

A Capstone Project Report on
Patient Care for Hypertension Under the National Program on
Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases,
and Stroke (NPCDCS):
Gaps and Enablers in Chomu Community Health Centre, Jaipur,
Rajasthan

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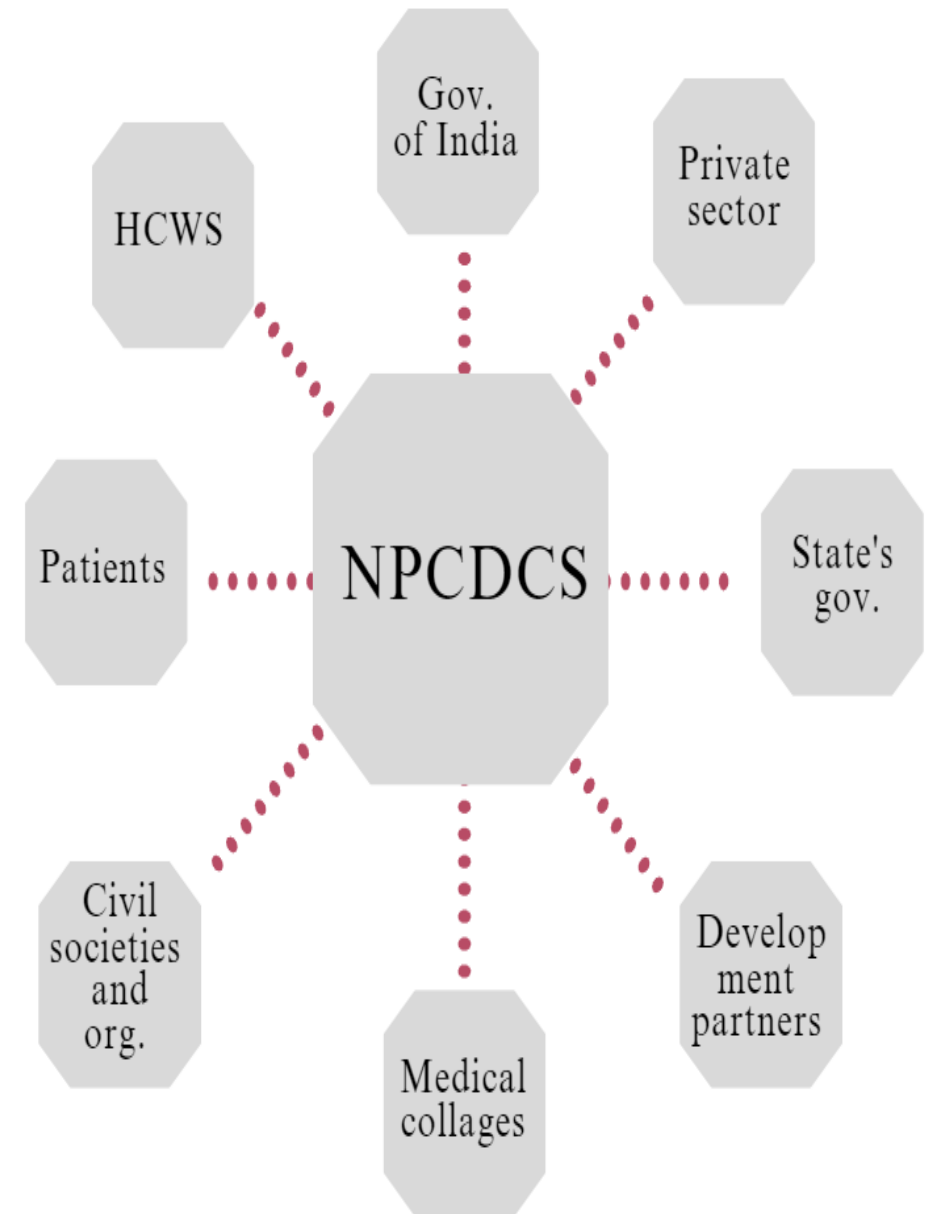
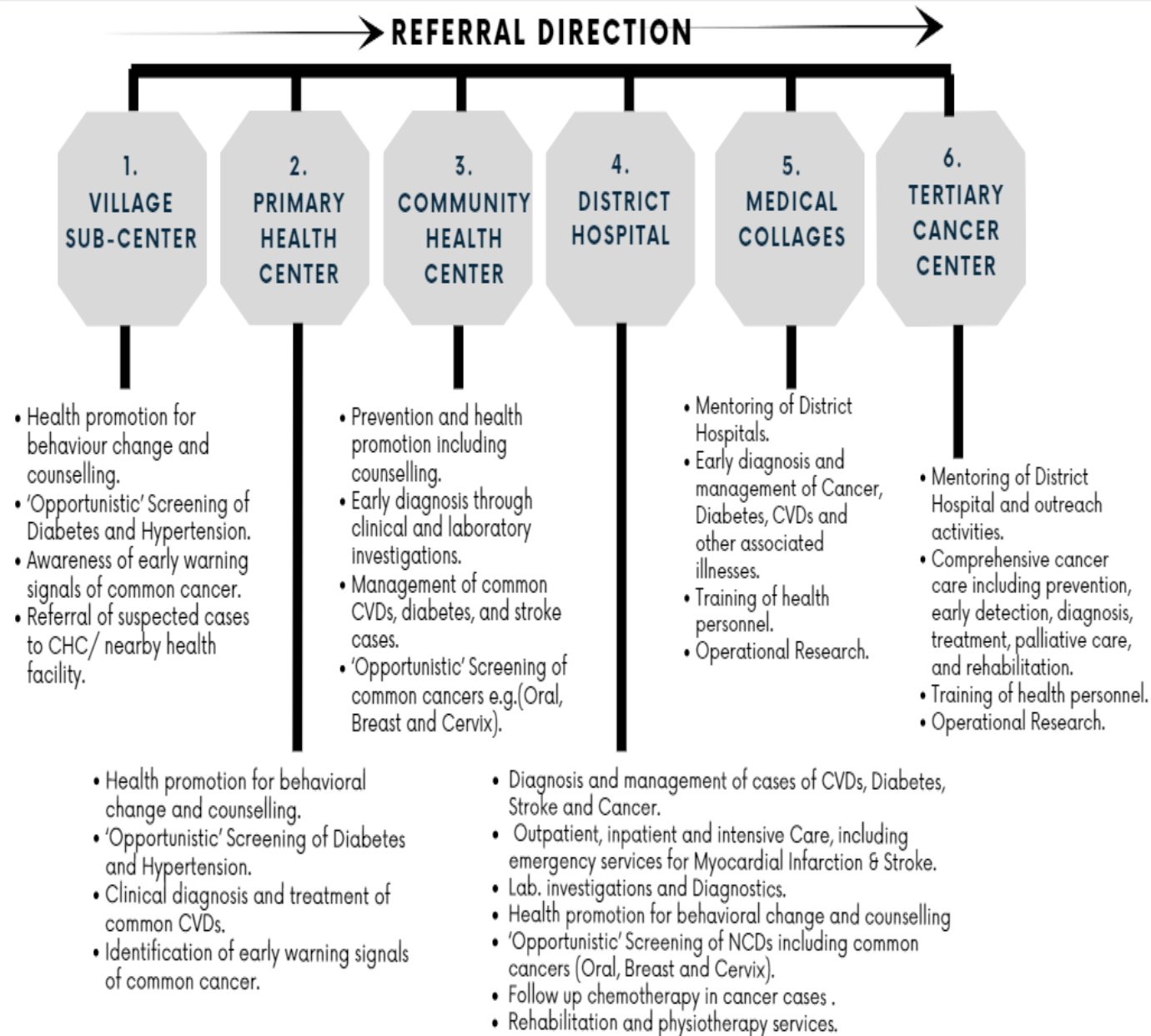
Under The Guidance of:

