2022-23 ANNUAL REPORT

JAN SWASTHYA SAHYOG

PEOPLE'S HEALTH SUPPORT GROUP

HTTPS://WWW.JSSBILASPUR.ORG/

Our VISION and MISSION

We wish to contribute to the health, happiness, and well-being of the people by:

- Developing a low-cost, effective, and comprehensive health programme that provides both preventive and curative services delivered with empathy and love in the tribal areas of rural central India. We strongly believe that access to healthcare should not be denied to anyone due to lack of money or due to discrimination on account of caste, sex, religion, social class, etc. And this is built on a continuing and mutually enriching dialogue with the people and derives its strength and long term sustenance from this
- Identifying problems during our work which demand scientific scrutiny and working on them on a long term basis
- Being part of the process of development and rejuvenation of village communities by facilitating efforts to improve education, the environment and the level of sustenance of the people
- Contribute towards improving public health policy that is more robust, accountable and inclusive, and help strengthen public health systems through lessons that are learnt in the course of our work

FROM THE SECRETARY'S DESK

Dear friends,

This was an eventful year on the whole with discussion on new ideas and exploratory forays into new domains and sub-domains, unlocking the potential of collective decision making and action. The overall direction of our work remained towards bridging the huge inequity gap in health, making communities self-reliant and healthy through facilitating their initiatives, while trying to find potentially scalable solutions that are amenable to local contextualisation. Action, reflection and discussion led to some ideas that need to be explored further through research.
In the current environment, we were also forced to think on 'how does the organisation navigate or adapt to the ever-changing social, political, policy and economic landscape, while remaining true to its mandate and the people?'

While the community health work in the program villages made progress, the work with women Self Help Groups stood out. Of the nearly 45 products that are being produced by these groups over 30 are listed on a platform called GARIMA (Grameen Atmnirbhar RozgaarI MAnch), that helps local processing, value addition, packaging and sale of the products. Currently Garima is strongly supported by JSS, but over the next couple of years it is intended to be an instrument of the local people, fostering a spirit of cohesiveness, and collective action. JSS also signed an important MoU with the CFTRI, Mysore, for transfer of relevant food processing technologies that would help the women SHGs with whom JSS is actively engaged, to add value to the organic agriculture produce.

Going through the quality benchmarking process for the JSS referral hospital at Village Ganiyari (NABH), provided an opportunity to reflect on what we could do better. It also allowed us to question what quality health care really means for the poor, living on the brink of day to day survival and little to fall back on, where access to good care, that is at no cost to them and which is available promptly. It is notable that this was achieved without external consulting agencies with our own resources, as our team wanted this to be an organic exercise and not just a cosmetic stamp. We also learnt how documentation and generating proof for the accreditation agency generates unnecessary burden on the organisation- straining both human and financial resources. One only hopes that this would come down once systems are set up and processes are in place, though we are well aware that 'quality' is an elusive horizon.

Research and dissemination were part of the various activities that our team was involved in. The two studies with the ICMR reached their final phase while new research areas were explored, including the role of surgery in the diagnosis and management of extra-pulmonary TB. Teaching for all cadres of healthcare providers from Village Health workers, mid-level care providers, nurses and post-graduate doctors continued.

Highlighting the large number of cancer patients that JSS has been seeing over the last decade, our experience of their clinical presentation, management and challenges, and the socio-economic implications on the family of these cancer patients was presented and discussed at a National Cancer Congress organised in Delhi. What should be the future direction of research and management strategies to reduce this high incidence, and increase access to high quality care close to where people live, were some areas that were explored.

Our experience of screening, diagnosis and management of sickle cell disease in eastern MP in collaboration with the NHM MP has been written up and sent for publication. Similarly, our experience of running rural creches in tribal predominant Pushprajgarh block of Anuppur district in MP for children six months to three years, and its impact on their nutritional status was studied and written up for publication. JSS was invited to make a presentation during a National Tribal health 'Samvad' held at Delhi. Discussion was focussed on health, nutrition, livelihood and housing issues faced by the tribal population living in remote and difficult to access areas.

Sickle cell 'elimination' mission has been launched by the ministry of tribal affairs and health. This seems unachievable for a genetic disorder, though we hope that the limelight provided by the mission will bring into focus the plight of these patients with sickle cell disease, most of whom live in remote rural areas, with poor access to any form of healthcare. We need to move resolutely to achieve a goal where all those with SCD can be picked up (diagnosed) early in life, can receive comprehensive care through the public health system and live their lives free of pain and complications and to their fullest potential. We also hope the policies of population level screening, genetic counselling, and premarital counselling do not go overboard in trying to reduce the incidence of SCD, neither do they create taboos and discrimination against those detected with the disease/gene. We intend to work with the state and public health system providing technical support and helping operationalise newborn and infant screening and their comprehensive care from an early age. We also intend to deep-dive into the causes of death among patients with SCD so that gaps in care can be suitably addressed.

The referral centre at Ganiyari was a hub of clinical activity with care being delivered with empathy. The huge burden and advanced presentation of illnesses points to the lack of reliable, comprehensive care while ensuring that this care is not impoverishing. Women used our facilities more than men, as in the previous years, both for outpatient as well as inpatient care. The spectrum ranged from managing cancers, Tuberculosis, Diabetes, RHD, newborn malformations, surgery of children and their safe intraoperative and postoperative care, care for children with severe pneumonias, to Intensive care for Complicated pregnancies, snake and scorpion bites, poisoning, liver disease, kidney failure, respiratory failure, heart disease and acute coronary syndrome, diabetic ketoacidosis, stroke and several others.

The role of AB PMJAY for inpatient care was significant, with almost 90% of patients from CG and nearly two-thirds from MP receiving inpatient care under the scheme, especially covering urgent and semi urgent medical and surgical expenses. But the pitfalls and gaps in its implementation remain and this scope for improvement has been shared with authorities from time to time. We have been working with the district administration to ensure enrolment of the remotest adivasis and backward castes under the PMJAY, but this is still elusive.

We attracted two India fellows to work with us on two broad themes – one on health system strengthening, and another to help local communities through SHGs to reap the benefits of local processing, value addition and packaging through sales. One of our senior members attended a 3-month long ILSS Fund raising program for organisational leaders between September 2022 to January 2023. It was an online interactive program with many learnings and meeting new friends and fellow travellers. The learnings were discussed internally to help us brainstorm on our fundraising efforts. A full time Public Health specialist joined us this year along with a fulltime dentist.

As part of this year's report, we have tried to bring you the flavour of a rural healthcare setup- spaces and design where rural and tribal communities feel comfortable and adopt as their own. We believe this is extremely important in reducing inequity and encouraging the poorest and most deprived to utilize the care facilities well. We are grateful to Arch Hemen Sanghvi for generating the architecture in dialogue with people.

Our constant engagement and dialogue with the rural and tribal communities in this area, their resilience in the face of a difficult life and sometimes treacherous circumstances gives us tremendous strength and is a source of constant inspiration. This also makes us wonder what the push for a five trillion economy with burgeoning inequity would mean for the huge swathes of ordinary citizens such as these here. One only hopes that the need for better nutrition (that is wholesome, diverse and free of poisonous chemicals), better education (that is qualitatively superior and leads to better employability and skills), better livelihood opportunities in our villages and small towns (that help our villages prosper in a healthy way)and better health and health care (that is comprehensive, provided with dignity and empathy close to where people live as a continuum) would now be immediate priorities ahead of the overall economic targets. Migration for labour to a new distant urban 'cold' environment is a reality for many who choose to escape from the drudgery of village life. Their safety, work and living conditions, and healthcare are our sacred responsibility and this needs to be borne in our national consciousness at all times. Some progress has been made but much more needs to be done so that the benefits of this growth that is happening on the shoulders of the ordinary citizens does not crush them. As rightly emphasized by our Prime minister – 'Sabka saath, sabka Vikas' is essential to fulfil our aspiration for a 'Vikasit Bharat'.

We are happy to share that JSS was shortlisted for the Infosys Aarohan Social Innovation Award 2023 and is to make a presentation before a jury in Bengaluru. JSS has also been selected to receive the Bhagwan Mahaveer Award for Medicine for the year 2023.

Looking forward, we are working towards improving eye care both at the community level and in the hospital for which we are augmenting our infrastructure. The model of care would be to train local people as vision technicians, who can help screen for eye problems in the community, as also diagnose and treat simple, yet common vision defects such as refractive errors, infections, etc and know when to refer patients to the hospital for specialist care. We are also planning to train local tribal youth as operation theatre technicians and laboratory technicians with financial support of the tribal welfare department, government of India. We envisage that after a one-year training and one-year hands-on experience during their internship at JSS, they would be ideally suited to provide high quality surgical and operating room assistance as also work in laboratories in the public health system that is currently starved of well trained personnel at this level. With their knowledge, skills and empathy, they can take on several responsibilities which are otherwise managed by doctors and specialists in rural facilities, where their numbers are scarce.

We are also in the process of upgrading our Electronic medical records - the open source software developed at JSS for our rural hospital, keeping in mind our patients' and care givers' needs. This was developed pro bono by Thoughtworks, and many of the platforms used are now outdated and may cease to function in a couple of years. The system also needs to be ABDM compliant so that patient records can be smoothly shared with other care providers with consent and under instructions of the patients. It will be a challenging task, considering that deployment of the upgraded version with customisation required at JSS, will have to be done seamlessly without interrupting our daily workflow and without loss of data, while ensuring that our team feels comfortable with the new changes.

I take this opportunity to thank all our partners, supporters and well-wishers, without whom, this work would not have been possible. We look forward to more enriching partnerships and continuing guidance from the members of the Executive committee.

THE YEAR IN REVIEW

STORIES FROM THE FIELD...

In the tranquil tribal forest village within the Achanakmar Tiger Reserve, 28 year old Meera Baiga (name has been changed) was abruptly woken up at 4am with an overwhelming sense of unease. Finding an increasing difficulty to breathe, she kept tossing on her floor bed. It was then that she called her husband for help. He rushed to the house of Jeevanti didi, a dedicated health worker affiliated with Jan Swasthya Sahyog, just 100 meters away.

By the dim light of dawn, Jeevanti didi could see Meera's laboured breathing. Drawing from her monthly health worker training where cases like these are discussed, Jeevanti suspected a venomous snake bite and suggested immediate referral to the JSS subcentre in Bamhani where senior health workers specialised in bite management are stationed.

Meera's perilous journey to medical aid commenced on a charpai with her mother vigilantly tending to her semiconscious state. Jeevanti didi managed to make a crucial phone call from a nearby hello point (corners in the forest with access to network) to the Bamhani subcentre; while preparing for Meera's arrival, the senior health workers, in turn, immediately contacted the Ganiyari referral centre to dispatch an ambulance with a doctor since the patient may require intubation during transportation even after anti snake venom is administered.

Due to the monsoon season flooding, access to this village was restricted for 2-3 months, necessitating a challenging river crossing with the assistance of a charpai and later a tractor from Jakadbandha village to reach the Bamhani subcentre, however, despite the treacherous water levels, Meera's relatives and neighbours were ready to shoulder this neck-deep-in-water responsibility to reach her to safety.

At the subcentre, she was administered anti snake venom based on her symptoms. After completing the necessary dosage, they transported her to Katami village where an ambulance with a doctor was waiting on the other side of Maniyari river to take her to the Ganiyari hospital. Yet again, a charpai was organised to cross the overflowing Maniyari river which cuts off Katami village and yet has no bridge. The team persevered, ensuring her safe passage to medical aid.

During the journey to Ganiyari, Meera's condition deteriorated, prompting the doctor to administer oxygen and provide respiratory support with an ambubag. After a tense one and a half hours, they reached the hospital and Meera was immediately admitted to the High Dependency Unit (HDU) and placed on a ventilator.

Over the course of 2 days, Meera showed signs of improvement, eventually regaining consciousness on the 3rd. The hospital staff and doctors rejoiced at her recovery, providing much-needed relief to her children and family members who anxiously awaited her discharge on the fifth day.

CREATING A CONTINUUM OF CARE

powered by a robust community health programme...

TIER I & II

In a tribal-dominated state like Chhattisgarh, characterized by vast expanses of dense forests and hard-to-reach hamlets, JSS adopted a "where there is no doctor" approach. We have been diligently training a cadre of community health workers, predominantly women, to address the healthcare needs of villagers at the grassroot level. Our emphasis on enhancing primary healthcare has been made achievable through the dedication and training of these frontline health workers. They not only respond promptly to emergencies but also provide timely and high-quality care for chronic diseases. This approach has significantly reduced the demand for secondary and tertiary care over the years and people have been able to seek care closer to their homes.

