

# Child Family Health International

Public Health & Community Medicine in India, September 2010

Willerie T. Razote



## Table of Contents

Introduction: .....	3
Sulabh International Social Service Organization .....	4
Nai Disha .....	5
HIV/AIDS Prevention Programs: .....	7
Sahara .....	10
Michael's Care Home.....	10
Venue Eye Institute.....	11
Reflections On My Experience: .....	12

## Introduction

Name: Willerie Razote, Fall 2010 CFHI Scholarship recipient

Program: Public Health and Community Medicine Program in Delhi, India

Date: September 2010

I am honored to be a CFHI Scholarship recipient. The CFHI scholarship was instrumental in furthering my interest in global health by enabling me to participate in the Public Health and Community Medicine in Delhi (PHCM-D) program. The PHCM-D program provided an opportunity to learn some of the most pressing healthcare issues faced by India and the initiatives in place to combat them. In addition, the program was instrumental in providing a set of tools that I can use as a future healthcare worker to address the many healthcare challenges of developing countries.

The PHCM-D program provided an exceptional introduction to global health. The program involved a number of healthcare organizations that provide support services to a variety of populations located in and/or around urban and rural areas of Delhi. These organizations address key healthcare challenges facing India, including unsanitary living conditions, high HIV/AIDS infection rate, increase in the number of marginalized persons, and providing for the many visually-impaired persons. In addition to providing commentaries on my participation, I have included a detailed description of each organization and additional statistical information on the issues each is trying to address.

## Sulabh International Social Service Organization

Sulabh is a world-renowned non-governmental organization (NGO) that uses sustainable sanitation technologies in creating a socially acceptable solution for recycling human waste to improve sanitary conditions where sanitation, by Western standard, is non-existent. Dr. Bindeshwar Pathak founded Sulabh in 1970 as a result of his work with the Bihar Gandhi Centenary Celebration Committee in 1968 in finding an alternative to *scavenging*, the manual removal of human excreta (urine and feces) performed by India's lowest caste known as the "untouchables". Today, Sulabh is recognized globally for improving public health through sanitation technology, advancing social progress, and improving human rights in India and other countries.

To help eradicate the practice of *scavenging*, Dr. Pathak developed cost-effective and culturally appropriate toilets and related treatment systems to replace the traditional unsanitary bucket latrines used throughout India. Known as the "Sulabh toilet", the twin-pit pour-flush compost toilet can be constructed using local labor and materials for as low as USD 15. The Sulabh toilet uses a sustainable technology that is able to safely dispose human excreta on-site by converting it into pathogen-free manure that can be used to fertilize fields and gardens.



**Sulabh - September 6:** A Sulabh circular two-pit substructure.

In India, access to toilet facilities is lacking all across the country, with only 366 million--or 31% of the population--having access to improved sanitation facilities in 2008. According to the 2007-2008 District-Level Household and Facility Survey, 51% of Indian households are without any toilet facility (an improvement from 70% in 1993). Even more alarming is the huge disparity in access to toilet facilities between urban and rural areas: 66% of rural households do not have toilet facilities compared to 19% of urban households. To meet basic sanitation needs, Sulabh has built public toilet complexes throughout India. These toilet complexes are located in public places, bus stands, hospitals, markets, and slums, and are used by the public on a 'pay-and-use basis' at a cost of 1 to 2 Indian Rupees (INR), which is equivalent to USD 0.02 -0.04, per use. Each toilet complex is operated and maintained by trained individuals from the community, which helps to promote hygiene education and awareness in local communities.

In keeping with its mission in recycling human excreta and sustainable technology initiative, over 200 of the Sulabh public toilet complexes are connected with biogas plants. Sulabh pioneered biogas generation from public toilet complexes by developing a system in which feces pathogens are eliminated through anaerobic fermentation without manual handling. Human excreta-based biogas can be used for cooking and lighting mantle lamps. A public toilet complex produces approximately 65 units of power a day for every 2,000 uses.



