BHS (G)ROUND UP

CLOSING QUARTERS ON THIS QUARTER

Primary healthcare helps us integrate preventive and promotive with the curative. So when you see an infant with diarrhoea, you can check for immunization and counsel her mother for complementary feeding as well as Family planning. Knowing where the family lives helps, as does knowing where is the closest Anganwadi near her home (where the immunization sessions happen, and if she is lucky, gets to take home ration for the baby too!). The drive for chlorination of wells that your team does just before the rains set in, will likely also reduce the risk for diarrhoea. Finally, you can drop in at her home to also speak to the child's father, and build male allyship. Primary healthcare is thus best suited to respond to the many **social determinants of health**- livelihoods, nutrition, gender, access to entitlements,....and more.

Which is why, for many healthcare providers, one of the most exciting and alive areas to work in is Primary Healthcare. Providing care here, is not just seeing patients and prescribing drugs. It is care in its whole form.

Care providing in this context is done in collaboration with each other and everyone takes on responsibility of care.

The following content is to remind us of the work at the roots which take part in shaping parts of the bigger picture. So what all happens on the ground to help support multiple needs of the work?

Read on...

CONTENTS

THIS SUMMER AT PHC

The people at PHC Nithauwa have been engaged in upgrading the PHC as per the National Quality Assurance Standards (NQAS) set by the Government for the last few months. This exercise has helped take the PHC closer to the model of an ideal PHC. Many new things hae been added in the PHC: Our walls now have beautifully designed IEC materials which speak of workplace hygiene to first aid in emergency to fire safety.eAll patients visiting are assessed for severity using the *Emergency Triage Assessment and Treatment* system. Once or twice a week, patients can see us arranging and rearranging our stores and other rooms. One of our patients even said, "Sir PHC me CM ane wale hai kya?".

A humongous task as part of the preparation was testing of ALL the water sources in our field area. Our LHV along with the field staff identified 500 water sources, assessed their condition and collected water samples for testing. We simultaneously ran a chlorination drive where the local public representatives, government officials and other enthusiastic inhabitants of the village helped our team. The long campaign was completed impressively in 1 and a half months. Our team members also noticed that many sources are not well maintained: many had no cover, or had farms and houses drainage very close to them. We have communicated to the concerned department for optimum maintenance of these sources.

Other highlights from the PHC are installation of an X ray machine, a Hemogram coulter and a biochemical analyser. This has significantly expanded the scope of our services: Patients who had to be sent to a CHC or DH for investigations are now tested and treated at the PHC. Investigations like Creatinine, urea, have been helpful in detecting the complications that usually arise in chronic diseases like diabetes, hypertension. ; and also in differentiating various infections from one another.

The X-ray machine has been an instant hit ! We have seen many patients coming in groups of 5-10 asking primarily for an X ray before they tell their symptoms. We remember an elderly man who was resting at home for 4 days because of pain in his right shoulder after a road accident. He thought he had broken his bone and was not willing to go to a hospital thinking that he might be sent for a surgery which will be expensive. His brother forced him to come to the PHC where upon doing his X ray we found that he didn't have a fracture but an anteriorly dislocated shoulder. We corrected the dislocation after mildly sedating him in our ward. Next week he came again elated, saying that he is completely pain free and has brought 5 of his neighbours who had different aching parts in their body. They all thought that doing an X-ray would relieve their pain. Though it took 30 minutes to convince them that not every pain needs an X ray, it was good to see them excited for this new facility which is the only one within a 40-50 km area.

Overall, it has been pleasant to see the new interventions keeping our feet moving, entertaining our curiosity and enhancing satisfaction one wishes to draw from one's services. We wish to use them more efficiently in the times to come.

