ANNUAL REPORT

Chronic Disease Care Programme

Jan Swasthya Sahyog

[2020-2021]

The 72 tribal villages catered to by the Community Health Programme of Jan Swasthya Sahyog are a witness to ever increasing load of Non-Communicable Diseases (NCDs)/ Chronic Diseases (CDs). These diseases include:

- Hypertension
- Diabetes
- Epilepsy
- Heart diseases
- TB and Leprosy
- Asthma and COPDs
- Arthritis and rheumatoid arthritis
- Stroke
- Mental illness
- Sickle cell anaemia
- Asthma
- Thyroid disorders
- Cancers

Some of the above chronic diseases namely diabetes, hypertension, epilepsy, sickle cell disease, mental illness, TB, leprosy are actively screened and followed up under the chronic disease care programme. Patients with diseases other than these are provided care at the subcentre and referral centre at Ganiyari.

Care provided at the village-level:

The Village Heath Workers (VHWs) (on an average 2 per village) play a key role in creating awareness about and screening of these diseases in the village community with support from Senior Health Workers (SHWs). They are trained to identify some of the risk factors and symptoms of these chronic diseases and perform basic examination activities like taking vitals and preparing slides. Cases of patients suspected with chronic diseases by VHWs are reported to and reviewed by SHWs on their visit to the village every month and if needed, the patients are called for a consultation by the doctor during the weekly mobile clinic at the subcentre or are referred to the 100-bedded centre at Ganiyari in case of emergency or when further work up and investigations are needed. Active screening for hypertension in persons above 30 years of age is also done during village rounds by VHWs. For prevention of NCDs, the village community is made aware of best practices for a healthy lifestyle and avoiding any kind of addiction through the monthly meetings conducted by Village Health Workers and through patient education in support group meetings, at subcentre OPDs and during village visits by SHWs.

Subcentre level care

All 72 villages are divided into four clusters out of which three have subcentres, also called Health and Wellness Centres (HWCs), run by JSS. The subcentres are manned by Senior Health Workers (SHWs). SHWs bridge the gap between VHWs and doctors. SHWs are trained in diagnosing common illnesses including some emergencies, managing some common emergencies and their referral and performing basic labs.

One of the key responsibilities of SHWs is to manage chronic illnesses after the therapeutic plan has been made by the physician at the HWC/referral centre.

Screening done by SHWs and Doctors:

Once a week, a mobile clinic is hosted at all three subcentres where a team comprising of a doctor, a pharmacist, and a lab technician goes from the referral centre. Patients that the VHWs or SHWs want to get reviewed by the doctor are seen at the mobile clinic and their follow up care is explained by the doctor to SHWs and also to VHWs if they have accompanied the patient that day.

Opportunistic screening is done by the doctor on mobile clinic day and by SHWs on remaining days during their subcentre OPD. SHWs also screen the patients for diabetes and hypertension during their visit to villages. For other diseases too, they do field-based screening based on the symptoms.

Monthly follow up by Village Health Workers (VHWs):

During their village rounds, VHWs pay monthly visits to patients diagnosed with chronic diseases to ensure adherence to treatment, look for any side effects due to medication and to assess whether a referral is required. VHWs also measure blood pressure of all patients with hypertension and diabetes once a month and notify the respective SHWs about patients with abnormal vitals. Motivating patients for monthly follow-ups and for visiting the subcentre/referral centre for various lab investigations is an important part of their job in care of chronic diseases.

In their register called 'Gaon Ghumhana Kitab' which they use while doing the village round, they mark all NCD patients in order to keep track of regular follow-up visits. This register also serves as a document for record keeping.

With the pandemic spreading rapidly, monitoring by Village Health Workers proved very helpful. They recorded the vitals including oxygen saturation of all NCD patients in their village on a weekly basis initially and later fortnightly and those suspected for covid were sent for screening/rapid antigen test at the designated facilities.

Monthly follow up by Senior Health Workers (SHWs):

SHWs follow patients diagnosed with chronic disease by means of:

1. Running disease-based Peer Support Groups (PSGs)
2. Home visits for patients who are not a part of PSGs – especially for those who can't access care due to old age/disability
3. At the OPDs for patients who are not a part of the support groups and prefer to come to the subcentre.
4. Paper based formats for monthly follow up for diseases like diabetes, hypertension, epilepsy, sickle cell disease, TB etc. are used by SHWs to capture information on vitals, compliance, lab investigation and drugs, complications etc.

during their home visit or on the day of the PSG meeting. These formats are then shown to doctors on the day of mobile clinic for their review.

Lately, we have also started application based documentation of new cases and follow up of patients with Hypertension by SHWs where paper format is substituted by a digital open CHS App called "Avni". The same is planned for Diabetes, Sickle, Epilepsy and TB.

All of the above means to diagnose, manage chronic diseases and ensure good compliance continued to run as usual with adequate protection to prevent the acute COVID-19 disease.

