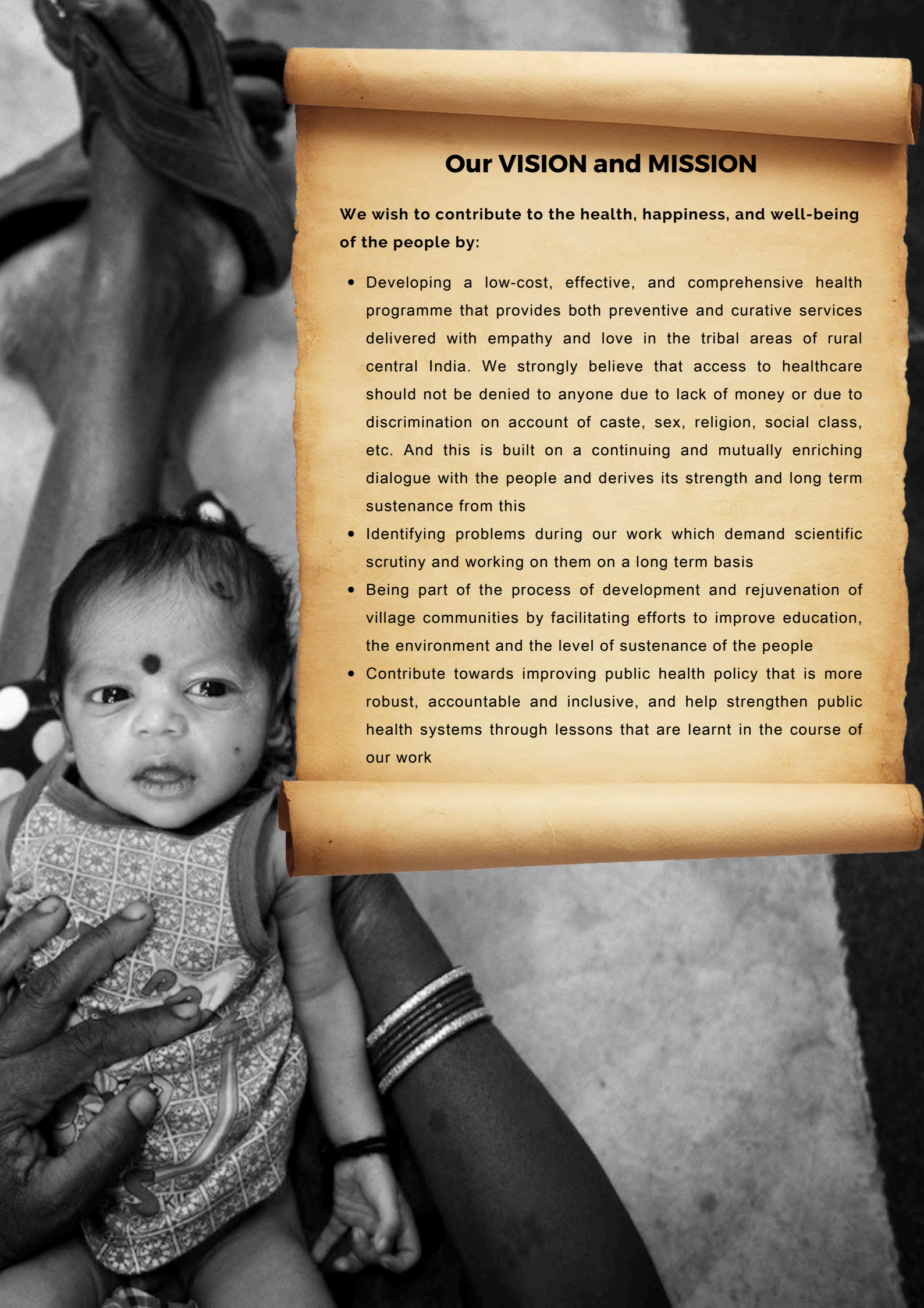
ANNUAL REPORT 2023-24

JAN SWASTHYA SAHYOG



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

As I see the hospital buzz with activity, I see it as a melting pot for men, women, children, old people, differently abled, mostly cheerful despite their meagre resources, ready to chat with one another from topics ranging from philosophical discussions to recent marriage or Chathi functions, to how someone may have spent a fortune (tens of thousands) at a hospital elsewhere or how this hospital makes sure you get treated irrespective of your paying ability and whom to approach for what. These conversations go on while waiting during the day until well into the night when they settle somewhere to sleep. Their social backgrounds and geographies are diverse- tribals, primitive tribals, backward social castes and varied occupations, forest dwellers, those from typical rural areas, to those living in cities or small towns. What unites them at this point of time is their zeal to get better/healthy for themselves or one of their loved ones whom they have accompanied. Life just goes on as usual and the atmosphere is one of socialization and bonhomie, despite disturbing sickness around.

This year, the care offered by JSS at the hospital and in the community increased in their scope and depth, supported by some additions to the human resources and infrastructure, as well as improvements in certain processes through dialogue. The NABH accreditation to our hospital, without any external help, is the result of this team effort and an understanding of why certain new procedures were discussed and implemented. Lab automation got a fillip with the new CLIA analyser while external quality control continued to be practised for all biochemical parameters. The hospital Electronic Medical Records, Bahmani has been upgraded with support from the Thoughtworks team. We have also become ABDM compliant and are in the process of securing the WASA compliance from the government.

The newly constructed Eye ward and Operating room have become functional, as also the maternal health unit supported by different grants. Specialist Orthopedic and ENT care is now available with 2 additional consultants working part-time. With the procurement of a Laparocator, tubal ligation (a method of terminal contraception) is now done routinely and our hospital is empanelled by the State for this purpose.
Sanction for a new godown from the NRLM for storage of produce at the village level as also machinery for millet processing will help strengthen the process of community level self-sufficiency (Swavlamban).

Training of the 1st batch of OT technicians, selected from amongst tribal students who have completed their 12th class, began in January this year. In the year ahead, we intend to begin Pathology Technician training as well. Both these courses are recognised by the State Paramedical Council.

We started research projects with support from the Azim Premji University and as in the past, the emphasis was on research that is rooted in the real needs of the rural and tribal communities. A 3rd one is a multi-site collaborative research on the impact of digitization on food security for the marginalised.

There was initial unease due to the denial of renewal application for the FCRA in mid-March. This was short-lived, with support promised by several organisations. Our heartfelt gratitude to all the well-wishers of JSS and its work.

There was recognition for the work of JSS by the Bhagwan Mahaveer Foundation, though for us there is no greater recognition than the smile on the face of a patient who has become well after a struggle, or the opportunity to work with tribal communities in improving their income, nutrition and health.

THE JSS MODEL

Tracing the footsteps of the patients

Primary healthcare at the village level

Tier I: Village Health Workers

When a person, in the 72 forest and forest fringe villages we cater to in Chhattisgarh, falls ill, they go to our healthcare providers- the Village Health Workers (VHWs), all of whom are women from the community. These trained healthcare workers, posted in their own hamlets, are vested with the responsibility to offer door to door care, identify early signs of an illness, and respond promptly to the need of the hour by either offering medications from her stock or assisting the patients to seek care at the second tier of our healthcare model i.e. the subcentres. VHWs ideally form the first point of contact between village folks and JSS.

Tier II: Our village subcentres

Our village outposts/subcentres run by our mid-level care providers or the Senior Health Workers (SHWs) cater to 25-30 hamlets each with provision of daily SHW led outpatient services, normal vaginal delivery through a sterile labour room, and once a week doctor led mobile clinic. The SHWs are equipped to manage emergencies, including snake, scorpion, and dog bites, and can stabilise patients during critical situations. While most of the illnesses are managed at the village level, for more advanced care including surgery, SHWs refer patients to our hospital in Ganiyari.

Secondary to Tertiary level care at base hospital

Tier III: The referral centre in Ganiyari

The 130-bed hospital offers a variety of specialised services including Family Medicine, Obstetrics and Gynecology, Surgery, Pediatrics, Ophthalmology, Dental Care, and Ayurveda. Our facilities include a 24/7 laboratory (including a micro lab), a well-stocked generic pharmacy, an on-site blood storage unit, a rural High Dependency Unit (HDU), 3 fully equipped operating theatres, a neonatal care unit, and a dedicated labour room. We are dedicated to delivering advanced healthcare in resource-limited settings.

Besides serving as a referral unit for patients from our intensive community programme area, the hospital sees a huge influx of patients traveling long distances from districts across Chhattisgarh and eastern MP. We have been able to provide remarkably affordable care to over 400,000 patients hailing from more than 2500 villages, representing a population of 1.5 million.

Our mantra: *No one is denied care irrespective of their paying capacity*

A Life Saved: Rajkumari's Journey Through High-Risk Pregnancy

This is the story of Rajkumar Maravi (name has been changed), a resident of Katami village in rural Chhattisgarh. Rajkumari's first 2 pregnancies were uneventful, a blessing in a village where healthcare was often far away and unpredictable. Rajkumari's first child was born at home, with only a single antenatal care (ANC) visit beforehand. When her firstborn was 9 months old, she conceived again but decided, with her husband's support, to end the pregnancy through a medical termination at JSS. To avoid another unexpected pregnancy, she used a copper-T (Cu-T) for a year before deciding it was time for another child. This time, Rajkumari took no chances- she attended ANC clinics diligently, and once again, her pregnancy was smooth, leading to another normal delivery.

It wasn't until nearly 9 years later that Rajkumari found herself pregnant again. This time felt different, perhaps because she was older now or simply because life had taught her the value of caution. She attended her ANC checkups every month, feeling reassured by the attention and care. But in her 9th month, her routine visit revealed troubling news- her blood pressure was dangerously high. She was prescribed Labetalol, a medication to lower her blood pressure, and she took it faithfully. Despite our best efforts, her blood pressure refused to normalize, and soon swelling began in her feet.

The community health team from JSS, led by the village health worker and the maternal and child health worker, became frequent visitors at Rajkumari's home. They urged her to get admitted to the hospital before things worsened. Rajkumari knew they were right, and she wanted to go, but her husband hesitated. He kept finding excuses- he needed to work on the farm, there were too many chores to do, and besides, Rajkumari wasn't in any apparent distress. When the team returned to convince him, he argued stubbornly, questioning why she should be hospitalised when she had no physical symptoms of danger. He promised that once labour pain started, he would take her to the hospital himself.

The health team didn't give up. They spoke of the risks of untreated high blood pressure, of the stories they had seen of women who hadn't made it because they didn't act in time. But her husband remained obstinate. During one of their mobile clinics at a nearby village, the JSS team stopped by to speak to the couple again. They insisted that both Rajkumari and her husband must be ready with their essential items for the hospitalisation. The team felt a sense of urgency- they knew that if Rajkumari didn't get admitted soon, there was a real risk of something going wrong.

Later that evening, when the team returned, they were relieved to find the couple ready with their packed bags. The team members' faces lit up with joy and relief as they escorted Rajkumari to the hospital. She was admitted to the High Dependency Unit (HDU), and at the time of admission, her blood pressure was critically high at 200/120. Upon examination, she appeared to be at 34-36 weeks of gestation.

The next day, Rajkumari's condition began to stabilise, with her blood pressure dropping to 144/100. At around 2:10 pm, she underwent a lower segment cesarean section (LSCS) and delivered a healthy baby girl weighing 2.13 kg. At the same time, a tubal ligation procedure was performed. The couple was overjoyed, not only because Rajkumari was now out of danger, but also because they had been hoping for a daughter.

During her postoperative recovery in the HDU, Rajkumari and her husband witnessed another pregnant woman being admitted with eclampsia and severe HELLP syndrome, experiencing multiple complications. She had been in the bed next to Rajkumari's, and this deeply affected her. Seeing firsthand the dangers she herself had narrowly escaped, Rajkumari became very emotional. She thanked her husband for finally agreeing to the hospital referral and expressed heartfelt gratitude to the community health team for their persistence in ensuring her timely admission.

