PROPOSAL

for Support for the Village and Subcentre Level Health Care Program at Jan Swasthya Sahyog, Bilaspur

Submitted to:

Friends of JSS UK

Submitted by:

Jan Swasthya Sahyog, Ganiyari

(October 2020)

Jan Swasthya Sahyog (JSS) runs a three-tiered community health program in 72 villages, where the village health workers at the base are chosen by the village community from among them, and trained and supported by JSS. At the second tier are subcentres that support clusters of up to 20-25 villages each, manned by a team of 3 senior health workers, who again have been trained by JSS in clinical and community health skills. These in turn are supported by the referral centre at Ganiyari at the third tier.

While the 100-bed referral centre supports the huge unmet need for effective and low-cost care for serious and significantly complex problems that poor rural communities face in disproportionately large numbers, it is the village-based health program that allows us to constantly find solutions for unsolved primary health care problems. It is this program that learns about the problems that people face and enables real observational research while working.

COMMUNITY HEALTH PROGRAM

JSS Village Program

The JSS community health program currently has 148 **Village Health Workers (VHWs)** in 72 forest and forest fringe villages in rural Bilaspur and Mungeli districts. Village Health Workers are first point of contact for primary health care and key persons in communication between village and health institutions. Health workers take care of

common illness in the village and they use around 25-30 odd drugs with the help of a pictorial drug formulary. A health worker makes use of some technologies in her work such as a breath-counter (developed at JSS) to measure respiratory rates in newborns and infants, digital BP machine, thermometer, H2S bottle etc. in diagnosing various health conditions. VHWs make 4 rounds every month covering every household to know about the health condition of people and offer appropriate treatment. Patients, who the village health workers cannot manage, are referred to Senior Health Workers (SHWs) at the subcentre.

A **weekly mobile clinic** is run at every subcentre, where a physician-led team (which includes a lab technician and a pharmacist) visit from the referral centre. This clinic is important for initial diagnosis and management planning but continuing care for illness and promotive and preventive care is exclusively looked after by the village team. People from around 225 villages access care at the each of the subcentres. JSS subcentres also work as a health and wellness centre, which provides curative, preventive and promotive services to the catchment of about 25 villages.

Senior health workers (SHWs) are an important link between the doctor and health worker at subcentres. SHWs are given a basic training of 9 months. Main responsibilities of SHWs at a subcentre are – running the daily OPD at the subcentre, managing some emergencies, performing some lab investigations, decision making and referral. The key role they perform is taking care of patients with non-communicable diseases such as diabetes, hypertension, sickle cell, epilepsy, mental ailments etc. and major communicable diseases such as TB, leprosy. SHWs follow up on all these patients once the doctor has diagnosed and started treatment.

To improve compliance, JSS has started **disease-based support groups** for non-communicable disease patients. An SHW facilitates all the activities in a support group. On a fixed day all the patients of nearby villages who are part of the support group, come together, discuss their experience about the disease and treatment, side effects etc. and

learn from each other. On the same day, SHW does the basic health check and replenishes their medicine. SHWs visit patients, who are not a part of any support group, at their home to know about their health status. SHWs also monitor and mentor the village health workers in terms of providing handholding support and spot training in villages.

Antenatal services are provided through monthly clinics run at 15 locations. Women from nearby 4-5 villages come to these clinics for antenatal checks. A trained team consisting of cluster coordinator, SHW, Auxiliary Nurse and Midwife (ANM), Maternal and Child Health Worker (MCHW) and lab technician conduct these antenatal clinics. Expectant mothers undergo a full physical examination by the cluster coordinator/SHW. All the standard lab investigations (HbsAg, VDRL, Blood grouping, Urine analysis, Blood count, Hb, HIV and malaria) are done for each pregnant woman at the first visit and Hb, urine sugar and malaria tests are done during every subsequent visit. To every pregnant woman, our MCH worker administers Iron, Folic acid, Calcium, Tetanus immunization, and also gives instructions on proper nutrition, family planning, self-care, delivery and parenthood. MCHW also make a list of all high-risk pregnant women to follow them up once a month in between the two antenatal checks. Health workers in the village also visit these pregnant women on a regular basis.

