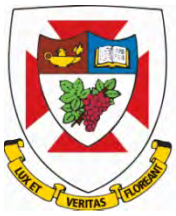
Inner City Health and Social Services Project: Progress Report II

1972

The Institute of Urban Studies



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INNER CITY HEALTH AND SOCIAL SERVICES PROJECT: PROGRESS REPORT II
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The Institute of Urban Studies is an independent research arm of the University of Winnipeg. Since 1969, the IUS has been both an academic and an applied research centre, committed to examining urban development issues in a broad, non-partisan manner. The Institute examines inner city, environmental, Aboriginal and community development issues. In addition to its ongoing involvement in research, IUS brings in visiting scholars, hosts workshops, seminars and conferences, and acts in partnership with other organizations in the community to effect positive change.

Inner City Health and Social Services Project

Progress Report II

Institute of Urban Studies

May 1972

PROGRESS REPORT II - Inner City Health and Social Services Project

I INTRODUCTION

Generally, efforts to rehabilitate deterioriated inner city communities have focused on the physical problems of blight and poor housing, on social problems such as family breakdown, juvenile deliquency, economic problems such as high unemployment, and poorly equipped labour force. As well, the approach to these problems is often fragmented, with multitudes of public and private agencies each dealing with a single set of social problems.

While the need to meet the problem of poor housing, social disorganization and low income has been accepted by public authorities, only more recently has the public sector begun to look into improving the utilization of health services by residents of lower income areas. Too often it is assumed that the standard forms of health care delivery are suitable, when in fact they may not be.

Such is the case in that area of Winnipeg commonly known as Urban Renewal Area II or the area bounded by the CPR tracks to the north, the Red River to the East, Portage Avenue to the South and Sherbrook Street to the West. This part of the city has poor housing, the highest incidence of social breakdown, juvenile delinquency and reliance on social assistance. It is physically deteriorated, lacks adequate recreational facilities and contains a very low income population with comparatively low socio-economic characteristics. Previous reports have suggested serious health problems in the area such as alcholism, the high incidence of infectious diseases, and high infant mortality rates.

This is the kind of community for which improved means of providing health and social services should be developed, geared to meet the particular needs of the population. For the last eight months the University of Winnipeg's Institute of Urban Studies has been involved in just such an effort. Using methods of action-research, the Institute has addressed itself to (1) finding out the particular health problems and health needs of the population, (2) examining the utilization of and satisfaction with present health services, (3) conducting a series of community meetings on health and (4) encouraging members of the community to take initiatives to improve the health and social services available to them, (5) and more recently, acting as a resource to a citizens group that are trying to obtain a health facility for the community.

II THE METHODOLOGY OF ACTION-RESEARCH

The Institute of Urban Studies is involved in other community action projects, primarily in the areas of housing, renewal planning and community television. These various projects also employ the method of action-research.

Nevitt Sanford, one of the pioneers of this research method, has described it as research that has direct consequences for its subjects. The technique of gathering information about a community is through a community self-study, a process by which people of the community study themselves. Through this process people begin to identify their common problems and they gain a new awareness of themselves, their situation and their goals. As a group they acquire a sense of community, of shared purposes, dissatisfactions, and ideas about what needs to be done. In this way a process of change can begin and the community can proceed to organize. When the members of a community are interviewed they are the first to get reports of the findings and these

reports are then presented to encourage discussion, which in turn yields more information.

The elements of this approach are as follows:

1. The importance of receiving the consent and co-operation of neighbourhood agencies and leaders. In our case this was done through meetings with the agencies during the summer of 1971. Two agencies, Neighbourhood Service Centres, and Alcoholic Family Services were actively involved in the project during the fall and winter of 1971.

2. The main research tool is the community self-study, developed in co-operation with residents of the community and administered by these same residents. The community self study becomes not only a method of gathering data but also a way of organizing a community around the problems that are identified by the survey. The legitimacy of the survey is not only that it provides research data but that it also assists in community problem-solving.

The residents who conduct the survey establish quick and immediate rapport with their fellow residents and remove the major obstacle to the gathering of information about their community. The survey that is employed contains mainly open ended questions that promote discussion and begin the process of community awareness and discussion about health services and problems. The utilization of community residents results in a valuable interaction process between interviewers and researchers. The information that is gathered is then reported back to the community, the community being both the subject and the client of the information.

3. A process of continuous experimentation and evaluation. A procedure or technique is instituted and it is changed if it is felt necessary. The survey questions are changed until the interviewers are in fact asking the relevant

questions. Initiatives are taken to develop new surveys with the effectiveness of such initiatives recorded and evaluated.