As written by our Medical Officer, PHC Nitthauwa-Gamri, District Dungarpur
Dr. Vidit Panchal

OUR X-RAY MACHINES

Besides our PHC, two AMRIT clinics are also now equipped with X- Ray machines: Manpur and Ghated. A large number of patients who visit our clinics are suffering from TB and we do everything in our capacity to treat them. One issue we noticed was that patients suspected to have TB, had to travel upto 40 kilometeres in order to get their x-rays.

A health worker tells us, "The patients who visit us already travel huge distances and come from the remotest of villages. In addition, the test and travel cost them around Rs 700. Our elderly patients who didn't have anyone to support them especially suffered. To avoid these hassles, some of them gave up on treatment altogether. We also witnessed deaths in families and saw the disease spread to their family members as well."

"Earlier, our patients would come for treatment, then travel back for their duty. For so many of our patients who are daily wage workers, they would lose out on an entire day's pay."

In order for these factors to not become a hindrance in their journey toward seeking further treatment, we decided to have X-ray machines installed at our clinics and are able to save their time and money.

Now we can get X- Rays done on the same day that the patient comes to consult the physician or nurse. They thus need not wait for the results. This saves two trips for the patients as well. In the last 1.5 months, we have done 60 X-rays and find it encouraging to see more patients willing to get tested and then continue seeking care.

A nurse recalls,

Once we got the machines, we also had to ponder over where we could place the machines. It was later the members of our community who gave us space for the machine saying, "They are doing all this for our ease and betterment so the least we can do is clear up some space for them."

The community cleared, repaired and repainted an unused space meant for a vet clinic and that's where our machine now is.

Something that made us smile was people coming to see the x-ray machine out of curiousity. Many persons visited us and looked on in amusement.

GOGUNDA:SILICOSIS MEETING

Silicosis is a chronic lung disorder caused by inhalation of tiny particles of Silica dust. It is the oldest known occupational disease and even today is responsible for thousands of deaths. This disease is more prevalent among male population who are working in stone mining, grinding, carving and tile making in Kotra, Sirohi and Pali distrctis of Rajasthan. Individual organizations are giving their best efforts to help people who are affected with this disease.

BHS is working on awareness and management of Silicosis. Ajeevika Bureau is working on empowering and advocacy of labourers working in stone mines as well as helping them with their registration as silicosis patients. KAS is working in Kotra district to help migrant workers at source and destination and also fight for the rights of silicosis patients . STEP Academy is working toward providing alternate livelihood to these patients or the young people in their families who otherwise would choose to work in areas where there is risk of getting silicosis.

Recently, we noticed a steep rise in Silicosis patients visiting us at Rawach AMRIT clinic where we are treating around 300 patients suffering from the same. Most of these patients are from our non-catchment areas like Pindwara, Kotra and Bali where other organizations like AB, STEP and KAS are working on their rights and advocacy. All these organizations are working individually in their respective areas which is why we decided that coming together and collectively working on this cause would have a greater impact since our end goals are the same: how can we provide support in our own ways to make life a little more comfortable for the ones already suffering from this disease but more importantly, to prevent more persons succumbing to this disease.

The meeting began with reviewing our current clinical data and our current strategies for Silicosis management. Ajeevika then discussed current strategies on the social front like social security camps, advocacy events, capacity building, sensitization workshops and screening camps. In view of the current data, strengthening current strategies and new strategies that can be implemented were discussed.
Next, KAS presented strategies they are working on with respect to community involvement and awareness. We also discussed possible ways KAS could help replicate the current work in other areas to increase awareness about Silicosis.
But a question that arises is, what can we do for other, safer occupations. The focus could be on the young population who can be provided vocational training, make them aware of the hazards of working in certain areas, encourage work where they can earn well enough with the right amount of training. Different methods to encourage a shift in occupation and alternate livelihoods were presented by STEP with data representation. Aggressive strategies to ensure a gradual shift were planned out.
Toward the end, the discussion opened up ton how the government could be improving management of silicosis.

