JAN SWASTHYA SAHYOG

ANNUAL REPORT 2024-25

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

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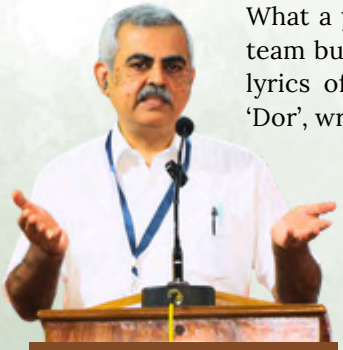
From the Secretary's Desk



DR RAMAN KATARIA
Co-founder, Secretary

What a year, full of reflection, learning, fostering collaborations, team building and action on several fronts! I am reminded of the lyrics of this beautiful and inspiring song from the Hindi film 'Dor', written by Mir Ali Hussain and sung by Shafqat Amanat Ali -

यह होसला कैसे झुके,
यह आरज़ू कैसे रुके..

मंजिल मुश्किल तो क्या,
धुधंला साहिल तो क्या,
तन्हा ये दिल तो क्या

राह पे कांटे बिखरे अगर,
उसपे तो फिर भी चलना ही है,
शाम छुपाले सूरज मगर,
रात को एक दिन ढलना ही है,

रुत ये टल जाएगी,
हिम्मत रंग लाएगी,
सुबह फिर आएगी

Rural and tribal communities and the poorest have been at the centre of all our work and even amongst them, the focus has been on the most vulnerable - children, women, the elderly. Embracing change - the younger generation of our expanding team have brought a breath of fresh air to our work, with new ideas and areas of work while leadership development remained in focus through the year, and our core values are well imbibed.

I had the honor to deliver the IAPS Prof Mridula Rohatgi oration for 2024-25 at the Annual conference of the Indian Association of Pediatric Surgeons (IAPS) at AIIMS, Rishikesh. This was an enriching conference, that also provided a platform to share the work of Jan Swasthya Sahyog with the mainstream pediatric surgical fraternity. JSS hosted the Annual conference of the Association of Rural Surgeons of India (ARSICON 2025) on its Ganiyari campus. This was a first large pan- India meeting and sharing of ideas on diverse subjects pertinent to provision of high quality rural healthcare, including surgical care (vide infra).

The experience of our extensive community level work on sickle cell disease was well received and published in the Indian Journal of Medical Research. The Yash Raj Bharti Samman, a National award for excellence in the field of Medicine, was conferred on Jan Swasthya Sahyog, by the Governor of Maharashtra at a ceremony in Mumbai.

We had an unexpected financial surplus reflecting in our accounts statement for the year, partly due to a longstanding backlog cleared from the government health insurance scheme (PMJAY) of over two years, and partly due to project related funds arriving towards the later part of the financial year, and meant to be expended over the next FY.

There are continuing and significant challenges that affect the health of our communities. Poverty, food insecurity (often seasonal) are ongoing crises which are leading to disasters on a daily basis, that are often unacknowledged. For eg., over 80% of TB in our population is amongst the undernourished and poor and vulnerable communities, something that is preventable and should be the foremost responsibility of the State. Yet, one person dies prematurely every two minutes due to TB (total 3.2 lac deaths in 2023), with the large proportion being among those who are undernourished. The incorporation of the importance of nutrition in our guidelines following the RATIONS trial, is but a small step, and these need to be operationalised with a vigour and urgency seen during the COVID pandemic. And the poor and undernourished are vulnerable not only to infections like TB, leprosy, malaria and community acquired infections presenting late in their course leading to severe sepsis, but also to non-communicable diseases - diabetes, hypertension, cancers, chronic airway disease, sickle cell disease , seizures, mental health disorders, rheumatic heart disease and more. Lack of access to any form of reasonable, quality healthcare makes it highly improbable that a poor person, urban or rural dwelling, with an illness - whether acute or chronic, would be picked up early in its course and appropriate treatment started. OPD care is often impoverishing due to direct and huge indirect expenses. Most poor try to find quick solutions in the hope that they can resume their work and livelihood at the earliest - the reason for quacks to thrive. Insurance, be it the PMJAY or any other, is exclusively for people when they become sick enough to require hospitalisation. And this road is riddled with several obstacles from lack of appropriate documents, distress migration for livelihood, biometric authentication issues, exclusively government reserved packages that limit options available for the poor, and in general poor quality of services, whether public or private in the backward districts.

The onslaught of overt or covert privatisation of even primary and secondary care public health facilities using different models of PPP, have been clearly shown to be exclusionary for the poorest and marginalised. To realize our vision of an inclusive and truly Vikasit Bharat, we need to spend atleast three times our current health spend on Primary and secondary care, rejuvenating these public health facilities with skilled manpower, who need to be not only doctors, but also better trained and empowered nurses, paramedical technicians,

pharmacists, social workers, counsellors, physiotherapists, and others. Digital technology to link the care pathways across primary, secondary, tertiary and supra-tertiary, needs to be harnessed, so that the most marginalised are able to access the level of appropriate care in good time, and with minimum indirect expenses. The provision of high quality drugs and diagnostics at no cost to the patient during these health encounters is mandatory.

Some of the strategies that JSS has adopted are not new, but countercurrent in the present regime of disease centered and high tech, expensive care. These are decades old but have been practised with honesty, grit and humility over the last two and a half decades by our organization. Sharing these learnings briefly here at the cost of repetition.

A. Availability of primary and preventive care close to where people live and provided by one of them - community health worker, volunteer or the ASHA, Anganwadi worker, or ANM is something that is essential to ensuring that the poor get timely care close by. Developing trust in these frontline workers may take some time, but will happen if they are honest and responsive, and supported by the rest of the public health system, co-creating a continuum that acts in synergy. These are tall orders, but our work in rural, predominantly tribal communities in central India, has taught us that this is critical to building an inclusive health care system. Some of the principles that enabled development of this crucial trust were:

- C**ommunity participation** and an ongoing dialogue with the people - Village/hamlet level meetings - going beyond the formal panchayat to include the poorest and socially marginalized, women and involve them actively in decision making.
- **Selection of village health workers** - all women, by the village, many of whom were semiliterate and very poor, but were wise and had good communication skills.
- **Regular Trainings -** Besides the induction training held close to their dwelling for three months, there were **regular refresher trainings** every month, that are continued to date. At these refresher meetings, they discuss about the problems faced, their experiences, besides refilling their drugs and diagnostic kits.
- **A responsive next level of care** at the level of a cluster of 20-25 villages (5000-6000 population) **Health and Wellness centers,** manned 24x7 by mid level care providers and nurses, two each for each HWC. A doctor led weekly clinic at the HWC equipped with lab facility, a more elaborate pharmacy, eye care through technicians, and care and counseling especially for the elderly and disabled. Those requiring intervention at the hospital are referred to the150 bed JSS referral hospital at village Ganiyari - where care with empathy and dignity is provided at minimal or no cost, people's problems are understood and nuanced advice is offered.

B. Peer support for chronic conditions - sharing, learning from other's experiences, motivation to follow long term measures, learning as a group from the physician or therapist or counsellor - all this while follow up and treatment are ensured.

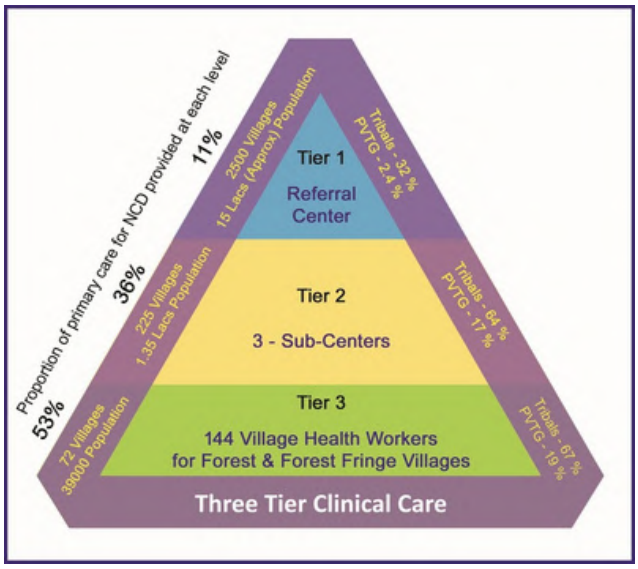
C. Caring within the community/family for those who have faced complications - amputation or near blindness in a diabetic, or stroke or CKD in a hypertensive, or severe Hip arthropathy in a patient with SCD, etc. Role of Health workers, HWC, community physician - reversing what is feasible and improving quality of life where not, within the circumstances and family and social support available.

D. **Migration** for work/livelihood is often a distress response as there are few opportunities for livelihood within the villages. Migration is often exploitative with poor living conditions, bereft of entitlements and proper healthcare and education for children. The family members left behind in the villages are the elderly, weak and disabled, sometimes left in the care of neighbours or an eleven or twelve year old child. Many factors contribute - low investment in villages on quality education, agriculture in general becoming non-remunerative, single rainfed crop, rising dependence on farm inputs that are increasingly getting monopolised and expensive, reduced land productivity, issues with MG NREGA (GRAMG), and markedly reduced access to forest resources.

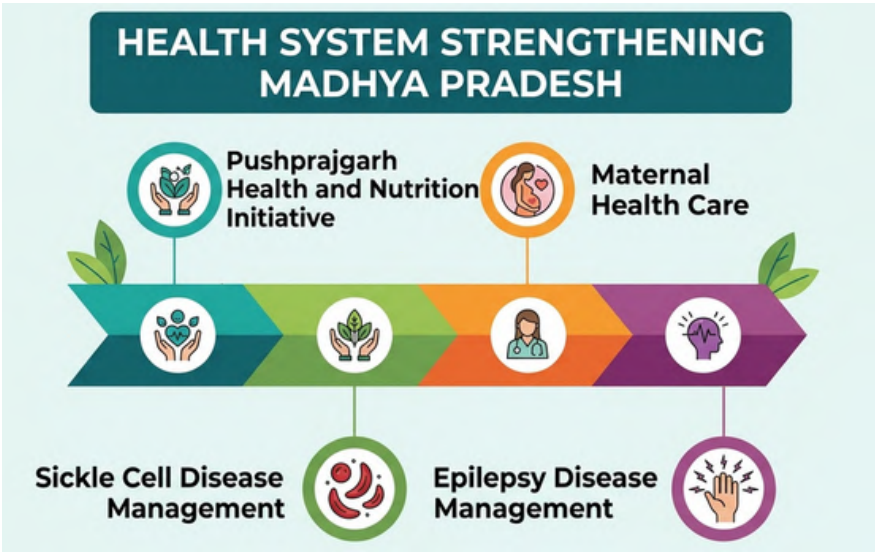
If village communities decide, and get organized to generate livelihood options within their villages- women self help groups understand the importance of nutrition - diversity in their food basket and crops, using natural farming methods and traditional seeds, techniques like SRI, processing and value addition at the village level, and packaging to improve shelf life and help marketing with minimal intermediaries. These interventions not only promote true Gram Swaraj, but also help improve nutrition in villages, take away harmful and toxic chemicals from their land, water and food, and help rejuvenate the land. Our collectives of self help groups and the Garima platform have been working very actively to realise these goals.

Voluntary organisations can play this very important role of being in dialogue with marginalized communities, working with them and catalyse these interventions with minimal external inputs from government schemes (NLM), helping them get their entitlements (Foersts Rights Act) and helping them leverage funds from agencies such as the District Mineral Fund, and special government allocations made for tribals especially the PVTGs. For it is these small affirmative steps that will ultimately make the difference. Rumi, a 13th-century Persian poet and Sufi master, in this profound quote, 'You are not a drop in the ocean. You are the entire ocean in a drop,' speaks to our inner potential and interconnectedness.