**Sulabh - September 6:** Biogas from the public toilet complex outside Sulabh being used to cook chapatis.

Sulabh has been successful in providing toilet facilities to the Indian public with the installation of 1.2 million individual toilets and 7,500 public toilet complexes. However, sanitation remains to be a tremendous challenge for India. Even with the increase in installation of public toilet complexes, open defecation is prevalent: of the 1.2 million open defecators worldwide more than half are from India and approximately 44% of Indian mothers dispose their children's feces in the open, according to World Health Organization (WHO). India, however, is implementing additional measures to improve sanitation throughout the country to try to meet the Millennium Development Goal on sanitation deadline by 2015, which may result in additional installations of toilet facilities.

## NaiDisha

NaiDisha is a vocational training center in the Alwar district of Rajasthan. Founded by Dr. Pathak in April 2003 as part of the Sulabh Sanitation Movement, the center conducts training in various trades that aim to provide an alternative to scavenging.

The practice of scavenging in India dates back to ancient times. This inhuman "profession" is based on the Hindu caste system and is forced upon the lowest among the Dalits, or "untouchables" as known by the upper castes. Because untouchables are considered impure, they are often ostracized by mainstream Indian society and denied all avenues of development, social and economic opportunities and basic human rights.

Although India enacted The Employment of Manual Scavengers and Construction of Dry Latrines (Prohibition) Act, in 1993, which makes it a punishable crime to employ manual scavengers, there are approximately over one million persons--of whom 80% are women--who are employed as scavengers today (no employer has been punished to date). Currently, India's National Advisory Commission (NAC) has set a goal to fully abolish manual scavenging by 2012, which will require liberating scavengers from their traditional occupation.

In order to meet NAC's goal, the establishment of rehabilitation programs, specifically ones that target women scavengers, is therefore necessary. NaiDisha offers a 3-year rehabilitation program consisting of a 2-year-training in food-processing, beauty-care, tailoring and embroidery followed by one year of rehabilitation. During the rehabilitation period, participants are taught Hindi and English, and learn to produce and market their goods and services. NaiDisha has rehabilitated 28 women, with the next 28 under training.



**Nai Dasai - September 8:** Program participants rolling out papadum, a thin, crispy Indian cracker.



**Nai Dasai - September 8:** Program participants threading beads and sequins into a sari by hand.

## HIV/AIDS Prevention Programs

According to National AIDS Control Organization (NACO), a Government of India sponsored organization, approximately 2.7 million people are living with HIV/AIDS in India today, making India the third country with the highest HIV infections. In India, most HIV infections occur through heterosexual transmission, accounting for 87.1% of the total infected. Infection is also transmitted via parent to child, injected drug use, men who have sex with men (MSM), and contaminated blood products, each accounting for 5.4%, 1.6%, 1.5%, and 4.4% of the total infections, respectively. The primary drivers of the HIV/AIDS epidemic in India are unprotected paid sex/commercial female sex work, unprotected sex between men, and injecting drug use. However, sex work continues to be the most important source of HIV infections.

To address the proliferation of HIV infections since India's first HIV/AIDS case in 1986, NACO launched a comprehensive program for prevention and control of HIV/AIDS in 1992. The program is being implemented in phases. Phase I's (1992 – 1999) objective was to slow down the HIV infection rate, while Phase II's (1999 – 2007) was to increase the capacity to respond to HIV/AIDS on a long-term basis. Phase III aims to stop the spread of the HIV/AIDS epidemic in India by 2012 by covering high-risk groups with targeted interventions (TI), scaled-up interventions for the general population, and through integration and augmentation of systems and human resources in prevention, and care, support and treatment at the district and state levels. Prevention services under Phase III include the following:

- Awareness raising: dissemination of information, education, and communication on HIV/AIDS prevention for high risk groups (commercial sex workers, injecting drug users, MSMs)
- Management of Sexually Transmitted Infections (STI): increase in STI facilities through the Reproductive and Child Health Program
- Condom promotion: free condom supply in STI clinics; promotion and facilitation of unconventional sales venues such as vending machines
- Access to safe blood: reduction in the transfusion associated with HIV transmission
- Integrated Counseling and Testing Centers (ICTC): providing a safe place for HIV/AIDS testing and counseling

In India, only 13% of HIV positive people are aware of their HIV status. The challenge, therefore, is to make all HIV infected people in the country aware of their status to help prevent further transmission. ICTCs play a key role in reducing and management of HIV/AIDS infections by providing counseling and testing services. Through these centers, people can access accurate information about HIV/AIDS prevention and care and undergo HIV testing in a supportive and confidential environment. In 2009, over 5,000 ICTCs provided services to 6.8 million Indians.



**ICTC, truck yard in Lal Quan, Delhi - September 9**



**ICTC, truck yard in Lal Quan, Delhi - September 9:**  
Peer educators providing HIV/STD information to truck drivers

To strengthen each state's capacity to respond to long-term HIV/AIDS challenges, NACO has decentralized its HIV/AIDS prevention program to state levels through State AIDS Control Societies (SACS). The role of SACS is to prevent and control HIV transmission using targeted intervention for high risk groups. SACS has also partnered with several NGOs in the implementation of its TI program. Currently, there are 1,290 TI program-related projects throughout India.



**Yamuna Bazaar, Delhi - September 13:**  
SHARAN/SACS needle and syringe exchange program, which is completely operated by local current and former drug users and people living with HIV.

I had the opportunity to work with the SHARAN/DSACS Targeted Intervention Program in Delhi. This TI program targeted the Yamuna Bazaar area of Delhi, which has a high concentration of injecting drug users. SHARAN, an NGO involved in the field of drug treatment and HIV/AIDS prevention, has partnered with Delhi SACS (DSACS) in implementing DSACS's needle and syringe exchange program. In this partnership, SHARAN provides organizational support and administration while DSACS provides financial support.



**Yamuna Bazaar, Delhi - September 14:** Outreach as part of the SHARAN/DSACS needle and syringe exchange program.



**Yamuna Bazaar, Delhi - September 14:** Drug user under SHARAN's abscess management program.

## Sahara

Founded in 1978 as a therapeutic transitional community, Sahara is an NGO that provides services to drug addicts and alcoholics and women who are displaced. The organization's main focus is to help people get off their dependency on drugs and/or alcohol. However, with India's staggering HIV infection rate, Sahara has incorporated the provision of health care services for those who are infected by HIV/AIDS with Michael's Care Home. Sahara services include drop-in centers for basic health care, detoxification and rehab for addicts, day care and non-formal education for marginalized children, and vocational training.



**Sahara Women and Children Home - September 21:**  
Day care for marginalized children.



**Sahara Women and Children Home - September 21:**  
Children posing for the camera.

### Michael's Care Home

Sahara Michael's Care Home provides HIV/AIDS health services including treatment, training, and patient rights advocacy. The Care Home was Sahara's response to the increasing need for care giving of a greater intensity and longer periods to those infected with HIV/AIDS. Today, the Care Home is a 16-bed facility strategically located to serve resource-constrained areas of Delhi.

The Care Home's model of care includes care giving, counseling, a nutrition program, cost viable treatment strategies, crisis care, and training for self and family care provided by a team of professionals and non-professionals. The professional team consists of a consulting physician and nurses. The care staff includes men and women who perform a variety of tasks ranging from autoclaving, cooking and driving to hospital visits. HIV/AIDS communities throughout India now use this model.