This experience served as a powerful reminder of the importance of timely medical intervention in high-risk pregnancies. Rajkumari's story highlights the critical role of community health workers in saving lives, especially in underserved areas where cultural beliefs and barriers can often delay necessary healthcare.

COMMUNITY HEALTH PROGRAMME

Our work in the forests of Chhattisgarh

Traveler, there is no path, the path must be forged as you walk ~ Antonio Machado

With our team of trained community health workers, we continued to invest our efforts in enhancing comprehensive primary healthcare. Our intensive community outreach programme saw its regular service delivery activities in the past year which encompasses basic curative care provided from the village level to complex care at the base clinic in Ganiyari, antenatal and postnatal clinics, chronic disease care and care of under-3 children in creches. Apart from these, activities included animal health care, support for self-help groups, agriculture-related activities, and development and promotion of appropriate technology.

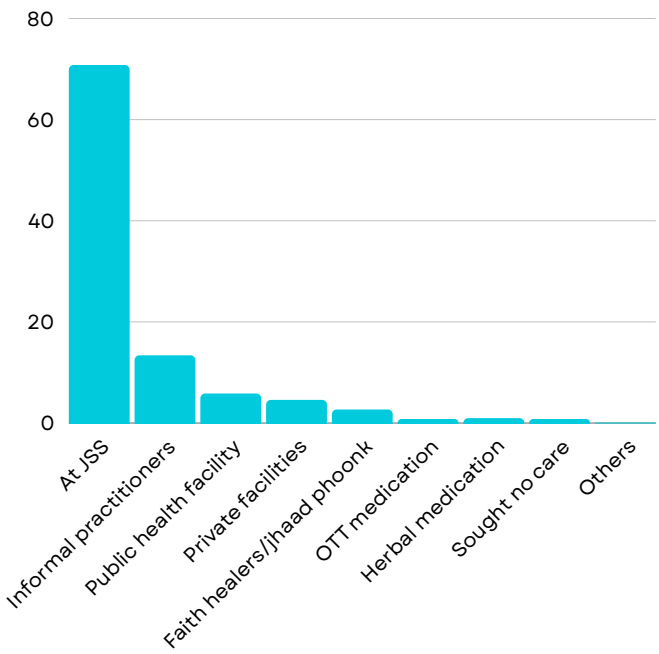
From January to March 2024, village-level active screening for hypertension was conducted by VHWs for individuals over 30 years age, occurring in three rounds to ensure comprehensive coverage. During home visits, VHWs also assessed features of Diabetes, TB, Leprosy, Epilepsy, and mental illnesses, referring suspects to SHWs for further evaluation. Active screening for sickle cell disease was initiated among families of sickle-positive ANC mothers, with additional opportunistic screenings at sub-centres by SHWs and doctors.

SHW facilitated meeting

SHWs provided follow-up care for chronic disease patients through peer support groups and home visits for those missing appointments due to social barriers. This year, 60 new hypertension patients and 26 new TB patients began treatment. Patients engaged in peer support groups exhibited improved treatment compliance and disease control. Currently, there are **1,850 members in peer support groups** for Hypertension, Diabetes, Epilepsy, Mental illnesses, and Sickle cell disease, with 1,660 receiving care from JSS. **The best compliance was among epileptic patients**. Focus will continue to be on reducing the number of defaults.

SHWs are encouraged to create informational materials for patients and caregivers. To share insights on decentralization and communitisation of NCD care, JSS hosted officers from PATH and community health organisers from Satara district for two days.

To understand the healthcare seeking pattern, we did a mapping of all the places the patients from our 72 villages go.



Mapping healthcare providers

As per the information sourced from our VHWs “gaanv ghumanna kitaab”, a total of **41,257** patients reported experiencing ill health. This year a greater focus has been on community meetings in addition to individual counselling. This has resulted in care being sought from us across various service levels in 70% of illness episodes in the community. However, 13% of the population turned to informal practitioners (quacks) in search of "quick fixes" involving injectable treatments that provide only temporary relief.

This is a common scenario among many patients we encounter in our OPD, who report being financially drained after seeking treatment from informal practitioners. Over time, when the temporary relief fades and the illness progresses to an advanced stage, they ultimately turn to JSS for care. Despite being free of cost, public health facilities remain less popular among the population due to the lack of adequate services and facilities, with only 6% of patients seeking care there, while only 5% sought treatment at private facilities.

Faith healing is another common practice observed, similar to many rural tribal regions across India. Designated members of the Baiga community in these villages provide 'jhaad phoonk' treatments for various ailments in exchange for gifts in kind. This often leads to delays in the early diagnosis and treatment of chronic diseases or acute conditions, such as snake bites, which pose significant health risks and frequently result in death due to the lack of timely and appropriate medical intervention. The prevalence of this practice has tragically claimed the lives of many young individuals. In response, we have been actively working to raise awareness and educate the community.

This year, we hosted a group from Maharashtra at our hospital as well as our community programme area for an engaging session titled "Jadu Ki PolKhol" (Uncover the Mysteries of Magic). Patients awaiting their OPD rounds, along with bystanders of admitted patients, participated in this myth-busting awareness session, which provided both entertainment and valuable information. Paired with our regular awareness programmes conducted by our nurses and nursing students, these sessions contributed to understanding the gravity associated with illnesses and need for timely medical care.

Maternal and Child Health

Our Maternal and Child Health (MCH) programme in the community ensures comprehensive care for mothers and babies, covering antenatal, intranatal, and postnatal phases. Each month, 16 antenatal clinics are conducted at different locations, supported by a specialized ANC team, including laboratory services. These clinics serve women from 4-5 nearby villages, totaling **192** clinics (catering to about 4000 women) annually. During each clinic, pregnant women receive anthropometric assessments, abdominal examinations, and lab tests such as Hb, HIV, Syphilis, Sickle disease, Hepatitis B, and diabetes screenings. Detailed individual counseling is provided to women diagnosed with high-risk conditions, who are then closely monitored at home by our Maternal and Child Health Workers and Village Health Workers. In emergencies, these women are referred to a nearby public health facility or the referral centre at Ganiyari. Awareness sessions using videos, posters, games, and discussions are held at each clinic, and all pregnant mothers receive a hot cooked meal along with a fruit to emphasize the importance of nutrition during pregnancy. Additionally, all of our subcentres and the referral centre are equipped with labour rooms for normal deliveries.

One of the significant challenges posed by the new Ayushman Bharat guidelines is the removal of the C-section package from the list of conditions eligible for coverage by private and non-governmental institutions under PMJAY. As a result, the cost of care must be borne by the patient which can hinder access to necessary services. Our aim is to minimize costs for patients while at the same time ensuring that no one is denied care. Thus, we have been offering discounts and cost waive offs to the patients for the same.

In core forest areas, some villages remain inaccessible during the monsoon due to flooding, isolating them from healthcare facilities. To address this, JSS trains Traditional Birth Attendants (TBAs) to safely conduct home deliveries using modular safe delivery kits developed in-house. During this period, JSS TBAs facilitated **71** home deliveries. Additionally, TBAs are trained to recognize red flag signs of complications, enabling them to prioritize transporting women to hospitals when necessary.

Nearly **two-third** of the deliveries in the programme villages are **institutional**. However, out of the home deliveries, less than a third are carried out by trained Traditional Birth Attendants (TBAs). Family members and untrained TBAs attend to a majority of the home deliveries. This has been due our own limitation of team members and time available to train additional birth attendants in villages that have been added into the programme more recently, especially in the most remote Bijrakachar cluster. Due to increased awareness, registration of antenatal mothers has increased even in the interior villages. ANC clinics have been decentralized and brought closer to where women live, so many more of them are able to complete at least 3 antenatal checkups. Home visits for postnatal and newborn care has helped in early diagnosis of infections and any other problems the mother or newborn may have. The number of **under-5 deaths** due to pneumonia has **reduced** in this year compared to last year, largely due to early diagnosis and improved care-seeking by the community.

Social determinants of health

Work on determinants of health includes agricultural activities, as well as livelihood support. Agricultural activities showed increased community interest and participation as issues of organic pesticides, organic farming and millet cultivation were discussed in village meetings as well as in meetings of farmers' groups.

The main achievements of this year have been provision of Forest department funding for collective fencing of farmland in Chaparwa village located within the Tiger reserve, and MLA sanctioned DMF (District Mineral Fund) funds for collective fencing in Manpur, Saraipali, Karka and Karpiha villages in the buffer zone.

More farmers have started cultivating millets (since the Government has declared MSP for kodo and kutki last year), and household consumption of millets has also risen. Several farmers are now cultivating organic crops (rice, millets, mustard) and the attempt is to advocate for the government to declare MSP for organic products too.

Women's self-help groups have continued their individual and group income-generation activities. The main achievement last year was the increase in sales of products made by SHGs through the GARIMA platform. Products like processed and packed kodo, kutki, ragi, mustard seeds, mustard oil etc are made and marketed by the women's co-operatives through GARIMA directly to consumers. The turnover this year has been nearly double compared to last year. Organisations from across the country, including some Government bodies have visited JSS to understand how the SHGs are managing this process.

Appropriate Technology

This year has been an exciting one for us in terms of developing appropriate technology:

1. **A low-cost insulin storage system** is being developed for rural patients who live without electricity or cannot afford a refrigerator. The prototype has been successfully tested.
2. **A low-cost bio-gas unit** has also been developed that can be used by small farmers having as few as 2-3 cattle. The prototype has been tested and the Forest Department has agreed to support setting up 15 such models in the forest villages.
3. **A water filter cum purifier** has been developed costing only Rs. 1500 per unit. This is efficient and easy to install and so far 10 units have been sold with orders for 10 more.
4. The challenge of a good heat source to place within **sleeping bags** for low birth weight newborns (to prevent hypothermia) has been a persistent one with leakage from the palm oil pouch or container when heated. Currently a new heat source using mustard seeds is being researched and tried out.

Looking ahead

In our priorities for the coming year, we want to focus on reduction of under-five deaths, especially due to pneumonia and deaths among low- birth weight babies. Reducing child malnutrition and growth faltering will also be a priority area of action through the phulwari programme. Special attention will be paid to pregnant women with risk factors, especially those living in hard-to-reach areas. Training of dais in these villages will be taken up so that a higher proportion of home deliveries can be conducted by trained birth attendants. Motivation of patients with non-communicable diseases to comply with treatment will remain a priority. Integrated community meetings as are being held currently will continue, and will include feedback on the health and nutrition data from the village. We hope this will lead to discussion and actions to reduce deaths, disability and malnutrition. Agricultural initiatives and income generation activities will continue to be promoted, along with health care for animals. Focus will be on increasing farmers' collectives. The impact of increased income and increased consumption of millets on members of the community needs to be studied. We hope to register GARIMA as a non-profit company this year.

THE BURDEN OF ILLNESS

"गुलशन कि फ़क़त फूलों से नहीं काटों से भी ज़ीनत होती है,
जीने के लिए इस दुनिया में ग़म कि भी ज़रूरत होती है" ~ Saba Afghani

Over the past year, we provided **64,046** consultations through our outpatient services at JSS, encompassing both the hospital and peripheral clinics. Notably, **34%** of these patients were seeking care with us for the **first time**. To emphasize comprehensive care and ensure continuity from diagnosis to treatment completion, we prioritize follow-up patients over new ones. Consistent with previous years, **women** accounted for **approximately 60%** of our outpatient consultations, indicating an encouraging trend of improved healthcare-seeking behavior among women over time.

With our three-day dedicated General OPD services, supplemented by specialized chronic disease care clinics on other days, the Ganiyari referral centre attended to a total of **58,416** patients, representing the bulk of our outpatient consultations. Additionally, our village subcentres saw **5630** patients through a combination of weekly doctor-led mobile clinics and daily SHW-led OPD services. .

