2019-2020

ANNUAL REPORT

ANAHAT FOUNDATION

www.anahatfoundation.org

anahat

ABOUT US

VISION

Every person in India should be healthy and well, and should have the confidence to access health services when needed

MISSION

ANAHAT FOUNDTION is bridging the gap between poorer communities and the government healthcare system, by strengthening the demand for health services and by building the capacities of non-medical health workers to provide these services.

MESSAGE FROM OUR TRUSTEE & MD - BRIGADIER M. A. DEVAIAH

Dear Reader

The year 2019-20 was an excellent year for ANAHAT FOUNDTION. Pace and volume of work increased manyfold. Large number of health camps was conducted spread over various geographies, we are now working in 40 underserved communities across Bangalore, Tumkur, Chamrajnagar, and Davangere. A special mention needs to be made of the untiring work done by Rani, Dr Abraham and the dedicated staff of St Martha's Hospital to ensure proper health care delivery.

The highlights of the period were:

a. Developing a good working relationship with the Government Health Department.

b. Increase in the number of camps and foot falls at each of the camps.

c. Improvement in the follow up protocol by the ASHA workers and the PHCs.

d. Rise in the level of confidence among the slum dwellers; resulting in improvement of health index.

e. Improved professional relationships with the doctors and staff at the PHCs.

MESSAGE FROM OUR TRUSTEE & MD - BRIGADIER M. A. DEVAIAH

In August and September of 2019, Anahat Foundation and St. Martha's Hospital's Community Medicine team, conducted health checkup camps for Pourakarmikas (PKs) in BBMP's East Zone. The objective of these camps was to understand the health status of BBMP's PK workers and recommend a sustainable and easily accessible health care delivery program for the workers. In addition to producing an actionable report of this initiative, we were able to extract interesting comparisons of health metrics between the PK patient cohort and the other patient cohorts that we work with – migrant and non-migrant workers.

These positive developments have been the motivating factor to reach out more aggressively to the under privileged population. In March 2020 we witnessed the ominous signs of COVID-19 virus and we had to stop our community work temporarily. However, we are optimistic and remain committed to deliver health care to the underprivileged population even under the new normal environment.

Sincerely,

Brigadier Mac Devaiah

COMMUNITY MEDICAL CAMPS

Our primary intervention continues to be community medical camps, Below is a list of the camps conducted by us from April 2019 to March 2020

No	Date	Location	Patients
1	10 May 2019	Machohalli, Kadabagere Cross	100
2	24 May 2019	Mariyamma Nagar, Tumkur	159
3	07 June 2019	Neelamangala	114
4	21 June 2019	Meddarahalli, Chikkabanavara	105
5	20 July 2019	Banashankari	113
6	29 August 2019	Chamrajnagar	115
7	05 September 2019	Monekolulu	102
8	20 September 2019	BBMP PKs Austin Town (114 & 115)	52
9	23 September 2019	BBMP PKsVasanthnagar	83
10	25 September 2019	BBMP PKs Domlur (112)	49
11	27 September 2019	BBMP PKs Shantinagar (116 & 117)	112
12	03 October 2019	BBMP PKs Nilsandra (111)	144
13	04 October 2019	Bbmp PKs Taskar Town (63 & 92)	57
14	05 October 2019	BBMP PKs Ulsoor (89 & 90)	67
15	18 October 2019	Mediagrahara	145
16	24 October 2019	Jagluru, Davangere	150
17	25 October 2019	Vishwapriya Layout, Begur	105
18	31 October 2019	Rayasandra, Electronic City	100
19	15 November 2019	Dubburu, Tumkur	136
20	21 November 2019	Shetty Halli	68
21	22 November 2019	Chandana Layout, Kariyamma Agara	100
22	25 November 2019	Chiranjeevi Layout, Hebbal	93
23	29 November 2019	Sumanahalli	150
24	15 December 2019	Vinayak Nagar, Shantinagar	154
25	18 January 2020	ELCITA	125
26	23 January 2020	Mariyamma Nagar, Tumkur	93
27	12 February 2020	Kunthigrama, Hebbal	82
28	14 February 2020	BK Nagar, Giddenahalli	77
29	01 March 2020	Bazar Street, Nilasandra	113
30	12 March 2020	Monekolulu	101
31	13 March 2020	LR Nagar	143
			3307

HEALTH CAMPS FOR BBMP POURAKARMIKAS: EAST ZONE

Background
In September & October 2019 Anahat Foundation conducted 7 camps for the Pourakarmika workers of 11 wards in the East Zone of Bangalore.

This report covers details of the demographic and provisional disease data of this cohort of 564 women and men.

Partners
The BBMP health camps were conducted in partnership with:

- BBMP, Bengaluru
- St. Martha's Hospital, Bengaluru
- Axxonet System Technologies Private Limited, Bengaluru
- Kidwai Hospital, Bengaluru

BBMP Pourakarmika Workers
Pourakarmikas collect, sort and dispose garbage from houses, shops, hotels, and from the roads. Traditionally PKs or waste pickers are unorganized labour, and since they usually belong to the poorest economic strata, they are also the most exploited labour force. In an effort to reduce exploitation, many cities such as Greater Bengaluru, contract their services, or employ them directly.

Occupational Health & Safety

The BBMP is committed to ensuring the health and safety of the Pourakarmikas, at work and at their homes. In order to ensure that sustainable systems are introduced, it is necessary to systematically document the health conditions of the PKs, and to do this the BBMP commissioned Anahat to screen PKs in 3 zones of Greater Bengaluru. Phase 1 was a pilot – which covered 11 wards through 7 health camps held in the BBMP Urban Primary Health Centers.

The working conditions of BBMP's Pourakarmikas are generally better than that of independent waste pickers. However, they still face multiple health risks which are directly or indirectly connected to workplace conditions.

Common occupational health risks which Anahat specifically looked for during the health camps:

- Use of protective gear
- Ease of use of implements (pushcart and broom)
- Body pain
- Fatigue levels

In addition to the above we tried to assess the following parameters, but the PKs were reluctant to answer a few questions, hence results for the following have not been included in our report:

- Access to toilets and water when at work (during the time when they are cleaning the streets)
- Risks – cuts & wounds, dog bites, burns, falls etc
- Abuse – verbal or physical abuse while at work.

RESULTS

Table 1: Number of PKs at the camps

				Number of PKs at the camps		
No	Date	Location	Wards	No. expected	No. attended	%
1	20/9/2019	Austin Town UFWC	114 & 115	144	52	36
2.	23/9/2019	Vasanthnagar UPHC	93	132	83	63
3	25/9/2019	Domlur UPHC	112	68	49	72
4	27/9/2019	Shanthinagar UPHC	116 & 117	167	112	67
5	3/10/2019	Neelasandra UPHC	111	154	144	94
6	4/10/2019	Taskar Town UPHC	92 & 63	144	57	40
7	5/10/2019	Ulsoor UPHC	89 & 90	125	67	54
			11 Wards	934	564	60

DETERMINANTS OF HEALTH – Understanding the context for public health data

According to the WHO, many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

The determinants of health include:

- The social and economic environment,
- The physical environment, and
- The person's individual characteristics and behaviours.

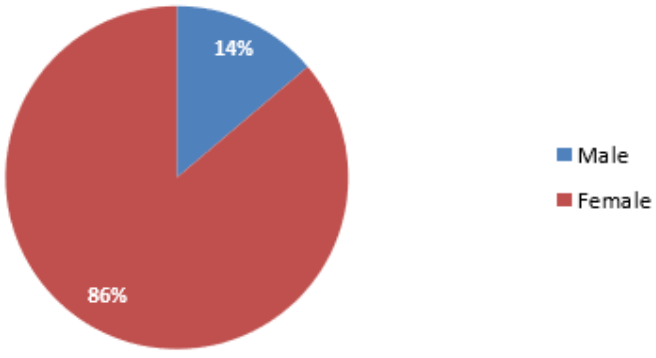
The context of people's lives determines their health, and so blaming individuals (or the government health system) for having poor health or crediting them for good health is inaccurate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants - or things that make people healthy or not - include the above factors, and many others:

- Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- Education – low education levels are linked with poor health, more stress and lower self-confidence.
- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health.
- Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
- Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.
- Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses.
- Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
- Health services - access and use of services that prevent and treat disease influences health
- Gender - Men and women suffer from different types of diseases at different ages.

