30/7/99

DEV-3.

Report on 'PEENYA SLUMS' by the Community Health Cell Team

Basappanakatte Slum and Rajagopalnagar-Slums were **visited by Mr. Rajendran on 19-5-1999; Dr. Roopa & Ms. Shyla on 7-6-1999.**

All of us visited the slum in Peenya's industrial belt accompanied by Ms. Jyothi and had the pleasure of interacting with the different groups ~~of~~ members. Some of the information shared with us was:

- The slum is under the Bangalore Mahanagara Palike and is an extension of Rajagopalanagara slum.

- There are approximately 530 families living in huts (population approximately 12,000). 80% of the people (approximately 7000) belong to the SC/ST groups. Approximately 30% of people speak Tamil and 50% Kannada, with a smattering of Telugu and other languages.

- The slum is on the dried up lake. Just beyond this lake is the cremation ground. Drinking water is from corporation pipes and tap connections. There is also one bore well and bed; with very little water remaining. All the severage water drains into this sump and this is used for washing. During the monsoon, the entire slum is flooded and water enters the houses, we were told. Amazingly, fish survive in this water.

- The houses are small, approximately 5' x 5' (one or two rooms) and there are no toilet facilities there. There are a row of large sewerage pipes fixed vertically in a row, which are supposed to be public toilets, obviously unused as there is no water facility. Waste is everywhere, the people have not thought of a system to dispose of it, nor is there any good facility.

- The women work as casual labourers on construction sites; roll agarbathis and as helpers in the factories and garment units nearby. Construction work pays Rs. 30/- per day, 15 days average a month. Girls in garment factories earn Rs. 300/- to 600/- per month. Agarbathi rolling pays Rs. 3/- for every 1000 sticks perfectly rolled; so they earn between Rs. 9-12 per day depending on their skill. This work is adjusted to the housework and managing young children.

  The men go to the factories or work as coolies in neighbouring markets, or odd jobs in carpentry / construction.

- There is a balwadi school, non functional. 3% of children attend a private school in Laggare and most are either playing or helping parents at their work.

- There is a government clinic (one km away) with a lady doctor and ANM visiting daily. The women we spoke to did not know the ANM or anganwadi worker. Most women use the multiple 'clinics' in the nearby bus-stand area; some have 3-4 beds for "serious" cases. The cost of a visit to the doctor is Rs. 15/- and a drug prescription of medicines worth Rs. 40-50, which may or may not be bought. The average cost of an 'admission' is about Rs. 600/-. The chief problems the women have are complaints

of back ache, headaches and white discharge. The presence of the lady doctor does not seem to enable the women to seek help.

The community organised by Ms. Jyothi / Mr. Basavaraju with the Dalit Kranti Dal / and Mr. Samuel and their colleagues in the neighbouring belt of slums was due to have a meeting in a local public hall on Sunday.

After visiting Peenya with Jyothi, we at CHC feel that:

1. Considering our ongoing commitments, and physical distance from Peenya, we may not be able to get involved at direct grass root level. Also considering the ongoing work of Jyothi and friends, we (particularly Mr. Rajendran) would be happy to come in as resource people for ~~meeting organised in the slum.~~ in collaboration with Sadhana in conducting health awareness training programmes.
2. On the health front, we could involve Jyothi and any other women leaders in training programmes in which CHC is involved eg., the ~~WAIT~~ project. This might help in imparting health information in a spirit of empowerment to the women. Women + Health Empowerment Training Project
3. CHC could use its network of contacts to put pressure / ~~find out how to~~ help the community put pressure on the slum development board. Also 'Sadhana' ~~the~~ group could be put in touch with other groups working like them and with or resources – particularly at government programme level they can tap.
4. Referral links with a few hospitals such as K.C. General Hospital and St. Martha's Hospital (Dr. Sr. Teresita, Medical Superintendent) could be established with Sadhana / Astha.
5. A priority issue to be addressed is provision of safe water supply and sanitation facilities. This will need to be taken up with the concerned Government Departments through peoples organisations such as Sadhana, supported by Astha. This intervention will result in good health gains.

* Observations – The following situational problems have indirect & direct effects on the health of people living in the area.

I Physical / Infrastructural
1. Poor Environmental Sanitation.
2. Non-availability of safe drinking water
3. Lack of functioning toilets.
4. Inadequate shelter.

II Social
1. Oppression of women including violence.
2. Alcoholism
3. Unemployment (reported) and low wages.

III Health + Health Services
1. Inadequate knowledge about health preventive + promotive measures
2. Poor utilisation of government health services due to inconvenient working hours and possibly other problems
3. Work related (occupational) health problems.
4. Poor care for TB & chronic diseases like asthma

" Right to health care campaign" in India

by the Peoples' Health Movement

(Jan Swathya Abhiyan)

Poster Presented by: S.J.Chander
Community Health Cell,
Bangalore- South India, South Asia

Peoples' Health Movement (PHM) is a network of organization and individuals concerned about the widening gap between the rich and the poor due the process of globalization, privatization and liberalization, and its adverse impact on the health of millions of the poor and the marginalized all over the world.

People's Health movement was launched at the first people's.Health Assembly held in Dhaka, Bangladesh in the year 2000.

Governments and World Health Organization failed to achieve 'Health For All by 2000 AD" PHM demands Health For All now!

PHM is an emerging movement striving towards achieving health for all. It is present in over 80 countries.

www.phmovement.org

PHM movement in India isknown as Janswasthya Abhiyan(JSA)

One of the aims of JSA is to establish health as fundamental right in India.

In order to achieve this JSA in Collaboration with the National Human Rights Commission (NHRC) is quazi government body)

Launched a campaign called

' The Right to Health Care Campaign" during the silver Jubilee of Alma Ata Declaration in 2003.

PROCESS

To hold regional public hearings on Health and Human Rights in five regions of the country followed by a national public hearing in New Delhi.
Preparation of guidelines for documenting individual and Health center case studies
Translation and Information Dissemination of Case of denial of access to health care Selection &Documentation
Screening and short listing
Preparation for presentation

HELD PUBLIC HEARINGS IN THE FIVE REGIONS OF THE COUNTRY

During the day-long public hearings, selected cases or instances, wherein individuals or groups have suffered denial of right to health care, and have not received mandated health care from a public health facility, were be presented before a panel consisting of the NHRC and the state level public health officials. Similarly, violation of health rights due to structural deficiencies in the heath care delivery system was also presented.