Last year, we had started a dedicated OPD for palliative care, primarily focused on the significant number of cancer patients, many in advanced stages, seen at our centre. This has helped reduce turn around time for patients with malignancy and helped the team do a detailed symptom assessment and curating the treatment accordingly. The subjective patient reported satisfaction has been promising with improved follow ups. We are now an identified centre for palliative care in Chhattisgarh as per Indian Association of Palliative Care's (IAPC) directory.

In addition to our in-house specializations in Family Medicine, Obstetrics and Gynecology, Surgery, Pediatrics, Ophthalmology, Dental Care, and Ayurveda, we welcomed new physicians this year in Pediatrics, Orthopedics, and ENT. Visiting specialists in urology, neuro surgery, plastic surgery, and other fields continued to offer their expertise as needed. For other specialized needs where we lack in-house as well as local experts, we provide care through weekly telemedicine sessions coordinated by a resident doctor. These sessions cover psychiatry, infectious diseases, cardiology, and rheumatology, with the active participation of specialist colleagues from both India and abroad, including experts from institutions like CMC Vellore and AIIMS Delhi. Such collaborative consultations not only improve patient care but also enrich the knowledge and skills of our doctors and care providers, incorporating valuable insights and the latest updates from leading experts in the field.

Communicable and non communicable disease

In our ongoing efforts to address non communicable diseases (NCDs) in vulnerable rural communities, we are seeing significant cases of hypertension, diabetes, various cancers, epilepsy, asthma, chronic obstructive pulmonary disease (COPD), sickle cell disease, mental health disorders, different types of arthritis, and thyroid issues. Common co-existing conditions include anemia and undernutrition (although a section is with obesity and metabolic syndrome as well). Unfortunately, many patients only seek care when their symptoms become severe enough to disrupt their daily lives, often due to challenges in accessing affordable, continuous healthcare.

Patient with a BMI of 12.6kg/m2

Patients presenting with complications such as heart failure, chronic kidney disease, atrial fibrillation, often come with a diagnosis from another centre, but have failed to take medicines regularly. A key issue is that many patients do not recognise the importance of ongoing treatment, as conditions such as hypertension and diabetes often show no symptoms in their early stages. Additionally, addictions to tobacco products like Gudakhu (a tobacco and jaggery mixture used for rubbing on gums), chewable tobacco, gutkha, and alcohol, along with the stress of poverty, lack of social security, changing nature of physical activities and social relationships, are significant contributors to the rise of these diseases.

Patient information booklet

Our care strategy focuses on accurate diagnosis while also checking for complications and co-existing conditions. We provide counseling from both physicians and dedicated NCD counselors. To empower patients, we distribute education handbooks in Hindi and have translated assessment forms for hypertension and diabetes. We have also started a whatsapp group for disseminating information regarding NCDs improve existing knowledge. This helps our paramedical staff support doctors more effectively, which is crucial given the rising number of NCDs. We also follow up with patients who miss their appointments, reminding them of the importance of ongoing care.

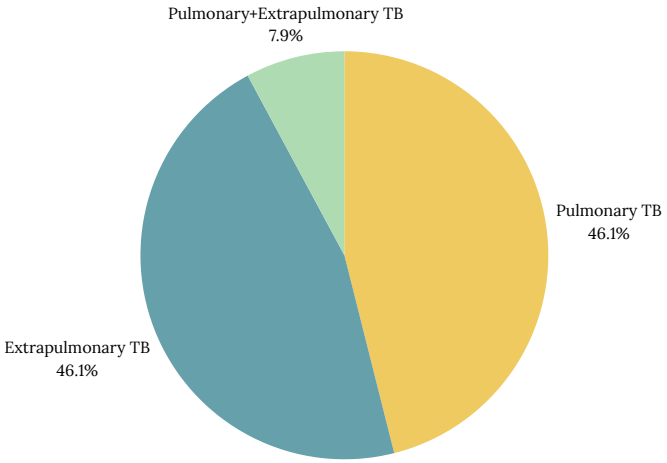
To combat addiction, we have introduced ***Saugandh Churna*** in our Ayurvedic Pharmacy as a healthier alternative to chewable tobacco. We work closely with the public health system to ensure that patients with stable conditions can easily access their medications from local health facilities. For those who choose to continue their care at JSS, we provide quarterly refills. Our team is continuously brainstorming ways to slow the NCD epidemic. We promote healthier food choices, encourage stress-relieving activities like yoga and sports, and educate young people to resist tobacco and alcohol influences through community radio programmes. Our comprehensive approach involves collaboration among various teams- agriculture, ayurveda, nutrition, nursing, and clinical care- to effectively tackle these health challenges in our communities.

The number of new cases this year:

864	779	682	369	117	63
Hypertension	Diabetes	Cancer	Tuberculosis	Leprosy	Sickle Cell Disease

Our TB care programme includes a dedicated weekly clinic every Tuesday besides regular outpatient services, and an 8-bed TB ward including isolation options. TB care is managed by a team of at least four clinicians, an Ayurvedic doctor, a counselor, and our well supported inhouse laboratory. Our lab provides crucial services such as sputum microscopy, pus and other body fluids microscopy with ZN staining, CBNAAT, and forms referral linkages for LPA and LJ medium culture without the patient having to move around seeking a diagnosis.

We at JSS believe in **person tailored TB care**; during each visit, we assess a patient's symptoms, changes in weight, potential side effects of medications, and lab results for conditions like hepatitis, anemia, and diabetes. Recognizing that many of our patients are undernourished, we follow WHO guidelines by providing 9 months of anti-TB medication, consisting of 3 months of intensive treatment followed by 6 months of continuation.



Out of the **367 new cases** of Tuberculosis we saw this year, it was noted that extrapulmonary spiked up to match pulmonary TB numbers. This is exceptional since detection rate of extrapulmonary TB in public health centres of India is usually poor. **The median BMI** noted was **17.2** which is below the normal criteria.
A total of **144** patients, including the ones on follow up, required inpatient care and we strictly monitored their comorbidities. In our inpatient facility, we ensure patients receive additional nutritional support, including sprouts, eggs, milk, and bananas.

Therapeutic Mix

Our canteen also prepare **Therapeutic Mix** (locally identified as 'halwa') which is a calorie-dense ready-to-eat nutritional supplement based on a WHO formula, providing significant quantities with and without sugar to accommodate patients with diabetes. Every month, close to 1.5 quintal of therapeutic mix (with sugar) and 25kgs of sugar free one for diabetic patients are offered to our patients since most of them are below the required nutritional status. Since food plays a vital role in most of these preventable illnesses found in the population we work with, our pharmacy also dispenses soyabean oil, sattu, chana, and soya badi which are mostly prescribed for patients with precarious BMI numbers. Additional support in the form of meals, oxygen, ventilator, procedures etc were provided as necessary.

Our lab processed **1283** samples for AFB and **903** for CBNAAT with positivity rate of 8.3% for the former and 21% for the latter. **170** samples were referred to Raipur and Mumbai for **LPA and LJ**. We also detected **4 cases of MDR** and due to unavailability of facilities required to manage MDR, we referred them to the nearest medical college.

To improve adherence to treatment, our pharmacy uses a specially designed drug box for dispensing fixed-dose combination (FDC) drugs received through the National Tuberculosis Elimination Programme (NTEP). We also separately maintain stock of pyridoxine along with individual ATT drugs for dose modified dosing in patients with liver and kidney dysfunctions. We faced **ATT stockouts** in February and March and had to purchase our supplies from the market.

TB medicine box

"Which side wins?
Love wins. Love always wins"

We continue to see patients with severe symptoms and advanced TB, raising concerns about the feasibility of eliminating the disease by 2025. We have noticed a shift toward more cases of extrapulmonary TB, suggesting that diagnosing pulmonary TB may have become easier. Some of our learnings over last year includes identification of an increase in post-COVID TB cases and patients traveling longer distances for treatment.

While direct cash transfers have provided some support as an additional resource, delays and inaccessible banking facilities limit their effectiveness towards nutritional supplementation. There is a pressing need for involvement of local administrative bodies, including panchayats and self-help groups, to enhance TB elimination efforts.

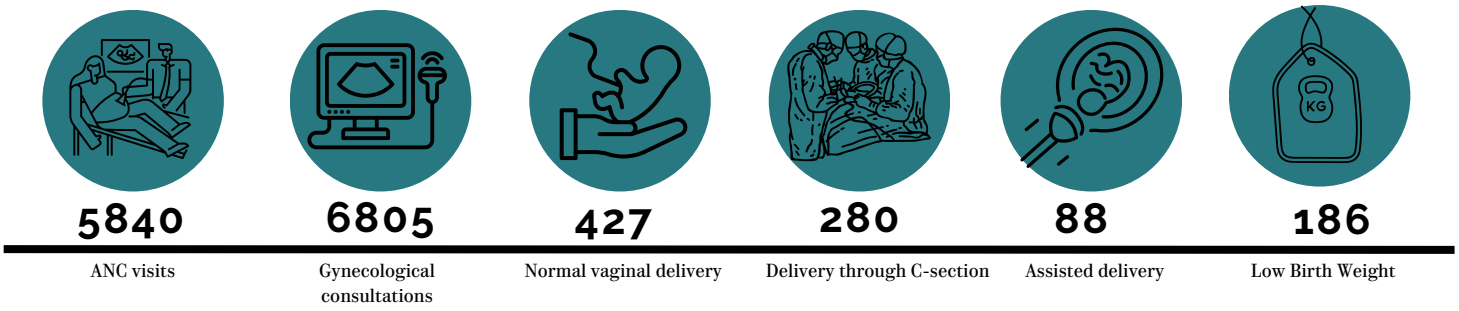
We are currently studying utility of active symptoms based case finding in the PVTG population of two blocks, Kota and Lormi, to understand the burden of unidentified TB along with nutritional supplementation choices and health seeking behaviour barriers and facilitators. The learnings from this would help us understand the needs of PVTG groups further.

The state of maternal and child health as seen at JSS:

JSS Ganiyari provides an exclusive women's health programme that addresses the physical, mental, and social well-being of women, from the community level to hospital care.

At JSS Ganiyari, antenatal care is provided according to the latest guidelines, with monthly visits until 28 weeks, biweekly visits until 36 weeks, and weekly visits until delivery. This approach enables the early detection and management of high-risk pregnancies, ensuring safe confinement and reducing maternal and perinatal mortality. Special intrapartum and postpartum care is provided for high-risk pregnancies, particularly for elderly gravida, grand multipara, antenatal cases with Sickle Cell Disease, diabetes, hypothyroidism, and other conditions.

"***Remarkably, there was zero maternal mortality at the JSS hospital or subcentres in 2023-24!***



The numbers seen at the JSS hospital

The hospital acts as a higher care centre for patients from our intensive programme area; besides offering C-section delivery to 100 women from our programme villages, we could also offer advanced care to 204 women who were referred from our village ANC clinics as high risk cases.

While pregnancy is often a time of celebration, in a rural setting like ours, it can also bring loss, especially when many women require high-acuity care due to high-risk conditions, and their nutritional status is often below the national average. During the reporting period, we recorded 4 stillbirths, 12 intra-uterine deaths, and 67 preterm deliveries.

We need to focus on reducing preterm and low birth weight births by emphasizing improved maternal nutrition, early identification and treatment of infections (particularly UTIs), and close monitoring of maternal weight gain. Among the gynecological issues we encounter, the most challenging are gynecological cancers, especially cervical cancer, as most cases present at an advanced stage, often from remote areas of Madhya Pradesh.

We wish we could implement screening for this malignancy in these regions, as we do in our community programme areas. At JSS, cervical cancer is the most common gynecological cancer we see (95 cases), followed by ovarian cancer (24 cases), and less commonly, endometrial cancer (2 cases) and vulvar cancer (1 case). Opportunistic screening for cervical, uterine, and ovarian cancers is routinely conducted at JSS using visual inspection with acetic acid (VIA), endometrial biopsy, and serum CA125 estimation to facilitate early detection and management of reproductive tract malignancies.