III ORGANIZATION

The above principles have acted as the general guidelines for the health project in which the Institute of Urban Studies has been engaged since last summer. The area in which we have been working has approximately 40,000 residents of low income. Residents from that area who showed a interest in improving health services were recruited and were put through a training process by which they were taught skills in home visiting and interviewing. These residents have been working in the field for six months conducting interviews. In the last four months, these interviewers have established a group called the Health Action Committee through which they also serve as community representatives. These residents are both an instrument of the research in the sense that they are gathering information and a result of the research in the sense of developing into more aware and capable community advocates. Through a series of public meetings, distribution of information material and home visiting, we have been reaching the community and trying to promote discussion of health as an issue, gathering information on community health problems, letting the residents know one anothers experiences and problems and trying to facilitate a process of community action to improve medical and social services. The goal of the above action research is improvement through community action, not just the collection of data.

Since the community under discussion was too large to handle as a single unit, it was broken down into ten small relatively homogeneous sectors.

In each sector we have been seeking information on community health problems and publicizing a community meeting for interested residents. Following the publicity, a health survey team has gone into the area to conduct the survey and to begin community discussion on health matters. At the meeting, the findings of the surveys have been presented, people have discussed their experiences and have then proposed action to improve their community's services. Interested people have then been invited to follow-up meetings where people ahve been offered involvement in alternative courses of action to affect change.

As of April 31st, six sectors or two-thirds the total area have been delt with in the above manner. About 700 - 900 information sheets have been distributed door-to-door in each sector, for a total of about 3,500 - 4,500 people. Six community meetings have been held with an additional four general follow-up meetings.

After the survey team had been in operation for two months and once the first large follow-up of interested citizens had been held, several citizens wanted to take concrete action. They decided to formulate a proposal to be presented to the federal government to fund a winter works program that would support a team of residents who would initiate a research program on health services and operate a health information and referral service. At this time the group adopted the name of the Health Action Committee. While awaiting word on the winter works proposal, Health Action Committee members continued in the community self-study and began to chair the community meetings.

In March, after work had been conducted in three sectors, a conference for citizens was held to provide an opportunity for the Health Action Committee to present its findings to the community and to begin a program of larger

meetings at which providers of medical services could begin to meet residents and exchange ideas. In preparation for the conference, members of the Health Action Committee approved a piece of promotional literature and about 3,000 of these leaflets reached the community explaining the work and findings of the Health Action Committee and announcing the holding of the conference. The conference was attended by about 40 residents of the community, excluding a few organizational and professional people. At the meeting, providers of medical services explained the various services they offered to the community. During the question periods and in the subsequent discussion groups citizens responded with their ideas on these services and suggested specific ways in which they could be improved, thus establishing a two way flow of communication between clients and providers.

The Health Action Committee chaired the public meetings, presented their findings and led each of the various discussion groups. More recently, the Health Action Committee has begun to meet with providers of medical services and other institutions in order to get assistance and help from these people. Those contacted have included doctors from Childrens' Hospital, and the Manitoba Medical Association. Meetings are being scheduled with other organizations. Meetings are regularly held with the resident workers to discuss approaches on future plans for the project. At two meetings the questionnaire was expanded and reworked to make it a more effective form of data collection. This re-working was based on the initial findings of the neighbourhood contact. Under its own initiatives the group made representation to the Centennial Community Committee on the need to improve health services. Two members of the Health Action Committee were elected as resident advisors and have been presenting briefs and trying to take initiatives to improve medical services.

The group is also making contacts on its own with agencies such as the Winnipeg Council of Self Help Groups in order to gain support for its goals.

The work in the community and with the citizens' group being accompanied by a program of research and evaluation of medical and social services. The various providers of medical and social services. The various providers of medical and social services are being contacted and are being interviewed on matters such as:

1. the role of the institution, and the type of service that it is providing to its clientele
2. the problems in delivering the service
3. any plans that are being made to improve health services and the general attitude towards the reorganization of medical services.

The directors of large medical centres, private physicians, the City of Winnipeg, and Provincial Departments of Public Health, the General Hospital and the Manitoba Medical Association have been contacted thus far.

A review of the literature on the experiences of other communities in improving medical services and of changes in the delivery of medical care is also being made, particularly the American Office of Economic Opportunity (OEO) programs in experimenting with neighbourhood health centres in places as such/Boston and New York.