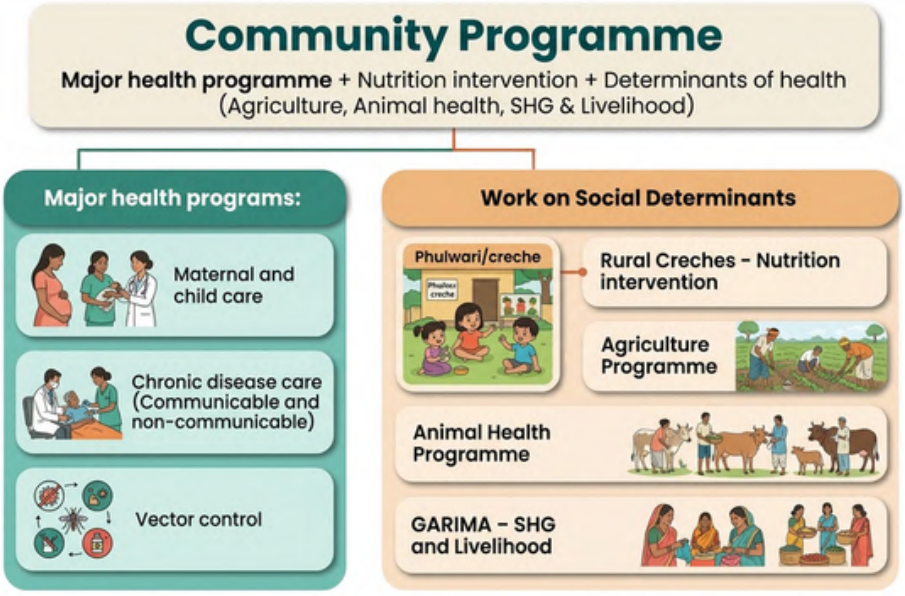
THE JSS MODEL



THREE TIER MODEL FOR CLINICAL CARE



HEALTH SYSTEM STRENGTHENING IN MADHYA PRADESH



COMMUNITY LEVEL COMPREHENSIVE PRIMARY CARE

INNOVATIVE TECHNOLOGY FOR RURAL CARE

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

Village level care by VHWs

Village health workers are the backbone of village health programme. 148 health workers (avg. 2 /village) identify and treat common illnesses in the villages and serve as a first contact for all the health needs in the villages. There were 57305 illness episodes recorded during this period, and the pattern of accessing care is shown in the accompanying pie-chart (Figure 1). While the majority accessed care from JSS (63%), a significant number used traditional healers and quacks (17%). The expenditure on health during these illness episodes is shown in figure 2 where the majority spent less than Rs.100 per episode (65%) and only 7% had to spend more than Rs.500.

Nearly 23 commonly seen health conditions (aches, pain, minor fever related illness, respiratory illnesses, waterborn infections etc) were managed by VHWs at the village level. Some of the lab tests performed by VHWs are slides for malaria, use of RDK for malaria, UPT test and preparing slides for sputum microscopy for TB. 3350 (8.9%) people were referred by VHWs from villages to the JSS subcenter/Ganiyari referral center for higher level care.

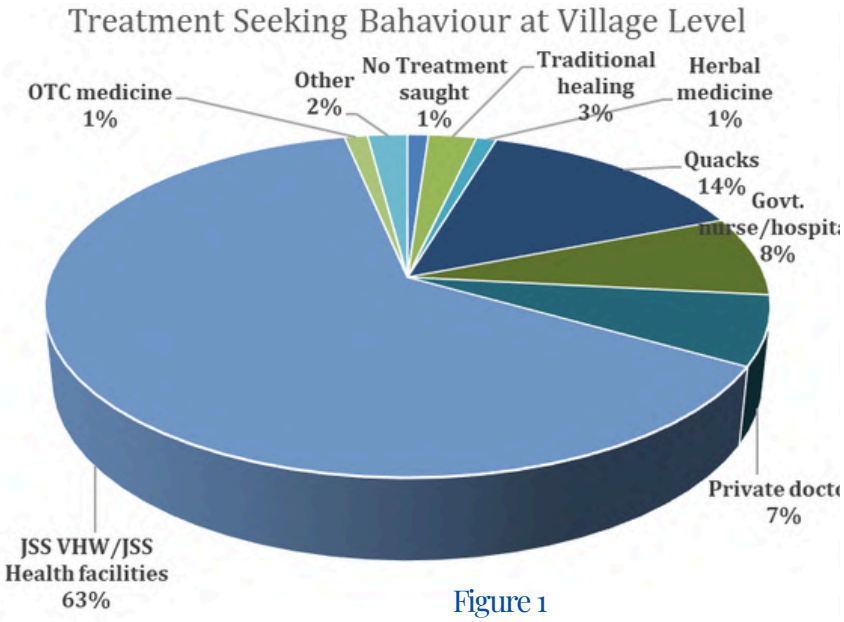


Figure 1

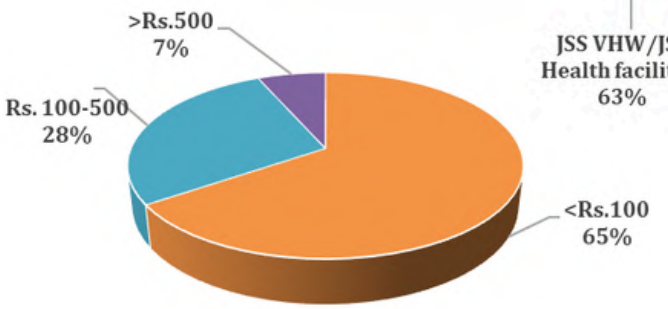


Figure 2 – Health Expenditure

Due to their contact with the community, the VHWs play a pivotal role in running other programmes such as maternal and child health, chronic disease care, prevention of young child undernutrition and different awareness activities.

Care at the subcentre level

Subcenters are staffed 24x7 by two Senior Health Workers (SHWs) and two nurses, forming a link between the health workers at the village level and the doctors at the health facility in Ganiyari. They run the daily OPD at JSS' subcentres while also participating in the weekly doctor-run clinic at the subcenter. They manage referrals by VHWs, conduct deliveries, ensure monthly follow up of all the patients with chronic diseases, as well as are the first responders to handle any emergencies at the subcenter. They also help in running activities of the various programmes at the cluster level. All the SHWs and nurses are supported by a doctor round the clock through telephonic consultation.

Of the **5256** patients seen by SHWs at the subcentre, 52% were females and 6.5% required referral to the base hospital at Ganiyari (Figure 3).

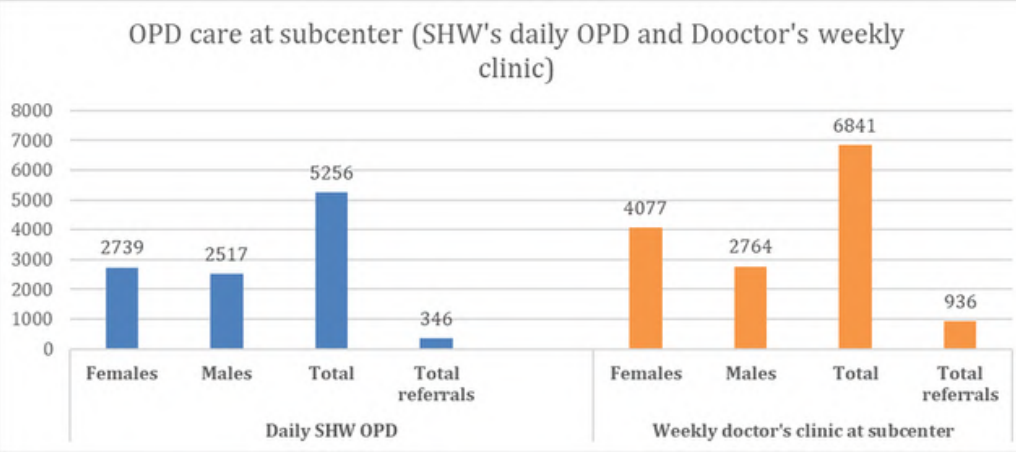


Figure 3

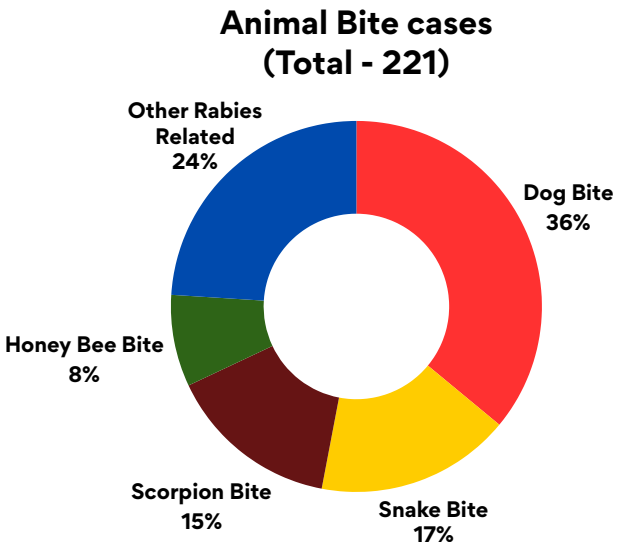


Figure 4

At the weekly doctor-run clinic at the subcentres, 6**841 patients were seen,** of which **59.5%** were female and 13.6% required referral to the Ganiyari base hospital (Figure 3).

Among the emergencies managed initially at the subcentres, animal bites including snake bites and dog bites were prominent Only 9.5% of patients with animal bites needed referral to Ganiyari (Figure 4).

The subcentres also served as delivery points providing comprehensive maternal and newborn care. There were **26** deliveries conducted during this period.

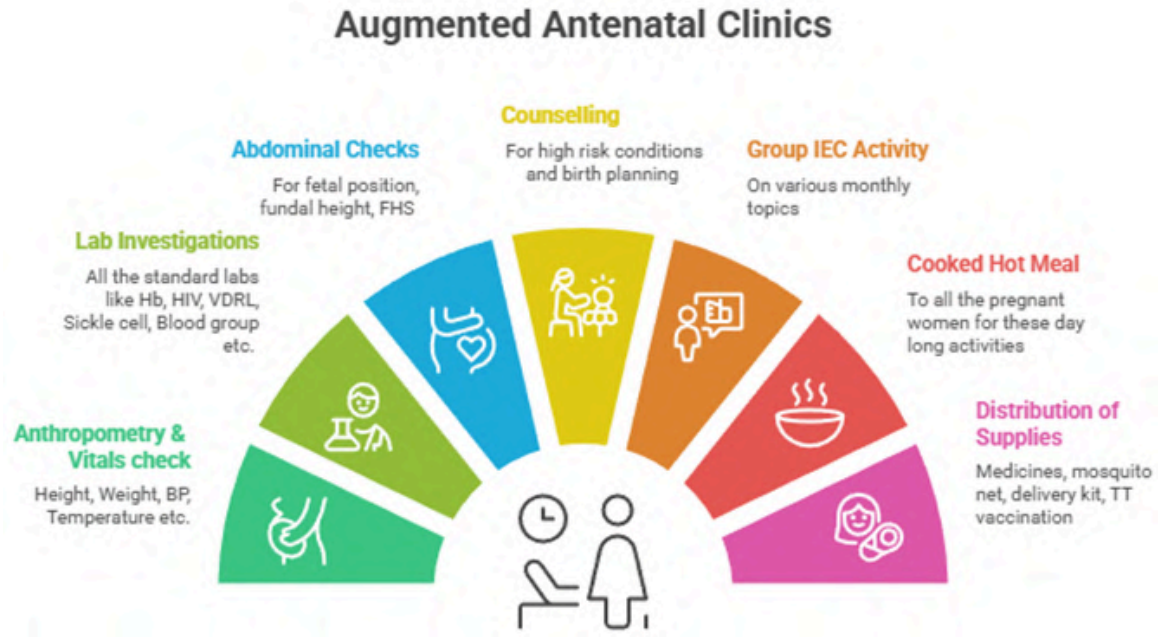
Maternal and Child Health Programme

Antenatal services through augmented antenatal care (ANC) clinics in villages

Objectives of MCH programme

- Registration of all the pregnant women in 72 villages
- Identification of high-risk pregnancies ahead of time through routine augmented antenatal clinics.
- Provision of safe delivery services and surgical intervention and capacity building of TBAs (Local Dais)
- Provision of postpartum mother care and homebased neonatal care

The high-risk pregnant women identified at these clinics are followed up by Maternal and Child Health workers (MCHW) and Village health workers (VHWs) in the intervening month between 2 ANC clinics. 807 new pregnant women were registered this year, of which 42.5% were registered in the first trimester, and there were 4561 antenatal checks were conducted.



ANC clinics were conducted in such a way that no pregnant woman had to walk more than 30 minutes in the 72 villages scattered across the large forest and forest-fringe area. These clinics were conducted at regular intervals at 17 different places as well as at the subcentres. A team of programme co-ordinator, cluster co-ordinator, an SHW and nurses along with VHWs conduct these clinics. The expectant mothers go through various stations at these clinics as detailed in figure 5. Completing their comprehensive checkup, counselling and IEC while also receiving hot cooked meals and their necessary supplies.