Dr S.D. Gupta

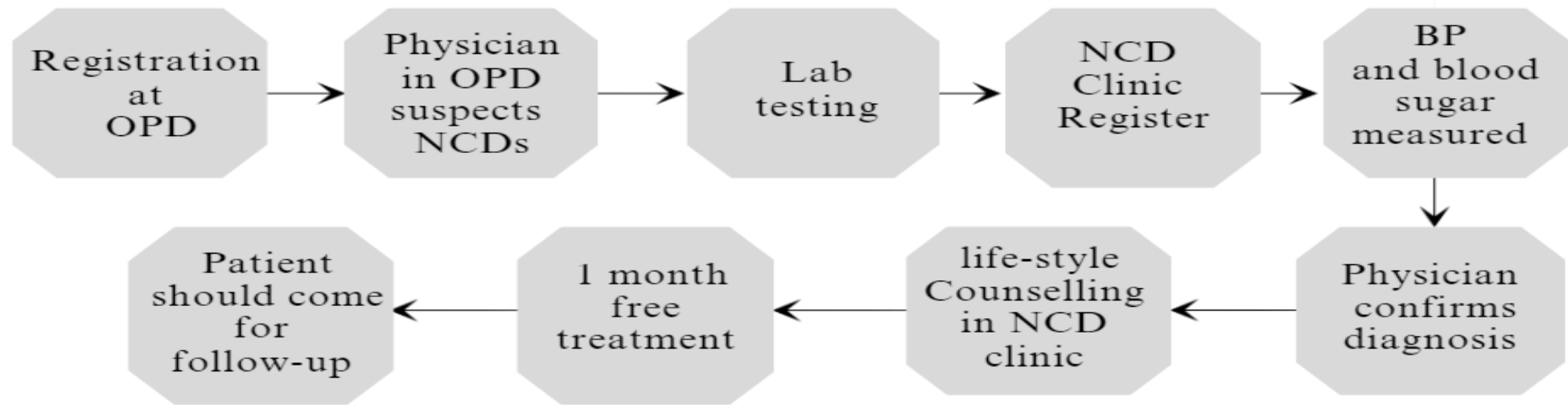
BACKGROUND ON NPCDCS PROGRAM:

- According to 2016 estimates of the disease burden globally, there is a significant burden in India since **62%** of deaths and **55%** of disability-adjusted life years are attributed to NCDs.
- With the goal of **preventing and controlling major NCDs**, the National Program for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was introduced in **2010**, which is focusing on strengthening **infrastructure, human resource development, health promotion, early diagnosis, management, and referral**.
- Objectives of the program:
 - Health promotion.
 - Early detection through Screening.
 - Prevention and control of NCDs.
 - Capacity building of health care professionals .
 - To provide cost-effective services.
 - To monitor NCD morbidity, mortality, and risk factors through a surveillance system.

SCHEMATIC ILLUSTRATION ON THE PROGRAM DESIGN AND STAKEHOLDERS :



PATIENT'S PATHWAY OBSERVED IN THE NCD CLINIC:



WORK AREA OF THE PROJECT:

- Hypertension: Presently, in India, Disability-adjusted life years (DALYs) were predominantly caused by high blood pressure with a percentage of 8.5% of total DALYs.
- The selected area for is the patient care provided for hypertension patients, which is a part of the control process.
- The program strategy: “Management and control of chronic non-Communicable diseases, through early diagnosis, treatment and follow up by setting up of NCD clinics”

OBJECTIVES OF THE PROJECT:

1. To determine the challenges and enablers in patient care for Hypertension provided.
2. To suggest recommendations to address the challenges in patient care for Hypertension.