IV FINDINGS

(a) Tentative Nature of the Findings

The work so far has consisted mainly of a program of contacting the community, through home visiting, the community self-survey, small community meetings and larger area meetings. This first wave of information has provided

the basis for more detailed investigation and a refinement of needs as expressed. The questionnaire that was employed was designed as a tool by which the community could begin to understand itself, its problems and then based on this information develop some strategies by which residents can plan changes to improve services. Accordingly the results are not definitve but serve mainly as indicators of trends and patterns that can now be more specifically explored. The information derived from this initial neighbourhood contact does however, provide useful information on health problems in the area.

(b) The Survey

From the sector work a profile of the area is emerging. The general characteristics of each of the sectors are as follows...(see the enclosed map for the location of each sector):

Sector 1: The most depressed sector of the community - poor housing, high alcoholism and drug sbuse, much social disorganization, significant level of native population.

Sector 2: Poor walk-ups and rooming houses in poor condition containing mostly elderly males. They live alone and many are alcoholics - a kind of Downtown Skid Row.

Sector 3: Perhaps the most stable part of the area yet - good housing and solid working class families.

Sector 4: Another area of good housing: a stable working class community.

Sector 5: Contains both decent housing on the west and poor, dilapidated housing and social disorganization in the east.

Sector 6: Basically a working class area of modest housing.

This brief profile of each of the sectors explains some of the results that we obtained and the different responses that were given to the same questions.

Some preliminary findings from the survey are as follows:

Question	Sector					
	1st	2nd	3rd	4th	5th	6th
Health is a problem	40%	52%	45%	49%	58%	-
Have their own doctor	58%	40%	90%	89%	75%	66%
Go to Outpatient's	65%	30%	25%	21%	30%	20%
Are satisfied with medical services	45%	40%	60%	70%	60%	-
Are under treatment	40%	13%	20%	30%	50%	21%
Have heard of Health Center proposal	-	38%	61%	43%	40%	32%
Are interested in working on a committee	-	-	9%	10%	15%	24%
Feel a Health Center would help	-	-	84%	70%	95%	78%
Would use a Health Center	-	-	81%	60%	80%	75%

Certain results can be immediately understood when the characteristics of each sector are considered. It is found, for instance, that the sectors with the highest socio-economic characteristics have the highest use of a private family physician (Sector 4 - 89%, Sector 5 - 90%), and are satisfied with medical services because they meet their needs and they know how to use them (Sector 4 - 70%, Sector 5 - 60%). On the other hand the sectors with the lowest socio-economic characteristics go to Outpatients (Sector 1 - 65%, Sector 2 - 30%, and show the least satisfaction with medical services, 40% and 45% for

Sector 2 and 1, respectively, compared to rates of 60%, 60%, and 70% for the three more prosperous sectors.

There appears to be support for the establishment of a health centre, with 83% of people believing it would help the community and 75% indicates that they would use one if it were established. The lowest felt need for a health centre and lowest expressed intent to use one, occurs in the sector with the highest use of private family doctors - sector 4.

Through the program of home visiting, community meetings and the self-study, the following patterns and health problems and needs have been observed:

1. People do not visit a doctor regularly in order to maintain their health nor do they seek medical attention as soon as they experience a problem. Instead they wait as long as possible and seek medical care only when it is absolutely necessary and their condition is acute.

2. People receive medical care from basically two sources -- private doctors in various clinics and the Winnipeg General Hospital's Outpatients Department. Most people complain about the long waiting times and impersonal service at Outpatients, but they use it because they get free drugs and because they can get medical attention the same day.

3. Most health problems are related to social-environmental problems such as poor housing, nutrition, hygiene, lack of information about available medical services, loneliness and lack of a family or social life.

4. High levels of alcoholism amongst adults and alarming levels of drug abuse, (almost exclusively glue sniffing) amongst children and juveniles is a singularly important problem .

5. There is a serious lack of information on the services that are available.

6. There is a need for a home assistance service for mothers with small children and for senior citizens. These groups are confined to home, with little mobility. When health problems develop, the tendency is to forego treatment until it becomes acute.

7. The need to involve senior citizens in day centres in order to provide information on available services, such as free drugs, hearing aids, and glasses.

8. The need for assistance to mothers with disturbed children (many people have said that a health centre could help mothers to bring up children).

9. The need for a day care and well-baby centre.

10. The need for a medical facility that is close by, available at all times, and equipped with a transportation service for senior citizens and other disabled people.