Intrapartum care at JSS Health and wellness centres & referral centre at Ganiyari

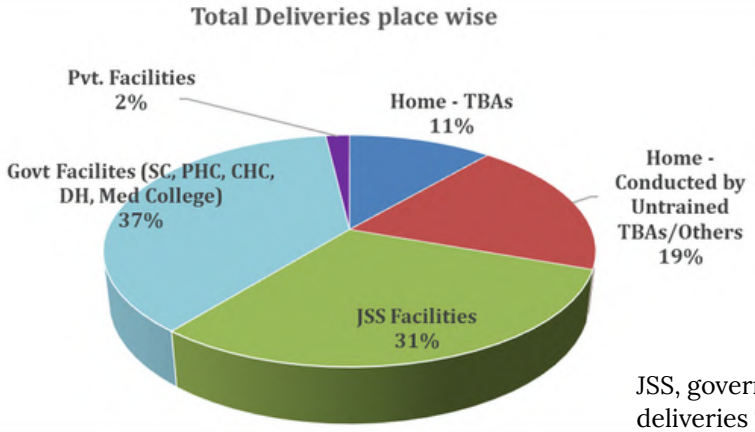


Figure 5

- 70% of the deliveries were institutional in the programme area, of which, 31% were conducted at JSS facilities, 37% at govt facilities and 2% in private facilities. Of the 30% home deliveries, 11% were conduced by trained birth attendants, while 19% were conducted by untrained ones (Figure 5).
- 131 women required C-sections (15.2% of total deliveries).

JSS, government and private facilities : Institutional deliveries TBAs and others : Home deliveries.

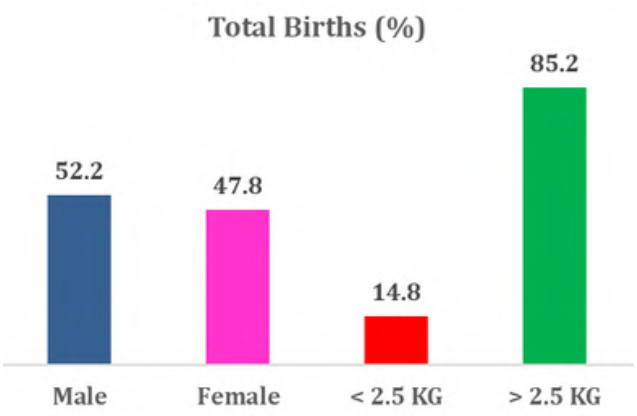


Figure 6

Of the 869 births which happened during this period, 52.2% were males and 14.8% were low birth weight babies (Figure 6).

Capacity building of Traditional Birth Attendants (TBAs)/Local Dais

In view of a significant number of home deliveries in these forest villages (30%), JSS has been training traditional birth attendants (TBAs) to conduct hygienic and safe deliveries at home using the modular safe delivery kit developed by us. All the TBAs (110) and pregnant were given these kits to be used when required either at home or at the place of delivery. The major reasons for continuing home deliveries are inaccessibility (road and no telephone network), fear of surgery, and fear of going to a new place. These TBAs are routinely trained to conduct safe normal deliveries and identify complications as also arranging referral transport for mothers with complications.

Postpartum mother care and homebased neonatal care

Maternal and Child Health workers (MCHWs) routinely visit homes of postpartum mothers for 42 days after delivery. They are trained to identify postpartum infections and other high-risk conditions in mothers and newborn when the risk of morbidity and mortality is high. They provide specialized care to low birth weight babies, counsel regarding newborn feeding techniques, nutritional issues, and contraceptive needs amongst young mothers. MSHWs are also trained in management of birth asphyxia, neonatal sepsis, and hypothermia.

A monthly training-cum review meeting for MCHWs is conducted at the JSS referral center. A recent add-on has been the training of MCHWs in the use of an offline app called “Avni” to facilitate information transfer and data collection.

There were 27 neonatal deaths during this period and 17 babies were stillborn. Low birth weight and pneumonia were the major causes of neonatal deaths. It is sad to note that there were two maternal deaths during this period, despite out best efforts.

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.

878
Births

486
Normal vaginal delivery

392
Delivery through C-section

275
Assisted delivery

227
Low Birth Weight

CASE STORY

Priyanshu was brought to us by his parents when he was 8 months old. His parents, who were daily wage laborers in Anuppur in adjoining Madhya Pradesh, had noticed a lump in his abdomen which was rapidly increasing in size.

On examination, the child was found to have a large mass on the right side of the abdomen.

Considering the possibility of a malignant mass, the child was immediately admitted for further workup and imaging including an ultrasound and MRI of the abdomen.

With a preoperative possibility of a congenital mesoblastic nephroma, which is a benign renal tumor,for which surgery is the modality of treatment, the child underwent a right nephrectomy, from which his recovery was uneventful.

However the histopath report was suggestive of Wilm's tumor which is a common malignant tumor in young children.

The child was started on chemotherapy which consists of weekly injection over a period of 6 months.

11 month old Priyanshu on his last visit for chemotherapy, active and playful like any other child.

CHRONIC DISEASE CARE PROGRAMME

The chronic disease care program, primarily led by SHWs, took care of **2423** patients with major 16 NCDs/ Chronic diseases. **77.8% of them took regular treatment** while the remaining had challenges in adhering to treatment. 285 of these chronic disease patients were newly diagnosed this year.

This year saw the inclusion of new areas into the chronic disease care programme and the skills and capacity of the SHWs. This included participatory learning and action (PLA) module creation on mental health in collaboration with Team Ekjut (group pictured above). The fine-tuning of this newly developed module is an ongoing process.

Another area for new training of SHWs was diagnosing and managing ENT problems, including some emergency conditions. Physiotherapy and physical rehabilitation in the community was integrated in the curriculum of the VHWs and SHWs. Emphasis was placed on reducing consumption of pain killers while integrating healthy practices such as daily exercises, yoga and stretching for common problems of back pain, body ache, and muscle pain.

Total people screened	3493	%
Total cataract	422	12.08%
Pterygium	76	2.17%
Hypermetropia/Myopia	274	7.84%
Presbyopia	149	4.26%
Total glasses given	128	12.42%
Total Cataract surgeries done	85	20.14%

Eye care at the community level including screening for eye problems is now smoothly operating at the village level. A separate eye OPD is established in all three subcenters and those are functional on mobile-clinic days like routine OPDs. School-going children are screened at schools.

Geriatric care: While the research study is going on, identification of the destitute, vulnerable, and needy is simultaneously being carried out in non-study areas. Assistance is provided to them as per the need in the form of aids- walker, crutches, airbeds, hearing aids, spectacles, etc,.

Adolescent care: Adolescents or ***"kishor-kishori"*** meeting are going on regularly with the leads taken by Peer-educators or volunteers. At present, **18 volunteers/PEs** come to Ganiyari regularly for two days' residential training in each month.

A **one-day play-meet-gathering** was organised in Bamhni to encourage girls' sports participation. That even made other youths enthusiastic where the adolescents program is not running, and demand came from other villages to start there as well.

Awareness facilitators are a two-way link with the community - discussing common problems/prevalent health issues including treatment seeking, misuse of anti-biotics and irrational use of injections, while also bringing people's issues back to us for action/more detailed discussions. This information exchange may happen as a meeting or as nukkad nataks.

Another innovation that has been tried this year is to involve active members from the existing support groups with NCDs to become disease champtions. Their training has just started and we hope that they will help and support our team to improve NCD care in the community.

SOCIAL DETERMINANTS OF HEALTH

Health Beyond Hospitals: At JSS, health is understood not merely as access to medical care, but as the cumulative outcome of how people live, eat, work, and earn. This understanding resonates with the **WHO's** long-standing assertion that "*Addressing the* ***social determinants of health equity*** *is fundamental for improving health and* ***reducing*** *longstanding* ***inequities in health***".

In the spirit of **Article 47** of the Indian Constitution, which places a duty on the State to improve nutrition, public health, and living standards, our work focuses on strengthening sustainable livelihoods, improving nutrition, and building community-owned systems that support long-term wellbeing.

Natural agriculture, women's collectives, animal-based livelihoods, and fair market access are not treated as parallel interventions but as interlinked pathways to better health—closely aligned with SDG 2 (Zero Hunger), SDG 3 (Good Health and Well-being), and SDG 8 (Decent Work and Economic Growth).

Women at the Centre of Livelihoods

Women's Self-Help Groups (SHGs) continue to be the backbone of livelihood initiatives. During the year, **84 SHGs** across **41 villages**, comprising **851 women**, functioned as a medium for economic activity, leadership, and collective decision-making.

Beyond income, these initiatives strengthened women's agency within households and communities—advancing our constitutional vision of equality and dignity.

371 women benefited directly from livelihood activities during the year

- **85 women** engaged in individual livelihoods such as milk supply, general stores, stitching, animal husbandry, and vegetable cultivation.
- **28 SHGs** undertook group-based enterprises including fisheries, pig and goat rearing, forest produce collection, hygiene products, food processing, flour mills, and farming

Garima

Linking Producers to People : To reduce dependence on middlemen and improve price realization, JSS established **GARIMA** (**G**ramin **A**tmanirbhar **R**ojgar**I** **MA**nch)— a community-owned marketing platform that connects SHGs and farmers directly with consumers.

Scan the QR code for the product list and to join the GARIMA WhatsApp Group

- 31 SHG-produced items were sold under the GARIMA brand
- Total sales: ₹6,40,960/-
- A dedicated WhatsApp consumer group enabled direct communication and ordering.

A conscious effort was made to build a customer base that values environmentally responsible, nutritious, millet-based foods. Small-scale oil processing has also begun, with plans to scale up through village-level processing units—supporting local economies in line with SDG 9 (Industry, Innovation and Infrastructure).

From Soil to Plate: Community-Led Pathways to Nutrition and Sustainability

"Healthy soils grow healthy food, and healthy food sustains healthy communities."

Across 16 villages, JSS promoted natural and organic agriculture through practical trainings, field demonstrations, and continuous farmer engagement. The focus on soil health, natural inputs, and indigenous seed conservation helped farmers reduce dependence on chemical-intensive practices, lower production costs, and protect environmental and human health.

Reviving Traditional Food Systems: Community ownership was central to strengthening local food systems. The **Jevnaar Mela** in Gram Saraipali brought together around 70 women's groups who showcased over 140 traditional dishes through a fully community-managed event. Folk songs, dances, and participation from neighbouring villages highlighted the link between culture, food diversity, and nutrition.

Community plant nurseries were initiated to locally raise seedlings of improved varieties, supporting timely sowing and seed self-reliance.

Linking Natural Farming with Nutrition and Health: Farmers were trained in preparing Jeevamrit, vermicompost, and green manure using locally available resources.

Community Fencing: To protect crops and improve productivity, villages adopted collective fencing. In Karka, 250 acres of farmland were fenced through collective effort, safeguarding paddy and enabling a second crop after many years. Pulses and mustard grown through this approach were incorporated into household diets. The same model was adopted in Saraipali, followed by utera cropping across 300 acres in Saraipali, Manpur, Karka, and Karpiha.

Nutrition-Sensitive Farming Practices: Nutrition-sensitive practices were further strengthened through multilayer farming, with 10 farmers trained to grow fruits, vegetables, and leafy greens in small backyard spaces, improving year-round dietary diversity for women and children.

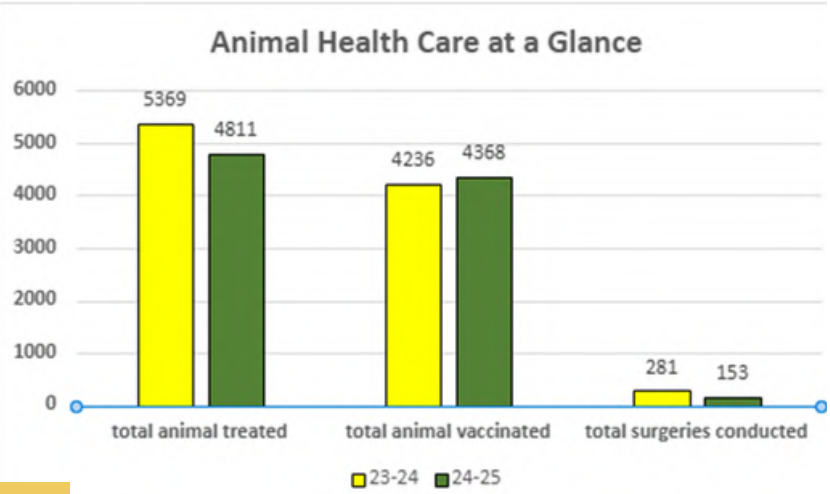
NEW

Six farmer groups were formed to enable peer learning and collective planning. Nutrition and health discussions—covering millet consumption, unpolished rice, and the risks of pesticide exposure—were integrated into SHG and farmer meetings, reinforcing the connection between agriculture, diet, and health.