During our health camps we attempted to capture data on some of these determinants, so as to identify possible areas in which changes can be made to help improve the health of the PKs. An example that immediately comes to mind is the PKs' access to drinking water and toilets while they are at work on the road. If they have to wait to get to a public toilet they may control the amount of water they drink, leading to dehydration and possibly to high blood pressure, and other illnesses.

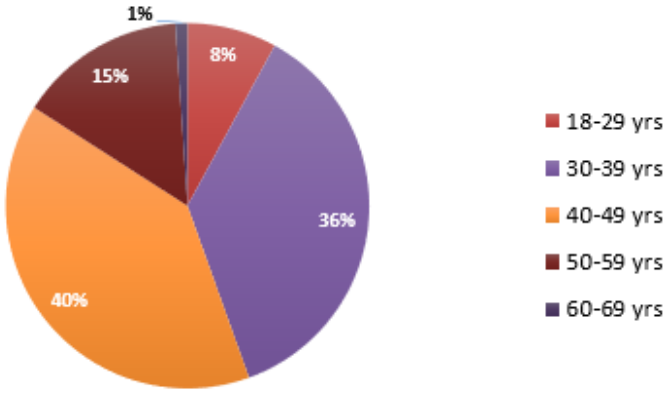
Demographic Profile

Figure 1: Gender N = 564



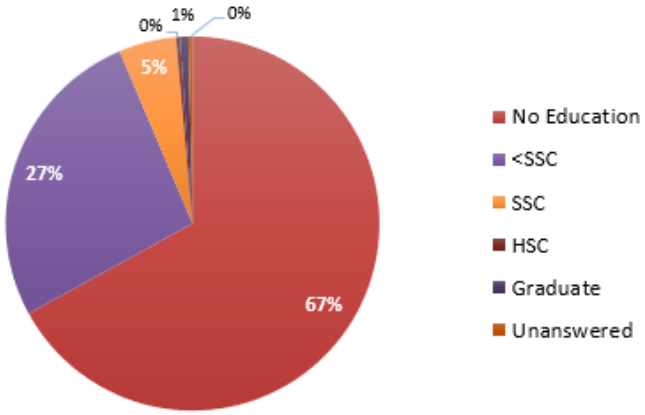
86% of the workforce is women

Figure 2: Age Breakup N = 564



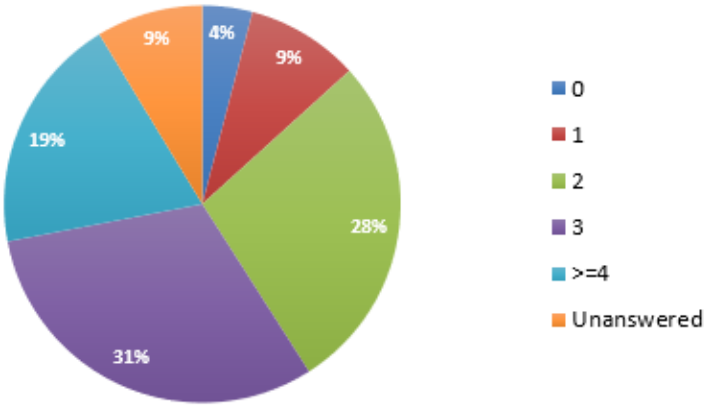
56% of the PKs are above 40 years old.

Figure 3: Education N = 564



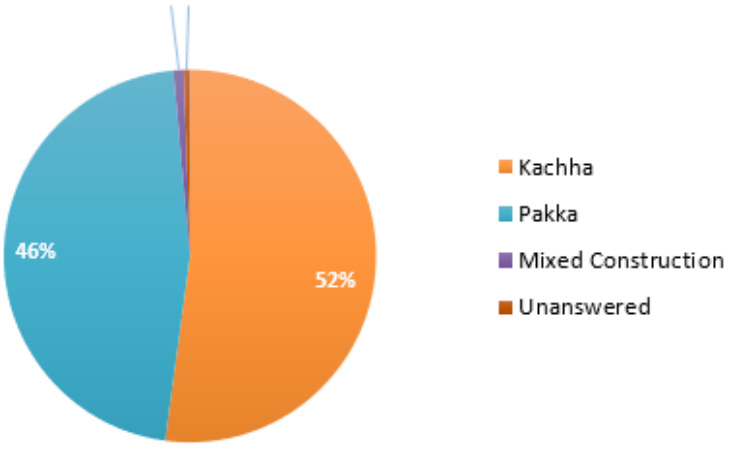
Most of the PKs have not been to school at all.

Figure 4: No. of children N = 564



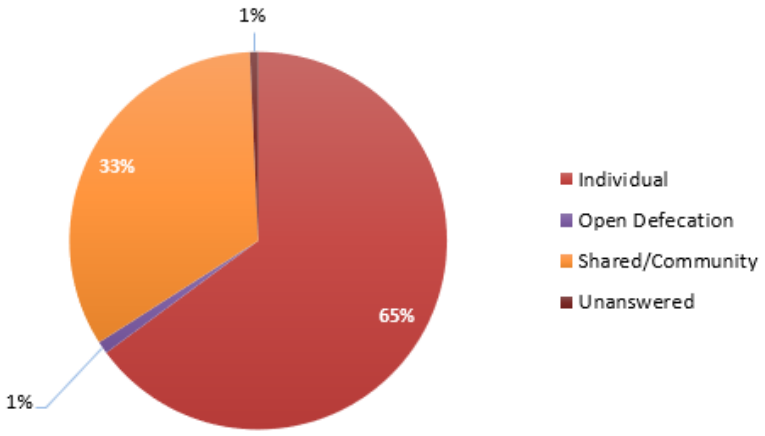
50% of the PKs have 3 or more children and almost 20% have 4 or more children.

Figure 5: Type of house N = 564



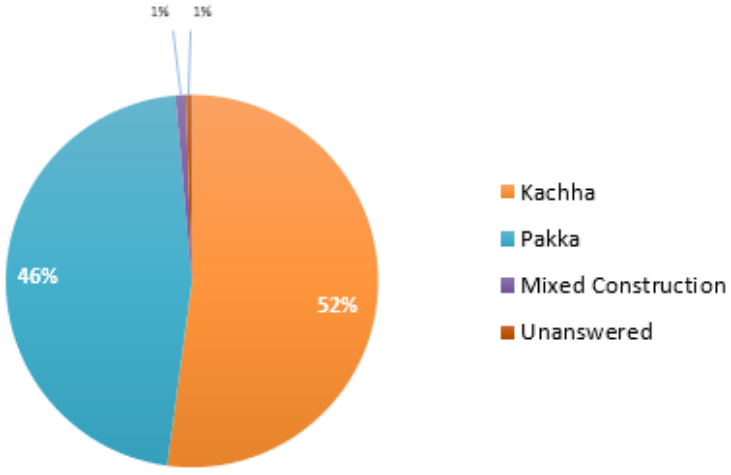
Most of the PKs are worried as they live in rented homes and they feel insecure.

Figure 6: Access to toilets (at home) N = 564



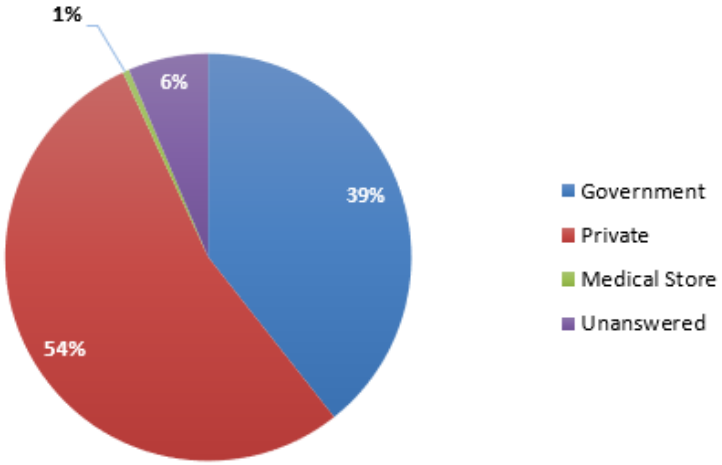
65% have toilets in their homes, 33% use community toilets.

Figure 7: Access to water (at home) N = 564



Access to water is excellent, most of them have a tap inside their homes or they have access to a community water source.

