eligible for medical facility at government hospitals because they do not have ration card or other national identification. They are victims of HIV infection, TB, asthma, dental problems and many other seasonal illnesses as they are unaware of life-course culture and unprotected. They are victims of compounding effects of environmental, cultural and economic extremes.17 Pre-mature exposure to sexual activities at teenage and with (?) blood-lineages further aggravates the disease burden with untreatable heritable genetic disorders. Environmental impact and epigenetic expression will even favor street-kids for early neoplasia and several otherlife-threatening ailments. Their professional engagement further weakens their vision,orthopedic, skin and many other systems due to 24x365 h exposure to sunlight, automobile exhaust, industrial and environmental pollutants with additional effects of lack of overall nutritional status and inherent immune-compromised physiology.18-20

Street children in India are "a manifestation of societal malfunctioning and an economic and social order that does not take timely preventative action" stated by Bose. 21 Indian government has set in place various forms of public policy concerning street children over the years, but they have hardly been effective because they are uniformed by sociological, anthropological, and geographical research on street children, meaning they do not always correctly assess and address the cause-and-effect relationship. The system of issuing identity card to children working on the streets in order to protect them from police violence was adopted on pressure of NGOs. Indian government created the "Scheme for Assistance to Street Children," which launched in February

1993;22 however, effective implementation has yet to be achieved. Since their entrance into the policy arena and the scheme, street children have been included in some other policies and programs as well. The Indian Council of Child Welfare has included street children in their programs, and a scheme for children has also been set in place in GOI's five year plan. The Ministry of Labor has also included street children in their livelihood training programs, though this has been met with minimal success because many street children do not have the education necessary to participate in the programs (Beyond Survival: Status of Livelihood Programs for Street Youth in India, Railway Children, June 2008). A.B. Bose of UNICEF and Sarah Thomas de Benitez of the Consortium for Street Children suggested that the main responsibility of assistance should be given to NGOs, which should be backed financially by the government.

Because NGOs have the ability to be more flexible than the government and they are better able to meet the needs of street children in varied circumstances.

Indian policies

The Government of India (GOI) has dedicated programs for uplifting the SC and ST economically and socially such as provision of development packages, reservation in educational institutions and employment, and so on. Such measures are intended to reduce the adverse conditions and social exclusion of these populations. GOI and the state governments (SGI) have also undertaken specific measures to address the problem of exclusion and to overcome the problems of accessibility and availability of healthcare to such excluded populations.

Governmental efforts have focused on reaching a package of services to tribal habitations through Integrated Child Development Scheme (ICDS) comprising of health care, immunization, supplementary nutrition, non-formal pre-school education, and health and nutrition education through several Balwadis and Anganwadis. However, the coverage of these services is deficient in interior/inaccessible tribal pockets, despite the introduction of a new concept called `Mini-Anganwadis'. The inadequate health infrastructure for their health-needs and lack of maternal and child health services among the hilly tribal areas increases maternal and infant mortality rates. High disease-burden is augmented by extreme poverty and consequent under-nutrition, poor environmental sanitation, lack of safe drinking water, lack of awareness about and access to health care, excess consumption of home-brewed alcohol, and social and economic barriers to utilization of available healthcare facilities.3

Lack of standards of care on accommodation, sanitation, leisure, food, mainstream education, and family culture/ ties etc, as the most 24-hour shelters do not provide all the basic facilities required, lead the children to drug addiction, HIV/AIDS and pre-mature sexual abuse. None of the existing government schemes address the needs of child beggars; and minimal use of non-institutional care options like adoption, foster care and sponsorship, etc. to children without home and family-ties; lead to development of anti-social attitudes among the street-children. There is no rehabilitation service for children above 18 years nor do they exist under the Juvenile Justice (JJ) Act 2000. Hence street children reproduce and parent another generation of street-children on the street itself and the system continues. Millennium Development Goals (MDGs) cannot be achieved unless child protection is considered as integral part of the programs, strategies and plans. Failure to protect children from violence, child labor, harmful traditional practices, child marriage, child abuse, the absence of parental care and commercial sexual exploitation among others, means failure in fulfilling both the constitutional and social commitments towards children.20, 23-25