Enhancing primary healthcare

With an army of dedicated community health workers, we continued to invest efforts in enhancing comprehensive primary healthcare, adopting an integrated approach that encompasses both preventive and curative services.

Throughout this period, our Village Health Workers (VHWs) have been actively engaged in providing doorstep healthcare, adeptly identifying early signs of distress and refining their diagnostic abilities. Through regular home visits, they have rightly identified several high-risk cases, including under 5 children with severe pneumonia, pregnant women exhibiting elevated blood pressure and not coming to the augmented antenatal clinics run by us and offered screening to individuals showing symptoms of respiratory infections and hypertension.

A total of **29515** patients sought care from our VHWs across 72 villages, with over **85%** having received **effective management** at the **village level**, while the remainder were referred to the base hospital in Ganiyari for specialized care. This progress is a testament to the consistent training provided to our health cadres, who have been instrumental in steering the primary healthcare programme and ensuring that the community has access to healthcare services closer to their homes. While the majority sought assistance from VHWs or JSS facilities, the practice of seeking care from traditional healers and informal practitioners still persists which often delays a diagnosis.

For above 30 population, active screening of hypertension is done once a year while opportunistic screening is carried out for other chronic diseases.

Treatment, initiated by doctors at weekly subcentre mobile clinics, is followed through by Senior Health Workers via routine subcentre OPDs, home visits, or peer support groups. Peer support groups, focusing on selected diseases like Hypertension, Diabetes, Epilepsy, Mental illnesses, and Sickle cell anemia, include **1764** patients. Emphasis during these meetings is also placed on the origins of these illnesses and working on them, especially a healthy diet and exercise.

In all, our programme area has **1982** patients with chronic diseases out of which **1415** have been seeking care with us, **166** from other providers, and **401** have not been seeking care from anywhere.

Stretch and Bend, Curve and Rotate- Gives your illness Check n Mate!

Physical activities at PSGs

Maternal and Child healthcare programme

The MCH programme consists of three main components:

a) Antenatal care, **b) Intranatal care**, **c) post-natal care for mothers and newborns**.

Each month, 16 antenatal clinics are held across locations, serving women from 4-5 nearby villages per clinic. A total of **144** antenatal clinics were conducted during this period. Each clinic included anthropometry, abdominal examination, lab investigations (e.g. Hb, HIV, Syphilis, Sickle cell disease, Hepatitis B), and individual counselling for high-risk pregnancies.

Pregnant mothers received one hot cooked meal and one fruit at every clinic to highlight the importance of nutrition during pregnancy. VHWs mobilized pregnant women for these checks. All of our subcentres and the referral centre have labour rooms for conducting normal institutional deliveries.

602

No. of new pregnant women

275

Registration within 3 months of pregnancy

292

No. of women who completed 4 ANC visits

41

No. of high risk pregnancies

Note: High-risk conditions included PIH, abnormal lab investigations, abnormal fetal positions, pregnant women with preeclampsia.

In the reporting period, **76** women from our programme area required Caesarean section deliveries. Notably, the new guidelines of Ayushman Bharat no longer include C-section packages among conditions for which private and non-governmental institutions provide cost-free management, increasing treatment costs for delivery care at JSS. Consequently, we had to request our partners to support some of the cost borne by JSS so as to offer discounts/cost waivers to poor patients.

Awareness sessions at ANC clinics

With the help of our modular safe delivery kits, our trained traditional birth attendants conducted **82** safe home deliveries. Their training in identification of complications and quick decision making about transferring the women to a hospital have been critical in saving lives in interior forest villages.

THE REFERRAL CENTRE

a *mecca* for the rural poor....

TIER III

At the third tier of our healthcare delivery strategy lies a base hospital in Ganiyari village of Bilaspur.

The 130 bed hospital offers specialized services including Family Medicine, Obstetrics and Gynaecology, Surgery, Paediatrics, Ophthalmology, Dental care, and Ayurveda. Boasting a well-equipped laboratory operational round-the-clock (including a microbiology lab), a pharmacy stocked with a wide range of medications at affordable prices, an on-site blood storage unit, a rural High Dependency Unit (HDU), three fully-equipped operation theatres, a neonatal care unit, and a dedicated labour room, we have been delivering advanced clinical care in such resource-limited settings.

Our primary objective is to ensure equitable access to healthcare regardless of patients' financial capabilities. Moreover, when necessary, we facilitate referrals to higher-tier medical facilities to ensure that the patients receive the comprehensive care they require, thus preventing them from falling through the gaps in the healthcare system.

Outpatient services

Over this one year, **62340** consultations were provided through our outpatient services at JSS (both hospital and peripheral clinics) out of which **31%** sought care with us for the **first time**. To emphasise on comprehensive care and create a continuum to follow through from diagnosis to treatment completion, we prioritise follow up patients over new. As in the previous years, **women formed about 60% of the outpatients**, a trend that has shown better healthcare seeking by women over the years.

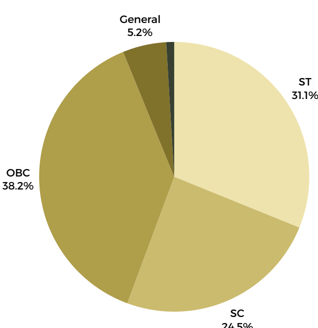
Packaging of ayurvedic formulation

With our 3-day dedicated General OPD services along with specific chronic disease care clinics on the other days, the Ganiyari referral centre saw a total of **58349** patients out of the total share of outpatient consultations while our subcentres in the forest and forest-fringe villages saw a total of **3991** patients through the weekly doctor-led mobile clinics and the daily SHW-led OPD services.

Of the patients seeking care at the referral centre, 2300 patients sought **Ayurvedic care** at our dedicated Ayurveda OPD led by our senior Ayurvedic doctor.

We had seen our OPD numbers plummet during COVID and in a place like Ganiyari, an empty hospital doesn't mean patients have stopped falling ill; it usually means that there is a significant barrier to accessing care. Post the 2nd wave, the OPD numbers have improved and this year, it reflects our usual pre COVID OPD count.

This year, we also opened up a separate OPD for Palliative care mostly geared towards the large number of Cancer patients, many in advanced stages, seen at our centre. Guest faculty for Plastic surgery, Orthopedics, Neurosurgery, ENT and urology, take care of several patients in need of this care. Other specialised care, falling in the ambit of specialities for which we do not have an in-house expert, is provided through weekly telemedicine sessions, coordinated by a resident doctor. This includes consultations in psychiatry, infectious diseases, cardiology, and rheumatology with active contributions from specialist friends in India and abroad from institutions such as CMC, Vellore, and AIIMS, Delhi. Such discussions around patient care enrich perspectives among our doctors and care providers and helps widen their knowledge and skills with nuances and updates from the best in the field.



Population characteristic of people coming to Ganiyari hospital

Burden of illness

When 32 years old Kallu (name has been changed) woke up with extreme pain in his hands and feet, enough to keep him tied to the bed, he recognised the need to visit a hospital. Working as a driver, Kallu had noticed some mildly painful patches in his hands 3 months back. When it persisted, he had gone to an informal practitioner in his village who had administered some injections which seemed to subside the pain for a while. Besides this, his father had taken him to a traditional healer for local medicinal herbs from the forest. Every time the pain would resurrect, he would take an injection and diligently follow the treatment from both the sources. However, they could see the painful lesions take shape of something which seemed to require more advanced care.

Upon consultation with neighbours and others who knew about "Ganiyari hospital", Kallu's father decided to bring him to the JSS OPD where he was seen by a doctor and sent to the dedicated neuropathy OPD for further investigations.

When I first saw him, he was walking with a hunchback due to the crippling pain in his entire body. Following clinical assessment and lab investigations where he had a smear positivity of 4+, Kallu was diagnosed with Lepromatous leprosy (which is a severe form of leprosy with widespread disease and huge bacterial load). Additionally, he had Erythema nodosum leprosum (ENL) or Type II reaction which is rare.

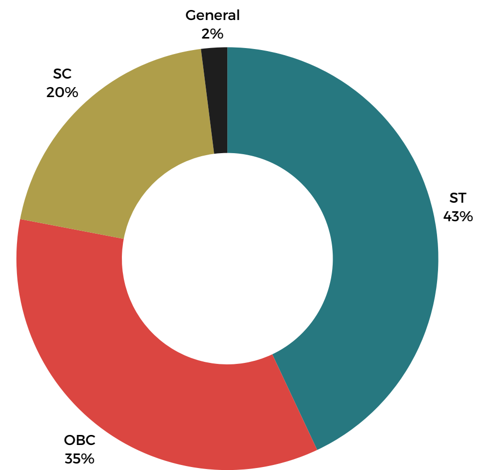
Because of associated stigma and poor awareness about Leprosy, they were scared at first. Counselling played a very important role here; after an in-depth personal counselling session with him and his father, and all queries answered, they realised the need to follow through the planned treatment which, though long and intensive, is the path to recovery.

Kallu is following up and showing improvement with Thalidomide and other required medications. We have given him moisturisers made in-house to soothe the ulcers. We are very grateful to be an institute which can offer these essential medications and to have a team who deliver care with compassion and empathy, which work as a magic drug in reflecting improvement in not just disease outcome but also mental well-being of patients.

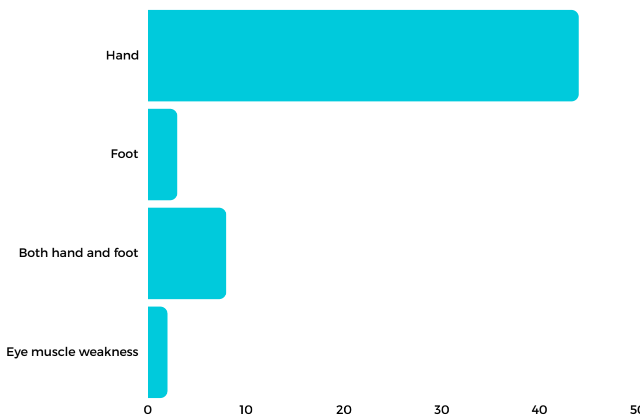
~ Counsellor, Jan Swasthya Sahyog

Our catchment area continues to be a **Leprosy** endemic region with another **116** patients newly diagnosed at the referral centre during this period. A chronic disease, widely regarded as the disease of the poor, Leprosy has been ravaging lives ever since it stopped being a high-profile public health concern. With India being one of the highest contributors of Leprosy in the world, we need to pull up our socks in active case detection and appropriate individualised management.

Limited awareness about the disease characteristic coupled with poor access to well equipped public health facilities in and around the Achanakmar Tiger Reserve which is a difficult terrain, and hence, diagnostic delays often allow community transmission. This reflects disproportionate burden of Leprosy amongst the marginalised, most of whom are tribal.