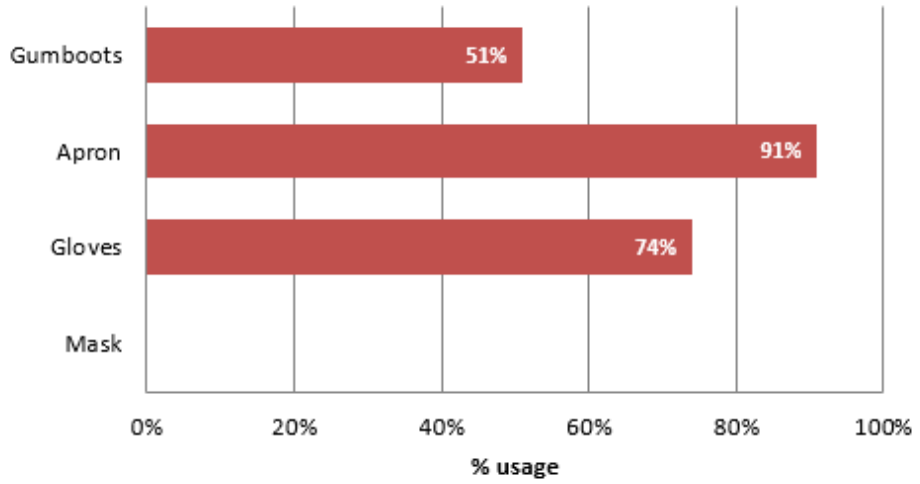
Figure 8: Access to government health services N = 564



More than half of the PKs use private health services, and the PKs who say they are using government services are referring to tertiary hospitals like Victoria or Bowring Hospitals. All of them said that they cannot use the BBMP PHCs because these are closed by the time they go home – this is true, BBMP UPHCs close at 4 pm.

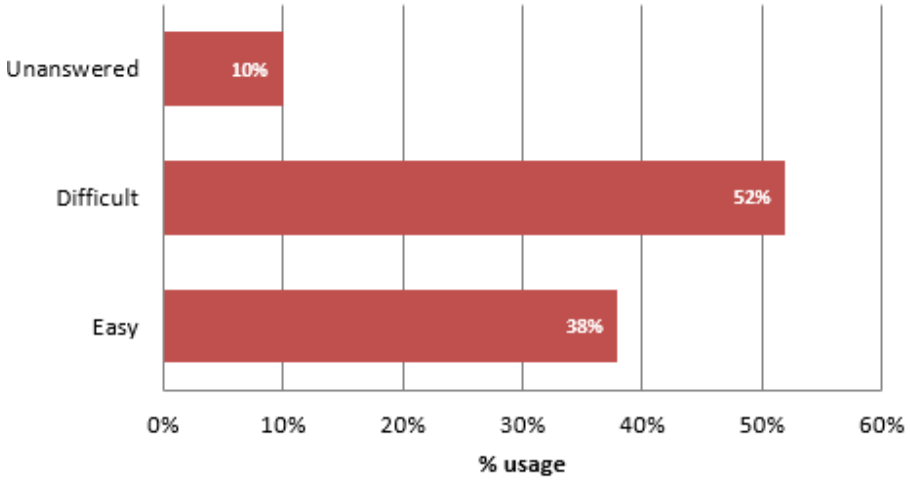
Occupational health profile

Figure 9: Use of protective gear (Masks, Boots, Gloves, Aprons) N = 564



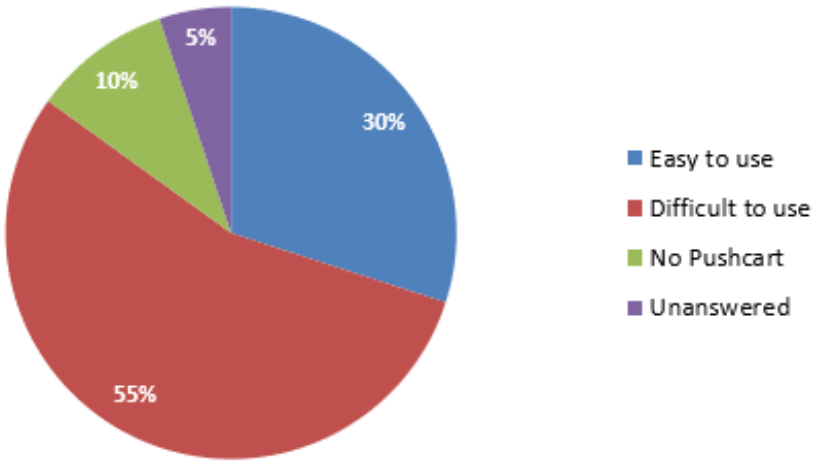
We did not ask about the mask and hence it shows as zero usage. This data may not be reflective of reality, especially with regard to the use of protective footwear

Figure 10: Ease of Use of Implements – Broom N = 564



A little over half complained of lower back ache (LBA) from bending to sweep the streets.

Figure 11: Ease of use of implements – Pushcart N= 564

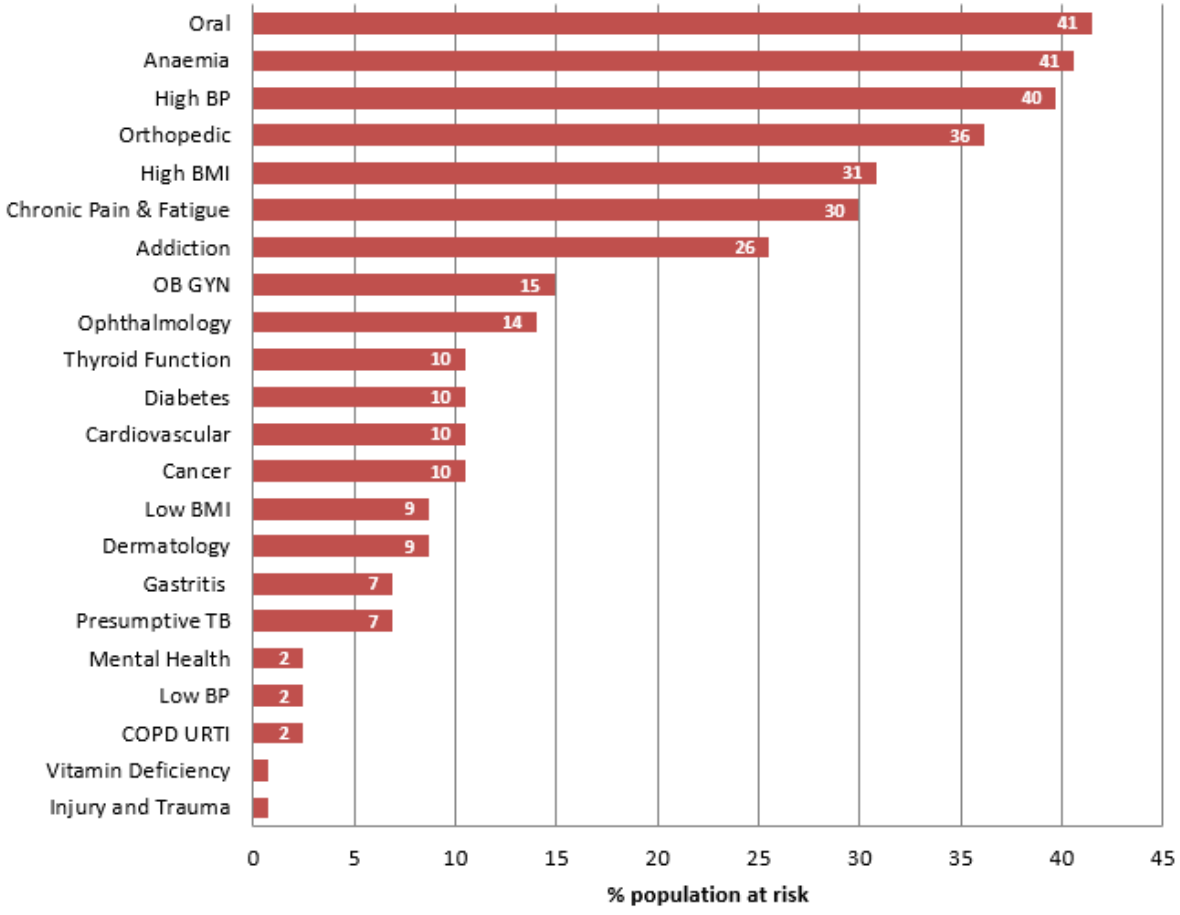


More than half of the PKs find it difficult to manage the pushcart. Shoulder pain and pain in the arms and wrists is common and this is largely due to the unwieldy carts, which they find difficult to manage. We also saw evidence of minor cuts and wounds from handling rusty pushcarts without gloves. The younger ladies and the men said they could manage the pushcart easily.