## Venue Eye Institute

Started by the late Dr R.K. Seth in 1980, Venu is a not-for-profit voluntary organization that provides medical care to people with visual impairments, majority of who live below the poverty line in the urban slums and the rural areas of northern India. Over the last three decades, Venu has served over three million patients from nine states through its Referral and Teaching Eye Hospital, five satellite hospitals, 25 primary clinics, and 15 community-based programs.

According to World Health Organization (WHO), approximately 314 million people are visually impaired worldwide, of which 45 million of them are blind. Approximately 85% of all visual impairment and 75% of blindness could be prevented or cured. India, as one of the biggest developing countries, has a disproportionate number of people who are visually impaired or blind. To meet this demand, Venu, along with other health organizations, have increased service availability and heightened outreach screening efforts. Venu raises awareness about eye diseases through regular screening camps that are conducted twice a week by optometrists and ophthalmologists in urban slums and rural areas in northern India.

Cataract remains to be the prevailing cause of visual impairment and blindness globally. Cataract, the condition of clouding of the lens of the eye that impedes the passage of light, is responsible for more than half of global blindness. Hence, cataract poses a major challenge for India. Recognizing both the problem of cataract-related blindness and the lack of existing cataract treatment programs, the Government of India established programs such as the Cataract Blindness Control Program to reduce cataract-related blindness. These programs consist of introducing more effective surgical technique, effective strategies in providing treatment via mass camps and fixed medical sites, partnering with hospitals such as Venu and other NGOs for delivery of services, and improving management and training. These initiatives have increased India's cataract surgery rate (CSR) in the last 10 years from 3,000 per million in 1997 to 4,200 per million in 2008. However, it remains to be seen whether this increase in India's CSR is sufficient to keep pace with the incidence of cataract as numerous barriers, such as financial reasons, distance, fear, lack of service awareness, lack of support, or other obligations, especially for the poor, remain.



**Hastinapur, Uttar Pradesh - September 28:** Rural women in queue for eye screening.



**Hastinapur, Uttar Pradesh - September 28:** A Venu ophthalmologist screening for cataract.

## Reflections On My Experience

My participation in the PHCM-D program exposed some of the current healthcare problems and challenges faced by India and the initiatives/programs in place to meet them. The program focused on the challenges of the delivery of health care to India's underserved and marginalized communities. As a result, the program gave insight into the issues that many organizations have in servicing these communities effectively. Additionally, the experiences gained in the program gave a different meaning to the word "service" as it relates to the delivery of health care services. Importantly, participating in the program confirmed that I want to promote health through education and preventative measures in developing countries.

From my observation, there are two main barriers to a successful implementation of a healthcare program in India: 1) lack of education of the targeted population, and 2) lack of financial resources to support the delivery. Because many of the people who live in underserved and marginalized communities lack education, they are less apt to seek current information to become better aware. As told to me by a peer educator from one of the ICTC centers, many of his clients still believe that by having sex with a virgin or a donkey, one can cure HIV. These superstitious beliefs are not only harmful to the individual, but may increase the spread of HIV infection to others. Additionally, many organizations do not have the financial resources to support the influx of clients due to migration from rural to urban areas. In Delhi, migration is contributing more to the rise of Delhi's population than the birth rate. For the SHARAN/DSAC's needle exchange program, this year's budget supported 400 clients, which left the remaining 1,000 clients unsupported. Combined, these two barriers are impediments to a program's progress.

As a result of the experiences gained in the program, I recognize the importance of "service". In developing countries, service does not only mean provision of services or administrations of treatments. It means cultural and social awareness of client's condition and needs. Service means being able to listen and empathize, and to advocate for client's basic necessities. Equipped with this understanding of what service truly means, I am convinced that I will incorporate service, in every sense of the word, in promoting health in developing countries.

The PHCM-D program was a gateway to the world of global health. It introduced the many challenges and rewards that a future healthcare worker in developing country may encounter. The program and the people who are part of the program were instrumental in confirming that working with the many varied healthcare issues faced by the people in developing countries is what I would like to do in the future.