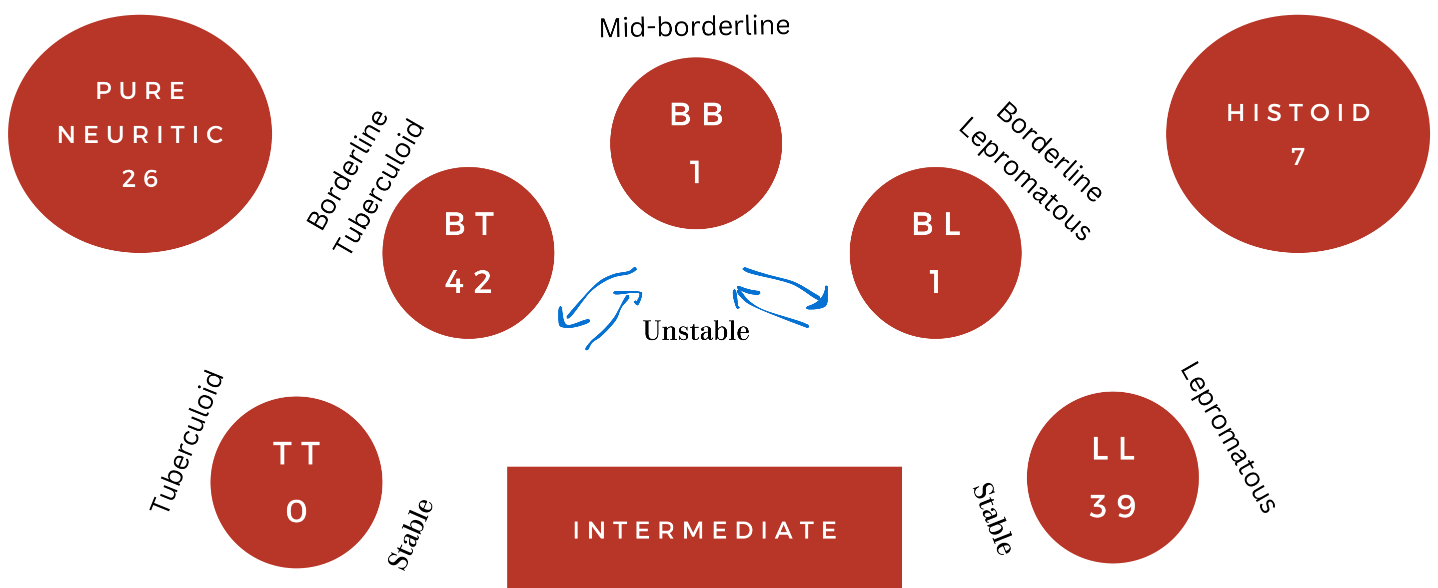


Caste distribution in Leprosy patients



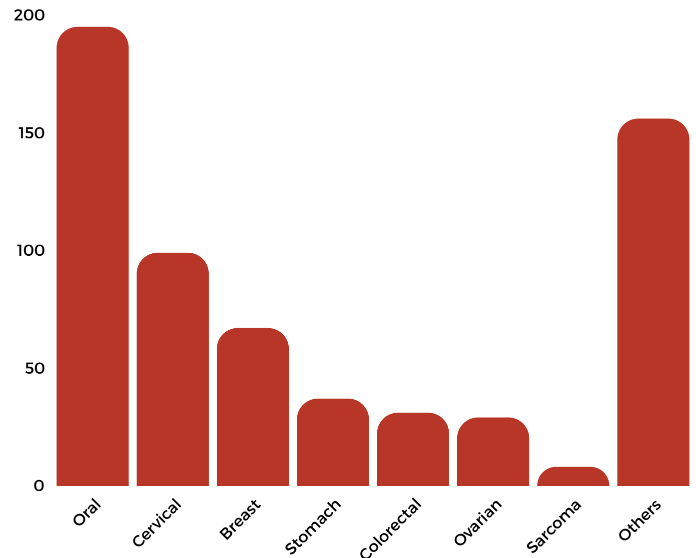
Deformities found in 57 new patients

This year, we saw two cases of **leprosy in children**, one of whom had a smear positivity of 6+ and extensive disease spread in her entire body. We continue to see more number of **Multibacillary Leprosy (98% of the patients)**, which is more severe in nature and require prolonged period of treatment. 9% of the patients had Type II lepra reaction like Kallu. At presentation, 83 patients had neuro-deficit, 36 had painful ulcers with high grade fever, and 49 had no sensation (complete anaesthesia) in the affected parts of their body.

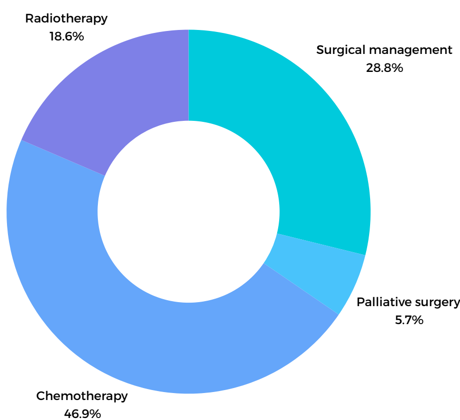


THE SPECTRUM OF LEPROSY

Cancer is one of the leading causes of morbidity and mortality in this hinterland with oral cancer topping the list followed by cervical and breast cancer cases. This year, we saw a jump in the number of new cancer patients with **622** new patients, majority being women, being diagnosed over a year. Though the age distribution of the cohort shows a peak in the middle age group, the highest concentration of cases were found in the working age group (15-64 years) forming 85% of the total share of new diagnosis. Additionally, we treated 9 cases of paediatric cancers.



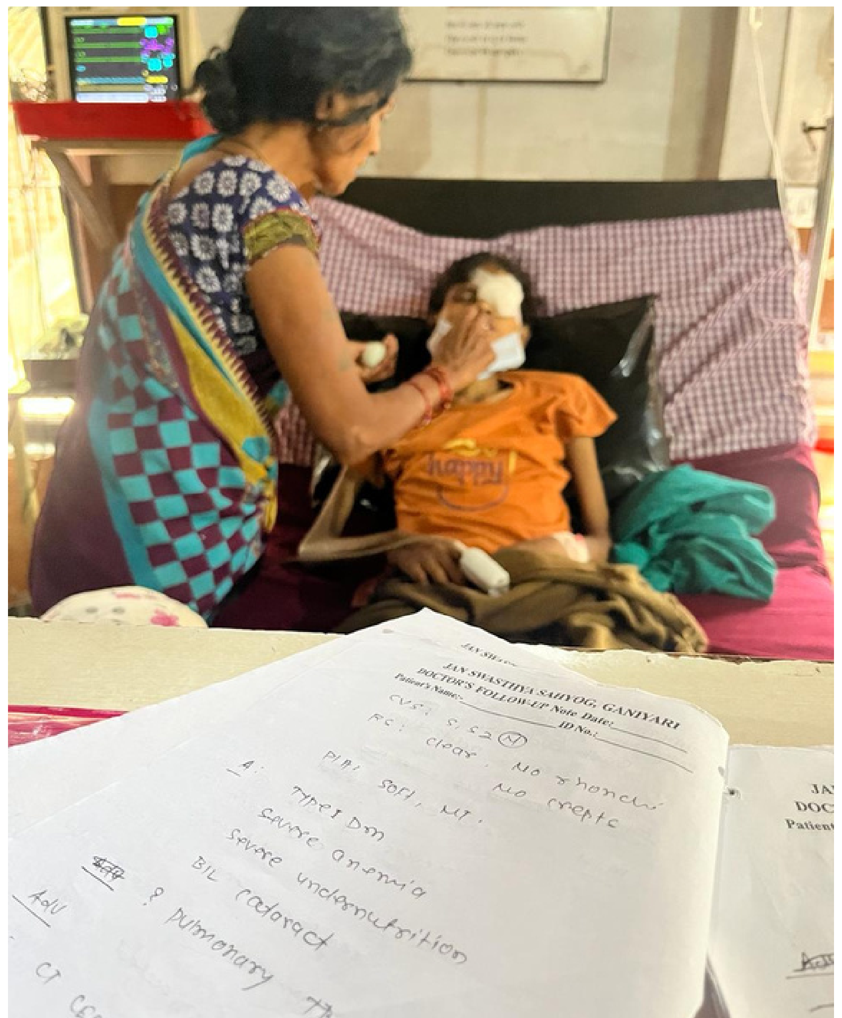
Tobacco remains a major cause of concern despite various forms of health communications and relatively lowered life expectancy. Chewing tobacco is extremely common in this population with 34% of cancers falling in the working age group being oral cancer. This shows the urgent need of awareness and other forms of interventions required for putting a stopper at this largely preventable cause of cancer. At JSS, we prescribe an alternative to tobacco developed by our Ayurvedic team, that can be chewed to reduce tobacco craving.



Both cervical and breast cancers are fairly common in this part with a huge number presenting at an advanced stage of malignancy (See the graph). Other malignancies treated at JSS include, colorectal, Gastric, Ovarian, lung, thyroid, penile, sarcomas- both bony and soft tissue, melanomas and other cutaneous malignancies, lymphomas, testicular and germ cell, hepato-cellular carcinoma, etc.

We have seen an inordinate delay in making a diagnosis of a cancer even after a person is suspected of harbouring the disease in a modern medicine facility, and for most rural and poor people, it is attributable to inability to access appropriate care and the high cost of diagnostic procedures and imaging, which despite the PMJAY (Govt Health Insurance), has to be borne from their own pockets. This delay maybe in months and often jeopardizes their chances of cure. We have tried to ensure that suspected malignancy patients are investigated promptly and have a diagnosis by the end of one week, and a treatment plan chalked out and communicated within the next 3 days.

Diabetes is one of the top 3 chronic diseases we see here at Jan Swasthya Sahyog. However, unlike cities where sedentary lifestyle is the primary cause of Diabetes, what we see here in this rural tribal belt of Chhattisgarh is resultant of chronic poverty and undernutrition. Lean diabetes is common here and over 500 new patients, both paediatric as well as elderly, are diagnosed with Diabetes at JSS every year.



Severely undernourished diabetic patient

During this period, we saw **572** new diabetes patients in our programme out of which 326 were diagnosed first time in-house while the rest had come pre-diagnosed from outside to seek care with us. Most of the newly diagnosed patients were in the late middle age group with the median age being 50; however, we also had 5 new cases of juvenile diabetes. Type II Diabetes was seen in 96% of the patients, most of whom paid only a small amount for their comprehensive care. Those requiring injectable insulin were able to get it at a minimal cost due to external support provided by JSS partners, uninterrupted. At presentation, 54% of the patients had some complications such as neuropathy (most common), retinopathy, diabetic foot, and co-morbid conditions of tuberculosis and hypertension.

At JSS, complete work up followed by individual and family counselling are ensured for all our patients especially those suffering from chronic illnesses. At monthly follow ups, they are gathered through a peer support group led by our senior physician to create a platform for all patients, old and new. This group serves not only as a community of moral support but also a unit to share correct information about the disease, discuss barriers in continuing care seeking, and mitigating them through a dialogue.

Diabetes support group

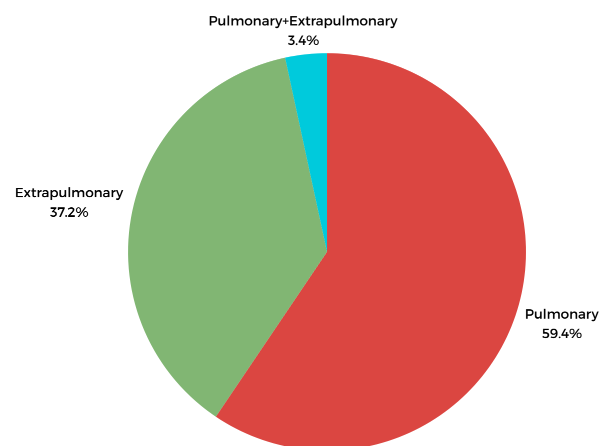
After treatment initiation and periodic follow ups, symptom improvement was seen in 57% of the patients. **No patient deteriorated** under our care plan. 33 (of the 572) patients did not turn up for follow up visits. For

those with uncontrolled diabetes, we have been reviewing their treatment plan and trying to assess the reasons behind compliance issues through telephonic follow ups. 21% of the newly diagnosed patients were from the eastern districts of Madhya Pradesh which tells us the importance of strengthening the public health systems and the care for NCDs so that people can seek care closer to their homes. So, we build a rapport with government facilities near their homes so that we can give handover to them for the patients to be able to easily seek care in their villages without expending on travel and accommodation to come all the way to Ganiyari. Till now, we could refer only 31 patients whose diabetes was controlled. We have started collaborating with other institutes and development of an updated referral slip is underway for easy facilitation of this process.

With COVID symptoms being deceptively similar to that of **Tuberculosis** (TB) in some patients, the pandemic and its successive waves had been a nightmare for TB patients worldwide. Not only has it derailed all the progress made towards eliminating TB by 2025, it generated panic and fear of hospitalisation amongst people suffering from TB in the area we work in. The fear of contracting COVID, and being incarcerated upon testing positive, had made patients with cough and respiratory distress avoid hospitals. This caused a delay in diagnosis, and eventually, a poorer outcome of the disease.

Post COVID, the TB numbers have been limping back to normal......

In 2022-23, **355** patients were freshly diagnosed with Tuberculosis at the referral centre. Though the vast majority had Pulmonary TB, we continued seeing a high no. of Extrapulmonary TB, and a small fraction of Pulmonary+Extrapulmonary TB. Additionally, 34 of these patients had **associated Diabetes**, and 2 patients had **HIV** which increases the risk of the disease to an extreme. We had 5 patients with **multi drug resistant TB**; a total of 25 patients were transferred out to a higher centre which is closer to their homes or manage MDR TB.