PROVISIONAL DISEASE PROFILE

This provisional disease profile indicates the number of PKs who are at risk of contracting diseases. All results are being handed over to the PHCs for further evaluation and treatment.

Figure 12: Provisional Disease Profile N = 564



- Oral issues – include poor oral hygiene, cavities, caries, ulcers, gingivitis, stained teeth etc. Poor oral health can lead to multiple health problems like cardiovascular disease, stroke, bacterial pneumonia and other diseases.
- 40% of the PKs are at risk for hypertension. They should be retested by the PHC doctors and put on a regimen of medication if required.
- 31% had high BMI readings, at the same time anaemia levels are very high (41%). Diet counseling was given at the camps; this should be reinforced by the PHC staff.
- Chronic pain and fatigue, and orthopedic issues affect around one-third of the PKs – these include general and localized body pain and profound tiredness. Early onset osteoarthritis too was seen in many workers.
- Addictions to gutka and other combinations of smokeless tobacco are high.
- Ophthalmology includes a number of patients who require cataract surgery.
- 10% of the PKs, around 50 people are at risk for diabetes and should be tested and put on treatment if required.
- 10% require complete evaluation for cardiac disease.
- 7% or 39 patients require complete evaluation for TB. These names have been handed over to the health department.
- 10% are at risk for cancer and require further testing – mostly oral cavity biopsies. The reports from the cervical and breast screening done by Kidwai Hospital will be submitted as a separate document. Please note these are not confirmed cases of cancer, but biopsies should be done and can be done at the BBMP hi-tech labs in the city.

CONCLUSIONS & RECOMMENDATIONS

- Invest in designing ergonomic pushcarts and brooms. MIT has done some work on this in partnership with an organization in Pune.
- We recommend that BBMP's SWM department appoints Health & Wellness Counselors to work towards strengthening best practices in preventive health among the PKs.
- Continue with periodic health camps by third party organizations to maintain the integrity of the data.
- DIET COUNSELLING – diet plays an important role in controlling illnesses and symptoms like hypertension and anaemia. There are many innovative and cost effective dishes that can be taught to the PKs to improve iron content and reduce fat content in their diet.
- Access to drinking water and toilets while at work – can BBMP co-opt one building on each street to provide these for the PK. They should drink more water, since they are working in the sun on most days.

- Regular dental and oral health clinics should be conducted to improve oral health of the PKs. Again preventive practices like just improving oral hygiene will help a lot.
- ·Many PKs are nervous that they will lose their jobs if BBMP (or the contractors) find out about their health conditions. BBMP may want to re-assure them so that they continue to come for health checks.
- We have found 39 Presumptive TB cases. While these are not confirmed TB cases, patients usually get very scared and upset. However, their names have to be handed over to the RNTCP staff, as they and their families have to be tested and counseled. Once they start treatment, they will feel much better and their productivity will increase.
- Strengthen links with government hospitals like Kidwai and Minto. Kidwai for instance, is very intimidating for most people to access. The Health and Wellness counselors could assist to make these hospitals more accessible and make sure that follow up is done.
- PKs who need further evaluation for cardiac disease should be taken to one of BBMP's Hi-Tech labs. These labs can also be utilized for other diagnostic tests like pap smear, mammograms etc.
- PKs should be encouraged to use the PHCs in the ward where they work, and this should be facilitated by BBMP. This will ensure better compliance with medications.
- Develop a reporting framework for PHCs to monitor their health, especially for NCDs and TB.
- Ensure that they all have their ESI cards and that they know how to use these.

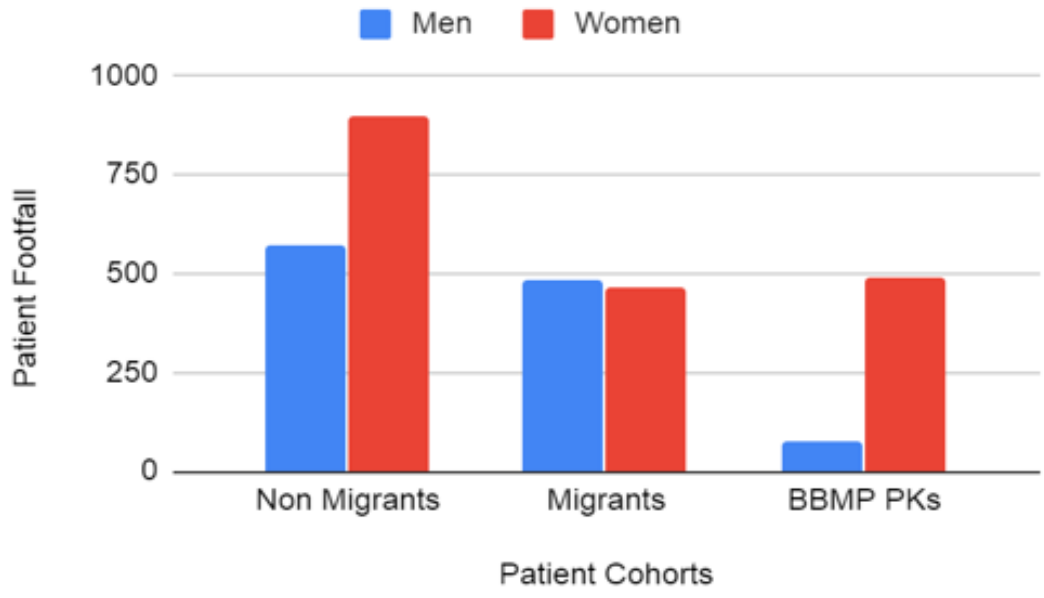
COMPARATIVE DEMOGRAPHIC PROFILES

We compared the demographic profiles of all three patient cohorts, Before looking at the comparative graphs here are the numbers in each cohort.

Table 1: Adult Patient Cohorts (18 years +)

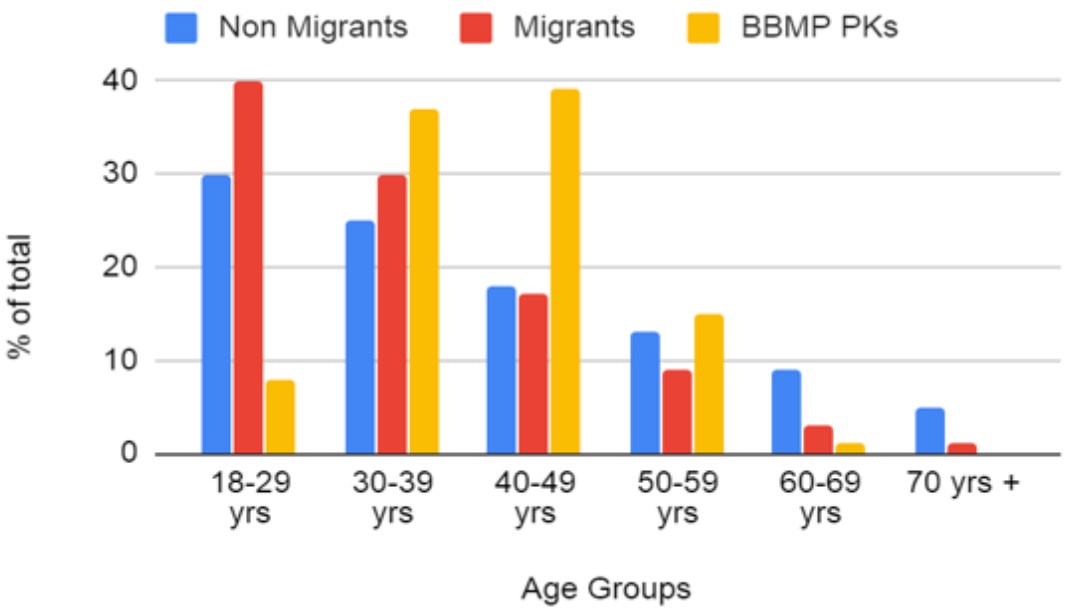
Patient Cohorts	Men	Women	Total
Non-Migrants	568	896	1464
Migrants	483	465	948
BBMP PKs	74	190	564
Totals	1125	1851	2976

Figure 13: Gender breakdown



80% of the BBMP PKs were women.

Figure14: Age Profile



Here you can see that most of the BBMP workers were between 30 and 49 years.