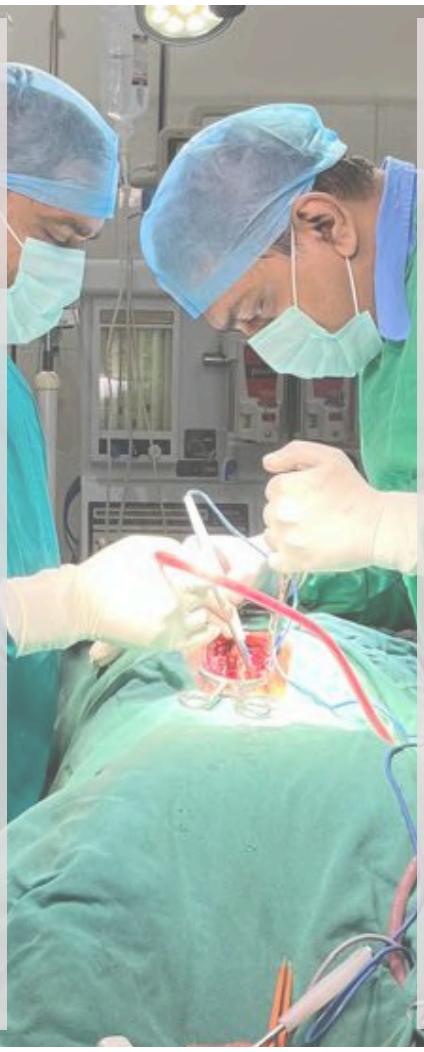
Dr. Meenakshi, our senior gynecologist with over 30 years of experience, tells us: ***"my work at JSS has been the most fulfilling of my career, after spending nearly three decades at SECL. I thoroughly enjoy every aspect of what I do and the impact we make. I only wish we had a skilled ultrasonologist at JSS Ganiyari to better support our patients, so they would not need to seek this crucial imaging elsewhere."***

RURAL SURGERY

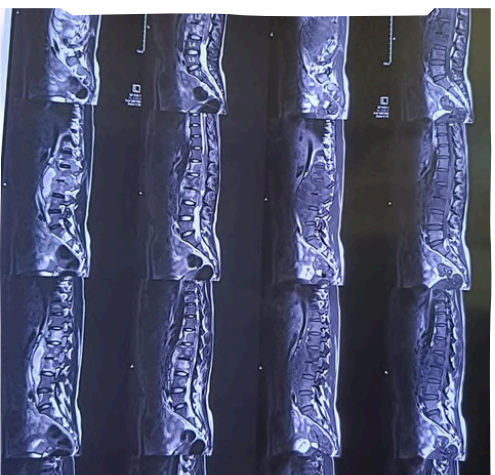
'Discretion is the better part of valor' ~ William Shakespeare

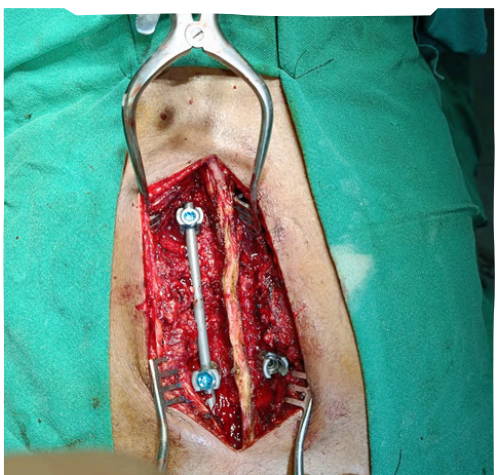
'The best part of courage is caution when applied to surgery'

16 year old Varsha (name has been changed) was brought into the OPD room at JSS in the arms of her father. She was in obvious pain as he gently lowered her into the examination bed. She had started having backache for nearly a month that grew worse with each passing day and she had become bedridden since one week. The family had been to the district hospital nearly 60 km from her village and then to two medical college hospitals in different districts, before someone told them about Ganiyari hospital. She had been running fever and did not feel like eating. She had lost weight and felt weak. She was admitted and was found to have reduced muscle power in her legs, though her bladder and bowel functions remained unaffected.



MRI scan showed extensive involvement of the thoracic and lumbar spine with pressure on the Spinal cord, likely due to tuberculosis of the spine. She was started on anti-tubercular medication and planned for decompression of her cord and fixation of the vertebrae - a delicate and complex procedure. Our visiting neurosurgeon and our team completed the procedure and one week later she was sitting on her bed, smiling after the relief from pain and much improved muscle power. She walked in after a month into the TB clinic at JSS to get a refill for her medicines which she would need to continue for atleast 12 months. Her chirpiness belied her serious state only a few weeks ago!





The need for rural surgery in India is critical due to the lack of accessible healthcare facilities, with most specialist surgeons concentrated in urban areas, leaving rural populations underserved. High disease burden, including trauma from accidents, obstetric emergencies, and infections, requires timely surgical intervention that is often delayed due to the absence of local facilities. Financial barriers further exacerbate the issue, as traveling to urban centres for surgery is costly. Expanding rural surgery could improve maternal and child health, reduce preventable deaths, and foster community trust in local healthcare services, ultimately addressing healthcare disparities and improving outcomes for underserved populations.

Despite the challenges of our setting, our surgical services have continued to make a big difference, with around 3,000 surgeries performed every year across various specialties. This includes a large number of emergency surgeries, making advanced surgical and critical care accessible for conditions that are often overlooked.

This year, we carried out **2794** surgeries spanning general, oncology, obstetric, pediatric, ophthalmic, gastrointestinal, plastic, neuro, cardio-thoracic, and urological specialties. Of these, **95%** were **major surgeries**, which shows how complex and wide-ranging our work is. Most surgeries were in general surgery, followed by obstetrics and gynecology, cancer, and pediatric surgery.

We also performed about **290 emergency surgeries**, showing our commitment to delivering urgent, life-saving care when it's needed most. This year, we conducted a number of free flaps which have shown positive results in patients presenting with advanced malignancies.

Our surgical team includes senior surgeons, anesthesiologists, and 7 surgical residents who are receiving hands-on training from experienced mentors. Our dedicated operation theatre technicians and trained nursing staff also play a key role in making sure surgeries are safe and efficient. We prioritize emergency and semi-emergency cases and follow strict protocols to maintain quality and safety, ensuring that all our patients receive the best care possible.

The making of a true general surgeon

A competent general surgeon ready to practice her/his speciality needs to be exposed to a large mix of cases ranging from soft tissue tumour- benign and malignant, breast pathology, gastro-intestinal including colorectal, hepatic and pancreatico-biliary, endocrine, head and neck, urology, thoracic, neurosurgical, vascular and cardiac, etc. It is obviously not possible to master each of these sub-specialities in a short span of three years, but the exposure helps the budding surgeon choose a subspecialisation of his liking. Some may choose to remain true general surgeons. A postgraduate residency in general surgery at the Jan Swasthya Sahyog hospital offers this rare opportunity to get exposed to the vast array of surgical cases and learn from people who not only excel in qualities of the head and heart but are also the best in their field. The training includes sharpening clinical skills, decision making in difficult and critical situations, while understanding the social and economic predicament of patients.

Critical care skills, clinician operated ultrasound to aid in diagnosis and management, skills in cystoscopy, upper GI endoscopy, colonoscopy and flexible bronchoscopy can be learnt while caring for patients. Inhouse urology, pediatric surgery, surgical oncology, plastic surgery and laparoscopic surgery specialists make for comprehensive and well rounded exposure. Regular seminars, case discussion and journal clubs help in the process of learning and enhancing critical thinking and presentation. While residents and consultants are aware of the recent advances in their field, the true test comes with judicious application of this knowledge in the context of our patients.
This aspect of surgical care is hardly touched upon and needs much wider discussion and dissemination of ideas.

To this end JSS is hosting the upcoming Annual conference of the ***Association of Rural Surgeons*** of India in **February 2025**. Stalwarts in their fields will deliberate and enlighten over 6 days, and we welcome participation for the ARSICON 2025: **https://arsiindia.org/arsicon-2025/**

Against All Odds: Sonali's Triumph Over Tuberculosis

Sonali (name has been changed) was in the middle of her graduation, pursuing a Bachelor of Science in Health Analytics, when her life took an unexpected turn. As part of her studies, she often visited households in her district, assessing the impact of chronic illnesses. It was during this time that she started to lose weight rapidly, becoming frail and weak. She came to us with gross ascites, a classic sign of severe illness. After thorough examination, she was diagnosed with Abdominal Koch's disease. The diagnosis was confirmed by ZN staining of the ascitic fluid, which came back 3+.
A 3+ result in ascitic fluid meant that Mycobacterium tuberculosis—the silent destroyer—had already done significant damage. Sonali was admitted to the hospital and discharged a week later, with hopes that she would recover with appropriate medication and care.

But as someone once said, "**ज़िंदगी में मुश्किलातें आती रहेंगी, ए राही तू बस चल कर दिखा**" (Obstacles will keep coming in life; traveler, you just have to keep moving forward).

Just ten days after her discharge, Sonali returned, now in severe pain with increasing abdominal distension. She showed clear signs of bowel perforation due to extensive abdominal tuberculosis. After completing the necessary investigations, we took her in for emergency surgery. What we found was a "cocoon abdomen"—a tangled mess of intestines filled with countless tubercles. It was impossible to find even a 10 cm straight segment of bowel. Sadly, we had to leave the surgical field without being able to do much; there wasn't much we could do.

Sonali was readmitted for total parenteral nutrition and intravenous anti-tubercular drugs. Unfortunately, during her stay, she developed fungal sepsis. Her weight dropped to a mere 22 kg (BMI: 9 kg/m²). I remember a question from my postgraduate entrance exam about the BMI incompatible with life in females, and the answer earned me +4 points. But now, seeing Sonali's condition, I truly understood what that number meant- textbooks are there to guide us, but real life teaches us the true meaning.

Sonali was put on anti-anxiety medications. Her mother remained hopeful, yet it was evident that she was also deeply distressed by her daughter's condition. One day, as I walked through the ward, I saw Sonali eating rice with salt, despite having dal and eggs available. Her mother told me, "We have been eating like this for the past 20 years." I sat down and explained to them the importance of nutrition.

During her stay, Sonali developed large enteric fistulas, with a high daily output of 750-1000 ml. She underwent another surgery in hopes of finding something that could be fixed. Unfortunately, we found nothing but large and small bowel fistulas. We closed what we could with two or three drains and exteriorized one of the fistulas.

I still remember my mentor saying that day, **"If she recovers, consider it a miracle."**

Sonali remained in the hospital ward for 120 days- a third of a year. There were times when even she seemed to lose hope. But the people who trained me, not just in medicine but in the deeper understanding of it- my mentors, the nurses, and all the staff- never gave up on her.

And then, a miracle began to unfold. The fistulas started healing. Sonali was eventually discharged after discussions with her mother, who had stayed by her side throughout the ordeal.

और मां के बारे में मैं क्या लिखूं और क्या ना! वो मां है, दुनिया के तूफ़ानों से लड़ना जानती है
(What can I say about a mother? She's a mother, after all- a force capable of facing the world's fiercest storms for her child)

Throughout Sonali's illness, we fought not just the disease but also the system. Her Ayushman Bharat health insurance claim was rejected multiple times, even when she was admitted with severe sepsis, with the excuse that "the blood culture is negative; hence the claim can't be approved." But the words of the teachers echoed in my ears, "**अगर बिच्छू अपना व्यवहार नहीं छोड़ रहा, तो तुम संत होकर क्यों अपना व्यवहार छोड़ रहे हो** (If the scorpion won't change its nature, why should you abandon yours as a saint?).
We continued to fight for her. They even asked us for a video of her on her hospital bed, despite having submitted it earlier to approve her claim.