Counselling of TB inpatients

The BMI numbers of our TB patients often hover below 18 kg/m2 and sometimes even below 12 which is medically considered incompatible to life.

From our experience, we know that nutritional support is a crucial intervention in TB treatment and thus, besides the usual nutritious food cooked in our mess, every day, TB inpatients are given eggs, milk, fruits, ankurit dal, sattu, chana, and a WHO recommended Therapeutic Mix which is packed with protein and other nutrients. Since food is as important in these patients, besides their daily regimen of AKT doses, our TB outpatients are also given sattu, soyabean oil, and Therapeutic Mix.

22 year old Suraj Baiga (name has been changed), a resident of Dindori, Madhya Pradesh, had dropped out of school early and started working as a daily wage labourer to supplement the meagre income of his family of 7. A year back, while working in the field, when he fell to the ground and started wriggling uncontrollably, his family took him to a traditional healer in their village for an exorcism. He had been having these seizure episodes ever since and they have been frequenting temples for sacrificial offerings, a common belief in this hinterland for overturning perils of life. These 5-10 minute long seizures would come unforeseen and land him with injuries, postictal confusion, and loss of memory. Newly married, his wife abandoned him in just a few weeks.

It is a sad testament to their ignorance coupled with a lack of affordable and accessible care that so many of these patients in our country are still considered to be possessed and taken to faith healers for cure.

When the symptoms persisted even after a year, holding onto their minimum resources and frail hope, they decided to seek care through outpatient service of our referral centre. However, while waiting for his turn, he had a seizure episode and sustained injury from the fall and was rushed to the emergency room. Following stabilisation, he was diagnosed with Epilepsy and started on medication.

At his latest follow-up visit 7 months later, he happily shared that he is not only back on his feet but has regained his confidence and glad to be back at work.

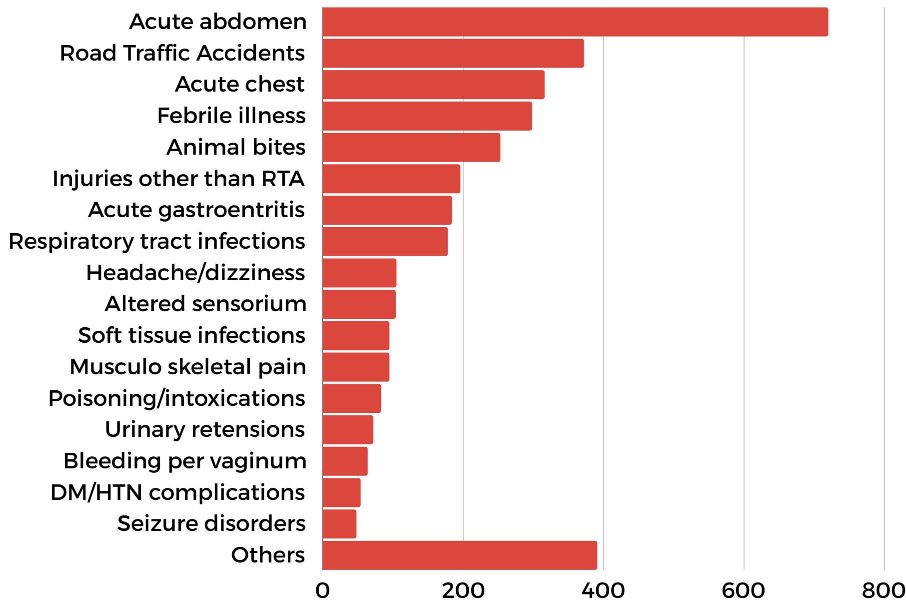
Emergency Room

Like Suraj, a number of patients seek emergency care at the JSS hospital for medical, surgical, paediatric, obstetric, and other specialised services.

The 6 bed emergency room is run by a team of nurses and on-call senior and junior residents; the ER has availability of bed side X-ray and ECG facilities besides round the clock support of the laboratory, labour room, and operating facilities.

After two long years of battling COVID, our emergency care services were in full swing this year keeping the **occupancy more than 80%** across the months. Though we continued suspect screening of patients for COVID Omicron, none of the cases got severe.

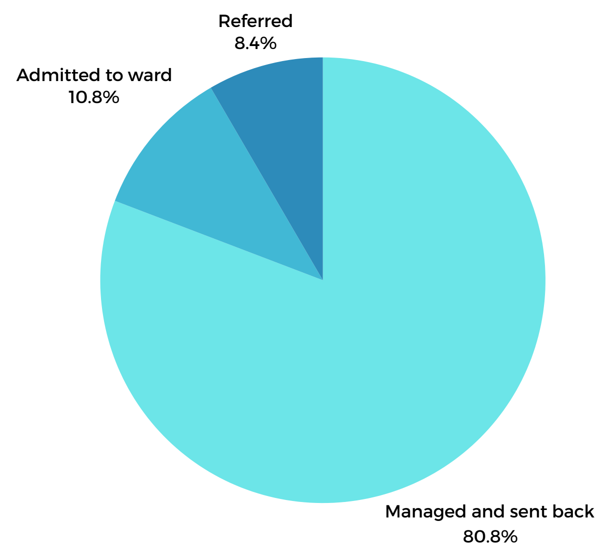
During this period, we saw **3628** cases, almost **double of last year's count**, through our emergency room. Over **52%** of these patients sought care after dark which highlights the importance of having a **24*7** accessible emergency care room in a rural forest landscape where electricity is still not a norm and animal attacks/bites are quite common.



The conditions seen at the ER ranged from acute abdomen including pain crises, abdominal distention, hematemesis, ectopic pregnancies, RTAs and bites, altered sensorium to neonatal emergencies like meconium aspiration, birth asphyxia, oesophageal atresia, PUJ obstruction and the like.

54 patients presented with Diabetes and hypertension complications such as Diabetic ketosis, ketoacidosis, weakness, hypoglycemia, etc. Monsoons, especially, see the highest influx of patients presenting in the evening from snake bites. We saw **253 cases of snake and animal bites** during this period, and thanks to the availability of our HDU, **we have not lost any patient who reached on time**.

Emergency patient management



Despite the constraints of limited resources, we were able to save many lives through our ER with **81% of the patients managed** and sent back and **11% admitted** for inpatient and critical care. This year, the **referral numbers dropped** significantly from last year's 17% with only 8% of the patients having been referred to a higher centre due to unavailability of beds or required facilities.

Whether there were patients requiring observation after poison ingestion or relentless cycles of CPR, our teams at the ER were on their toes to ensure no one is denied care for want of money.

STORIES OF STRENGTH

Radha Baiga (name has been changed), a woman from Lamni village of the Achanakmar Tiger Reserve, was brought to the Emergency Room with severe abdominal pain. She was 33 weeks pregnant and seemed to have had an abruptio placentae which put the life of her baby at risk. She was taken up for an emergency caesarean section in the middle of the night even though we knew the baby was premature and his lungs would not be mature enough to allow him to breathe by himself.

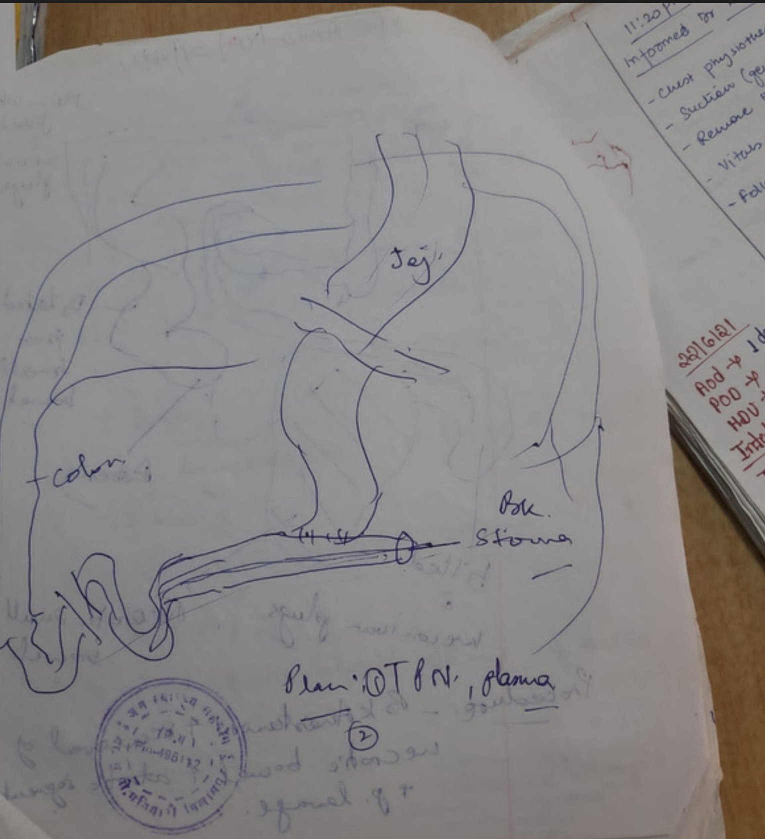
A 1.8 kg baby was delivered and as anticipated, the baby developed respiratory distress soon after birth for which he was put on bubble CPAP. However, the baby continued to worsen and had to be mechanically ventilated.

This clinical course was consistent with Hyaline Membrane Disease which is known to develop in preterm babies due to surfactant deficiency. The option before us was to give synthetic surfactant to help the baby recover. This would usually be done in a high end tertiary care centre with a level 4 nursery. We procured surfactant from Bilaspur at a cost of Rs 20,000 and administered it to the baby through the endotracheal tube.

The baby started recovering soon after and was weaned off the ventilator. Feeds were introduced and gradually built up till the baby was gaining weight and ready for discharge.

The happy mother and baby at 20 days

STORIES OF STRENGTH



Risabh (name has been changed) was born by elective LSCS at JSS in June 2021, the dreaded time of the COVID second wave.

His mother's antenatal ultrasound showed grossly dilated bowel loops with an enlarged stomach bubble. The baby had features of intestinal obstruction and required surgery soon after birth. He was diagnosed to have complicated meconium ileus with meconium peritonitis, gangrene of small bowel and atresia at the level of mid small bowel.

He underwent a BK anastomosis with removal of the necrotic bowel and atretic segment along with peritoneal lavage.
The baby was in our HDU for 3 weeks and received total parenteral nutrition before he recovered enough to be able to take oral feeds and be discharged.

The BK stoma was closed at 1 year of age.

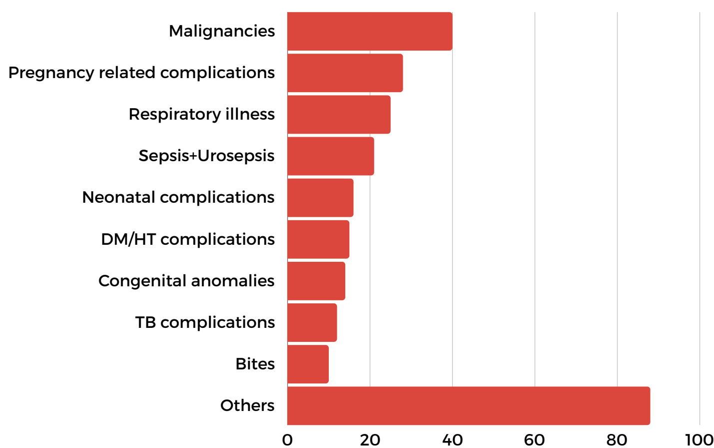
On his last follow up, Risabh was a bubbly boy with only a minor scar to remind them of his previous complaints.

All work and no play?

Rural HDU

While critical care needs are high in rural areas, the availability of hospitals with specialist led critical care services are far scarce compared to urban India. Patients seeking ICU/HDU beds often fall through the cracks of the system which cannot provide for them in times of urgency since referral to an appropriate facility that is non-impoverishing, causes a delay and risk to life. Snake bites, severe anemia, and undernutrition are common problems that plague the people of rural India. They fall prey to so many preventable causes of morbidity and mortality. What repeatedly comes through is that they are often mere victims of socio-economic distress, long delays in presentation and poor access to health facilities. Critical care for the poor is often synonymous with **'catastrophic'** healthcare expenditure.

It has been a boon to have a rural HDU and NICU at JSS which are equipped with ventilators, phototherapy units, bedside X-rays, and designated staff for round the clock critical care.



