Executive Summary

The **One Billion Lives Foundation (OBLF) Public Health Initiative** continued to strengthen its impact in Q1 2025, advancing healthcare access for underserved communities through integrated service delivery.

Our program focused on three critical health verticals:

- **Non-Communicable Disease (NCD) Management**
- **Geriatric & Palliative Care**
- **Community Mental Health**

Through mobile clinics, home visits, and community-based care models, we expanded outreach to a significant population, ensuring essential services reach those most in need. Multidisciplinary teams, supported by strategic partnerships, delivered compassionate, holistic care while integrating community feedback into program design.

Key Achievements this Quarter:

- Strengthened accessibility of healthcare through mobile clinics and localized services.
- Enhanced patient-cantered care for elderly and palliative patients.
- Expanded mental health support at the community level.
- Improved program responsiveness through continuous feedback loops.

Looking Ahead:
OBLF aims to expand its coverage in upcoming quarters, deepen service quality, and further empower local communities to sustain health outcomes. By fostering collaboration and innovation, we are building resilient healthcare systems tailored to the needs of marginalized populations.

Remedy: Holistic Health and Community Centered Care

OBLF
EMPOWERING COMMUNITIES

Submitted by

One Billion Lives Foundation

Quarterly Progress Report

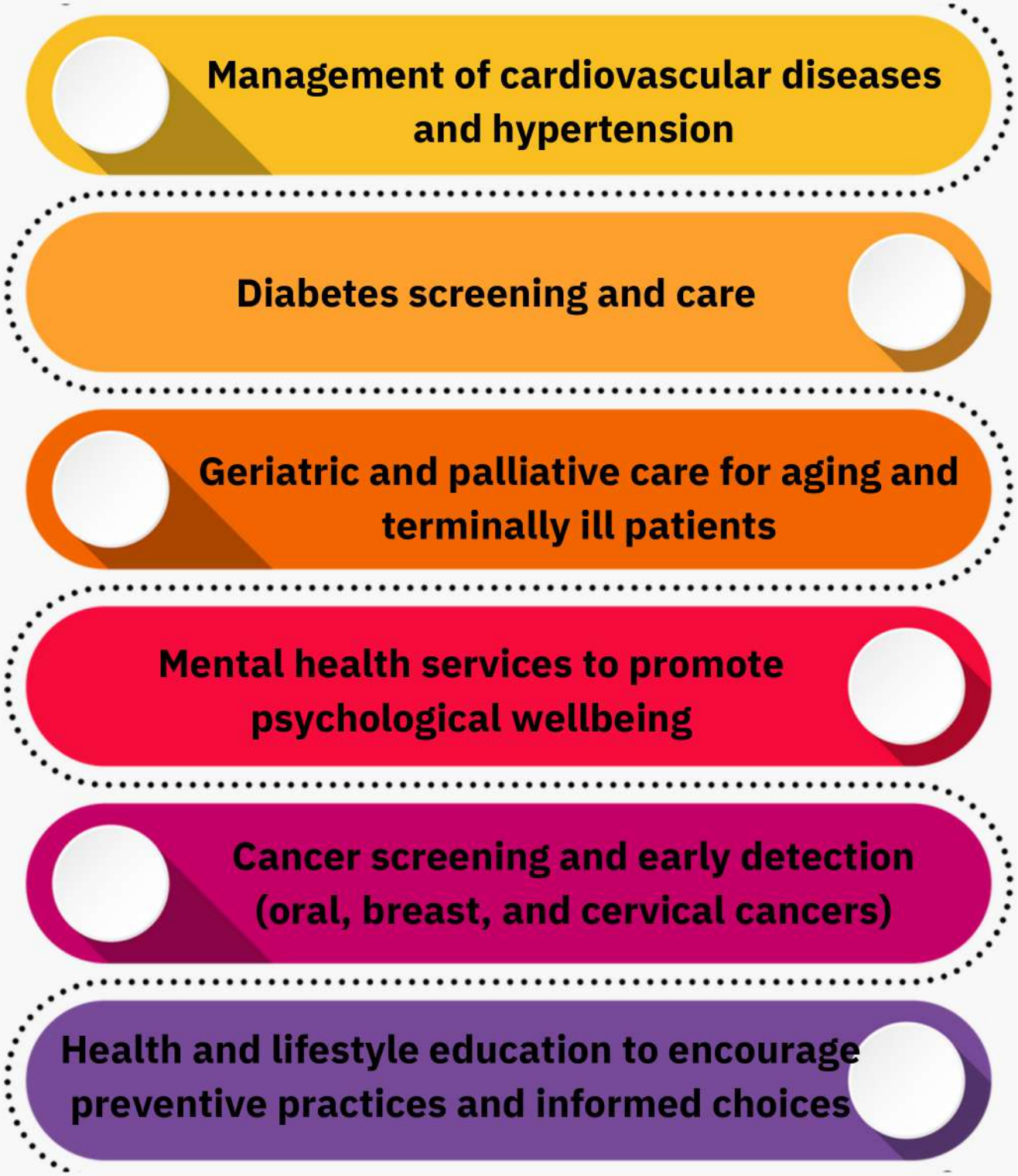
Progress overview for Q1 2025

Overview of OBLF Public Health Initiative

The OBLF Public Health Initiative has successfully extended essential healthcare services to a significant number of individuals. Our program focuses on three vital health verticals: NCD Management, Geriatric & Palliative Care, and Community Mental Health. Through innovative mobile clinics and home visits, we ensure that critical services are accessible to underserved communities, fostering a healthier future for all.

Our dedicated multidisciplinary team works tirelessly to deliver compassionate care through strategic partnerships. By integrating community feedback, we continuously enhance our approach, ensuring that the needs of the population are met effectively. Our goal for the upcoming quarters is to expand our outreach, optimize our services, and empower local communities to take charge of their health. Together, we can build a more resilient healthcare system that thrives on collaboration and innovation.

