OBLF

EMPOWERING COMMUNITIES

Impact Evaluation

Health Program 2022-2023

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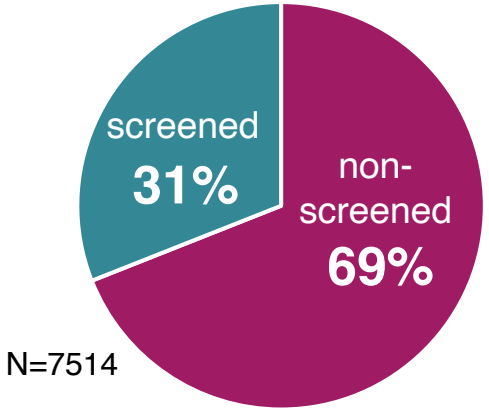
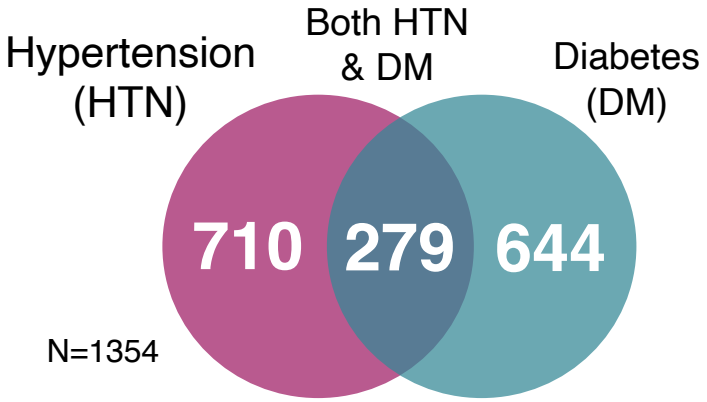
Lead - Program Design, M&E & Stakeholder Partnerships

Executive Summary

- The Foundation's public health framework seeks to enable Primary healthcare that is **accessible, acceptable, affordable, and predictable** – to vulnerable households and communities in marginalized areas of Anekal Taluk.
- By **building community consciousness & deepening ties** we seek to Reduce Non-Communicable Diseases in vulnerable communities via Preventive, Curative and Facilitative Healthcare services.
- Our target population is individuals over 30 years and currently extends to **7514 individuals out of which 2287 individuals have been screened for NCDs across 5 clinic cycles.**





1354 NCD cases detected

- The **prevalence** of NCD in the target population is **18%** and **10%** in the general population.
- There has been a **5-14%** rise in detection of NCDs across the clinic cycles.

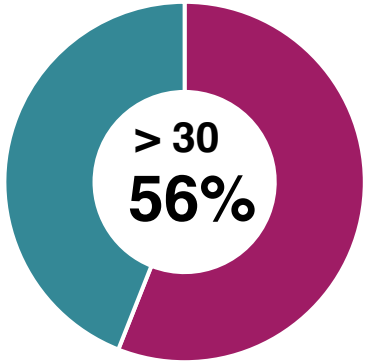
- There has been a noticeable shift in **community sentiments and collective awareness.** Subsidized quality screening and treatment, home visits and telephonic conversations by FLWs. in-person counselling at clinics and dismantling of patient-practitioner power dynamics have transformed our clinics into spaces of community gathering & learning – where patients have now reclaimed the onus of their own healthcare and voluntarily show up to clinics for screenings, treatments & follow-ups.

1. Socio-Demographic & Screening Details

- **Project site:** Anekal Taluk. The PHC at Indlawadi spans **30 villages** with **3 sub-centres** of 10 villages each with a total population of **13,388.**
- **Target Population:** Each year, more than 15 million people die from an NCD between the ages of 30 and 69 years; 85% of these "premature" deaths occur in low- and middle-income countries. (SDG3, WHO) Thus, given the high risk and onset of NCDs, we have limited our target population to those individuals **above 30 years of age.**
- Most of the older population works in agriculture while the younger generation migrates or commutes to various industries for wage work.

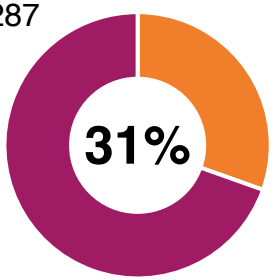
56% of the total population is >30 with 7514 as the target population under the intervention

N=13388



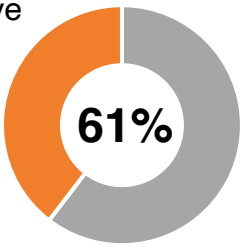
31% of the target population has been screened – 2287

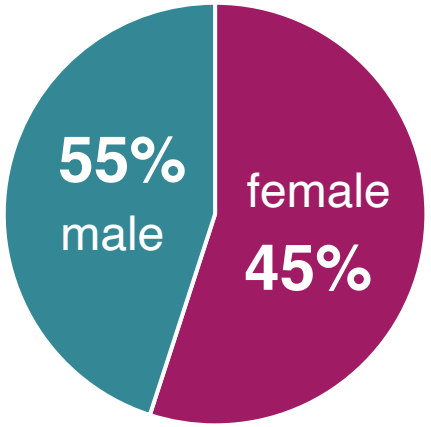
N=7514



61% of the screened population have NCDs – 1354

N=2287





Gender-based segregation of the target population

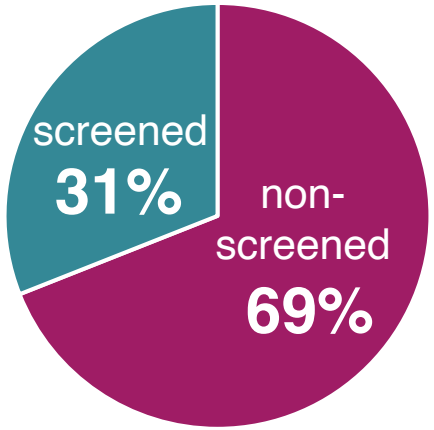
N=7514

Target Population (>=30)

7514

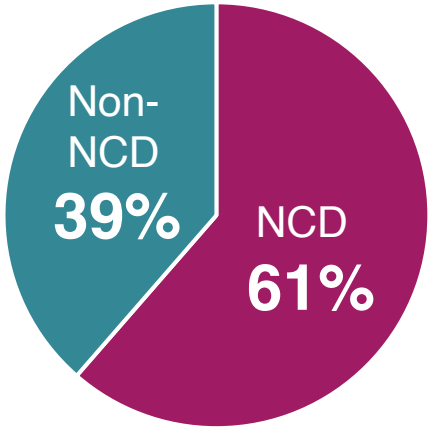
Screened Patients (>=30)