Figure 15: Education Profile

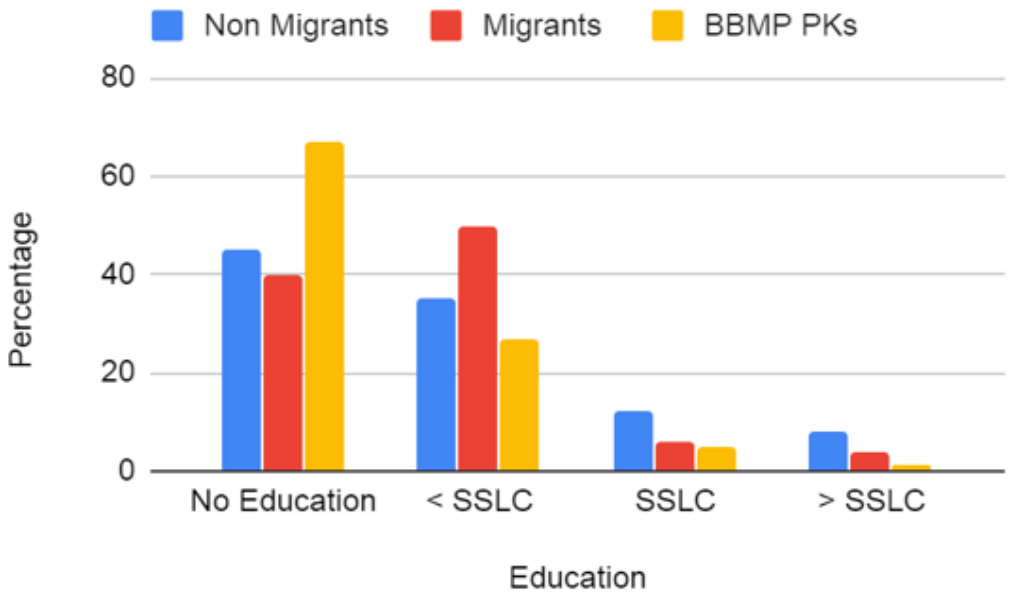
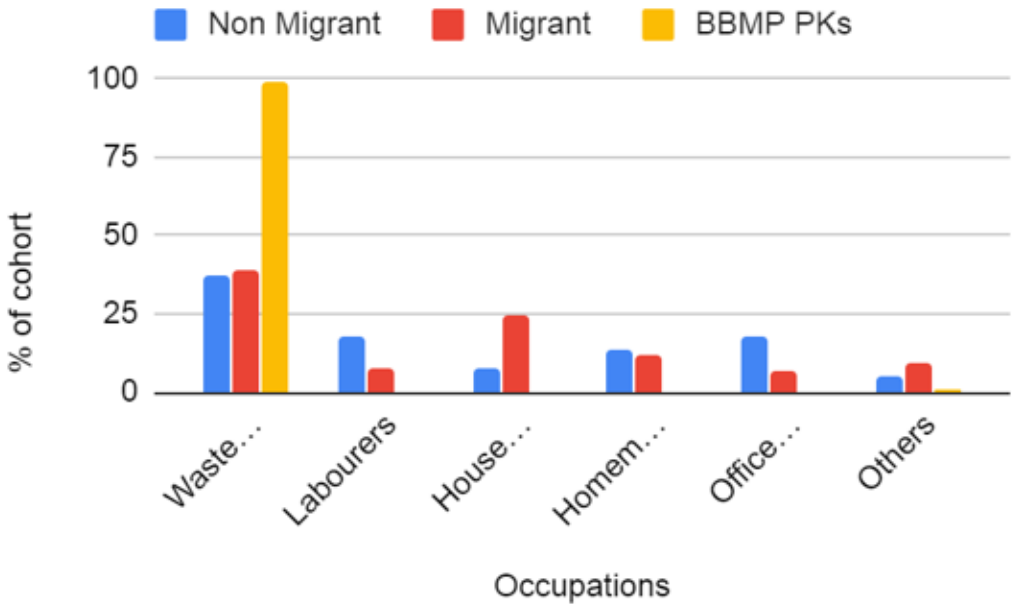


Figure 16: Occupation Profile



All three cohorts were mainly workers who are employed to manage solid waste in the city.