Caring for Livestock as Livelihood Security

Livestock remains a critical economic asset for rural households. To strengthen animal-based livelihoods without encouraging exotic breeds, JSS introduced a desi Nandi (native breed bull) in one village as a pilot to improve milk production.

Seven community-selected Animal Health Workers were trained to manage common illnesses in cattle, goats, buffaloes, pigs, dogs, and poultry. Supported by a veterinary doctor and field coordinator, the programme now covers 47 villages across three clusters.

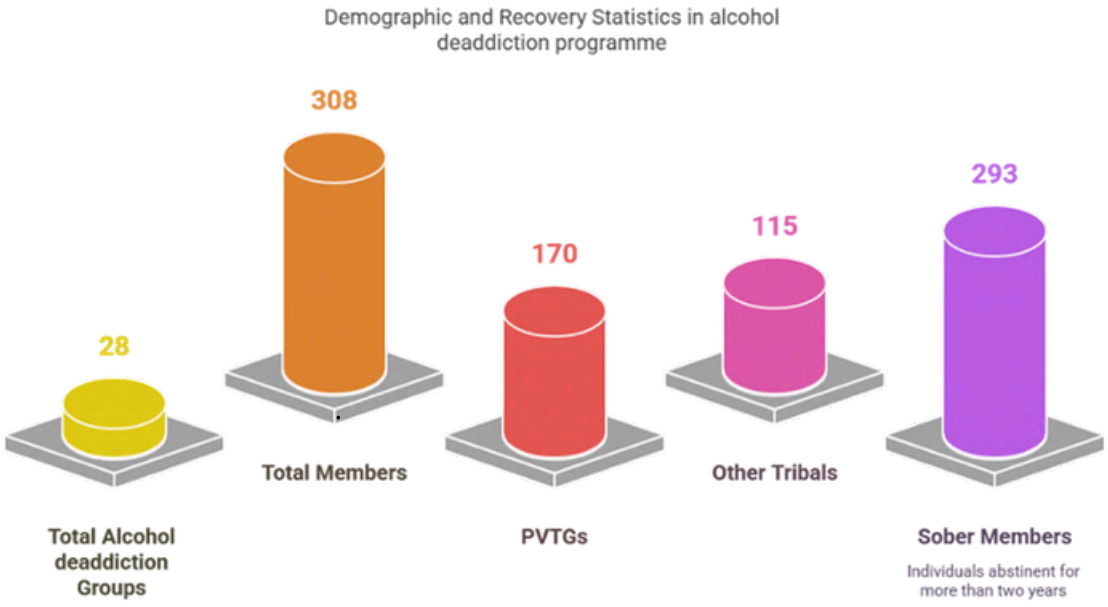


Alcohol De-addiction through Livelihoods

Alcohol abuse has had a disproportionate impact on women and household wellbeing in tribal communities. JSS adopted a livelihood-linked de-addiction model that combines counselling with meaningful economic engagement.

- 293 members alcohol-free for over two years
- 28 groups practicing regular savings

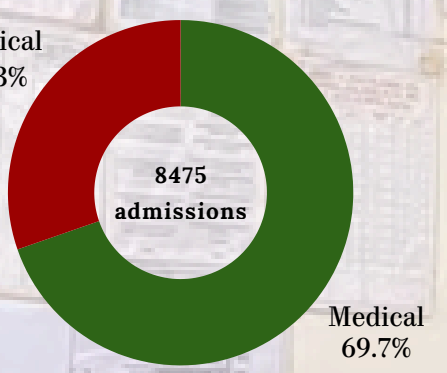
As Mahatma Gandhi observed, “Poverty is the worst form of violence.” Addressing addiction through dignified livelihoods directly confronts this violence.



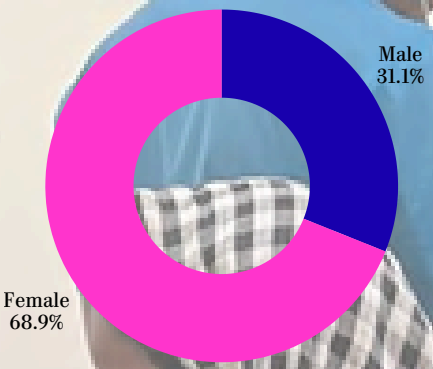
THE BURDEN OF ILLNESS

Over the past year, we provided **64805** consultations through our outpatient services at the JSS referral centre in Ganiyari. Notably, **32.76%** 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. **2701 children** below 15 years age. Consistent with previous years, **women** accounted for **approximately 68.94%** of our outpatient consultations, indicating an encouraging trend of improved healthcare-seeking behaviour among women over time.

Inpatient numbers



Gender wise OPD



The number of new cases diagnosed in the hospital this year:

852	750	424	71	80
Diabetes	Cancer	Tuberculosis	Leprosy	Sickle Cell Disease

CASE STORY

Nilesh Baiga, a 1.5 year old boy was brought to our hospital with a weight of just 4.5 kg suggesting severe malnutrition and a history of requiring repeated blood transfusions, in August 2019. His mother had sickle cell disease and was on folic acid for the same. The father was found to be a carrier of beta thalassemia trait. A diagnosis of sickle cell disease was confirmed in Nilesh and he was started on hydroxyurea. Gradually, his requirement for blood transfusion started reducing. During one of his subsequent visits, his 9 months old sister was investigated and she too was diagnosed to have sickle cell disease. Nilesh, his sister, and mother, all three are on regular treatment from our OPD.

However, the two children grew poorly and also started developing rickets. Subsequently both were diagnosed to have renal tubular acidosis. With the start of treatment, the children started doing well, though they need to be on regular follow up, and require multiple biochemical investigations and venous blood gas evaluation for monitoring the response to treatment.

Nilesh, who is 8 years old now, has been taken care of by all the batches of resident doctors in JSS over the past seven years, as can be visualised by his medical records signed off by almost every resident doctor, thereby providing a continuum of care and also a continuum of cordial relationship with the hospital for this family.

During hospitalization, the whole family would need to stay in the campus, compromising livelihood for up to a week or sometimes even longer, pushing the family further into poverty. Chronic care for debilitating diseases like these, has a potential value not only in improving the quality of life for the individual but also for the economic and social prospects of the whole family. Here, the problem of chronic disease care becomes a problem of social justice, and not just of public health. This problem can therefore be solved by socialising medicine for everyone, as an extension of basic human rights.

But, where do we stand at present, when it comes to preparedness of the public health system to deal with such anissue?

The level of care that these children need is available at a public hospital located in the capital city of the state, as the public sector superspeciality hospital in the district has not yet fully operationalised its critical care facilities.

Nilesh's story can provide many vantage points to discuss limitations of public health systems on many fronts such as supply chain of essential medicines, comprehensive primary health, referral chains, bioethics standards of clinical practice in public or private hospitals, and so on. And yet, Nilesh's story is not at all unique for this purpose, considering the myriad health problems and their presentations that we get to witness at JSS, in many of our patients. The diseases are the embodiments of social deprivation and JSS' work stands out as a testimony to this social evil.

Contrary to this unfortunate reality, JSS provides a warm space for people from marginalized communities and PVTGs, in addition to appropriate and affordable clinical care. While the objective has always been to prioritize primary care, Nilesh's case is one of many examples where JSS extended its support for tertiary care for those who cannot access it. For Nilesh's family, JSS supports their treatment as much as possible, streamlining their care by seeing all three of them together to ensure regular follow up. Even though a complete cure is not possible, treatment with love, empathy and dignity can make all the difference with the children and their mother doing well on regular follow up, changing the quality of life for everyone in the family.

- Dr. Amit Dhage

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.

Leprosy Patient in our OPD

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.

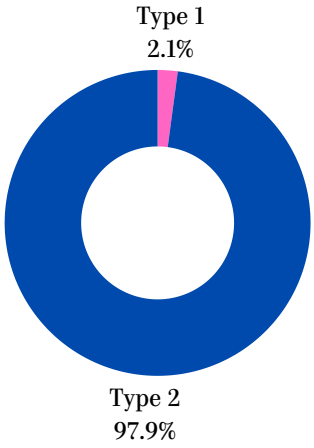
Patient information booklet

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 to 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.

A total of 1963 Diabetes patients visited the OPD this year, and attended group counselling sessions providing information on diet as well as guidance on exercise.

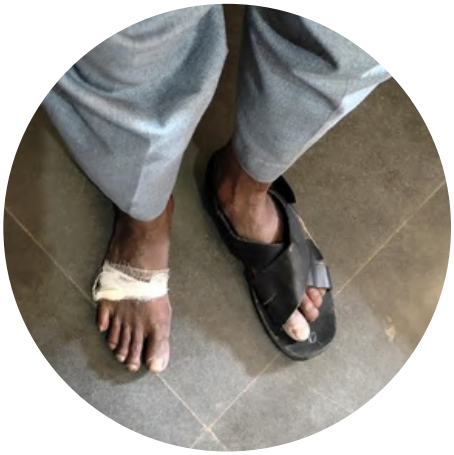
Diabetes type wise



Diabetes is one of the top 3 chronic diseases we see here at Jan Swasthya Sahyog. However, unlike cities where sedentary lifestyle is the primary cause of Diabetes, what we see here in this rural tribal belt of Chhattisgarh is resultant of chronic poverty and undernutrition.

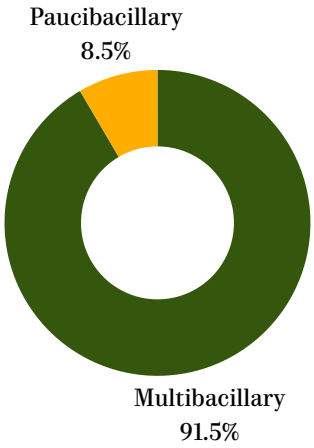
Of the 852 newly diagnosed patients, 32 have associated TB.
At JSS, complete work up followed by individual and family counselling are ensured for all our patients especially those suffering from chronic illnesses. At monthly follow ups, they are gathered through a peer support group led by our senior physician to create a platform for all patients, old and new. This group serves not only as a community of moral support but also a unit to share correct information about the disease, discuss barriers in continuing care seeking, and mitigating them through a dialogue.

Those requiring injectable insulin were able to get it at a minimal cost due to external support provided by JSS partners, uninterrupted.



MCR chappals are made in-house and provided to diabetic patients

Of the 71 newly diagnosed patients with Leprosy -



- **47 tested positive for slit skin smear**
- **13 have Grade 2 deformity**
- **12 presented with ulcers**
- **15 have ENL, a severe, systemic, type 3 hypersensitivity reaction**

DENTISTRY

We saw nearly 3600 patients at the Dental OPD this year where major and minor oral and maxillofacial surgeries are performed, all endodontic, pedodontic, and prosthodontics treatments by Dr. Shital and a team of interns from the dental college in Bilaspur.

We have plans to start a rural dental OPD soon at the subcentre level.

Deaddiction counselling is provided at Ganiyari and at our subcentres.

Patients with diabetes are regular counselled on matters of oral hygiene.

TUBERCULOSIS

Our canteen also prepares **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 samples for AFB and CBNAAT. We detected 6 **cases of MDR** and due to unavailability of facilities required to manage MDR, we referred them to the nearest medical college.

i. Number of samples sent for LJ Culture: 75
ii. No. samples sent for LPA: 183

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.

TB medicine box

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.