Trained Auxiliary Nurse-Midwives (ANMs), who are posted at subcentres, provide **intra-natal care** using quality labour room standards. JSS has trained 130 **Traditional Birth Attendants (TBAs)** for conducting delivery at home for women, who are unable to go to the hospital due to unavailability of transport facilities in the villages. The objective here is to ensure adequate care even if the circumstances don't allow access to an

institutional delivery. TBAs use a safe delivery kit prepared by JSS to conduct safe delivery. In case of complications, referral is made to the referral centre at Ganiyari both by ANMs and TBAs.

JSS also provides **post-partum care**, wherein 7 **Maternal and Child Health Workers (MCHWs)** monitor the mother and newborns up to 42 days, and conduct regular check-ups, record vital statistics, provide counselling regarding breast-feeding and post-partum family planning.

Besides these, the supporting team includes 6 **program coordinators**, 3 **cluster coordinators**, 3 **field coordinators** who support various programs such as maternal health including the antenatal and postnatal care, **tuberculosis care**, **falciparum malaria control**, **child health and nutrition** especially for the under-three age group, use of appropriate technology in primary health, water borne disease control and chronic disease care. These coordinators also share responsibilities of training health workers at the village and the subcentres too. These frontline people are supported by two **managers** in each subcentre, a total of 6 (cluster coordinators and field coordinators) who supervise, liaise and facilitate multiple activities that go on at the subcentres.

The **combined scope of work** done by this team includes providing first contact health care for common and important health problems, organizing referrals for problems they can't manage, education of the communities such as self- help groups, parents' groups, adolescent girls and boys, patient support groups such as those for epilepsy and sickle cell disease, organizing and running programs for antenatal care, tuberculosis, falciparum malaria and non-communicable diseases. Special curative and preventive programs in animal health and organic agriculture for better food availability are also arranged. Community based monitoring of public programs in health, public distribution systems, *Panchayati Raj* and health education programs are also important activities. Innovative methods of data collection, surveillance and communication through interactive voice recording systems and use of cell phones are recent inputs that have allowed us to remain a live interactive community. Careful documentation through electronic database systems allows us to run monitored analysis of our work.

INDICATORS

Indicators of major activities in the period from April 2019 to March 2020 exemplify the work done through the community health program:

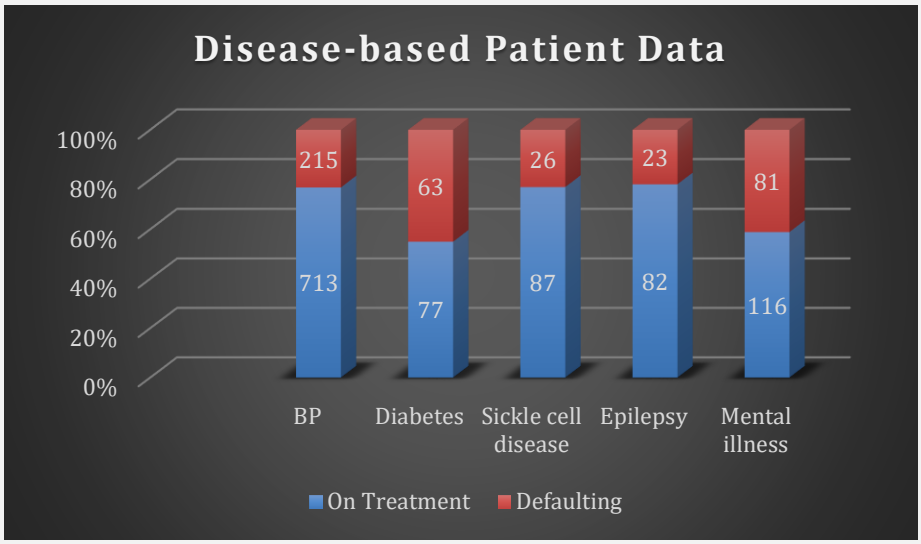

Figure 1: Distribution of patients based on diseases

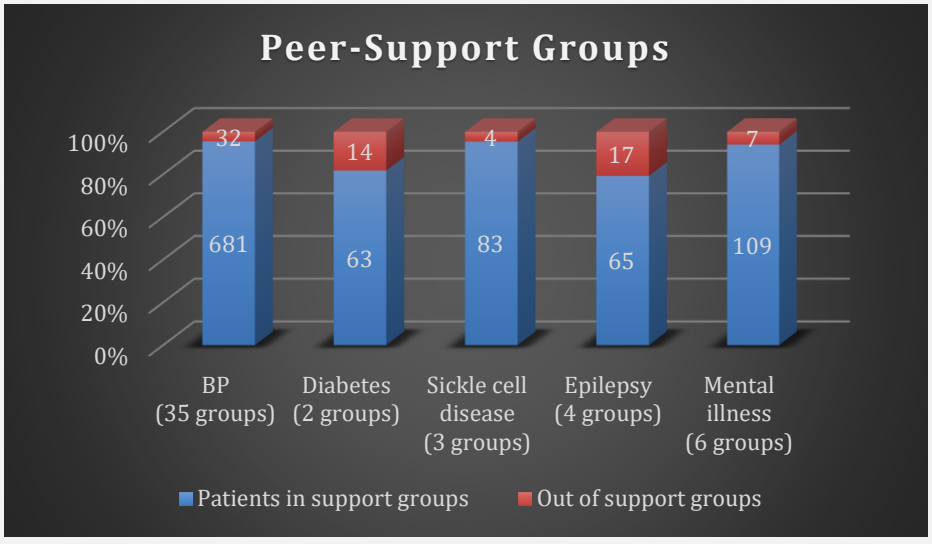

Figure 2: Distribution of patients based on peer-support groups

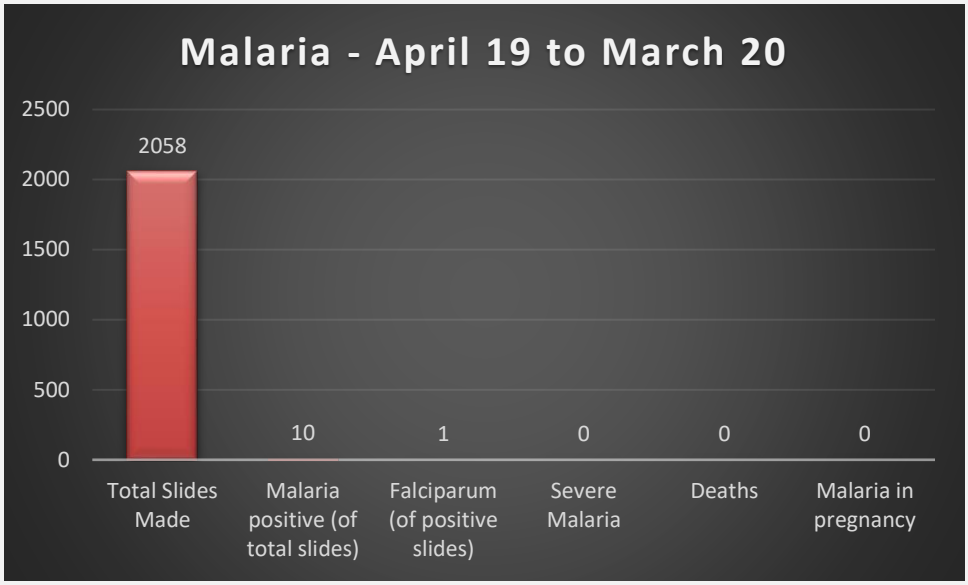

Figure 3: Malaria program

Total camps	Total women screened	VIA +ve	Women with cancer			Women with		
			Cervical	Breast	Oral	HTN	DM	Anaemia
31	1283	266	3	1	0	27 (12 new)	5 (3 new)	22 (3 new)

Table 1: Women's health screening camps for cancers (breast, oral and cervical), NCD (diabetes, hypertension)

