Health Care Beyond Zero

Ensuring a Basic Right for the Homeless

by **Health Initiative Group** *for the* **Homeless (H I G H)**

A collaborative effort of

Aashray Adhikar Abhiyan
Institute of Human Behaviour & Allied Sciences
Sahara

DELHI

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No progress is ever possible without our venturing on a path beset with difficulties.

– Mahatma Gandhi

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Do enrich us by informing about your work with the homeless community in your city/country.
LET'S REACH OUT

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Dedication

To all those homeless who acknowledge our efforts to alleviate their health conditions and provide us an opportunity to touch their lives meaningfully.

Acknowledgement

We would, first and foremost, like to express our gratitude to all the homeless people who by their involvement and participation made this report possible.

The printing and publication of this report were only possible through the help and support of many people. We are grateful to Harsh Mander, Country Director of ActionAid India (AAI) for conceptualizing the process of documentation of the Outreach Health Service right from its inception. We highly appreciate Cherian K. Mathew and Aditya Nath Jha of AAI for their initiative and drive in this endeavour. We are extremely thankful to Trudy B.J. from Aashray Adhikar Abhiyan (AAA) who made the outline draft of this report. Our thanks to Puja Trisal from AAA for her competence in creating the secondary draft on which this report has been balanced.

We are extremely thankful to the AAA team in launching and establishing the Outreach Health Service, especially the HIGH clinic and fondly recollect the enthusiasm and the spirit of the 'Deepalaya' team for their street play, on the occasion of the inauguration of the clinic, through which we were able to disseminate information about the clinic to the Homeless.

We have a special word of appreciation for Abdul Ahad for his untiring help and support at the clinic, as also for Sharmaji of Daryaganj, who unfailingly has been donating medicines every month.

Particularly helpful has been the questioning and examination of concepts and ideas by colleagues and partner organizations, which have existentially both supported and challenged our initiative, and for which we are grateful.

Colleagues who have shared in the writing are, of course, the major sources of inspiration. Form them, we have learnt much in working through various drafts of this report. We also thank our designer friend, who has designed all the covers (front, back and inside) of this report. He prefers to remain anonymous.

We also commend the hard work put in by both Prakash Zaveri and Ipshita Mukherjee from AAA, in taking this report to its completion.

We also thank J.S. Dubey of Print-O-graph, whose patience was tested during the typesetting and printing of this report but was able to deliver this report in the shortest possible time. We are also appreciative of and thankful to all our Partner and Supporting Organizations, Volunteers, HIGH clinic team, and especially to Babloo for his zeal and enthusiasm towards running of HIGH clinic.

सत्येन्द्र पाल अग्रवाल
भा. प्र. से.
प्रधान सचिव

S.P. Aggarwal
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MESSAGE

I am conveying this message of my congratulations to all the teams involved in the Health Care Services for the Homeless, with regrets for not having been able to join the Session today, at the India Habitat Centre. I have requested Mr. Anand Prakash, Special Secretary (Health), Government of NCT of Delhi to sit in for me for the Session today. As discussed in our meeting yesterday with the HIGH partners, I consider the effort that has been made a very laudable one. All the individuals, and organizations involved in this effort deserve praise. The homeless populations have usually been neglected in many aspects, and particularly in humanistic services like health care. I quite support the position taken with follow up action by the HIGH, of ensuring that the basic right of health care is made available to the homeless.

I also wish to convey the support of the Department of Health & Family Welfare, Government of NCT of Delhi for the HIGH Clinic & Services at Jama Masjid Clinic, in the coming years. It will be highly desirable that the partner organizations involved in the current effort viz. AAA, IHBAS & Sahara, consider preparing a Plan of Action for reaching the health care services to all the homeless population in Delhi, based on the model developed. I can assure you of full support in this endeavour.

(S.P. AGGARWAL)
PRINCIPAL SECRETARY (H&FW)
GOVERNMENT OF NCT OF DELHI

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A Word from the Partners

AASHRAY ADHIKAR ABHIYAN (AAA)

The Health Intervention amongst the Homeless emerged from the needs that were projected through the Rapid Assessment Survey carried out by Aashary Adhikar Abhiyan in June 2000. To effectively carry out the intervention a process was undertaken in which a Health Needs Assessment Survey was undertaken and consequently a coalition between organisations was formulated. This coalition came to be known as Health Intervention Group and in course of time it was re-named as Health Intervention Group for Homeless.

The coalition between the partners came to be termed as "collaborative measures" as each partner was to service a specific component of the Health Intervention. It was a unique and innovative experiment to carry out such a program. We may state here that the diversified vision and objectives of the partner organisations was a difficult task to try and converge, so as to formulate a plan of action keeping in mind the specific health needs of the Homeless. The issue that proved to be a meeting ground for the partner organisations was the target group of Homeless people which had never been addressed. This coming together was also to address the misconceptions about the Homeless that the members of partner organisations had within them.

In the course of two years of working with the Homeless the myths about them got dispelled as did the fears that inhibited the partners in the initial stages. The close communication and interaction with the Homeless enabled us to understand them better and provided us the opportunity to touch their lives in a meaningful way.

The operational factors of Health Intervention which went through changes for better achievement of our objectives was possible because of the understanding and commitment towards the Homeless which emerged through the effective co-operation between the partners.

This report seeks to provide the details about the nature of co-operation, and the process adopted to achieve the vision and objectives. The title of the report "Health Care Beyond Zero" reflects completely the journey covered from the beginning to the present with a "rights based approach."

Our endeavor is that through this report similar Health Interventions may be established throughout the country, specifically for the Homeless.

PARAMJEET KAUR
Director
Aashray Adhikar Abhiyan, Delhi

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Coordinator – Health
Aashary Adhikar Abhiyan, Delhi

INSTITUTE OF HUMAN BEHAVIOUR AND ALLIED SCIENCES (IHBAS)

Our colleagues and we have been enriched by the opportunity of understanding the health care scenario for the homeless populations, which is certainly in a zero situation, and joining the effort to go beyond the zero situation, through this innovative and collaborative endeavour. The opportunity occurred when the Aashray Adhikar Abhiyan team contacted us at the Institute of Human Behaviour & Allied Sciences (IHBAS), for assisting them with the problem of dealing with mentally ill and drug dependent persons they had begun to come across in the initial part of their work with these populations. The collective deliberations among the two teams led to the idea of a systematic Health Care Needs Assessment Study which was carried out in September, 2000. The major health problems identified included Severe Mental Illnesses (SMIs), Common Mental Disorders (CMDs), and Alcohol & Drug Abuse Problems, besides Respiratory Infections and Skin Problems. The Needs Assessment Survey also included eliciting the health service needs and identifying the strategies for meeting these service needs. A careful evaluation of the possible strategies, following the community based assessment study, led to the crystalization of the idea of a collaborative programme with a mobile health clinic service for the homeless populations.

The IHBAS team has provided the specialist and general duty medical personnel, the medicines and the training facilities for the specialist areas of mental health & drug abuse problems, in addition to the overall medical & public health expertise, as well as the scientific perspectives. The nature of this collaborative effort required facilitation by the Director, IHBAS which was available readily and the participation of various categories of the clinical & general duty staff, which has been possible with some effort. The encouragement by the officials of the Department of Health, Govt. of Delhi has also been helpful in sustaining these activities. The participation in the Health Initiative Group for the Homeless (HIGH), has been seen as a learning experience at the community level for the faculty, the staff and the students of IHBAS. This service programme has been accepted as one of the community outreach programmes of IHBAS, and is considered as one of the innovative programmes. The institute, specially in view of the tremendous need for such programmes and the opportunity to work with the Non Governmental Organisations (NGOs). This program has been recognised as one of the important activities of the outreach Mental Health Programme of the Govt. of India, for the State of Delhi.

The reach of the programme for the persons with alcohol & drug abuse problems has been reasonably satisfactory, although the retention rate for this group of patients can be further improved. On the other hand, the reach of the programme for the mentally ill persons in the homeless populations has been limited in the initial years, and the legal and ethical issues of enhancing this reach, as well as the operational and the programmatic

needs for ensuring a more extensive reach of such an effort are being explored. There is room for more work in these areas, and the responsibility of doing so is well recognized. Nonetheless, the relative success of integration of the services for the mentally ill persons and the alcohol & drug abuse persons, with the services for the general health problems is striking as one more evidence of such an integration being feasible and meaningful.

The immense potential of the application of this innovative, collaborative experiment which has been carried out in Delhi, needs to be realized by the concerned agencies, organizations and academic institutions and departments. The replication of this programme in the other cities and towns of India, and possibly also in the other developing countries, needs to be taken up by interested voluntary agencies and the NGOs, with the involvement of academic institutions and departments of community health, with participation of mental health professionals and active support from the State. It has been a privilege and a learning opportunity for us at IHBAS, to have been a part of this model experiment, not only as specialists in the fields of mental health & behavioural sciences, but also as health professionals interested in community health and public health.

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Introduction

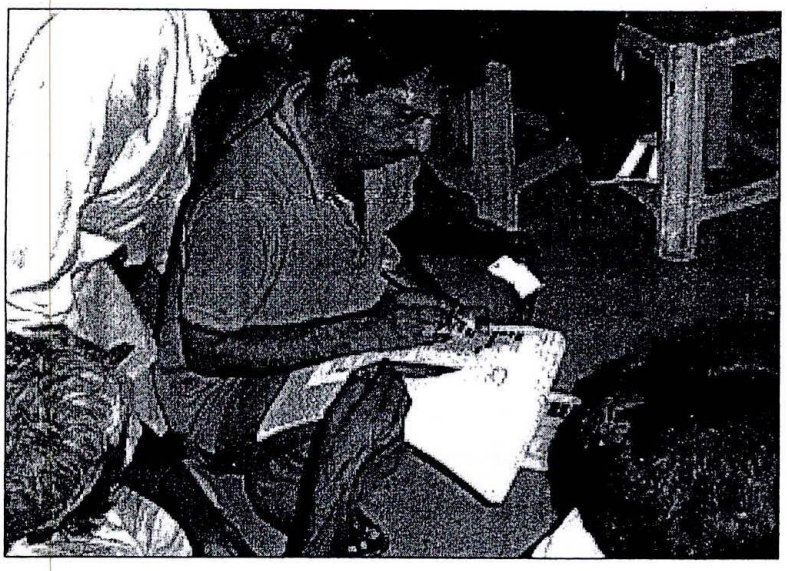
This report is a description of an innovative and collaborative initiative to ensure one of the basic rights of the homeless population, viz. health care services, over an initial period of two years i.e. 2000-2002. The report has been prepared with the larger purpose of sharing experiences and stimulating further action. The collaborative experience amongst the three partners along with the supporting organizations has been meaningful and yet not always smooth sailing or easily synchronous. The constant endeavour on the part of the collaborative group had been to maintain an ongoing dialogue and synthesize or integrate apparent and real differences in approaches. The fact that this has been possible has been rewarding in itself, in addition to the primary satisfaction of being able to ensure the basic right of access to health care for this highly disadvantaged section of the population.

This report is also reflective of the attempt at integrating the various approaches and practices, which have ranged from the academic and scientific through to a community outreach perspective and a rights based approach. This could well be seen as a public health approach to a problem like the health care services for the homeless. The task of documenting such a collaborative initiative as this, is fraught with its own inherent strengths and weaknesses. It is hoped that this report will be seen as an earnest attempt at documenting and sharing the facts and the impressions as seen collectively by the partner organizations involved in the process.

Chapter One titled **Health Care Scenario for the Homeless: At Zero Level,** describes the current situation in Delhi and some other cities in India, which is nearly non-existent, in the context of the larger issues and emphasizes the international legal provisions for health care being a basic right.

Chapter Two titled **Outreach Health Service for the Homeless: An Initiative Beyond Zero Level** explains the process of the collaborative effort for reaching the health care services to the homeless, from the abysmal extant situation to a minimal level of health care services delivery.

Chapter Three titled **Profile of Health Problems at the Outreach Health Service** describes the profile of patients and their health problems seen at the outreach health services, while referring to some important issues of access and utilization of these services.



Chapter Four titled **Preliminary Evaluation : Making the Initiative More Meaningful** describes the observations and the findings of the preliminary evaluation carried out in the period of first two years of services, which include the ongoing process evaluation and the endpoint evaluation through PRA (Participatory Reflection And Action) exercises carried out at the end of each year. It also highlights the other methods of evaluation that are proposed to be carried out.

Chapter Five titled **Future Horizons: Carrying the Initiative to Completion** briefly outlines the future course of action of this collaborative initiative, mainly in terms of sustaining and expanding this health outreach services, as well as potential for its application country wide and in other developing countries.

The **appendices** provide some of the tools and inventories, which have been developed as part of this collaborative effort, which are likely to be of utility for application of this model at other places.

It is fervently hoped that the readers of this report will find it as meaningful and satisfying, as the various teams from the partner organizations, which have played an invaluable role in sustaining this outreach health services, and the authors who have documented it. The feeling of satisfaction at having been able to carry this initiative so far is juxtaposed with the reality of the larger picture in two perspectives i.e. the wide range of problems that the homeless population has to deal with and the deprivations thereof, and the whole gamut of issues related to the availability of health care services for various disadvantaged populations. In the context of these two grim realities it is recognized that the experience documented here provides a possible solution for a relatively small problem area. Nonetheless it is reiterated that health care services is one of the basic rights of all populations including the Homeless. The model described here makes a small but critical and decisive contribution towards ensuring this basic right and ameliorating both the grim realities with positive action.

1 Health Care Scenario for the Homeless: At Zero Level

1.1 Political and Legal Scenario

India has made great strides in overall development and progress in different spheres of life. While we are exploring the possibility of a mission to the moon, the stark reality is that a basic concept, such as 'Health For All', till date, remains a distant dream. As a nation, health has never been an area of priority. This is further compounded by major constraints facing the health sector viz. lack of resources, inadequate medical staff, lack of an integrated multi-sectoral approach, poor involvement of voluntary organisations, inadequate laboratory services, poor disease surveillance and response systems (VHAI, 1993).

The issue of health care is also aggravated by the inequity of coverage - a malaise inflicted by the disparity of income distribution on one end and lack of awareness and socio-cultural prejudices and practices on the other end. A large section of society is not in a position to meet the basic needs of food and shelter.

The Indian Government has not spent more than 1.8 percent of the Gross Domestic Product (GDP) on health (Sainath, 1996) and this is constantly falling. The government budget allocation for hospitalisation of the poor has decreased from Rs. Six crores in 2000-2001 to Rs. Four crores in 2001-2002 (Times of India, 13 March, 2001). As state support for health care services decreases, poor people are increasingly forced to resort to private services of variable quality. According to the National Sample Survey (NSS) conducted by the National Council for Applied Economic Research (NCAER), 60 to 80 percent of primary health care is sought in the private sector for which households contribute four to six percent of their total income. Recent studies show that healthcare is the second most important cause of indebtedness (The Telegraph, 31 January 2001).

State health care institutions/providers are obliged to provide medical treatment to all persons without discrimination. The concept of non-discrimination is incorporated in Article 14, 15 and 16 of the Constitution of India. Every citizen in India is entitled to health care. Under Article 47 of the Constitution of India, "it is the duty of the state to raise the level of nutrition and the standard of living and to improve public health." Under Article 21, the right to health is inherent in the right to life. Therefore, "attending to public health is of high priority, perhaps at the top" (Vincent Parikulangara vs. Union of India 1987 (2) SCC 165, AIR 1987 SC 990).

The right to health is also recognized by various International Covenants/ Instruments to which India is a signatory (see Box 1.1).

1.2 Health Status of the Urban Poor

The health status of the urban poor is

influenced by several factors, such as urbanisation, urban economy and urban environment.

As per census 2001, 285 million Indians live in nearly 4378 towns and cities spread across the length and breadth of the country. This comprises 27.8 percent of population, in sharp contrast to only 60 million (15 percent) who lived in urban areas in 1947 when the country became Independent. During the last fifty years, the population of India has grown two and half times, but urban India has grown by nearly five times

The scale and speed of urbanization in Delhi is markedly different from other metropolitan cities of India. Delhi has witnessed one of the fastest growth rates when compared to other metropolitan cities. Since 1941, Delhi has grown 427 percent, Bombay 227 percent, Madras 49 percent and Calcutta 39 percent (VHAI 1993). The census of 2001 confirmed this trend as among all the States and Union territories, the National Capital Territory of Delhi is most urbanised with 93percent (of 127.9 million) urban population.

Almost two-thirds of the employment in the manufacturing, trade, transportation and commerce sectors is concentrated in the urban areas. However, the benefits of this urban growth is not shared by every one living in urban areas. In the large cities around 15 percent of the male workforce and 25 percent of the female workforce have no regular employment (Mathur, 1993). Such persons are considered a burden from the economic point of view and are vulnerable from the health point of view.

Imperfections in the land and housing markets and exorbitant increase in land prices have virtually left the urban poor with no alternative except seeking settlement in small groups in slums and unauthorised colonies. Today, about 35 percent of Delhi's population resides in slums. The health status of people living in urban areas is generally better than that of the rural population, but this is not true of those living in urban slums. The major problems that arise in context of slums are unhygienic accommodation, inadequate

Box 1.1

The Right to Health under International Laws

- Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control (Universal Declaration of Human Rights (UDHR) 25.1; International Convention on Economic, Social and Cultural Rights (ICESCR) 11; Convention on the Elimination of Discrimination Against Women (CEDAW) 14.2h; International Convention on the Elimination of all forms of Racial Discrimination (ICERD) 5e; Convention on the Rights of the Child (CRC) 27.1)
- Everyone has the right to the highest attainable level of physical and mental health and the right to equal access to health services, including family planning (ICESCR 12; CEDAW 12; CRC 24)
- Women have the right to special health services with respect to pregnancy, childbirth and the postnatal period (ICESCR 12.2a; CEDAW 12.2; CRC 24.1df)
- Every person has the right to have safe and adequate water and sanitation and to live in a hygienic environment (ICESCR 12.2b; CEDAW 14.2h; CRC 24.2e).

Box 1.2

Homelessness as a Crime

To begin with homelessness itself is perceived in India to be a crime. Wandering persons (vagrants), mentally ill homeless persons (MIHP), are all 'guilty' of violating several penal statutes under which the entire enforcement is left to the police and the magistracy. In a moving study in 1991, leading Supreme Court lawyer and civil rights activist S. Murlidhar points out:

Criminalising the homeless is a serious problem; wandering people of a wide variety can be defined as beggars and powers are given to the police to deal with such persons. Squatting on the pavement is a nuisance under the Municipal laws. Creation of nuisance can be penalised. Same is the approach of the law of trespass. Given the non-availability of space in urban centres every unauthorised dwelling would amount to trespass and be punishable as such. Housing, therefore, has law and order dimensions and there is a crying need for a human rights approach to it.

Source: AAA, 2001.

water supply, sanitation and solid waste disposal, rights over land tenure, inadequate food supplies and the increasing demand for employment and social services.

The link between urbanisation, a degraded environment, inaccessibility to health care and deteriorating quality of life, is particularly significant. Large-scale unplanned rural-urban migration and the continuous growth of towns and cities have resulted in overloaded public services, scarcity of housing and inaccessible health care facilities.

Delhi is the only urbanised territory having 93 percent urban population. It also has a large network of medical and health services but there are many organisational, managerial and technical problems with the health care services in Delhi as there are multiple authorities responsible for delivering different services relevant to health and they are without any co-ordination (VHAI, 1993). Despite the multiplicity of the health care services, a strong private sector has emerged in the field. But even with this addition there is no visible improvement in the fair distribution of services for the rich and the poor (VHAI, 1993).

1.3 Urban Poverty and Homeless

Urban poverty remains, for the most part, an area of significant and persistent neglect in public policy, despite evidence of burgeoning urban populations, fuelled by distress migration from impoverished villages, with stubbornly high levels of both absolute and relative poverty.

The general belief is that glamour and privileges of metropolitan cities like Delhi attract people from the hinterlands. On the other hand, it can also be argued that the homeless are pushed out of the rural economy, as there is no work for them / they are redundant as their skills of weaving, crafts etc. do not fetch a living/ they have no or little land holding/ recurrent droughts and floods have made agriculture impossible/some are also socially persecuted, divested of property by their relations or dominant castes and a host of other personal and economic reasons. Despite over five decades since Independence, our villages remain starved of any tangible development. To address their grim situation they are left with no options but to seek better opportunities in urban areas. As per a head count survey conducted by AAA, in the year 2000, there were 52,765 homeless on the streets of Delhi. They are migrants, mainly from UP, Bihar, West Bengal, Rajasthan, MP, etc., who have left their homes in the village due to extreme distress situations. They have their unique problems and in order to solve some of those, they are compelled to lead varied existences, be they children, women, men, elderly, disabled or destitute (AAA, 2001).