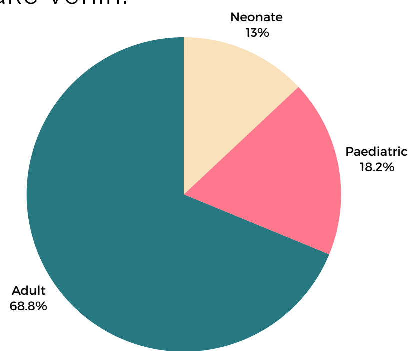
In the reporting period, we could offer critical care to **269** patients through our HDU, majority of whom were patients with advanced malignancies requiring surgical services followed by critical care. Pregnancy related complications such as eclampsia and pre-eclampsia, pregnancy induced hypertension, ante-partum and post-partum haemorrhage, ectopic pregnancies were some of the causes of critical care needs in women.

This calls for Antenatal clinics to be strengthened across the country so as to ensure the safety of women in pregnancy and reduce the risk of eclampsia, besides mandatory screening for NCDs through public health system and awareness generation on prevention. During this period, we also managed several cases of diabetic and hypertensive complications, including Diabetic ketoacidosis, sepsis and other comorbidities with diabetes, hypertensive emergencies, and stroke in our HDU.

Undernutrition is a common risk factor for severe and prolonged morbidity in this rural hinterland. It contributes to increased surgical infections and complications, often requiring total parenteral nutrition and critical care. Alcohol induced and less commonly gall stones induced pancreatitis have been managed, a few with complications such as pancreatico-pleural fistula and pancreatic ascites, requiring prolonged HDU care.

While respiratory illnesses, sepsis, and cardiac illnesses are commonly admitted critical cases, an **extremely rare** case which is still seen in rural Chhattisgarh despite availability of vaccines is **tetanus**, a potentially fatal health concern. In the reporting period, we saw 2 such patients who were managed with tetanus immunoglobulin and other supportive measures. Both of them did well over.

Another typical problem in our forest and rural settings is snake bite. Cobra, Kraits and less commonly Viper bites were seen and managed, requiring ventilatory and other support besides the anti-snake venin.



Of the 269 patients seeking critical care, 90 required ventilator support and 3 required CPAP. More than 65% of the patients on ventilator could be saved due to timely critical care support.

Inpatient services

In all, our total inpatient numbers rose by 45% this year with **5577** admissions during this period out of which 42% were admitted for medical reasons (including paediatrics and obstetrics), 37% for surgical reasons, and the rest 21% to receive Chemotherapy.

The 8 bed Neonatal Intensive Care Unit at JSS became functional at the beginning of the year 2022. The senior paediatrician in our team, also a founding member of JSS, took the lead to establish this rural NICU. Our nursing staff received special training, both in-house and through exposure visit to MGIMS, Sewagram, Wardha, in the knowledge and skills to manage these little babies. The NICU is equipped with overhead warmer bassinets, phototherapy units, infusion pumps, SpO2 monitors, bubble CPAP machines, and newborn ventilators and is supported by a mobile x-ray unit, and round the clock lab services. Babies with low birth weight and preterm babies, those with respiratory distress, neonatal jaundice, sepsis, and meconium aspiration are managed here regularly. With the presence of a full time paediatric surgeon in our team, babies with congenital malformations and neonatal necrotizing enterocolitis are also offered care here.

Surgical and obstetric services

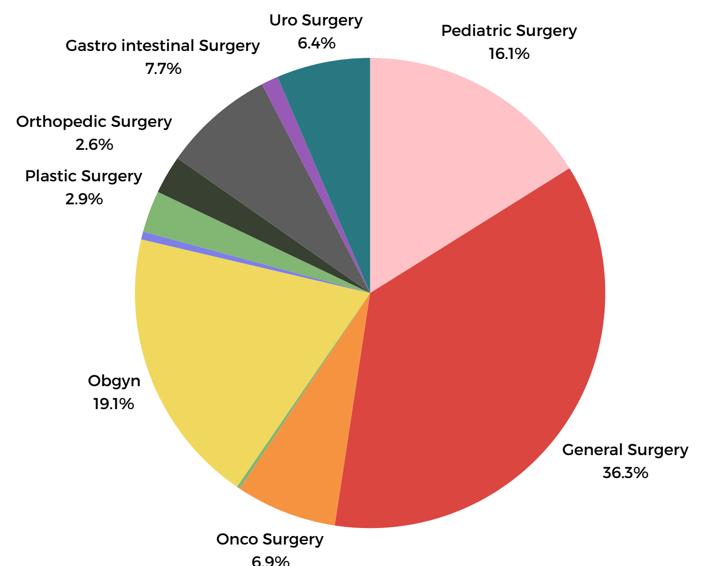
Pregnancy represents a moment of celebration; however, in a rural setting such as ours, where many women require high acuity care in high-risk situations including the ability to manage complications or do a caesarean section, a pregnancy could also mean risk of death. In the absence of surgical services, we tragically witness elderly men succumbing to urinary obstructive diseases leading to sepsis or renal failure, conditions easily preventable with timely prostatectomy. Equally disheartening is the sight of children and young adults facing lifelong disabilities from treatable surgical conditions like burns or open fractures, and working-age individuals unable to engage in physical labour due to untreated hernias or large hydroceles. Therefore, we assert that a comprehensive healthcare system must encompass surgical services to address common yet life-threatening or disabling conditions. Therefore, we believe that a comprehensive healthcare system must encompass surgical services to address common yet life-threatening or disabling conditions.

Hands-on training by Sr. consultants

Our surgical services, despite the challenging landscape, have stood out with approximately 3000 procedures performed annually across various specialties. This includes a significant number of emergent procedures highlighting the accessibility of advanced surgical and critical care for neglected ailments.

This year, we conducted **3010** surgeries across specializations of general, onco, obstetric, paediatric, ophthalmic, gastrointestinal, plastic, neuro, cardio-thoracic, and uro surgery. **689 deliveries** were conducted out of which 46% were through Caesarean section while 11% required vacuum assistance per vaginally.

Notably, **88% were major surgeries**, underscoring the complexity and scope of our interventions. The majority of surgeries were in general surgery, followed by obstetrics and gynaecology, paediatric surgery, and oncological procedures. Approximately 350 surgeries were performed in emergency settings, underscoring our commitment to prompt critical care delivery. Our surgical team comprises experienced senior surgeons, anaesthesiologists, and 8 surgical residents undergoing rigorous hands-on training under their guidance and mentorship.



Additionally, our operation theatre technicians and trained nursing staff ensure safe and efficient operations. We prioritize emergencies and semi-emergencies while adhering to stringent protocols to maintain quality and safety standards, ensuring comprehensive care for all patients.

WHAT DOES A RURAL HOSPITAL HAVE TO BE LIKE - SPACES AND DESIGN?

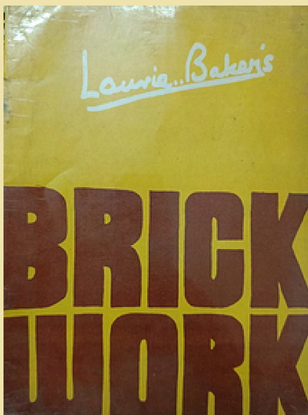
- Where the people from the community feel comfortable, is close to their lifestyle, and aesthetics, and has an openness and greenery which rural and tribal people like, yet provides for privacy when necessary.
- Has a minimal environmental footprint, whether in terms of lighting and power needs, waste generation, water usage and groundwater recharge, waste water treatment and discharge, air quality, foliage and open spaces: 'Green' architecture
- Is constructed using local materials, locally relevant architecture and local masons and workers who know their craft traditionally or can be taught.

HEALTH ARCHITECTURE

........in dialogue with the people

खंडहर उम्मीद देते हैं कि उनमें कोई दबा खजाना हो सकता है

(Where there is ruin, there is hope for hidden treasure) ~ Rumi



Laurie Baker, a British-born architect who made India his home, is renowned for his pioneering work in sustainable architecture and rural development. His architectural philosophy centered on using local materials and traditional building techniques to create environmentally-friendly structures that harmonize with their surroundings.

Baker's legacy includes numerous iconic buildings across India, showcasing his commitment to accessible, cost-effective design that prioritizes the needs of the community.

Much inspired by Baker's work, Hemen Sanghvi, a seasoned architect with decades of experience in both traditional and contemporary architecture, is the man behind the timeless architecture of the JSS buildings. With a deep respect for local traditions and a keen eye for innovation, his designs emerged as a testament to sustainability and inclusivity. Each building told a story of collaboration and community empowerment. His architectural practice is rooted in a deep appreciation for indigenous and time-tested design principles. Sanghvi is dedicated to revitalizing fading traditions and ensuring their practical application in modern contexts, emphasizing the importance of preserving cultural heritage while adapting to evolving needs and trends.

Adequate waiting areas and semi-open spaces

Training Centre enclosing a green courtyard

Exposed brick, Lime with sand and powdered bricks binding, Local mud Roof tiles, Green spaces

Artisans/masons, design and Functionality as per needs. Doors made with more than 100 years old Burma Teak retrieved from Morbi, Gujarat after the Quake.

Stones from Shivrinarayan, Belha and Rajim, Sal wood auctioned by the Forest department

Trees as centres of Architectural planning
Space for Sitting under them

TB ward – Open design, spacing and ventilation; Cool interiors for scorching summers

Linking pathways, protecting the green

To each, one's own

Splash of Bougainvillea outside OPD

Forest Village Sub Health Centre

Spaces for comfortable communication

And some quiet work

Specious dharamshalas with cooking facilities

Spacious Paediatric OPD

Full fledged operation theatre amidst nature

High Dependency Unit and NICU demonstrating importance of light in spaces within hospitals

Labour room

24*7 laboratory

High roof wards ensuring adequate ventilation and lighting

Ayurvedic Doctor at her Ayurvedshala

Hostel for tribal girls - Nursing trainees

SEEING THE SOCIAL IN MEDICAL

our work on the social determinants of health

To grasp rural healthcare, it is imperative for health practitioners to go beyond the text-book and bio-medical understanding of proximate causes of diseases and identify the social realities that perpetuate it. Where the true roots of marginalisation lay in poverty and social divides, offering excellent clinical care is not enough to reduce the huge burden of illnesses.

Over the last few years our involvement in this sphere has grown and is manifesting amazing results in terms of food security, dietary diversity, empowerment of women and most importantly solidarity and self-reliance within the communities. Additionally, with the realisation that animals are assets to these marginalised families, we have also been offering animal healthcare as and when needed to prevent these families from spiralling into poverty any further due to the loss of livestock.

Livelihood initiatives and health

Natural farming practices

An intensive agricultural programme has been initiated across **16** carefully selected villages, emphasizing natural farming practices through comprehensive training, live demonstrations, and widespread awareness campaigns. Agriculture field coordinators are actively engaged in organizing farmer meetings covering diverse topics, fostering the adoption of organic and natural farming techniques, desi seed conservation, and local-level preservation efforts. Farmers have received training in crafting organic fertilizers like Jeevamrit, vermicompost, and green manure. Moreover, **6 farmers' groups** have been established across six villages, facilitating regular gatherings for farmers to deliberate on farming strategies and explore innovative methodologies. We aspire to extend the reach of such groups to additional villages, envisioning greater participation from farmers across the region.

Agriculture coordinator enlightening the farmers on the journey of food from farm to fork

Over the last 12 months, our agriculture and Self-Help Group (SHG) team diligently organized monthly meetings with SHG members to fortify their cohesion and resilience. These gatherings served as a pivotal platform not only for strengthening group dynamics but also for fostering awareness on a spectrum of health-related topics.

Emphasis was placed on the significance of incorporating millets into the diet, advocating for the consumption of unpolished and home-grown rice over nutritionally deficient PDS rice. Additionally, focused sessions were conducted with small clusters of farmers, shedding light on the detrimental effects of pesticide usage in agricultural practices.

In this photo, our team took a group of farmers to the field to offer live demonstration of natural production of millet and its benefits.

Let's grow millets

Women’s Self Help Groups

Currently, there are a total of **83** women's Self-Help Groups (SHGs), with **3 new SHGs** formed during the reporting period. The collective membership of these SHGs comprises **920 women**.