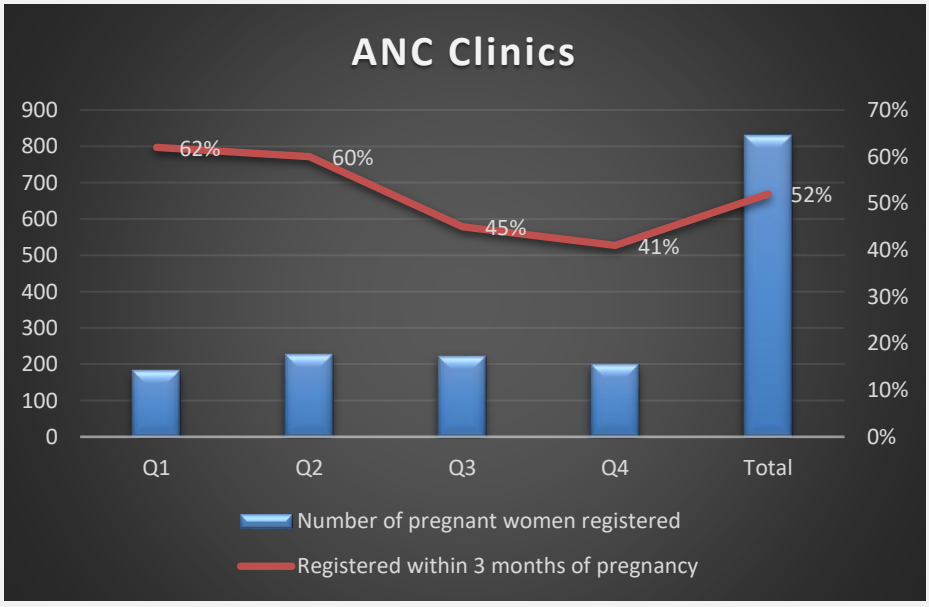

Figure 4: ANC Clinics

Intrapartum care

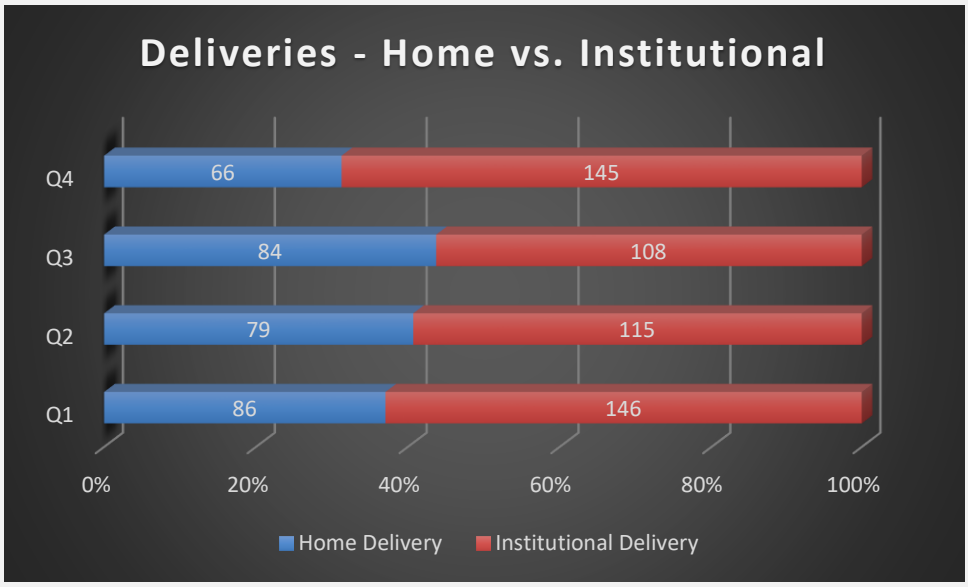

Figure 5: Home vs. Institutional Deliveries

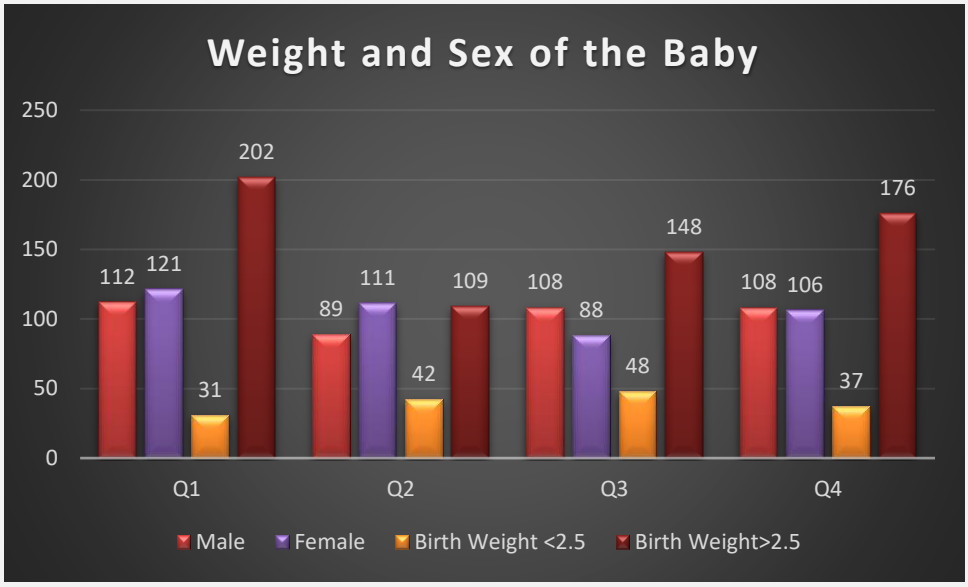

Figure 6: Birth Weight and sex of the baby

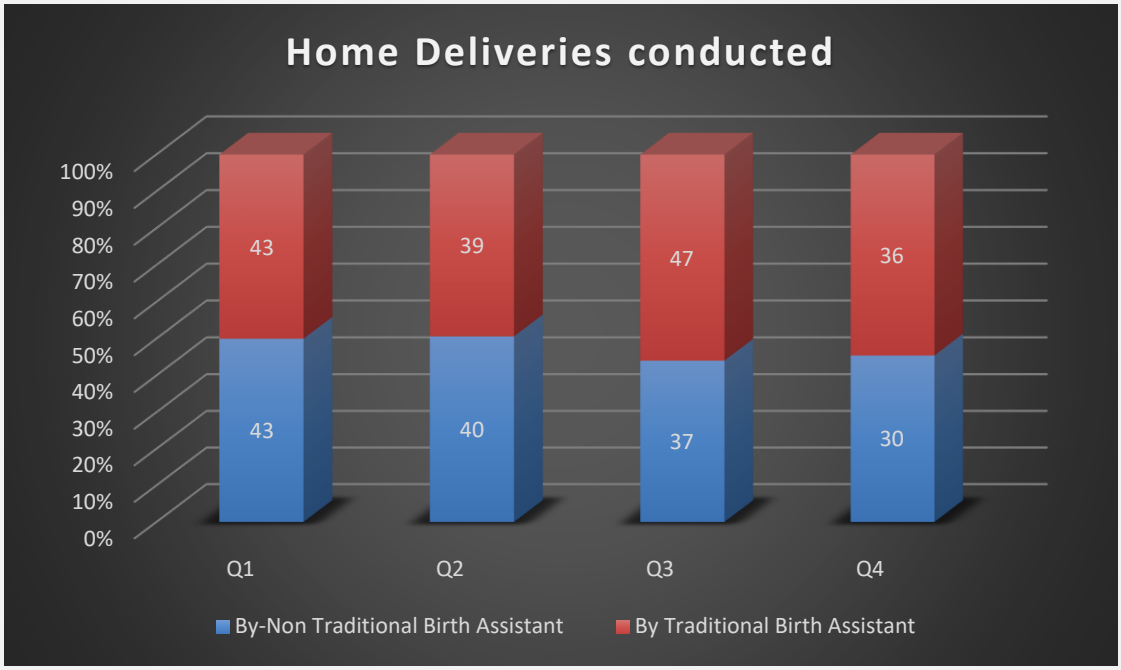

Figure 7: Deliveries by Traditional Birth Assistants

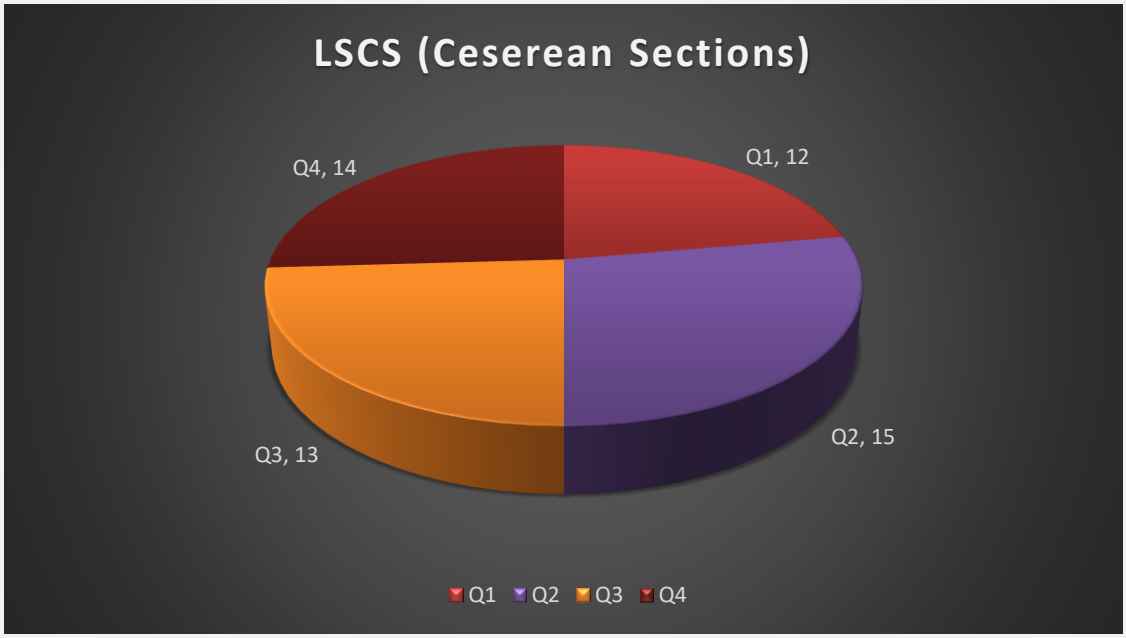

Figure 8: Lower (uterine) Segment Caesarean Sections (LSCS)

Our experience shows that illnesses are not of medical nature alone. The geographic, cultural, social and economic predicaments that lay behind the illness play an equal or more important role. The causes are deeply rooted in these factors. To give an example, in remote rural areas where qualified health care providers are either unheard of or inaccessible, quacks rule and their practice mostly survives on painkiller injections and IV fluids. This provides some degree of symptomatic relief. With no alternatives available, such malpractices are common and popular in rural areas. The poor status of literacy and specifically health literacy coupled with such unregulated health care practices are often reasons for the delay in reaching appropriate health care and therefore for the delay in getting treatment.