The most visible manifestation of urban poverty is in crowding of large masses of the urban poor people under the open sky,

Box 1.3

Homeless Defined or Ill-defined

As per Report of United Nations Centre for Human Settlements, Nairobi (1999), "People sleeping rough, which means in the street, in public places (on railway platforms, under flyovers, in parks or in any other place not meant for human habitation), are those forming the core population of the 'homeless'. Those sleeping in shelters provided by welfare or other institutions will be considered as a part of this population. Persons or households living under these circumstances will furthermore be defined as houseless".

The "poorest of the urban poor" (Jagannathan and Halder, 1998) are homeless people also commonly referred to as "pavement dwellers", "beghar log" (people without houses) or "kangla" (destitute).

The census of India defines the notion of 'houseless population' as persons who are not living in 'census houses'. The latter refers to a 'structure with roof', hence the enumerators are instructed 'to take note of the possible places where the homeless population is likely to live, such as on the roadside, pavements, drainage pipes, temple-mandaps, platforms and the like'. This part of the population includes those sleeping without shelter, in constructions not meant for habitation and in welfare institutions.

completely vulnerable to the extremes of nature.

Moreover, by definition the homeless have no stable address, no ration card and do not appear on any voting list. Among those living on the streets, some of the most defenceless groups are women, children, aged, destitutes, mentally ill and the handicapped. There are no reliable surveys available to estimate the actual proportion of these groups in the total population. But case studies portray sub-human conditions of stigma, exclusion and survival.

1.4 Health Status of the Homeless

1.4.1 General Health Status of the Homeless

There is very little existing data on the health status of homeless people in India and more so for Delhi, as most studies on urban poor and health have concentrated on slum dwellers. It is known that the health status is determined by three basic factors – healthy environment, adequate nutrition and lifestyle (VHAI, 2001) and by exploring these factors in the context of homelessness an assessment of the health status of homeless people can be undertaken.

Healthy environment: Homeless people have no access to safe drinking water or sanitation facilities. They sleep in the open exposed to high levels of pollution, extreme weather conditions and mosquitoes. Their working hours are long and much of the work done by homeless people is physically demanding and sometimes hazardous with little or no safety precautions (see box 1.4B).

Adequate nutrition: The food habits of the homeless in their living conditions make them prone to health hazards. Some of the homeless in Delhi collect food at religious places and there is no dearth of it. The concern arises from the fact that their intake of food is not balanced either they over-eat or eat stale food (purchased/ collected for later consumption), and it is believed that therefore, homeless people fall sick more often.

The homeless have no place to cook food, which exposes them to odd food habits; including buying food regularly from *'Khomchas'* (pavement food vendors), which are not always hygienic. To sum up, instead of nutritional value, price and filling capacity determine the choice of food.

Lifestyle: The rural people, when they come to a city like Delhi, are at loss of cultural identity, lack of community bonds and even communication due to the problem of language. This situation drives the homeless to pursue a life in isolation. Usually homeless are employed in unskilled or casual jobs which are insecure and poorly paid. The realities of urban life

Box 1.4A

A Description of the Health Condition of the Homeless

According to government figures, 70 unidentified homeless people have died this winter: while several homeless die on the pavements, others are simply dumped in hospitals, often in an irredeemable condition. Doctors say these deaths are due to malnutrition that pulls down body temperature to below normal and poor protection against the cold.

"Most of the homeless are brought into the hospital with a body temperature less than 20 degrees Celsius and rarely survive," said Vineet Kumar Soni, medical officer with Deen Dayal Upadhyay hospital. The hospital on an average receives one or two such cases daily.

A person is said to die of cold when he is not able to maintain a minimum body temperature of 35 degree Celsius (98.4 degree Fahrenheit). "The Basal Metabolic Rate (BMR) of the Person comes down and the functioning of the heart is impaired," said associate professor of medicine with All India Institute of Medical Sciences (AIIMS), R. Guleria. The BMR is maintained by the reserves of Glucose and fat that a person has in his body. And hence, those who suffer from malnutrition such as beggars and homeless people are more prone to cold related problems.

Soni feels it is lack of nutrition coupled with inadequate protection against cold that leads to hypothermia. In such cases, the extremities such as the nose, ears and feet get affected first. "They may go blue, swell or get blisters," said P.C. Mohanty from the Department of Surgery in Safdarjung.

Times of India, January 14, 2003, Delhi

become overwhelming. In such a situation, the stress level mounts up; the homeless become more susceptible to communicable diseases or take refuge in drugs.

It is obvious, even without specific data that in the face of such poverty the health of homeless people is likely to be neglected. In a study of 60 homeless people in 2002, over half (55 percent) reported falling ill frequently (Chaudhry, 2002).

1.4.2 Health Status of Homeless Women

A study on reproductive health and fertility of homeless women in Calcutta found they suffered from conditions like leucorrhoea (28.5percent), menstrual irregularities (12.3 percent), infertility (2.5 percent) and STIs (1.3 percent). The reproductive behaviour of street dwelling women was characterised by early marriage, teenage pregnancies, and scarce use of contraceptives (32 percent) as well as frequent abortions (2.8 percent) (Ray et. al, 2001).

1.4.3 Health Status of Street Children

In a survey of 300 street children in Thiruvananthpuram 1998, it was found that skin disease was the most common problem followed by diarrhoea and fever. Besides, unhygienic living conditions, many illnesses are caused by poor diet. Nearly one-fourth of children feed themselves from the dustbins (Don Bosco, 1998).

Sexual activity amongst street children starts very young and is undertaken with numerous partners (with the younger boys, girls living at the railway station, sex workers in the red light area and also with eunuchs). Condom use is negligible as children do not know how to use them or where to get them. Many boys are also under the false impression that condoms are only required if they have sex with sex workers. A study of 100 street adolescents at New Delhi Railway Station found that 30 percent of the boys had sex related complaints (Raj Kumar, 2000).

Box 1.4B

Factors Contributing to Health Problems of the Urban Poor

Health problems amongst the urban poor, many of which are homeless are determined by three main groups of factors, which act in consonance

- Direct problems of poverty: unemployment, low income, limited education, inadequate diet, malnutrition, etc.;
- Environmental Problems leading to communicable and infectious diseases (air-borne and water-borne), accidents, etc;
- Psychosocial problems: stress, alienation, instability and insecurity, leading to depression, smoking, drug addiction, alcoholism, etc.

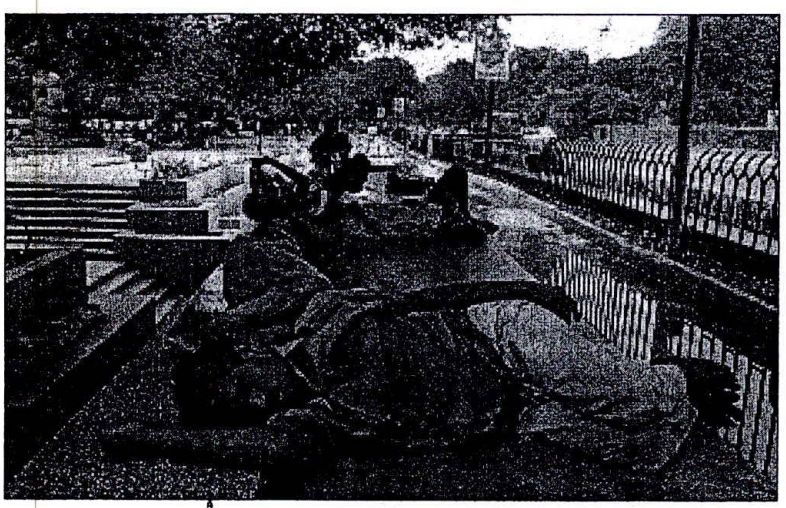
Source: Harpham et al, 1988

1.4.4 Mental Health of the Homeless

"Discarded by families or wandering further and further away from home, their real selves are lost or submerged under layers of dirt and idiosyncrasies – handicaps both primary and secondary. They become non-persons, consciously ignored or worse, paid unhealthy attention. Women are particularly prone being easy targets of sexual abuse. The mentally ill destitutes comprise a largely forgotten and unthought of section of the homeless. Lacking protection by law, there are no Government plans/programmes for these people who by law, simply do not exist" (Out of sight, Out of Mind, 2002).

There are not many studies on the mental health of homeless. However, Patel's study, (Patel, 1996) reveals that poverty is strongly associated with common mental illnesses, such as depression and anxiety, because they are triggered by adverse life-events such as physical illness, housing problems and unemployment, events more likely to affect the poor. This suggests that homeless people, who are the urban poor, houseless, exploited and socially excluded, are more vulnerable to mental health problems which do not get adequate

attention. The social neglect of the mentally ill homeless persons (MIHP) coupled with the difficulties involved in the implementation of the provisions of the Mental Health Act, 1987, often lead to these persons continuing to be living in the street, with virtually no social support or sense of self care or protection, and so they deteriorate further into vegetative existence. This is certainly true for persons with Severe Mental Illness (SMIs). The plight of these persons has been one of the factors contributing to the collaborative initiative described here. The psychosocial needs of the homeless persons with Common Mental Disorders (CMDs) like Depression, Anxiety, Phobia and other such disorders, are of course hardly even recognised, leave alone being met with.



Box 1.4C

Substance Dependence and Mental Health Problems

Considerable research and clinical experience has pointed to the fact that a significant number of people with drug or alcohol abuse problems have a concurrent psychiatric disorder (sometimes termed 'dual diagnosis'). Personality disorders, affective disorders, anxiety disorders and organic disorders are among the commonly diagnosed co-morbid disorders.

Source: UNDCP *South Asia:* 1998

The mental health service needs of the homeless population have been highlighted in the initiatives on urban mental health services (Desai and Shah, 2002).

1.4.5 Substance Dependence and the Homeless

In 2002, a 'Rapid Assessment Survey of Drug Abuse in India' was commissioned by the United Nations Drug Control Programme and the Ministry of Social Justice and Empowerment. Interviews were undertaken with 4648 substance dependents in 14 states. The majority of respondents (36 percent) reported heroin as the primary drug of abuse. Other opiates (buprenorphine, propoxyphene and opium) accounted for 29 percent and cannabis 22 percent. Most persons interviewed had been using drugs for five years or more. Overall, 43 percent confirmed injecting drug use (ever). Sharing injecting devices with three persons or more was common in Amritsar, Delhi, Thriuvananthapuram and Hyderabad. The study revealed that about one-fourth of respondents were homeless and this was much higher in urban centres such as Ahmedabad (83 percent of 314), Hyderabad (65 percent of 300), Mumbai (54 percent of 356) and Delhi (39 percent of 465).

In a study Sharan, an NGO working with substance dependents in Delhi, estimates there are 1.40 lakh substance dependents in the city and that 10,000 to 15,000 are injecting. It is estimated that approximately 1percent of substance dependents in Delhi are females (Sharan, 2001).

It is clear that chronic substance use impairs health and shortens life span (UNDCP, 1998). Adverse health consequences of drug abuse depend on the drug taken and its route of administration. In a substance dependence treatment centre

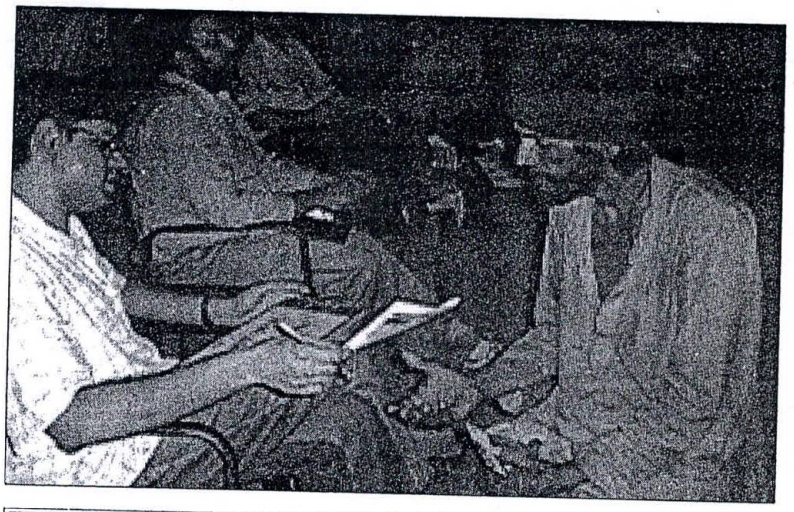
at All India Institute of Medical Sciences (AIIMS) 20 percent of heroin users had symptoms suggesting pulmonary disease and 55 percent of them had pulmonary tuberculosis. Various other ailments such as cardiovascular problems, skin problems and poor dental hygiene were also found (UNDCP, 1998)

Infections commonly seen amongst injecting users include cellulitus (infection of subcutaneous tissue), infection and blocking of veins, bacterial infection of the heart (endocarditis) and serious generalised infection (septicaemia) (UNDCP, 1998). A study of 200 injecting users in Delhi in 1998 showed the rate of 44.8 percent sero prevalence (Sharan, 1998) and in the northeastern states between 1989 and 1990, 54.2 percent of injecting users screened (out of a sample of 1412) were found to be infected with HIV.

As per the study by Association For Development (AFD) on the 'Problems of Street and Working Children Living at Railway Stations in Delhi', about 78 percent of the children disclosed that they use different substances such as correctional fluid, cannabis, smack, alcohol, etc. Out of these children, a majority (48 percent) did so daily, while 10 percent had it often and 20 percent occasionally. Over 67 percent of these children smoked cigarettes too. (AFD, 2002). The effects of sniffing glue, correctional fluid and kerosene are potentially fatal and include irreversible damage to internal organs and mental development (England, 2002).

1.4.6 Disabilities and the Homeless

As per the World Health Organisation's estimate 10 percent of the Indian population is disabled (VHAI, 1992). However, there are no statistics on how many homeless people are disabled, although disabled destitutes or distressed people, many of whom are homeless, can be seen on most roads in Delhi suggesting that the proportion of disabled amongst the homeless may be higher than the housed population. This hypothesis is backed up by the fact that the poor are more likely to suffer from disabilities (see box 1.4D). Over 70 percent of disabilities are preventable but only 2 percent of the rural and 5 percent of the urban physically challenged population have access to rehabilitative services and so easily curable medical problems such as cataract and glaucoma go untreated and then result in a permanent disability such as blindness (VHAI, 1992). Poor hygiene and diet can also cause disabilities such as hearing loss (blockage of ear canal by wax),



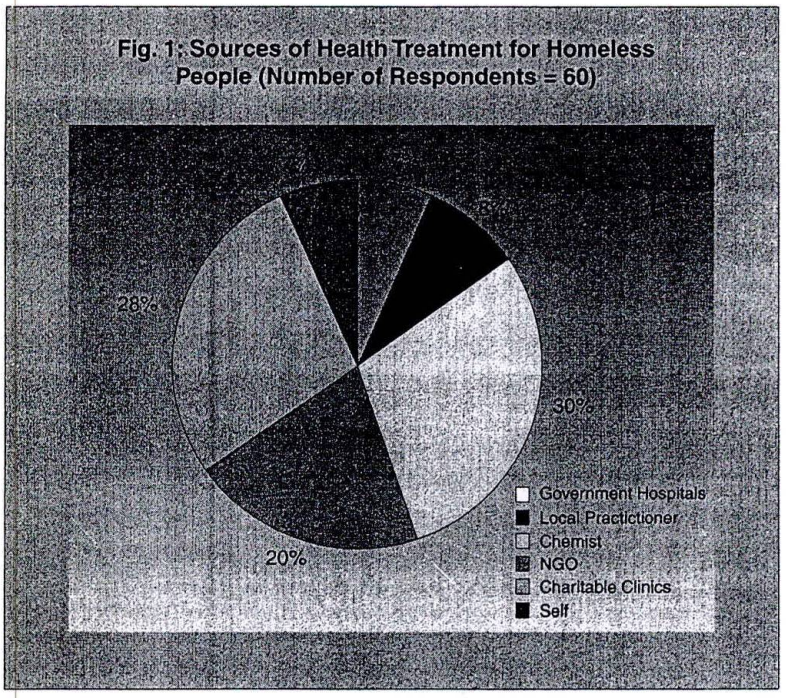
Box 1.4D

Disability and Homelessness

Jag Mohan, now 55 years old had to leave his flourishing job in Iraq during the 1991 Gulf War. There he was earning Rs. 13,000 per month. That money he was sending home.

Once back in India, he started working in a factory. As fate would have it, he received severe burns during an accident in the factory. This accident made him unfit for work. Once he lost his job, he became a burden on the family and finally one day his children threw him out of house. Now-a-days, homeless Jagmohan lives on the street near Hanuman Mandir, Connaught Place

Observations by M.S.W student, Feb. 2003



Source: Choudhary, 2002

nutritional blindness (lack of vitamin A in diet) and mental retardation (lack of iodine).

Accidents are also a major cause of disabilities in India. Nearly a quarter of all amputations (24.3 percent) in urban areas are due to accidents (VHAI, 1992). These accidents often happen at the workplace and on the road. Homeless people pulling rickshaws or pulling handcarts are particularly vulnerable to accidents as the modes of transportation that they haul, built as they are, expose them to serious injuries even when the crash is of a low velocity.

1.5 Barriers to Accessing Hospital Services

Most of the homeless people do not seek medical help when they are ill. In a study of female pavement dwellers in Calcutta, three-fourths of women did not get their gynaecological illnesses treated. Very few pregnant women received adequate antenatal care (3.8 percent); delivery on the street was a common practice (51.8 percent) and conducted mostly by untrained birth attendants (Ray et. al, 2001). Studies of street children show that they are also unlikely to seek medical treatment but depend on their friends to care for them (Don Bosco, 1998; Rajkumar, 2000).

A study of homeless people in Delhi revealed that those who do seek medical treatment rarely go to government hospitals (Chaudhry, 2002). They are more likely to go to private clinics and medical stores or depend on NGOs and religious organisations (Fig. 1).

1.5.1 Why Homeless people do not go to Government Hospitals

The main reason for homeless people not seeking medical treatment is the cost. Even visits to the government hospitals, involves direct costs (cost of clinical investigations, implants, medicines, etc) as well as indirect cost (loss of a day's wage, etc).

There is a National Illness Assistance Fund (NIAF), which allows each government hospital to sanction up to Rs. 50,000 for the treatment of poor patients. However, to access the money in this fund, patients are required to provide a certificate to show they are below the poverty line and also give proof of residence. The complexities of the process are brought to fore in Box 1.5. Homeless people who do go to government hospitals are many times turned away. Since over 80 percent of homeless people do not have any form of identification (AAA, 2001), this means they are unable to access this fund. In 1999-2000 the All India Institute of Medical Sciences, the largest hospital in Delhi, only assisted the hospitalisation and treatment of 12 poor patients (Times of India, 2001).

This is highlighted by the recent case where a 25-year-old migrant worker with TB was told he was "ineligible" for treatment at a government hospital because he did not have any evidence to prove he lived in Delhi. Doctors at the hospital involved said it was not an isolated case and that "a large number of patients are turned away on the ground that they can not provide any proof of residence in the Capital" (Hindustan Times, 2000b).

In another incident during the survey of homeless in Delhi, AAA found a homeless man with a serious infected wound on his head infested with maggots (AAA, 2001). The man said he had been to the hospital but medical staff had refused to dress the wound. AAA then accompanied the man to the hospital and again the medical staff refused to treat him because the man was too "dirty". Says one homeless man of his experience, *"When I fall sick, I go to the nearby Government hospital. The doctors there are always reluctant to treat people like me. They are right, in a sense because I am shabbily dressed and never look neat. How can I go well dressed when I don't even get enough money to fill my stomach?"* (Menon, 2001). This attitude by hospitals has also been observed by Delhi House, an NGO that works with sick and dying destitutes. In their experience, hospitals will treat homeless patients if they have been cleaned up first. However, they say it is difficult to admit a homeless patient to hospital because family support has a large role to play in the care of patients in government hospitals and homeless people do not have this support. The difficulty of admitting patients is highlighted in Box 1.5.

Street children cited "lack of knowledge about the location and procedure in government hospitals" and "time shortage" as the most common reasons for not going to hospitals (Institute of Manpower Research, 1999). These two reasons are related because not knowing the hospital procedure, where to go and whom to see, makes a trip to the hospital much longer and tedious.

Most homeless are paid below the minimum wage (AAA, 2001) and are not given benefits such as sick leave, therefore, they can not afford to forgo a days' wages to visit the hospital, which is often a full day affair. Says one paper bag producer in Nizamuddin; "Doctors do not bother about us in government hospitals, we are

Box 1.5

20-hour ordeal to get into hospital

It took 20 long hours and a gruelling journey from one hospital to the other to get a 32 year old mentally challenged woman, bitten by a dog, admitted to a hospital.

Aashray Adhikar Abhiyan (AAA), an NGO found Poonam outside the New Delhi Railway Station on August 3 at 2 am. She had suffered a dog bite and had a broken right arm. AAA volunteers took her to Sucheta Kriplani Hospital (SKH), from where she was sent to Ram Manohar Lohiya Hospital (RMLH). "A dog bite patient needs immediate attention and we do not have the Anti Rabies Serum (ARS)", said SKH Medical Superintendent, Maheshwari Sharma.