2287



Screening of the target population

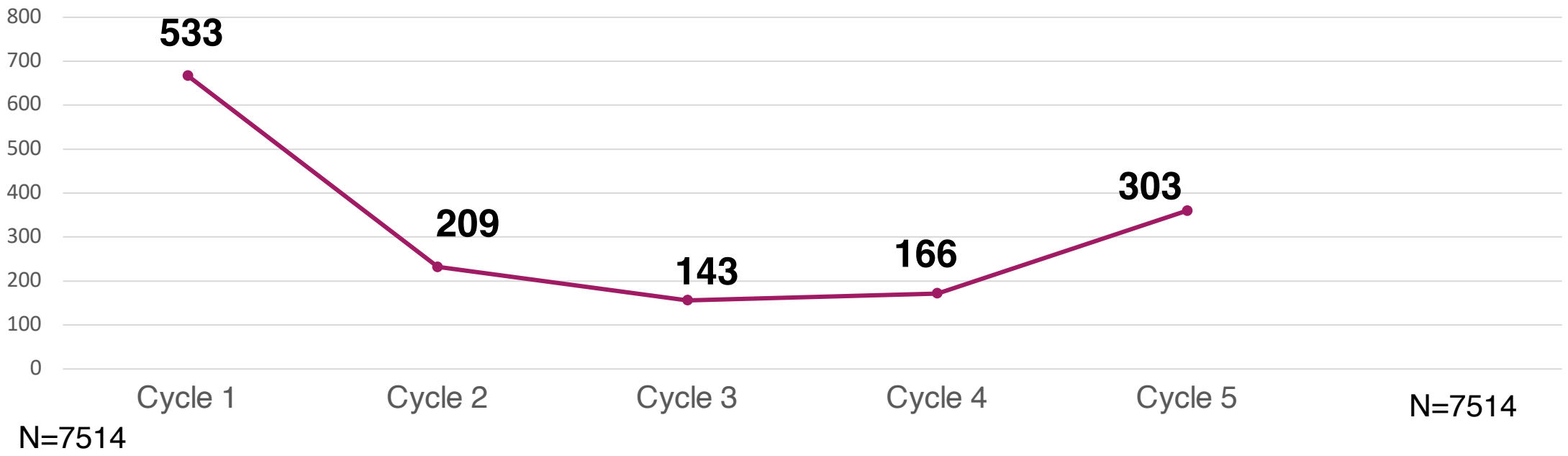
N=7514



NCD & Non-NCD screened population

N=2287

An Overview of Screening Across Clinic Cycles

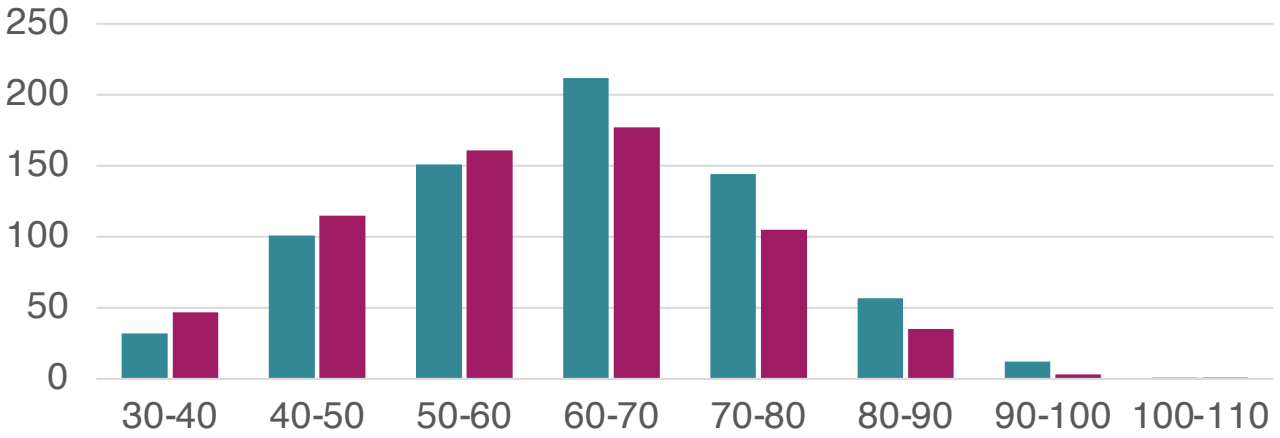


N=7514

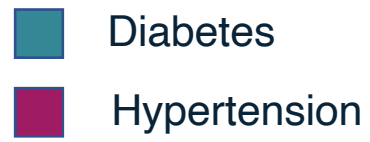
- The high footfall observed in the first clinic cycle can be attributed to the novelty of a free mobile healthcare clinic in these areas. The following clinics highlighted issues of a **lack of community awareness, biases & preconceived notions towards screening, inability to avail care due to wage earning responsibilities & migration and an aged untended population** across households.
- Our frontline workers continue to build community awareness and mobilize households to attend the health clinics through their robust door-to-door follow-ups. Local FLWs enjoy more trust & community visibility in comparison to those that reside outside these villages.