A new mother was brought into the emergency room, unconscious, two days after giving birth to her child. This was not the first time she had come to JSS. She paid regular visits for antenatal check-up in the past. It was only this one time that she did not come to the hospital – for her delivery. Labour pains started at night and no one in the village had a vehicle. It was suggested by the elders of the family that the traditional birth assistant (Daai) be called. She was not reachable then, but came in the morning and the baby was delivered around noon. It was after she delivered the baby that things started going downhill. There is a custom in the rural tribal communities in Chhattisgarh that women are not given food and very little to drink for 5-6 days after delivery. It is considered that this helps in drying of the umbilical stump. She was given hardly two glasses of water to drink and no food in two days. Even after her condition worsened, the first choice was unfortunately the local 'Baiga', who performed black magic.

Such age-old traditions are endangering women. This new mother and her husband have finished school but she could not go to college because there was lack of transport and no other girls from the village to accompany her. Despite favouring an institutional delivery, the husband and wife found it difficult to convince the elders of the family to put an end to these traditions that only do harm and no good. But this episode brought them around. The parents admitted that perhaps it would have been better, if she had delivered here and they would be more mindful about their choice of treatment in the future.

There was another instance, where Aarti (name changed), a 16-year-old girl from one of our program villages of the remotest cluster Bamhani, was bitten by a Krait (a poisonous snake) in her sleep. It was around 9:30 pm and the family members called out for baiga (a faith healer), who came and did some jhaad-phoonk. The family was sure of the treatment being provided to Aarti and thus everyone went to sleep peacefully again. The next day too, the baiga was there for Aarti's treatment as her condition was getting worse and while all this was going on, one of our Daai karykarta, Bisahin Bai, came to know of this. She took no time to reach Aarti's place and examined her. Aarti was unable to open her eyes and her speech was already slurred. Bisahin Bai realized the gravity of the situation at once and advised the family to take her to Bamhani subcentre. The advice was ignored by Aarti's family and they insisted on carrying on with the baiga. Bisahin Bai

understood that this might be the last chance to save Aarti and she fought with the family members asserting the need to take Aarti to the centre. After a lot of verbal struggle, she could somehow convince the family for the same.