❖

Regional Public Hearings were culminated with a two-day national Public hearing held in the capital; Health minister and senior health officials were present to listen and respond to the issues.

Issues discussed at the NATIONAL PUBIC HEARING

Urban health care

(Urban Health care emerged as a one of the key issues of concern as a result of the public hearing conducted by the state chapter of JSA in Bangalore in a slum)

- Health Policy Issues and Violation of Health Rights

Group A

KEY AREAS OF HEALTH RIGHTS VIOLATIONS

- Women's Right to Health Care
- Children's Right to Health Care
- Mental Health Rights

Group B

Right to essential drugs

- Health Rights in the context of the Private medical sector
- Health rights in the context of HIV-AIDS
- Occupational and Environmental Health Rights

CONCLUDING SESSION OF THE HEARING

Towards a National Action Plan to Establish, Fulfill and Monitor the Right to Health Care'.

Public hearing on
Urban Health in Bangalore
11 individual cases of denial and 2 health centers case studies were presented.

easons for accessing health services

Childbirth

Cancer care

Key issues raised by the Case studies

- Incompetent and negligent care
- Delay in care
- Non –performance of postmortem
- Doctor not qualified to practice allopathic medicine.
- Not informing the patient the condition
- Lack of attention
- Bribery
- Corruption

- Disrespect
- Forced delivery
- Psychological trauma
- Stigma and discrimination
- Refusal to provide treatment
- Violation of confidentiality
- Investigation apparatus not available in pubic health care institution
- Referred to a private health care institution from public health care institution
- Violence on a patient with mental health complications due to worsening diabetes
- Ill treatment of patients
- Not given free medicine
- Delay in care

CONSEQUENCES

Five of the eleven case studies resulted in death

- Death
- Death of baby and mother
- Excessive expenditure
- Loss of time waiting for the doctor
- Harm to baby during delivery
- Loss of money
- Debt to be repaid
- Huge, unaffordable expenses for the purchase of medicines

Health centers -Issues

- Lack of staff
- Lack of trained staff
- Unavailability of staff
- Lack of medicine
- Lack of facility for investigations
- Vacancies
- Surroundings of health center unclean
- Poor utilization
- No community participation
- No water supply

FOLLOW UP ACTION

NHRC has given recommendations to each state government to address on the issues raised during the pubic hearing.

Setting up a joint monitoring committee with JSA member to monitor the implementation process

Snehadaan File

DEV-3A.

Meetings of collaborators on Community Based Continuum of Care in an Urban Setting

Date: 22-06-2006.

Venue: Snehadaan, Bangalore.

Members present

1. Mr. Eddie Premdas (Community Health Cell)
2. Mr. S.J.Chandar (Community Health Cell)
3. Mr. Augustine C. Kaunds (Society for Peoples Action for Development)
4. Mrs. Lissy (SUPPORT)
5. Fr. Jose Thoompanal (SUPPORT)
6. Fr. Mathew Perumpil Snehadaan
7. Fr. Baby Naikarakudy Snehadaan
8. Mr. Sunil George Snehadaan

Mr. Abraham Mathew of SWASTI excused himself from attending this meeting due to ill health.
The meeting began at 11.20 and Fr. Baby who is the Director of Snehadaan welcomed all on behalf of Snehadaan. While Snehadaan had been collaborating with all the organisations that were present, this was the first time that they ahd gathered to work together on a specific programme.Fr. Baby expressed the hope that this would also help to build a stronger bond between everyone present and ultimately prove beneficial to the community of People living with HIV/AIDS.

Mr. Sunil George the Community Programme Coordinator of Snehadaan then suggested that everyone could introduced themselves along with a brief profile of the organisation that they were representing in order to familiarise one another with the nature of the group.
After the round of introductions, Fr. Mathew the Coordinator of Sneha Charitable Trust gave a brief background of this initiative. The idea was conceived within the particular context of an urban setting (Bangalore). Some of the factors that prompted this thinking were.

1. The nature of HIV that has changed from a near fatal disease to chronic manageable syndrome.

2. The high rate of readmission that Snehadaan was experiencing that pointed to the lack of systems in the community to help PLWHA to maintain their health once they are discharged.

In a rural setting there are slightly more organised systems than what we find in an urban setting. Some of the unique features of an urban setting that affects the sustained care for

PLWHA are, people living alone with no social support, migration... All these factors necessitate a unique kind of response in an urban setting as opposed to a rural setting.

In July 2005 MILANA a Family Support Group for People infected and affected by HIV&AIDS approached Snehadaan for building the capacity of their Peer Workers with regard to providing Home based Care to their members. While discussing the issue both Snehadaan and MILANA seemed to face a similar problem and had a common vision of ensuring healthy productive lives to PLWHA and their families.
As a result of the various discussion that were held the Peer workers from MILANA started making regular visits to Snehadaan to talk on positive living to the in-patients. Because of these visits, the peer workers were able to interact with the patients and share their own stories, struggles and successes. Many in-patients were surprised to meet people who were HIV positive and yet leading a healthy, normal life.
In the month of December, a three-day training programme was held at Snehadaan covering the areas of Counselling, Nutrition, Opportunistic Infections, and ARVs. After this training it was decided that the peer workers would make home visits to in-patients of Snehadaan who had been discharged and a Support Group would be formed for PLWHA in Bangalore urban who had been in-patients of Snehadaan. Based on the experiences during this trail period (Jan 2006- Mar 2006) it was decided that there was a felt need for an Urban based Community Care programme and hence a decision was taken to start a pilot project during this year.