The healthcare platform addresses a broad spectrum of health concerns through targeted service areas including:



In addition to medical care, the program integrates components like tele-health support to expand specialist access, and initiatives focused on women's empowerment, and livelihood, thereby addressing social determinants of health. Through this ecosystem approach, OBLF is not just delivering healthcare it is cultivating resilience, dignity, and long-term wellness in the communities it serves.

I. Cardiovascular & NCD Management

InQ1,our NCD verticalmadesignificant strides in tackling hypertension and diabetes through targeted screening, early diagnosis, and timely intervention. Clinics across 31 villages remained fully operational, providing continuous care and outreach. Frontline health workers played a pivotal role in driving community mobilization, raising awareness, and ensuring strict adherence to treatment regimens. Their dedicated efforts not only strengthened local health infrastructure but also empowered individuals to take control of their health, fostering long-term health improvements across the region

Progress Highlights (Quarter 1 - Apr-June, 2025):

The program reached **8,975** individuals, reflecting strong engagement and broad community impact

Over **2,028** patient consultations, highlighting extensive outreach and service delivery

2,840 screenings completed, reflecting the program's focus on proactive health prevention

A total of **44** clinics held, showcasing the program's wide-reaching access

A total of **21** referrals made, ensuring timely access to specialized care

A total of **31** villages served, extending healthcare access and support to remote communities in need

Following are the key indicators of the program:

Indicator	Number
Total coverage of the program	8,975
Number of villages served	31
Number of clinics conducted	44
Number of cycles	2
Number of patient consultations	2028
Number of screenings conducted	2840
Number of referrals	21
Number of patients diagnosed and treated with Diabetes	423
Number of patients diagnosed and treated with Hypertension	693
Number of pre-diabetic patients	159
Number of pre-hypertensive patients	168