After giving her an ARS shot, RMLH directed her back to SKH for the want of round the clock psychiatric care. SKH further directed Poonam to Institute of Human Behaviour and Allied Sciences (IHBAS) for psychiatric treatment.

At IHBAS, she was administered sedatives to relieve her pain. After waiting for two hours, she was sent back to SKH by the doctor on duty saying "she needs to be treated for the physical ailments first".

But Poonam's ordeal did not end there, AAA had to win an argument with a doctor at the Psychiatry OPD who insisted that Poonam could not be admitted to the hospital. Finally, after an hour's wait, a consultant examined her. She was sent to Psychiatric Department where she was admitted after a gynaecological examination.

"Despite the proclamation of the 'Citizen's Charter' of giving priority to treatment over paperwork. Poonam's gynaecological examination was held up for the want of a letter from police", said AAA Director Indu Prakash Singh.

Source: The Indian Express: "20 hour ordeal to get into hospital" - 7th August, 2002

N.B: The above description highlights the difficulties involved in obtaining hospital based care for the homeless. It also highlights the issues of interdependent functioning of various health care systems which require to be effectively coordinated.

After successful psychiatric treatment and an operation on her fractured arm at SKH, Poonam recovered at the Delhi House Sewa Ashram. AAA by then located her family in Asansol, West Bengal. Seven months after finding her at the Railway Station, AAA staff accompanied her back to Asansol and she was reunited with her husband and five daughters, the youngest being 1½ year old

Box 1.6

State of Health Care in Rural Areas

45-year-old Sheila hailed from village Purnea, Bihar. She was working in the village as an agricultural labourer along with her husband on meagre wages, which made their life very difficult. In the meanwhile, her husband had contracted T.B. Despite her meagre income, she tried to treat her husband at the local health institutions. But to their bad luck, the lack of medical facilities forced her to migrate to Delhi with her husband in order to get her husband treated in a government hospital. But nothing has improved for her. The apathetic attitude of the government hospital made their predicament worse. Getting uprooted from her native place for the treatment of her husband and secondly unable to manage their livelihood, she started begging and living on the street. Disillusioned with the government hospital, she said " *shayad hamare naseeb mein til-til ke marna hi likha hai. Hamare liye to kuch bhi nahi hai, shayad bhagwan bhi ameero ke liye hai.Kehne ke liye yeh hospital hamare liye hai magar ghanto kataro mein khade rehne ke bavajood bhi hame nirasha hi haath laagti hai. Kash! hamari bhi aawaaz koi sun pata, Tab kahi jakar mein apne pati ko til-til kaar apni aankhoon ke saamne marte to na deekhti. Kasise lachaari hai!* (May be we are destined to die a thousand deaths. There is nothing for us. Probably God is also only for the rich. For namesake, the hospitals are for us, but in spite of standing for hours in queues we get nothing but disappointment. I wish someone would pay heed to our cries, and then I would not have had to see my husband dying in front of my eyes. What helplessness!!).

Observation by M.S.W
Final Year Student, Feb 2003

kept sitting there all day at the risk of losing a days' wage. And during an emergency, we merely get pushed around" (VHAI, 1992).

1.6 Homelessness Caused by Lack of Medical Care

The total government per capita expenditure on health for cities is Rs.161 per person per year, while in the rural areas it is Rs.16 (VHAI, 1992). The inadequate health services in rural areas results in many poor people coming to major urban centres for treatment. Leaving their families behind in the village, they come to places like Delhi with very little money and when they reach the hospital they find that a) whatever treatment they need will cost money and b) during the operation and recovery period they are required to provide an attendant in the hospital. The AAA team has encountered many homeless people in the street contact programme who had come to Delhi for medical treatment and after spending all their money had been unable to get treatment or return home and thus forced to beg, all in order to survive, and walk that extra mile for life before calling it quits (see box 1.6). The backdrop reinforces Health Care scenario at Zero level for the Homeless.

2 Outreach Health Services for the Homeless: An Initiative Beyond Zero Level

2.1 Prelude to the Initiative

A comprehensive and integrated response to the city's health issues requires an assessment of both local needs and the level of provision citywide. This assessment must include strategies for identifying those most in need and hardest to reach. As explained in the previous chapter the health problems of urban poor are closely tied to their living conditions and must be tackled in the relevant context. The needs of the homeless population have been largely overlooked and neglected.

The magnitude of the homeless situation has never been addressed, and to fill this void Aashray Adhikar Abhiyan came into existence adopting a rights based approach. This campaign was brought about by the efforts of concerned individuals both from the Government (including the Planning Commission) and civil society, who came together to address the ever-increasing issues of Homelessness in Delhi.

In order to address this issue, at the very outset, a Rapid Assessment Survey (RAS) was undertaken by the AAA team as it was essential to know the scale of the problem so as to obtain a basic understanding of the lives of the Homeless and the ways and means adopted by them to deal with their different problems. This survey was carried out in June 2000.

Delhi is no exception to the phenomenon of neglect of the urban poor, specifically the homeless, when compared to other cities of India. Indeed, Delhi fares possibly the worst, in terms of the way the poor are treated. Amongst the poor, the homeless i.e., the people who sleep on the pavements, rickshaws, handcarts, *rehris*, railway platforms, flyovers, in parks, under bridges etc., are really the vulnerable ones. These also include sizeable proportions of the physically and mentally challenged and persons with significant health problems which are not attended to.

In the light of the understanding gained through the rapid assessment survey, the need for some kind of health intervention in collaboration with some civil society organisations (CSOs) was felt. To further this, AAA held a voluntary organisations meet on 10th August 2000 at the Indian Social Institute in which the attending organisations were asked to come forward and extend their cooperation for dealing with the health problems of the homeless. The organisations that came forth on the health issue were Sahara House and World Vision. IHBAS had already committed itself for treating the mentally ill individuals amongst the homeless.

2.2 Health Needs Assessment Survey (HNAS)

In response to the concerns raised about the health of the homeless in the survey (RAS), on 12th August 2000, a brainstorming session was held with the Aashray Adhikar Abhiyan (AAA) and the

Institute of Human Behaviour and Allied Sciences (IHBAS) teams so as to determine the approach to be followed. Through this session, the need for carrying out a small scale but intensive survey to determine the health need of the homeless was felt. This Health Needs Assessment Survey (HNAS) was undertaken by AAA, IHBAS and members of Narcotics Anonymous and World Vision. The objectives, geographical area, methodology and expected outcomes were discussed and identified. The survey was conducted between August 21st to 31st, 2000, between 7 p.m. till midnight for 10 days. The team for the survey consisted of doctors, psychiatrists, psychologists, social activists from the different organisations cited above. (see appendix 16)

2.2.1 Objectives of HNAS

The objectives of the HNAS were :

- To identify the major health problems prevalent among the homeless
- To assess the priority health service needs of the homeless
- To study barriers in accessing health services
- To identify suitable strategies to meet the health needs of the homeless

2.2.2 Area of coverage

For the purpose of the HNAS, the stretch between Turkman Gate and Ambedkar Stadium were identified as being the peripheral area of the Walled City. This area, due to the high concentration of homeless, provided a comprehensive understanding of the various health problems being faced by those living on the streets. After surveying the specified area from 21st to 27th August, the group moved towards the interiors of the Walled City (Jama Masjid and adjacent areas) and came to understand the severity of the health problems in the inner concentration area of the Walled City, as compared to the peripheral area.

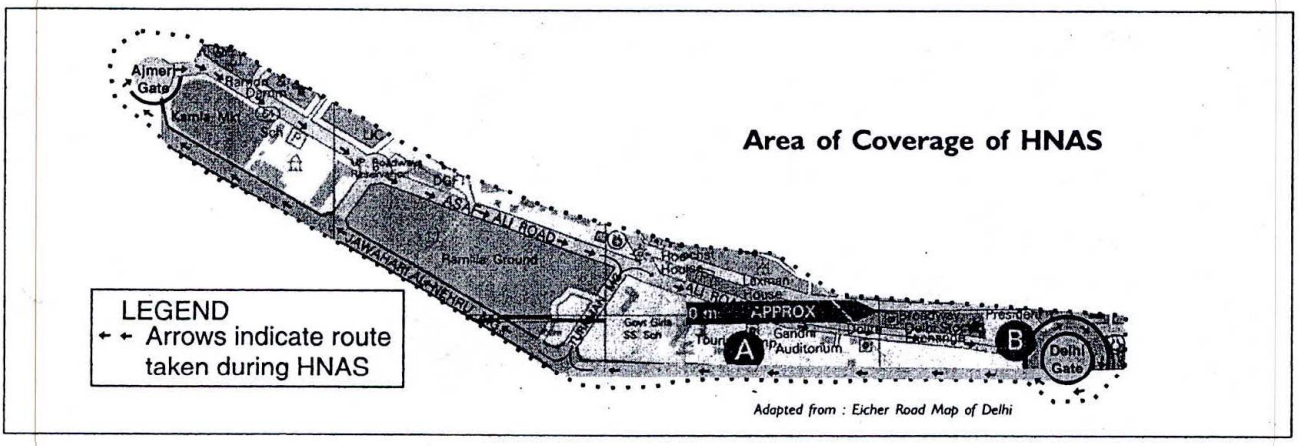
2.2.3 Tools used for data collection

- Free listing of the illnesses prevalent among them
- In-depth Interviews
- Focus Group Discussions – a) inside the night shelters; b) outside the shelters i.e. on the street
- Direct Observation – a) inside the night shelters; b) outside the shelters i.e. on the street

2.2.4 Findings of the Survey (HNAS)

The analysis of the survey revealed the following findings:

- A high proportion of homeless people



were suffering from serious respiratory ailments including tuberculosis, acute and chronic infections, skin diseases and diarrhoeal diseases.

- Substance dependence was a major problem, especially in Yamuna Bazaar, Ajmeri Gate, Delhi Gate, Turkman Gate and ISBT.
- Severe mental illnesses were an important component of the mental health needs of the homeless in Delhi. The team was able to identify nineteen persons with severe mental illness during the short assessment period of ten days.
- Common mental disorders were usually unrecognised and so were likely to remain untreated.
- Many terminally ill or chronically physically/mentally ill patients were surviving in the open without any kind of medical help
- The majority of the homeless people are unable to access government hospitals: a) they are turned away as they are unkempt and have no identity card / proof of residential address b) they cannot arrange for any attendant which is a requirement for being admitted in government hospitals.
- A few good private health facilities are available but are expensive and hence virtually out of reach of the homeless.

In terms of service needs, the survey revealed that the homeless population considered the existing health facilities as far placed in terms of their need; most considered visits to these facilities as unfruitful for want of proper home address or an identity document and lack of support to guide them through the cumbersome procedures; many feared past hostile experiences of discrimination and neglect. Thus, health care has been considered at zero situation for the Homeless.

As expected, HNAS provided an understanding and an insight into the health situation of the homeless which served as a basis for setting up some initial services to address immediate health needs.

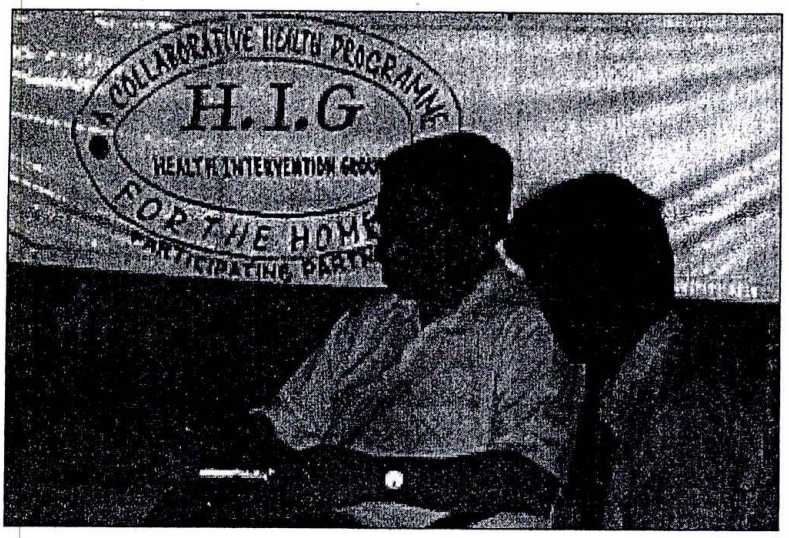
2.2.5 Reflections

The collaborative participants met several times to discuss the kind of health intervention appropriate for the homeless community. During strategic brainstorming by the group, it emerged that any health service for this population would be incomplete without general and mental health aspects being catered to. This necessitated a team of physicians, neurologists and psychiatrists as a basic requirement for the health facility. The homeless people's perceptions of fear, rejection and distance from current health services led to the considerations that the facility would be better utilized if it is made available at an appropriate place and time and being exclusive to their needs it would be accessible to the homeless population all the time for emergencies and would have the flexibility of catering to the most vulnerable of urban poor viz. the homeless.

Initially, advocacy for opening a specific facility for the homeless within the existing nearby government hospitals was considered as one strategy, with the HIGH partners providing medical and non-medical logistical support. Later discussions revealed that in such a scenario the interested and motivated group loses its energies, at least initially, to an uninvolved, already ignorant professional setup. The limitation of service provisions in a government setting would still be persisting and all the more, will not be cost effective.

2.3 Health Intervention Group for the Homeless (HIGH)

Based on the striking findings of the



HNAS mentioned above, AAA, IHBAS, Narcotics Anonymous, Sahara, Youthreach and World Vision decided to form a Health Intervention Group for the homeless (HIGH)[1]. In view of the multi-faceted health problem of the focus population, demanding varied resource inputs, it was decided that a collaborative health initiative would best manage the health issues of this homeless population. In due course of time, Dr. Shroff's Charity Eye Hospital, Youthreach and Delhi House Seva Ashram joined in as supporting organisations. (see appendix 3).

2.3.1 Objectives of the HIGH's Outreach Health Services

The constituent partners of HIGH identified the following objectives for their health outreach services,

- To provide street based free medical services, suiting the needs and priorities, for the general health problems of the homeless.
- To attempt to engage in treatment at the outreach service, Mentally Ill Homeless Persons (MIHP), specially persons with Severe Mental Illnesses (SMIs)
- To provide street based counselling and treatment for homeless substance dependents and persons with common mental disorders.
- To create awareness amongst homeless people regarding their health rights as provided by the Indian Constitution and equip them to access health facilities.
- To sensitise government hospital staff to recognise and respond to the rights of the homeless for medical treatment.
- To develop a referral system between the outreach health service and government hospitals.
- To formulate a database for further intervention and research.

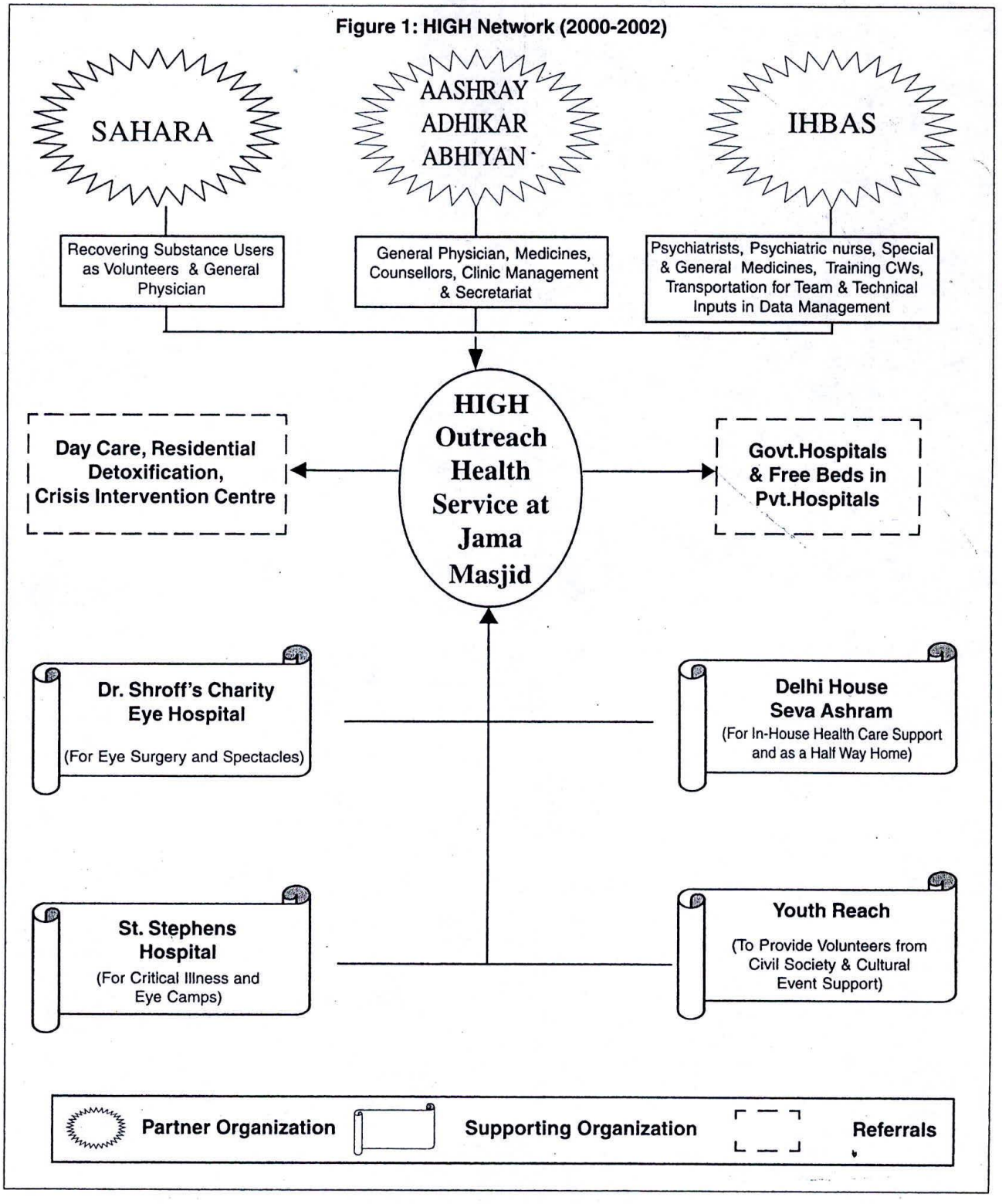
2.3.2 The HIGH Outreach Health Services

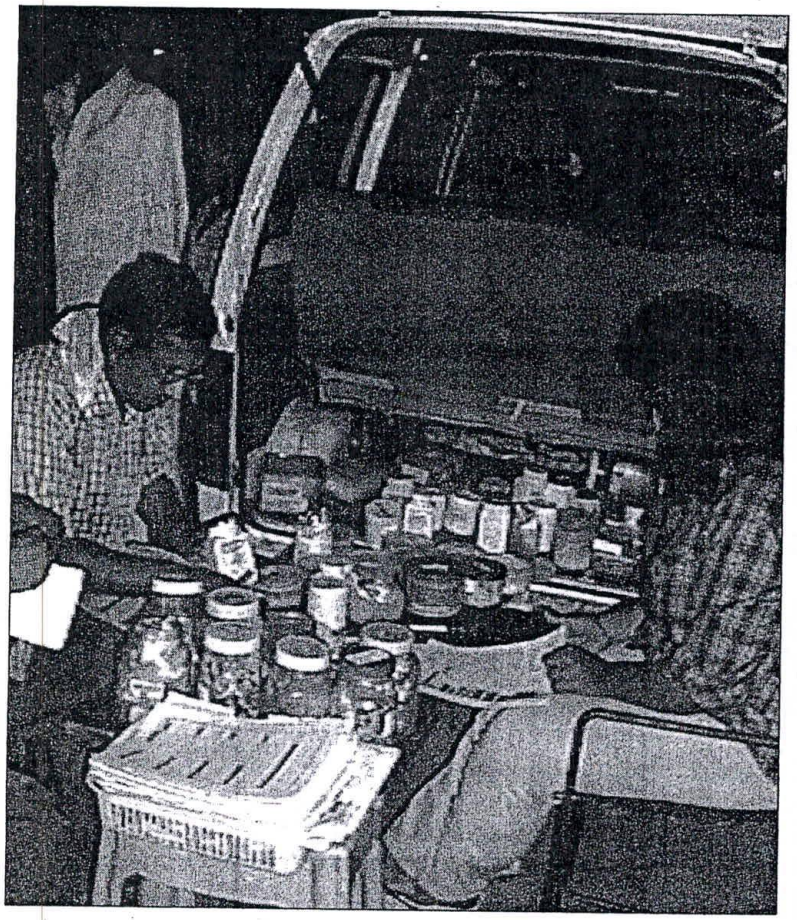
Thus, through a series of consultations among the potential partners, a consensus for the appropriate service facility for the concerned population rested upon starting a Outreach Health Service for Homeless. It was envisaged to be an out patient outreach health service with resources to cater to the health needs of the homeless at their sleeping places. It was also decided that this outreach service would have to be held in the evenings because the majority of homeless work during the day. Just adjacent to Jama Masjid is Meena Bazaar which came to be chosen for the location of the clinic, not only because of the many people sleeping in the nearby Urdu Park but also due to the fact that the Meena Bazaar* Night Shelter was near by and the

[1] After HNAS, the collaboration of health partners was called HIG. It was only in February 2003, that HIG partners decided to suffix the word 'Homeless' to their name. Hence Health Intervention Group for the Homeless came to be referred to as HIGH.