SALUMBAR: CONVERGENCE MEETING

Salumber district is another region we provide primary healthcare in. Ajeevika Bureau (whose work is focused on supporting vulnerable segments within migration dependent communities) and Shram Sarathi (provides financial services to migrant communities) work in this region too. And since we interact with the same population on issues that are correlated, in June, six of us different organizations came together in Salumber to identify synergies in our work.

Basic HealthCare Services raised the need for linking the growing number of TB patients to skilling: Tailoring, mobile repair, setting up a small shop, etc. As the illness damages their lungs, they are no longer able to work in construction of large buildings, as most of them did earlier.

Aajeevika Bureau committed that their Women's groups will take up the matter of absence of ANMs from a very remote PHC, that is disrupting immunization and care of pregnant women. And join hands to improve functioning of the Anganwadis (which hardly open or give the take home rations for young children).

PRADAN shared the Lift irrigation set up in many villages that is bringing water (and many smiles) to the communities. And of community sessions where the BMI of women is being measured and shared with all: how men and women are so stuck at the high levels of malnutrition amongst themselves. Hopefully this will also spur affirmative action.

Udaipur Urja Initiatives Producer Co. Ltd. spoke about 'cooking chulhas' they will be introducing that require less wood and generate much less smoke, besides also bringing Carbon credit.

Shram Sarathi spoke about an emergency loan that provides so much relief, especially for those who have no sources for funds in such situations. And of creating awareness for government Life Insurance: many in the tribal communities are covered but they do not know. If a poor family is entitled to a large sum of money on the passing away of a family member, they must absolutely get this.

Being a part of such discussions makes you bolder: you feel that (almost) anything is possible. A TB patient for whom the family had given up hope of survival, can not only get better but also learn a new skill (tailoring, or mobile repair, or even set up a small shop) and start a new life.

May there be many more convergences, louder voices and action for the social determinants of health. And lots of lives transformed and saved!

TRAININGS THIS QUARTER

A health worker says, "It's only because of these constant trainings that we feel confident in delivering content in our awareness sessions in field too".

Primary healthcare is not just about providing treatment. We also focus on prevention. One way to prevent illness is by increasing communities' awareness. We do this through trainings. We hold regular trainings with different groups who come together to make primary care possible. Here's a glimpse into the trainings we had this quarter.

HEALTH WORKER TRAINING

We focused on areas like trust building through activities, a session on Participatory Learning Action, learnt how to fill the phulwari enrollment form. Growth monitoring was retouched on and we ended with a session on storytelling.

SWASTHYA KIRAN TRAINING

This was the first time all our community volunteers were part of a session on Mental Health, discussing alleviation of stigma, existing ways of responding toward persons suffering an illness, understanding the health-illness spectrum.

How to improve our family profiling method and bringing its necessity back into focus.

After having seen multiple cases of heatstroke in this summer heat, heatstroke and prevention in our communities was another topic covered.

PHULWARI WORKERS TRAINING

The training began with early child development and education. We also reviewed the phulwari form. a session on Malaria. The last session was a motivational one with a peer learning angle. We discussed certain good practices some phulwari worker has that needs to be acknowledged and appreciated while it also becomes something every other worker could gain from.

NURSES TRAINING

For our nurses, we've had sessions on Hyperthermia, Diabetes, Malaria, TB, HIV and communication.

COMMON TRAINING

This was the first time ever we had a training where the participants were a mixed group. Nurses, health workers, cluster teams and doctors. Topics covered were HIV, Tuberculosis and Gender.

PHYSIOTHERAPY

Most persons with physical pain and joint stiffness continue living with the pain if it doesn't impede them going about their daily routine. If they can manage daily chores, they do not seek care. One issue is also that such care is available only in cities. These were some of the triggers for integrating physiotherapy into primary healthcare.

In the last quarter we have seen 108 patients for Physiotherapy. One of them is Kavita.

Kavita had a malignancy in her brain for which she underwent surgery after which she developed complications and was unable to move. This went on for 6 months. Our health worker, physician and physiotherapist went to visit this patient at her home in Manpur. Both her legs were too weak and there was no movement present.