Among these, 84 women are actively engaged in various livelihood endeavours, including:

- **Milk supply: 09 women**
- **General store management: 20 women**
- **Animal husbandry: 10 women**
- **Vegetable gardening: 45 women**

These activities are part of a broader spectrum of livelihood initiatives encompassing 09 major activities undertaken collectively by groups of women. These activities include:

- **Fish farming: 7 SHGs**
- **Midday meal contract: 3 SHGs**
- **Pig farming: 1 SHG**
- **Goat farming: 2 SHGs**
- **Forest produce collection and sale: 5 SHGs**
- **Hygiene-related products manufacturing: 25 SHGs**
- **Food products processing: 5 SHGs**
- **Farming: 1 SHG**
- **Flour mill operation: 4 SHGs**
- **Other activities: 7 SHGs**

SHG meetings

A total of **28 SHGs** are actively involved in these diverse activities, with each SHG contributing to one or more initiatives. Throughout the reporting period, **371 women** have **benefited** from these livelihood activities.

GARIMA

We have launched a marketing platform called "GARIMA" **(Grameen Atmnirbhar RojgaarI MAnch)** to link Self-Help Groups (SHGs) and farmers directly with consumers. This initiative aims to eliminate the exploitation faced by these groups from nearby town middlemen.

Under GARIMA, a total of **31 products** produced by SHGs have been listed, resulting in sales of Rs. 236,778 during this period. By cutting out middlemen, farmers and SHGs can now earn fair prices for their produce and products, a significant improvement from the lower rates they were previously forced to accept.

Furthermore, we have set up a WhatsApp consumer group to directly share information on all available products with consumers. This innovative approach empowers farmers and SHGs by providing them with a platform to showcase their offerings directly to consumers, fostering a more equitable and sustainable marketplace.

List of GARIMA products

Khet se Pet tak....

Experts often suggest a combination of physical activities and a shift towards healthy dietary pattern to curtail diseases like Diabetes and Hypertension. However, in rural Chhattisgarh, where agro forestry is mainly practiced, though physical activities are immense, the ones who grow ultimately end up consuming the least because of socio-economic constraints. This leads to repeatedly falling sick and a further push down the poverty line.

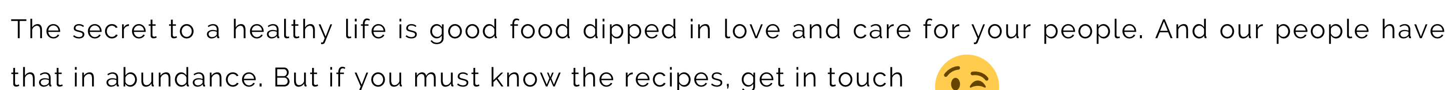
To commemorate our local food and time tested traditional recipes made of "mote anaaj" in Chhattisgarh like Kodo, Kutki, Madiya, Sanva, Kangni, Rajgira, varieties of pulses, different roots and tubers, seasonal vegetables and fruits, and to talk about the importance of food diversity, we organised a Jevnaar Mela at Shivtarai village located in Achanakmar Tiger reserve of Bilaspur.

Jevnaar Mela is the celebration of the traditional food of Chhattisgarh which got lost in the zig zags of modernity and fast pace of life. Women from 90 Self Help Groups presented delicious cooked food of over 120 varieties to about 1200 people who joined us in the celebration. School going children to aged folks dropped in to revisit the traditional food and cherish the gifts of forest.

The day followed our people gorging on Chilla roti, Madiya pulao, Mahua puri, Rasputka, boiled kanda from the forest, Amla chutney, Ber chutney and so many other mouthwatering dishes, learning about the health benefits of these high fibre, low carb food, sharing the happiness that food brings into our lives, and soaking in the winter sun.

Sharing is caring

The secret to a healthy life is good food dipped in love and care for your people. And our people have that in abundance. But if you must know the recipes, get in touch



HEALTH SYSTEM STRENGTHENING

Building a strong and resilient public health system

INITIATIVES IN MADHYA PRADESH

The referral centre in Ganiyari has a fairly large share of patients coming from far flung places of MP for minor to major health issues. People travel for about 300kms to seek care with us. When we assessed the reason behind the huge influx of patients especially from the eastern tribal belt of MP, we recognized the lack of credible public health facilities there. These poverty-stricken areas, where people are dependent on agriculture and forest produce, mostly have access to government facilities which lack medical supplies or trained personnel essential to deliver quality care. This led us to work towards strengthening the public health system in order to close the care gap.

This would in addition reduce the collateral financial and social cost the people have to bear in seeking care so far away from their home. From 2016, we started a health system strengthening programme in 6 districts of Madhya Pradesh in collaboration with National Health Mission and the National Health Systems Resource Centre. Our work is spread across Anuppur, Shahdol, Dindori, Mandla, Umaria, and Sidhi. The work encompasses training and mentoring different cadres of health workers in the public health system.

System strengthening

In the pursuit of achieving health for all, the role of public health systems cannot be overstated. Despite their myriad challenges, they stand as the largest organized healthcare provider, and often the last refuge for the poor and rural population of our country. JSS has been working in collaboration with the State Health Systems Resource Centre (SHRC) of Chhattisgarh since its inception in 2002. Our partnership with SHRC commenced with the initiation of the Mitanin (ASHA) programme in 2002.

Our partnership with SHRC commenced with the initiation of the Mitanin (ASHA) programme in 2002. Chhattisgarh is the first state to implement this programme in our country. Currently, JSS in collaboration with CMC Vellore supports the SHRC in conducting Postgraduate Diploma in Family Medicine training for medical officers stationed in remote PHCs and CHCs.

As an integral part of the Executive Committee of SHRC Raipur, JSS actively contributes to the enhancement of public healthcare system in Chhattisgarh.

Our formal engagement with the National Health Mission (NHM), Madhya Pradesh began in 2016, facilitated by the National Health Systems Resource Center, New Delhi. This collaboration initially focused on the quality improvement of maternity wings in District Hospitals (DH) and Community Health Centres (CHC) through training and mentoring. Subsequently, our scope expanded to primary healthcare, young child (under 3) nutrition (see section on Phulwaris), and Sickle Cell Disease. Our interventions spanned in seven districts of eastern MP, namely Anuppur, Dindori, Shahdol, Umaria, Mandla, Sidhi and Singrauli.

Maternity Wing Quality improvement

The concept of quality is slowly developing in public health institutions, with most States trying to adopt the National Quality Assurance Standards (NQAS), a platform for the evaluation and accreditation of public health facilities. Kayakalp and LaQshya programmes by the GoI are an offshoot of NQAS. For long, healthcare professionals believed that competence in clinical care is all that is needed. But slowly the picture is changing and they are understanding the importance of sound quality management principles.

Using the JSS experience of over two decades of providing high quality, low cost, comprehensive care efficiently, and using broad principles and tools for quality improvement, our project teams support the District Hospital and Community Health Centre teams in the process of quality improvement. NQAS and LaQshya are used as the framework for evaluation and improvement. We have developed and use a concise 6 session training on quality improvement. Dakshta training modules are used for clinical training.

Before and after photos of labour room, CHC Majholi, Sidhi

Quality improvement training

This year QI trainings were carried out in District Hospitals in Umaria and Dindori. Our joint efforts helped the facilities achieve the State level benchmark for LaQshya.

Strengthening primary healthcare

Pushprajgarh block of Anuppur district is a tribal predominant block **(78% ST population, census 2011)**. 2 sectors (74 villages, 12 subcentres, 1 CHC and 1 PHC) are the hardest to reach. On an invitation from Collector Anuppur, we engaged in this area to improve primary healthcare from 2018.

With help from Collector, construction, road, electricity and water was ensured in the initial period. This was followed by training, hand-holding and mentoring of ASHA and ANMs. For this, our project staff live with the govt. staff in the subcentres at multiple remote locations.

Sector meeting by our ANM mentor

Activities	
Village Health and Nutrition Day (VHND) Supportive Supervision	
Number of VHND supportive supervision visits	566
Number of VHNDs conducted against the target	748
ANC Registration	1024
Institutional Deliveries	598
Maternal Deaths	5
Infant Deaths	50
High Risk Pregnant Women Followup	
Number of HRPW follow-ups visits	344
Number of High risk pregnant women	346
Number of HRPW who had institutional delivery	48
Health and Wellness Centre (HWC) supportive supervision	
Number of Supportive Supervision visits	704
OPD	16366
Deliveries	165
ASHA Training	
Number of training person days	345
ASHA Sahyogini Mentoring	
Number of mentoring visits	20
Mobile Fever Clinics	
OPD at fever clinic	2595
Number of patients referred from fever clinic	41

Monitoring visit at CHC Karpa with CMHO and DHO Anuppur

Sickle Cell Anemia control mission

Sickle Cell Disease (SCD) is one of the common neglected genetic diseases in the world. This is a haemoglobin disorder, causing severe pain, anaemia and multiple serious complications. If untreated, patients often die in childhood or adolescence. Diagnosis of SCD is based on Hb electrophoresis or HPLC, which are usually expensive and not easily available. This disease is prevalent in forest and forest fringe areas, thus very prevalent in tribal population. JSS developed a low cost Hb electrophoresis to diagnose SCD. We have been using this apparatus for more than 20 years now at our hospital. This, caught the attention of public health officials of MP during a visit at JSS. Thus, on their request SCD screening and management programme was started in 6 districts in 2018.

Activities	
Total number of Sickle Cell Disease Patients	2187
Total number of people screened by JSS team (Aug 2018-March 23)	99276
Number of facilities providing Hydroxyurea	21
Number of facilities carrying out solubility test	22
Number of Peer Support Group Meetings held during the year	70
Number of Supportive Supervision visits at the facilities during the year	54

Our teams conduct community level screening for SCD targeting pregnant women, school going and anganwadi children, family members of patients and traits.

Treatment and follow-up of patients is carried out by peer support group meetings held at CHCs and DH every month. Our counsellors facilitate these meetings with the government staff at these facilities.

Sickle cell screening

Home visit by counsellor

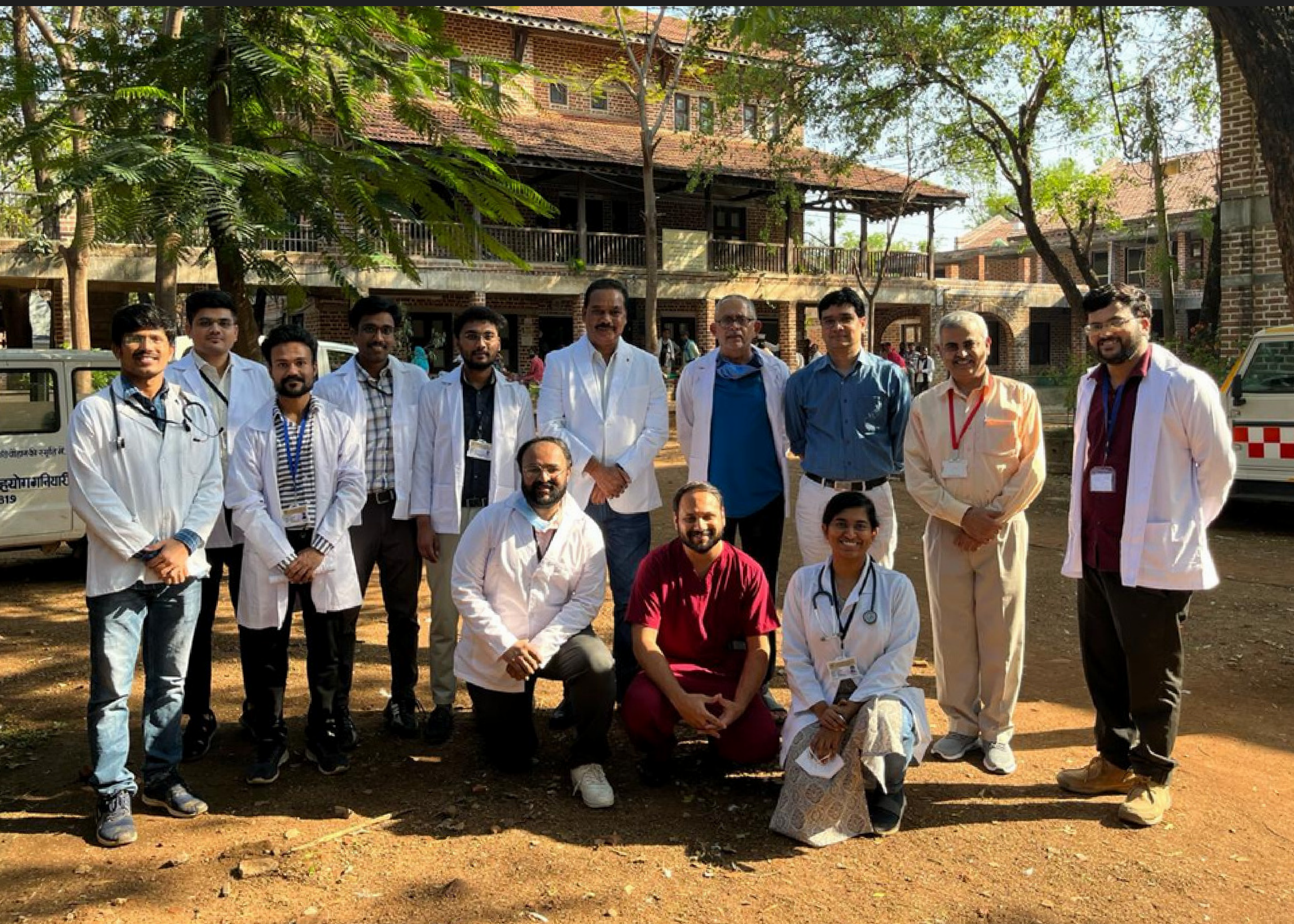
Group counselling at Sickle support group