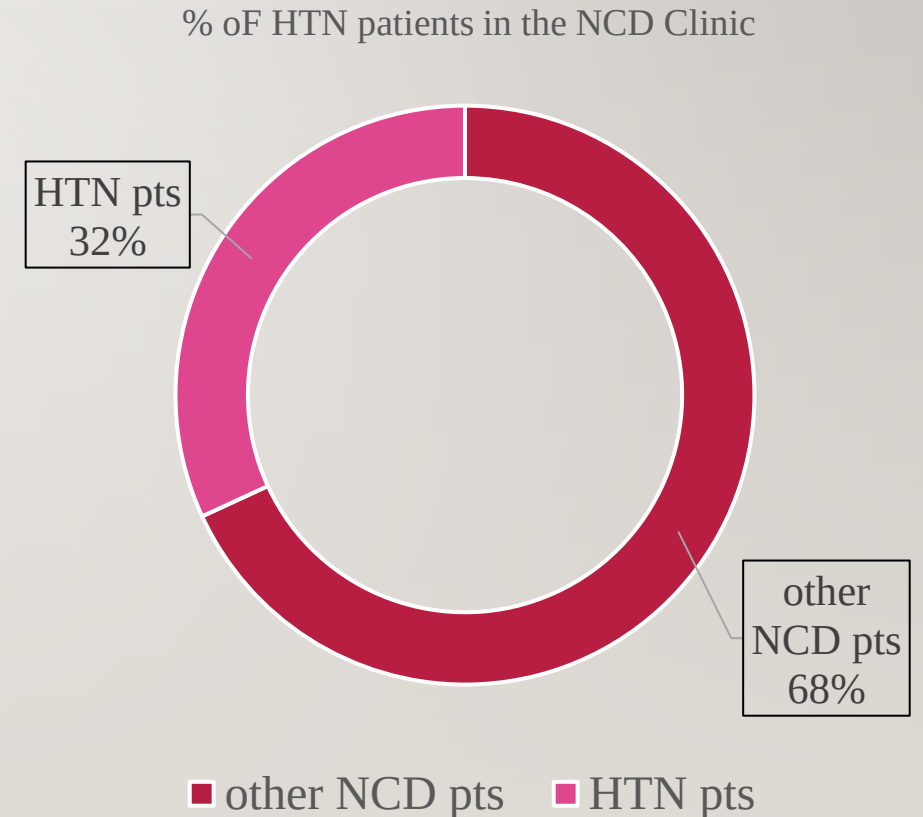
METHODOLOGY OF THE PROJECT:

- Facility: Chomu Community Health Centre, Subcentre.
- Data collected: qualitative and quantitative data.
- Data collection method: interviews, service statistics, and observations.
- Respondents: Care providers (1 MO, 4 CHWs, 2 Clinic staff) and 10 beneficiaries (HTN patients).
- Sampling method: purposive (staff), random (patients).
- Project visits: 4 visits (3 to the CHC, 1 to the subcentre)