Sonali's weight gradually increased during her follow-ups, and so did our hopes. I got a chance to meet her and hear her story in her own words. Over the last eight months, she had gained 19 kg, and her fistulas had completely healed. She was ready to resume her studies. With a smile, she reminded me, **'आपने बोला था जब मैं ठीक हो जाऊंगी, आप एक मेडिकल** certificate **बना देंगे जिससे मैं फिर अपना कोर्स ज्वाइन कर पाऊं'** (You had said that when I recover, you'll make a medical certificate for me so I can rejoin my course).

I stood speechless, lost in thought, before finally nodding in agreement. These moments will always serve as a reminder that some decisions shape lives, while others define who we are. This institution has always given me the chance to discover the human being within myself.

PHULWARI PROGRAMME

Combating undernutrition in children under 3 through rural creches

“ये तो है सर्दी में धूप की किरणें, उतरें जो आँगन को सुनहरा सा करने
मन के अँधेरों को रोशन सा कर दें, ठिठुरती हथेली की रंगत बदल दें
खो ना जाएँ ये, तारे ज़मीं पर”

Hunger remains a persistent issue in rural India. The nutrition levels, especially among tribal communities are appalling, exposing them to the risk of contracting chronic diseases which further impoverish them. Though we have staved off the threats of food insecurity, the average BMI of the population we work with are far lower than reference India.

Children under 6 months of age get sufficient amount of nutrients from breast milk. However, lack of nutritious food thereafter results in progressive malnourishment starting from 6 months of age, which peaks at 2-3 years. When malnutrition occurs in early childhood it also leads to poor physical and intellectual development, which is likely to have its effect throughout one’s life and perpetuating a cycle of undernourishment and poverty. The most obvious reasons behind malnourishment among children are: unavailability of food, long working hours of mothers and no adult to look after or feed them during the day, inadequate knowledge on nutritional needs of children after six months of age. Young children are especially prone to malnutrition since there is usually no one to regularly feed them and they can’t feed themselves.

In that backdrop, our Phulwari programme aims to tackle childhood malnutrition by understanding the specific needs of the community. In a tribal-dominated State like Chhattisgarh, characterized by vast expanses of dense forests and hard-to-reach hamlets, where both parents must go for work to fight poverty and its associated vulnerabilities, children are left behind often in care of their elder sibling, who in turn has to drop out of school. This led us to ask:

"***If there are crèches for children in urban areas, why can’t rural areas have them too?***"

Our programme adopts a unique community-driven approach to combat undernutrition. We train village women to manage these crèches for at least 8 hours a day, fostering a strong sense of community ownership and sustainability. By selecting workers from within the local community, we ensure parents' confidence in their children's safety while also creating livelihood opportunities for these workers, contributing to the local economy. This culturally relevant model has led to greater acceptance and active participation among the community.

Programme update

Currently, JSS has 86 creches in the community programme in Chhattisgarh and 75 creches in Pushprajgarh block of Anuppur district in Madhya Pradesh. In addition we run 40 creches in Singrauli district as well owing to the precarious condition of children living in the mining district.

In Chhattisgarh, the focus this year has been on home visits and counselling of parents of severely malnourished children through repeated home visits and during parents' meetings. Detailed information regarding what the child ate, as well as immunization status and illness episodes was obtained to make the counselling more specific and appropriate to the family. A physician also examined these children and appropriate investigations and treatment were given when required. Immunization coverage was also tracked and missing vaccinations administered by the Government staff. This has shown positive results: in 2022-23, the average proportion of severely malnourished children through the year was 8.9%, whereas in 2023-24, this has reduced to 7.1% of children being severely malnourished. A total of 346 children exited (either graduated or left the creches) from the Phulwari in this year. Children with more and more time spent in the creches have shown improved nutrition; about 90% children out of 346 were prevented from getting malnourished by the age of 3 years.

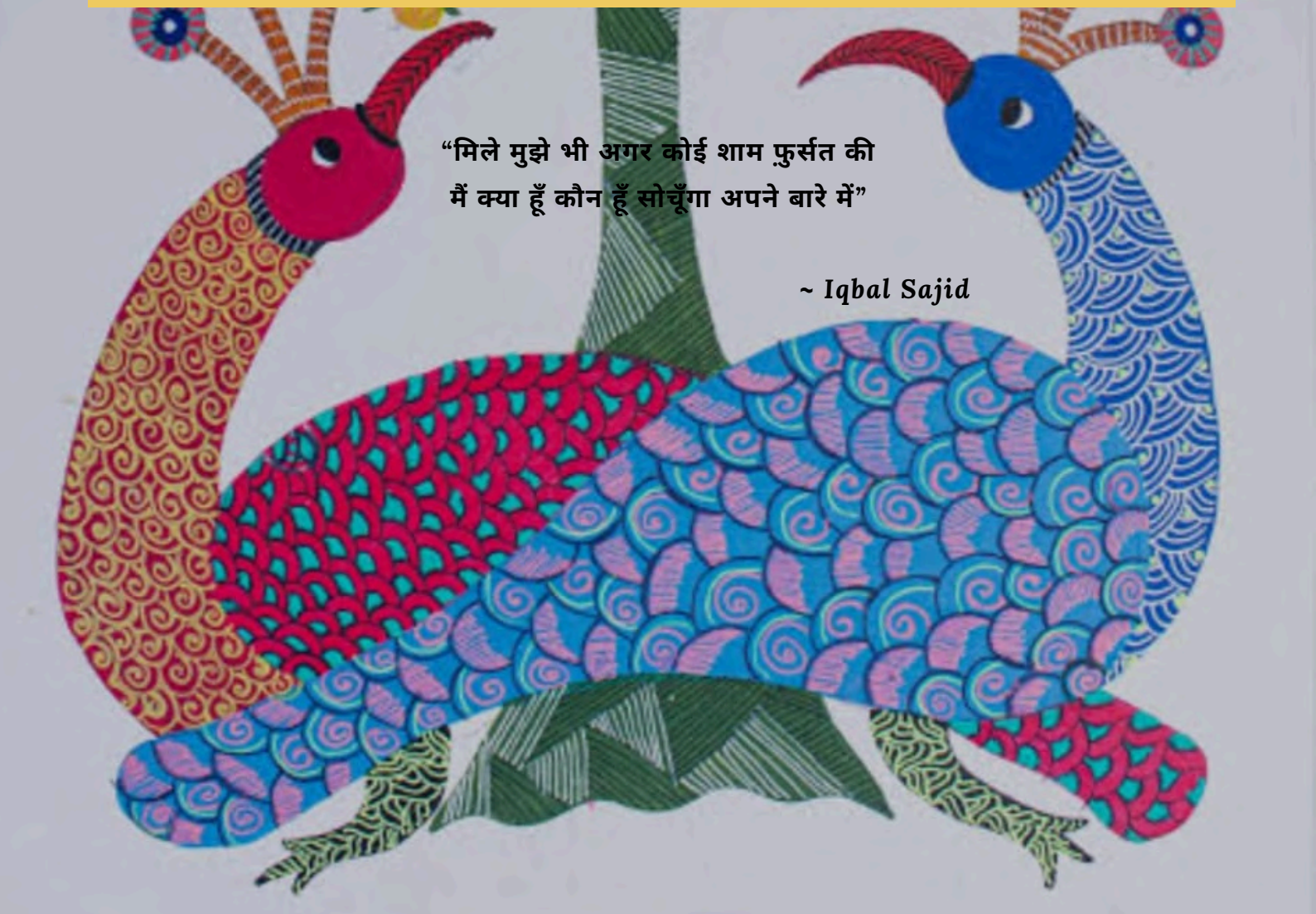
Home visits of Phulwari children

Growth faltering, however, has not shown much improvement. In the present reporting period, an average of 20% of Phulwari children in Chhattisgarh showed growth faltering every month, though this varied seasonally. Repeated upper respiratory infections with reduced appetite seem to be the main cause of growth faltering, followed by episodes of diarrhoea. These children will be the focus in the coming year. The issue of migration from the programme villages for several months in the year continues to affect the impact of the creche programme. When children are taken away by parents who migrate as agricultural labourers, they stay away for a few months during which the nutritional status of the child worsens. There is always a spurt in the number of malnourished children in the creches when the parents return. Episodes of diarrhoea occur after festivals and in the wedding season and this again leads to growth faltering.

In Madhya Pradesh, out of 1667 children across Pushprajgarh and Singrauli, 67% of the children showed improvement of maintenance in their weight for age as per their Z score. The team recorded 2,812 home visits and 1,432 encounters for anthropometric measurements, emphasizing its extensive outreach and commitment to addressing malnutrition. Looking ahead, we plan on expanding its reach by running 40 additional crèches in Singrauli and creating models in Anuppur and Singrauli districts. Future initiatives include building community engagement and monitoring systems, conducting team capacity-building workshops, and promoting kitchen gardens with hundreds of families to ensure sustainable nutrition sources. Support from the state, including materials for crèches and budget allocation for basic operations, is crucial for the continued success and expansion of Phulwaris.

TIME FOR A BREAK

All work and no play?



“मिले मुझे भी अगर कोई शाम फ़ुर्सत की
मैं क्या हूँ कौन हूँ सोचूँगा अपने बारे में”

~ Iqbal Sajid

Women for women

The protectors of the realm

Surgeons' day out

All smiles at the blood donation drive

Music for social awareness and mental health by Vinay and Charul ji

Annual marathon at JSS

On a BP apparatus crunch day

Rowing away at Kori dam

The doctor serves

Divided by work areas, united by chai

Some cook at the office picnic, some think of tally ledgers of the picnic expenses

Group dancing till sunset

JSS at MFC, Wardha

Screening of India vs Australia

HEALTH SYSTEM STRENGTHENING

Contributing towards a robust public health system

'It is our choices, Harry, that show what we truly are, far more than our abilities'

~ Harry Potter and the Chamber of Secrets

Well-functioning public health facilities are crucial for providing quality comprehensive healthcare, particularly for the poor and marginalized. JSS recognized the need to enhance the depth, scope, and quality of services offered at these facilities. In 2016, JSS formally began its intervention by signing an MoU with the State of Madhya Pradesh to improve maternal and newborn care in district hospitals and First Referral Units across six districts. This effort involved building trust through appreciative inquiry, forming quality teams at the facilities, mentoring them through quality improvement cycles, conducting targeted training, and providing ongoing support.

At the primary care level, JSS worked in the remote Pushprajgarh block of Anuppur district, training ASHAs and ANMs to improve care at Village Health and Nutrition Days (VHND), subcentres, Health and Wellness Centres (HWCs), and Primary Health Centres (PHCs), thereby ensuring a continuum of care for these underserved communities.

Recognizing the need to support young children's nutritional needs, JSS also established 75 rural creches (phulwaris) in Pushprajgarh block after training Phulwari workers. Additionally, Sickle Cell Disease (SCD) emerged as a significant cause of illness and premature death among children and young adults. In 2017, JSS, in partnership with the State Health Department, launched the Sickle Cell Disease Control Mission. From a baseline where SCD was barely recognized by medical officers or specialists and diagnostic tests were unavailable, JSS was able to screen and diagnose patients with SCD until 2023, ensuring they received appropriate counseling and medications. Patient Support Groups were also formed to communitise care. The State adopted JSS's methodology and guidelines to launch the Sickle Cell Programme in 2020, which eventually influenced the launch of the National Sickle Cell Elimination Mission in 2022.

Family counselling of a sickle cell patient at her home

Pushprajgarh Health and Nutrition Initiative

The Comprehensive Primary Health Care (CPHC) programme operates in 74 tribal villages in Pushparajgarh block, Anuppur, providing vital medical and social support. Seven Auxiliary Nurse Midwives (ANMs) are stationed in key locations and handle OPDs, Village Health and Nutrition Days (VHNDs), vaccination drives, maternal health, and other medical needs. ANMs also conduct monthly supportive supervision visits to ensure VHNDs meet standards, tracking facilities such as lavatories and medical supplies. High-Risk Pregnant Women (HRPW) receive additional monitoring, including referrals to hospitals for complications.

The programme also runs Mobile Fever Clinics, initiated in 2021, which respond to community needs based on reports from ASHA workers. These clinics serve 15 to 100 patients and are set up as needed to address localized health concerns, adjusting based on patient numbers and severity.