* The Meena Bazaar Shelter was closed in Sept. 2001 by the Municipal Corporation of Delhi for beautifying the area, going by Zafar Saifullah Committee report, and subsequently demolished.

Figure 1: HIGH Network (2000-2002)





findings of the RAS had revealed at the high concentration areas of the homeless people, such as Asaf Ali Road and Yamuna Bazaar were in close proximity.

Initial service limits were decided so as to set at practical level, a minimum reliance on referral for admission to other health agencies, in view of the limited human resources at the beginning.

At a more finer level, apart from location, timing and frequency of the clinic, these issues were considered: free medicines; avoidance of stronger substitution agent than Proxyvon, (Dextropropoxyphene) for substance abuse treatment, for fear of misuse; immediate referral, without local intervention, to manage patients with a clear history of open tuberculosis, for fear of making them reluctant or resistant to more specific treatment and taking local /legal authorities in confidence, for managing severe mentally ill persons.

For better utilisation of the available resources, HIGH partners distributed their work and functions among themselves. AAA agreed to take care of the organizational coordination, publicity, IEC, record keeping aspects of the clinic and in recruiting community workers for capacity building. IHBAS agreed to provide input in terms of medical professionals (psychiatrists and neurologists), medicines for general as well as mental health, training of volunteers on mental health issues and providing the scientific and technical inputs on public health issues. Sahara agreed to provide a general physician and volunteers for day-to-day functioning of the clinic and so did Youthreach with the addition that they would provide volunteers for other activities related to health service provisions for the homeless. Unfortunately, World Vision and members of Narcotics Anonymous were unable to continue their support because of lack of resources and withdrew from the group in January 2001, after completing their commitment of three months.

2.3.3 Pre-launch preparation

It had been decided to launch the Outreach Health Service on 26th September 2000. Publicity and information activities included distribution of about 1500 handbills, one to two days prior to the launch date. The leaflets contained information about the clinic, its timings and purpose (see appendix 4). As many homeless are non-literate, it was decided to spread information about the services and purpose of the clinic through a street play. Volunteers of an NGO "Deepalaya", presented a street play on 26th and 27th

September, 2000 at Meena Bazaar, depicting various health problems and information on the clinic. An initial batch of volunteers were also identified through preparatory fieldwork for help at the clinic and were trained by the AAA team members.

Sensitisation of key local residents, shopkeepers and police personnel had been also started before the clinic actually started functioning. Informing and sensitising the public and opinion leaders in the local area and local government agencies were identified before hand, as part of a constant and ongoing exercise.

On September 27, 2000, an Outreach Health Clinic for homeless people, was started in the Walled City of Delhi, through a clinic based at Meena Bazar. (see appendix 2).

In the two years from September 2000 to September 2002, 220 outreach clinics have been conducted and 4139 patients have been treated.

2.3.4 Services

The priority of providing treatment services for the health problems and the constraints of the service provider teams necessitated an approach of the Outreach Health Service to be one of conducting a "clinic" for providing a minimum package for the homeless populations in the initial years. It is expected that the Outreach Health Services will take on a more comprehensive perspective, including the preventive and promotive elements. The service limits envisaged for this outreach service were out patient treatment of general physical ailments, substance use disorders and other mental illnesses with the underlying guiding principle of providing care on the spot. This means minimum reliance on tertiary care institutions for help. Also, patients needing specialised care including patients with Tuberculosis are encouraged to seek medical help at the specified centres and a minimal or reluctant intervention is provided so as not to enhance avoidance of care at specified facilities.

All emergencies are referred with community volunteers / workers for further specialized treatment at appropriate facilities. If admitted, such patients are always being provided support in terms of medicines and day-to-day help till the patient is medically fit to take his or her own care.

All patients with substance dependence syndrome are treated towards acute detoxification by substitution or supportive treatment technique as the case may be. All patients requiring detoxification for opioid dependence are being treated with substitution therapy in form of Cap. Proxyvon instead of tablet Buprenorphine (Tidigesic). Buprenorphine substitution was considered less appropriate as the conditions were less controllable like OPD setting, and already prevalent abuse of Buprenorphine. It is considered that harm reduction value of Proxyvon is greater in such a scenario.

It also became clear to the medical service providers that for patients with substance abuse disorders, it would be appropriate to extend the length of acute detoxification treatment (from the usual 7-10 days) due to the mobility of the patients in relation to the clinic, OPD nature of the service, harm reduction strategy and motivational factors.

2.3.5 Human resources

The HIGH medical team consists of one general physician, two consultant psychiatrists, psychiatry trainees and one nurse. The specialist psychiatrists and the trainees often function as general physicians in addition to their own role. The orientation and training of the general physician and other health workers, on the issues of mental health and substance dependence, has helped

in their being able to provide these services, if required. The medical team is supported by Community Workers and Volunteers who man a registration counter and dispense the prescribed medicines. They also look after the arrangements for setting up and winding up the clinic, maintaining adequate communication among team members, maintaining discipline, guiding and informing the general public about purpose, scope, services and aims of the clinic.

2.3.6 Timings

The outreach health clinic is held twice a week on every Monday and Thursday at Meena Bazar, Jama Masjid.

The timings are:

5:30 PM to 8:00 PM – 1st October to 31st March (winter)

6:30 PM to 9:00 PM – 1st April to 30th September (summer)

This timing was kept to cater to the specific needs of the homeless people as during the day most of them are busy earning/arranging their livelihood. This health outreach runs twice a week in order to enhance the contact of the homeless with the medical professionals so as to keep the motivation for abstinence high in persons seeking substance abuse treatment and to minimise misuse and the large loss of medicines that may occur if prescribed for a longer period of time. This helps in ensconcing the faith in the minds of the homeless that help was available very close-by and frequently and there was no need to pass through an agonizing wait in case of any need or emergency.

2.3.7 Registration

Registration is done at a registration counter positioned at a distance from the consultation area in order to avoid disturbance. All registered patients are given a registration number, a patient record is made and s/he is handed over a registration card bearing the date and number of registration. All patients are provided with a card bearing the registration number in a plastic ID card holder and asked bring the registration card at each follow-up. No patient of substance use disorders is entertained without a valid registration card as the same is made at the counselling sessions held each Wednesday. Any patient reporting after registration timing is requested to attend the clinic, the next OPD day. Emergency, if any is looked into and if needed, help is provided immediately as also further medical care.

During the later part of 2002 and early 2003, all patients with substance use disorders were requested to bring four photographs before being registered at the clinic. One photo is attached to the centralized record register, another on the daily registration book, third photo is pasted on the patient file and the last on the registration card given to the patient. The patient is also required to ensure regular attendance at the weekly experience sharing meeting held on each Wednesday between 7 to 9 pm in summer and 6 to 8 pm in winter at Urdu Park, Jama Masjid.

The above mentioned measures were added as a precondition for registration and follow-up of all patients with substance dependence in order to minimize misuse of medicines, duplication of records through re-registration, inculcating discipline and increasing chances of treating patients with high motivation and preventing or minimizing functional and financial load on the system.

To ensure only homeless people access the health clinic, all patients at the time of registration are asked about their place of sleep. Homeless community workers are also asked to identify people who are not from the homeless community.

2.3.8 Medicines and Dispensing

All the medicines to the patients are provided free of cost for a period of three days following Monday OPD and for four days following Thursday OPD. IHBAS and AAA provide resources for procuring monthly medicines for the patients. IHBAS provides specialised psychiatric medicines for mental health and also essential medicines for patients with general ailments. Any medicine prescribed by the doctor, if not available at the clinic dispensary, is purchased and made available to the patient by AAA. At present, a qualified nurse is supervising dispensing activity of trained supporters/workers/ volunteers at the clinic dispensing counter.

Each dose of the medicine prescribed is explained to the patient at two levels. First, by the clinician, while providing consultation and then, at the dispensing counter by the supporters/workers, while handing over the sealed medicine pouches. The pouches are made up of transparent vinyl plastic for easy identification and secure storing of medicines at patients end. The pouch carries a sticker on which the prescribed dosage is noted for the patient. The dosage is depicted in symbols instead of numbers (00-0-000) for the convenience of non-literate patients. All medicines given to the patients are dispensed without their original packaging in order to minimise chances of the medicine being sold off and prevent misuse by not divulging the identity of the medicine, particularly for patients of substance abuse.

The prescriptions are kept with the HIGH staff because homeless people have no place to keep them. The prescription is recorded in the patient profile card. A list of medicines used by the HIGH clinic is appended as appendix 8. Most of these are commonly used medicines for general health problems such as those mentioned above. However, a few specialised medicines are included for patients suffering from mental illness.

2.3.9 Infrastructure

Following infrastructural resources have been made available by HIGH Partners for the Outreach Health Clinic:

- A van for storing and dispensing medicines.
- Banner with the name and purpose of the clinic
- Seating and lighting arrangements for the doctors, patients, registration and dispensing counters.
- Basic medical equipment like stethoscope, BP apparatus and Otoscope etc
- Water proof tent in order to run the services on rainy days. (see appendix 9).

2.3.10 Public awareness exercises

During each clinic a banner depicting name, purpose, scope and services of the clinic is displayed. This seeks to inform the general public about an unusual activity taking place on the street. Apart from this, the clinic organisers and supporters/workers are always available for the more curious bystanders to answer their queries. This is a constant and on-going activity at the clinic and helps avoid interference in the functioning of the doctors and facilitates disciplined OPD functioning.

The other aspect of awareness involves making local residents, shopkeepers, policemen, politicians, government representatives, local agency officials aware of the activities of the Outreach Health Service. This helps in avoiding day-to-day inconvenience caused by festivals, rallies, processions and other stray instances which may hinder the clinic's functioning. It may be noted that appropriate relocation of the clinic under such circumstances has been possible due to these awareness activities.

Box 4.3

Functional difficulties

From time to time, HIGH team has experienced some harassment from the police. In one incident, a police officer tried to expel the drug de-addiction sharing session from the Park.

The clinic was also stopped from entering Meena Bazaar because of a recent High Court directive to clean up the area around Jama Masjid. The venue of the clinic was shifted from Urdu Park gate to the adjoining Plaza of Maulana Abul Kalam Azad's tomb (just opposite to the prior location). Later, through the intervention of the Joint Commissioner of Police, the clinic was allowed to be operational in the area. Even then, during Id, the clinic cannot be set up, as temporary markets spring up around the area.

B. Weaknesses

(i) Logistics

The non-availability of a laboratory facility, ambulance services, drinking water for the patients.

(ii) Community Participation

Participation of patients in the management of the clinic, was felt to be low although this was not blamed on the clinic team, but on the patients as one patient observed "*we come only when we require medicines.* Another patient said, *"the problem is with us and after getting treated we don't come back".*

(iii) Reaching out to the poor

Limited extent of out reach to the needy ones (as explained in chapter 3) were reported to be one of the weaknesses.

(iv) Follow-up

Almost a third of patients come back to the outreach for a follow-up session with the doctor although this figure reduces by half for each further follow up. In chapter 3 follow-up rate is reported to be poor which needs to be worked upon.

(v) Specialist Doctors

The participants said that too many people with dental, gastroenteritis and eye problems come to the clinic, therefore, the services of specialist doctors e.g., a dentist, etc, are very much required (also see **suggestions**).

(vi) Effective Referrals

The second lowest score was given to hospital referrals, though participants stressed the need for having some provision which can help in admissions to hospitals. Patients are referred to various hospitals in Delhi, if they are very ill or doctors think they need further tests to diagnose a problem. In discussions with patients, it was revealed that while hospital referrals for OPD treatment such as x-rays, sputum tests, etc. were successful, hospital admissions was a difficult task (also see **suggestions**).

"Still when we are referred from here then we get better treatment in the hospitals and we are given medicines which were not available before". A patient at the HIGH Clinic.

Even with facilitation by AAA, hospital admission without family support, especially for mentally ill homeless people, is almost impossible in-spite of Health Outreach providing attendants. (As shown in Box 4.5).

C. Suggestions for Improvement

"The clinic should be advertised more by distributing pamphlets, posters and keeping a banner or board fixed at this place". A patient's observation at HIGH Clinic.

i) In the second round of PRA, the participants stressed that an ambulance should be made available so that the needs of emergency patients are met. Though HIGH acknowledges the need for an ambulance, no headway till now is possible due to resource constraints.

ii) Duration of health outreach needs to be extended by half an hour.

iii) A small laboratory / testing facility for

doing routine examinations like blood, stool, urine etc. at the health outreach should be provided. If it is not possible to have a testing facility, at least an arrangement with a laboratory or government hospital be looked into whereby samples could be collected from the outreach clinic and subsequently the report be given to doctors at the clinic.

iv) Some monetary incentive to be given to the homeless people especially elderly to encourage their involvement in the management of the clinic.

v) In order to enhance user participation, fortnightly/monthly meeting with patients preferably on Sunday should be organised. The participants assured that if HIGH partners take the lead, they were willing to provide their full support especially in terms of logistical support as they have benefited from it immensely.

vi) A 'Grievance Redressal Committee' of the patients should be set up to look into the complaints of the patients.

vii) Traditional / basic knowledge to prevent health problems should be provided to the homeless community through volunteers.

viii) The services of specialist doctors e.g., a dentist, etc. need to be arranged.

ix) Ambulance should be made available to meet the needs of emergency patients.

x) Small group of attendants/volunteers should be formed to attend to the needs of hospitalised cases.

xi) One patient suggested that the clinic should be advertised more by distributing handbills, posters and keeping the banners or boards fixed at the place of clinic.

Box 4.4

Accessibility to Health Care Services

According to the patients, HIGH health outreach is the most accessible to homeless people, followed by Sheeshganj Gurdwara because it treats people from the footpath, the service is free, it sends an ambulance if needed and even provides food and tea. They further said that the Gurdwara provided a good first-aid and dressing service, however, they added that the drugs distributed were limited and ineffective.

The patients seeking treatment at Guru Nanak Gurdwara's (Charitable Hospital) dispensary liked the doctor's attitude. But complained that one has to wait for 2-3 hours before getting treatment, whereas it just takes ½ -1 hour at HIG health outreach clinic.

LNJP, a government hospital was considered inaccessible because the doctors refused to treat homeless people whereas in Civil Lines Hospital the treatment by doctors was considered to be good but it was too far away. Patients said that MCD clinic costs money and that the medicines given by the MCD clinic in Kashmiri Gate were not effective. Quality of medicines given by charitable clinics were also deemed to be poor.

xii) Drinking water should be provided at the outreach for weak and acutely sick patients.

4.3.2 Evaluation by Patients with Substance Dependence

Substance dependent patients were separately asked to score the effectiveness of the drug outreach including the sharing/ counselling sessions and the drug de-addiction programme, against the indicators they had identified during the group discussion (refer to Appendix 14, Table 2).

A. Strengths

Motivation for Treatment	*Score*
Free Medicines	10
Good Medicines	10
Meetings/ Sharing sessions	10
Information/ Knowledge	7
De-Motivation for Treatment	***Score***
Smack Use	10
Engagement in Work	9
Other interests/ entertainment	2
Greed	2

exists, e.g. Sahara Day Care Centre. They further remarked that it is ideal to have a 24 hours care facility for homeless drug patients. However, Counsellors pointed out that during sharing sessions they do talk about other residential options for detoxification such as Sahara House, Navjyoti and Asha Bhavan (also see **suggestions**).

C. Suggestions for Improvement

i) Sharing Sessions

Overall suggestion for making the outreach service more effective, the group suggested that the sharing sessions should be on daily basis. The time of sharing session should be increased, which would divert their

Box 4.5: AAA's Stressed Night Out!

In the dead of the night, 2.30pm, AAA van enters Chandni Chowk area and comes across one young man standing in the middle of the road. Ranjan, (21years of age) stands with a handkerchief tied on his face (covering his eyes), exhibiting martial art poses. The AAA team succeeds in getting Ranjan to the side of the road in spite of his (obvious) mental instability. Thereafter, the AAA team approaches the nearby police station so that Ranjan could be admitted to a hospital. We tried hard to convince the Police to accompany us. They refused, we then asked them to give a written statement about Ranjan. After initial resistance, the police finally agree to give a written statement on Ranjan being found in an unsound state. By 4am the 'drama' in the police chowki ends and AAA team along with Ranjan heads for LNJP hospital.

At LNJP the doctor asks the AAA team to take Ranjan to LHMC/ S.K. Hospital as LNJP has no psychiatric ward. Hence Ranjan is taken to LHMC where a doctor examines him and refers him to IHBAS. Meanwhile, Ranjan is administered sedatives to calm him (as he becomes a little violent).

By 5.30 am AAA team brings Ranjan to IHBAS. The doctor in-charge refuses to admit Ranjan without the Metropolitan Magistrate's (MM) order. He asks the AAA team to call Police Control Room (PCR)/ No. 100 so that the police would arrive and handle the case. So AAA members call 100 and wait for the police van. In spite of repeated calls and assurances given by the PCR, no police van arrives till 9 am. When the wait turns futile, at 9.20am AAA team takes Ranjan to the Dilshad Garden police station. The Investigating Officer (IO) tells the AAA team to take Ranjan to Chandni Chowk police station as he was found there. This time AAA team calls up Mr. Amod Kanth, Jt. Commissioner of Police, seeking his help. Mr. Kanth asks the IO to help the AAA team in admitting Ranjan in a hospital while doing the needful. Therefore, the IO and the AAA team along with Ranjan leave for Karkardooma Court for the MM order.

By 10 O'clock they reach the court. The IO already enters the concerned MM chamber while AAA team struggles to bring Ranjan to MM's court. On returning the IO tells the AAA team that the MM had directed them to take Ranjan to the Chandni Chowk police station. Feeling that justice had not been done, AAA team decides to challenge the 'unheard' decision and represent Ranjan in the court immediately. Hence, they take Ranjan to MM court room and Mr. Indu places the case, giving details of Ranjan's precarious conditions and the 'torture' he had to undergo all through the night. The MM decides in favour of Ranjan, instructing the IO to get Ranjan admitted in IHBAS after writing an application to him for the same. By the time the IO completes his application, the MM moves to the BSES (Bombay Suburban Electricity Supply) office nearby. So, 2 members of the AAA team and the IO go to the BSES office and get the application signed from the MM. In the event, the MM asks the AAA team to first visit GTB hospital to get the opinion of 2 psychiatrists before admitting Ranjan in IHBAS.

At around 12 noon, Ranjan is brought to GTB hospital. By the time the papers are readied, the psychiatric ward closes at 12.30pm. The case is therefore referred to Medicine ward, room no. 259 on 2nd floor. Ranjan finally finds a bed and AAA team assigns John as his attendant. At 3.15pm the AAA team, except John, leave for home. But, the story does not end here. At 4pm John makes a call to Mr. Indu, informing him that Ranjan has been discharged from GTB hospital. Mr. Indu calls up Dr. Nimesh Desai and tells him about Ranjan. Dr. Nimesh suggests that the Chief Medical Officer (CMO) of the Medicine ward, GTB hospital should make a referral in order to facilitate Ranjan's admission in IHBAS. By 6pm, the formalities are completed and Ranjan is taken to IHBAS. At 7.30pm Ranjan is finally admitted in the Emergency ward of IHBAS. And he is again administered sedatives to calm him and that he may get some rest.

But, will Ranjan's soul ever rest, although he may get a physical calm? He may be quiet, not speaking of the 'ordeal' he underwent through the hands of his fellow men and systems of his motherland. But, his soul will cry out in pain! and it will pain the hearts of all who are human. And how long will it cry...only time will tell.

P.S. - Ranjan remained in IHBAS for one and half month, for about a fortnight in our office, and then in Delhi House for a month. After that he came back to us in November 2002 and told us that he wanted to leave and work. Ranjan came back again in January 2003. He is working for marriage parties nowadays. We have told him that in case of any problem he can come back to us, anytime, he wanted to come. He visits the HIGH clinic to tell us that he is fine.

– Zaved Nafis Rahman, Project Officer with AAA

mind from their addiction and help in attaining greater self control. Another suggestion to divert attention was to have sessions on meditation.

ii) Prescription of Medicines

Some patients, suggested that a person who had been taking drugs for a long period of time should be given a higher dosage of medicine for a longer period but currently doctors are providing medication at the same dosage as those newly addicted to drugs.

iii) Hospitalisation

The participants recommended that hospitalisation should be for a period of 15 days as a person cannot leave drugs while living on the pavement.

iv) Day Care Facility

There should be some programme for the whole day. A camp in the daytime should be organised where people are asked to work so that they don't have time to take drugs. There should also be provision for food and if the person can be paid some amount for his work, it will be an added advantage and act as an incentive to come to such a facility.

v) Sitting Arrangements

Some of them suggested that plastic/ tarpaulin sheets could be used during the rains.