2. NCD Detection (HTN, DM & Both)

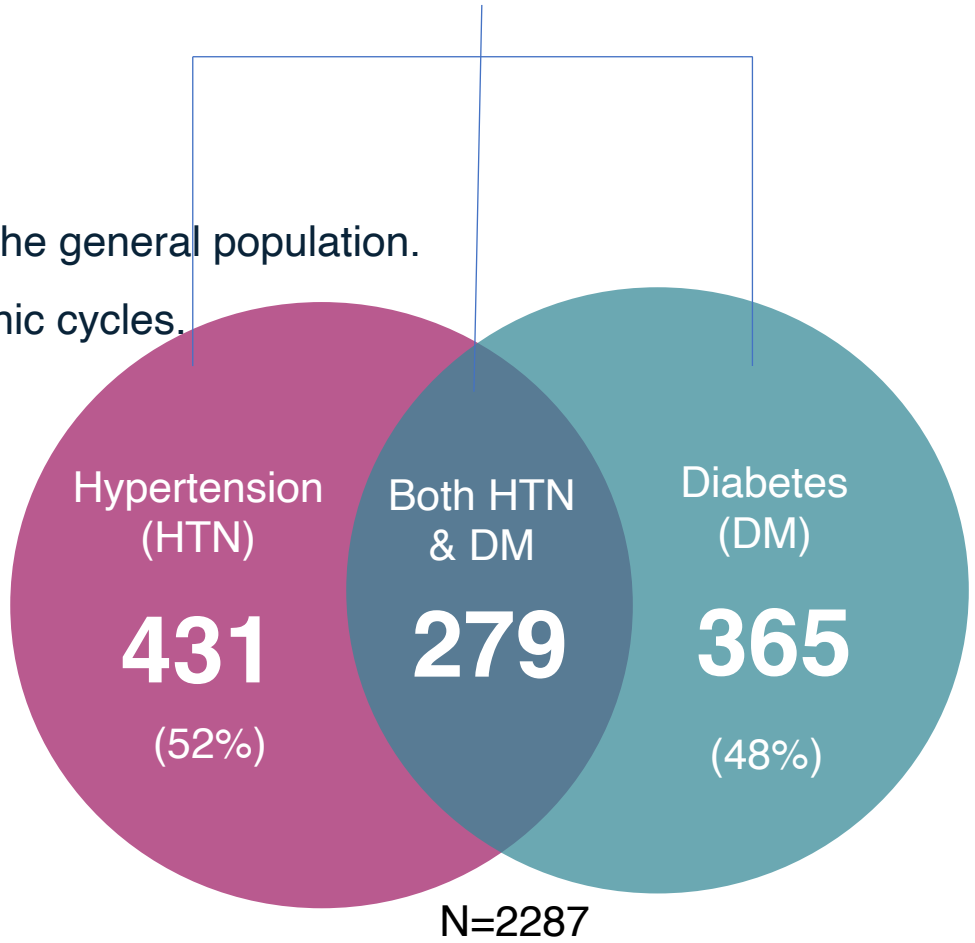
- The target population (those above 30) is **7514**.
- HTN = **710 (52%)**
- DM = **644 (48%)**
- BOTH = **279 (21%)**
- The total no of NCD cases detected in the target population is **1354**.
- The **prevalence** of NCD in the target population is **18%** and **10%** in the general population.
- There has been a **5-14%** rise in the detection of NCDs across the clinic cycles.