Numbers at a glimpse	
Number of VHND supportive supervision visits	371
Number of HRPW follow-ups	464
Number of visits at HWCs	340
Patients treated during mobile fever clinic	2521
Number of Phulwari children treated	1698
Number of ANM training sessions held	5
Number of ASHA meetings attended	32

Plan for Next Year:

- Conduct home visits for family assessments of malnourished children in collaboration with Phulwari supervisors.
- Facilitate peer support group meetings for individuals with Sickle Cell Disease (SCD) and epilepsy at Health and Wellness Centres (HWCs).
- Engage with the community, including Village Health, Sanitation, and Nutrition Committee (VHSNC) members, parents, and other community members, through meetings at Anganwadi centres.

Support Required from the State:

- Facility and Infrastructure Improvement: HWCs require upgrades in both facility quality and infrastructure to enhance service delivery.
- Enhanced Quality of Care for Mothers and Children: Efforts should focus on improving the quality and quantity of antenatal care (ANC) services. It is crucial to ensure that all four ANC visits are mandated at Community Health Centres (CHCs) and Primary Health Centres (PHCs).
- Addressing Staffing Shortages at HWCs: Most HWCs are understaffed, highlighting the need for additional personnel to provide counseling services and to ensure that all women receive their four ANC sessions.

Maternal health training

Training sessions for Auxiliary Nurse Midwives (ANMs) and Community Health Officers serving at the Health and Wellness Centres were conducted to equip them with the necessary knowledge to effectively manage Antenatal Clinics (ANC) and Postnatal Clinics (PNC). These training programmes were organised in collaboration with district trainers, with senior ANMs from the JSS team serving as master trainers. The training covered a range of topics, including infection identification and management, as well as anatomy.

During the year, 14 ANC-PNC training sessions were facilitated, involving the training of 301 participants by district trainers. Of these, 7 sessions (125 participants) were conducted in Anuppur, and 7 sessions (176 participants) in Dindori. Our team directly supported 8 of these 14 maternal health training sessions. To further promote awareness of antenatal care, pregnancy, and newborn health, IEC sessions were conducted during the antenatal clinics, utilizing videos, discussions, talks, and posters.

Numbers at a glimpse	Anuppur	Dindori	Total
Number ANC-PNC training sessions facilitated with district Trainers	7	7	14
Number of participants in the ANC-PNC training	125	176	301

Plan for next year:

- Recruitment of Staff Nurse for facilitating training and mentoring
- Supporting district coaching teams in nurse mentoring and LaQshya programme

Support Required from state:

- Follow up on whether proper medication is administered and is complied with
- Increase the number of trainings - ANMs are not able to conduct abdominal check-ups

Sickle Cell Disease

In 2023-24, Sickle Cell Disease (SCD) screening was conducted in Anuppur and Dindori. Patients testing positive ('SS' or 'AS') received counseling on confirmatory tests and their options. 'AS' patients carry the trait and are advised on preventing transmission to offspring, while those diagnosed with SCD, require medications like hydroxyurea and folic acid. They also face complications such as susceptibility to changing weather and avascular necrosis (AVN).

To manage SCD, patients attend Patient Support Group (PSG) meetings. In 2023-24, 15 PSG meetings were held, where JSS counselors conducted follow-ups, updated records in the AVNI app, and coordinated with doctors for evaluations and treatments. The SCD team also supported patients needing hospitalization, including blood transfusions and consultations.

Numbers at a glimpse	Anuppur	Dindori	Total
Number of PSG meetings	67	86	153
Number of home-visits to SCD patients	318	358	676
Number of patients supported for IPD	126	108	254
Number of persons screened by the JSS Screening team	6036	4649	10,685
Number of online training sessions conducted for doctors	10	10	20

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Plan for next year:

- Expand smaller Patient Support Group meetings at Health and Wellness Centres with Community Health Officer support. This has begun in SHC Baharpur (Dindori) and HWC Alwar (Anuppur).
- Develop a follow-up system for all patients and identify those facing avascular necrosis (AVN) for expert evaluation. So far, 72 patients in Dindori and 39 in Anuppur have been identified.
- Create a volunteer group of patients to support others through counseling, blood donation, and awareness of patient rights.
- Initiate death reviews for Sickle Cell Disease patients, working on literature review and methodology.
- Initiate Newborn and young child screening for SCD in the two District hospitals
- Establish a functional Sickle Cell Ward in the District Hospital, Anuppur, to manage acute vaso-occlusive crises and complications.

Support Required from state:

- Ensure uninterrupted and sufficient drug supply for PHCs/CHCs.
- Include Cap-Hydroxyurea in the E-Sanjeevani portal for easy telemedicine consultations.
- Ensure availability of Syrup Hydroxyurea or smaller strength caps for improving accurate dosaging for children
- Issue PSG meeting guidelines for districts.
- Provide training for doctors, pharmacists, and staff nurses for better patient care, and train district hospital/CHC lab technicians for HPLC interpretation.
- Support the creation of a functioning Sickle Cell Ward in the district hospital.

Counselling a hard-to-reach patient, a tractor driver, at his worksite

Ramkali Kujur, a senior health worker with Jan Swasthya Sahyog community health programme, was invited as a guest speaker at the Clairvoyance 2024 in February 2024. The theme was health and health care, Lived experiences with Indigenous communities. She traced her journey from a novice in her village in the Bamhani cluster in the year 2003, to her current position as a change maker in her community. As a village health worker after her training at JSS in 2003, she was immediately faced with diarrhoea and cholera in her village. Her training and hand-holding by the community health team including doctors, gave her confidence to spread the word about the importance of frequent hand washing, hygiene and sanitation, the use of safe drinking water which is boiled or treated with chlorine drops and the use of Oral rehydration solution made at home using salt, sugar and boiled water. Practices were difficult to change, especially the use of untreated water from 'jhiriya', or pond or river water. Also the practice of injection by a jhola chhap in the village or getting an IV drip were prevalent. These took a lot of 'seeing and believing ' over several years.

The other major problem that she encountered was malaria. She described how the team devised an innovative strategy of slide preparation for the patient (by her as a village health worker), it's transport using the only bus that crossed the road near her village on its way to the JSS hospital at Ganiyari, immediate reporting by the JSS lab staff and despatch of the report with advice through the same bus on its return journey to their village. This helped the health workers decide on treatment for malaria and also know when to refer the ones who are sick or may turn sick. Stressing the importance of mosquito nets, especially those that are treated with DEET, Ramkali recalled what havoc malaria can cause during pregnancy. She effortlessly talked about the need for screening asymptomatic pregnant women and the need for drug prophylaxis during pregnancy.

Ramkali then recalled the atrocious regime a new mother had to face. She had to go without food for five days as this was considered good for her recovery. And the newborn remained attached to the placenta even after delivery as cutting the umbilical cord was considered a low caste job even amongst the tribals. This low caste woman called 'suin' was often unavailable for more than a day and the newborn would like uncovered until then. Neonatal deaths were very high and even maternal deaths were not infrequent. Changing these practices by showing how hygienic cord cutting in time helped the baby survive, and early institution of food for the mother lead to better lactation and healthy baby, took a long struggle and often ugly arguments with village elders.

Ramkali received a standing ovation for her remarkable and fearless work to help alleviate suffering in her community.

KNOWLEDGE DISSEMINATION

"न चोरहार्य न राजहार्य न भ्रतृभाज्यं न च भारकारि ! व्यये कृते वर्धति एव नित्यं विद्याधनं सर्वधनप्रधानम् !"

(translates to): Not to be stolen by thieves, not to be taken by kings, not divided among brothers, and not heavy to carry. Knowledge is the supreme wealth that grows when spent. It is the wealth that excels all wealth

Research studies

Towards the end of last year, we were in receipt of two research grants by the Azim Premji University.

1. Assessing and Addressing Barriers to Improve Healthcare and Social Security Access for the Elderly in 43 Villages of Rural and Tribal Chhattisgarh

Elderly individuals in tribal areas are highly vulnerable due to poverty, worsening health, and disabilities. With reduced economic productivity, family care for the elderly declines, and those left alone due to family migration face even greater challenges. Limited resources for essentials like food, combined with increasing disabilities, exacerbate their issues. This study aims to map the vulnerabilities of the elderly in these 43 villages, design interventions to improve access to healthcare, nutrition, and social security, and ultimately enhance their quality of life.

The objectives include:

- Mapping the health status of the elderly, focusing on nutrition, morbidity (e.g., diabetes and hypertension), disabilities, and mental health.
- Assessing their financial and social well-being and access to social security.
- Implementing interventions to address identified challenges.
- Evaluating the status of the elderly post-intervention.
- Documenting effective interventions and their costs to improve the quality of life for the elderly.

Assessing health status of the elderly

2. Study of Enhanced TB Package for Particularly Vulnerable Tribal Groups (PVTGs): Implementation Research in Rural Central India

Community level screening

The COVID-19 pandemic significantly impacted the health of the poor, worsening nutrition and reversing gains in TB care, especially for tribal communities. The prevalence of tuberculosis (703 per 100,000) among tribals, particularly PVTGs like the Baigas and the Birhors, is considerably higher than the national average (256 per 100,000). The pandemic reduced TB case detection, leading to advanced disease at diagnosis. This study aims to identify the true burden of pulmonary TB (PTB) among PVTGs through active screening, early diagnosis, and community-centric management, including nutritional and psychosocial support. The research will assess the effectiveness of this enhanced TB care package and document best practices for active case detection, adherence improvement, and the feasibility and cost-effectiveness of interventions compared to routine care, providing valuable insights for organisations working with marginalized communities.

3. Effect of Palliative Care on Adult Cancer Patients Presenting to a Tertiary Care Hospital in Rural India

A prospective longitudinal cohort study, in a sample of 269 patients, was undertaken to assess the impact of palliative care offered to adult cancer patients at JSS by our palliative care team who underwent a rigorous training conducted by Indian Association of Palliative Care. Following a detailed symptom assessment and treatment intent, cancer patients who are seen at a designated OPD and followed up till their 3rd visit from baseline were included in the study. At JSS, the management included addressing the clinical as well as psychosocial complaints of the patients, individual as well as family counselling, chemotherapy, surgical services (both curative and palliative), facilitation for radiotherapy, and occasional home visits for bed ridden patients.

Palliative Care home visit

The observational study highlighted the challenges and benefits of providing palliative care to populations in chronic poverty zones with limited access to quality health services. Key findings include:

- Cancer Demographics: Most patients present at an advanced stage, with a median age of 50 years. The most common cancer type was oral cancer, primarily due to high tobacco use (94% of oral cancer patients had a history of tobacco use).
- Access and Gender Disparities: Despite common gender biases in healthcare access, female patients formed over 50% of the study population, likely due to the low-cost and easily accessible source of healthcare since rural tribal women do not go far from their hamlets. More importantly, because of our robust community outreach programme, the patients from those hamlets were also offered transport and social support to seek care
- Effect of Palliative Care: There was a significant positive impact on pain management, performance status, and quality of life. This improvement was assessed using tools like visual pain scales, ECOG, and EORTC.
- Impact of patient-centred care: Palliative care included pain control, addressing socio-economic concerns, and involving patients in their treatment plans. The availability of opioids, dedicated spaces for patient consultations, and personalized care all contributed to improved outcomes.

The positive effects were evident through both objective measurements and patient-reported subjective experiences.

4. Patient Demography and Disease Characteristics of Breast cancer in a Tertiary Care Hospital in Rural India

Another prospective longitudinal cohort study analyzed patient demographics and disease characteristics of female breast cancer patients at JSS hospital, finding that over 90% came from rural and forest areas with low literacy and socio-economic status. Many patients misinterpreted their symptoms as benign issues like infections or wounds, delaying diagnosis by 1-6 months. Most cases were diagnosed at locally advanced stages, leading to poorer prognoses. Factors like early menarche, delayed menopause, and radiation exposure were not prevalent, but socio-economic barriers and late presentations were significant challenges. The study also highlighted the high prevalence (42%) of triple negative breast cancers in this population. Follow-up rates were low, largely due to patients traveling long distances for care. While 96% of patients received health insurance through PMJAY, financial barriers remained which were mitigated through discounts offered by JSS. To improve outcomes, the study recommended community awareness about breast self-screening, population-wide screening for those over 40, better access to timely care, and addressing socio-economic barriers that hinder treatment.