4.3.3 Evaluation by the HIGH team

Simultaneously, when PRA was being held with General health patients and substance dependents, the HIGH team (Doctors and Community Workers) as well as other stakeholders (heads/ coordinators of partner organisations) also sat down separately to assess the effectiveness of the clinic using Participatory Reflection and Action (PRA) methods.

The exercise proved helpful in finding how the service providers rate their work. Also how close or different is their rating / perception vis-à-vis the Homeless i.e., general ailment patients, substance dependent patients and psychiatric patients.

A. Strengths of Outreach for Patients with Substance Dependence

Like the patients, HIGH team, too was satisfied with the punctuality and regularity of the team, frequency and accessibility (except in cases of female patients) of the clinic, quality of medicines being provided at the clinic, punctuality of the HIGH team and relationship between HIGH team including doctors and the patients. But in the year 2002, doctors felt that the HIGH team inclusive of community workers became less cordial with the patients as compared to the previous year.

CWs emphasised that services of specialist doctors are not required, if the referral system is improved.

ii) Location of the Clinic

Doctors remarked that the place of health outreach is fine but for community workers the place is not suitable as there is a lot of disturbance from various on lookers.

iii) Awareness of Existence

Some of the doctors had given 10 points saying that there is considerable awareness of the HIGH amongst the homeless in Jama Masjid area and patients are also coming from other areas like Nizamuddin and Yamuna Bazaar but still awareness about this facility needs to be created among the homeless.

iv) Basic Medical Equipment

The medical equipment already present in the clinic is adequate.

v) Appropriate Timings of Registration and Clinic

The patients are registered for an hour from the start of the clinic. The timings of the clinic (6pm-9pm) are appropriate in the sense that it suits a majority of the homeless. But the participants also felt that the clinic could cater to more patients.

vi) Adequate Composition of Staff

The present composition of clinic team was appreciated well. Still there could be more doctors involved and the management staff could also improve in terms of quality. Also, other medical professionals could be approached to contribute voluntary services.

vii) Voluntary Participation of Locals

The doctors remarked that participation of locals is present in the form of support from the local market association. However, the participation could improve through increased awareness, creating volunteers, and having friendly staff at the clinic.

"For the last 19 years, I used to see people sleeping here on the pavements, taking injections, being beaten up by the police and by other people. I thought if I would be able to contibute even a little bit to their betterment, I would be very happy".

Abdul, a Volunteer at HIGH clinic living at Jama Masjid area

B. Weaknesses of the Outreach for Patients with Substance Dependence

i) Logistics

The doctors felt that the team is motivated, able to handle patients well and establish rapport easily. However, improvement is possible in the registration of patients/ filling in complete data/ distribution of drugs/ taking patients to hospitals/ bringing patients to the clinic.

As per doctors and CWs, the facilities were satisfactory. Few of the infrastructural deficiencies at the HIGH were listed as follows:

- No drinking water facility for patients
- Inadequate Lighting
- No protection from the cold for patients in winter
- No benches for patients who cannot sit on floor.
- Disturbance during the festivals and due to government orders
- A bigger mobile van is required

ii) Shortcomings involving the team

- Time spent by doctors is less
- The exercise of running the clinic has become mechanical and monotonous. Motivation is falling and insensitivity seems to be creeping in.
- One to one relation between the doctors and patients is missing.
- Lack of knowledge amongst the patients / the homeless about the possibilities of their participation.
- The HIGH team is not really focusing on involving the patients.

iii) Audio Visual Aids for I.E.C (Information Education Communication)

The participants felt that no audio-visual medium is being used for generating health awareness amongst the homeless.

The group felt that whatever awareness the HIGH has been able to generate is through its own goodwill.

(iv) Need for Expansion

The participants felt that HIGH has not expanded according to its potential. They listed the following as areas of expansion:

- Number of staff.
- Availability of doctors, i.e. doctors with different specialisations.
- Expansion of the clinic to other places.
- Composition and quality of staff.
- Participation of local community

(v) Regular Monitoring by Community

There is no real monitoring by the homeless community of the HIGH. There are only few instances when people have come up to give their feedback about the clinic. According to the participants, monitoring will happen when homeless become a part of the clinic operations.

(vi) Referrals

The participants felt that referrals have worked only sometimes and no mechanism has been created to facilitate the referral of patients to hospitals on a regular basis. Some participants gave the example of Dr. Shroff's Eye Hospital and Sahara, which have responded positively to the HIGH referrals while the referrals to LNJP have not always been entertained.

Reasons for Not Visiting Hospital	*Score*
Patient's belief system	9
Long and cumbersome procedure	8
Long queues	2
Due to distance	2
Fear of being insulted	1

Box 4.6

SILVER LININGS

Shanti is 35 years of age and has been an addict since 1984. She is a divorcee with two children – a boy aged 15 years and a girl of 4 years. When Shanti was 17, she got married to a rickshaw puller who was an addict and was the first person to introduce her to drugs. He used to force her to take drugs and soon she was addicted. Her husband got involved with another woman, Shanti was unable to take in all the ill treatment by her husband and decided to leave him.

Life was difficult – unable to make ends meet with rag picking, she started working as a domestic help. Presently, Shanti stays under a tree in Jama Masjid. Her sister takes care of her children. Shanti cannot keep her children with her as she is required to go to work and she fears for their safety. She wants to send her daughter to a hostel because she fears that if her daughter stays in that area she may get sexually exploited.

About the Drug De-addiction Outreach Shanti says, " I came to know from the people living here that doctors are good. I did not believe them but I thought there was no harm going there once. I am taking the medicine for past three months and find it helpful. After attending sharing sessions, I feel if they can leave drugs, why can't I?

Interview with Rimmy, ActionAid, Delhi on 25th March. 2002

The drug counsellors stressed the point that no referral facilities exist for patients with substance dependence.

HIGH staff also pointed out that referrals for TB patients were not successful[1]. DOTS centres do not accept homeless people. This has serious implications for homeless people with TB as they could die without treatment (see Box 8).

The TB centre does not accept people from here. If we go there they ask for a ration card or some Netaji's (political leader's) signatures. Many people come here coughing, we know who all are suffering from T.B., but they are not admitted to the centre. They don't even

1 TB medicine must be taken on a regular basis for an extended period of time. If a person fails to take TB medicine s/he can become resistant to the medicine and if a relapse occurs, treatment becomes very difficult. The World Health Organisation has developed a system called the Direct Observation Treatment System (DOTS), whereby a TB patient is required to attend a TB clinic three times a week and take the medicine in front of health workers. If the patient does not come to the clinic, health workers are required to visit their homes. This system ensures that patients take their medicines and do not become resistant to the disease.

Box 4.7

SHARING AND CARING

As a counsellor here at Urdu Park, Jama Masjid, many substance dependents come and talk to us. We have to keep in mind what kind of addiction s/he has, how s/he can recover. We try to explain things to them. We tell them our life story in the hope that if we can do it, why can't they. Many who come here also take injections, we tell them about HIV/AIDS —the disease and its implications. What makes our task more difficult is that the homeless people who attend the sharing sessions by and large have psychiatric problems besides addictions.

Prem Kamla, drug de-addiction counsellor from Sahara

Box 4.8

Going Down Memory Lane

On May 5, 2001 weekly sharing session with drug users was started in Urdu Park near Jama Masjid. Initially, the number of substance dependents attending the Wednesday session was less but slowly and steadily it started growing. Not only people from the Jama Masjid but far flung corners of Delhi started coming. The drug addicts started realising that this sharing helps them in improving their life. Through this sharing process, the substance dependent individuals' realised how they abstain from drugs forever and why they should refrain from same.

My experience says that sessions also proved fruitful in improving the strained relations of substance dependents with their family members, children, relatives, friends and society. Many drug addicts who had lost jobs started getting jobs and thereby were again gainfully employed. Some of the substance dependents, who were from other states than Delhi, went back to their homes. And those who belonged to Delhi continued taking benefits of the sessions while having integrated with their families. Also, they were an invaluable support in explaining to the new substance dependents the benefits of sharing session.

There have been some bitter memories as well. Some substance dependents quit drugs after having gone through sharing sessions but relapsed. Most of them have come back to the sessions and seemed to acknowledge that they have been unable to imbibe or assimilate the insights gained through sharing sessions in their life. Inspite of the malaise they find themselves in it is heartening to see them come back to the sharing sessions with renewed vigour to overcome their substance dependence.

It is also noteworthy that occasionally, due to some event at Urdu park we had to do the session in some other location. But it was not ever cancelled, probably because substance dependents don't want to be deprived of the benefit.

Babla - Drug De-addiction Counsellor in October 2002

give them the forms". — Amir Khan, a Supporter at HIGH clinic

vii) Sensitising Key Persons

The doctors were of the opinion that there is a need to identify opinion leaders and start the process of sensitising them. This should also be in the agenda of policy level meeting of the partner agencies comprising the HIGH.

viii) Need Oriented Services

The doctors said that 70 percent of the time the needs of the patients are known, hence the clinic is very much need-oriented. But it can improve. Also, it is important that the services provided at the HIGH clinic are updated/ enhanced according to the feedback from the patients particularly regarding the referrals.

ix) Laboratory Testing Facilities/ Minor Surgical Items

At present there are no surgical items and arrangement for a testing facility at HIGH clinic is lacking.

C. Suggestions for Improvement

i) Coordination Among HIGH Team Members

To have better coordination, the CWs expressed the need to have regular meetings at least twice a month.

ii) Free of Cost Treatment

The doctors as well as CWs stressed that nothing should be charged from the homeless. A suggestion was made that there can be a donation box at the HIGH clinic. Volunteers/Supporters / CWs should talk about the donations[2] to various on lookers.

iii) Criteria for Registration

There should be criteria for registration and treatment and people in distress should be encouraged to attend the clinic.

2 During the PRA with homeless patients, some of them had said they would be willing to pay for the medicines.

iv) Referrals

- Identifying medical professionals in government and private hospitals/ clinics and motivating them to take up cases
- Talking to the concerned professional and seeking his/her commitment in advance.
- List of referrals of nearest places and tie-up with them
- Make sure the patient reaches the right place
- HIGH Staff emphasised the need for more volunteers (ready group of attendants) especially for taking patients to hospitals for referrals or follow-up treatment.

v) Sharing Session

- There should be education on common illnesses in the meeting
- Feedback should be shared with doctors
- The frequency of the meetings needs to be increased.
- Continuous sessions should be held for six days with different groups
- In addition to discussion, there is a need for some kind of action
- Sports and more creative engagements should be introduced
- To ensure one to one counselling, there should be an additional counsellor
- The sessions should be longer so that patients would be kept busy and have no time for drugs
- Counsellors agreed that the sharing sessions would be more effective with one to one counselling sessions and that activities such as games and sport would be good group building exercises
- Counsellors complained that there has been very little time for individual counselling and suggested more frequent sharing sessions or 'camp' type sessions which would be more intense and continue for about six days. Doctors suggested a day care centre where there could be different activities.

vi) Basic Medicines

- The supply of medicines could be increased.

Box 4.9

Recovery from addiction

Slowly I got addicted to alcohol and became an alcoholic. Under its influence, often I used to get into huge fights with people. In the meantime, I became friendly with a person who used smack and he told me that if I take smack I won't get into fights with people. Then I started using smack and got totally hooked to it. It became very difficult to get rid of the habit and to come out of the mire. I started living and sleeping on the streets in Yamuna Bazar.

Then one day I met Sirji (Indu Prakash Singh from A.A.A)at 2:30 am in the night. I told him about my problem. He asked me to come to Jama Masjid on Wednesday, if I want to get rid of addiction. I went to Jama Masjid on Wednesday; attended the sharing session, then Babla Bhai (DrugDe-addiction Counsellor) made out a card and gave it to me. From Thursday, I started with the medicine: it helped me a lot. When I took the medicine regularly, I got rid of my addiction to smack.

A strong fear lingered that as long as I stay in this environment, I could get addicted to smack again. So I asked Babla for help. Then Babla directed me to the daycare in Madangiri; Bus No.419 used to take me there. I stayed there for the whole day, and returned in the evening after attending the Narcotics Anonymous (N.A) meetings. I used to come to Chandi Chowk, and sleep on the footpath near the Gurdwara or in Yamuna Bazar or somewhere in between. But I vowed to stay away from drugs. After one week of participation at the Day Care, attending the N.A meeting and returning to Chandni Chowk, I was sent to Sahara House. I stayed there for about five months. Then I got work as a volunteer in the HIGH project. I help people staying on the footpath and what I like most is where before I had to stand in line to get medicines, now I sit there on a chair and distribute medicines, make the cards for the people, etc. I like doing this a lot.

Attending the N.A meetings and the Wednesday sharing session regularly at Jama Masjid provided me the means of getting rid of drug addiction. Now, I would like to share my experiences with other substance dependents on how I kicked my habit. I will try to build their confidence by sharing my experience with them. Also I want to help serve the people in HIGH and others too – Manoj

Manoj is now full time community health worker with Aashray Adhikar Abhiyan

- New types of medicines especially antibiotics and anti TB treatment could be introduced after discussion on common requirements.
- Provision for dressing should be made available

vii) Doctors

It was suggested that only those doctors should come who are familiar as well as regular to the HIGH operations.

viii) Registration at the Clinic

CWs suggested that registration should be done in Hindi. They end up taking out wrong patient cards sometimes.

ix) Awareness about the Clinic

- In order to increase the awareness about HIGH among the homeless and other sections of society, the following methods were suggested such as use of banner at the sight, making announcement, increased interaction with the patients and increased more involvement of the patients in the management of the clinic. Also, the waiting time of the patients can be used for information dissemination on health issues, motivating the patients to bring more patients to HIGH clinics, use of role models e.g. recovered patients in the clinic for sharing information. Paramedical staff should spend more time with patients for rapport building. The team needs to be more sensitive to the needs of the homeless. Time spent with the doctor needs to be more.
- There is a need to cater to wandering mentally ill persons. This will enable the doctors to examine a variety of patients and reduce monotony.
- The HIGH must be equipped with trained and competent staff. They should be sensitised so that the misconceptions regarding the homeless are removed, and they handle the patients well
- There should be a dedicated and a constant team of doctors for the HIGH. There are people who have reservations about dealing with the homeless or going to the community but they are forced to go. *If things are forced, it is de-motivating.* Therefore, a separate team of doctors from IHBAS or Sahara should be exclusively for the HIGH
- The changing or shifting of staff or volunteers in the clinic should be avoided as the new ones are usually unaware of the conditions of the homeless and it is likely that they work with a negative attitude, which is inappropriate. Even if a change is necessary, the new comers should be oriented to the situations the homeless face and the functioning of the HIGH
- Some of the participants suggested that the old doctors could sensitise the new ones. Moreover, there could be a sensitisation mechanism in the respective hospitals. Also, general workshops on homelessness/ AAA activities could be conducted with all doctors in IHBAS or elsewhere
- The involvement of AAA staff with the homeless patients needs to improve. It has gone down as compared to the previous year. Also, the community workers need to have meaningful interactions with the homeless patients than just following the routine.

x) Basic Medical Equipment

- Facility for examining patients. e.g. instruments like ophthalmoscope, etc
- Folding screen to enable doctors to examine female patients and patients with sexually transmitted infections (STIs)

- Stretcher
- Testing facilities at the clinic.

xi) Audio Visual Aids for I.E.C (Information Education Communication)

- Use of posters on health education
- Policy level discussion on finding ways to use audio visual IEC.

xii) Trained and Competent Staff

Number of Supporters and Community Workers to be increased, they should be trained especially in follow up.

xiii) Appropriate Timings of Registration and Clinic

The patients are registered for an hour from the start of the clinic. The length of time for registration of patients at the clinic may be increased. This depends on the number of patients being turned down on a daily basis. However, the increase in the registration should be accompanied with an additional staff.

xiv) Dressing Facilities

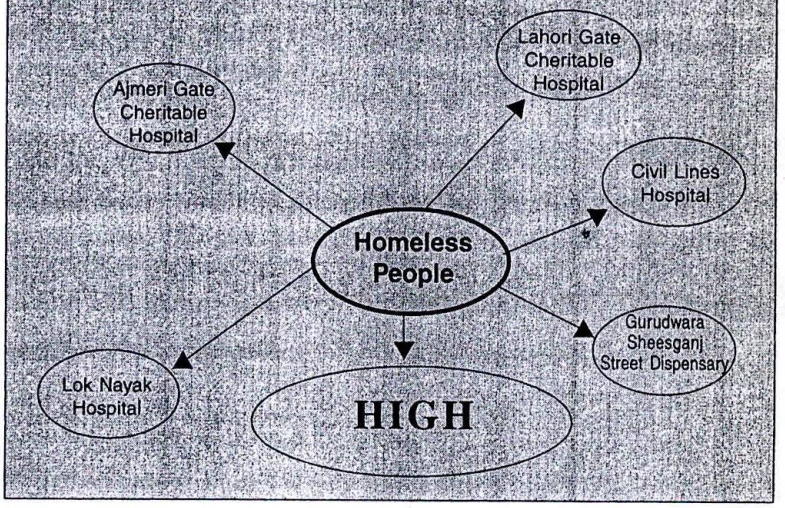
HIGH staff suggested that to improve the services available, basic first aid should be provided e.g. simple dressings and preventive health education for common illnesses could be undertaken.

4.3.4 Evaluation by Heads and Coordinators of Partner Organisations

The coordinators as well as the heads of the partner organisations met in December 2002, the last day of the PRA. The purpose of meeting on the last day was to know their views and also to appraise them about the findings of the PRA exercises done with stakeholders so as to finalise a plan of action for the smooth functioning of the clinic and determine a future course of action. It was also to ascertain what the grey areas were which as heads of the partner organisations they felt needed to be checked or improved upon. The process of exercises was similar as with the others and they came up with indicators along with their scores.

Box 4.10

Accessibility of Health Care to the Homeless People in and around the Walled City of Delhi



Length of arrow indicates accessibility

Once the self evaluation had been done, the findings of the Participatory Reflection and Action (PRA) done with general patients, substance dependents and HIGH staff (Volunteers, Supporters, Community Workers as well as doctors were shared with the partner organisations. Interestingly, the evaluation scores were very similar.

Like other stakeholders, this group of participants in PRA were satisfied with the consistency, punctuality, easy access and utilization of the clinic. Regarding some issues of concern like involvement of community, poor rate of follow-up, referrals to the government hospitals, good relations between doctors and patients, participation of the community, there had been a general feeling that they need thorough planning and immediate redressal.

All agreed that three factors namely credit sharing, transparency and mutual sharing are the key factors which have kept HIGH going for three years despite having problems. The heads of the partner organisations also felt that these three factors should also be a key to future collaborations.

A problem area that they encountered was since there was no point of reference, as no other model of this nature existed, framing a policy was difficult. But the experiences of the past three years and the wisdom gained thereon could now help in formulating a policy. This will also help in the future expansion of work at HIGH and enable other organisations to follow this model. The partners reiterated that all of them apart from AAA (since AAA is already working on this) would also like to play a more important role in the health advocacy for the homeless. They all agreed that AAA is playing a very important role in advocating the health cause of the homeless but in some areas where they are facing difficulties partners could help/assist in finding solutions. This is not happening and sometimes partners feel left out of the whole process hence it was suggested that there could be an information pool which can solve many of the existing problems. The forum for sharing all relevant information was considered to be the monthly meetings.

5 Future Horizons: Carrying the Initiative To Completion

The future course of action has been discussed among the partners from time to time and especially at the time of PRA exercise at the end of two years as well as during the routine process evaluation exercise in the third year. The course of action thus identified involves many levels of programmatic and conceptual tasks, as described below. It is clarified that the identified course of action provides a broad and flexible template, which will require being adapted from time to time. The intent crystalised and expressed in this chapter should be possible to fulfill, if the cooperation and assistance due from the multiple agencies involved can be ensured.

5.1 Improvement in the functioning of the clinic and the services

As part of an ongoing process, the effort to improve the functioning of the clinic and the services, in terms of the logistics as well as the programmatic elements continues. The PRA exercises with the users of the service has provided insight into some aspects of the functioning which required to be improved. For example the need for better waiting facilities and privacy for medical examination. The insight about the programmatic elements have been obtained from the PRA exercises with the service providers as well as with the users. The need for minimal diagnostic laboratory facilities have been emphasized by both the service providers and the users, while the need for additional medical equipment, and some more specialist doctors specifically in pediatrics and dentistry, was approved by the service providers.

5.2 Fulfilling the Service Gaps

The initial period of two years has provided some minimal health services, but quite understandably there have been some important gaps in the services. These have been identified though the ongoing process evaluation over the initial years as well as the PRA exercises. The efforts made in the initial years for fulfilling these gaps, have not been very successful due to various reasons. These are enumerated here with the possible strategies for fulfilling these gaps. The possibility of correcting these gaps will depend on the extent to which cooperation and facilitation will be possible, to be achieved from various agencies.