Figure 17: Type of House

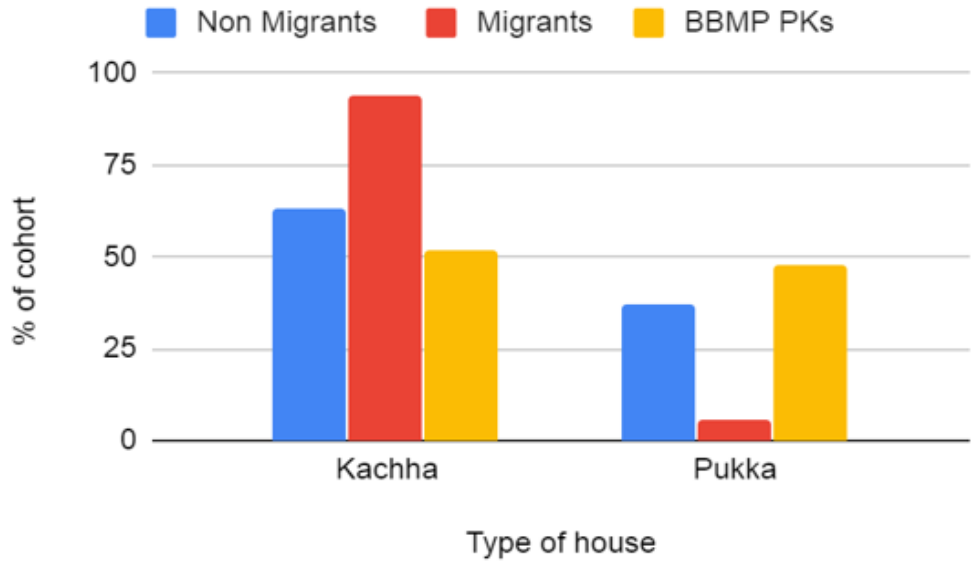


Figure 18: Access to Sanitation

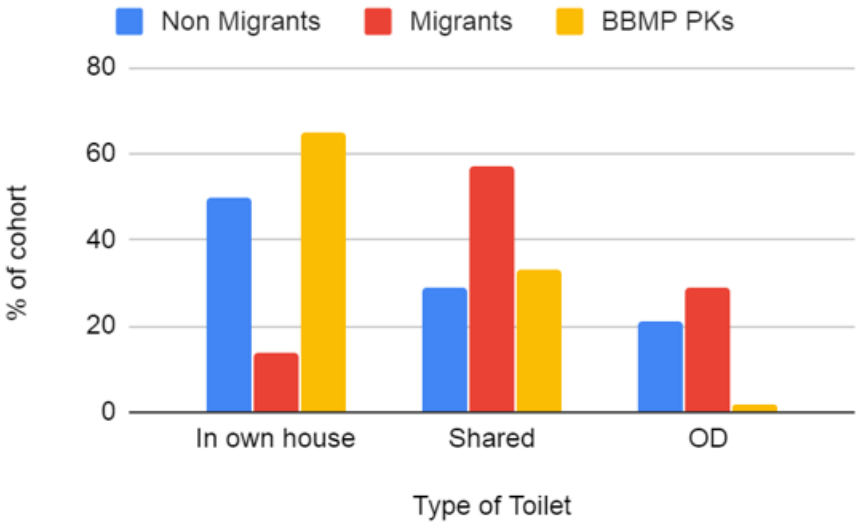


Figure 19: Access to Water

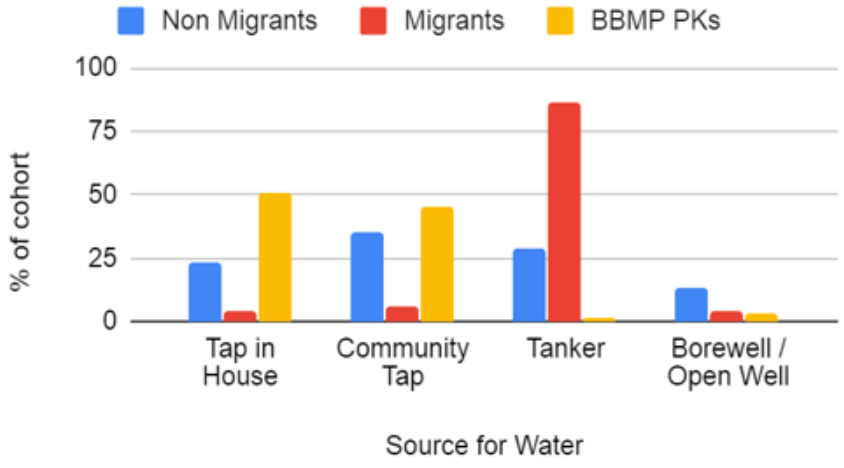
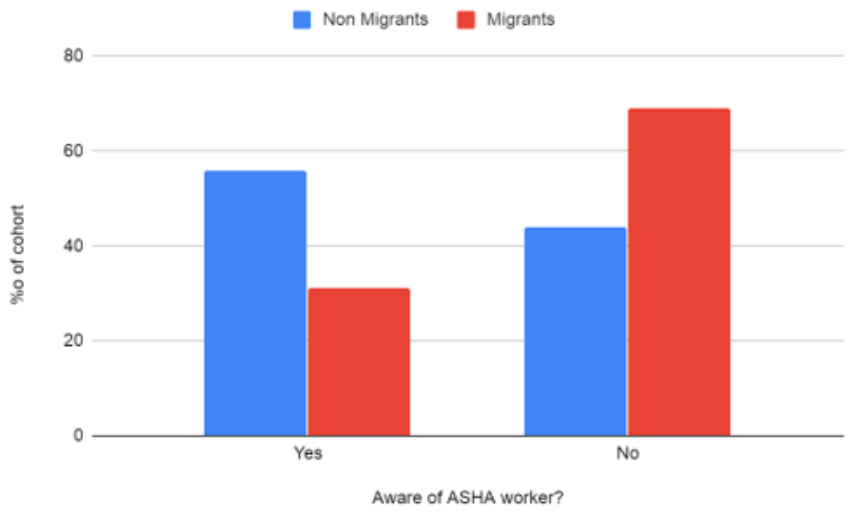
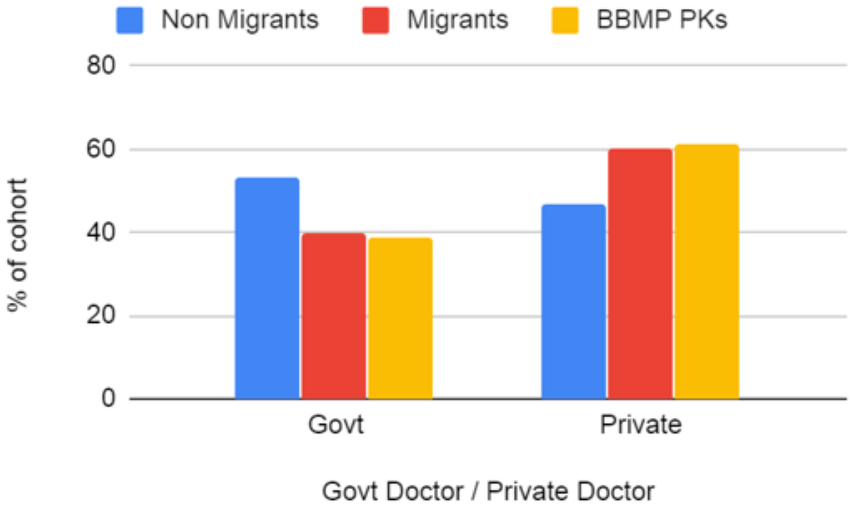


Figure 20: Do you know your ASHA worker?

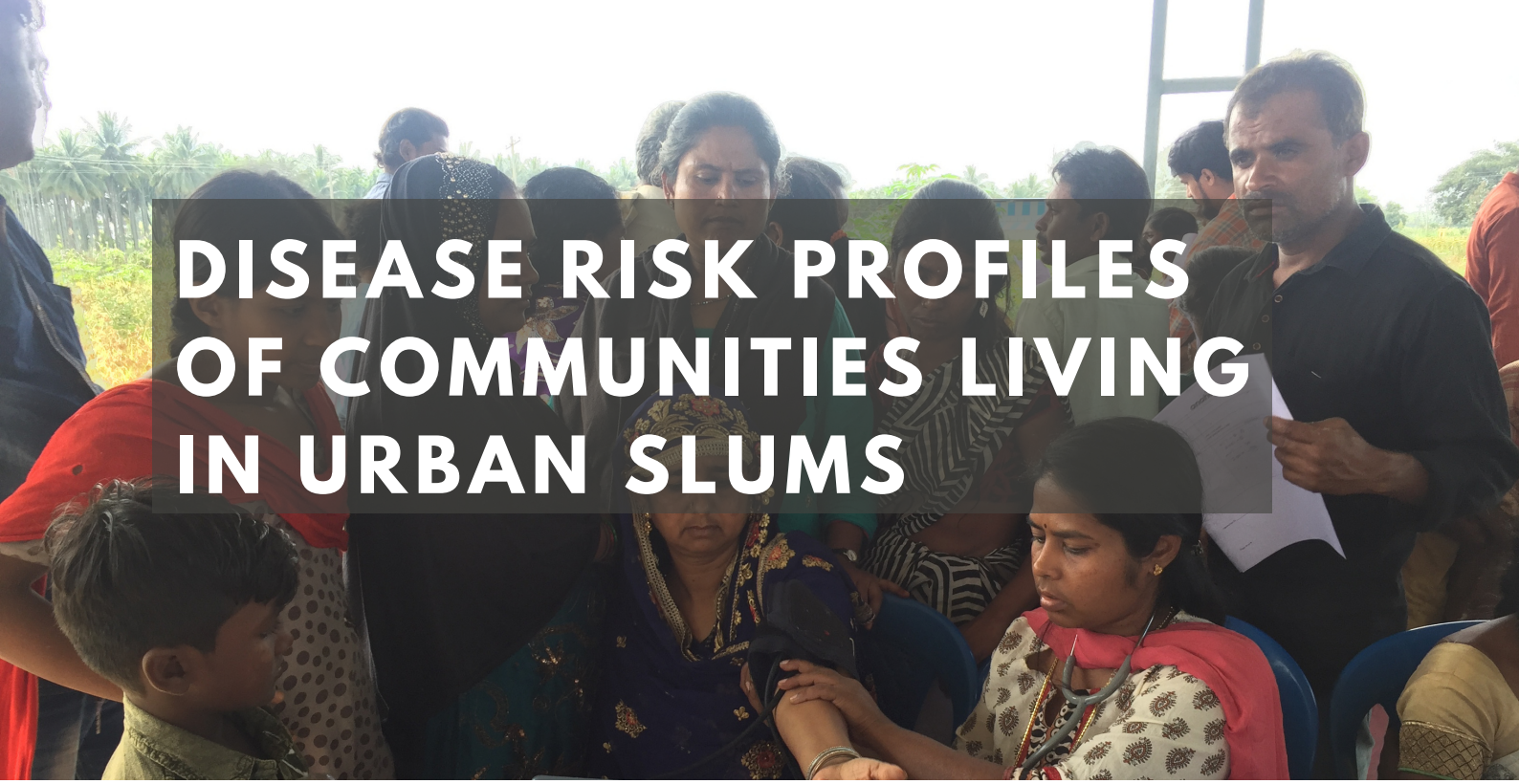


We did not ask the BBMP workers this question because they came to the PHC of the ward where they work, not where they live.

Figure 21: Government or Private Doctor?



The demographic profiles of our patient cohorts are very similar. Most of them work as either private or government solid waste management workers, education levels are very low, and awareness of health services is low among all of them. As a result, they all tend to ignore symptoms until they cannot manage without medical help.



DISEASE RISK PROFILES OF COMMUNITIES LIVING IN URBAN SLUMS

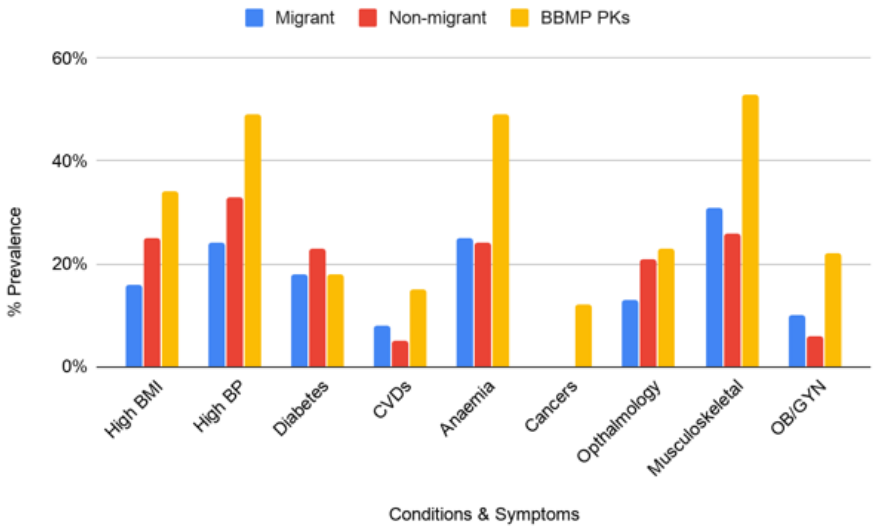
These charts are based on data from our medical camps in slums, across Bangalore, Tumkur, Davengere and Chamrajnagar. Vital parameters measured at camps are BMI, BP, RBS and Hb. Unless a patient has already been diagnosed with a disease we provide only provisional diagnoses and we encourage and assist patients to access a complete clinical evaluation at the primary health centre. These graphs provide a disease and symptom risk profile which can help PHCs plan their interventions better. Our objective is to provide a platform that will bridge existing gaps in delivering healthcare to urban slums - by strengthening both demand and supply.