N=7514 Age-wise break up of NCD population



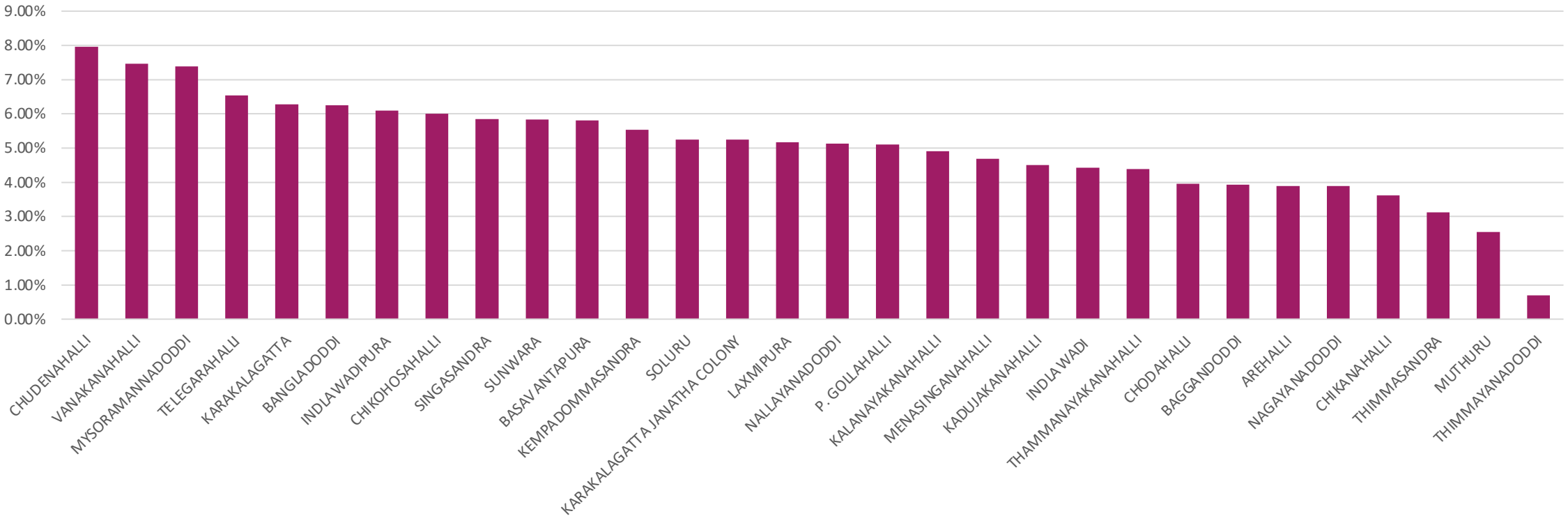
1354 NCD cases detected



N=2287

HTN: A village-wise breakdown

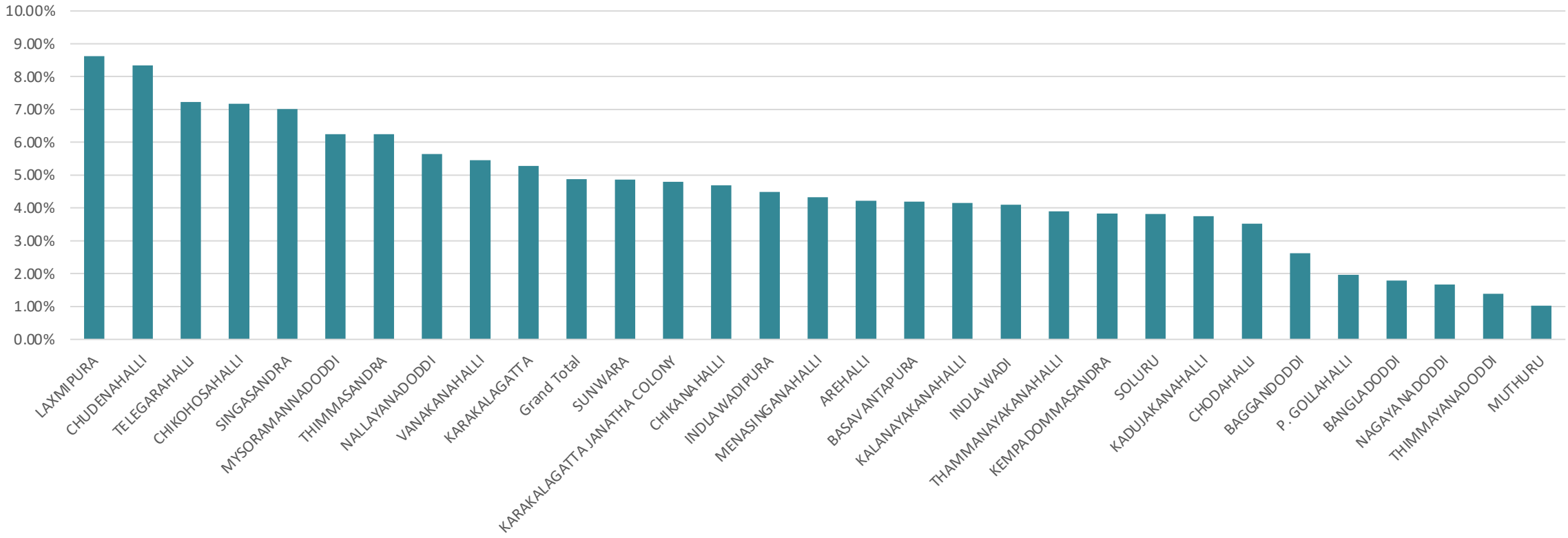
HTN diagnosed across five clinic cycles: 710



Chudenahalli, Vanakanahalli, Mysoramannadoddi & Telegarahalli & show the highest number of HTN cases across the 30 villages.

DM: A village-wise breakdown

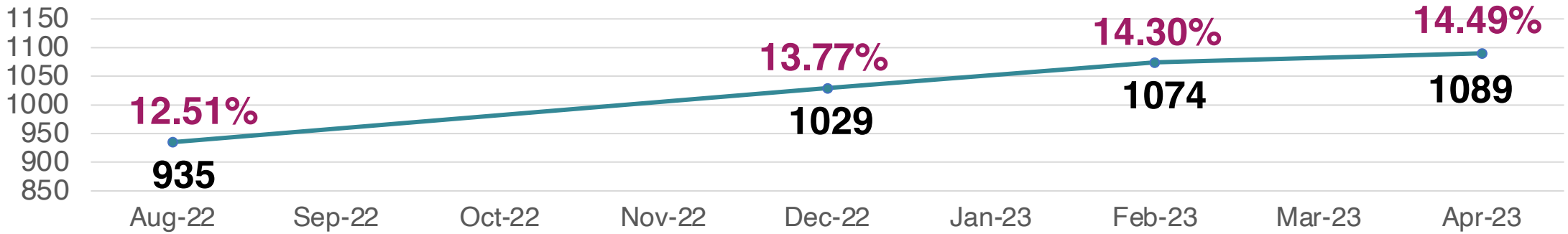
DM diagnosed across five clinic cycles: 644



Laxmipura, Chudenahalli, Telegarahalli show the highest number of DM cases across the 30 villages.