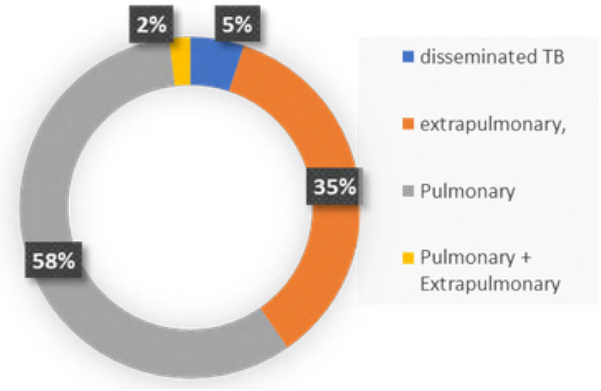
We are currently studying utility of active symptom-based case finding in the PVTG population of two blocks, Kota and Lormi, to understand the burden of unidentified TB along with nutritional supplementation choices and health seeking behaviour barriers and facilitators. The learnings from this would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

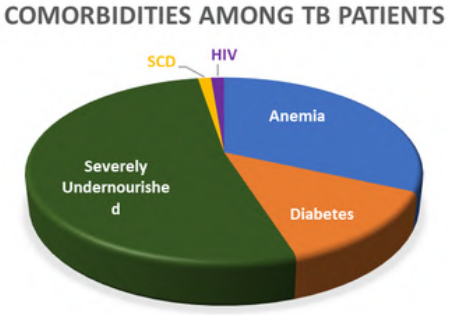

"Which side wins? Love wins.
Love always wins"

TB Study for food supplements

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.





In This financial year a total of **424 new cases** of Tuberculosis were diagnosed, meanwhile 200 already diagnosed patients were also kept on continuation of treatment, so total **624 TB** patients were treated.

A total of **233** 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.

Cancer

CASE STORY

When Aadi was 6 months old, his mother noticed a lump on the left side of his abdomen. They consulted several doctors near Bhilai, where they lived, but no definite diagnosis or plan of management could be made.

The lump kept on increasing in size, and finally the parents brought him to JSS Ganiyari when he was 1 year old.

In view of the clinical features, a diagnosis of Nephroblastoma, which is a common tumor at this age, was considered and the child was admitted for work up.

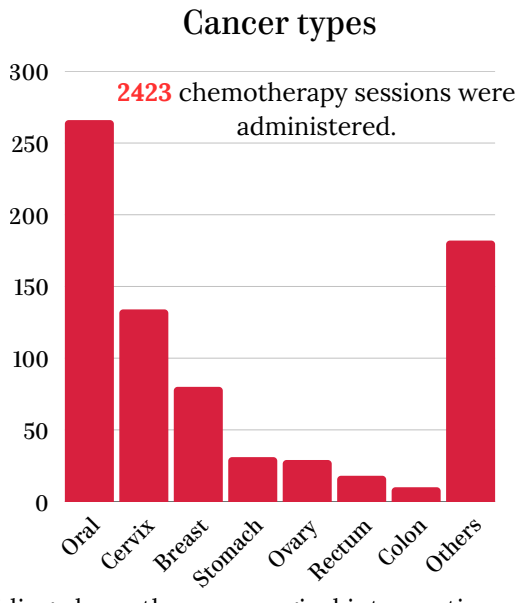
After confirming the diagnosis with ultrasound, the child was started on Para op chemotherapy and after a couple of weeks when the tumor had reduced in size, the child was taken up for surgery.

He underwent a radical nephrectomy followed by chemotherapy and radiotherapy.

The child recovered well with the treatment and is now a healthy 9 year old, studying in class 4.

Cancer is one of the leading causes of morbidity and mortality in this hinterland with oral cancer topping the list, followed by cervical and breast cancer cases. This year, we saw a jump to 750 new cancer patients being diagnosed in a year.

A trained team of women cluster coordinators with other staff conducted 9 women's health camps for screening of three major cancers - breast, cervical and oral. A total of 300 women were screened and 44 referred for biopsy if indicated in examination.



Malignancy care was provided with various components namely providing chemotherapy, surgical intervention, providing palliative, end of life care and training of nurses and other field staff. It has been observed that patients miss their follow up due to various reasons - financial constraint and communications found to be a major challenge with the cancer patient. Linkages have been created between community programme through women's health camp referring to the hospital at Ganiyari and other hospitals in Raipur and Bilaspur.

Ongoing innovations in Appropriate Technology

JSS has been developing health related technologies for past several years. Besides health, JSS has started developing other technologies as well which will be used to address various social determinants of health. This year we undertook development of the following technologies while the older ones were produced for use by patients and health workers.

1. Portable Centrifuge machine with battery back up – A portable centrifuge machine was developed which was required for various lab tests in the remote centers or in the health camps at the village level where electricity supply is interrupted or of poor quality.

NEW

NEW

2. Finalization of insulin box testing – Quality testing has been completed, and the model for the insulin box designed for use by patients in rural areas with unpredictable power supply has been finalized.

3. Digital height meter – Arduino based digital height meter has been developed and now given to creche supervisors to measure heights of Phulwari children. The product is being field tested to be finalized soon.

NEW

4. Yellow torch light for various examinations - Torches with yellow light are required for some physical examinations which are not easily available in the market. JSS developed these torch lights which are now used in the clinics and field.

NEW

DOCTORSPEAK

Dr Meenakshi Deb speaking at ARSICON 2025

When you work where it truly matters, medicine becomes more than a profession - it becomes a purpose.

My association with Jan Swasthya Sahyog Ganyari began in 2020, after my retirement from Coal India Ltd. Having worked in structured institutional setups throughout my career, stepping into JSS was both a new experience and a deeply enriching transition.
What struck me most on my first visit was not just the infrastructure, but the spirit of service that defines this institution. In a resource-limited rural setting, the level of commitment, clinical excellence, and compassion displayed by the team is truly remarkable.

At JSS, patients often come from remote villages, having travelled long distances, many times with very limited means, yet the care they receive is not only affordable but also dignified and comprehensive. There is also a strong sense of teamwork and shared purpose. The dedication of young doctors, nurses & support staff, working tirelessly, is truly inspiring. Even though JSS does not have high end gadgets/equipments, however, with collaboration it is possible to provide near-optimal care.

As a gynaecologist, I have had the opportunity to serve women who otherwise have very little access to specialised healthcare. Many of them come with advanced conditions due to lack of awareness and delayed treatment. Providing care to them, ensuring safe motherhood, and addressing their health concerns, gives a deep sense of satisfaction.

What makes JSS unique is that it goes beyond hospital care. Its work in community outreach, health camps and its connection with the villages reflects a holistic approach to healthcare. The fact that JSS has adopted numerous villages and continues to serve thousands of people, speaks volumes about its commitment.

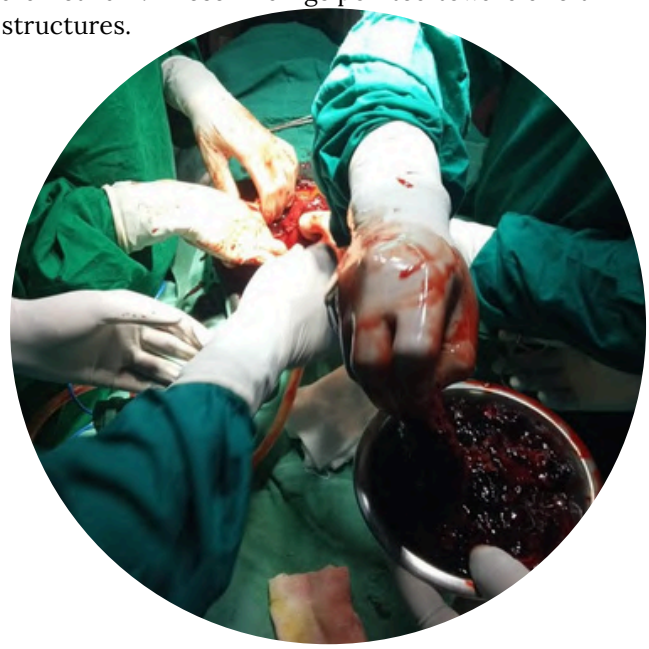
Personally, working at JSS has added a new dimension to my life. After retirement, many people slow down, but here I found renewed energy and purpose. JSS is not just a hospital - It is a movement towards equitable healthcare.

- Dr Meenakshi Deb

A serious presentation, unexpected surprise and happy learning!

Mrs. Divasiya Baiga, a 50-year-old woman from a remote village in GPM, was brought to our Emergency Room with complaints of lower abdominal pain for the past four months, which had significantly worsened over the last seven days. She also reported a progressively increasing abdominal mass, severe fatigue, loss of appetite for one week, and jaundice for the past two days. When I first saw her in the emergency ward, she appeared extremely weak and exhausted. On general examination, she had severe pallor and marked icterus, indicating a serious underlying condition. Her clinical presentation immediately raised concern for a chronic intra-abdominal pathology with recent acute deterioration.

On per abdominal examination, I palpated a firm, boggy, tender mass measuring approximately 8 × 8 cm in the left hypogastrium and left iliac fossa, which was dull to percussion. Surrounding this was a large cystic mass of approximately 20 × 20 cm extending up to the umbilical and epigastric regions, suggesting intra-abdominal fluid collection or hemorrhage. Per vaginal examination revealed a normal cervix with a firm bulge in the left lateral fornix, while per rectal examination showed a bulge in the left parametrium. These findings pointed toward a left adnexal pathology with possible extension into the surrounding structures.

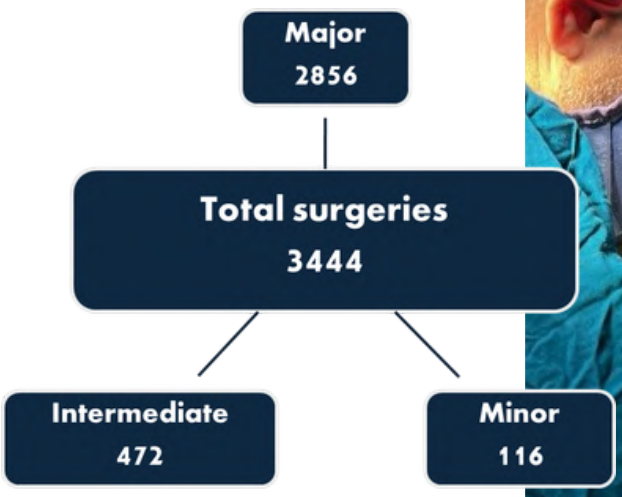


Her laboratory investigations revealed a hemoglobin level of 3.3 g/dL, indicating severe anemia, most likely due to chronic internal bleeding. Immediate blood transfusion was initiated to stabilize her hemodynamic status. Once stabilized, we proceeded with a contrast-enhanced CT scan of the abdomen and pelvis (CECT A+P). The imaging showed a moderate amount of loculated fluid collection in the peritoneal cavity with internal hyperdense areas (HU ~60), suggestive of hemorrhage. Mild peritoneal enhancement and diffuse fat stranding were noted, indicating inflammation. On the porto-venous phase, contrast extravasation was seen through tributary veins in the left adnexa with possible drainage into the left iliac vessels and left renal vein, confirming ongoing intra-abdominal bleeding from a left adnexal source. Given the ongoing hemorrhage and the patient's deteriorating condition, we decided to take her up for emergency exploratory laparotomy.

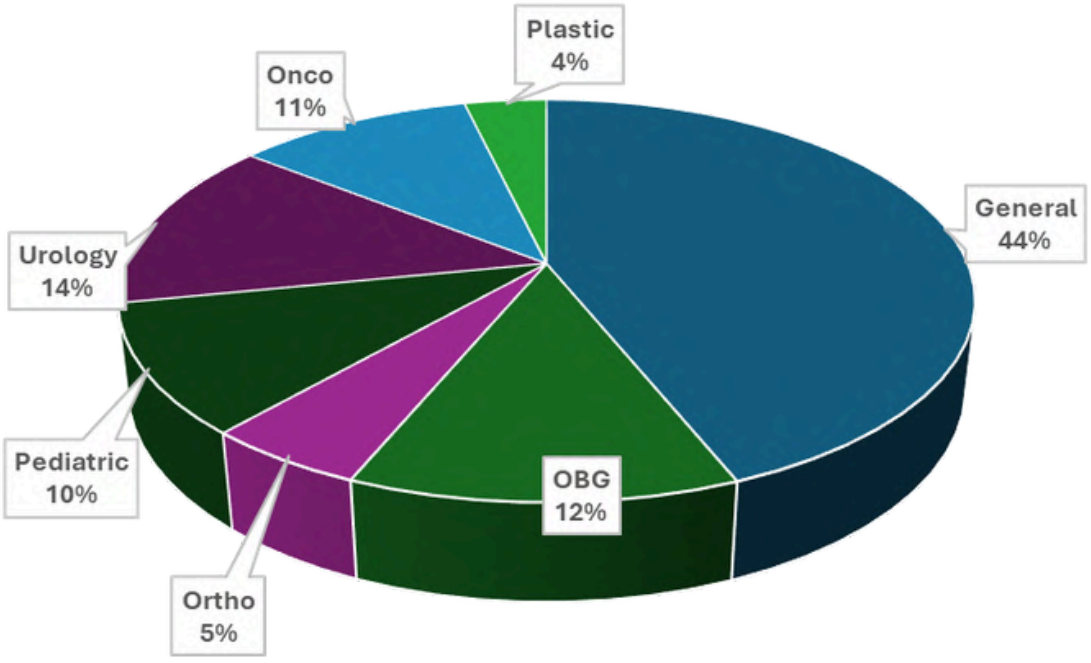
Intraoperatively, we encountered a left adnexal mass with profuse bleeding from the base of the adnexa, with the omentum plastered around the mass, likely as a protective inflammatory response. The bleeding was significant and required urgent control. We proceeded with excision of the left adnexal tissue along with pedicle ligation to achieve hemostasis and remove the pathological tissue. The patient responded well postoperatively. Her recovery was uneventful, and she was discharged in stable condition on postoperative day five. he most surprising aspect of this case emerged after histopathological examination. The report showed tubal ectopic products of conception in the left fallopian tube with non-secretory endometrium. This was an extremely rare and unexpected diagnosis, especially in a 50-year-old woman who was likely in the perimenopausal or postmenopausal age group.