5.2.1 Treatment of Tuberculosis

Amongst the respiratory system illnesses, which form the largest group of health problems seen at the outreach health service, many of the infections have been possible to treat effectively at the street level, but effective and sustained treatment regimen for pulmonary tuberculosis has been difficult to be implemented. The technical and administrative difficulties in obtaining a DOTS center at a non-hospital specially at the street level have been attempted to be overcome, without success. The possibility of building a liaison with one of the supporting organisations viz. the St. Stephen's Hospital is being explored. The fact does remain that the service gap in treatment of patients with tuberculosis

remains, and requires to be effectively tackled.

5.2.2 Initiating Treatment for Mentally Ill Homeless Persons (MIHPs)

As outlined earlier, although identified as a health service need from the outset, the task of initiating treatment for the Mentally Ill Homeless Persons (MIHPs), specially the persons with Severe Mental Illnesses (SMIs), has been difficult to achieve. The plight of this group of persons has been described earlier, specially the lack of support systems and the lack of insight on the part of such persons. The need for involuntary treatment with this group of illnesses becomes more difficult to be met with in homeless persons. The possibility of initiating involuntary treatment of these persons on the street, with periodic depot injections is promising in terms of clinical science, but has obvious ethical and legal dilemmas and pitfalls. The partner organisations of the HIGH have often held internal discussions, and consultations with some experts in the field of law, for overcoming the ethical and legal dilemmas. The possibility of seeking advice and/or intervention from the Court of Law has been actively considered and is expected to be followed up.

5.2.3 Psychosocial Interventions for Persons with Common Mental Disorders (CMDs)

The need for psychosocial intervention in many conditions is high, but certainly in Common Mental Disorders (CMDs) like Depression and Anxiety Disorders. The identification and diagnosis of CMDs in homeless persons involves its own conceptual and pragmatic difficulties, since the definitions and the criteria for diagnosis of these disorders for the general populations, are not easily applicable in the extremely adverse circumstances of the homeless persons. The perceived need and the willingness for seeking help, in such persons are also difficult. In spite of these issues, there has been an initial success in ensuring that some of these persons avail of the outreach health services, but becomes somewhat infructuous since the need for psychosocial interventions have not been possible to be met with. The limitations have been in terms of the qualified mental health professionals and the time available. The idea of training volunteers from the community of homeless persons in basic counseling skills has been actively considered, and is being pursued. The resources for making trained counselors available for this programme need to be obtained, along side exploring the possibility of developing technology and obtaining resources of training of lay volunteers from the homeless community. The screening of patients who reach the outreach health service for general health problems and for Common Mental Disorders has also been planned and attempted, but was aborted due to the shortfall in services for these persons.

5.2.4 Treatment Programme for Childhood Substance Users Specially Solvent Abuse

It has been difficult to evolve a meaningful treatment programme for childhood substance users with solvent abuse, for reasons of lack of definitive scientific incidence in this matter and the practical difficulties for a programme at the street levels. It is planned that a treatment programme be initiated similar to the programme for adult drug users, and if required, in liaison with other agencies in the field area, working with street children.

5.2.5 Minimal Laboratory Diagnostic Facilities

As outlined earlier, the need for minimal

laboratory diagnostic facilities has been felt all through the initial years. That has been so for persons with Gastro-Intestinal Tract (GIT) problems, respiratory infections and alcohol use problems, more specifically. In addition to these conditions, the need for laboratory diagnostic facilities has also been felt for the assessment and treatment of general medical conditions of deprivation and malnutrition, most notably anemia. The difficulties involved in initiating the facilities available at the nearby government hospitals have been outlined earlier. At the same time, since the outreach health service is being provided more as a "health service on wheels", the possibility of incorporating laboratory facility as part of the outreach health service, will be limited. Various options are being explored to fill up this service gap.

5.3 Enhanced Community Participation

Although envisaged from the outset, community participation has been possible to a very limited extent. In the first year, there was initially no involvement possible beyond interest and appreciation. In the second year, it has been possible to initiate some participation in terms of contact meetings and evolving of some volunteers from the community of homeless persons. These volunteers have played a useful role in the logistical operation of the clinic and in identification and motivation of persons with mental health problems. The medium term plans for community involvement are for a stable work force of volunteers for identification of patients, follow-up care, networking for hospital based treatment, operation of the clinic and provisions of counseling and other psychosocial interventions. The long term plan is to be able to hand over the task of a large part of the operation, if not the entire operation of the clinic, and if possible, the outreach health services, to the homeless persons. The professional and scientific aspects of the service will require to be carried out by the partner organizations. As in many other outreach efforts, this ultimate goal of passing over the responsibility is likely to be difficult to be implemented, but it should remain as the goal and must be attempted. .

5.4 Comprehensive Health Services

The services in the initial two years have been predominantly of therapeutic nature in treatment of health problems. It is recognized and planned that the expansion of the services to a more comprehensive level should include preventive and promotive services.

5.5 Strengthening the Networking

Although a reasonably satisfactory networking has been possible a lot more needs to be done in strengthening the networking. This is required for the service gaps, which have been identified, as well as for the more comprehensive health services proposed above.

5.6 Expansion of Services to a Larger Population

As noted earlier, the experience gained through this initiative needs to be applied in other settings and expanded to a network of similar services in the city-state of Delhi, other parts of India, and possibly the other developing countries. The cooperation and participation of the government health departments, and the facilitation required from the policy makers, should be possible to obtain considering the fact that this collaborative initiative has been able to demonstrate successfully the feasibility and the usefulness of an outreach health service for the homeless population.

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Epilogue

The experience of the initial two years of a collaborative initiative by a government funded academic institution, IHBAS, and two Non-Governmental Organizations (NGOs), AAA (a project of ActionAid India) and Sahara has been documented in this report, in the background of the path breaking report on the "Capital's Homeless" by the AAA in 2001. Access to health care has been recognized as one of the basic rights, and the effort in the partner organisations for ensuring this right has been initial in the effort. The Health Needs Assessment Survey (HNAS) carried out at the early stage, led to the identification and implementation of the strategy of an outreach health service. The profile of health problems seen at the outreach clinic has been documented, along side identifying the service gaps through preliminary evaluation exercises. The findings from the evaluation exercises are phased with the future course of action to be followed.

The Health Care Services for the homeless population at zero level leading to the collaborative initiative for taking the situation beyond zero level, and the satisfaction of making a difference, has been associated with a constant endeavor to make the difference more meaningful and carrying the initiative to its completion.

The dream of carrying the initiative to its completion i.e. to ensure that all homeless population in the state of Delhi, and possibly in all of India, can be realized only, and only if, it is recognized and accepted, that health care is one of the basic rights of the extremely disadvantaged population. Such recognition and acceptance should lead to initiative(s) by academic institutions and hospitals, as well as voluntary organizations and Non-Governmental Organisations (NGOs) for application of this model Outreach Health Service in different settings. The application of this model, quite understandably, will have to be with sensitivity to the local situation and adaptation as per the needs and the resources.

The model shared here need not be, and should not be, the only one to be followed. As the application gets a wider base, the innovations and adaptations will get documented. The individuals and the teams in the partner organisations await eagerly these developments. Above all, it needs to be ensured the basic right to health care is made available to the homeless population. The sustainability of any such outreach health service, will require and must get support from state health services. As per the international conventions on right as well as by the constitution of India, make if incumbent upon the State to actively implement outreach health services for the homeless populations. In the meanwhile, the possible collaborative efforts can be initiated.

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Appendices

List of Contents

Appendix I

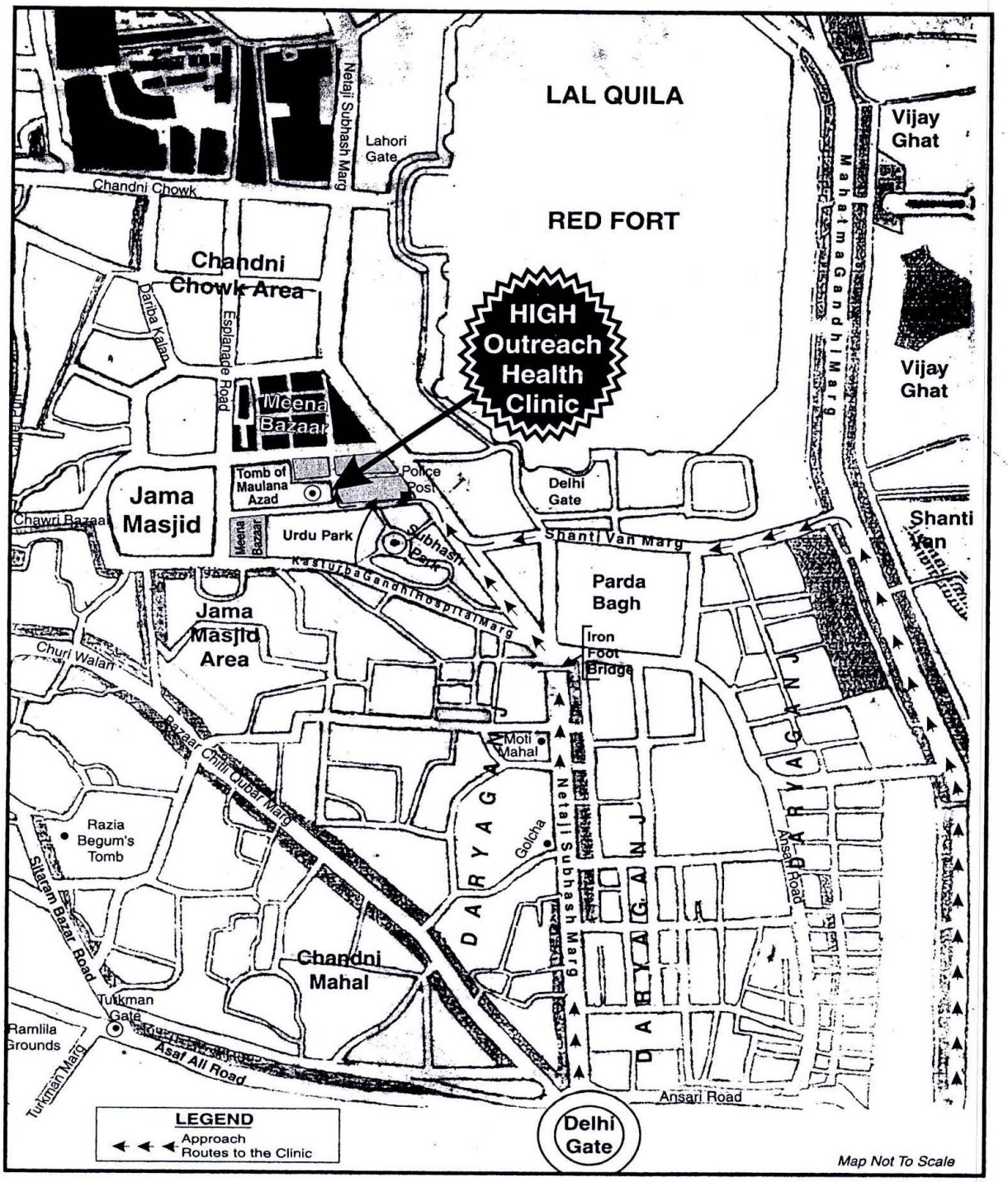
Abbreviations

AAA	Aashray Adhikar Abhiyan
AIDS	Acquired Immuno Deficiency Syndrome
AIIMS	All India Institute of Medical Sciences
AIR	All India Reporter
SD	Substance Dependents
CEDAW	Convention on the Elimination of Discrimination Against Women
CMDs	Common Mental Disorder
COPD	Chronic Obstructive Pulmonary Disorder
CP	Connaught Place
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
CST	Comply Same Treatment
CWs	Community Workers
DHSA	Delhi House Seva Ashram
SCEH	Dr. Shroff's Charity Eye Hospital
FGDs	Focus Group Discussions
GDP	Gross Domestic Product
GIT	Gastro Intestinal Tract
HIGH	Health Intervention Group for the Homeless
HIV	Human Immuno Virus
HNAS	Health Needs Assessment Survey
IEC	Information/Education/Communication
ICERD	International Convention on Elimination of all forms of Racial Discrimination
ICESCR	International Convention on Economic, Social and Cultural Rights
IHBAS	Institute of Human Behaviour and Allied Sciences
ISBT	Inter State Bus Terminal
LHMC	Lady Harding Medical College
LNJP	Lok Nayak Jai Prakash
MIHP	Mentally Ill Homeless Persons
MR	Mental Retardation
NA	Narcotics Anonymous

NCAER	National Council for Applied Economic Research
NGOs	Non Government Organisation
NIAF	National Illness Assistance Fund
NSS	National Sample Survey
OPD	Out Patients Department
PRA	Participatory Reflection and Action
RAS	Rapid Assessment Survey
RMLH	Ram Manohar Lohia Hospital
SCC	Supreme Court Cases
SKH	Sucheta Kriplani Hospital
SMIs	Severe Mental Illnesses
SMDs	Severe Mental Disorders
SPSS	Statistical Package for Social Sciences
SSH	St. Stephen's Hospital
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UNDCP	United Nations Drug Control Program
URI	Upper Respiratory Infections
VHAI	Voluntary Health Association of India
VO	Voluntary Organisations

Appendix 2

Topographical Map: Location of HIGH



Appendix 3

The HIGH Partners and Supporting Organisations

The Health Intervention Group for the Homeless is made up of the following partners:

Aashray Adhikar Abhiyan (AAA)

Aashray Adhikar Abhiyan (AAA), a programme of ActionAid India is a shelter rights campaign for homeless people in Delhi founded in the year 2000. AAA believes that homeless people (men, women and children) have the right to live in peace, dignity and security just like other Delhi citizens. This belief is supported by the United Nations Universal Declaration on Human Rights and the Indian Constitution. However, homeless people's rights are violated every single day and night in the city of Delhi. They are deprived of civic amenities such as water and sanitation; denied access to medical treatment; forced to work for below the minimum wage; face daily beatings and harassment from the police; and must sleep in the open because of a lack of shelter. AAA's aims are to empower, mobilise and strengthen the capacity of homeless people so that they are able to assert their rights and live with honour and dignity; and to help the wider public and government recognise that homeless people have inalienable rights and that it is the responsibility of everyone to ensure these rights are protected.

Nodal person for HIGH

Jagdish Bhardwaje
Coordinator - Health

Paramjeet Kaur
Director

Aashray Adhikar Abhiyan
HIGH Secretariat, S-442, School Block, Shakarpur, Delhi 110092
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Institute of Human Behaviour & Allied Sciences (IHBAS)

The Institute of Human Behaviour & Allied Sciences (IHBAS) is a multidisciplinary institute which provides tertiary level services with a mix of primary and secondary care in the form of community outreach programmes in psychiatry, neurology, behavioural and allied sciences. The main emphasis of the institute has been to convert custodial care into hospital care and finally to socio-therapeutic community or school for life. It is the nodal agency for NCT of Delhi for drug de-addiction as well as for training social and paramedical workers for drug de-addiction programmes.

IHBAS
Dr. Meena Gupta
Director
Dr. Nimesh Desai
Medical Superintendent
Institute of Human Behaviour and Allied Sciences (IHBAS)
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Sahara

Sahara, addresses the needs of chemical dependent persons through planned qualitative programmes of treatment and rehabilitation. In addition, Sahara is involved in spreading awareness of drugs and HIV/AIDS, its dangers and method of prevention on a regular basis. Sahara provides long-term home based care for those people living with AIDS and runs a hospice called Michael's Care Home for sero-positive individuals. Sahara's methodology is to first meet the individual's need for treatment and then provide hope and avenues for an alternative, healthy life. Sahara started as a pioneer organisation in 1978 and was registered as a non-profit NGO in 1985.

Sahara
Mr. Neville Selhore
Director
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SUPPORTING ORGANIZATIONS:

Dr. Shroff"s Charity Eye Hospital (SCEH)

Dr. Shroff"s Charity Eye Hospital (SCEH) began in 1914 with the setting up of an Eye Clinic for the needy in Daryaganj. Since 1999 through their outreach programme nearly 2000 poor patients have been brought from Delhi and adjacent villages for sight restoring surgery at SCEH.

Dr. Shroff's Charity Eye Hospital
Dr Stevens Roy, CEO
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Delhi -110002
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shroffhospital@vsnl.com

Delhi House Seva Ashram (DHSA)

Delhi House Seva Ashram (DHSA) is a multi-branched community dedicated to the practical application of spirituality to the reality of suffering, present among destitute, sick and dying homeless, street children and slum dwellers of Delhi. As such it focuses on hands-on service, community intervention, and action for relief from conditions and structures that perpetuate dehumanization of the most vulnerable of the poorest of the poor.

Delhi House Seva Ashram
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Appendix 4

Hand Bill in Hindi distributed to the Homeless at the launch of HIGH Outreach Health Service

हमारा अधिकार – स्वास्थ्य का अधिकार

यह आपका अभियान है, आपके लिये है, आपके सामाजिक अधिकारों एवम् आपके अपने हकों के लिए – **आश्रय अधिकार अभियान।**

दिल्ली सरकार, केन्द्रीय सरकार, एम.सी.डी., एन.डी.एम.सी., दिल्ली पुलिस, स्वयं सेवी संस्थाएं एवम् बुद्धिजीवी, वकील, आम नागरिक और छात्र-छात्राएं इस अभियान को सफल बनाने में हमारे साथ हैं। **आश्रय अधिकार अभियान** का शुरुआती दौर में प्रयास रहा है कि दिल्ली की पटरियों पर रहने और सोने वाले भाइयों-बहनों की मुश्किलों को समझें, इसके लिए कुछ दिन पहले हम आप लोगों के बीच आए थे। उस दौरान आप लोगों की काफी परेशानियां हमारे सामने आयी हैं। इन सारी अलग-अलग परेशानियों का हम आपके साथ मिलकर हल ढूंढने की कोशिश कर रहे हैं।

हम शायद सारी परेशानियों को दूर न कर सकें। लेकिन हम सब मिलकर कुछ न कुछ कर गुजरने की ताकत रखते हैं। हमने अपनी ओर से हकों की लड़ाई शुरू करते हुए सबसे जरूरी समस्या जो कि स्वास्थ्य की है, जो कि हमें पटरी पर सोने वाले बहनों और भाईयों ने बताई, पर काम शुरू कर रहे हैं। इस काम के लिए हफ्ते में दो दिन डाक्टर एवम् दवाईयों का प्रबन्ध किया गया है। हमें यह बताते हुए खुशी हो रही है कि वर्ल्ड विज़न, इन्स्टीट्यूट ऑफ ह्यूमन बिहेवियर एण्ड एलाईड साईन्सेज, यूथ रीच, नारकोटिक्स एनोनिमस, सहारा होम तथा समाधान जैसी संस्थाएं मिलकर ये सुविधायें आप तक ला रही हैं।

यहां डाक्टरी मदद तथा दवाईयां दी जाएंगी। ये इन संस्थाओं द्वारा बाँटी जा रही है। हम इस कार्यक्रम की शुरूआत ऐसे कर रहे हैं।

दिनांक : 26 और 27 सितम्बर
स्थान : मीना बाजार (उर्दू पार्क गेट के सामने)
समय : रात्रि 7 बजे से 9 बजे तक

इस दौरान 26 और 27 हम आपके बीच आकर आप लोगों से बात करेंगे और 27 तारीख से दवाईयां बटनी शुरू हो जाएंगी। इसके बाद यह कार्यक्रम हफ्ते में दो बार चलता रहेगा।

दिन : सोमवार और वीरवार
स्थान : मीना बाजार (उर्दू पार्क गेट के सामने)
समय : रात्रि 7 बजे से 9 बजे तक

आपके पास अगर इन बातों पर कोई राय या सुझाव हो तो आप बिना झिझक हमारे कार्यकर्त्ताओं से बात करें।

आश्रय अधिकार अभियान
यू-55बी, लेन 4, शकरपुर, दिल्ली-110 092
फोन नं. 2450277

Appendix 5

Outreach Health Service in Operation : Drug Abuse Treatment Outreach

A combination of pharmacotherapy and psychosocial therapy is undertaken in the drug de-addiction outreach. The pharmacotherapy consists of prescribing patients a combination of Proxyvon, Diazepam and Brufen. These drugs are used for the amelioration of withdrawal symptoms (detoxification); decline of craving and prevention of relapse; and restoration of normal physiological functions.

About six months after the start of the de-addiction outreach programme, it was found that almost a third of patients coming to the clinic were substance dependants. However, there was some concern that some of the patients were not practising abstinence and were taking the prescribed medicine along with drugs or selling the medicines. As a result of these concerns, psychosocial therapy in the form of group sharing/counselling was set up in May 2001.

The group sharing counselling is run by former drug users and held every Wednesday between 7-8pm in Urdu Park. Participants talk about their difficulties leaving drugs and the problems they face in their daily lives. Together they try to find solutions to these problems. Only those who participate in these sessions can get medicines from the HIGH clinic. This rule has reduced the number of substance dependants coming to the clinic dramatically. The decline in numbers is disappointing; however, it is thought that those who are attending the sharing/counselling are more committed to giving up their addiction.