After this Mr. Sunil George the Coordinator of the Programme made a presentation on the various components of the programme. They included

1. Home Visits

A home visit to a PLWHA will be made after an initial contact has been established during the persons stay in Snehadaan. The specific objectives of a Home Visit are as follows

a. To assess the situation in the person's home and the extent to which the person is able to cope up with the status of being positive.

b. To counsel the PLWHA and the family on positive living and coping with the various issues arising out of stigma and discrimination from the family, relatives and society at large.

c. To help the family with the nutritional needs of PLWHA by teaching them about the nutritive value of foods that is locally available as well as to teach them how to prepare them.

d. To help the family with regard to hygiene and precautions that needs to be observed.

e. To make an initial assessment of the PLWHA for referral in conjunction with the counselling department of Snehadaan

The first Home Visit is planned even before the person is discharged and is incorporated into the discharge procedure

2. Support Group Meetings

The following activities will take place in every Support Group Meetings

a. Theme-based Sessions

Theme based sessions in order to build skills of PLWHA and their families to facilitate positive living (E.g. Session on Nutrition, Hygiene, Yoga, Meditation etc.)

b. Health Monitoring

A very important component of the Support Group Meeting will be this monthly health monitoring. This will include a monthly check up by the resident physician at Snehadaan in order to detect signs and symptoms of any Opportunistic Infection so that prophylaxis or early treatment can be given.

c. Diagnostic and Drug Support

Part of the health monitoring would also be diagnostic services that are available at Snehadaan in order to ascertain the proper course of treatment required for individual PLWHA who require it as well as supply of drugs (primarily prophylaxis/maintenance therapy) that have been prescribed by the physician for prophylaxis.

In addition to this the Support Group meeting will also serve as a space for newly discharged PLWHA to share their fears and doubts with others like them as well as to raise issues that concern them the most. The Support Groups Meetings shall also serve as a platform to discuss with the larger body of PLWHA programmatic issues on a regular basis. While the Support Group was currently functioning only in Snehadaan the idea was to decentralise it and make it functional at least in a few other areas s well so that PLWHA and their families do not have to travel all the way to Snehadaan to make use of this.

3. Community based fund for Health Care

In order to take care of the health care needs of the PLWHA such as prophylaxis, diagnostics services, referrals etc, we propose to start a community-based fund through contributions from each family under this programme. This fund will then be used to take care of the various health care requirements such as prophylactics, diagnostics, inpatient admission etc. This is a long-term plan and the specifics need to be worked out. This also takes into account the issue of long-term sustainability of the programme. Sunil also mentioned that Mr. Abraham Mathew of SWASTI had mentioned to him earlier that they would be able to contribute in the design of such a scheme and the specifics of how to go about it needs to be worked.

4. Training/Advocacy and Sensitisation of Physicians in Bangalore

Building a network of physicians in Bangalore Urban District who are professionally trained on the Management of Opportunistic Infections will be an important activity of this programme. This training will include

a. Medical Management of Opportunistic Infections related to HIV/AIDS
b. Legal and ethical issue surrounding HIV/AIDS
c. Patents/Drug issues
d. Interactions with PLWHA in order to understand their perspectives on access to Care and Support and the problems they face

Sunil also mentioned that this training would be an ongoing programme and not a one-time affair. Sensitisation and community monitoring of the physicians is very important. Mere training does not serve the purpose, as knowledge alone does not seem to make a major impact. Even if we have a good network 20 to 30 committed doctors by the end of this year it would make a major difference in the medical management of Opportunistic Infections in the community itself.

5.Support for Children Infected and Affected by HIV/AIDS

One of the area that is the concern of positive families is the support and future of their children, both infected and affected. Two specific initiatives are planned in order the address the problem of infected and affected children. They are as follows

a. Advocacy and liasoning with schools in Bangalore in order to ensure proper educational facilities for infected and affected children. In this regard the idea was proposed on sensitising the principals of catholic schools in Bangalore with the goal of adopting a policy on ensuring access to education for both infected and affected children in these schools. This was to be a goal during the pilot year itself and it was decided to approach the archbishop of Bangalore Most Rev. Bernard Moras for his support for this venture.

b. Building up fund/sponsorships for infected children through local contributions. The purpose of this would be to provide financial support to families to make sure that infected children receive proper nutrition and care as well as educational expenses.

Again the specifics as to what exact amount, how will the programme be implemented etc. needs to be worked out

6. Awareness and Sensitization Programmes

Building awareness on issues relating to HIV/AIDS as well as sensitizing the public to the rights and problems faced by PLWHA will be another important activity of this programme. Various mediums such as street plays, meetings, awareness programmes are planned and they will be conducted in various parts of Bangalore addressing various classes of people such as students and teachers, high risk groups, professionals etc.

Sunil shared his experiences over the years with various groups of young people who had expressed that they did not have any proper forum I order to know the correct information about HIV/AIDS, sexuality etc.

The plan was conduct these among the youth and build up a committed team of volunteers who would then be organised on the lines of a forum that would meet regularly and would be guided by competent resources persons on various pertinent issues such as life skills, sexuality, HIV/AIDS etc. This is important especially considering the fact that a large number of the new infections happen among the young.

Following this Sunil suggested that the group could take up each component and discuss it in detail.

Mr. Augustine: This programme will be limited to PLWHA who are in Bangalore Urban district. But what about those who are admitted here from other parts of Karnataka. Do we have a plan for hem as well?

Fr. Mathew: Community based care can happen only within a particular geographical area. Currently Snehadaan refers people who call up from other districts to Care centres in their own areas. In case of admission of a person who is from another district we make sure that we put them in touch with other groups in their own areas before they are discharged.

Chander: Why don't we think of very NGO working in the field of health and work out a general networking with all so that each of their Community Health Worker can be trained. The capacity building could be done by Snehadaan and this would ensure that more people are available for providing care for PLWHA. Also instead of having specialised health workers for each problem /disease we should look at developing the skill of the general Community Health Worker who can then respond to each problem comprehensively.

Sunil George: It's a very good suggestion. Can CHC help us with networking with the other NGOs in Bangalore in order to achieve this?

Chander: Definitely. It can be worked out

Augustine: Why only Health Workers or Health NGOs? Anyone can be trained for this work. We should look at mainstreaming this response further from health to the general group of people working in the development field.

Augustine: What will the Peer Worker do in a Home Visit?

Sunil George: The Peer Worker makes an assessment on various parameters such as health, socio-economic and other issues that are affecting the PLWHA and their family. We have developed a format that is being tested in order to make sure that they are able to get a more or less objective picture of the current situation of the PLWHA. In case there are issues of stigma and identification by the neighbours then we do not visit the home but meet them here. All this is worked out during the discharge procedure itself.

Fr.Mathew: The issue of identification is more relevant to a rural set up while in an urban set up there is more anonymity.

Augustine: This is very important by this initiative we can address stigma and discrimination effectively. If people see a PLWHA who gets better and leads a normal life then it will change their attitudes and help I the fight against stigma and discrimination

Also we should remember that economic issues are extremely important. Most people who come to us are very poor.