Supportive supervision by Lab mentor

Marathon, World Sickle Cell Awareness Day

SERVING AS A TEACHING INSTITUTE

consolidation of our work and dissemination of knowledge



Recognizing the critical importance of effectively addressing rural healthcare issues, we have embraced a comprehensive approach to consolidate our efforts and knowledge. Our three-pronged strategy involves training, research, and documentation, with continuous input from our community health programme serving as a key source of innovative ideas. Our main aim is to strengthen our organization, providing a welcoming place for people who care about helping the disadvantaged. We see our organization as a "home" where people can learn, share, discuss ideas and concerns, develop a career path, and connect with others who are passionate about rural healthcare.

In recent years, we have been privileged to serve as a Technical Resource Group for esteemed bodies such as the Governments of Chhattisgarh and Madhya Pradesh, the Planning Commission, the Mission Steering Group of the National Health Mission, the National Asha Mentoring Group, the High-Level Expert Group for Universal Health Coverage, and various other agencies. We are grateful for the opportunity to contribute meaningfully to both state and national-level healthcare systems.

In-house training programme

On we go with academics...

Learning is a life-long journey, and at JSS we take every opportunity to learn, whether it is from individual patients, our staff members in the community and the hospital or community members with whom we have had the privilege to be associated. It may be experiential, informal, impromptu, or through collection of information, data points, analysis, reading and reflection, and could happen anywhere.

While it's important to know the ground problems intimately and be close to the people, it is also imperative to have a bigger picture in mind and an intellectual framework to ground one's practice. We at JSS are proud to be at an intersection of these two where we combine our academic rigor with hands-on work by drawing on professional expertise and a culture of evidence and broader perspectives while being thoroughly grounded.

Thus, we had been running an in-house nursing school for tribal and Dalit girls, offering both ANM and GNM courses to build our own army of health professionals. However, due to the government's discontinuation of ANM and GNM courses, we upgraded to a nursing college and began offering Bsc. in Nursing to young women.

Essay competition

The first batch of BSc Nursing at the JSS School of Nursing was a new experience as we had no control over the social background of the candidates or on the fee structure. 24 students joined the course at JSS and have been performing reasonably well.

Our major regret was that the complete freeship which we were able to offer because of the support of the Tribal Welfare Department, was not possible for these students, because of different scheme already operating with the Directorate of Medical Education. We are trying to find a way to ensure that the most deprived and poor students are able to come to the JSS school of Nursing and we can find means to support their education.

In addition to nursing, we are also a National Board of Examination in Medical Sciences (NBEMS) accredited institute for offering post-graduate degrees to MBBS doctors.

Patient work up by resident doctor

Previously, we used to offer a DNB course in Family Medicine which was discontinued for a while. However, the training programme for doctors in Family Medicine resumed this year with the admission of two PGs after a hiatus of nearly four years. This is a post-MBBS 2 year Diploma course to help postgraduates become competent in the knowledge and skills to practice this broad speciality, that we strongly believe is direly needed by our country in order to provide high quality primary and secondary care in the public health system.

With our aim to train a cohort of truly "general surgeons" equipped with the skills needed to address the diverse health challenges our communities encounter, our 3 year DNB General surgery course continued with 4 new students joining this year.

This year, **our first batch of DNB General Surgery defended their thesis and graduated with flying colours.** Both of them have decided to continue serving the disadvantaged populations in rural settings. Their immediate junior batch is gearing up for their finals.

Surgical residents at work

Training workshops for residents

Regular seminars, journal clubs and case discussions, while discussing topics related to current patients have laid a strong foundation for learning.

Research studies

We carried out an ambispective study over a 5 year period to evaluate the need for surgical intervention for various types of extra-pulmonary Tuberculosis (EPTB), while also assessing delays and barriers in seeking healthcare for EPTB at the patient level and health system level. High index of suspicion, skills to perform various diagnostic interventions such as CSF tap and evaluation, FNAC or biopsy for lymph node disease, pleural tap and diagnostics including ADA, CBNAAT, bronchoscopy, synovial biopsy, etc and availability of high end imaging such as CT scan and MRI, especially in the Public health system, are major barriers in seeking care for symptoms which may be attributable to EPTB. These same skills and diagnostic abilities in the private setup are extremely expensive, and impoverishing (not covered by the Govt Insurance schemes) especially for the rural poor, who seek care at our health facilities. There is often a tendency to seek care locally (in and around their village) from traditional healers and informal practitioners, thus delaying their presentation to a facility capable of appropriately managing these patients without impoverishing them. The contribution of EPTB to the overall cases of TB diagnosed at our hospital was more than twice (49%) reported in the National programme (19%).

Next, a prospective study on the prevalent pre-operative and post-operative nutritional and socioeconomic status of patients, the complications of major abdominal surgery over a period of 18 months, and its eventual correlation using subjective and objective scales was under taken. Three scales for nutritional evaluation were compared and it was found that Body mass index (BMI), Patient generated Subjective Global assessment and Lab values based Nutritional Risk Index, all showed a positive correlation with occurrence of post-operative complications. There was concurrence with nutritional status classification and grades of complications, thus implying that inexpensive patient generated nutritional status scales that are quicker to execute in rural care settings, were as efficient as the more expensive lab based indicators

We had also started a multi-centre study last year with support from the ICMR on the patterns of Anti-microbial Resistance (AMR), practices & perceptions related to antibiotic use in rural communities with the aim to strengthen rational antibiotic usage policy. The progress has been satisfying and helpful for individual patient care besides fulfilling the study objectives. We have already finished collecting more than two thirds of the total sample size committed of urine, blood and stool samples, maintaining our yearly target. We have established the antibiograms of E.coli, Klebsiella pneumoniae and Pseudomonas aeruginosa- the major pathogens in urinary tract infection, and these findings are of immediate relevance in starting presumptive treatment of UTIs. ESBL producers, Carbapenemase producers and Metallo-beta-lactamase producers among the isolates have been identified by phenotypic methods. Also, the percentage of diarrhoeagenic E.coli in stool samples have been estimated, and the major pathogens implicated in sepsis at our setup identified. DNA extraction of 160 isolates has been completed, while PCR has been done to detect antibiotic resistance genes in 20 of them. We have completed the population survey (sample size 1067) and analyzed the results. Potentially harmful practices which lead to emergence of antimicrobial resistance was the most significant data obtained under this section. It would be interesting to analyse results of exit interviews

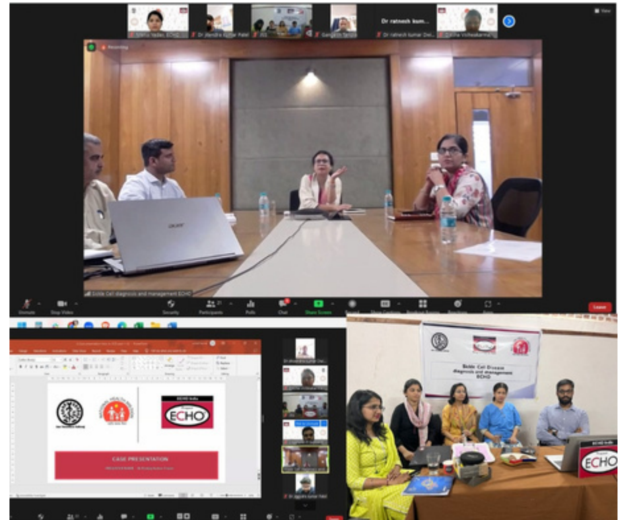
(completed 200 of the sample size of 350). Survey of 170 Healthcare Providers (HCPs) were completed and analysed to understand their knowledge, beliefs and practices pertaining to antibiotic usage and AMR. In addition, focused group discussions of 3 groups of ANM, GNM, mitanins and ASHA workers were conducted to understand their views on antibiotic prescription practices. Also, people dealing with domestic animals and poultry were interviewed about antibiotic usage in animals.

Lastly, JSS was one of the four study sites for a research study funded by ICMR titled "Impact of Improved diagnostic tools, practises, training and communication on acute fever case management and antibiotics prescription for children and adolescents presenting to Outpatient facilities". The interventions of electronic clinical decision algorithm, point of care (rapid) diagnostic tests and communication package for properly taking antibiotics were tested amongst intervention and control arm study participants. We found slightly increased antibiotics prescription in the intervention arm and no difference in the outcomes of control and intervention arms. The adherence to prescription was also the same among the two arms. The collective results of the four sites will soon get published.

All the above studies are soon to be put up on our websites.

Extramural training and Networking

In February, Jan Swasthya Sahyog, in partnership with **ECHO** India and the National Health Mission (MP), inaugurated a capacity-building programme focused on the diagnosis and management of Sickle Cell Anemia. The training initiative, launched in the presence of MD NHM, MP, aimed to enhance the expertise of Medical Officers currently serving in government facilities across Madhya Pradesh. We extend our heartfelt appreciation to Mission Director and Deputy Director of the State Blood Cell, and the entire NHM Bhopal team for their invaluable support and guidance.

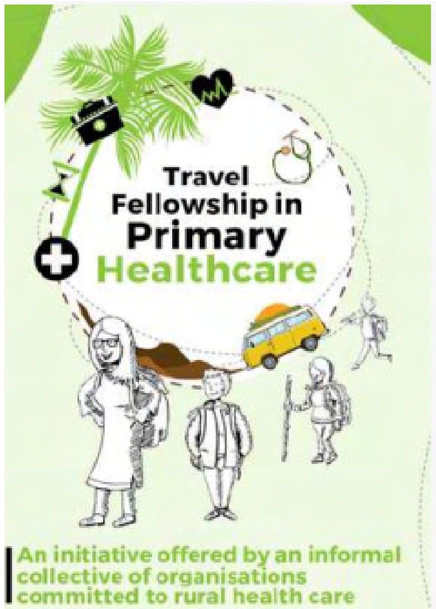


We express gratitude to the Echo India team for providing their platform and establishing the hub team at JSS, Ganiyari. Additionally, we commend the dedication and eagerness of the doctors and participants who have joined forces to combat this disease.

First batch of PGDFM

We were also chosen as one of the two centres for contact programme of Medical Officers of Chhattisgarh, doing an in-service **Postgraduate Diploma in Family Medicine** offered by the Distance Learning department of the **CMC, Vellore**. We had three batches of 25-35 medical officers, totalling **103** in the first contact programme, each lasting one week. The feedback from the students and faculty was encouraging.

Rural hospitals like ours face perpetual challenges due to a scarcity of skilled and dedicated healthcare professionals, including doctors, nurses, and hospital managers. The recent introduction of a platform that disseminates work opportunities at rural hospitals has been a tremendous asset for us. We are proud to announce our membership in the **Rural Hospital Network** (ruralhospitalnetwork.org), which has already begun to alleviate some of our staffing pressures. This year, we had a fresh graduate doctor join us as a Medical Officer through Rural Hospital Network. Hit the link to find out his experience: **https://ruralhospitalnetwork.org/?p=2813**



JSS has been dedicatedly reaching out to young doctors and the broader youth community. As a member of the Rural Healthcare collective, we contribute to a one-year **travel fellowship programme** designed for young doctors (post-graduation or PG) to delve into alternative approaches to rural and primary healthcare, and their potential roles as responsible citizens. The programme's goal is to immerse these young doctors in primary healthcare initiatives and social development projects, facilitating interactions with mentors and practitioners in the field. It also fosters networking and cross-learning opportunities among fellow participants. (ruralsensitisationprogram.org). This year, we had two young doctors join us as travel fellows. One of them indulged in a study whereby she shadowed growth faltering children going to JSS Phulwaris throughout the day (both at the Phulwari and their homes) to see what children eat and how it impacts their nutritional status.