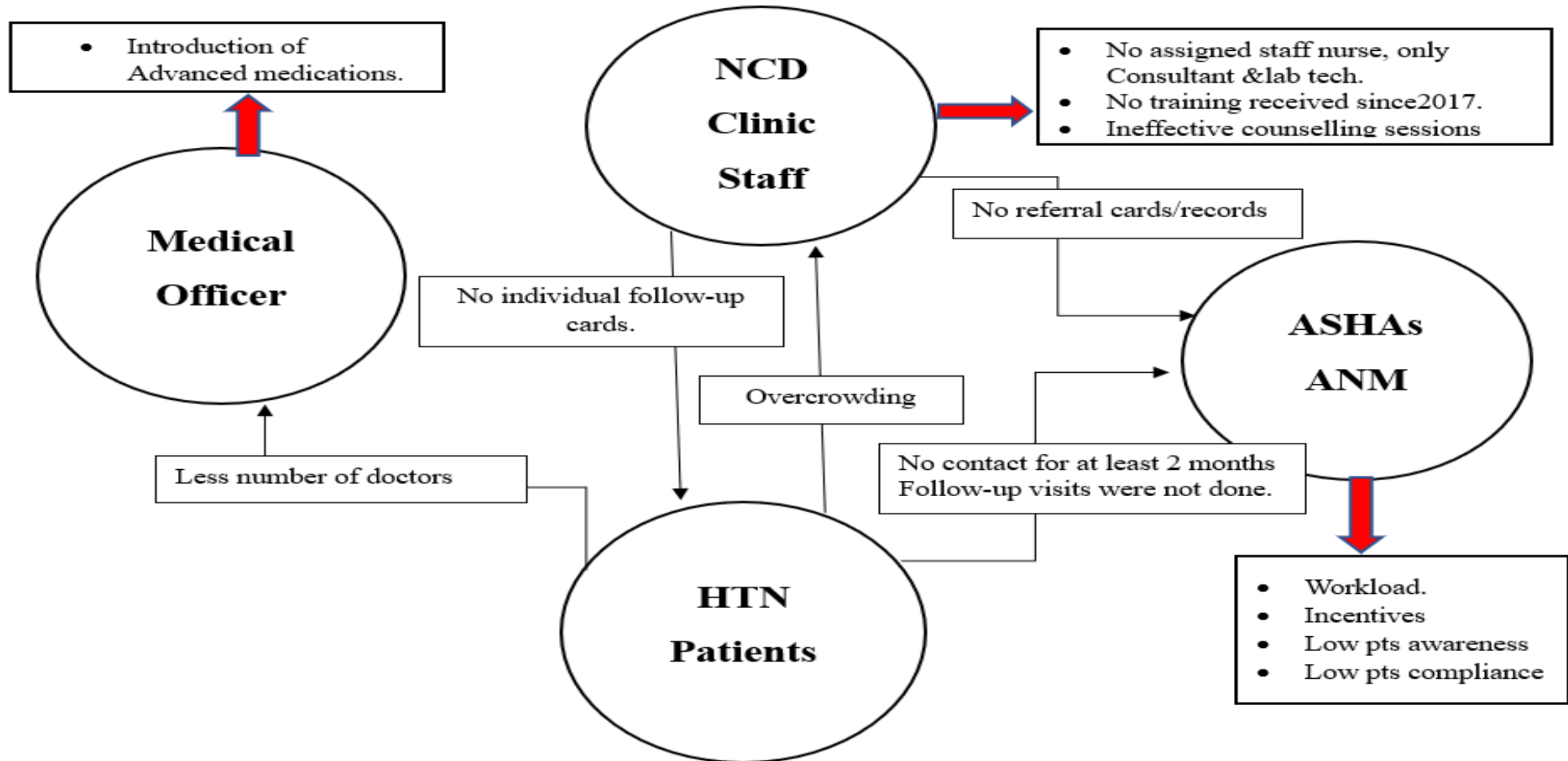
FINDINGS OF THE PROJECT:

The findings are based on provided statistics, interviews notes, observation on the service provided:

- **Service statistics:** According to the service statistics provided by the NCD clinic of only the year 2022, the percentage of hypertensive patients attending the NCD clinic out of the total patients in that year was **32%**, leaving the rest of NCDs with **68%** of patients.
- The high contribution of HTN of the clinic patients highlights the need for **more focus on the quality of care** provided to this big proportion of patients.
- These statistics are supported by the **testimony of the providers** (MO,ASHAs,ANM) that hypertension patients are more encountered than any other type of NCDs.



GAPS OBSERVED IN THE PATIENT CARE PROCESS:



GAPS OBSERVED IN THE PATIENT CARE PROCESS:

In The NCD Clinic:

- No records of referred patients from sub-centre level or referral slip.
- No patient card/booklet for history and follow-up.
- Overcrowding in the clinic settings
- Ineffective counselling sessions.
- No pamphlets provided.
- No assigned staff nurse.
- No training was provided to the clinic staff since 2017.
- Low patient compliance to medications.