In the recent era, India has a significant transformation at demographic, societal, and economic level. Although there have been

substantial advances in life expectancy and disease prevention since the middle of the 20th century through implementation of vaccination at primary health centers, the Indian health systems provide little protection against financial risk, and most importantly widespread inequity for the underprivileged population, who have much higher levels of mortality, malnutrition and fertility than the rich. India has adopted a number of laws and formulated a range of policies to ensure children's protection and improvement in their situation; however, these laws and policies on child rights, their protection and well being have not resulted in much improvement in lives of millions of Indian children who continue to be deprived of their rights, abused, exploited and taken away from their families and communities. Failure to protect children has serious consequences for the physical, mental, emotional and social development of the child, with consequences of a loss in productivity and quality of human capital for the nation.3

An Integrated Program for Street Children (IPSC) without homes and family-ties was introduced under THE INTEGRATED CHILD PROTECTION SCHEME (ICPS) - A Centrally Sponsored Scheme of Government - Civil Society Partnership. The scheme supports NGOs to run 24 hours shelters and provide food, clothing, non-formal education, recreation, counseling, guidance, enrolment in schools, vocational training, occupational placement reducing the incidents of drug and substance abuse, HIV/AIDS, etc. and other referral services for children. The other component of the scheme includes mobilizing preventive health services. However, the scheme does not charter about the scenario on global development and health of the street children.

Various State Governments are also running different state-specific schemes for institutional (residential) and non-institutional (non-residential) care of children in difficult circumstances (Plan India Program Priorities, Child Rights, Girl Child education.htm).

The Ministry of Women and Child, is supposed to be committed to creating a solid foundation for a protective environment for children. The Ministry is expected to strengthen prevention of child violation; enhance infrastructure for protection services; increase access to a wider range and better quality of services; increase investment in child protection and raise awareness of child rights and their violation and the situation of India's children. In early 2006, the Department of Women and Child Development became a full-fledged Ministry when implementation of Juvenile Justice (Care and Protection of Children) Act 2000, and its Amendment Act, 2006 as well as implementation of various programs including an Integrated Program for Street Children were conceived. In order to achieve effective child protection there is a need for lateral linkages between the government and non-government agencies and other relevant sectors such as NGOs for defining the strategies and implementation of actions for introduction of plans towards betterment of child development. Major shortcomings and gaps have been revealed in existing child protection schemes and their implementation at all levels of the Ministry of Women and Child Development policies and programs. Policies, programs and structures to prevent children from falling into difficult circumstances are mostly lacking. Inadequate outreach and funding of existing programs result in marginal coverage of children in extremely difficult situations. Ongoing large scale rural-urban migration and inter-state and intra-state transfer of children especially for their restoration to families creates an enormous variety and number of problems related to social dislocation, severe lack of shelter and rampant poverty, most of which are not addressed at all. There has been very little interventions for children affected by HIV/AIDS, drug abuse, militancy, disasters (both manmade and natural), abused and exploited children and children of vulnerable groups like commercial sex workers, prisoners, migrant labors/population and other socially vulnerable groups, etc, and for

children with special needs, particularly mentally challenged children.26

Several governmental and non-governmental organizations (NGOs) have initiated prevention programs aimed at controlling child abuse, attempting to embark upon various abuses and ensuring their safety and security. The Constitution of India guarantees many fundamental rights to the children, which are mostly need-based. The evolution to the rights-based approach in the Government and civil society is still evolving due to apathy in the families, and the society as far as the issue of child abuse is concerned, is becoming more and more sensitive and conscious about the statutory and constitutional rights of children.