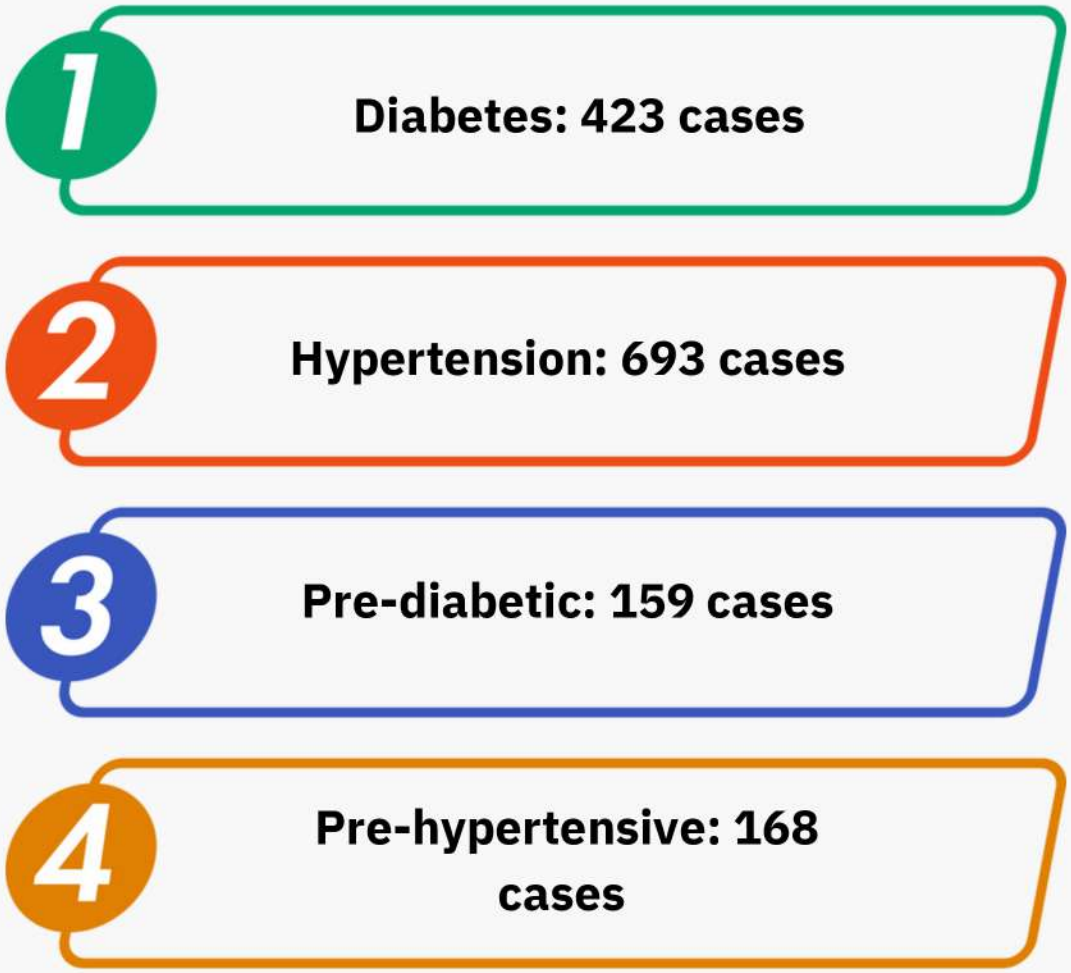
Key Inferences:

1. **Screening Effectiveness:**

2,840 screenings were conducted across 31 villages. A higher number of screenings likely correlates with early detection and better management of chronic conditions like diabetes and hypertension.

2. **Non Communicable Disease cases reported:**

From the 2,840 screenings, the following details outline the reported Non-Communicable Disease (NCD) cases.



- A total of **423** cases were treated for diabetes, and **693** cases for hypertension, underlining the program's critical role in managing prevalent chronic conditions.
- Additionally, the identification of **159** pre-diabetic and **168** pre-hypertensive cases highlights a significant opportunity for early intervention.
- Addressing these conditions at their early stages can effectively prevent progression into more severe forms, reducing long-term health risks and promoting better overall health outcomes within the community.
- This proactive approach emphasizes the program's focus on not just treatment, but also prevention, ensuring a healthier future for those at risk.

3. **Consultations:**

A total of **2,028** clinic consultations were conducted during the two cycles of this quarter. This high consultation rate underscores the program's effectiveness in identifying individuals with ongoing medical needs, ensuring that they receive timely and appropriate care.