This year, as a **technical partner of Azim Premji Foundation** for their health system strengthening initiative in Odisha, our teams helped develop identification and referral protocols for malnourished children and high risk pregnant women by the Quick Response Teams in 5 deprived blocks. These protocols would enable the implementing agencies to counsel and facilitate referrals for high-risk mothers and children. Also, we helped the implementing partners in identification of data collection gaps in Avni app which is being used by them for the same project.

As someone from a developed region, my goal during the fellowship was to explore institutions like JSS, which offer impactful healthcare services to society, particularly its underprivileged segments. The effective combination of social programmes and a dedicated team of health workers made my experience at JSS incredibly enriching. Engaging in village visits and staying in the rural interiors of Bahmni significantly altered my perspectives on healthcare delivery and patient care. And a special thanks to Shramana for making it feel like home!

(Rural Travel Fellow)

PHULWARI INITIATIVE

Building a brighter future for children...

More than half of the mortality rate among children under the age of 5 is directly attributable to undernutrition. Early childhood undernutrition not only impacts physical health but also hampers cognitive development, potentially affecting an individual's entire lifespan. Children born to malnourished mothers often grow up with diminished physical strength and cognitive abilities, limiting their capacity for productive work and thereby restricting their earning potential. This perpetuates a cycle of poverty and poor health.

In Chhattisgarh, most families have both parents go out for work during the day, leaving young children in the care of older siblings or grandparents who may be unable to adequately provide for their nutritional needs. Thus, there is lack of consistent feeding throughout the day and unlike adults, young children require frequent meals, ideally at least five times a day.

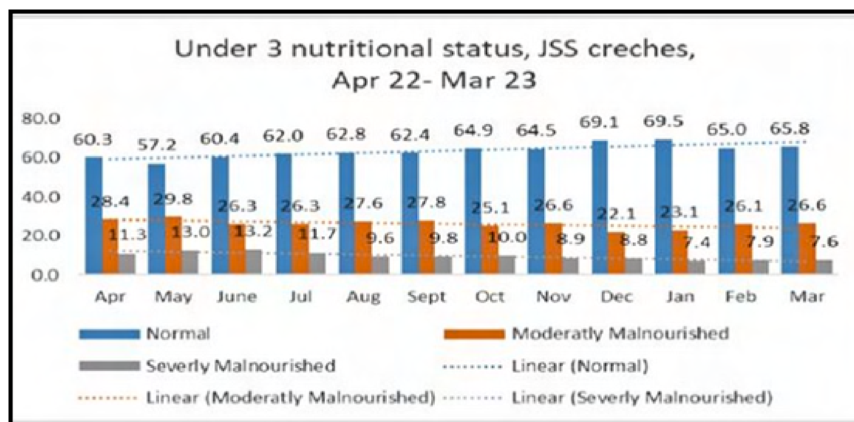
To address the prevalent childhood undernutrition, JSS initiated a rural creche programme 12 years ago, recognizing the need for a comprehensive solution. Following a successful assessment of its impact, we extended this model to the Pushprajgarh block within the Anuppur and Singrauli districts of Madhya Pradesh.

Our day-long rural creches (Phulwari, as we call them), based in the community, serve a triple problem solution: apart from preventing and treating undernutrition in children under 3, Phulwaris allow both parents to go out to earn, a crucial factor in families that are below the poverty line, and prevent elder children to drop out of school to look after their young siblings.

Here's a snippet of the activities that are carried out through the programme:

1. Day care for children 6 months to 3 years old. In villages with no Anganwadi, children between 3 and 5 years are also allowed to be at the creches
2. Supplementary feeding- 2 meals of khichdi, one of sattu, and eggs thrice a week
3. Growth monitoring and counselling of mothers about their children's nutritional status
4. Treatment of common ailments by the village health workers
5. Early child education through songs, toys, locally available materials, picture charts, and play methods.
6. Promotion of kitchen gardens adjacent to the Phulwaris to improve the quality of the food provided to the children
7. Parents' meetings to discuss their children's nutritional status as well as health issues pertaining to children

In Chhattisgarh, we continued running **85** creches in 43 programme villages with **838 children** cared for by 114 creche workers. Most villages are forest villages in the Achanakmar tiger reserve. 372 children joined the creches in this period and 430 children either graduated or discontinued from the creches.



The graph shows the nutritional status of creche children in the period from April 2022 to March 2023. The number of severely malnourished children reduced from 11.3% in the month April 22 to 7.6% in the month of March 23. There is 2 % reduction in the moderately malnourished children and there is 5% increase in the normal children in the creches.

In Pushprajgarh of Madhya Pradesh, we continued running **75** creches across 65 villages with **1152** children being offered Phulwari services by 79 creche workers.

568 children joined our Phulwaris during this period, and 641 children either graduated or dropped out. The number of severely malnourished children was 134 in April 2022 which went down to 113 in March 2023. Similarly, we also saw a decline in moderately malnourished children from 353 in April 2022 to 260 in March 2023.

OUR FINANCIAL DETAILS

JAN SWASTHYA SAHYOG
STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED MARCH 31, 2023

Particulars	Schedule	Year Ended March 31,2023 (Rs.)	Year Ended March 31,2022 (Rs.)
INCOME			
Receipts from activities	X	11,12,40,070	6,82,17,941
Donations		48,23,301	1,07,70,931
Grants Received		9,79,55,709	10,38,58,556
Interest Income		1,24,90,089	1,63,84,248
Interets on Income tax refund		7,43,815	-
Total Income		**22,72,52,984**	**19,92,31,677**
EXPENDITURE			
Drugs & Consumables	XI	3,51,68,620	3,60,90,838
Administrative Expenses	XII	1,74,26,980	1,19,27,728
Research & Development Expenses		14,53,078	5,00,652
Manpower Cost	XIII	11,33,46,413	11,52,32,966
Program & Community Welfare Expenses	XIV	2,54,85,515	3,06,50,299
Depreciation	IV	53,77,832	47,35,586
Total Expenditure		**19,82,58,438**	**19,91,38,071**
Excess of Income Over Expenditure		2,89,94,545	93,607
Add: Depreciation for the year transferred to Capital Fund		53,77,832	47,35,586
Less: Addition to Fixed Assets (including WIP)		(58,32,112)	(1,71,65,279)
Transferred to Reserve and Surplus		**2,85,40,265**	**(1,23,36,087)**

For VED JAIN & ASSOCIATES
CHARTERED ACCOUNTANTS
F.R.No.: 001082 N

(Swarnjit Singh)
M.No. : 080388
Partner
Place : New Delhi
Date : 30-10-2023
UDIN : 23080388BGSOYL9562

(Dr. Raman Kataria)
Secretary

(Dr. Surabhi Sharma)
Treasurer

For, Jan Swasthya Sahyog
Secretary

For, JAN SWASTHYA SAHYOG
Treasurer

SAILING THROUGH 23 YEARS

There's some good in the world, Mr. Frodo, and it's worth fighting for!

~ The Lord of the Rings

On a cold February morning in the year 2000, we had started out with a small team and a big dream. Today, we are 500+ strong, chasing our vision of an equitable society fuelled by the faith and love of our people.

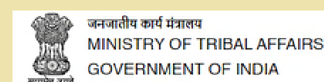
It goes without saying that our work would not be possible without the backing of our supporters who not only share the same vision towards bringing about a change in our society, but also exhibit profound faith in our work. In the last year, the following people and organisations have lent their support towards JSS and helped us continue our work with greater motivation and zeal. Here are some of our partners who stood beside us against all odds to keep our work ongoing. There are more partners who have supported us either financially or in kind. Or have extended lots of good wishes to keep us going stronger.

Mr. P. Jothilingam
Mr. Amardeep
Shri Arun Narayan
Shri Sridhar Tripathi
Dr. Sunita Dantare
Shri Gulab Chand
Mr. Ritesh Sharma
Dr. Ramesh Dhone
Shri Santosh Uikey
Smt. Sheetal Uikey
Ms. Shivangi Uikey
Mr. C.S. Rangaswamy
Dr. Piyush Dubey
Dr. Dilip Mitra
Mr. Amit Kumar Verma
Shri Ajay Kukreja
Shri Himanshu Mishra
Sunil Manchanda
Surabhi Foundation

Najruddin Jindran
Shri Rajendra Sahni
Shri Shyamlal Kankane
Shri Dashrath Singh
Shri Mani Thomas
Mr. N.H. Hussaini
Mr. Manorath Bajaj
Mr. Vikash Kumar Dhoot
Shri Dhruw Gupta
Smt. Bhagwanidevi Basudev
Ms. Kalpana Sisodia
Dr. Venkata Ramanamma Atkuri
Shri Ramawtar Agrawal
Mr.Virendra Singh Sisodia
Dr. Tushar Kanti Chattopadhyay
Shri Vinay Govil
Matrix Mining Solution
Ms. Manokamna Bajaj
M.G. Charitable Trust

Shri Poonam Chand Agrawal
Dr. B.K. Nema
Dr. Neelam Lingwal
Mr. Rohit Kumar Mathur
Ms. Snigdha Singh
Shri Sukumar Fouzdar
Ms. Uma Dattatrya Dhavale
Ms. Kalpana
Ms. Poonam Deshmukh
Mr. S.R. Shirodkar
Ms. Chitra Sachdeva
Mr. L.N. Maheshwari
Shri Rajendra Prasad Vasudeo
Pushpa
Mr. Prakash Vir Arya
Dr. Ajit Man Singh
Jayeeta Chowdhary
Dr.Ashakiran kaushik
M.L Outsourcing Services Pvt. Ltd.

Shri Gurpreet Luthra
Ms. Balwinder Kaur
Ms. Meena Gupta
Dr. Yogendra Parihar
Dr. Surekha Joshi
Mr. S.R. Shirodkar
Mr. Debasis Singh Solanky
Shri Laxmi prasad Gupta
Dr. Savita Kelkar
Krishnan
Vishal Tiwari
Vandana Tripathi
Shri B.G.Parmanand
Shri Ashwani Kumar Gupta
Ms. Madan Lal Sharda
Mr. Deepak Maheshwari
Ms. Sneha Dhamdhere
Dr. Meenakshi Ranjan Deb
Mohan Lal Seth Charitable Trust



OUR EXECUTIVE COMMITTEE

DR. SAIBAL JANA
PRESIDENT

DR. SURABHI SHARMA
TREASURER

DR. PRAMOD UPADHYAY
MEMBER

DR. ANURAG BHARGAVA
VICE PRESIDENT

DR. SUNIL KAUL
MEMBER

DR. SARA BHATTACHARJI
MEMBER

DR. RAMAN KATARIA
SECRETARY

DR. BISWAROOP CHATTERJEE
MEMBER

DR. REGI GEORGE
MEMBER

Life and death, chronic undernutrition and hunger, lack of livelihood opportunities, and poor access to quality care are some common causes of distress in the communities of central India. For the last 23 years, Jan Swasthya Sahyog has been working towards improving the landscape of rural health not only by offering direct health service delivery but also by delving into convergent areas of improvement for the holistic development of human lives.

In our journey to see a more humane, equitable, and just world, how can you help?

Make a donation

Whether you are an organisation, trust, budding philanthrophist, or an individual donor, every donation matters. Your contribution will make a difference by allowing us to continue our work with the marginalised communities who often have nowhere else to go

Work with us

Your experience and expertise could help us improve the landscape of rural healthcare. Dedicate some time to us; come join us as a volunteer or a teleconsultant and share your skills with our team. We're sure you'd gain something back.

Build our network

Our collective effort can go a long way in achieving development. In this regard, we appreciate sharing of new ideas, suggestions on improvement of our work, connecting us with like minded organisations for collaboration, and building a network of development practitioners

http://www.jssbilaspur.org/make-a-donation/

(All donations made in India are eligible for Income Tax benefits under the provisions of 80 (G)
If you wish to donate from an overseas account, please drop us an email at: janswasthya@gmail.com)