In The Sub-centre:

- Low motivation with increased workload and incentives among ASHAs.
- Low awareness levels among community about the diseases.
- Low patient compliance to medications.

Patients:

- Less number of doctors and overcrowding
- ASHAs didn't come for follow-up for at least 2 months back.

The major challenges and problems that with possible solutions and feasibility grades are proposed in the below analytic grid:

Gaps/problems	Suggestive Actions	Feasibility	Priority
No records of referred patients from sub-centre level or referral slip.	• Provision of referral slips that shows the patient referral details.	Swift	
	• Provision of a space in the register that captures the ASHA-referred patients.	Challenging	
No patient card/booklet for history and follow-up	• Provision of cards/booklets for all patient that contains the details of the patients, their follow-up visits, and medication acquisition track.	Challenging	
Ineffective counselling sessions	• Regular training of the staff on the counselling methods, skills, and behavioural change.	Swift	
	• Crowd management in the clinic settings	Challenging	
ASHAs didn't come for follow-up for at least 2 months back	• Strengthening the supervision on ASHAs activities	Swift	
No training was provided to the NCD counsellor since 2017.	• Conducting refreshing training sessions regularly.	Swift	

Furthermore, below are observed **enablers** that contributed to **enhancing the provision of care**, and are expected to be sustained by following the next supporting actions:

Enablers/ Best Practices	Supporting Actions Required for Sustainability
Active monitoring visits for the CHC by authorities (MHFW, NHM, WHO, State MOH)	Clear and organized record keeping will help facilitating the monitoring process and makes detection of areas that need more work.
	Appreciating the noticed improvements will increase the motivation levels among the healthcare workers
Free treatment and diagnostic tests under the Chief Minister initiatives.	Increase advocacy and awareness of people about the service provided will ensure that more patients are utilizing it therefore completing their treatment course.
Effective inventory management in all levels of the health system.	Strengthening the existing system by adopting new technologies and training the staff on them.
Multi-sectorial involvement in implementing the strategies.	Expanding the collaborations with other sectors and valuing the efforts they make to support the program.
Digitalization and using MIS.	Expanding the MIS system to include more features that ensures the quality of data and minimize chances for errors.

CONCLUSION:

- To put it briefly, this report demonstrates the gaps and challenges in patient care for hypertension which starts at the community level, with gaps in **supervision**.
- The extension of the care process was delivered in Chumo CHC, were fully done with mainly **recording, reporting, and training**.
- On the other hand, the high level of performance in **treatment provision, evaluation, inventory management, multisectoral engagement , and digitalization** were all played as process **enablers**.

RECOMMENDATIONS:

- The results of this report show how the **provision of healthcare is improving** in Chumo village in terms of an adequate health workforce, resources, technology, and accessibility of the services.
- In contrast, to provide sustainable services and high-quality hypertension care, **proactive solutions** are required to address **problems and gaps** in patient care.
- These **actionable steps** include enhancing the CHC's systems of **recording, reporting**, as well as providing the health workers with better **training, supervision, and motivation**.

FINDINGS OF THIS REPORT WERE AFFECTED BY:

- Firstly, the small **number of respondents** that might not be representative.
- Secondly, **lack of beneficial service statistics** from the CHC; the full statistics could have been a very helpful aspect in capturing the full picture of the service provided.
- Thirdly, the findings depend majorly on interviews and interactions with providers, as well as beneficiaries, therefore, the gaps mentioned are **limited to their perspective**, and more information might be obtained with the help of official documents and reports.
- Fourthly, the **language barrier** played a role in hindering the process of understanding the context and non-verbal communication, that may have impacted reporting difficulties experienced by the respondents.

INTERACTION'S PICTURES FROM THE FIELD:

- 1. Medical officer in NCD Clinic, Chumo CHC.
- 2. Community health workers in Chumo Sub-center.
- 3. Patients in NCD Clinic in Chumo CHC.



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THANK YOU FOR YOUR ATTENTION !