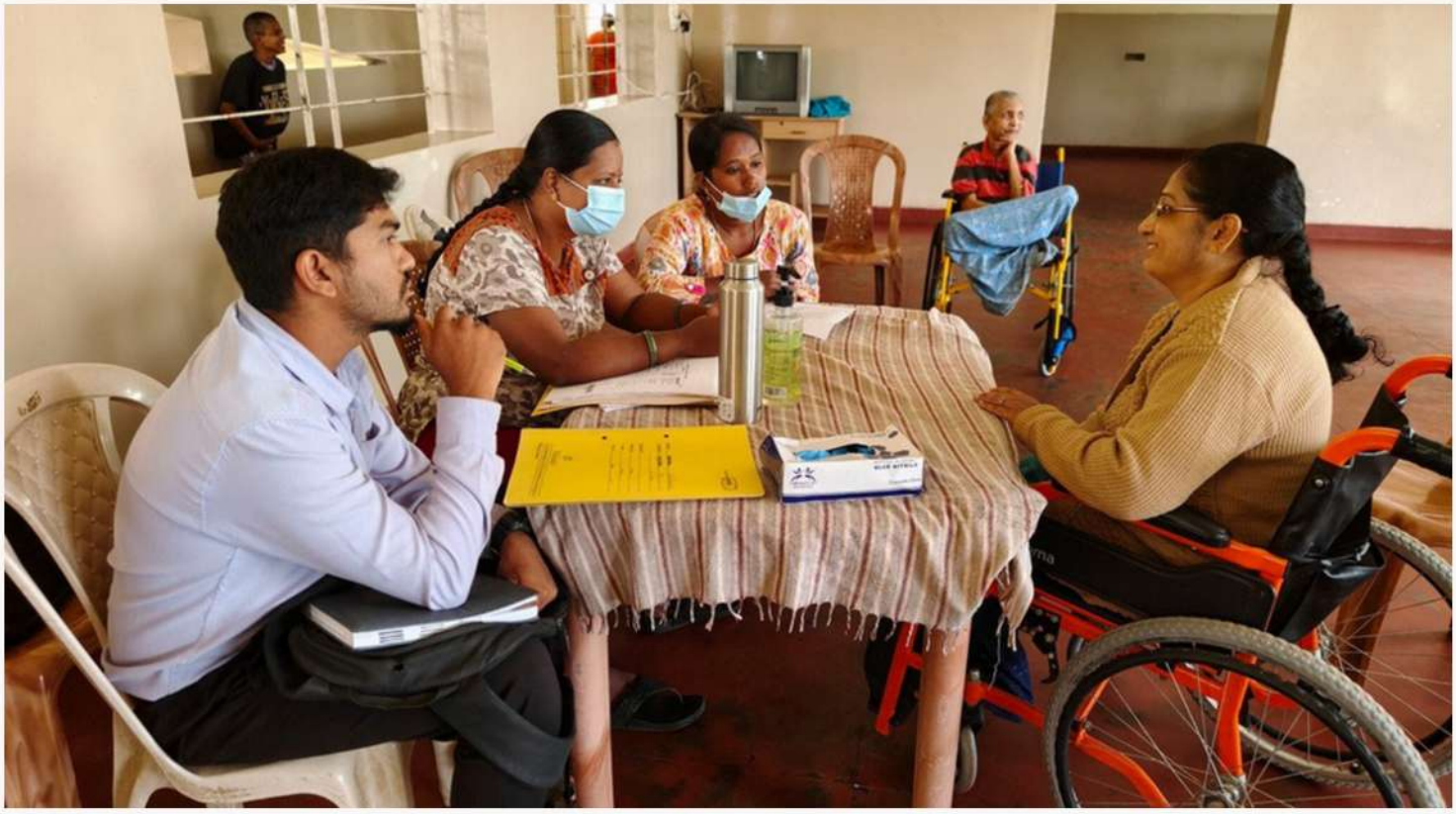
The significant number of follow-up consultations highlights the program’s capacity to engage patients in sustained care, addressing both immediate and long-term health challenges. By offering continuous medical attention post-screening, the program not only mitigates health risks but also enhances the overall well-being of the community, providing patients with a clear pathway to recovery and support.