The patient was very confident and eager to practice all the exercises taught to her in order to walk and also be able to go to school. Seeing her situation, it seemed like Kavita would take at least 4 months before she is able to sit or stand on her own.

Beginning with motivating her to try moving her toes and ankle in Week 1, we gradually progressed in our *movement (!)*

By the end of Week 4 we had surprisingly and drastically reached an extent where Kavita could move her limbs and even sit with support. By the end of week 6 she can stand with some support

Our physiotherapist says, "I am pleased to see Kavita. When I visited her on Day 1 she was on bed with weak limbs. And now in less than 2 months, after dedicated effort and will to recover in Kavita, her family's enthusiasm and support and continuity of care provided by our team, we have lovely, quick and encouraging results. A small quote I am thinking of is, "*Your body can stand almost anything. It's your mind that you have to convince.*"

With inputs from Dr. Mayank Khurana, Physiotherapist.

SESSIONS ON DIABETES

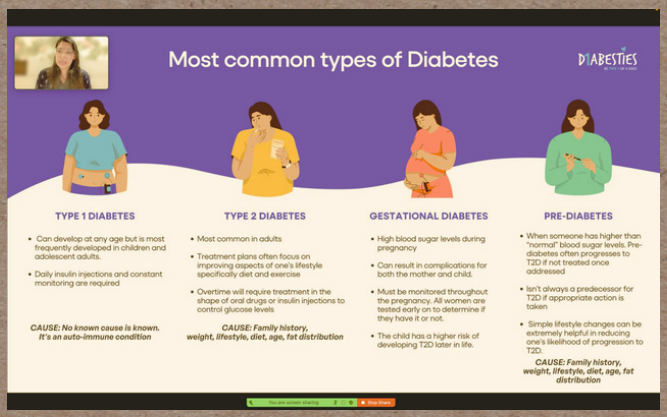
The burden of diabetes in rural areas is also increasing now. In the last quarter, our clinics recorded 25 patients seeking care for Type I diabetes. We currently have 114 cases for Type 2 diabetes but type 1 diabetes requires more rigourous management.

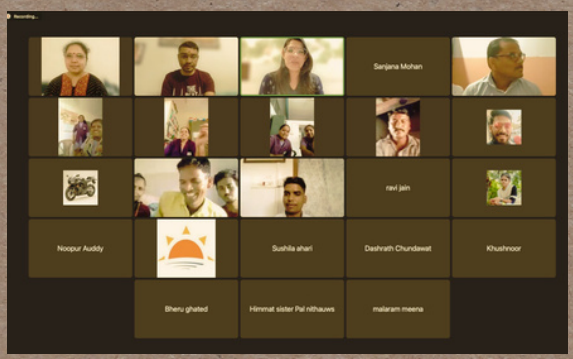
We need knowledge of the correct way to store insulin, being alert to every drop and rise of blood sugar and modifying doses accordingly. Although providing this treatment is more complicated, care for diabetes again must be a part of primary care. It's not possible for patients to travel every month to cities- which is where such care is provided. BHS is fortunate to be partnering with Diabesties Foundation who are helping us increase our knowledge and sensitizing communities to this problem.

It's been a month since we have begun with online and offline sessions on Diabetes. We learn of counselling skills, anatomy, the pathophysiology, symptoms etc. through mixed modes- presentations, quiz, videos and discussions around cases and experiences.

The sessions are especially valuable since these are facilitated by people with Type 1 diabetes themselves.

Until now, we have been prescribing medication but it's always useful to understand this condition better in order for us to also empathize with our patients much better. Our nurses and health workers are part of these trainings whilst other interested participants can join in too. (Let us know if you would like to join!)





SESSIONS ON MAKING OUR WORKPLACE SAFER AND HAPPIER

We had sessions aimed at promoting a safe and inclusive workplace environment by addressing micro-aggressions, and gossip, and fostering positive team dynamics. All 6 clinics and PHC teams were involved and asked to participate at individual and team levels.