This type of non-residential drug de-addiction outreach programme is particularly challenging as many homeless people do not have an alternative to drug use, such as meaningful employment, or family support and are unable to return to a 'drug free' environment but have to go back to the streets.

Over two years, 1158 drug users have participated in the sharing sessions

Appendix 6

Format of Form : Patients with General Health Problems and Psychiatric Illnessess

Regn. No | | | | | |

Date | | | | | 200 | |

PATIENT REGISTRATION FORM

H.I.G.H. — Health Intervention Group for the Homeless — Since 2000

Name | | | | | | | | | | | | |

Father's/Husband's Name | | | | | | | | | | | | | | | | |

Dept General/Psychiatry

Gender Male 1 | Female 2 | Eunuchs 3

Age 0-10 1 | 11-20 2 | 21-30 3 | 31-40 4 | 41-50 5 | 51-60 6 | 61-70 7 | Over 70 8 | Unknown 99

Education Illiterate 1 | Primary class 1-5 2 | Middle 6-9 3 | Sec. 10 4 | H. sc 11-12 5 | Graduate 6 | Postgraduate 7 | Functional Literacy 8

Religion Hindu 1 | Muslim 2 | Sikh 3 | Christian 4 | Other _____ 5 | Unknown 99

Marital Status Unmarried 1 | Married 2 | Separated 3 | Divorced 4 | Widowed 5 | Unknown 99

Nationality India 1 | Nepal 2 | Bangladesh 3 | Pakistan 4 | Other _____ 5

State of Origin Delhi 1 | UP 2 | Bihar 3 | Bengal 4 | Maharastra 5 | Rajasthan 6 | MP 7 | Punjab 8 | Haryana 8 | Punjab 9 | Assam 10 | Other _____

Occupation Unemployed 1 | Rickshaw puller 2 | Hawker 3 | Labourer 4 | Ragpicker 5 | Beggar 6 | Restaurant worker 7 | Domestic worker 8 | Construction worker 9 | Loader 10 | Other _____ 11

Income

No income	1	1001-1500	4	2501-3000	7	
1-500	2	1501-2000	5	Over 3000*	8	*Specify _____
501-1000	3	2001-2500	6	Unknown	99	_____

Sleeping Area

Jama Masjid	1	Ajmeri Gate	7	Other place in Old Delhi _____	13
Jamuna Bazaar	2	Naopul	8		
Chandni Chowk	3	Daryaganj	9	Other place beyond old Delhi _____	14
Old Delhi Rly st.	4	Old Delhi Shelter	10		
Turkman Gate	5	Old Delhi Temp. Shelter	11		
Delhi Gate	6	New Delhi Temp. Shelter	12	Unknown	99

Office use only Follow up: Follow up: (1) 1-5 (2) 6-10 (3) 11-15 (4) 16-20 (5) 21-25 (6) More than 25 visits (7)

© HIGH, Delhi 2002.

Complain: | **Duration**

Family/Personal Histor: | Psychiatric Illness: Yes/No | Specify, if required:

Past History | Psychiatric Illness: Yes/No | Specify, if required:

Physical Examination Psychiatric Illness: Yes/No

Specify Physical Problem:

Mental State Examination Psychiatric Illness: Yes / No

Specify Problem:

Provisional Diagnosis-Gen

No Illness	0	Nausea/Vomiting	15
Anaemia	1	Cold & Fever	16
Arthritis	2	Malaria	17
Back Problem.	3	Dental Problem	18
Fracture	4	Ear Problem.	19
Joint Pain	5	Throat Problem.	20
Heart Problem.	6	Eye Problem.	21
Respiratory	7	Gastro Int. Trck. Inf.	22
Skin	8	Haemorroids	23
Muscular Pain	9	Hepatitis	24
Nerve Pain	10	Worms	25
Vertigo	11	Testicular Problem.	26
STD/STI	12	Urinary Tract Infection.	27
AIDS	13	Injuries/Wound	28
TB	14	Unknown	29

Provisional Diagnosis-Psy

Organic Mental Disorders	1
Mental and Behavioural Disorders due to substance use	2
Schizophrenia & related Disorders	3
Psychosis	4
Bipolar disorder, incld. Manic episode	5
Depression, incld. Manic episode	6
Anxiety Disorder	7
Somatoform Disorder	8
Adjustment Disorder/Severe Stress	9
Disassociative Disorder	10
Psychosexual Disorder	11
Dhat Syndrome	12
Mental Retardation	13
Childhood Psy. Disorder (Onset before 16 years)	14
Other (Specify):	15

Final Diagnosis **(If same as Prov. Diagnosis specify code only)** ☐

Treatment Advd. Gen

Pharmacological Treatment (as per prescription)	1
Non Pharmacological Treatment (as per prescription)	2

Treatment Advd. Psy.

Phclg. Agt. used

Anti Psychotics	1
Anti Depressants	2
Anti Anxiety	3
Anti Epiliptics	4
Mood stabilizers	5
Opridagonists	6
Subt. Plan. S. Abuse	7
Suppt. Plan: S. Abuse	8
Adjunctive Medicines	9
Other	10

Non Pharmacological Treatment

Psychoeducation	1
Counselling	2
Supportive psycho-thpy	3
Behavioural Advice	4
Other	5

Referrals **(with reason)**

Doctor's Name: Doctor's Signature Date:

© HIGH, Delhi 2002.

Patient | | | | | | | | | | | | | **Regn. No.** | | | | | |

PRESCRIPTION DATED		DOSES	
PRESCRIPTION DATED		DOSES	
PRESCRIPTION DATED		DOSES	
PRESCRIPTION DATED		DOSES	

Summary of follow-up evaluation till date. (Important observations)

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Appendix 7

Format of Form : Patients with Substance Dependence

Regn. No. | | | | | |

Date | | | | | 200 | |

PATIENT REGISTRATION FORM

HEALTH INTERVENTION GROUP FOR THE HOMELESS — **H.I.G.H.** — SINCE 2000

Name | | | | | | | | | | | | |

Father's/Husband's Name | | | | | | | | | | | | | | | |

Dept. Substance Dependence

Gender Male 1 | Female 2 | Eunuchs 3

Age 0-10 1 | 11-20 2 | 21-30 3 | 31-40 4 | 41-50 5 | 51-60 6 | 61-70 7 | Over 70 8 | Unknown 99

Education Illiterate 1 | Primary class 1-5 2 | Middle 6-9 3 | Sec. 10 4 | H. sc 11-12 5 | Graduation 6 | Postgraduate 7 | Functional Literacy 8 | Unknown 99

Religion Hindu 1 | Muslim 2 | Sikh 3 | Christian 4 | Other _____ 98 | Unknown 99

Marital Status Unmarried 1 | Married 2 | Separated 3 | Divorced 4 | Widowed 5 | Unknown 99

Nationality India 1 | Nepal 2 | Bangladesh 3 | Pakistan 4 | Other _____ 98 | Unknown 99

State of Origin

Bihar	1	Delhi	4	Maharastra	7	Other _____	98
UP	2	MP	5	Rajasthan	8	_____	
W. Bengal	3	Assam	6	Punjab	9	Unknown	99

Occupation

Unemployed	1	Labourer	4	Restr. Wrkr.	7	Loader	10
Rkshw. puller	2	Ragpicker	5	Domestic Wrkr.	8	Other _____	98
Hawker/vendor	3	Beggar	6	Const. Wrkr.	9	_____ Unknown	99

Income

No income	1	1001-1500	4	2501-3000	7	
1-500	2	1501-2000	5	Over 3000*	8	*Specify _____
501-1000	3	2001-2500	6	Unknown	99	_____

Sleeping Area

Jama Masjid	1	Ajmeri Gate	7	Other place in Old Delhi _____			
Jamuna Bazaar	2	Naopul	8	_____	13		
Chandni Chowk	3	Daryaganj	9	Other place bynd. Old Delhi _____			
Old Delhi Rly st.	4	Old Delhi Shelter	10		14		
Turkman Gate	5	Old Delhi Temp. Shelter	11				
Delhi Gate	6	New Delhi Temp. Shelter	12	Unknown	99		

Office use only Follow up: Follow up: (1) 1-5 (2) 6-10 (3) 11-15 (4) 16-20 (5) 21-25 (6) More than 25 visits (7)

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FOR PATIENTS OF SUBSTANCE DEPENDENCE ONLY

Drug(s) in current use

Street Name of Drugs in use:

_____

_____

Withdrawal Symptoms:

Yes	1
No	2
Unknown	99

Route:

Inhaling	1
Injecting	2
Both	3
Oral	4
Unknown	99

None	0
Smack	1
Buprenorphine	2
Codeine	3
Proxyvon	4
Doda	5
Benzediazepine	6
Cannabis	7
Alcohol	8
Tobacco	9
Inhalants	10
Multiple	11
Antihistamine	12
Promethazine	13
Avil	14
Other	98
Unknown	99

Duration:

Less than a week	1
15-30 days	2
2-6 months	3
7-11 months	4
1-2 years	5
3-5 years	6
6-10 years	7
11-15 years	8
16-20 years	9
over 20 years	10
Unknown	99

Frequency:

Once daily	1
2 times a day	2
3 times a day	3
More than 3 tms. dly.	4
3 times a week	5
Once a week	6
Once in a fortnight	7
Once in a month	8
Dly. no. unknown	9
Other	98
Unknown	99

Typl. Intake Qty:

Less than 1 gm	1
1-2 gms	2
3-4 gms	3
5-6 gms	4
7-8 gms	5
9-10 gms	6
More than 10 gms	7
Unknown	99

Heaviest Intk. 1 day:

Not applicable	0
Less than 1 gm	1
1-5 gms	2
6-10 gms	3
11-15 gms	4
16-20 gms	5
21-30 gms	6
Over 30 gms	7
Unknown	99

Drug(s) used in past

Street Name of Drugs

_____

_____

Withdrawal Symptoms:

Yes	1
No	2
Unknown	99

Route:

Inhaling	1
Injecting	2
Both	3
Oral	4
Unknown	99

None	0
Smack	1
Buprenorphine	2
Codeine	3
Proxyvon	4
Doda	5
Benzediazepine	6
Cannabis	7
Alcohol	8
Tobacco	9
Inhalants	10
Multiple	11
Antihistamine	12
Promethazine	13
Avil	14
Other	98
Unknown	99

Duration:

Less than a week	1
15-30 days	2
2-6 months	3
7-11 months	4
1-2 years	5
3-5 years	6
6-10 years	7
11-15 years	8
16-20 years	9
over 20 years	10
Unknown	99

Frequency:

Once daily	1
2 times a day	2
3 times a day	3
More than 3 tms. dly.	4
3 times a week	5
Once a week	6
Once in a fortnight	7
Once in a month	8
Dly. no. unknown	9
Other	98
Unknown	99

Typl. Intake Qty:

Less than 1 gm	1
1-2 gms	2
3-4 gms	3
5-6 gms	4
7-8 gms	5
9-10 gms	6
More than 10 gms	7
Unknown	99

Heaviest Intk. 1 day:

Not applicable	0
Less than 1 gm	1
1-5 gms	2
6-10 gms	3
11-15 gms	4
16-20 gms	5
21-30 gms	6
Over 30 gms	7
Unknown	99

Injection use:

Not applicable	0
No	1
Yes	2
Unknown	99

Needle sharing now:

Needle sharing past:

Not applicable	1
No	99
Yes	1
Unknown	99

Attempts of abstinence - past

Yes/No

No. of attempts

None	0	11-15	3		
1-5	1	16-20	4	26-30	6
6-10	2	21-25	5	Unknown	99

Method of abstinence

Not applicable	0
On own	1
With medical help	2
Unknown	99

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Drug(s) used last on	Primary drug of abuse	Other drug of abuse
Date: ..... Time: ..... am / pm		

Seizures		
Frequency	None	0
	Daily	1
	Weekly	2
	F. Nightly	3
	Monthly	4
	Yearly	5
	Unknown	99
	Not applicable	0
	Less than 1 month	1
	6 month	2
	1 year	3
	More than one year	4
	Unknown	99

Drug related problems		
	None	2
	Job loss	3
	Irregular job	4
	Ineffective sex	5
	Financial debt	99
	Physical fights	99
	Police arrests	99
	Marital problems	99
	Family problems	99
Specify _____	Other	99
	Unknown	99

Drug related health problems		
Current Illness		
	None	0
	Abcesses	1
	Seizures	2
	Gangerene	3
	HIV/AIDS	4
	Accidents	5
	Cough	6
	Septicaemia	7
Specify _____	Other	98
	Unknown	99

Regn. No: | | | | | | |

PRESCRIPTION DATED		DOSES
PRESCRIPTION DATED		DOSES

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Patient | **Regn. No:**

PRESCRIPTION DATED	DOSES
PRESCRIPTION DATED	DOSES
PRESCRIPTION DATED	DOSES
PRESCRIPTION DATED	DOSES

Summary of follow-up evaluation till date. (Important observations)

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Appendix 8

List of Medicines Used in the HIGH Outreach Health Clinic 2000-2002

S.No.	*Generic name of drugs*	*Brand Name of Drugs*	*Category*	*Schedule*
1.	Tab. Acetylsalicylic acid – 325mg	Disprin	Non Oploid Analgesic	Schedule-H
2.	Tab : Activated charcoal fungal diastase pain	Unienzyme	Digestive Enzyms Preparation	Schedule-H
3.	Tab. Albendazole – 400mg	Zentel	Anthelmintic	Schedule-H
4.	Cap. Amoxycillin – 250/500 mg	Mox – 250/500mg	Antibiotic	Schedule-H
5.	Tap. Atropine Sulphate – 0.025 + diphenoxylate – 2.5 mg	Lomotil	Carminative	Schedule-H
6.	Lotion Benzyl benzoate	Lotion Benzyl benzoate	Antiscabies	Schedule-H
7.	Oint. Povidone Iodine	Betadine Cream	Broad Spectrum Microbicidal	Schedule-H
8.	Cream Betamethasone + Neomycin	Betnovate –N Cream	Topical Steriod	Schedule-C
9.	Tab. Bisacodyl sodium – 5mg.	Tab. Dulcolax – 5mg	Laxative	Schedule-H
10.	Tab. Calcium Carbonate – 500 mg	Tab. Shelcal	Nutrient	Schedule-H
11.	Tab. Carbamazepine – 200/400 mg	Tab Tagretal–200/400mg	Antieplieptic	Schedule-H
12.	Tab. Cetrizine – 10 mg	Tab. Antrizine/trizine–10mg	Antihistaminic	Schedule-G
13.	Tab. Chloroquine Phosphate – 250 mg	Tab. Larlago – 250 mg	Antimalarial	Schedule-H
14.	Tab. Chlorphenaramine Maleate –4mg	Tab CPM	Atnihistaminic	Schedule-G
15.	Tab. Chlorpromazine – 100 mg	Tab. Chlorpromazine–100mg	Antipsychotic	Schedule-H
16.	Tab. Dextropropaxyphene + Acetaminophen – 65mg + 500mg	Proxyvon	Oploid and Non Oploid Analgesic	Schedule-X
17.	Tab. Diazepam – 5mg	Tab. Valium – 5 mg	Antianxiety	Schedule-H
18.	Tab. Diclofenac Sodium – 50 mg	Tb. Voveron – 50mg	Non Oploid Analgesic	Schedule-H
19.	Tab. Domperidone – 10 mg	Tab. Domstal – 10 mg	Antiemetic	Schedule–H
20.	Tab. Etophyiline + Theophylline – 77 mg + 23 mg	Tab. Deriphyline	Bronchodialator + Mastcell Stabilizer	Schedule-H
21.	Cap. Fluoxetine HCL –20mg	Cap. Fludac – 20mg	Antidepressant	Schedule-H
22.	Tab. Fluphenazine – 1 mg	Tab. Anatensol	Sedative and Tranquillizer	Schedule-H
23.	Inj. Fluphenazine Decanoate-25mg/ml	Inj. Prolinate	Sedative and Tranquillizer	Schedule-H
24.	Tab. Frusemide – 40mg	Tab. Lasix	Diuretic	Schedule-H
25.	Tab. Furazolidone + Metronidazole	Tab. Dependal – M	Drugs used in protozoal Infestations	Schedule-H
26.	Inj. Gentamycin	Inj. Garamycin	Antibiotic (Broad Spctrum)	Schedule-H
27.	Eye Drop Gentamycin	Gentycin Eye Drop	Antibiotic (Broad Spctrum)	Schedule-H
28.	Tab. Haloperidol – 5mg	Tab. Haloperidol – 5mg	Antipsychotic	Schedule-H

Table contd.

S.No.	Generic name of drugs	Brand Name of Drugs	Category	Schedule
29.	Tab. Ibuprofen-400mg	Tab. Brufen-400mg	Non Steriodal Antiinflammatory Drug	Schedule-H
30.	Cap. Iron (Ferrous Sulphate)-150mg	Cap. Fefol	Nutrient	Schedule-H
31.	Tab. Liv – 52	Liv – 52	Hepato Billary Preparation	Scheule-H
32.	Tab. Metoclopramide – 10mg	Tab. Perinorm	Antiemetic & Antinauseatic	Schedule-H
33.	Tab. Metonidazole – 400 mg	Tab. Tab. Metrogyl-400 gm	Anthelmintic	Schedule-H
34.	Tab. Mutivitamins	Tab. Multi-Aid	For Prophylactic use	Schedule-C1
35.	Tab. Nimesuilde	Tab. Nise	Non Oploid Analgesic	Schedule-H
36.	Tab. Norfloxacin – 400 mg	Tab. Norflox	UTI Infections, Antidiarrhoeal Antiinfective	Schedule-H
37.	Tab. Paracetamol – 500 mg	Tab. Pacimol	Non Oploid Analgesic	Schedule-H
38.	Tab. Phenytoin Sodium – 100mg	Tab. Eption	Antiepllèptic	Schedule-H
39.	Tab. Ranltidine – 150 mg	Rab. Rantac	Antiulcer	Schedule-H
40.	Tab. Salbutamol – 4mg	Tab. Asthaline – 4mg	Bronchodilator and Mast Cell Stabilizer	Schedule-H
41.	Tab. Trimethoprim – 80mg + Sulphamethoxazole – 400mg	Tab. Septran	Sulphonamid	Schedule-H
42.	Inj. TetanusToxoid – 0.5ml	Inj. Tet-vac-0.5ml	Vaccine for Tetanus	Schedule-C&C1
43.	Tab. Tinidazole – 500mg	Tab. Tiniba	Anthelmintic	Schedule-H

Schedule-H:Warning: To be sold by retail on the prescription of a RMPs only.

Schedule-G: Caution: It is dangerous to take this prepartion except under medical supervision

Schedule-X: Warning: To be sold by retail on the prescription of a RMPs only.

Schedule-C: Vitamins and preparations containing any vitamin not in a form to be administered parenterly.

