Community Engagement in Chronic Care: Lessons Learnt from HealthRise India

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Community ownership – a visible reality

“Yes.....Roles have started changing, community is now organizing the health camps”
- District Program Manager after witnessing how the community started its own health camps following HealthRise project’s CLCP model.

https://aidscompetence.ning.com/profiles/blogs/yes-roles-have-started-changing-community-now-organizing-the
HealthRise Goal and Objectives

**GOAL:**
Contribute to 25% reduction in premature mortality associated with hypertension/CVD and diabetes among underserved populations

**Objective 1:**
Increase screening and diagnosis (detection)

**Objective 2:**
Increase management and control of CVD and diabetes (improved clinical outcomes)

**Approach 1:**
Empower Patients

**Approach 2:**
Strengthen Frontline Health Workers

**Approach 3:**
Advance Policy and Advocacy

### Udaipur and Shimla
- **Prevalence**
  - **Shimla**
    - Hypertension: 29.2%
    - Diabetes: 3.3%
  - **Udaipur**
    - Hypertension: 26%
    - Diabetes: 3.7%

- **Rural -80-90 % population**
- **Human resource shortage - 30%**
- **Low levels of awareness & control**
- **Lack of health records and infrastructure**
- **Inaccessible health services**
- **Hilly & tough terrain**
The care continuum for chronic disease

**Total intervention sites:**
- Shimla: 182 villages in 2 blocks
- Udaipur: 62 villages in 2 blocks

**ORWs** = Outreach workers (project staff)
**ASHAs** = Accredited Social Health Activists (public sector)
**PHC** = Primary Health Centres (public healthcare facility)
**CHC** = Community Health Centre (public healthcare facility)
Community empowerment approach in HealthRise India

Community Life Competence Process

S : Stimulate, Support, Share
A : Appreciate
L : Listen, Learn and Link
T : Transfer, Team

The Community Life Competence Process was introduced in 14 villages of Shimla and 5 villages of Udaipur.
For more on CLCP and SALT technique, visit https://www.communitylifecompetence.org/
Preliminary results in CLCP exposed sites in HealthRise India

- **Regular testing**
  - Shimla (n=136): 55%
  - Udaipur (n=22): 77%

- **Treatment Adherence**
  - Shimla (n=136): 69%
  - Udaipur (n=22): 73%

- **Patients taking alcohol**
  - Shimla (n=136): 1%
  - Udaipur (n=22): 0%

- **Food regulation**
  - Shimla (n=136): 39%
  - Udaipur (n=22): 27%

- ** Patients smoking**
  - Shimla (n=136): 6%
  - Udaipur (n=22): 1%

- **Physical Activity – Exercise 5 days a week @30 min a day**
  - Shimla (n=136): 35%
  - Udaipur (n=22): 8%

- **PSG Patients having test values under control**
  - Shimla (n=56): 33.9%
  - PSG = Patient Support Group: 58.9%
  - Udaipur (n=22): 43.8%
  - Udaipur: 63.6%

*Numbers in parenthesis denote %.*

*Source: Self assessment record sheets of patients before and after SALT intervention*
Lessons from community action

1. Family members displayed ownership of NCD care.
2. Health Workers realized - they are members of the same community they serve, thus were more active.
3. Children led by example by playing with adults and showing them ways to stay active.
4. Community displayed ownership to openly address neglected health conditions such as TB and malnutrition besides NCDs.
5. While the focus in most health interventions is on institutional care, people led care via organized community engagement is promising.
6. Recognition by local government and public health workers adds value to the community engagement process by private stakeholders.
Community in action

- Community knowledge fair on CLCP & SALT
- Community organized screening camp
- Morning Walks
- Health talk organized by villagers
Community in action contd..

Exercising women

Villagers cleaning village

Yoga session for women and children

Villagers planting garden vegetables