Innovation Report

Equipping CHWs for Improving Continuum of Care for Hypertension in Urban Health and Wellness Centres

Background: The Comprehensive Primary Health Care (CPHC) policy envisages Health and Wellness Centres (HWCs) to achieve continuum of care for a wide range of healthcare needs. Management of Chronic diseases is a key addition to services now being made available to people, close to where they live. Hypertension is one of the high-prevalence chronic diseases. Once a set of hypertension cases are under treatment, an important challenge is to ensure regular check-ups and medication. This requires each case to visit the HWC at least once a month. This challenge is particularly severe in urban HWCs where the HWCs are at the urban PHC level that cover a very large population, often exceeding 50,000. The number of ANMs is inadequate to adequately cover for services beyond Immunisation and ANC, and they can at best cover RCH and a few communicable diseases. In urban areas, there are no sub-centres or Male workers either. This makes follow-up of identified cases more difficult. In urban areas, the population per HWC is too high for achieving population based coverage of 30 year plus population.

For follow-up, hypertension cases had to go to private practitioners to get their BP measurement, incurring average expenses of around Rs. 140 per month. As a result, less than half of the hypertension cases got a monthly measurement of BP done. This resulted in poor adherence to treatment.

Intervention: In order to address the above challenge, it was necessary to achieve a favourable population ratio with a service provider who can measure BP. ASHAs in urban slums posed such an opportunity. Although the national NCD guidelines and modules used for training of ASHAs under HWCs have a provision for ASHAs to be equipped for measuring BP and blood sugar, it is not mandatory and the option has been left open for the states to decide. A pilot programme was designed to equip 231 ASHAs (known as Mitanin in Chhattisgarh) with skills and digital instruments to measure BP. 231 ASHAs from the slums of Raipur city were trained in use of digital BP instruments and provided the instruments. Their support structure was trained to provide supportive supervision and handholding support in the field. The intervention started from July 2019. Mitanins informed their communities about the need for regular check-ups of BP. Mahila Arogaya Samitis (MAS) were used to spread the message about availability of free BP checking services with Mitanin.

Results: Mitanins found existing cases of BP who were asked to visit urban PHCs for confirmation and subsequent treatment from government facilities. In addition, Mitanins carried out preliminary screening of persons above age of 30 years and referred presumptive cases to urban PHCs for confirmation.

The intervention was assessed at the end of three months. It was found that 92% of the Mitanins had used the instruments. In each month, they had covered 2640 hypertension cases at an average of around 12 cases per Mitanin. The drop-out rate was reduced.

In addition, Mitanins had screened a total of 6431 above 30 age persons over 3 months. The average rate per month is adequate to ensure screening of entire above 30 population in urban slums covered by Mitanins over one year.

It was found to be cost effective. It saved the patients from out of pocket expenditure for monthly BP measurement. The monthly check-ups by Mitanins and their advice resulted in better treatment

adherence. The referrals to urban PHCs increased. Improvement in the availability of adequate quantity of medicines at urban PHCs was needed in order to keep pace with increasing footfall of hypertension cases.

Replicability and sustainability: The cost of equipping CHWs with BP digital instruments was around Rs. 1200 including the training costs. It involved initial one-day training and another one-day refresher. All above costs can be managed within the existing training cost funds approved under NUHM. 5% of the BP instruments had to be replaced during warrantee period. The BP instruments otherwise did not require much repair. The battery cost is small, around Rs.40 per year which can be borne by the MAS. It can be scaled up. There is a plan to scale up the pilot to 1000 Mitanins across 3-4 cities in near future. There can be a case for a similar mechanism for measuring blood sugar of existing diabetic cases as well of above 30 population.

Conclusions and Recommendations: It is necessary to shift the task of BP measurement to ASHAs if the urban slum population has to be screened and followed-up in absence of sub-centres. It is feasible to train and motivate ASHA CHWs to measure BP. It can improve follow-up rates and treatment adherence. It can be an effective and cost-effective measure to ensure coverage of urban population under primary care for hypertension. Such experiments can be extended to other chronic diseases as well.