Appendix No. 9

Inventory of Logistical Requirements of Outreach Health Clinic

- ❑ Van – One
- ❑ Banners – Two
- ❑ Medicine Box – One
- ❑ Box for Storing Registration Forms – One
- ❑ Doctors' equipment Box (small)
- ❑ Folding table for medicine distribution and registration counter - Two
- ❑ Folding canvas camp chairs – Ten
- ❑ Plastic stools – Ten
- ❑ Plastic jars for medicine (assorted sizes) – Thirty
- ❑ Plastic trays for multiutility – Six
- ❑ Spot lamp with stand with automotive 12V batteries for each lamp - Three
- ❑ Wooden container for transporting the lamps – One
- ❑ Container for drinking water – One
- ❑ Large flask for tea (for staff) – One
- ❑ Clip Boards – Ten
- ❑ Polyvinyl canopy/Plastic sheeting required during monsoons

❖ **Contents of Doctors' equipment box**

- Stethoscope – Three
- Blood Pressure Instrument – Two
- Rechargeable torch – Two
- Otoscope – One
- Injection box: 6 disposable syringes, small bottle of methylated spirit,cotton
- Liquid soap dispenser – One
- Hand towels – Two
- Writing Pens
- Doctors' note pad

Appendix 10

List of Clinic Personnel

Registration Counter

- Volunteer to facilitate New Registration of General and Psychiatric Patients - One
- Volunteer to facilitate Re-admission of Substance Dependent Patients - One
- Volunteer to facilitate Re-admission of old Patients and card sorting - Two

Consultation Area

- Volunteers to facilitate sharing session of substance dependents' prior to treatment
- Volunteers to maintain queue for General, Psychiatric and Substance Dependent Patients

Dispensary

- Full Time Health Community Worker - One
- Trained Nurse - One
- Volunteer to assist in queue-up and explain the dosage

Professional Personnel

- Psychiatrists - Three
- General Psysician - One

Appendix 11

Tables: Patients with General Health Problems

Table 3.1: AGE GROUP (N=2955)

Age in Years	*No. of Respondents*	*%age of Respondents*
0-20	816	27.70
21-40	1476	50.10
41-60	555	18.84
>60	99	3.36
Information Not Available	9	-
Total	2955	100.00

Table 3.2: SEX

Sex	*No. of Respondents*	*%age of Respondents*
Males	2737	94.57
Females	157	5.42
Information Not Available	61	-
Total	2955	100.00

Table 3.3: MARITAL STATUS

Marital Status	*No. of Respondents*	*%age of Respondents*
Married	672	41.38
Unmarried	949	58.44
Others	3	0.18
Information Not Available	1131	-
Total	2955	100.00

Table 3.4: RELIGION

Religion	*No. of Respondents*	*%age of Respondents*
Hindu	1529	52.58
Muslim	1364	46.90
Sikh	2	0.07
Christian	13	0.45
Information Not Available	47	-
Total	2955	100.00

Table 3.5: EDUCATION

Educational Qualification	*No. of Respondents*	*%age of Respondents*
Illiterate	285	36.26
Primary	203	25.83
Middle	207	26.34
Sec/Hr.Sec	86	10.94
Graduation	5	0.64
Information Not Available	2169	-
Total	2955	100.00

Table 3.6: SLEEPING AREA

Name of the Area	*No. of Respondents*	*%age of Respondents*
Jama Masjid	777	36.39
Yamuna Bazaar	184	8.62
Chandni Chowk	52	2.44
Turkman Gate	41	1.92
Ajmeri Gate	4	0.18
Naya Pul	34	1.59
Darya Gunj	42	1.97
Old Delhi	74	3.47
New Delhi	16	0.74
Other (part of periphery of old Delhi)	911	42.68
Information Not Available	820	-
Total	2955	100.00

Table 3.7: STATE OF ORIGIN

Name of the State	*No. of Respondents*	*%age of Respondents*
Bihar	400	24.24
UP	647	39.21
West Bengal	125	7.58
Delhi	79	4.78
MP	71	4.31
Maharashtra	42	2.55
Rajasthan	42	2.55
Assam	37	2.24
Punjab	22	1.33
Other	185	11.21
Information Not Available	1305	-
Total	2955	100.00

Table 3.8: COUNTRY OF ORIGIN

Name of the Country	*No. of Respondents*	*%age of Respondents*
India	1059	90.67
Nepal	105	8.99
Bangladesh	4	0.34
Pakistan	0	0.00
Information Not Available	1787	-
Total	2955	100.00

Table 3.9: OCCUPATION

Type of Occupation	*No. of Respondents*	*%age of Respondents*
Unskilled	1432	88.78
Skilled	88	5.45
Unemployed	93	5.77
Information Not Available	1342	-
Total	2955	100.00

Table 3.10: MONTHLY INCOME

Monthly Income (in Rs.)	*No. of Respondents*	*%age of Respondents*
Nil	1310	50.81
1-1000	447	17.34
1001-2000	589	22.85
2001-3000	209	8.11
>3000	23	0.892
Information Not Available	377	-
Total	2955	100.00

Table 3.11: DIAGNOSIS

Health Problem	*No. of Respondents*	*%age of Respondents*
Orthopedic	87	4.32
Respiratory	568	28.23
Skin	159	7.90
STD	32	1.59
TB	51	2.54
Malaria	51	2.54
Dental	24	1.19
ENT	46	2.27
EYE	61	3.32
GIT	203	10.10
Wounds	88	4.37
Unspecified	98	4.87
Pregnancy	5	0.25
Other	539	26.79
Information Not Available	943	-
Total	2955	100.00

Table 3.12: DURATION OF ILLNESS

Duration of Illness	*No. of Respondents*	*%age of Respondents*
0-30 days	793	45.34
2-11months	559	31.96
1-5 years	204	11.66
>5 years	193	11.04
Information Not Available	1206	-
Total	2955	100.00

Table 3.13: REFERRALS

Hospitals Referred to	*No. of Respondents*	*%age of Respondents*
IHBAS	60	24.0
LNJP	124	49.6
SHROFFS	34	13.6
Other	32	12.8
Information Not Available	2705	-
Total	2955	100.00

Table 3.14: FOLLOW UP VISITS

Follow up Visit	*No of Follow up visits*	*Percentage of visits*
No Follow-up Visit	2303	60.430
1-5 Visit	1328	34.846
>5 Visit	180	4.723
Information Not Available		-
Total No of visit	3811	100.00

Tables: Substance Dependent Patients

Table 4.1: AGE GROUP (N = 1184)

Age in Years	*No. of Respondents*	*%age of Respondents*
1-20	84	7.68
21-40	783	71.64
41-60	213	19.49
>60	13	1.19
Information not available	91	-
Total	1184	100.00

Table 4.2: SEX

Sex	*No. of Respondents*	*%age of Respondents*
Males	1134	98.95
Females	12	1.05
Information not available	38	-
Total	1184	100.00

Table 4.3: MARITAL STATUS

Marital Status	*No. of Respondents*	*%age of Respondents*
Married	291	29.27
Unmarried	653	65.70
Other	50	5.03
Information not available	190	-
Total	1184	100.00

Table 4.4: RELIGION

Religion	*No. of Respondents*	*%age of Respondents*
Hindu	611	54.45
Muslim	503	44.83
Sikh	3	0.27
Christian	5	0.44
Information not available	62	-
Total	1184	100.00

Table 4.5: EDUCATION

Qualification	*No. of Respondents*	*%age of Respondents*
Non-Illiterate	633	66.49
Primary	133	13.97
Middle	127	13.34
Sec/hsc	50	5.25
Graduation	9	0.95
Information not available	232	-
Total	1184	100.00

Table 4.6: SLEEPING AREA

Sleeping Area	*No. of Respondents*	*%age of Respondents*
Jama Masjid	81	11.14
Yamuna Bazaar	161	22.15
Chandini Chowk	23	3.16
Turkman Gate	18	2.48
Ajmeri Gate	19	2.61
Naya Pul	8	1.10
Darya Gunj	14	1.93
Old Delhi	58	7.98
New Delhi	7	0.96
Other	338	46.49
Information not available	846	-
Total	1184	100.00

Table 4.7: COUNTRY OF ORIGIN

Name of the Country	*No. of Respondents*	*%age of Respondents*
India	730	97.99
Nepal	11	1.48
Bangladesh	3	0.40
Pakistan	1	0.13
Information not available	439	-
Total	1184	100.00

Table 4.8: STATE OF ORIGIN

Name of the State	*No. of Respondents*	*%age of Respondents*
Bihar	74	10.19
UP	315	43.39
West Bengal	63	8.67
Delhi	147	20.25
MP	17	2.34
Mahasrashtra	23	3.17
Rajasthan	14	1.93
Assam	7	0.96
Punjab	17	2.34
Other	49	6.75
Information not available	458	
Total	1184	100.00

Table 4.9: OCCUPATION

Type of Occupation	*No. of Respondents*	*%age of Respondents*
Skilled	166	23.41
Unskilled	365	51.48
Unemployed	178	25.11
Information not available	475	
Total	1184	100.00

Table 4.10: MONTHLY INCOME

Monthly Income (in Rs.)	*No. of Respondents*	*%age of Respondents*
No Response	0	42.19
1-1000	99	8.74
1001-2000	186	16.42
2001-3000	338	29.83
>3000	32	2.82
Information not available	51	-
Total	1184	100.00

Table 4.11: PRIMARY DRUG OF ABUSE

Primary Drug of Abuse	*No. of Respondents*	*%age of Respondents*
Smack	967	85.35
Buprenorphin	116	10.24
Alcohol	17	1.50
Cannabis	16	1.41
Other	17	1.50
Information not available	51	-
Total	1184	100.00

Table 4.12: SECONDARY DRUG OF ABUSE

Secondary Drug of Abuse	*No. of Respondents*	*%age of Respondents*
Buprenorphine	72	26.48
Tobacco	43	15.80
Cannabis	38	13.97
Alcohol	34	12.50
Other	85	31.25
Information not available	912	-
Total	1184	100.00

Table 4.13: DURATION OF USE

Duration in Years	*No. of Respondents*	*%age of Respondents*
<1yr	165	21.63
1-5 yr	198	25.95
6-10 yr	164	21.49
>10 yr	236	30.93
Information not available	421	-
Total	1184	100.00

Table 4.14: SUBSTANCE DEPENDENCE

Duration in Years	*No. of Respondents*	*%age of Respondents*
Past	73	37.63
Present	121	62.37
Information not available	990	-
Total	1184	100.00

Table 4.15: FREQUENCY OF USE

Usage Number of Times/day	*No. of Respondents*	*%age of Respondents*
1-3	78	53.79
>3	67	46.21
Information not available	1039	-
Total	1184	100.00

Table 4.16: USUAL DAILY INTAKE

Usual Daily Amount (in gms.)	*No. of Respondents*	*%age of Respondents*
<1	9	6.08
1-2	88	59.46
3-4	39	26.35
5-6	8	5.40
>6	4	2.70
Information not available	1036	-
Total	1184	100.00

Table 4.17: HEAVIEST INTAKE

Heaviest Intake (in gms)	*No. of Respondents*	*%age of Respondents*
<1	9	6.16
1-5gm	120	82.19
>5gm	17	11.65
Information not available	1038	-
Total	1184	100.00

Table 4.18: REFERRALS

Hospitals Referred to	*No. of Respondents*	*%age of Respondents*
IHBAS	21	63.64
LNJP	7	21.21
Others	5	15.15
Information not available	1151	-
Total	1184	100.00

Table 4.19: FOLLOW UP

Follow up	*No. of Visits*	*%age of Visits*
Nil	684	26.91
1-5	1389	54.64
6-10	356	14.01
>10	113	4.44
Information not available	2542	-
Total	1184	100.00

Appendix 13

Tables : Patients with Psychiatric Illnesses

Table 4.1: DISTRIBUTION OF PATIENTS – with Mental Health Problems

(N = 34)

Common Mental Disorders	*No. of Respondents*	*%age of Respondents*
CMDs	28	82.35
SMIs	5	14.7
MR	1	2.94
Total	34	100.00

Table 4.2: COMMON MENTAL DISORDERS (CMD's)

Common Mental Disorders	*No. of Respondents*	*%age of Respondents*
Dhat Syndrome	10	35.71
Erectile Disorder	2	7.14
Anxiety Disorder *NOS	4	14.29
Somatoform Disorder	3	10.72
Hypochondriasis	1	3.57
Depression	8	28.57
Information not available	6	-
Total	34	100.00

Table 4.3: SEVERE MENTAL ILLNESSES (SMIs)

Severe Mental Disorders	*No. of Respondents*	*%age of Respondents*
Schizophrenia	2	40.00
Psychosis NOS	1	20.00
Epilepsy	2	40.00
Information not available	29	-
Total	34	100.00

**Not otherwise specified.*

Appendix 14

Participatory Reflection and Action (PRA) Tools

- *Pair wise Matrix*

With the help of this tool the indicators of the appraisal were identified. The participants were asked to list the important criteria for an effective mobile health clinic. Through this tool, the Health well-being ranking (to ascertain what homeless people consider 'good' health) emerged.

- *Rank Scoring*

This exercise identified the priority areas for any mobile heath clinic. The identified indicators in the pair wise matrix were given scores on the basis of their importance followed by a detailed discussion.

- *Force Field Analysis*

This exercise helped in identifying the factors that pull the homeless towards the HIGH as well as the factors that restricts them from participating in the HIGH. It also identified the areas of improvement along with the suggestions to make HIGH more effective.

- *Venn Diagram*:

Through this exercise we were able to identify the needs of the homeless and the resources available for them. It also highlighted the importance of the resource and reasons for the inaccessibility to the homeless.

- *Problem Matrix* :

Through this tool problems in HIGH and their respective solutions emerged.

- *Focus Group Discussion:* A group of 10 to 12 persons, discussing the theme provided to them.
- *Observation:* Non-participatory general observation of the functioning of HIGH Clinic
- *In Depth Interview:* Intensive, detailed interview about their perceptions of HIGH Clinic

Appendix 15

Tables : Participatory Reflection and Action (PRA) Exercises

Table 1: Scoring Matrix for Health Outreach

Indicators	*Year Score 2000*	*Year Score 2002*[1]
Punctuality of the Clinic	10	9
Good behaviour by all Service Providers	10	8
Easy Accessibility	10	*
Quality of Medicines	9	9
Effectiveness of Treatment	*	9
Reduced Police Harassment	6	*
Follow Up	*	6
Appropriate & Permanent Location of the Clinic	*	6
Availability of Lab. Diagnostic Facility	*	6
Feeling of Belonging/Back up support of the organisation	5	*
User Participation in the Clinic	4	*
Clinic's Outreach to the Poor	4	*
Availability of Specialist Doctors	*	4
Availability of Ambulance	2	0
Availability of Effective Referrals	1	*
Arrangement of drinking water for Patients	*	0

* Indicator did not figure out in that exercise.

The process of evaluating the clinic's utility, and the scope for further improvement, the participatory exercise was adopted as explained below:

i) The participants listed down the indicators which form a good clinic.

ii) There were many indicators in each exercise but only 10 to 15 were selected for evaluation (as shown in Table 1).

iii) They evaluated each indicator with all other indicators. This was done in order to give priority scoring.

Table 2: Scoring Matrix by Substance Dependents for Drug Outreach

Indicators	*Score*	
	2001	*2002*
Availability of Free Treatment and Medicines	*	10
Suitability of Timings	*	10
Utility of Sharing Sessions	*	10
Sensitive Doctors	*	10
Prescription of medicines	8	9
Misuse of Medicines and Registration Cards by the Patients	*	7
Adequate Sitting Arrangements	*	6
Day Care Facility	2	0
Recovery of Patient with Substance Dependence	1	*
Facility of Hospitalization	0	*

Substance dependent patients were separately asked to score the effectiveness of the drug outreach including the sharing/ counselling sessions and the outreach for patients with substance dependence, against the indicators provided during the group discussions.

Table 3 : Scoring Matrix of Effectiveness of Existing Facilities at HIGH by HIGH team

Indicators	*Score by*		
	CWs	*Doctors*	
	2002	*2001*	*2002*
Quality of Medicines	9	*	8
Behaviour of Team	8	8	7
Appropriate Location of the Clinic	8	*	*
Dispensing of Medicines	8	*	*
Satisfaction Level of Patients	6	8	*
Punctuality of the Clinic	6	7	8
Doctors	6	*	*
Availability of Dressing Facilities	5	*	*
Effective Referrals	0	4	4
Consistency of Activities/Services	*	9	7
Availability of Free of Cost Treatment	*	9	*
Accessibility to the Clinic	*	7	8
Catchment Area of the Clinic	*	7	8
Awareness of Existence of the Clinic	*	7	6
Logistics (light, seating arrangement, etc) at the Clinic	*	7	*
Trained and Competent Staff at the Clinic	*	6	7
Usefulness of Sharing Sessions	*	6	*
Scope for Expansion of the Clinic	*	5	5
Adequate Clinic Operation Days	*	*	8
Adequate Composition of Staff	*	*	7
Availability of Basic Medical Equipment	*	*	7
Timing of Registration & Clinic	*	*	7
Regular Source of Funding for the Clinic	*	*	7
Need Oriented Services	*	*	7
Voluntary Participation of Local Community	*	*	6
Availibity of Minor Surgical Items	*	*	5
Sensitising Leaders	*	*	4
Audio Visual aids for I.E.C	*	*	2
Regular Monitoring by the Community	*	*	2

*Indicators not mentioned by the participants

The participatory exercises adopted are explained below:

i) The participants listed down the indicators which form a good clinic.

ii) There were many indicators in each exercise but only 10 to 15 were selected for evaluation (as shown in table 6).

iii) They evaluated each indicator with all other indicators. This was done in order to give priority scoring.

In order to decide the basis for evaluation, the patients were asked to list the factors that contributed to what they considered to be good medical facility (table1). There were two rounds of these exercises and the variables in each exercise varied.

i) Participants listed down indicators forming a good clinic.

ii) On the basis of listed indicators, participants scored HIGH on each indicator

iii) Final score was taken as an average of scoring of all the participants. Finally the score was rounded to the nearest number.

iv) Then each indicator and its scoring, was analysed by the participants. Emphasis was on the indicator scoring less than 5. Simultaneously solution / suggestions were sought against them.

Indicators with a score of 2, were further discussed/ debated and solutions were prioritised with scoring for further action.

Table 4: Scoring Matrix with Heads / Coordinators of the Organizations	
Indicator	*Average Score*
Consistency of the Clinic	9
Easy access and Utilisation of the Clinic	8
Punctuality of the Clinic	7
Follow-Up	7
Belongingness of the Clinic	7
Need Oriented Service (towards homeless)	7
Good Relation between Patients and Service Providers	6
Referrals	6
Financially and Organisationally sustainable	6
Sensitise Patients about Utilisation of Medicines (not to sell, etc and to take medicines regularly)	5
Good Relation between Doctors and Patient	4
Encourage Patients to Return to Clinic	4
Participation of Community	3
Community Ownership	3[1]

The process of this exercise was also the same as followed in the previous exercise.

Table 5 : Factors needed for the smooth functioning of HIGH as a Network	
Factor	*Average score*
Policy	3
Common Understanding	5
Information Sharing	5
Mutual Accountability	6
Problem Solving	5
Credit Sharing	7
Transparency	6
Mutual Respect	6
Cohesion	5

The participants (Heads of the particular organization/coordinator listed down the factors needed for the smooth functioning of HIGH partner network and then scored them on a scale of 1-10

Appendix 16

List of the Process Participants

PARTICIPANTS

Health Needs Assessment Survey

Dr. Arvind Gupta – (IHBAS)
Dhananjay Tingal – (A.A.A)
Indu Prakash Singh – (A.A.A)
Jagdish Bhardwaje – (A.A.A)
Dr. K.P.Rana – (IHBAS)
Dr. N.G. Desai – (IHBAS)
Paramjeet Kaur – (A.A.A)
Pradeep Kumar – (N.A)
Shalini Vatsa – (A.A.A)
Dr. Sumeena (IHBAS)

H.I.G.H – Evaluation

I.
Aditya Nath Jha – (A.A.I)
Cherian K. Mathew – (A.A.I)
Dananjay Tingal – (A.A.A)
Indu Prakash Singh – (A.A.I)
Jagdish Bhardwaje –(A.A.A)

II.
Dhananjay Tingal – (A.A.A)
Indu Prakash Singh – (A.A.A)
Jagdish Bhardwaje – (A.A.A)
Dr. N. G. Desai - (IHBAS)
Paramjeet Kaur – (A.A.A)

III.
Dhananjay Tingal – (A.A.A)
Jagdish Bhardwaje – (A.A.A)
Dr. N.G. Desai – (IHBAS)
Dr. Narindra Singh – (IHBAS)

Participatory Reflection and Action (PRA) Exercises

Facilitation of PRA (With Patients)

I.

Aditya Nath Jha – (A.A.I)
Cherian K. Mathew – (A.A.I)
Dhananjay Tingal – (A.A.A)
Indu Prakash Singh – (A.A.A)
Jagdish Bhardwaje – (A.A.A)
Paramjeet Kaur – (A.A.A.)

A) **Participants of PRA Exercise on general health problems**

Babloo, Nirmal, Meena, Md. Ismail, Mukesh, Raju, Ram Dhani, Sheela, Shohaib

B) Participants of PRA Exercise on Substance Dependence

Bhanumati, Gopal, Navneet Singh Pawan, Poonam, Rajinder, Ramesh Ram Kishan, Rafiq and others

II. Facilitation of PRA with Service Providers

Dhananjay Tingal – (A.A.A)
Indu Prakash Singh – (A.A.A)
Paramjeet Kaur –(A.A.A)
Trudy Brasell –(A.A.A)

III. Participants of PRA (Heads and Cordinators) of Partner Organisations

Indu Prakash Singh
Jagdish Bhardwaje
Dr. N.G. Desai
Sanat Shukla

WE NEED YOU!

Working with the homeless has been the most rewarding time of our lives. Struggling to ensure access to health, to the homeless, has been the most challenging area of our work. But this work of ours became a joy, for YOU ALL did support us.

As we enter a very crucial phase of reaching out to every homeless person: children, women, men, destitute, disabled, elderly, mentally ill; we know for sure that YOU ALL are still there. And with YOU, the support of your friends, relations, staff too is there, for this work with the homeless.

We need YOU! Your further support will allow us to accomplish our dreams, the dreams of the homeless. Of a society where they are accepted as a citizen, where they are nursed back to health, where they get empowered to take health in their own hands, where the language of speech is no longer the stick of the police, but the language immersed in love and concern for them.

We express our gratitude to all of YOU.

Do join us. Do support us. Do be part of this campaign and movement.

From all of us at the HIGH:
Aashray Adhikar Abhiyan (AAA)
Institute of Human Behaviour and Allied Sciences (IHBAS)
and
Sahara

Give me the strength never to
disown the poor or bend my knees
before the insolent might.

– Rabindranath Tagore

HEALTH INTERVENTION GROUP FOR THE HOMELESS

H.I.G.H.

SINCE 2000

IHBAS

आश्रय अधिकार अभियान • AASHRAY ADHIKAR ABHIYAN • اشرے ادھیکار ابھیان

SAHARA