Trainings and Workshops

Health worker training

In addition to monthly refresher training, our health workers are offered various in-house and external training opportunities. This year, our Village Health Workers and laboratory staff participated in a day-long session on infectious diseases, conducted by a trained microbiologist.

During the year, we faced outbreaks of cholera and malaria, prompting focused training sessions on the identification and management of these illnesses.

Infectious disease training

Postgraduate Medical training and BSc. Nursing

We also continued our NBEMS accredited postgraduate training programmes in DNB General Surgery and Diploma in Family Medicine, with a new cohort of doctors joining us towards the end of last year. Beyond regular seminars and case presentations, Dr. Ajay Sharma (consultant transplant surgeon, Royal Liverpool and Broadgreen University Hospital NHS Trust) contributed his expertise in facilitating the JSS Journal Club, where our residents gain familiarity with research methodologies and the critical appraisal of clinical papers.

Our college of nursing continued running its BSc. in Nursing programme with a team of skilled faculty offering theoretical as well as hands on training. Besides regular classes, their rotational posting at the JSS hospital, community outreach centres, as well as other public health facilities, helps them develop a broader understanding of healthcare needs, challenges, and sensibility required in offering care, especially to the populations we serve who have been historically marginalised.

Awareness generation session by nursing students

Paramedical training

This year, we got a green light from Chhattisgarh Paramedical Council to offer a full-time residential programme for Tribal students as Operation Theatre technicians where they are exposed to theoretical as well as hands on learning. With support from the Tribal Welfare Department and some of our partners, we are successfully running this training programme at no cost to the students. We are awaiting permission to begin a Lab Technician programme as well which we hope to begin soon.

First cohort of OT technician trainees

Clinical workshops

We conducted three clinical workshops this year:
A team from the Department of Emergency Medicine from St. John's Medical University, Bengaluru, visited JSS to conduct a two-day workshop on the management of emergency cases, assisting us in upgrading our emergency care protocols.
Additionally, a team of critical care specialists from Holy Family Hospital, Delhi, conducted multiple-day sessions on critical care management. Both workshops enhanced the knowledge of our doctors and nurses, facilitated discussions on complex cases, and provided valuable insights into mitigation practices.
We also had a senior consultant gynecologist take a few sessions for our healthcare team which were fruitful in understanding complications in pregnancy and health challenges in newborn.

Strengthening the public health system

We hosted a contact programme in Post-MBBS Diploma in Family Medicine for doctors from the public health system, in collaboration with CMC Vellore and the State Health Resource Centre, Chhattisgarh. Multiple batches of candidates benefited from the hybrid learning model, which combined hands-on experience with classroom instruction. Additionally, government RMOs visited the JSS hospital and community programme for exposure and practical experience in managing medical complications.

DOCTORSPEAK

Hear it from our doctors

'When you speak from the heart people will listen with theirs!'

It was October 2000 evening when I went to see Jan Swasthya Sahyog for the first time. I was on a visit to Bilaspur and had heard that some doctors from AIIMS Delhi has started a hospital. Curiosity took me to Ganiyari where I saw a 10 bedded ward and an OPD block. Also met Dr Raman at his residence late evening on the same day.

Subsequently, during my posting at the SECL HQ in Bilaspur, I visited JSS many times. I was highly impressed with their dedication, objectives and execution of work. I happened to meet the four young couples who founded this facility, each busy in making their dreams come true. And each one, besides being highly qualified, had different attitude toward patients, something not seen in this era.

A very merry Dr. Parihar at the 5km mark of our annual marathon

I had an image in my mind about an ideal doctor, which I was fortunate to see in person here. **"परहित सरिस धरम नहिं भाई"** was implemented here by all, including the staff and doctors who came in contact with them and started working here. Overall it was a spiritual experience.

After my retirement I hadn't thought of anything but to join this institute. It was my privilege they accepted me.

Time has flown and JSS Ganiyari has grown from its 10 beds to a 150 bedded hospital, recognised for its high quality care with deep empathy and for DNB in surgery and family medicine, BSc nursing, etc. I have seen over these two decades, a barren campus transformed to a lush green one.

Now I have developed a bonding, a feeling of **अपनापन** with all in campus. I try to not only look after my patients but also all who are involved in their care, from dharamshala to plants on campus, all have become my field of service.

For about 2 years during COVID time I discontinued going to JSS. Upon my return, once an old woman who was my patient told me in a scolding tone - **"कहां चला गया था, अब कहीं मत जाना।"**
Where I will get such love and affection??!

While hundreds of thousands of people are getting years in their life from JSS, I am filling life into my years!

DOCTORSPEAK

Hear it from our doctors

It was my luck that I happened to meet the founders of JSS some 28 years back!

It was just an idea at that time. Frankly speaking, I thought it was utopian. But those guys had a lot of guts and determination.

I am a cancer surgeon by training who thinks a bit out of the box. I got hooked. This was my chance of offering cancer surgery in a rural hospital/setting.

Guess what? It worked.

Tuesdays with Dr. Rahalkar

I would not have dreamt of anything like this when I left the Tata Memorial Hospital, Mumbai in 1989. Besides, the patients who get treated here cannot, at times, afford even to access care at a district hospital. The secondary and tertiary care services offered at JSS have to be seen to be believed. This is only a part.

There are other aspects- organic farming, animal husbandry, self help groups and livelihood activities, trainings, and the academic atmosphere...

India may be the 5th largest economy of the world but the gross inequity has to be seen and experienced on ground to let it really sink in. The abject poverty and state of helplessness with which some of our patients present can easily bring tears to any sensitive person. They who think and write or work towards bridging this huge gap can be easily labelled 'anti-national' or what not. It takes a lot of courage to face the truth and not succumb to the pressure.

The commitment and zest with which JSS is serving the poor of the region with their limited resources, especially in the field of healthcare, would be quite hard to emulate.

My small practice in the nearby town is enough for a living. But life is worth more than just living. Working at JSS adds that worth to my life. It gives it meaning or a purpose. I have got no intention to retire. My fantasy is to put the last stitch and collapse in this OT.

NETWORKING AND COLLABORATIONS

'Your network is your net worth'

JSS has partnered with several grassroots organisations, academic institutions and government institutions in the spirit of mutual learning and furthering the objectives of the organisation. Some of these are:

Forest department in the Achanakmar wildlife Reserve where after several meetings with the department and the forest communities, few development projects were sanctioned with financial support by the Forest department. These include organic/natural farming and livelihood activities in 10 core forest villages, providing bio-fencing for a cluster of farms in the forest villages to prevent wild animals from damaging their crops, construction of 3 bridges on Maniyari river, and installing network booster in core forest villages.

The Zila Panchayat through **DMF** funds has sanctioned projects related to millet processing by SHGs, solar power plant for irrigation and livelihood activities in forest villages, and construction of a godown to safely keep the produce from the villages, before it is processed/sold.

An MoU was signed between **CFTRI, Mysuru and JSS** wherein technology transfer for processing and value addition of local produce can be arranged on an individual case basis. We anticipate that this would prove useful when some of our SHGs are mature to handle this.

A **field visit** for our livelihood team members including some villagers was arranged to **Tribal Health Initiative**, Sittlingi, Tamilnadu. The team came back recharged and enthusiastic to implement several ideas that they had seen in action.

Epilepsy programme with **Dr. Mamta Bhushan**, Professor of Neurology at AIIMS, Delhi. She examined all patients in Anuppur and Dindori, provided training in counseling techniques, and trained local doctors in the public health system on accurate identification of epilepsy, its various types, and appropriate management protocols. The first health camp was organised in collaboration with the **District Health Society** and JSS, introducing 135 new patients into the follow-up programme. In Anuppur, 2 PSG meetings were also conducted to maintain regular contact with epilepsy patients and ensure the availability of their medications through the public health system. The district collectors and the Chief Medical and Health Officers of both districts actively participated in these training sessions and camps. Given the substantial unmet need and the significant benefit provided to patients suffering from this treatable chronic illness, the programme is expected to expand significantly in the coming year.

Academic linkages forged with **Azim Premji University, Bhopal, Tata Institute of Social Sciences, Mumbai, St John's University, Bengaluru, and AIIMS, Raipur**. There was posting of interns and post-graduate students from these universities for periods ranging from two weeks to four months at the field sites of JSS. Depending on their background and duration of posting, they were allotted short studies or activities helping JSS learn about the needs in the community and evaluate the impact of its work. This also sensitized the students to the 'real' issues of our rural and tribal brethren and how they could contribute.

India Fellowship- Two fellows were already posted at JSS since October 2022, while a third fellow joined the organisation in October 2023. This 18-month long fellowship allows individuals and organisations mutually select each other to work for a specific development project or role. These India Fellows are from diverse backgrounds and bring fresh ideas and perspectives to the work on the ground. They are groomed and mentored by the India Fellowship team. One of the fellows is working with the Health System Strengthening team in MP, another with the Livelihoods team in Ganiyari, and a third has recently taken up responsibility of Sickle cell disease screening and field research.

CPHC Alliance- Following the COVID pandemic several countries including India have realized the importance of robust public health systems, especially quality comprehensive primary healthcare. An alliance for comprehensive primary health care has been established and anchored by SWASTI a non-profit organisation. JSS is one of the members of this alliance. Currently the alliance has decided to work on designing district level initiatives under three thematic areas namely design, governance and finance. The plan is to work at the district level to implement this district level strategy for CPHC once a district is ready. Other major members include Blockchain for development, USAID, Piramal Swasthya, and CMS.

Ms. Arti Ahuja, IAS, Secretary, Government of India, visited JSS a few days following her superannuation. She has a special interest in health and nutrition. This was a hectic two day visit where she had a detailed view of all the activities of JSS, delving deep into the how's and why's of the different programmes and lessons that can be used in the public health system and elsewhere. The rounding off session was mutually enriching.

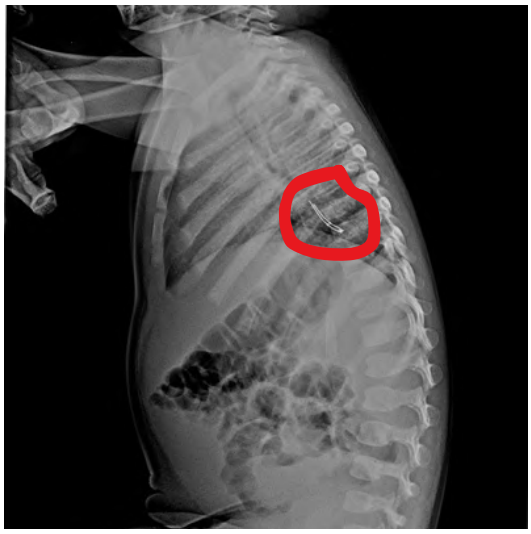
STORIES OF STRENGTH

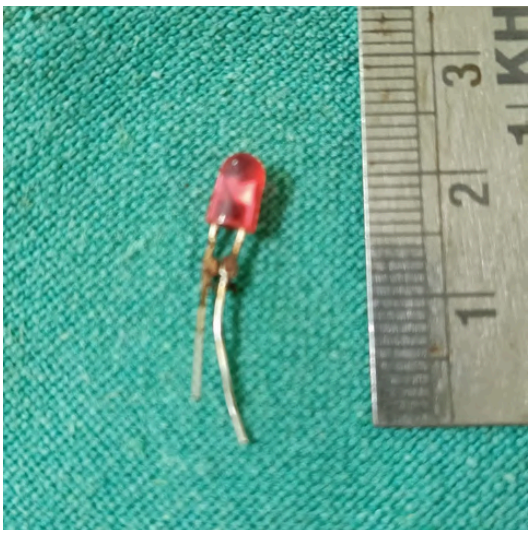
"दिल ना उम्मीद तो नहीं नाकाम ही तो है,
लंबी है ग़म की शाम मगर शाम ही तो है"

~ Faiz Ahmad Faiz

Billu (name has been changed) was hardly 14 months old and had already been to four large hospitals, including one in the private sector, in the State of Chhattisgarh without relief for nearly three weeks. His parents were cursing the day they allowed their child to play with a broken toy and unknowingly the child had aspirated an LED bulb hanging within the toy. He had choked initially, and then it went on as an unrelenting cough. Multiple x-rays, CT scan of the chest and three attempted brochoscopies, brought no relief in removing the foreign body that had now lodged deep into his bronchial tree.