II. Strengthening Community-Based Geriatric and Palliative Care

OBLF's Geriatric and Palliative Care (GPC) program, launched in 2022 in Indlavadi and Vanakanahalli Gram Panchayats, expanded to home-based care in March 2024 across Anekal Taluk, with strong local health authority support. Since August 2024, the program operates from a dedicated GPC Centre in Chandapura under Dr. Gopukrishnan Pillai's leadership, offering a distributed care model through home visits, centre-based services, and regular clinics, providing comprehensive medical, nursing, physiotherapy, and rehabilitation support.

Recognized for its system-strengthening approach, OBLF has been invited by the Government of Karnataka to expand services across Anekal Taluk and Central Bangalore. The next phase includes launching a 10-bed palliative care ward at Sir C.V. Raman General Hospital, in line with the National Program for Palliative Care.

The program has a coverage of a **population of 100,000** across **Marsur, Karpur, Chandapura, and Hennegere Panchayats,** ensuring widespread access to essential health and social services in these communities



Geriatric and Palliative Care Program

Inthe first quarter of FY2025-26,the programcontinuesto effectively expand and enhance its services across the communities of Marsur, Karpur, Chandapura, and Hennegere Panchayats, ensuring widespread access to critical health and social services. Our team remains dedicated to identifying individuals with life-limiting illnesses and unmet supportive care needs through systematic screenings and consultations, while prioritizing pain management and clinical interventions.

We are also committed to empowering caregivers by providing ongoing training and support, helping them build confidence and resilience in managing caregiving challenges. Furthermore, we are bridging gaps in care through a streamlined triage system that ensures timely, needs-based service delivery, strengthening the overall impact of our services in these communities.

Progress Highlights (Quarter 1 - Apr-June, 2025)

01 **577** services delivered, enhancing the quality of life for geriatric and palliative care patients

02 **204** screenings conducted, identifying individuals in need of critical geriatric and palliative care

03 **193** patients identified as eligible for specialized geriatric and palliative care services

04 **203** home visit consultations conducted, ensuring personalized and compassionate care in patients' homes

05 **249** community clinic consultations provided, delivering accessible and comprehensive care to local patient

Following are the key indicators of the program:

Indicator	Number
Number of Screenings Conducted	204
Number of Patients Eligible	193
Total Services Delivered	577
Number of Home Visit Consultations	203
Number of Community Clinic Consultations	249

Key Inferences:

1. **Efficient Screening Process**:

204 screenings conducted led to 193 eligible patients, resulting in a high conversion rate of **94%**. This suggests that the screening process is highly effective in identifying individuals who require geriatric and palliative care.

2. **Balanced Care Model:**

203 home visit consultations and **249** community clinic consultations reflect the program's balanced approach to delivering care. The home visits focus on personalized, in-depth support for patients, while clinic consultations provide an accessible setting for ongoing care. The high number of both visits indicates a robust service model that caters to diverse patient needs—home-based care for those unable to visit clinics and community clinics for those able to attend.

3. **Holistic Service Delivery:**

The **577** total services delivered, which is substantially higher than just consultations, indicates that the program offers a full spectrum of care, including follow-ups, rehabilitation, and social support, ensuring that patients receive comprehensive, continuous care.

4. **Impact on Vulnerable Populations**:

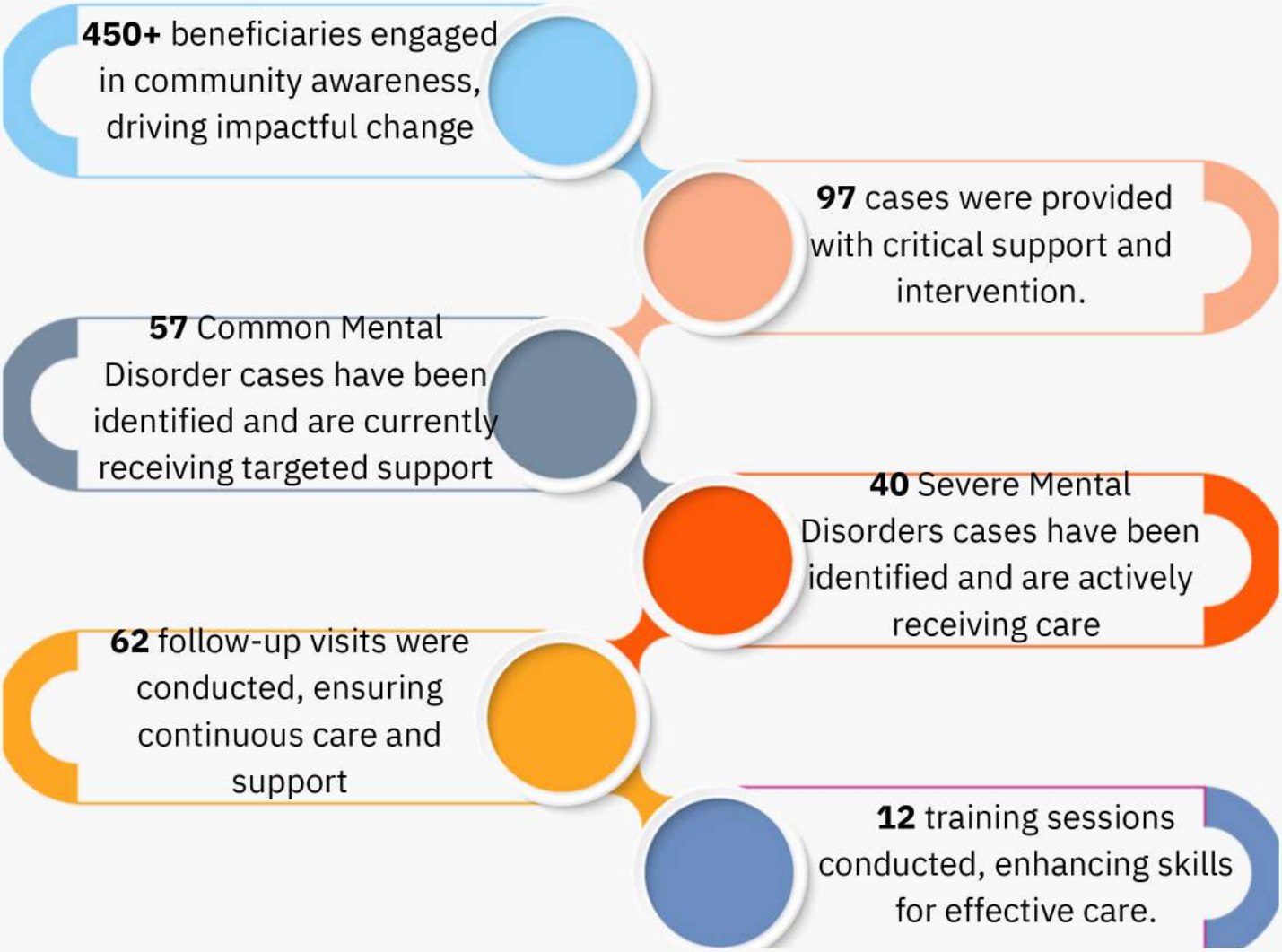
The combination of home visits and clinic consultations reinforces the program's comprehensive service delivery. It indicates that both in-person and community-based interventions are essential for maximizing patient reach and care effectiveness, ensuring that services are delivered at the right level of care for each patient's needs.

Mental Health Program

The OBLF Mental Health Program is transforming mental health care in underserved rural areas by integrating community-driven solutions. The program has its coverage in **11 villages**, and empowers local women as Non-Specialist Providers (NSPs), enabling them to deliver essential mental health services while creating livelihood opportunities.

Through comprehensive training and capacity-building, NSPs receive continuous support and supervision from OBLF psychologists and psychiatrists to ensure high-quality care. This approach effectively addresses both common mental health issues and severe conditions, with a focus on sustainability and local ownership of mental health care delivery.