The case highlighted the importance of considering ectopic pregnancy as a differential diagnosis in any woman presenting with an adnexal mass and intra-abdominal hemorrhage, regardless of age or presumed menopausal status. This case was both challenging and humbling for me. It reinforced the need for maintaining a high index of suspicion, timely imaging, rapid resuscitation, and decisive surgical intervention in emergency gynecological conditions. Early recognition and prompt management were crucial in saving the patient's life, especially given her severe anemia and ongoing intra-abdominal bleeding. This case stands as a reminder that in gynecology and obstetrics, atypical presentations are always possible, and clinical vigilance remains the most powerful tool in emergency care.

Surgical Services



Emergency surgeries: 394
Elective surgeries: 3050



Mothers are picking up their children enrolled in Phulwari in the evening.

CASE STORY

Bhavesh Kumar, the second born of twins, delivered at the local medical college developed poor feeding and abdominal distension 2 days after birth while his twin sister remained healthy. He was admitted in the neonatal unit of said medical college and discharged after 10 days .

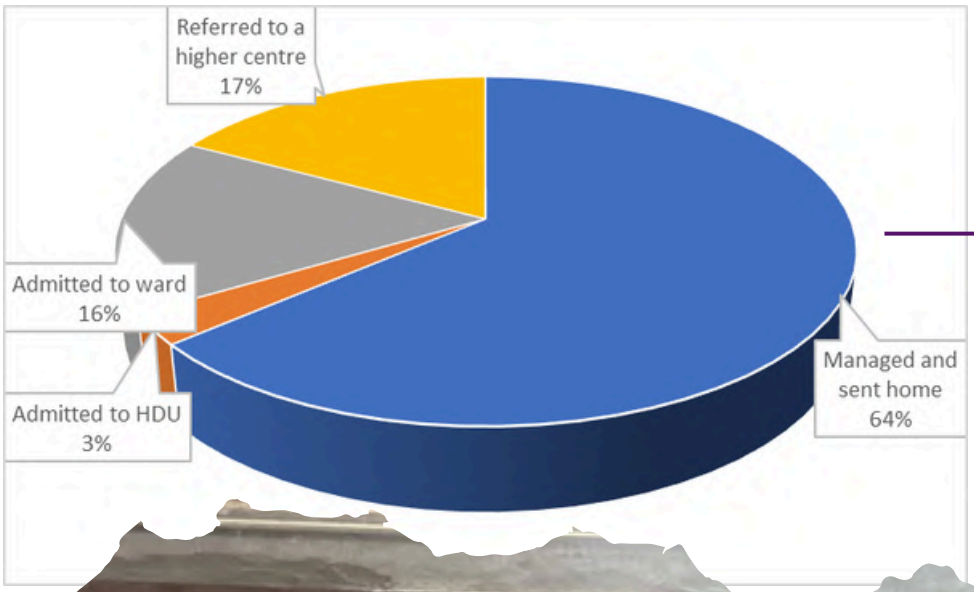
Though he had improved, his abdominal distension persisted and he failed to thrive.
When he was brought to us at 5 weeks of age, he weighed just 2.3 kg, just 100 grams more than his birthh weight.

A preliminary history and examination along with a barium enema led us to suspect Hirschsprung's disease-a disorder characterized by the absence of nerve cells in the large intestine which results in the inability to move the bowels normally. Untreated it can result in severe constipation, failure to grow normally and complications such as perforation and enterocolitis.

The diagnosis was confirmed by a rectal biopsy and correction was carried out by means of 3 staged surgery consisting of a right transverse colostomy, Duhamel pull through and a colostomy closure.

Now, at 6 and a half years of age, Bhavesh is a healthy child, who has just started school along with his twin sister.

Emergency Care



A total of **4917** patients were dealt with at our casualty, **36%** Patients sought care after dark.

Of the **318** patients referred out, **49%** were due to unavailability of beds.

Ayurveda

Around **20** types of health problems are treated using Ayurvedic medicines as per the principles of Ayurveda.

As per the requirement of the patients, we collect medicines, clean them, grind, cook and keep them in the form of tablets or powder or oil or guggulu.

On OPD days, patients are examined and prescribed medicines. Regular counselling is done about the importance of a good diet.

This year, a **new medicine** ***"Rasayan Churna"*** was made which is a blood purifier and is useful in urinary problems (Krichchhra). Another kshaar was made ***"Kadli Kshaar"***. It is used in the treatment of urethral stones.

5 types of oil,
5 types of guggulu,
2 types of other vatis - Lavangadi vati and Guduchi Ras Kriya were made.

DOCTORSPEAK

I joined JSS as a Family Medicine trainee in 2014. My basic aim to join Family Medicine residency program was to acquire skills to practice in rural India as a multi-skilled specialist. Until then, I was unaware about the fact that the role of doctor could be more expansive and could include teaching healthy habits, promoting agriculture and animal health (to solve the complex problem of under – nutrition), train village based frontline health workers (to expand healthcare access), develop technologies to solve health problems, do research on important health topics and advocate at different levels. JSS helped me to understand the problems at a greater depth, gave me an opportunity to be part of experienced solution designing team at different levels at every stage and thus helped me expand my vision of health work beyond just treating to innovating.

At the end of my residency, I was ready to treat but felt need to learn more to solve problems of health systems and social determinants of health. At JSS, while working as a senior resident, I got the opportunity to get involved in community health work which encouraged me to do my Master's in Public Health. While I was attending online lectures and doing my assignments, things on ground and practical involvement in problem solving helped me learn more. JSS also helped me get introduced to the politics of health policies and pushed me into many activities of Medico Friend Circle, Jan Swasthya Abhiyan and put me in touch with many individuals actively working in the field of public health. I could also participate in some national level consultations and implementation research trainings.

The COVID period was marked by crisis, including the loss of a family member and intense workplace turmoil, making it an emotionally and mentally challenging phase. It was a difficult time with a huge unmet need and we responded by setting up a system of an isolation ward and a system of home-based oxygen saturation monitoring with the help of health workers along with continuous awareness. COVID also demanded immediate expansion of the successful strategies and JSS gave me an opportunity to get involved in training non-health organizations in health work. Post COVID, I got involved more into research projects, livelihoods with GARIMA, AppTech innovations and Fellowships, mentoring MPH interns.

Thus, over last 12 years, JSS taught me to work holistically in health, to be with people, use resources and skills for people, train local community to engage in problem solving, set systems for long term changes and more importantly, not to lose hope despite challenges.

- Dr Gajanan Phutke

Health System Strengthening Program

Eastern Madhya Pradesh

A Decade of Dignity-Driven Systems Strengthening in Madhya Pradesh

For nearly a decade, Jan Swasthya Sahyog's Health System Strengthening (HSS) initiative has worked in Madhya Pradesh's most remote tribal districts—where healthcare often begins with long walks and quiet resilience—to build systems that listen, adapt, and endure. Launched in 2016 as a maternal and newborn quality improvement program across six districts (IGUNATMAC), it evolved into a formal partnership with the Government of Madhya Pradesh. Through trust-building, formation of quality teams, mentoring through improvement cycles, targeted training, and continuous support, JSS strengthened care in District Hospitals and First Referral Units.

Districts covered	Blocks	Field team size
Dindori	7	10
Anuppur	4	114
Singrauli	Chitrangi	50

At the community level, JSS expanded into the remote Pushprajgarh block of Anuppur, reinforcing the continuum of care through intensive training and supportive supervision of ASHAs and ANMs, and strengthening Village Health and Nutrition Days, 12 Sub-centres and HWCs, one PHC, and two CHCs. To address severe childhood malnutrition, JSS established 75 rural creches (phulwaris) in Anuppur and 40 more in the mining-affected district of Singrauli. Simultaneously, sickle cell disease (SCD) emerged as a critical focus. Beginning in 2018, JSS launched the SCD Control Mission with NHM and six districts, introducing low-cost screening, diagnostics, lab training, and peer support groups—later shaping the National Sickle Cell Elimination Mission in 2023.

CURRENT SITUATION

Today, HSS integrates maternal health, nutrition, sickle cell care, epilepsy management, primary healthcare, and rural creches across Anuppur, Dindori, and Singrauli. It is no longer a set of projects, but a living system co-created with government, communities, and frontline workers grounded in dignity, resilience, and shared purpose. For details please read upcoming pages...

Sickle Cell Disease Management

Madhya Pradesh bears the highest burden of SCD in India. JSS is supporting the National Health Mission, Bhopal, to manage the disease in **Anuppur** and **Dindori** districts.

The program focuses on **strengthening** the public health system while **addressing critical resource gaps** at the grassroots level.

Training of govt doctors, nurses, and laboratory technicians, along with ongoing **supportive supervision,** is a core component of the Health System Strengthening approach. Regular state- and district-level **review meetings** enable advocacy for timely and necessary systemic actions.

Screening - At the community level, trained screening teams conduct **focused population-based screening**, including **household visits** where required.

Confirmatory tests - Screen-positive cases are confirmatively diagnosed using **Hb electrophoresis developed by JSS** and HPLC machines which are installed in district hospitals.

Counselling - All diagnosed patients receive structured **counselling** through home visits by project **counsellors**, who also ensure regular follow-ups.

Management - The disease identified cases (SS) are enrolled into the **Peer Support Group Meetings** which are regularly conducted at the PHC, CHC, & DH level by the **govt staff,** JSS counselors fecilitate the processes. Where they get their regular check-up, opportunity to meet other wariors, and recieve medications.

Counselling of SCD warriors (SS) by our counsellor at their home

New born Sickle Screening Training for Staff of DH Anuppur

255
Hospitalised patients Supported

3
New training sessions were conducted for the Doctors

Activity	Data of FY 2024-25			Apr 2018 – Mar 2025
	Anuppu	Dindori	Total	
1. Screened by JSS team	2737	3910	**6647**	**118506**
2. SS Cases Identified (Diseased)	209	406	**615**	**3546**
3. Sickle Beta thal + Beta thal (Diseas	2	14	**16**	**55**
4. AS Cases Identified (Gene Carriers)	874	932	**1806**	**22287**
5. SCD PSG meetings	98	113	**211**	**568**
6. Patients attendance in PSGMs	3355	4420	**7775**	**18853**
7. Patients on medication (Hydroxyure	1304	1059	**2363**	**2108**
8. Home visits to SCD patients by cou	586	447	**1033**	**1553**
9. Patient follow-ups (home visits + te	2870	3554	**6424**	**23548**

Total 18 such monthly **peer support group meetings** were conducted at **18** government health facilities. These meetings are facilitated by counsellors, with clinical services provided by government doctors, nurses/CHOs, and laboratory technicians. Peer support groups have played a critical role in improving the quality of life of people living with sickle cell disease.