We have tried to compare three different cohorts to understand how differing lifestyles affect health. It is worth noting that blood pressure readings are much higher for both men and women PKs than in other cohorts.

Women over 40 years of age

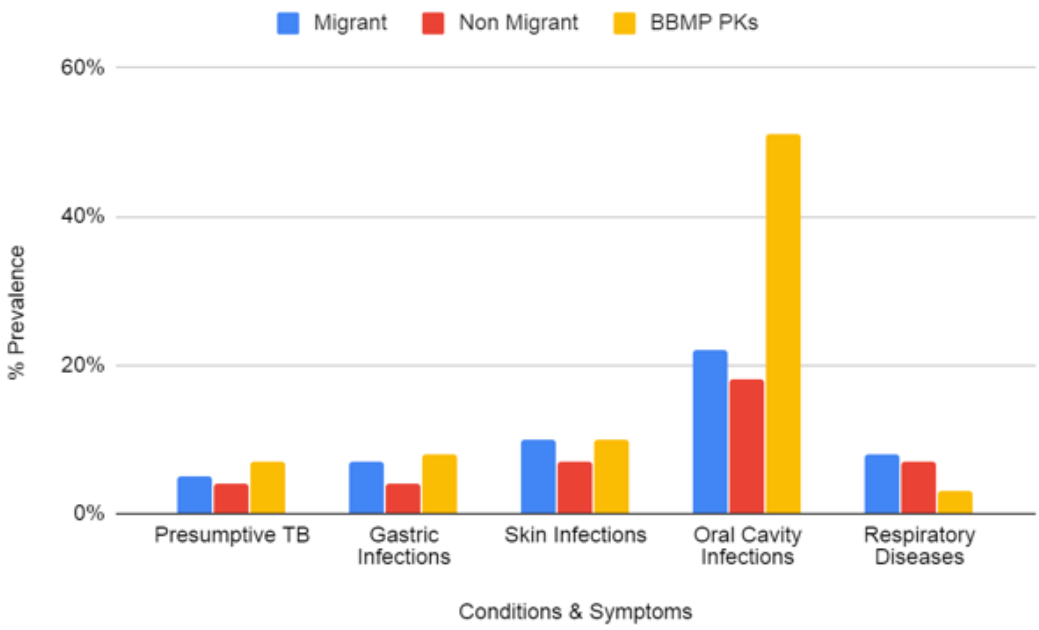
Number of women over 40 years in each cohort:
Migrant women: N= 150
Non-migrant women N=367
BBMP women N=234

Figure 22: Non-communicable diseases-conditions-symptoms (Women 40 years +)



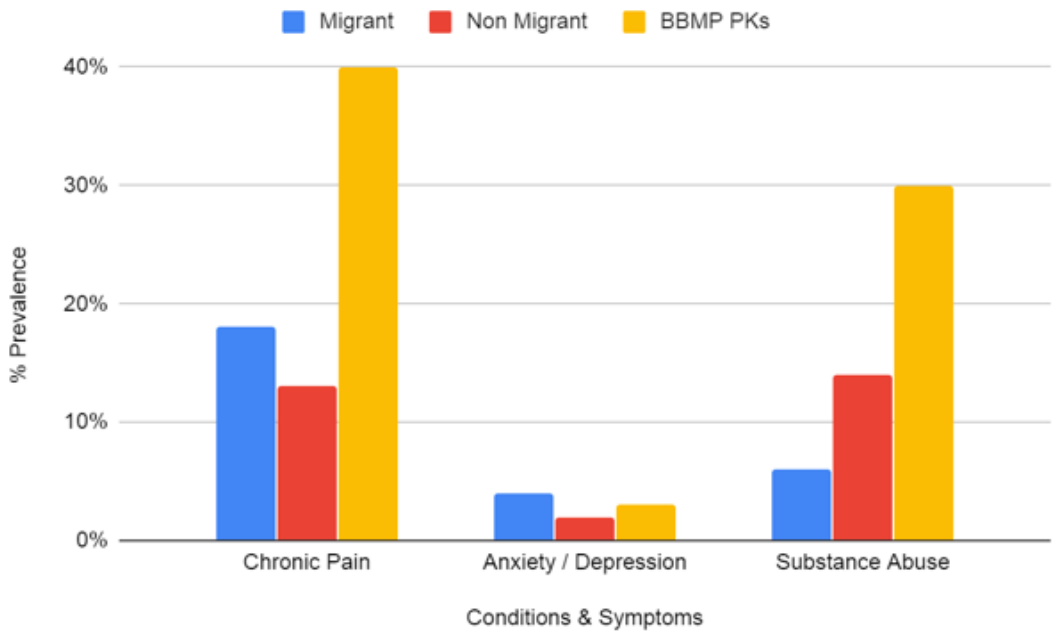
- Cancer detection was done only for the PK camps which were conducted in BBMP PHCs. This was mostly oral lesions and all patients were asked to do a confirmatory biopsy.
- Pap smears were done for about 30% of the lady PKs, all were negative.
- 2 women we asked to follow up for breast lumps.
- High BP was very much more prevalent among the lady PK workers than among the women of the non-migrant and migrant cohorts.
- CVDs are usually cases that show two or more symptoms and they are all asked to do confirmatory tests that are available at BBMP Labs or in Jaydeva Hospital.
- Many women complained of knee pain, shoulder pain and wrist and ankle pain. Most of our patients are waste pickers and other manual labourers. This is significant because undergoing surgery is difficult for them as recovery times are longer and harder given their living conditions.

Figure 23: Preventable / Communicable / Nutritional - Conditions & Symptoms (Women 40 yrs +)



- Oral cavity infections and lesions were much higher among BBMP workers due to the use of smokeless tobacco.
- Presumptive TB lists are handed over to the government / BBMP for follow up. The follow up for the PKs was better than the follow up for other communities.

Figure 24: Mental Health (Women)



- More BBMP workers complained of chronic general body pain and fatigue, even though they have better working conditions and facilities that waste pickers in the unorganized sector.
- Substance abuse is much higher among the BBMP PKs.
- At medical camps we are not able to pick up and address mild and moderate anxiety and depression, due to the crowd and time constraints - we feel the prevalence is much higher than shown here.

Men over 40 years of age

Number of men over 40 years in each cohort
Migrant men: N=150
Non-migrant men: N=228
BBMP Men PKs: N=40

Figure 25: Non-communicable diseases-conditions-symptoms (Men)