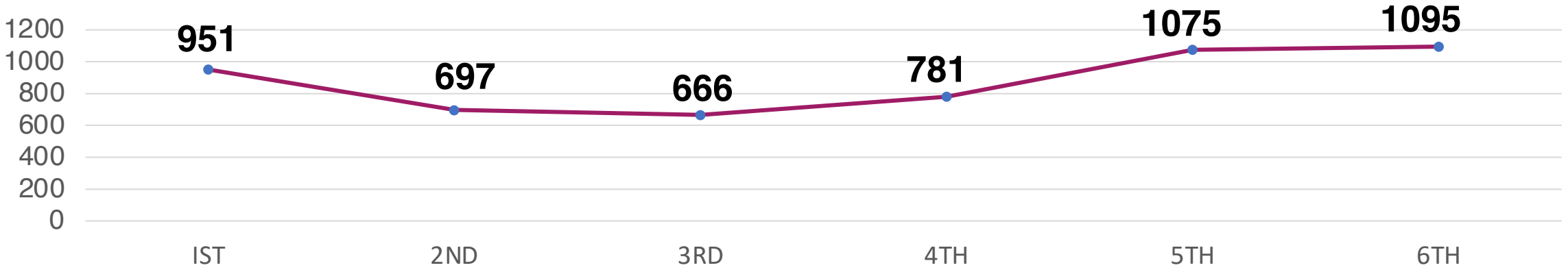
N=7514

3. Mapping Prevalence of NCDs



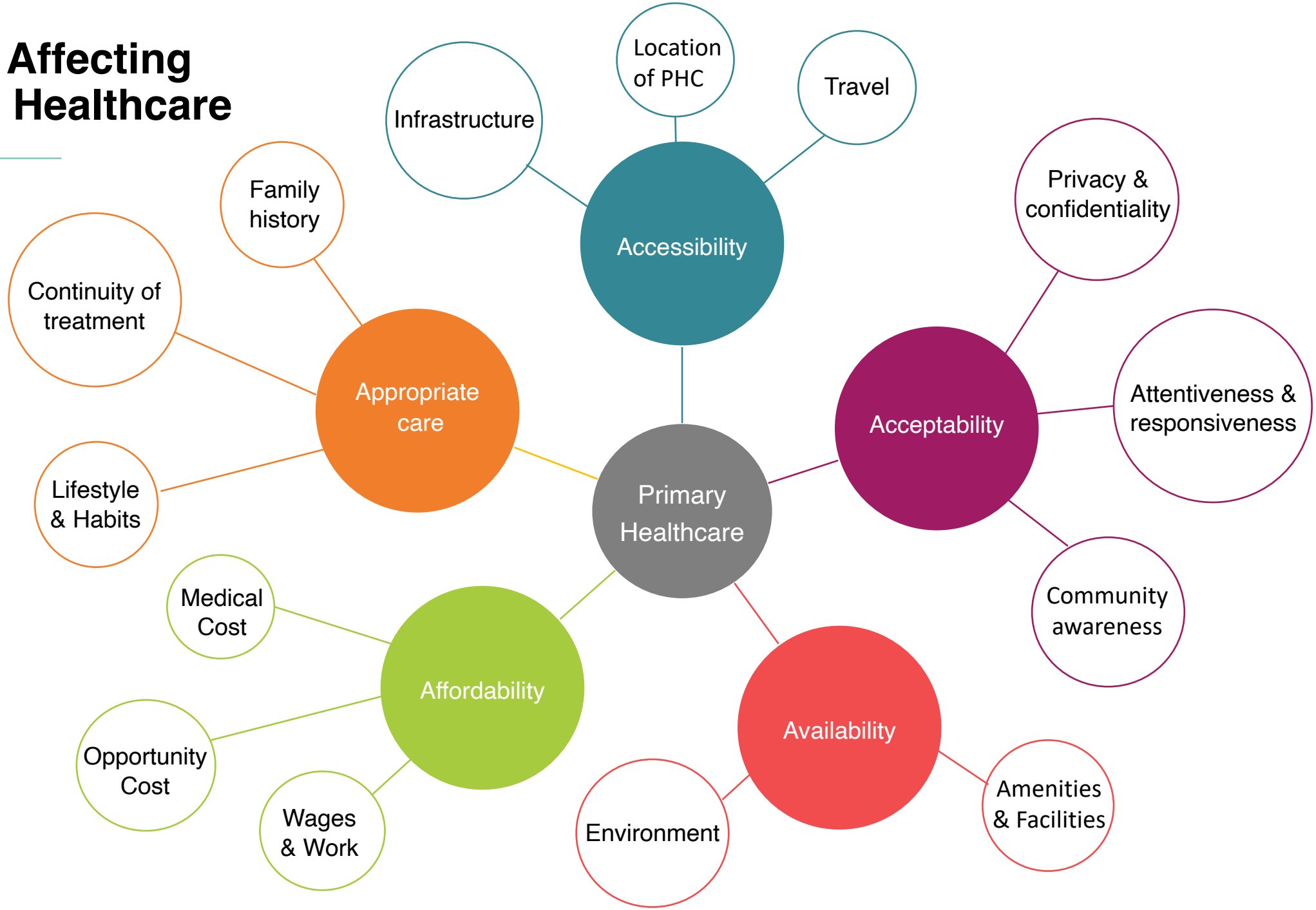
Prevalence of NCDs refers to the % of NCDs recorded among those individuals screened during a specific point in time. Our prevalence trend affirms our hypothesis of mobilizing larger community numbers for screening to drive the detection & treatment of NCDs.