Need of the hour Children's health of any community is a grave concern as it directly reflects the GDP and quality of the citizens of a country. The health of the children is seriously affected by a wide range of social determinants in a scenario of tribal villages and urban street life. Recognition of the societal factors and associated health-risk, and implementation of corrective actions are the two key necessities to curb the child mortality and improve child care and health. Lack of awareness and education on one hand, and basic living and healthcare facilities on the other jeopardizes tribal and street life in rural and urban habitats. Isolation from the society and deprivation of national identity and facility lead the two categories to magnitude of health risks. The children born to such at-risk families are further susceptible to environmental hazards and natural disease molecules.27-29 Therefore, planning outreach programs for interaction with such disadvantaged population with a view to understanding the life-course, support system and its impact on health and reproductive outcome is the need of the hour to address morbidity and mortality of these disadvantaged people. Exercise on gathering in-depth knowledge about the life and life-style of underprivileged groups would be the utmost important key for generating reliable data for analyzing the modules of successful implementation of government plans and policies for protecting their lives from a galore of illness.23, 30, 31

Conducting survey on geopolitical locations, population density, housing and sanitation, education and healthcare, social system and network, income and equity, family structure and health and so on, can create a huge database on the prevailing system, which may open avenues of improvement of health and life of underprivileged children. The exercise would help to understand the disease burden and management, and also may identify population-specific founder diseases and/or underlying genes or mutations responsible for disease etiology. Under reserved groups would be better equipped with basic awareness and knowledge about the lifecourse and its betterment through interactions and outreach programs. National policies and plans may require refinement to bridge the gap from inequity to equity of income and material services for lowering the disease burden and improvement of quality of life. There is also a clear and established need for a National Legislation to deal with child abuse, which should also address all forms of sexual abuse including commercial sexual exploitation, child pornography and grooming for sexual purpose. It should also deal with physical abuse including corporal punishment and bullying, economic exploitation of children, trafficking of children and the sale and transfer of children.

Integration of 'social pediatrics' in medical practice and implementation of the exercise at community level would measure child health problems with social causes and social consequences and child health care in society. Such practice would accomplish child care in four areas such as curative pediatrics, health promotion, disease prevention and rehabilitation in corroboration with social determinants of health.32 Such holistic and multidisciplinary approach considers health of a child within the context of their society, environment, school and family, and integrates the physical, mental and social

dimensions of child health and development.

Social pediatric intervention would direct tailoring of the facilities to meet the needs of the disadvantaged communities. Canada has set the first example;33 however, such program has also been implemented in United States, UK, Australia, Netherlands and other developed countries for addressing the issues of social determinants aggressively for nurturing child-health of underprivileged communities. Implementation of RICHER model (Responsive Intersectoral-Interdisciplinary Child-Community Health Education and Research) has been productive for understanding the intersecting social determinants through interpersonal communication with the families/respondents for multidisciplinary health measures.34-36 Therefore, it is time to pay off the attention towards betterment of millions of children's health and control the meter of morbidity and mortality of the disadvantaged groups.

Conclusion

In the post genomic era, advent of technological advances in health-management and new treatment modalities are far-reach objects for the disadvantaged children who are vulnerable because they are born to at-risk families. Their material and social circumstances compound their sufferings from delayed global and mental developments and poor health. Despite launching of ICDS and ICPS schemes by the government, the primary health care facilities are rarely available to tribal-villages and urban street dwellers. Understanding the impact of social determinants of health and act upon the factors should be the immediate plan of the government.

Tribal and street life at rural and urban setting share commonalities in disadvantageous

Conditions , though housing, education and healthcare facilities are available to tribal life for the namesake. Life of street children is aggressively affected by tons of environmental and automobile pollution of atmospheric air and manmade disasters of abuses, crimes and violence. Every disadvantageous condition has serious impact on child health and development. A sincere thought and on-time care may change the lives of millions of children living in difficult circumstances. Nevertheless, genetic and epigenetic consequences would exacerbate the health of children living in difficult circumstances.37

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