Disease based Peer Support Groups (PSGs)

Peer support groups are formed by patients with the common disease and living in the same or nearby villages. The monthly PSG meetings are facilitated by one of the Senior Health Workers from that cluster along with an Auxiliary Nurse Midwife (ANM) intern and Village Health Workers. The meeting usually spans 2-3 hours and is comprised of various activities. Once all the patients have come, the first activity that happens is Yoga. A brief 20-25 minutes Yoga session is sometimes supplemented with a game or sports activity. This is then followed by health talk of the day. The topic may be directly related to health like a disease, it's symptoms, prevention etc or it may be related to a more general/social issue like cleanliness, safe drinking water etc. Once the discussion is over, some healthy snack is served to patients like a fruit or *gud chana*. These meetings also allow vitals monitoring by VHW and sample collections for regular (annual/biannual) lab tests of patients. Medicines are then given to patients after the Senior Health Worker has assessed their disease status and mentioned it on their card accordingly.

We have support groups of mainly 5 diseases viz. Hypertension, Diabetes, Epilepsy, Mental illnesses, and Sickle cell anaemia. However, some patients with other diseases like Asthma, Air-borne contact dermatitis also collect their medicines from one of these support groups due to easy accessibility, convenience etc.

The meetings didn't take place their usual way this year to avoid spread of COVID-19. It felt like we were taken a few years back to a time when there were no Peer Support Groups. However, this time there still was an alternate care plan in place that ensured that treatment is not affected. Since most of the NCD patients are very vulnerable to contract the Covid-19 infection, it was not advisable to put them at risk by holding meetings. However, all the patients continued to get the healthcare they used to receive in group sessions. The Senior Health Workers paid home visits to patients with all the required armamentarium and collected samples in vials, if that was needed to be done, and then provided medicines to the patients. Referrals were made wherever needed and patients were sent in vehicles designated for referral work.

Women's health camp:

In order to bring about early diagnosis and screening of NCDs, women health camps were being conducted in all 4 clusters (about 4 camps per month) to screen for hypertension, diabetes, anaemia, obesity, cervical cancer, breast cancer, oral cancer and uterine disorders. The camp comprises of a team of workers trained for examination of breast, cervix, and per vaginal/per speculum uterus examination; dental interns for oral examination; lab technicians for required investigations; and VHWs to measure height, weight of women. VIA positive women are referred for colposcopy/ biopsy/ examination at the JSS referral centre by senior consultants. Women with raised BP, sugar etc. are referred to the mobile clinic OPD at the subcentre to be seen by a doctor.

With the backdrop of the pandemic, we decided to pause the Screening of NCDs in women >30years of age through women health camps and came up with other methods to continue screening. Our clinics played a part here and VHWs kept in touch with women of their hamlets to inform them of any discomfort/ symptoms they are experiencing, so that they can be seen at the clinics. Thus, for such women, the required tests like breast, P/S and P/V VIA examination, RBS etc. were done at the subcentre based on the case and the presenting complaint. A total of 4 new diagnoses for cancer in women were made this year.

Support and Monitoring

Cluster coordinators (CCs) and Field Coordinators (FCs) provide support and monitor work of SHWs and VHWs in terms of training, hand holding support during home visits, and PSG meetings.

Along with CCs and FCs, the programme coordinator is responsible for running overall chronic disease care programme under the supervision of a senior physician and a public health specialist.

Trainings

Regular monthly training is conducted for both VHWs and SHWs. JSS follows the strategy of residential training cum review meeting. Training topics are decided based on the problem seen in the community, seasonal problems and some topics are based on demands by SHWs/VHWs in order to improve various skills.

The programme coordinator, FCs and CCs conduct trainings for VHWs. They are joined by a physician for SHW trainings.

This year additional modules on COVID-19 were conducted for VHWs which will equip them to act as the screeners and to spread awareness about the disease. Subsequently, they did door-to-door awareness drives in all program villages. They were provided with the necessary protective equipment to safeguard them.

As of April 2021, the figures related to chronic disease care program patients are as follows:-

Disease	Total number of patients	On Treatment			Default
		Patients in support groups	Out of support groups	Total	
BP	1161	708	100	808	353
Diabetes	180	97	47	144	36
Sickle cell anaemia	93	53	21	74	19
Epilepsy	78	44	6	50	28
Mental Illness	162	57	38	95	67
Heart diseases	31	NA	22	22	9
TB	20	NA	19	19	1
Leprosy	32	NA	12	12	20

The pinch of covid was felt by all Peer Support Group members and VHWs/SHWs. Although care was not hampered for existing patients, the pandemic had an impact on the diagnosis of new patients which translates to people being bereaved of timely treatment which they needed. On having compared data for three months from last year and this year, it was seen that there was a drop by almost 47%. A similar pattern was seen in case of number of patients reaching the subcentre. The reasons are diverse – some thought that the clinic wouldn't be functional because of lockdown; some couldn't come as there was no means of conveyance from their place to the subcentre and some just thought that if they move out of the house, they will be taken to isolation centres. An adverse impact has also been observed on other activities such as Yoga and exercises which they were reminded of at the meetings and also enjoyed doing at the support group meetings.

The pandemic has been extra challenging for rural India, where not only this disease is affecting patients due to poor infrastructure but also making it worse by hampering access to non-COVID care.