Fr. Mathew: Yes this is very true.

Augustine: Asha Foundation has a very good programme. Each family is assessed and support is provided. This is working very well to the extent that PLWHA are able to repay the loans that they have taken. Sunil should visit them we could implement the learning's in this programme

Chander: What would be the approximate cost of prophylaxis for a month?

Fr.Mathew: It would be around Rs.30/- for the primary prophylaxis. These drugs (Bactrim D.S) are supposed to be available in the taluk hospital but in most case they are not there.

Augustine: That is true all PHCs are supposed to have STI drugs but the reality is different.

Fr.Mathew: We need to do the work of providing the care component and also advocacy so that these drugs are available in the government hospitals. Another issue is that they develop fungal infections later and then the drugs required are more costly.

Augustine: When medicines are not available even in Governemtn hospitals then how can we expect them to be available at the PHC level.

Fr. Mathew: We need to work on this as well as do advocacy so that theya re made available.

Augustine: We will give our data to CHC may be you could formulate a letter on behalf of all of us to the government.

Premdas: This concept of Community based Care is extremely good. I have just two comments to make.

1. There is a flood of funds into HIV/AIDS programmes but care programmes seem to lack sufficient resources

2. A lot of advocacy is associated with HIV/AIDS. One wonders where this advocacy is taking place and for what purposes? If at the PHC level there are no basic drugs then what is the use of this entire advocacy.

Unless we work on the Public Health System and revamp it we cannot really reach everyone. We need to do advocacy at the local level for this. For example why cannot KSAPS, KHPT and others provide medicines for PLWHA at the PHC level?

Fr.Mathew: We need to really participate with the Public Health System. To break through everything may be impossible but even if we can do this at a few places it would be wonderful.

Chander: We should remember that the PHC is the nearest point of service for the poor in any illness.

Augustine: And when the PHC works well the doctor is under tremendous stress. In our work we have seen this happen in the PHC at Kengeri. When people realised that it is working well they began to access the services and there was a great rush of patients.

Premdas: One component of the training of the Peer Workers should be that they should go to the PHC for initial services. It will be difficult initially as there will be ressitance but there will be an eventual break though.

Chander: Every PHC is allocated a certain amount of funds. The local community should know of this.

Augustine: may be each NGO should do an informal study of the PHCs in their areas to understand its functioning
Chander: We are already trying to do this. On the 25th there is a meeting at Ashrivad on comprehensive care at the PHC level.

Fr. Jose: Our experience on working with leprosy has been that medicines were there but doctors did not distribute them. Hence we have an agreement wherein we are involved in the PHCs in or area of work.

Premdas: Efforts shuld eb made to address the medical officers in the traiing of doctors.

Sunil George: The issue is not about training but follow up. Time and again wwe get PLWHA from the northern districts of Karnataka. We know very well that we have trained doctors, nurses and other health care providers in that are but there doesn't seem to be any difference. The follow up and monitoring of those who are trained is extremely important if there has to be any tangible results.

Chander: For that the Peer Worker is going to be very important.

Sunil George: This book is an example of what can happen if the government system functions. This has been prepared in Andhra Pradesh and is meant for Care givers of PLWHA and their families. It's very simple and uses pictures to convey important messages about Care and Support. In fact one of our goals is to bring out a similar book in Kannada that would have detailed information that is presented in a simple format on various aspects such as nutrition, hygiene, ARVs, yoga etc so that it could be a reference manual for PLWHA in their homes.

Augustine: we will also have to work around the notion that PLWHA themselves have that once they are positive they need expensive drugs and ARVs if they are to remain healthy.

Fr.Mathew: that is very true. The emphasis should be on preventive measure and not drugs.

Fr. Mathew then presented the total budget for Karnataka and the various allocations for HIV/AIDS for the next one year

Total:	2,777.22 lakhs
Prevention:	1,991.91 lakhs
(High Rish Groups, Bridge/Migrant population 392 lakhs, Mapping 23.59lakhs)	
IEC	419 lakhs

Even in the Executive Committee meeting of KSAPA that was held on the previous day there were demands that the amount allocate for IEC should be reallocated on more priority areas such as care and O.I. management

Even the government data of the no of PLWHA is Karnataka is 5 lakhs. Out of this around 2 lakhs would be in need of O.I. management. But the total allocation is 50 lakhs which roughly works out to 50,000 per year for every taluk hospital. The entire Careand Support/Treatment needs have been fixed at 345 lakhs. This is excluding ARVs which is provided by the Global fund.

The National Aids Control Programme III (NACP III) was more community oriented and focussed on treatment and care. Part of this was strengthening of Primary Health Centres (PHC)s and Community Health Centres (CHCs). Since the states programme went in late it will now take time for approval to come through. It was actually supposed to begin by April 1st this year but we are not sure when it will come. So we have in effect lost one year of NACP III and more importantly the focus.

Sunil George: What are the expectations of this group? We need to formulate concrete plans to move forward in every area. Two suggestion that I can make are,

1. Collaborate in certain specific components
2. Meet once every 3 months in order to review and assess the programme

Augustine: One suggestion would be to start an e-group for this community based continuum of care.

Chander: We should not duplicate but complement each other.

Sunil George: The future of all HIV/AIDS interventions lies in community based programmes and not vertical interventions. We are on the right track and need to move ahead

Fr.Mathew: One possibility is that we could list out our strengths and work on those areas thereby complementing each other's work. And the other suggestion by Sunil to meet as a mentoring group quarterly to review the programme

Premdas: When are you planning to launch this programme officially?

Sunil George: We will begin the programme from July 1st and have an official function to mark it on July 15th.

Fr. Jose: We need to have specific plans to implement and work based on each of the components that were presented if it has to be a success.

Augustine: One advantage is that we are all Bangalore based.

Sunil George: Can the next step be as follows?

1. I shall fix up meetings in each of your offices as a follow up. In this meeting we shall do the follwoing
    a. Work out specific areas from the components and what exactly can be done in each area by means of our collaboration.
    b. This can then be further refined to have a specific timeline with individual goals and objective to be achieved.

This programme though being initiated by Snehadaan belongs to al of us who are working in the field of health. Unless we all come together I am afraid we will not be able to achieve this goal of community-based continuum of care for PLWHA.

Premdas: Ultimately we need to lookat health as a right. We can use the data that we have and will be documented through this initiative as the evidence in our campaigns. HIV/AIDS can be used as a case to raise larger issues with the health systems I our country.