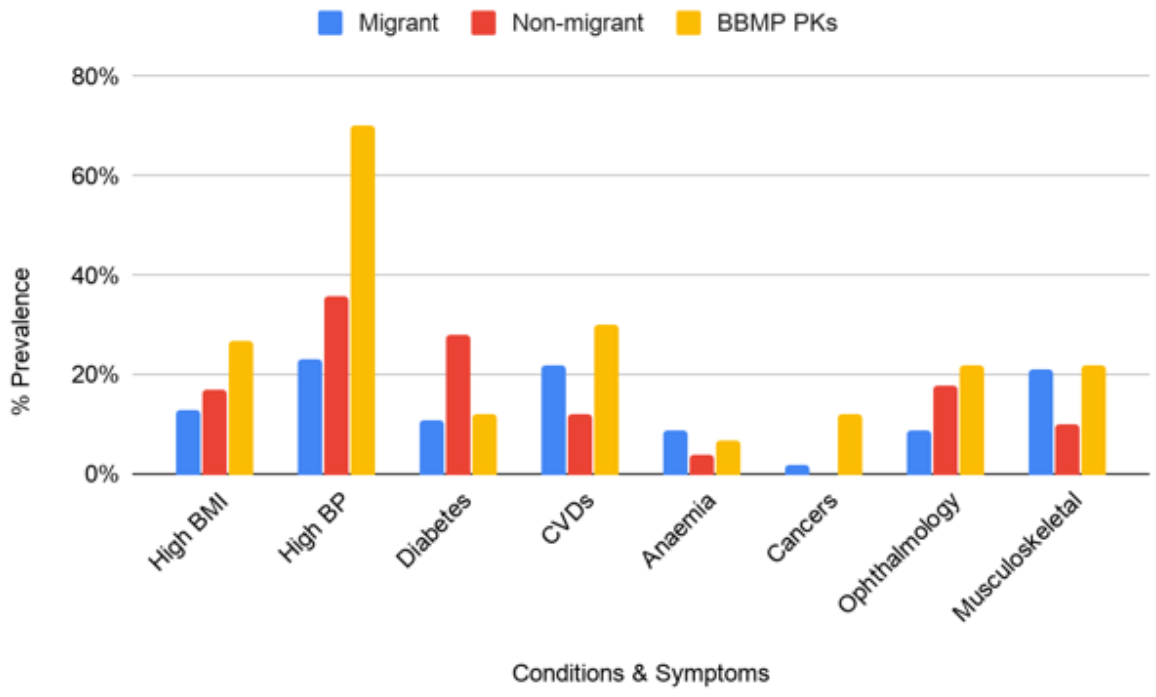


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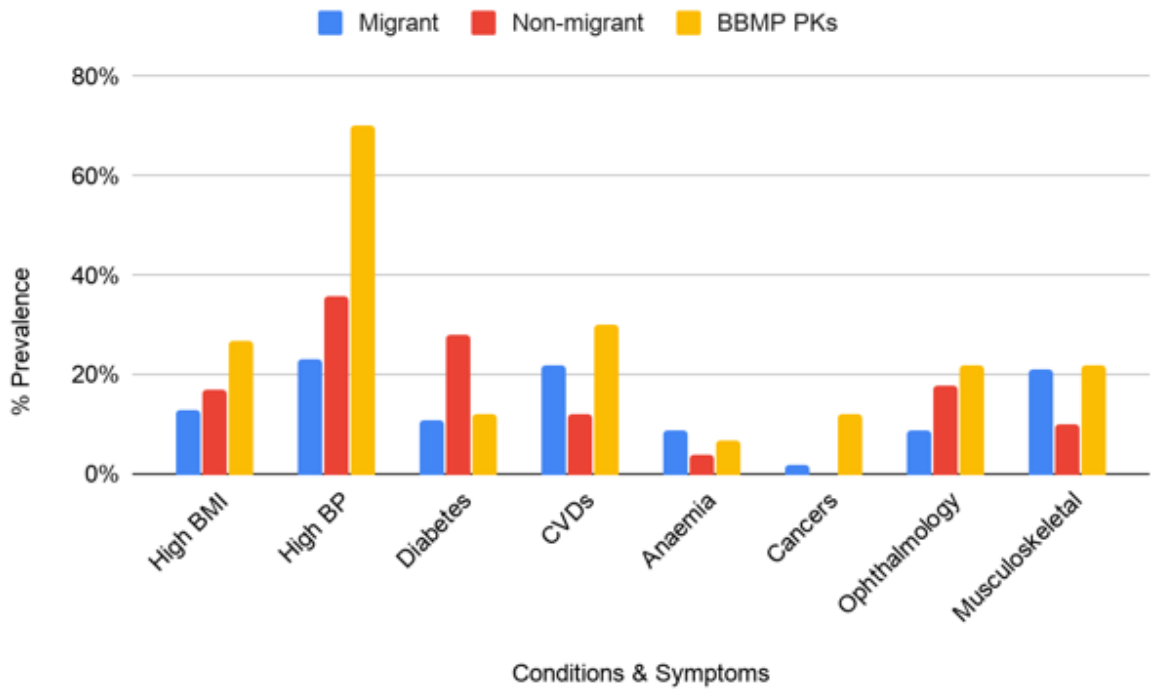
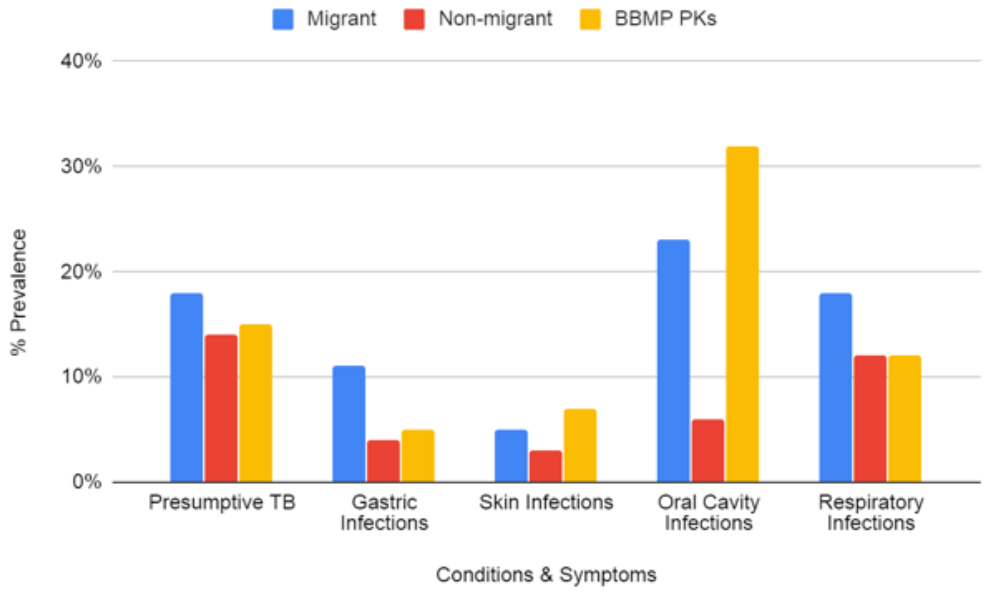
Figure 25: Non-communicable diseases-conditions-symptoms (Men)



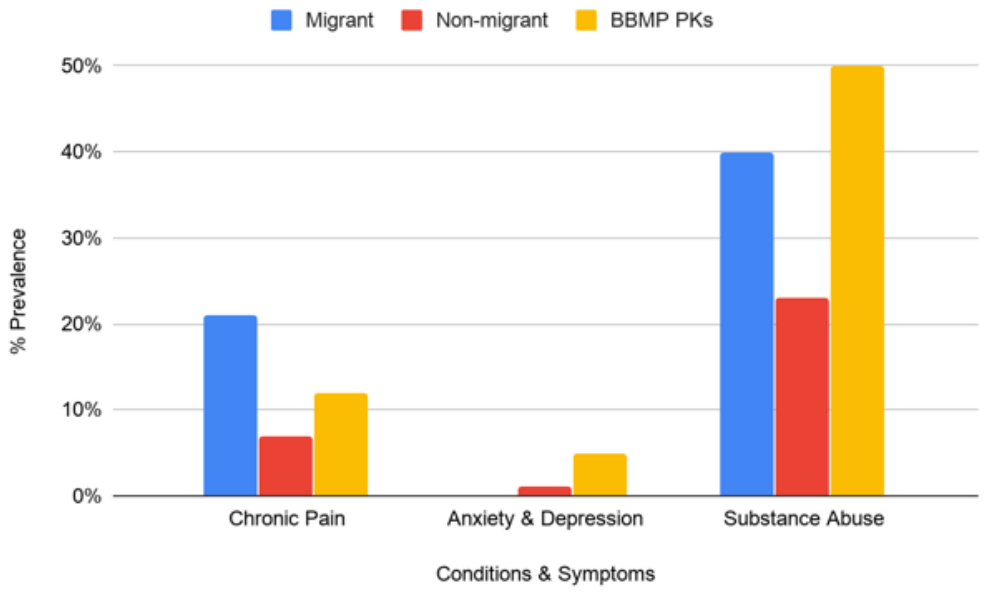
- High BP is much higher among BBMP PKs than in other patient cohorts.
- Cancers were tested only during the BBMP camps - only oral lesions were detected and patients were asked to get biopsies done at Kidwai.

Figure 26: Preventable / Communicable / Nutritional - Conditions & Symptoms (Men)



- Presumptive TB is higher among all men when compared to all women.
- Oral cavity infections are higher among all men and highest among BBMP male PKs.

Figure 27: Mental Health (Men)



Substance abuse is higher among men than among women and much higher among the BBMP male PK workers.

AWARDS, APPRECIATION, RECOGNITION