The participants learned about different types of micro-aggressions and their impact on individuals and the overall work environment. The session also emphasized the importance of empathy and fostering a culture of respect and inclusion.

They gained insights into the reasons behind workplace gossip and explored strategies to combat it effectively. The session emphasized the importance of open communication, trust-building, and establishing a positive work culture.

In the end, the employees also got a brief understanding of BHS's IC committee and its functions.

One session in the common training focused on discussing gender, power and patriarchy. This was done through activities where the group's current perceptions and deep rooted beliefs also came to shore and were questioned in a safe space.

After having attended the session, team members were asked to ponder upon what changes the teams can make to ensure safer workplaces at individual, team and organization level. Some responses the team came up with were, that they would refrain from making unnecessary comments and unwelcome comments about each other, would take more effort in understanding that every person's behaviour is just different and one cannot impose their own ways of behaving on those different from theirs.

OTHER NEWS

- In other news, we had our board meeting in June to discuss new development and additions like our work on Mental Health and Physiotherapy.
- We are also going to begin with a fellowship for nutrition and visited the College of Community and Applied Sciences, MPUAT Udaipur
- One of our team members completed a Gatekeeper training course for Suicide Prevention facilitated by Centre for Mental Health Law & Policy
- Our team has also begun an reading club where we meet once every month.
- Last quarter, we also had an induction for our new team mates.
- Trust for Reaching the Unreached, an NGO in Gujarat working for community health made an exposure visit to our organization to look at our work on Mental Health.
- We made an exposure visit to EKJUT in Jharkhand to understand PLA better.

DRAFTING OF THE RTH GUIDELINES

During this quarter Rajasthan became the first state in the country to legislate the Right To Health bill.

BHS has contributed significantly in providing inputs for drafting of the bill.

BHS has been involved in dialogues with civil society that advocated drafting of an equitable people centric bill and also with groups from other states for enacting the RTH bill.

Subsequently BHS has also been engaged in working with the government in helping frame an effective set of rules for right to health.

BHS team members have been involved in legislating RTH bill and also written extensively on the issue.

OUR PUBLICATIONS

- MAKING PRIMARY HEALTH CARE WORK: A Review of Evidence and Experience from India

This discusses the operation levers of PHC, political commitment and leadership, directions to leverage primary healthcare in India etc.

- DECENTRALISING MATERNAL CARE IN INDIA WHY IS IT REQUIRED AND WHAT WILL IT TAKE?

Where the authors discuss directions to promote effective, responsive, and equitable care for women and newborns

- Effective, Respectful and Affordable Care: A call for Decentralized Maternal Care

Where the authors call for an urgent shift to decentralized maternal care in India

- ISST made a film on childcare. The film touches on themes such as the value of daycare centres for children and also their mothers in rural as well as urban communities.

- Dreams of a Healthy India: Democratic Healthcare in Post-Covid Times (Rethinking India Vol. 9)

Where BHS has contributed in writing a chapter on responsive hospitals, drawing on experience of several not-for-profit hospitals serving marginalized populations across India.

NUMBERS

Apr 23 to Jun 2023			
Indicator	Amrit Clinic	PHC	Total
Footfalls	10103	9951	20054
Ante Natal Care	436	173	609
Deliveries	44	86	130
Post Natal Care	234	81	315
No of children fully immunised	-	150	150
Women provided safe abortion	115	0	115
DMPA	66	35	101
SAM Treated	117	20	137
Tuberculosis (TB) Treated	309	16	325
Diabetes Mellitus*	263	238	501
Hypertension*	376	475	851
Total no. of outreach sessions	313	-	313
Children reached through Growth Monitoring	1454	685	2139
No. of Phulwaris	16	-	16
No. of children enrolled in phulwaris	325	-	325
* Footfalls			