Unfortunately, it was around that time of the year, when the Maniyari river usually gets flooded with water due to rains. Thus, it wasn't possible to carry Aarti on charpai (jute cot) and cross the river. Just at that moment, Bisahin Bai identified two members of the Bamhani subcentre staff going towards the centre on a motorcycle. She stopped them and made Aarti sit in the middle on the bike, who was then taken to the sub centre speedily by our staff. She was administered anti-snake venom instantly and further referral was needed to JSS, Ganiyari. That happened with the help of our public transport vehicle in Bamhani and at JSS, Aarti remained admitted in HD ward on a ventilator for a couple of days. But finally, her life was saved. This could not have happened without the prompt action and advocacy of Bisahin Bai for Aarti's treatment. It is worth mentioning that Daai workers receive most of the training in Pregnancy care and delivery related work with topics of general importance being taught in lesser frequency than our Village health workers. But it was the presence of mind and brave decision of Bisahin Bai of going against the family that could allow her to save a life. Despite her efforts in the best interest of the family, she later received bitter words from Aarti's family for having kept her in JSS for two days. Nevertheless, Bisahin Bai and all workers like her are the backbone of our community program, who continue to serve the community with full zeal.

This incident underlines the importance of the work our dedicated health workers undertake. The community program is the interface that helps us get to the root of the issues and factors contributing to poor health and lacking health care services in rural central India. This further helps us in handling them from different angles and coming up with a more comprehensive solution. These 20 years of work have allowed us to improve the quality of lives of people in the area, though there is a lot more to be done for one to get a feeling of contentment, and we would like to describe this as a work in progress. If one measures it in survival and nutritional anthropometric assessments or in indebtedness prevented, there are some significant gains. Finally, we see the need to maintain and improve this absolutely amazing interface and platform to serve, observe and learn how inequities in health of the marginalized rural poor are to be addressed.

FINANCIAL SUPPORT

We request support for care of chronic non-communicable disease program under the comprehensive village health program elucidated above. As mentioned above, we provide focused care for patients suffering from chronic and non-communicable diseases in the form of disease-based peer-support groups. This activity helps in ensuring compliance by providing medicines on time and keeping the timely consumption in check. As of March 2020, we have 53 peer support groups (including three new recent groups) representing 5 chronic diseases (viz. hypertension, diabetes, epilepsy, mental illness and sickle cell anaemia) with 978 participants and have seen 90% attendance in the last year. This activity also includes women's health screening camps to diagnose illnesses in time, which they may not report due to social stigma and others. For better monitoring and taking adequate measures to ensure compliance we have recently developed a mobile Application to be used by the field level team.

We propose the following budget for this activity:

Chronic Non-Communicable Disease Program					
Sr. No.	**Particulars**	**Unit**	**Rate**	**Period**	**Total**
	Program costs				
1	Peer support group meetings including alcohol deaddiction groups	53	550	12	349,800
2	Subsidy for Medicines & Consumables for patients with chronic disease care	3	30,000	12	1,080,000
3	Subsidy for Lab investigations	3	5,000	12	180,000
4	Residential training of SHWs @ 225/SHW/month (lodging and boarding)	12	225	12	32,400
	Sub-total - Program costs				**1,642,200**
	Personnel				
1	Middle level health workers	1	16,000	12	192,000
2	Field Coordinator	4	22,000	12	1,056,000
3	Laboratory Technician	1	15,000	12	180,000
4	Logistics Manager	1	17,000	12	204,000
5	Doctor	1	45,000	12	540,000
6	Driver for community program	1	17,000	12	204,000
	Sub-total – Personnel				**2,376,000**
	Overheads				
1	POL for middle level health workers	7	1,900	12	159,600
2	POL for field coordinators	1	25,000	12	300,000
3	Communication, internet for monitoring app - AVNI	1	1,500	12	18,000
	Sub-total - Overheads				**477,600**
	Grand Total				**4,495,800**

Despite the current pandemic, this activity is running smoothly, but in a different format. Group meetings are not held currently but our health workers ensure continuation of treatment through regular home-visits and refilling medication. We plan to eventually start the groups again with adequate physical distancing measures. With the progress we have made so far it becomes extremely important that maximum compliance is continued to be achieved and that we do not let the pandemic affect non-COVID care which is equally if not more important. We are herewith submitting the grant request of **Rs. 44,95,800 (in words: Rupees Forty-four Lakhs Ninety-Five Thousand Eight Hundred)** for supporting this activity to help chronic care disease patients get better and at the same time reduce the risk of them contracting COVID.

We are extremely grateful to Friends of JSS UK for the continuous support provided. We hope that with this support, we would be able to improve and provide better services in the intensive community health program.