Chander: We should look at this initiative as a process model and not as a project.

With this the discussion came to an end and the group dispersed for lunch.

HRM

DEV-4.

Towards Urban Primary Health Care

By S.J.Chander, Community Health Cell

In the era of globalization only the glamorous part of the cities have attracted the attention of media. More the glamour the cities become for the rich and the elite more the misery it adds to the poor who constitute a significant portion in every city. Cities have always been the economic powerhouses and the political never centers but unfortunately neither the political power nor the economic abundance has done much to the urban poor ever to meet the bare minimum basic needs.

It is estimated that India has more than 250 million city-dwellers. Experts predict that this number will rise even further, and by 2020; about 50 per cent of India's population will be living in cities. This is going to put further pressure on the already strained basic amenities.

The widening gap between the rich and the poor accelerated by the process of globalization has been document worldwide. The rural poor turn to cities for survival. Those who turn to the urban areas to escape rural poverty and unemployment do not find much solace when the land up in the urban areas. They subject themselves to double peril: firstly they become more venerable to health problems caused undesirable living condition secondly they become target for the politically influenced liquor barons who aggressively sell their products among urban poor.

The key factors affecting health of the urban poor are poverty and undesirable living conditions. Poverty is defined as lack of specific consumption or not enough to eat; lack of command over commodities exercised by a population and capability to function in a society. Unemployment, irregular employment opportunities or unpredictable employment availability is key factor responsible for the inflicting poverty status. As result the basic minimum necessities for maintaining health is under stake leading to poor dietary intake, poor housing and illiteracy. The second major problem affecting the health of the urban poor is their poor living condition.

While there is inadequate response to improve the key determinants such as employment, water and sanitation and housing that can promote the health of the urban poor, the services for managing the life crisis affecting their mental, physical and social health is pitiable. India Family Welfare Urban Slums Project in its report admits that urban water supply and sanitation sector in the country is suffering from inadequate levels of service, an increasing demand-supply gap, poor sanitary conditions and deteriorating financial and technical performance.

India started responding to this challenge as early as 1982 by developing policy framework for urban primary health care. A new initiative known as Urban Revamping Scheme was started in 1984 with strong focus on improving linkages of primary health and family planning services with other urban basic services such as clean drinking water and sanitation. Once the externally aided project started providing services for the urban poor, the focused changed from comprehensive primary health care to family welfare and

family planning. The objectives of the world bank project implemented from 1994-2002 were a) reduce fertility by improving access and demand for family planning services; and (b) improve maternal and child health by decreasing maternal and infant mortality rates among slum residents.

The key problems of the urban poor are inadequate housing, water, sanitation, employment opportunities and various pollutions affecting the environment. These are the causes of their health problems. In what way the urban family welfare and family planning programme is justified to meet the challenges. How long the government is going to pump in million of rupees for medicines and family welfare services? What the urban poor need is a comprehensive primary health care.

The principles of primary health care stated in the Alma Ata declaration are as follows; *" Primary health care is a essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. "*

The components of primary health care are:

1. Education about prevailing health problems and methods of preventing and controlling them.
2. Promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation.
4. Maternal and child health care including family planning
5. Immunization against infectious diseases
6. Prevention and control of endemic diseases
7. Appropriate treatment for common diseases and injuries
8. Provision of essential drugs.

It is not at all justified when the fourth component gets a major focus and other component are either inadequately addressed or not addressed at all. It is time that people are mobilized to demand health as their right and to take collective action for their own health. They must work towards changing the focus of the government health programme. The government run Primary Health Centers must promote holistic health which should include preventive, promotive, curative and rehabilitate aspects. They should not focus only of physical dimension of health but also on mental and social dimensions

4TH INTERNATIONAL CONFERENCE ON URBAN HEALTH
October 26 - 28, 2005
The Westin Harbour Castle
Toronto, Ontario, Canada

CONFERENCE PROGRAM

Date/Time	*Event**
Wednesday, October 26	
9:00 am - 7:00 pm	Onsite Registration
12:00 - 4:00 pm*	Pre-Conference Workshops
2:00 - 5:00 pm	Community Tours
5:00 - 7:00 pm	Poster Session I and Opening Reception
Thursday, October 27	
7:30 am - 5:00 pm	Onsite Registration
7:30 - 8:45 am	Poster Session II and Breakfast
9:00 - 10:15 am	Welcome Address & Plenary Session Keynote Address: Dr. Gro Harlem Brundtland; former Director-General, World Health Organization; former Prime Minister, Norway
10:15 - 10:30 am	Break
10:30 - 12:00 noon	Breakout Session I
	A. Community Stream **HIV and Marginalized Populations** I. Women Under Arrest Striving for Health Rights (C)** II. A Community-Based Participatory Approach to Developing an HIV Prevention for Severely Mentally Ill Latinas (C). III. Community Empowerment Through Collaborative Research: The Sisters, Mothers, Daughters & Aunties Project to Promote Equitable Access to Future HIV Vaccines for Black Women in Canada (A)** IV. Committee for Accessible AIDS Treatment (C)
	B. Community Stream **Community-Based Participatory Research: Barriers and Facilitators** I. A Survey of Community-Based Research (CBR) in Canada: From Barriers to Solutions (A) II. An Academic-Community Partnership to Build Capacity for Community-Based Research in Immigrant Health (C) III. TBA IV. Sustaining an Urban Community-Based Participatory Research Program Through a National Influenza Vaccine Shortage (C) V. The Art and Science of Integrating Community-Based Participatory Research Principles and the Dismantling Racism Process to Design and Submit a Research Application to NIH (C)