(c) The Initial Findings from The Health Action Committee

The Health Action Committee has taken over much of the work and contact in the community. It will continue to survey the area, and report findings from the community meetings that it will continue to obtain. Future plans include the holding of health education meetings on matters such as nutrition, personal hygiene, care of children, homemaking and family planning.

The group is beginning a program of communication with agencies and organizations in order to gain assistance and support in its efforts to improve medical services such as doctors, the Manitoba Medical Association, the General Hospitals' Outpatients and the City of Winnipeg on improving the service being offered. Those responsible for Outpatients, in particular, have expressed an openess to the Health Action Committee and have suggested the establishment of an orientation program of several months duration, after which certain Health Action Committee members will serve on a steering planning group for the planning of Outpatients Department's central clinic.

One of the most significant results of employing neighbourhood people as interviewers is that they have already begun to work as health aides. While home visiting, the interviewers are often asked for information on where to go for particular problems. In certain cases they have requested a public health nurse to visit the resident and have called back to see how the person got along. In other cases they have advised the resident to visit a doctor or to get other medical attention. These interviewers have been acting as non-professional neighbourhood health workers providing an information and referral service, and serving as health advocates. Thus, they have been closing the gap and meeting the important need of <u>connecting sick people to available health services</u>.

Having identified this gap in services the Health Action Committee is now seeking funds for a program to establish an information and referral centre in the community that would provide services such as:

1. a storefront operation providing information on what services are available for particular needs and problems.
2. providing referals to private doctors and medical clinics where doctors are available evenings and weekends.

3. arrange calls by public health nurses.
4. a home visiting service for senior citizens and mothers with young children.
5. arrange for periodic clinics that would be staffed by doctors and nurses from existing institutions on geriatric care. well baby care, counselling etc.

This suggests a major area of future development in the quest to improve health services in the area.

(d) Services

Although the target area has a high concentration of medical services these services are provincial, metropolitan and community services. An examination of the clientele of the Manitoba Clinic, for instance, showed that in a sample of 106 patient visits only 14 were from the target area, and all of these were from the comparatively properous working class area on the south west. There were no patients east of Sherbrook or north of Ellice.

Interviews were held with directors of large medical clinics. They indicated in their views that one major problem in developing a better community orientation of medical services is a manpower shortage of family practitioners. Most graduating medical students want to pursue careers in research or in specialities. Furthermore the training they receive prepares them to diagnose and treat rare and acute diseases and not to maintain a program of preventative medicine or primary care. Plans are now being developed to improve the status of family practitioners through a new internship program. Other proposals include the training and development of para medical personnel to screen medical problems and refer to the appropriate source of medical care.

The General Hospital's Outpatient Department is the second most utilized source of medical care by the target community, the first being private doctors. The limitations of the service are obvious -- not enough space or staff, the absence of continuity or follow-up and impersonal service. Plans are now being made to expand Outpatients and, as mentioned above, the planners have indicated a willingness to involve residents of the community in the planning.

The City of Winnipeg's Department of Public Health provides health education and prevention programs in the schools and responds to the need for home visits to elderly people or mothers with infants and young children. The public health nurses working in the schools and in the homes find that children and parents often fail to follow up on a referral to a doctor or to follow the prescribed treatment. One weakness of the service being offered is that the area office of the department is not community-based as it is in other areas of Winnipeg. Instead it is located in the administration building of City Hall. As a result it is not as accessible or as highly utilized as it would be if it were part of the community. Tied in to an information and referral service using community workers, the effectiveness of the public health nurses could be improved.

We are presently in an evalutionary process where the emphasis has been towards production; now it seems to be moving towards an approach stressing distribution both in manpower and service. For instance, in the area of manpower, it has now been realized, that there is a shortage of family practitioners relative to specialists and a realization of the need to develope paramedical personnel. Secondly, medical institutions tend to lag behind in shaping their service to particular needs of the population, whether the need is geographic, socio-medical, or disease oriented. One way to meet this problem is through greater involvement by community residents in

planning programs.

V PRELIMINARY ASSESSMENT

This is only a progress report. The evidence at this stage is partial. Further investigation will be required to provide a more complete picture of health needs and to provide an assessment of possible courses of action.

Yet, even on the basis of the work done thus far, it appears that there is some mis-match between health resources and need. The problem of illness in the inner city is serious and there is a strongly expressed need for improved services by many residents.

One way that this can happen is by developing more effective linkages between the community and the health services. This could involve neighbourhood workers; who could provide the connection between community and medical service and who could initiate community-based health services that are directly related to needs as perceived by residents.

The form that this kind of service might take will be a major subject in the concluding report.