Comprehensive Primary Health care

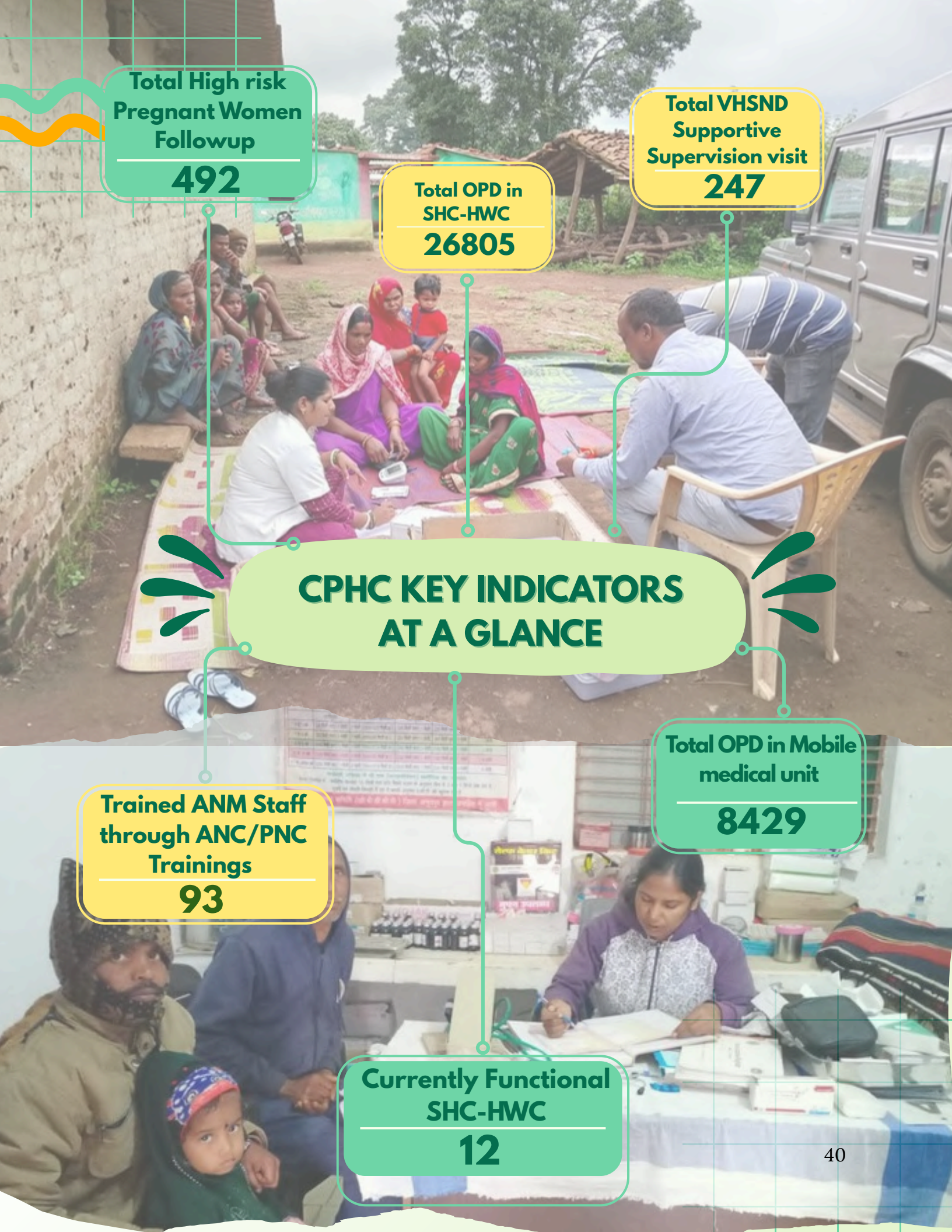
The Comprehensive Primary Health Care (CPHC) programme operates in 74 tribal villages in Pushparajgarh block, Anuppur, providing vital medical and social support. Seven Auxiliary Nurse Midwives (ANMs) are stationed in key locations and handle OPDs, Village Health and Nutrition Days (VHNDs), vaccination 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.

Key Activities of CPHC

- Interaction with community
- VHSND Supportive Supervision
- Gram Arogya kendra Activation
- SHC-HWC OPD and ANC PNC Support and Supervison
- ASHA Training and mentoring
- Mobile medical unit services
- Sector meeting cum ANM/CHO Training
- Community Awareness

ANM Mentor Supporting Health & Wellness centre



CPHC KEY INDICATORS AT A GLANCE

Total High risk Pregnant Women Followup
492

Total OPD in SHC-HWC
26805

Total VHSND Supportive Supervision visit
247

Total OPD in Mobile medical unit
8429

Trained ANM Staff through ANC/PNC Trainings
93

Currently Functional SHC-HWC
12

Epilepsy Care

3 years back there were no Epilepsy case registered in these two districts of Madhya Pradesh, which was caused due to unavailability of epilepsy trained practitioners.

Dr Mamata Bhushan international Epilepsy expert from AIIMS Delhi showed interest to work on identification of epilepsy sufferer patients.

Total of 357 epilepsy patients have been identified in the two districts Anuppur & Dindori through epilepsy camps conducted by JSS with the help of Dr. Mamta. These camps were conducted at the District Hospital & Community Health Center level with collaboration of District Health Societies.

These patients receive monthly check-ups and consultations, along with medication, through patient support group meetings conducted at the CHC and DH where JSS counsellors facilitate the processes and govt health staff (Doctors, & Nurses) provide the medicines. These staff were trained by the Dr Mamata and their team.

Follow-up is also being conducted through home visits and phone calls. Counseling tools—designed for families and frontline workers—help reduce stigma and improve understanding. Hospital referrals are streamlined through clear protocols, ensuring timely access to specialist care when needed.

This integrated approach has helped build trust, continuity, and confidence in epilepsy care across blocks.

Activity	Anuppur	Dindori	Total
1.Patients identified	283	74	**357**
2. Epilepsy PSG meetings	31	5	**36**
3. Home visits to Epilepsy patients	38	0	**38**
4. Patient Follow-ups done	494	74	**568**
5. Patients on AED medication	235	33	**268**

Patient's diagnosis by Dr. Mamata

Govt Doctor's training by Dr. Mamta Bhushan Singh at Anuppur

Monthly Epilepsy Peer support group Meeting at Anuppur

What the local media had to say

जन स्वास्थ्य सहयोग गनियारी का पोषण संवाद अभियान, सैकड़ों ग्रामीणों ने की सहभागिता

पोषण जागरूकता का अनूठा प्रयास, सामुदायिक सहयोग से बना पोषण युक्त पकवान

अनूपपुर ■ राज न्यूज नेटवर्क

पोषण माह के उपलक्ष्य जन स्वास्थ्य सहयोग गनियारी संस्था द्वारा पुष्पराजगढ़ ब्लॉक के 75 गांवों में पोषण संवाद कार्यक्रम का आयोजन कर ग्रामीणों को पोषण और स्वास्थ्य के प्रति जागरूक करने का अनूठा प्रयास किया गया । इस अभियान का उद्देश्य बच्चों, महिलाओं, किशोर, किशोरियों और वयस्कों को सही पोषण के महत्व से अवगत कराते हुए कुपोषण मुक्त समाज की स्थापना करना हैं। स्थानीय खाद्य पदार्थों से स्वस्थ जीवनशैली को बढ़ाने के लिए संस्था के कार्यकर्ताओं ने बताया कि पोषण, शरीर की जरूरतों के अनुसार हमारे द्वारा रोज के भोजन में शामिल किए जाने वाले आहार की मात्रा और प्रकार है। अच्छे पोषण का मतलब है कि शरीर के लिए सही मात्रा में पोषक तत्वों का सेवन किया जाना चाहिए। अच्छा पोषण, स्वस्थ जीवन शैली की कुंजी है। पोषण, स्वास्थ्य और विकास का एक महत्वपूर्ण हिस्सा है । बेहतर पोषण वह है जो हमारे शरीर को मजबूती देता हो,

क्योंकि पर्याप्त पोषण वाले लोग अधिक स्वस्थ रहने के साथ ही अधिक सीखते हैं और अधिक उत्पादक होते हैं। धीरे-धीरे गरीबी और भूख के चक्र को तोड़ कर कुपोषण मुक्त समाज की स्थापना करते हैं। समुदाय की सहभागिता से लाये गए अनाज फल और सब्जी दाल, चावल, कोदो, कुटकी, माड़िया, जवा, गेंहू, मटर, उड़द, मसूर, बरबटी, कंद, अमरुद, नींबू, तरबूज, कद्दू, खीरा, मक्का, भिंडी, तरोई, लौकी, पिटी, मुनगा पत्ति,भाजी आदि

सामुदायिक सहयोग से बना पोषण युक्त पकवान

कार्यक्रम की खासियत यह रही कि ग्रामीण समुदाय ने अपने स्तर पर स्थानीय अनाज, फल और सब्जियों का योगदान दिया। इन खाद्य पदार्थों से पौष्टिक खिचड़ी बनाई गई, जिसे कार्यक्रम में शामिल सैकड़ों लोगों ने एक साथ मिलकर खाया। सामूहिक भोजन के इस आयोजन ने न केवल पोषण के महत्व को उजागर किया बल्कि समुदाय में एकजुटता की भावना भी पैदा की। इस जागरूकता अभियान में कुपोषण के खिलाफ एक कुपोषण जाल खेल गतिविधि भी कराया गया। जिसने लोगों को आसानी से समझाया कि किस प्रकार से कुपोषण का चक्र गरीब परिवारों को जकड़े रहता है और इससे निकलने के लिए सही पोषण कितना जरूरी है। फुलवारी कार्यक्रम के अंतर्गत 6 सेक्टर के प्यारी, लमसरई, बरटोला, सरफा, बडीतुम्मी, सरईपतेरा गांवों में लगभग 650 महिला-पुरुष और किशोरियों ने हिस्सा लिया, साथ ही 700 से अधिक स्कूली बच्चों सहित पोषण संवाद कार्यक्रम में उत्साहपूर्वक बड़ी संख्या में लोगों ने भाग लिया। इस आयोजन को सफल बनाने में जन स्वास्थ्य सहयोग गनियारी संस्था के सुपरवाइजर रामप्रताप, आजाद, रामकुमार, संजय,निर्मल, रमेश एवं फुलवारी समन्वयक, अनीश दारसी, शिवकांत

निरीक्षण

68 मरीजों की जांच कर दी गई दवाई, तो चार नए मरीजों की हुई पहचान

सिकल सेल पेशेंट सपोर्ट ग्रुप मीटिंग में पहुंचे कलेक्टर एवं सीईओ, कार्यों का लिया जायजा

विजय मत, अनूपपुर।

जिला अस्पताल के स्वसहायता भवन में गुरूवार को सिकल सेल एनीमिया पेशेंट सपोर्ट ग्रुप मीटिंग का आयोजन किया गया, जिसमें सिकल सेल के रोगियों के रक्त का परीक्षण करने के बाद डॉक्टरों द्वारा जांच कर सलाह दी गई तथा मरीजों को एक माह की दवाई एवं पोषण युक्त भोजन के संबंध में सलाह दी गई। इस दौरान सिकल सेल एनीमिया के मरीजों को दिए जा रहे उपचार तथा सुविधाओं की स्थिति

का जायजा लेने सपोर्ट ग्रुप बैठक में कलेक्टर हर्ष पोंधोली एवं जिपं सीईओ तन्मय वशिष्ठ शर्मा पहुंचे। उन्होंने सिकल सेल एनीमिया के चिन्हांकित मरीजों के फॉलो अप तथा आगामी तीन माह का रोस्टर निर्धारित कर प्राथमिक एवं सामुदायिक स्वास्थ्य केंद्र में सिकल सेल एनीमिया की जांच कर मरीजों के चिन्हांकन तथा उन्हें अन्य आवश्यक सेवाएं एवं सुविधाओं को प्रदान करने के संबंध में दिशा निर्देश दिए। कार्यक्रम में डॉ एसआर परस्ते, डॉ. धनीराम सिंहश्याम, डॉ. एनपी मांझी, चिकित्सा विशेषज्ञ नोडल सिकल सेल, डॉ. प्रदीप कोरी एमडी मेडिसिन, डॉ. जय विश्वकर्मा, डॉ. शिवेंद्र कुमार द्विवेदी, हिमानी मकरोनिया नर्सिंग ऑफिसर, लक्ष्मी पाटकर, शीतल वर्मा, सुशील द्विवेदी, विद्या भारती, वैयभी, विनय विश्वकर्मा डिस्ट्रिक्ट कोऑर्डिनेटर जन स्वास्थ्य सहयोग संस्था उपस्थित रहे।