4. Consultations

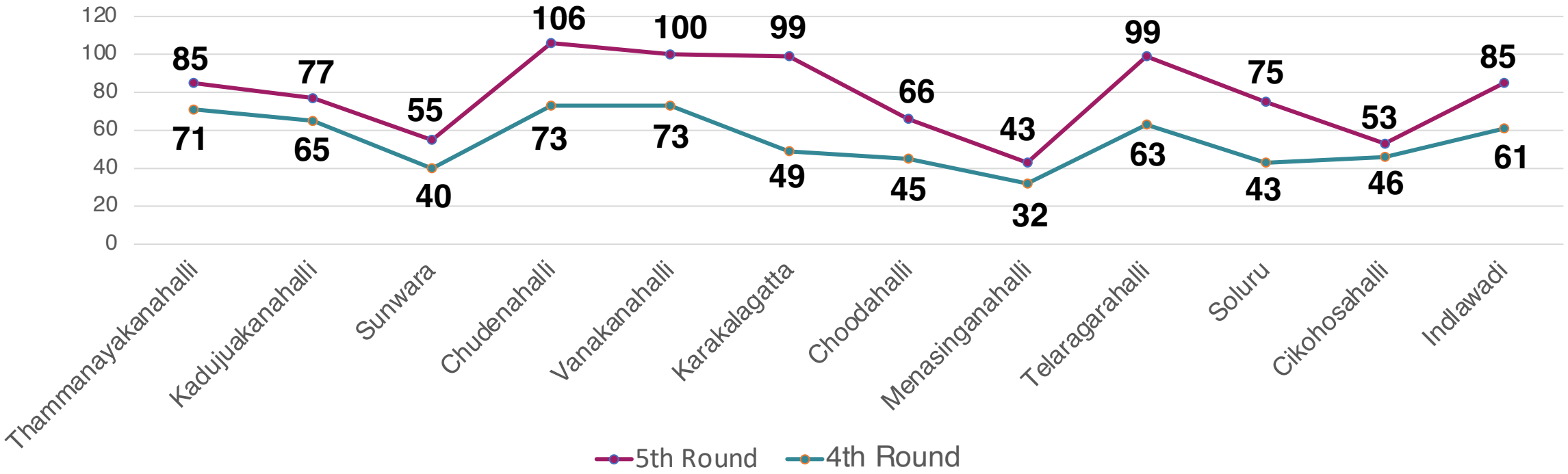


Total No of consultations held across **6** clinic cycles: **5265**

Factors Affecting Primary Healthcare



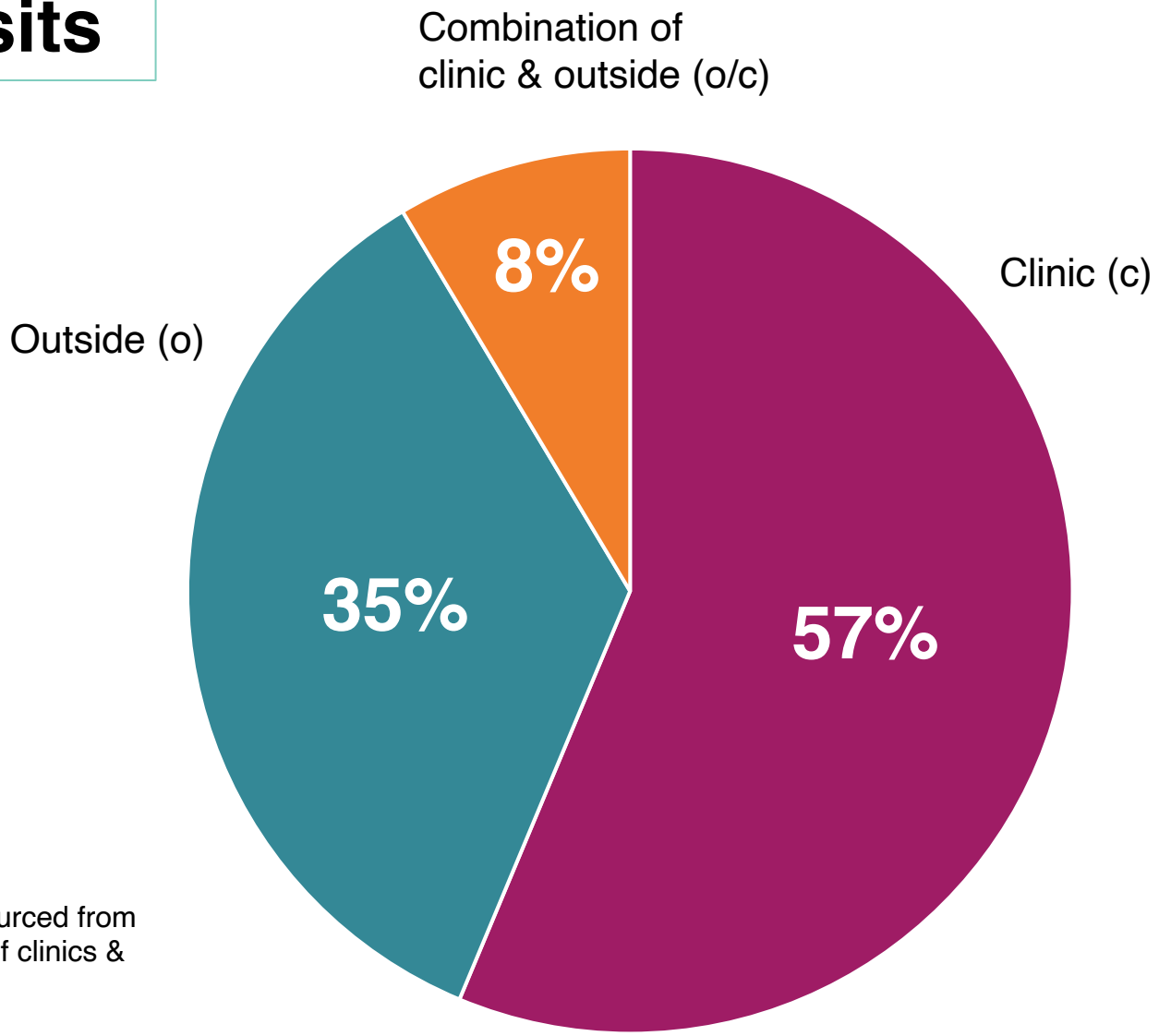
Integrating Learnings to Strengthen Rigour & Impact



Clinic Timings & Consistent Community Mobilization through FLWs emerged as significant determinants in increasing our screenings across villages. Learning from our experiences in the field, our clinic timings were changed from 10:00 am to 8:00 am to accommodate the timings of daily wage earners. There was a noticeable shift in the number of individuals accessing our clinic services as represented in the graph.

4. Patient Treatment & Visits

57% of the diagnosed patients avail healthcare treatment from the clinic while **35%** avail treatment from government or private clinics and **8%** of these patients obtain treatment both at the clinic and from other healthcare facilities.



Treatment is sourced from Clinic (c)

Treatment is source Outside (o)

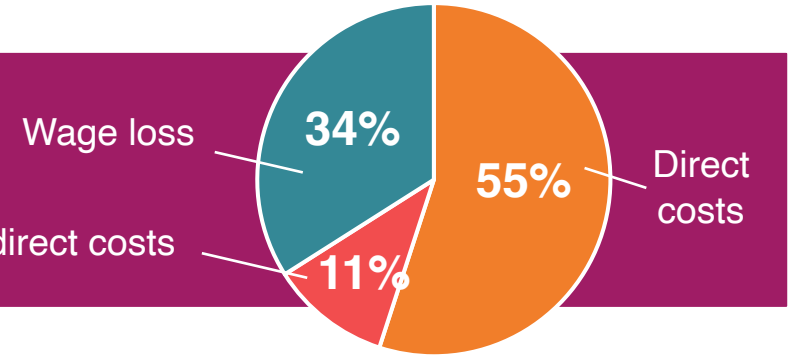
Treatment is sourced from a combination of clinics & outside (o/c)

Opportunity Cost of Availing PHC

N=7514

Opportunity Cost is the monetary & non-monetary value a patient forgoes to be able to avail of the healthcare facilities

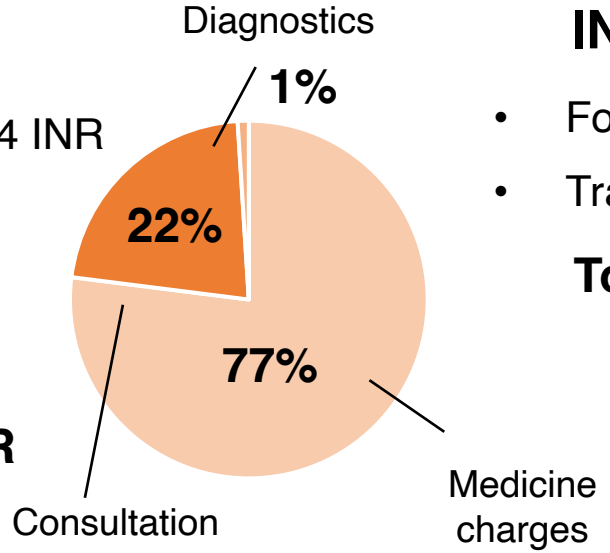
OPPORTUNITY COST: 1,110.76 INR



DIRECT COSTS

- Medicine Charges: 468.4 INR
- Consultation: 135.3 INR
- Diagnostics: 5.84 INR
- Informal Fees: None