	C. Academic Stream **Conceptualizing and Measuring Social Justice** I. Health Inequity in a Network Society: A Conceptual Framework (A) II. TBA III. TBA IV. Exploring Ideological Barriers to Addressing Health Inequalities at the Local Level (A)
	D. Academic Stream **High-Risk Youth** I. The Neighborhood Identification and Engagement Process: A Mixed Methodological Approach for Exploring Urban Youth Violence (A) II. The Emergency Department: Is it an Appropriate Venue for an Intervention Program to Reduce Youth Violence (C) III. Risky Alcohol Use and Daily Cannabis Use Differ between Low Educated Dutch Adolescents Living in and Outside the City of Amsterdam: A Result of Differences in Pleasure-Seeking Behaviour? (A) IV. Environmental Influences on Youth Gambling: Is the Deck Stacked? (A)
	E. Invited Panel: Urban Income Inequality and Health Sponsored by the Canadian Population Health Initiative
10:30 - 12:00 noon	Community Tour
12:00 - 1:45 pm	Conference Luncheon Dr. David Vlahov, President, International Society for Urban Health Special Guest: Hon. George Smitherman, MPP, Ontario Minister of Health and Long-Term Care Guest Speaker: *Community Perspectives* Loretta Jones, Founder and Executive Director of Healthy African American Families
1:45 - 3:15 pm	Breakout Session 2
	A. Community Stream **Peer-Led Harm Reduction** I. CRYSTAL CLEAR: A Peer To Peer Health Promotion Project (C) II. Community and Public Health Impacts of Medically Supervised Smoking Facilities for Crack Cocaine Users: A Peer-Led Feasibility Study (C) III. The Vancouver Area Network of Drug Users (VANDU): The Evolution of a User-run Organization in Vancouver's Downtown Eastside (C) IV. Community Driven, Participatory Research Projects Toronto Harm Reduction Task Force (C)
	B. Community Stream **Advocacy for Social Justice in Urban Health** I. Improving the Post-Approval Surveillance System for Prescription Drugs (C)

	II. In Our Own Voices: Surveying Asian Pacific American lesbian, Gay, Bisexual, and Transgender people (C) III. Women in Transit: Organizing for Social Justice in Our Communities - a PAR project of the Bus Riders Union (C) IV. The Development of Peer-Driven Intervention for Individuals Requiring Assistance with Injection (C)
	C. Academic Stream **Urban Neighbourhoods** I. Finding Good Places to Play: Exploring Social Justice and Public Park Provision in Urban Neighbourhoods (A) II. The Usefulness of Geographic Information Systems (GIS) to Reduce Inequalities in Urban Road Safety (A) III. Socioeconomic Inequality of Urban Core Neighbourhood Residents in Saskatoon (A) IV. Neighborhood Mapping as a Participatory Tool for Evaluating Community-Based Urban Health Initiatives (C) V. Spatial Association between Diabetes Prevalence and Neighbourhood Characteristics and Environment for Healthy Living in Toronto, Canada (A)
	D. Academic Stream **Policies and Interventions to Promote Social Justice** I. Barriers to Disability Benefits for Homeless and Under-housed People (C) II. Dismantling Racism: Promoting Social Justice through Individual Awareness, Institutional Policy Change and Institutional and Community Partnerships (C) III. Is the Public Ready? Understanding Public Attitudes Toward Federal Action to Reduce Inequalities in Healthcare - United States' Perspectives (A) IV. Recognition of Sexual Diversity in Urban Health Policy (A) V. Pharmacists as Health Service Linkages; Expanding Service Referrals to Injection Drug Users through the Expanded Syringe Access Program, New York City, 2001-2004 (A)
	E. Academic Stream **Urban Crises** I. Surmortality Related to the August 2003 Heat Wave: An Ecological Study of Socio-economic Factors in Paris (France) (A) II. High-Rise Building Evacuation: Lessons Learned from the World Trade Center Disaster (A) III. TBA IV. TBA
1:45 - 3:15 pm	Community Tour
3:15 - 3:30 pm	Break
3:30 - 5:00 pm	Breakout Session 3
	A. Community Panel: Community, Professional, and Scientific Collaboration for Environmental and Social Justice in the Southwest of Spain

	B. Academic,Stream **Global Urban Health** I. The Urban Environment from the Health Perspective: The Case of Belo Horizonte, Minas Gerais, Brazil (A) II. Sexual Behaviors of Street Children in Lahore, Pakistan: The Risk of Survival (A) III. Reported Use of Violence among Young Men in Dar es Salaam, Tanzania (A) IV. TBA V. The Delayed Engagement with Healthcare: Experiences of People with HIV/AIDS in Beijing, China (A)
	C. Academic Stream **Homelessness and Housing** I. The Aging of the Homeless Population: Fourteen-year Trends in San Francisco (A) II. Risk Behaviours For Sexually Transmitted Infections (STIs) in Canadian Street Youth: Does Time Spent On The Street Matter? (A) III. Access to Health Care for Homeless People with Serious Health Conditions in Toronto, Canada (A) IV. TBA V. Homelessness Following Eviction in Amsterdam (A)
	D. Academic Stream **Mental Health** I. Stressful Neighbourhoods and Depression: An Examination of 25 Metropolitan Areas in Canada (A) II. A Learning Collaborative to Improve Mental Health Service Use for Low-Income, Urban Youth (A) III. Affective Suffering in Older Women: Evidence of a Threshold Affect that Varies by Race/Ethnicity (A) IV. Mental Illness as a Risk Factor for Poor Health, Substance Use, and Dependence Among Unmarried Urban Mothers (A) V. Quality of Life Outcomes for Mental Health Care Clients Engaged in the Workman Theatre Project (C)
	E. Academic Stream **Gender and Urban Health** I. Gender Differences in Depression among Low Income Recent Immigrants in Canadian Urban Centres (A) II. Gender Issues and the Health of Disadvantaged Persons (A) III. Whither Gender in Urban Health? (A) IV. Housing Policy, Women, and Health in Canadian Cities (A)
3:30 - 5:00 pm	Community Tour
Friday, October 28	