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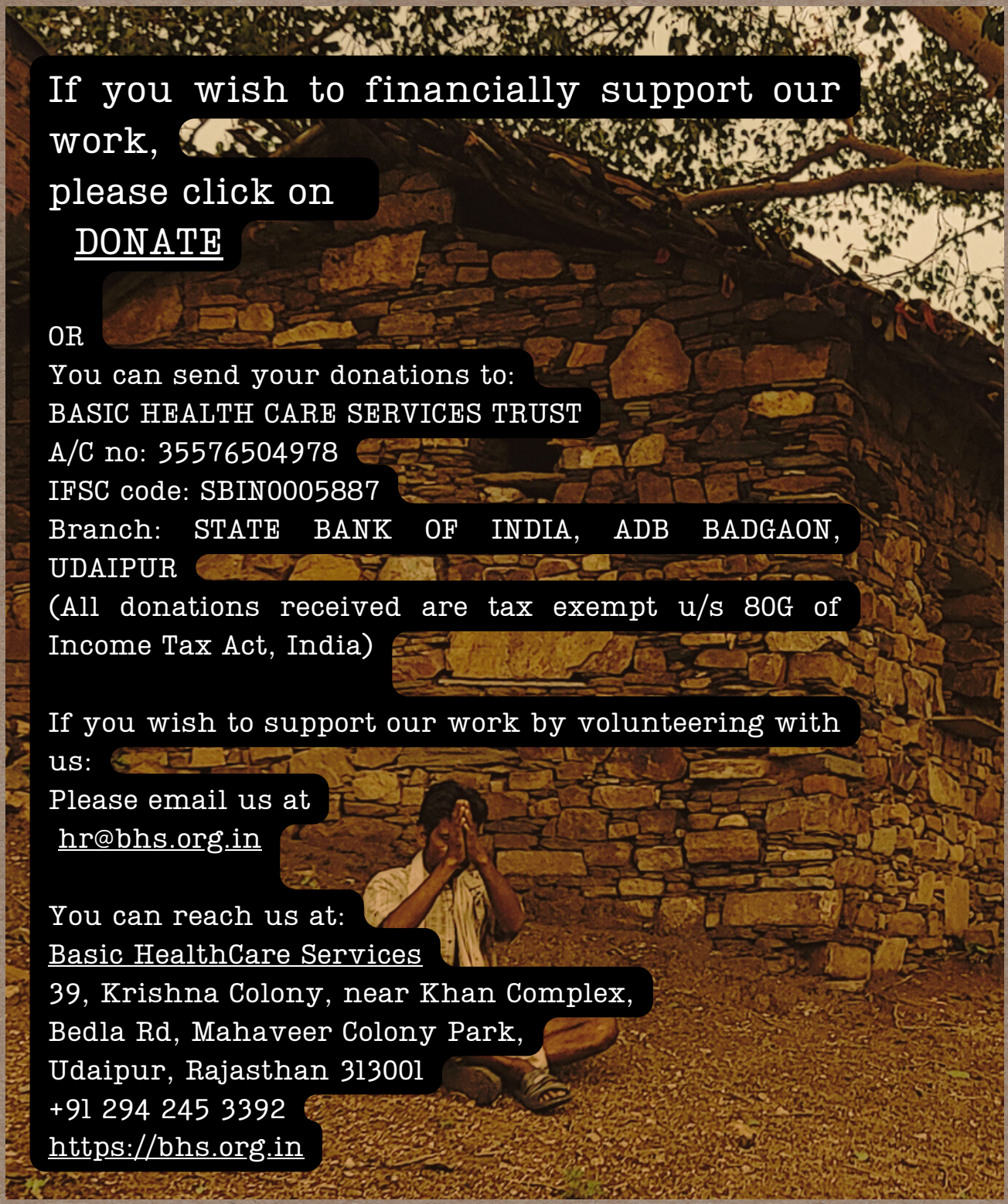

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