Total Cost: 608.6 INR



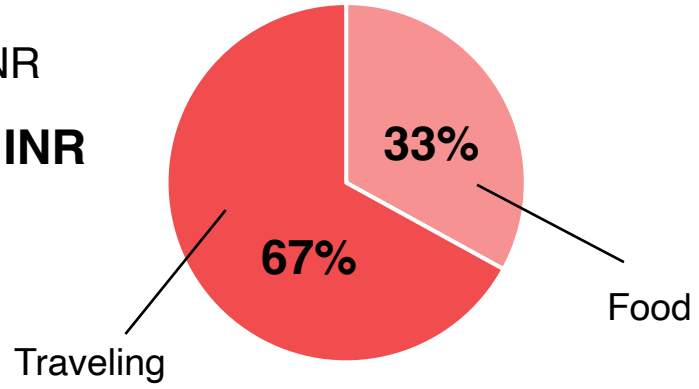
INDIRECT COSTS

- Food: 82.6 INR
- Travelling: 41.12 INR

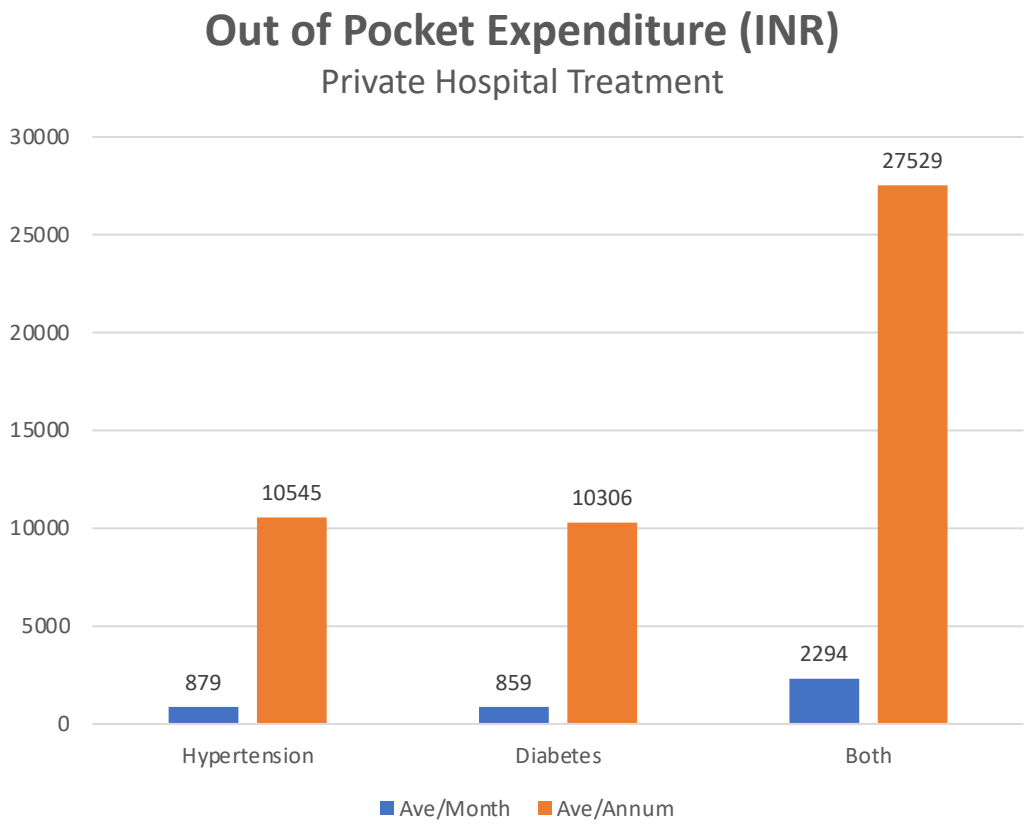
Total Cost: 124 INR

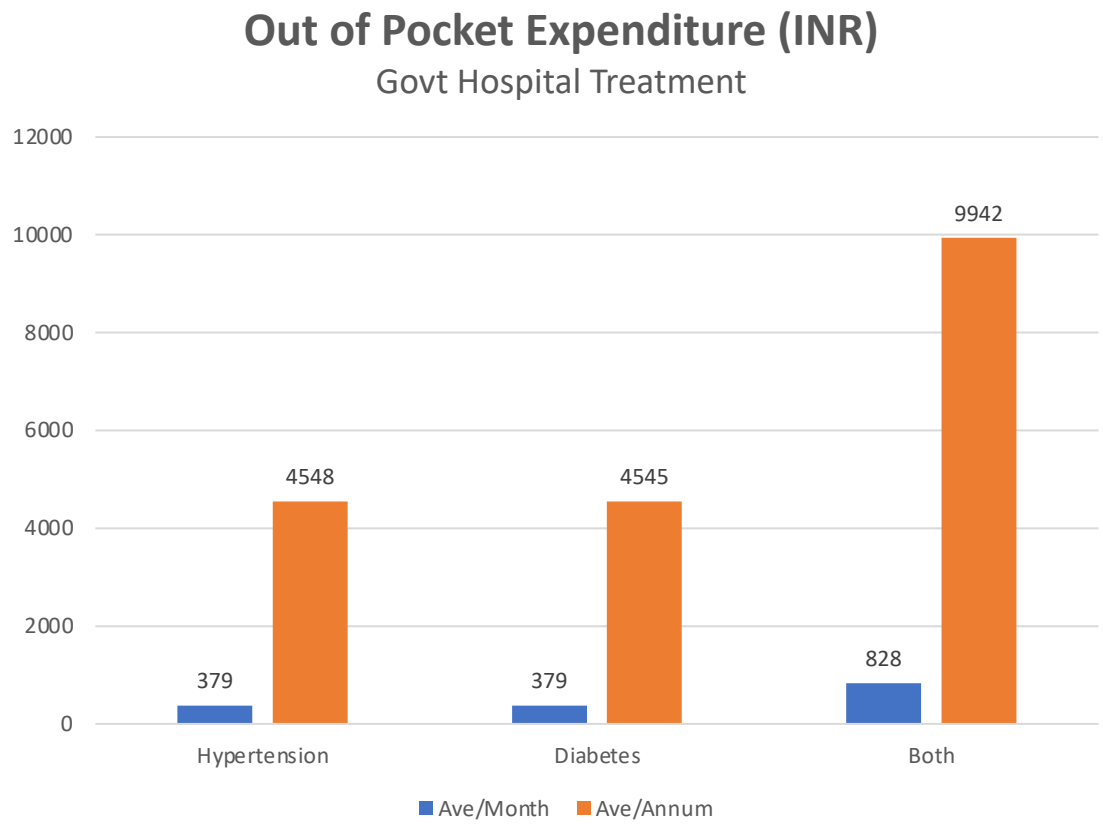
WAGE LOSS

379.75 INR



Opportunity Cost of Availing PHC

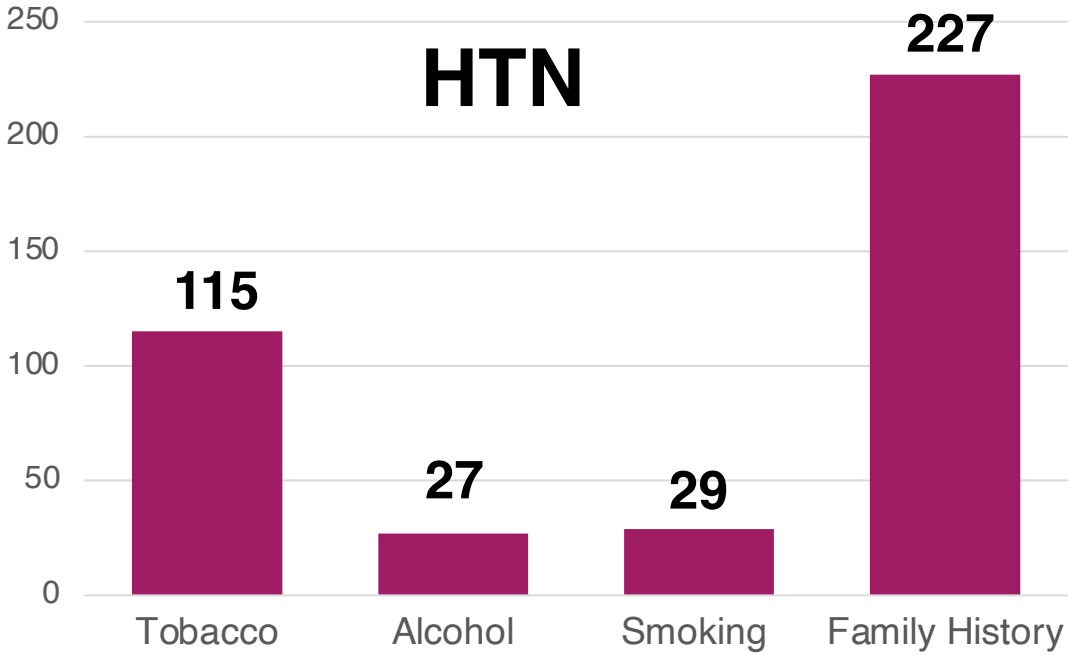


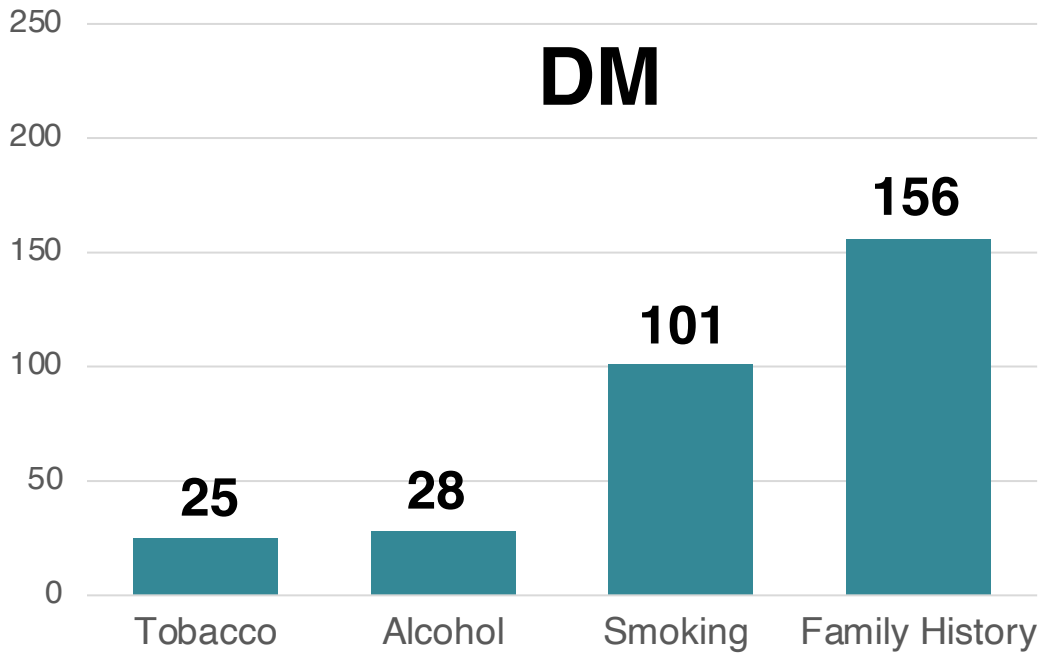


The residents across villages reported paying **2294 INR** a month & **27,529 INR** per annum when availing of treatment services in Private Hospitals whereas they reported paying **828 INR** a month and **9,942 INR** per annum when availing these treatment services at a government hospital.

Health Habits & Risks among NCD Patients

N=1354





- Family history has emerged as a key risk factor with **32%** of the HTN and **24%** of DM-diagnosed patients reporting a family history of NCDs. Substance usage and dependency have also shown linkages with Hypertension & Diabetes diagnosis.

- The clinics also incorporate a ‘counselling’ aspect of care where the patients are advised and supported on making lifestyle changes. The FLWs even deliver required medication to specific households that are unable to procure medication themselves.

Executive Summary & Reflections

- A plethora of research on Primary Healthcare deems it as subjective, complex and multi-dimensional. A holistic healthcare framework places focus on monitoring the **availability, accessibility, affordability, acceptability, and appropriateness** of healthcare. OBLF's Public health model integrates this robust framework with **community mobilization** by placing the community at the centre of our activities in Anekal.
- There has been a noticeable shift in **community sentiments and collective awareness** around accessing timely healthcare and treatment. Subsidized quality screening and treatment, home visits, telephonic conversations, in-person counselling at clinics and dismantling of patient-practitioner power dynamics have transformed our clinics into spaces of community gathering & learning – where patients have now reclaimed the onus of their own healthcare and voluntarily show up to clinics for screenings, treatments & follow-ups.
- The frontline healthcare workers have been **instrumental in deepening community ties**, **monitoring individual healthcare status across households & instilling a sense of awareness & confidence in other women in the community** to access primary healthcare services. Women are able to discuss their sexual reproductive health concerns with the FLWs with the utmost privacy.
- As rewarding and promising as our model of PHC is, it is not without its own challenges and constraints. Friction between patient and practitioners around the waiting time persists, there are constraints of time & manpower when determining the frequency of our clinics, and building trust & credibility of the treatment remains an on-going process that requires purposeful mediation from our end.
- We are now in the process of planning more clinic rounds, further leveraging community ties, increasing access to medication & treatment & strengthening the systemic process around capturing and monitoring patient data.