8:00 - 9:00 am	Poster Session III and Breakfast
8:00 - 9:00 am	International Society for Urban Health: Annual General Meeting
9:00 - 10:30 am	Plenary Session Keynote Address: Dr. Richard Lessard, Researcher and former Director of Public Health, Montreal Regional Health and Social Services Board Featured Speaker: Dr. Francisco Armada, Minister of Health and Social Development, Venezuela
10:30 - 10:45 am	Break
10:45 - 12:15 pm.	Breakout Session 4
	A. Community Stream **Innovative Youth Engagement** I. Toronto Teen Survey (TTS) Phase One: How Do We Meet the Specific Sexual Health Needs of Youth in Diverse Urban Environments? (C) II. Young People in Control; Doing It Safe. The Safe Sex Comedy (C) III. Youth-Led Research: A Successful Model of Community-Based Participatory Action Research (C) IV. Queer Youth Speak: A Model for Developing Equitable Partnerships for Community-Based Research (C) V. A Community-Based Participatory Approach To Assess The Context Of Sexual Risk Taking In Urban, African-American Girls (A)
	B. Community Stream **Community-University Partnerships** I. Making a SWITCH: Opportunities and Challenges in Establishing a Student-Run, Interprofessional Health Clinic in a Saskatoon Core Neighbourhood (C) II. Using Community-Based Participatory Research to Develop and Implement Church-Based Cancer Education Modules (C) III. Urban Aboriginal Community-Based Research (C) IV. Making Things Work: On Being an Academic Research Working with a Community Partner (A)
	C. Academic Stream **Environmental Justice** I. The Right to Clean Water: How Community Groups Mobilize to Block Water Privatization (A) II. Food Deserts: Do Food Deserts Exist in More Disadvantaged Communities and How Are They Studied? (A) III. Neighborhood Poverty And Inequitable Exposure To Stressful Social Environments: Results from a Community-Based Participatory Research Partnership In Detroit (A) IV. Pollution And Health in Two Toronto Neighbourhoods: Challenges To Ensuring Environmental Justice (C) V. Community Health Study in "Chemical Valley", Sarnia, Ontario (C)

	D. Academic Stream **Immigrants and Urban Health** I. Community-based Intervention Strategies to Prevent Obesity among Turkish and Moroccan Women in Amsterdam (A) II. TBA III. Serologic Immunity to Chickenpox among Adult Immigrants and Refugees in Toronto (A) IV. The Role of the Urban Environment on Discrimination among Latino Day Laborers and Migrant Workers in California (A) V. Socioeconomic Disparities in Birth Outcomes by Recent Immigration Status in Toronto, 1996 - 2000. (A)
	E. Academic Stream **Injection Drug Use in Urban Settings** I. Vancouver's Supervised Injection Facility: The First Two Years (A) II. HIV Outbreak among Injecting Drug Users in the Helsinki Region: Social and Geographical Pockets (A) III. Risk Profile of Individuals who Provide Assistance with Illicit Drug Injections (A) IV. Examining the Effects of Illicit Drug Markets and Local Labor Markets on Employment and Self-Rated Health in Philadelphia (A) V. Residence in Vancouver's Downtown Eastside and Elevated Risk of HIV Infection among a Cohort of Injection Drug Users (A)
	F. Academic Stream **HIV Intervention and Risk Reduction Strategies** I. Addressing the Methamphetamine-Sexual Risk-Taking Link among MSM: Information Exchange between Science and Practice (A) II. HIV Risk Taking and Associated Cultural Factors (C) III. TBA IV. Employing Social Network Analysis in the Evaluation of Information Provision for HIV-positive Patients: An Exploratory Study (A)
12:15 - 1:30 pm	Closing Event

*Please note that scheduled events in this program are subject to change.
**Community Stream abstracts are identified by a (C); Academic Stream abstracts are identified by an (A).

4th International conference on Urban Health

Held at Toronto, Canada from 26-28th October 2005

A report by S.J. Chander

I made two poster presentation on this conference; one on a qualitative study on 'Patients perspective regarding TB treatment" and the other on " the Right to Health Care in India"

Pre conference workshop

The politics of Social Determinants of Health

Facilitated by Prof: Dennis Raphael and Toba Bryant presentation focused on Canadian situation. Both from the York University facilitated the session. 20 out of the 36 participants registered turned out for the session. Prof. Dennis said the concepts such as SD originated from Canada.

They said Canada has a history of playing the role in initiating many important health movements. He quoted the following movements:

The Healthy city movement began there in 1948 and the WHO website mentions this. Since 1986 Canada has been focusing on structural approach such as income and exclusion. Health promotion, population health approaches were developed here. However social determinants received a marginalized view.

They said chronic diseases such as heart diseases, respiratory diseases, and arthritis are high among low-income group in Canada but the government programmes focus on diet and exercises. 300 million dollars was allotted for promoting exercises and diet during the year. They said heart attacks are high among poor in Canada. Low income and social exclusion are major cause of heart disease in Canada. The government has taken from the poor and given to middles class.

They said unequal distribution resource is the cause for the present status. They compared the GDP of Sweden. Though Sweden's GDP is less than Canada's but Sweden has better health indicators as result of better distribution of resources. They said political decision-making plays a major role in allocation of resources. They also said effects of liberalization also has an effect of health of the urban poor. This was well articulated in a book "Health for some" published by center for social justice. Evidence from UK and USA show evidence for health iniquity this is described as breadline poverty and the widening gap between the rich and the poor.

Regarding public policy making they said the rationalization theory, focus on data and the public choice theory is a trouble for policy makers.

Regarding food supply and housing they said there is a need for intersectoral coordination.

Regarding the causes of some of the illnesses they said income and premature years of life correlated to most disease. They said life style diseases accounts for only 10-15%. The poor people are at four times greater risk due to lack of income and premature years of life.

Barriers to effective action
Regarding the barriers for initiating effective action they said ideological, institutional, attitudinal, Political and personal are some of the barriers that affect effective action.

Model for change
Regarding the model of change they advocated the civil societies on top. The professional policy analysis to be carried out with citizen activist. They also advocated a shift from for evidence based policy making -to-policy based evidence. Regarding social expenditure they said Norway and Finland spend more, Canada spends lowest. They emphasized the need to negotiate with the government on minimum wages as 30% of the Canadian income goes for rent. They also advocated for a census model to conflict model. They emphasized the need for the role of a socio epidemiologist and social economist. They explained the present situation as lack of political will and the powerlessness of the people. They commented on Michael Marmot and Wilkerson that they don't understand the poor. Their theory is based on the middle class and they depoliticize.

Plenary Achieving Social Justice – Key note address Dr. Gro Bruntland

Dr. Gro Bruntland in her speech said the public health challenges are a threat to local, national and global security. She said cholera and malaria kills more people. She referred to social economic problems and access to treatment in developing counties as Globalization made problems. She said access to treatment of malaria and TB is a major problem in developing countries.

Regarding HIV she said the health system is slow to response though condom use and ART have increased. While HIV is not a problem in some countries but it had a devastating effect on, Africa, China, India and many Asian countries.

She said while food insecurity, sanitation is a major problem in many countries war headlines in the newspapers reports deaths due to war than many killer diseases. She said SARS is a global public health problem but global out break was effectively controlled. She said China tried to hide but could not succeed.