Progress Highlights



Following are the key indicators of the program:

S.N.	Indicators	Number
1	Number of villages	11
2	No. of Common Mental Disorders cases identified	57
3	No. of Severe Mental Disorder cases identified	40
4	Total number of cases	97
5	Number of referrals made to Psychiatrist	30
6	Number of follow up visits	62
7	Number of psychoeducation sessions provided to the client	17
8	Number of community awareness events in collaboration with Gram Panchayat	4
9	Number of benificiaries who attended community awareness events	450+
10	Number of training sessions for mental health team	12
11	Number of cases facilitated for UDID card through District Mental Health Program	9

Infrences:

1. **Community Awareness:**

With over **450** beneficiaries attending the community awareness events, the outreach had a impact on fostering mental health awareness. These initiatives not only educated a large number of individuals but also played a pivotal role in reducing stigma and encouraging open dialogue about mental health.

2. **Strong Focus on Mental Health:**

The **12** training sessions and **30** psychiatric referrals demonstrate the program's commitment to professional development and high-quality care. By enhancing team skills and facilitating specialized support, it ensures effective and comprehensive mental health care for beneficiaries.

3. **Follow-ups and Psychoeducation Sessions:**

The **62** follow-up visits and **17** psychoeducation sessions reflect the program's commitment to sustained care and empowerment. These efforts ensure that beneficiaries receive not only immediate intervention but also continuous support and education, which are crucial for long-term mental health stability.

4. **Total Reach and Care:**

The **97** total cases under CMHP, in contrast to the **450+** beneficiaries attending community awareness events, highlights the program's broad reach and its ability to raise awareness across a large segment of the population. While only a subset is actively enrolled in direct care, this indicates that the program is successfully educating and engaging the community.

Case Study

A Close Call: When A Routine Home Visit Made All The Difference

Nagrathnamma, a woman from Thammaynakanahalli village, has grappled with the twin challenges of diabetes and high blood pressure for years. While she diligently took her medications, a nagging unease lingered about the inconsistent care provided by visiting mobile clinics. Then, a simple mix-up with similar-looking pills nearly turned into a crisis. But the quick thinking of Shashikala, a dedicated Frontline Health Worker (FLW) transformed her experience and restored her faith in accessible healthcare.

Nagrathnamma' journey with blood pressure began years ago at a factory job when, during a checkup, her blood pressure was found to be low. A simple remedy of pickles suggested by her husband helped normalize it. However, later, a diabetes diagnosis at the General Hospital in Anekal led to the introduction of blood pressure medications. She used to rely on medications from a visiting mobile clinic for the past couple of years, but a nagging unease lingered about their inconsistent care.

Managing her medications had always been a source of slight confusion for Nagrathnamma. Her blood pressure pills and diabetes medication were both white, making it easy to get them mixed up. Unfortunately, that's exactly what happened. For ten days, she accidentally took her blood pressure medicine at excessive doses, thinking it was her diabetes medication.

The effects were swift and alarming, causing severe hypotension that left Nagrathnamma battling severe dizziness and bouts of sweating. Thankfully, during a routine home visit, Shashikala, a frontline health worker with OBLF, noticed her distress. With her knowledge and experience, Shashikala suspected a medication error. She immediately advised Nagrathnamma to consult a local physician, who confirmed her suspicions and temporarily stopped her blood pressure medication.

This incident highlighted a crucial difference for Nagrathnamma. The visiting mobile clinics, while helpful, couldn't offer the level of consistent care she needed. This experience made her decide to shift to OBLF's mobile clinic for her medications. While she appreciated the visiting clinics, she realized they lacked the consistency that her conditions required. "They come and go," she explained, "but you people [OBLF] are always here, checking on me, on my family." Shashikala's attentiveness during that critical moment earned Nagrathnamma's trust, and she made the decision to completely shift her care to the clinic where she felt truly looked after.

Nagrathnamma's experience highlights a common challenge for those in rural India – inconsistent and fragmented healthcare. We at OBLF seek to bridge that gap with our emphasis on community-based care. Our FLWs embody the impact of this approach. Their work provides a vital safety net and promotes long-term health within underserved communities.