The child was otherwise playful, but coughing intermittently. He showed no signs of infection at presentation to JSS. We attempted a bronchoscopy again but could hardly visualize the metal and glass foreign body in his last part of the bronchial tree. Having no other options, after explaining to the worried parents we took the child for open surgery - a thoracotomy, and identifying the bronchus correctly to cut it open and retrieve the culprit. The baby made an uneventful recovery, seen here with his father ten days later on a follow up visit.





Chaitali Sahu (name has been changed), a 1.5-year-old child, was brought to us by her parents in June 2022. For the past three months, she had developed a large lump in her abdomen. Initially, her parents sought treatment at the government medical college hospital, and later at a government-run super-specialty hospital, where initial tests and a biopsy were conducted.

Despite these efforts, no clear treatment plan had been established even after one and a half months. Out of concern for their daughter's condition, her parents decided to seek care at a corporate hospital in Raipur. There, Chaitali received a cycle of chemotherapy along with additional tests. However, the high cost of the treatment became unaffordable, forcing her parents to discontinue care and turn to Ayurvedic treatment. Unfortunately, Chaitali's condition continued to deteriorate during this time.

It was then that the parents learned about Jan Swasthya Sahyog and brought Chaitali to our outpatient department.

Upon evaluation, we confirmed the diagnosis of childhood hepatoblastoma. The parents were thoroughly counseled about the disease, the need for regular chemotherapy, and the subsequent surgery that would be necessary.

We reassured the parents that Chaitali's treatment would be provided under the Ayushman Bharat scheme, ensuring that the family would not face financial ruin due to medical expenses. Chaitali was started on the PLADO chemotherapy regimen for hepatoblastoma and closely monitored for any complications throughout the treatment process.

As the tumor began to regress, Chaitali was timely referred to the Department of Pediatric Surgery at AIIMS, Delhi, where she successfully underwent a right hepatectomy. She returned after three weeks to complete her remaining cycles of chemotherapy with us.

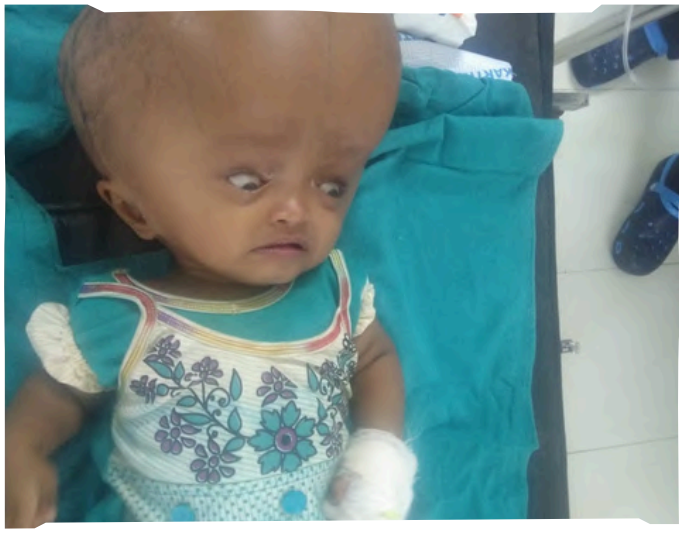
Today, Chaitali is healthy, disease-free, and continues to be monitored regularly through serial ultrasounds and serum alpha-fetoprotein level checks. Her parents are now looking forward to celebrating her second birthday soon- a milestone that not long ago seemed uncertain.

Smriti Manikpuri (name has been changed) was first brought to us when she was nearly 2 months old. Her parents, natives of Chhattisgarh, were migrant labourers working in a brick kiln in Bihar. At 2 weeks of age, they noticed that their child had a large head growing more rapidly than usual.

They consulted several doctors locally and were told that treatment would cost 40 to 50 thousand rupees with low likelihood of improvement.

The mother's grandfather had earlier been successfully treated at JSS. As a result of that the mother came to JSS to seek treatment.

The child was evaluated and found to have obstructive hydrocephalus with periventricular ooze. Left untreated, the increasing pressure would have resulted in atrophy of the brain, resulting in permanent neurological disability.



The child was operated within a couple of days and a right venticulo-peritoneal shunt was inserted which would reduce the intra cranial pressure and allow the brain to develop normally. All this was done under the Ayushman Bharat scheme without impoverishing the family further.

Since then child has been under regular follow up and developing normally like any other child.
At the last visit, the 18 month old could be seen walking and playing with age appropriate speech and other developmental milestones.

PEOPLE OF JSS

It's not the place, it's the people

"Mischief managed"

















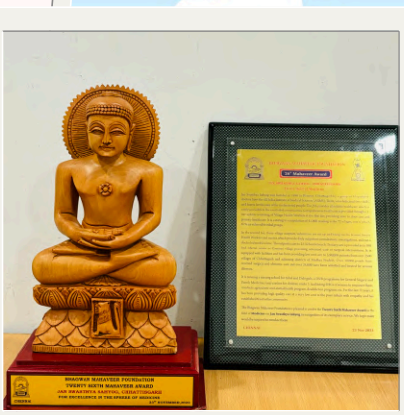







AWARDS AND RECOGNITIONS

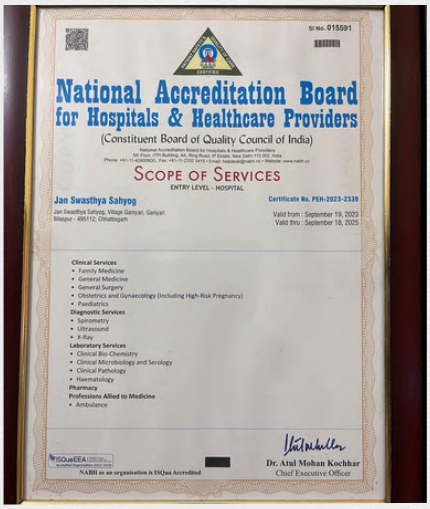
We did good



BHAGWAN MAHAVEER AWARD FOR EXCELLENCE IN THE SPHERE OF MEDICINE

DR. RAMAN COLLECTING THE BMF AWARD HANDED BY THE HONOURABLE GOVERNOR OF TAMIL NADU

RECOGNITION FOR OUR WORK ON SICKLE CELL DISEASE



THE NABH CERTIFICATION FOR THE JSS HOSPITAL

OUR NURSING STUDENTS RECEIVING AN AWARD FOR ROLE PLAY IN "100% MATDAN ABHIYAN "SWEEP-2023 AT BILASPUR

SOME GLORY FOR OUR SURGICAL SERVICES

ON TRIBAL HEALTH

WE ARE ABDM COMPLIANT

OUR PARTNERS

We have a lot to be grateful for

'You've left out one of the chief characters- Samwise the Brave.....
Frodo wouldn't have got far without Sam'

~ The Lord of the Rings

We cannot stress enough how crucial our partners have been in our 24 year journey of improving the landscape of healthcare in rural India. None of this would have been possible without the backing of those 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 through times of trouble and times of glory, and helped us continue our work. Their commitment to our mission inspires us daily, and we are deeply grateful for their trust and partnership in building a healthier, more equitable future for the marginalised communities. There are more partners who have supported us either financially, in kind, or simply by good wishes. The greatest success we achieve each year is the trust, faith, and love of the community and our patients, which drives us to work harder every day.

Mr. P. Jothilingam
Mr. Rajkumar
Shri Ramawtar Agrawal
Shri Sridhar Tripathi
Dr. Piyush Dubey
Mr. Vikash Kumar Dhoot
Mr. N.H. Hussaini
Dr. Dilip Mitra
Shri Gurpreet Luthra
Ms Sangitaben Mukeshkumar Shah
Shri Dashrath Singh
Dr. Kavita Rajeev Gujar
Dr. Yogendra Parihar
Mr. Pawan Sultania

Mr. Ritesh Sharma
Dr. Suman Singh
Mr. Bhartendra Singh Parihar
Mr. Amit Kumar Verma
Dr. Jyoti Agrawal
Mr. Vivek Kalaskar
Mr. Manorath Bajaj
Shri Vinay Govil
Shri Ashwani Kumar Gupta
Mr. Harish Iyer
Dr. R.K. Mishra
Mr. Uttam Das Manikpuri
Mr. L.N. Maheshwari
Ms. Shobhna Kekatpuray

Dr. Sunita Dantare
Shri Vaibhav Chopda
Ms. Uma Venkataraman
Dr. Rakesh Arya
Subimal Chakraborti
Shri Ajay Kukreja
Shri Santosh Uikey
Mr. Sudesh Shingote
Dr. Ajit Man Singh
Mr. Bhaskar Parmanand
Ms. Chitra Sachdeva
Ms. Smita Ratnawat
Ms. Pallavi Jain Govil
Mr. Anand Khediya

Deanna Jejeebhoy
Ms. Arti Ahuja
Dr. Jyoti Singh
Shri Sumit Bose
Mr. Debasis Singh Solanky
Mr. K Shiva Kumar
Shri Himanshu Mishra
Dr. Vasundhara Rangaswamy
Dr. Prasad Ganti
Mr. Deepak Maheshwari
Surabhi Foundation
ML Outsourcing Services Pvt Ltd
MG Charitable Trust
Hospital für Indien

OUR FINANCIAL DETAILS

JAN SWASTHYA SAHYOG
STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED MARCH 31, 2024

Particulars	Schedule	Year Ended March 31,2024 (Rs.)	Year Ended March 31,2023 (Rs.)
INCOME			
Receipts from activities	X	11,56,64,335	11,12,40,070
Donations		42,99,122	48,23,301
Grants Received		8,89,90,213	9,79,55,709
Interest Income		2,08,35,404	1,24,90,089
Interets on Income tax refund		-	7,43,815
Total Income		**22,97,89,074**	**22,72,52,984**
EXPENDITURE			
Drugs & Consumables	XI	4,55,55,240	3,51,68,620
Administrative Expenses	XII	1,43,31,157	1,74,26,980
Research & Development Expenses		11,51,453	14,53,078
Manpower Cost	XIII	12,55,45,885	11,33,46,413
Program & Community Welfare Expenses	XIV	2,75,12,604	2,54,85,515
Depreciation	IV	54,20,999	53,77,832
Total Expenditure		**21,95,17,337**	**19,82,58,438**
Excess of Income Over Expenditure		1,02,71,737	2,89,94,545
Add: Depreciation for the year transferred to Capital Fund		54,20,999	53,77,832
Less: Addition to Fixed Assets (including WIP)		(58,16,753)	(58,32,112)
Transferred to Reserve and Surplus		**98,75,983**	**2,85,40,265**

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

Ved Jain and Associates * New Delhi * Chartered Accountants

(Swarnjit Singh)
M.No. : 080388
Partner
Place : New Delhi
Date : 20-SEP-2024
UDIN : 24080388BKBLV08170

(Dr. Raman Kataria)
Secretary

(Dr. Surabhi Sharma)
Treasurer

For, Jan Swasthya Sahyog

Secretary

For, Jan Swasthya Sahyo

Treasur

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 24 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)