She said the poor countries are worst hit by many diseases. She said in the 1990-2000 the Human Development index has declined. 1/3 all children are malnourished. Average African consumes 20% less. A billion people live on less than a dollar. IMR seven times higher

Export led global market
She refereed to the export led global market is the cause as in many countries the IMR is increasing and the Life Expectancy is going down. Wars and conflict are a major threat in many countries. She said though the FCTC is signed by 119 countries and the continuing advertisement of tobacco products increase consumption.

She said while polio was eradicated in 16 African countries problems related health, development and Security persist in many countries. She said many countries views health as consumption not as investment. She said the stewards of global economy the IMF and WTO are turning the world into an altruistic war. She mentioned the report of Prof. Jeffery Sax commission on macroeconomics.

She said the malaria burden in Africa is increasing and there is need to invest in health and education. She mentioned social insurance, private insurance, community insurances can narrow thee health and equity gap. She mentioned in China 71% are insured for health.

She emphasized that democracy should lead to right to health and education and the governments must invest in health, education and environment. The approach of democracy is to safe guard basic human right and social justice. She said it is desirable that the Development Corporations invest 5% in health and even if they invest 2 % it would be possible it make difference. She referred to the GDP of Norway, which is 1%.

Regarding research she mentioned the 10/90 gap. She said the reason for this was the less monitory resources available with the public than the private sector. She said the media dominated by private money She referred the Public Private Partnership in malaria was successful initiative.

Breaking out session

1. Conceptualizing and measuring social justice

In this session a comparative study conducted in US was presented on Pre term Birth Disparity (PTB) the presenters said when they compared the birth outcome between black and white women, it is evident that that PTB is steadily rising among the black. The study found PTB among the black was 17% and among the whites it was only 11%. They said poor socio economic factors among the black are the cause for this.

Methods
The presenters said the data for the study was gathered from the Census reports, Crime reports and the research included as explanatory variable.

Model
The model of the study was ecological using the following index housing, neighborhood deprivation and violent crime rate.

- Violent crime associated with PTB
- Stressful neighborhood
- Housing and high rent associated with PTB disparity

Conclusion:
The presenters reported that the study found the PTB was high among the people lining in stressful neighborhood, living in area where the house rent is high and there was violent crime rate.

2. MCH and neighborhood context

The next presentation that I attended focused on MCH outcomes. The study examined the relationship between contextual and individual determinants.

Method
The researchers reviewed the literature on the subject of the past five years and identified 31 selected articles. The researchers reported that they analyzed the following characteristics using a multilevel model.

Neighborhood characteristics

Income/wealth	housing
Employment	mobility
Family structure	education
Population composition	occupation
Social resources	violent crimes and deviant behaviors

Conclusion: theoretical, methodological and practical barriers in the measurement of neighborhood context. They said they found it difficult to fit into the operationalization of the study into a theoretical framework and they also faced methodical problems related to the index measures used by the and finally there were practical limitation such as no availability of respondents.

3. Exploring ideological barriers to addressing health inequities at the local level.

The next presentation that I participated focused on the above-mentioned topic.

Objective: To understand how the values of active citizens in Hamilton, Ontario could act as facilitators or barriers to address the local health inequities.

Method: The method of study was through postal survey of volunteers and employees of CBOs. The researchers reported that 240 surveys were conducted.

Conclusion: They said less than 46% of the respondents were aware of SDH prior to the study. Being aware was positively associated with increased openness and greater support of addressing SDOH. The study also identified the gap in knowledge and action. The respondents identified political system, structural barriers and attitude of service providers as barriers. They respondents did not see voting as a political activity

STREET HEALTH VISIT

The next progarmme that I attended was a visit to an organization that works with people living on the streets. According to the 2001 census there are about 15000- 20000 homeless people in Toronto, which is out of the 2 million populating of the city.

The organization's name is 'Street Health' located in the prime locality of Toronto. It was started by a group of nurses in 1986. At present there about 10-12 staff both volunteers and full timers working for the organization. 50% of the board of director of Street Health are homeless people themselves. The working hours are 9-5 Monday to Friday. They said the organization has built up a good street credibility over the years. The users their service users are people who are homeless, homosexuals and large number of transgender.

The strategy adapted by the organization is to advocacy. They said they go to the people and people don't come to them. Street Health is a politically active organization; they are constantly engaged in dialogue with the people in power to advocate to meet the need of the people living on the street. They said they lobby with the government to get more funds, Health Cards (They have helped over 5000 people to procure ID cards)

The director of Street Health said the cause of homelessness in Canada is due to cut in welfare, hosing projects are being scarped and the evacuation drives. The common health problem among their services users are URI, chronic cough, skin diseases, parasitic infection such as such as bed bugs, scabies and lies. TB, Mental Health, muscle ache are the other problems.

BREAKING OUT SESSION III

1. Global Urban Health

The last session that I attended was on Global Urban Health. The presenters listed the following as major problem of the urban dwellers: Spatial patterns of mortality and morbidity, five major urban health problems in urban environment identified were; homicides, pregnancy among adolescents, asthma hospitalization in children, dengue and visceral leishmaniasis. These problems were high among socio economically disadvantaged

Methodology

The Researchers aid the data was collected from the city health offices.

The second session that participated under global urban health was on violence among young men.

Violence among young men

The researchers did a study on the hypothesis that violence high risk factor for negative health outcomes. The researchers identified 949 both men with the age group of 16- 24 in Dar es Salaam. They reported that more than 10% reported history of childhood sexual abuse. 42% reported serious physical violence. 46 % felt it was acceptable for a mean to beat his wife.

Finding: violence was higher in those men with a history of sexual or physical violence in childhood.

My feedback

The conference was well organized with appropriated resource persons. The conference venue was well suited for the purposes of holding sessions on both the community stream and the academic stream. The plenary sessions also had right people. The address of the Venezuelan health minister through satellite medium had technical problem with linkage, it interrupted the continuity of his message. The technical sessions were too packed with many presentations as a result there was not much time for discussion. Most of the presentations were from the North American continent and a few were from European and Latin American continents. Since this was an international conference, though the participation of Asians were there, more space in oral presentation would have been helpful. Since the conference had the theme Achieving Social Justice in Urban Communities, it would have been helpful a declaration or statement be issued at the end of the conference highlighting the concern areas regarding the urban communities.