चार नए मरीजों की हुई पहचान, 121 परिजनों की काउंसलिंग

जिला अस्पताल में अयोजित सिकल सेल पेशेंट सपोर्ट ग्रुप मीटिंग में 68 मरीजों की जांच कर दवाई प्रदान की गई। यहां कुल तीन शक्ल सेल बॉक मरीज पाए गए, जिन्हें उचित सलाह चिकित्सकों द्वारा दी गई। इस दौरान चार नए मरीज मिले व 121 सिकल सेल हितग्राहियों के परिजनों की काउंसलिंग भी की गई।

जागरूकता

विश्व सिकल सेल दिवस के उपलक्ष्य में गाँव-गाँव में जागरूकता कार्यक्रम का आयोजन

डेढ़ दर्जन ग्रामों में चलाया गया जागरूकता कार्यक्रम

विजय मत, अनूपपुर।

विश्व सिकल सेल दिवस के अवसर पर अनूपपुर जिले के विभिन्न गाँवों में व्यापक जागरूकता कार्यक्रम आयोजित किए गए। इन कार्यक्रमों का उद्देश्य सिकल सेल एनीमिया के प्रति जागरूकता बढ़ाना और लोगों को इसके लक्षण, रोकथाम और उपचार के बारे में जानकारी प्रदान करना था। जागरूकता कार्यक्रम में जन स्वास्थ्य सहयोग गनियारी संस्था के कार्यकर्ताओं ने सिकल सेल एनीमिया की गंभीरता पर प्रकाश डालते हुए कहा कि सिकल सेल एनीमिया एक आनुवंशिक रोग है, जो लाल रक्त कोशिकाओं को प्रभावित करता है और जो एनीमिया (खून की कमी) और जन्म से वयस्क जीवन तक विभिन्न गंभीर समस्याएं पैदा कर सकता है । यह रोग महिला और पुरुष दोनों को हो सकता है । सिकल सेल एनीमिया एक आनुवांशिक बीमारी है, जो जन्म से ही इन्सान में आती है, और कोई दूसरा कारण नहीं है इस बीमारी के होने का रोगी के माता-पिता दोनों में सिकल वाहक या सिकल रोगी होंगे तभी उनके बच्चे को

सिकल रोग होने की संभावना हो सकती है । सिकल सेल बीमारी में लाल रक्त कणिका का आकार हंसियाकार हो जाता है, जिससे रोगी के शरीर में खून की कमी, कमजोरी, बुखार जैसी समस्याएं होने लगती हैं । शुरुआत में इस बीमारी का पता लग जाये तो बहुत सारी समस्याओं को कम/खत्म किया जा सकता है एवं रोगी की जिंदगी को बेहतर बनाया जा सकता है । जागरूकता और सही जानकारी ही इस रोग से लड़ने का सबसे बड़ा हथियार है। इस दौरान कातुरदोना गाँव के सक्रिय महिला साथी रामरति बाई ने कहा कि इस तरह के जागरूकता कार्यक्रम हमारे गाँवों में स्वास्थ्य के प्रति जागरूकता बढ़ाने में महत्वपूर्ण भूमिका निभाते हैं। हम इस प्रयास को निरंतर जारी रखेंगे और लोगों को स्वस्थ जीवन जीने के लिए प्रेरित करेंगे। गाँव के लोगों ने बड़ी संख्या में इस कार्यक्रम में भाग लिया।

जन स्वास्थ्य सहयोग गनियारी संस्था के जिला समन्वयक ने जानकारी देते हुए बताया कि अनूपपुर जिले के कुल 20 गाँव में सामुदायिक बैठक एवं जन संपर्क कर सिकल सेल विषय पर जागरूकता अभियान चलाया गया ताकि जन-जन में अधिक से अधिक सही जानकारी पता चले सकें एवं गाँवों में गलत भ्रांतियों को बढ़ने से रोका जा सके. जागरूकता बैठक कार्यक्रम का समापन सिकल सेल पम्पलेट वितरण करते हुये धन्यवाद ज्ञापन के साथ हुआ, जिसमें सभी सहभागियों और आयोजनकर्ताओं का आभार व्यक्त किया गया। इस कार्यक्रम में स्वास्थ्य विभाग की टीम गाँव की आशा,ए.एन.एम. सेक्टर सुपरवाईजर, पंच सरपंच एवं ग्रामीण जन उपस्थित रहें. इस कार्यक्रम को सफल बनाने में मुख्य रूप से जन स्वास्थ्य सहयोग संस्था के सदस्य लैब टेक्नीशियन शीतल धुरिया, काउंसलर लक्ष्मी पाटकर एवं पवन गुप्ता ,ए.एन.एम. मेंटर,सावित्री सूर्यवंशी, माया खरे, रीमा पैकरा, शीतला खरे, फुलवारी सुपरवाइजर रमेश, रामकुमार एवं प्रोजेक्ट असिस्टेंट पवन सिंह की सराहनीय भूमिका रही.।

PHULWARI PROGRAMME

Combating undernutrition in children under 3 through rural creches

“ये तो है सर्दी में धूप की कि रणें, उतरें जो आँगन को सुनहरा सा करने मन के अँधेरों को रो शन सा कर दें, ठि ठुरती हथेली की रंगत बदल दें खो ना जा एँ ये, ता रे ज़मीं पर”

Hunger remains a persistent challenge in rural India. Nutritional levels (especially among tribal communities) are deeply concerning, exposing populations to chronic diseases that further entrench poverty. While overt food insecurity has reduced over time, the average Body Mass Index (BMI) among the communities we work with remains significantly below national reference levels.

Children under six months of age generally receive adequate nutrition through breast milk. However, the lack of nutritious complementary feeding thereafter leads to progressive malnutrition beginning around six months, peaking between two and three years of age. Malnutrition during early childhood results in poor physical and cognitive development, with lifelong consequences that perpetuate cycles of undernourishment and poverty. Key drivers of child malnutrition include **unavailability of nutritious food**, long working hours of mothers, **absence of adult caregivers during the day,** and limited knowledge regarding children’s nutritional needs after six months of age. Young children are particularly vulnerable as they cannot feed themselves and often have no one to feed them regularly.

In tribal-dominated regions of Chhattisgarh characterized by dense forests, remote hamlets, and widespread poverty, both parents are compelled to work, leaving young children in the care of older siblings, who are often forced to drop out of school. This reality led us to a simple but transformative question:

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

In this backdrop, Jan Swasthya Sahyog (JSS) initiated the Phulwari (Rural Crèche) Programme, establishing the country’s first rural crèche model to address childhood malnutrition through a community-driven approach. The programme trains women from within the village (who is **selected by the community** through community meetings) to run crèches for at least **Seven hours** a day, six days a week **(9:00 AM to 4:30 PM** or until parents return). This model builds strong community ownership, ensures parents’ trust in their children’s safety, and simultaneously creates local livelihood opportunities, contributing to economic resilience. This culturally relevant model has led to greater acceptance and active participation among the community.

Children Having meal in phulwari observed by phulwari worker

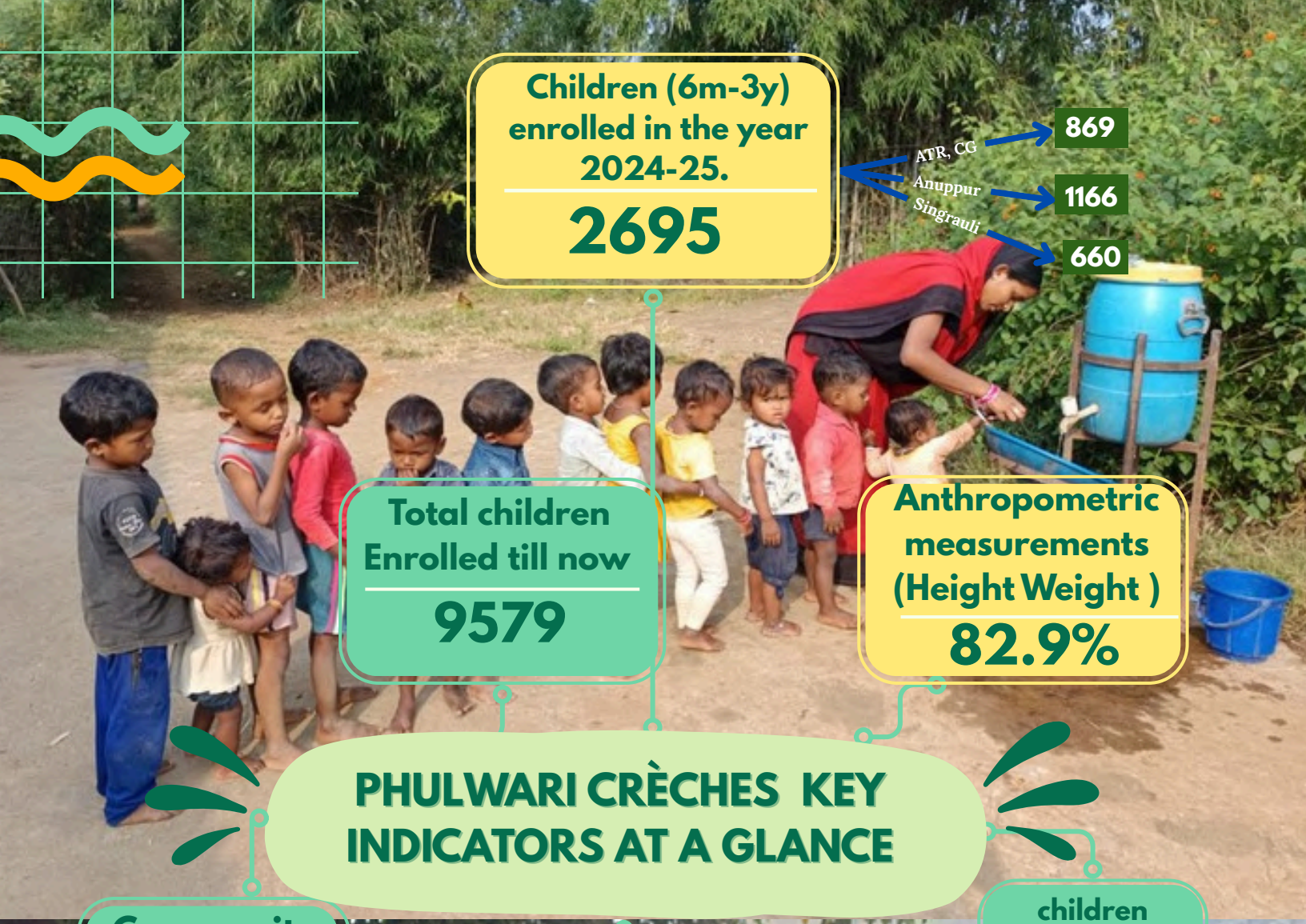
Key Activities of Phulwari

- Nutrition
- Early childhood education
- WASH
- Health Checkups of children
- Reducing School dropouts in siblings
- Safekeeping of children

At Phulwari centres, children receive **age-appropriate nutrition** and **basic health care**. Nutritious meals such as **sattu**, **khichdi**, **eggs**, and **iron syrup** are provided as per a fixed schedule. Early childhood stimulation is integrated through **games**, **songs**, and **activities** in the local language, supporting children's physical, cognitive, linguistic, motor, moral, and social development. The cultural relevance of the programme has resulted in high community acceptance and active participation.

Currently, JSS runs **194 Phulwari crèches**: **79** under the community programme in Chhattisgarh, **75** in Pushprajgarh block of Anuppur district in Madhya Pradesh, and an additional **40** in Singrauli district, responding to the particularly vulnerable conditions of children living in mining-affected areas.


Swasthya & Poshan Samvad



Children (6m-3y) enrolled in the year 2024-25.

2695

- ATR, CG → 869
- Anuppur → 1166
- Singrauli → 660

Total children Enrolled till now

9579

Anthropometric measurements (Height Weight)

82.9%

PHULWARI CRÈCHES KEY INDICATORS AT A GLANCE

Community Meetings

848

children gained weight

64.61%

Active Phulwari s in 2024-25

194

- ATR, CG → 79
- Anuppur → 75
- Singrauli → 40

ATR CG : Achanakmar tiger reserve, Bilaspur & Mungeli, Chhattisgarh

New Initiatives in Phulwaris

JSS observed a consistently high number of growth-faltered children in the Phulwaris, attributed to multiple factors. A short exploratory study revealed that -

- several children were low-birth-weight babies,
- some were enrolled while already in the Severe Acute Malnutrition (SAM) category, and
- many regularly skipped dinner at home due to the consumption of unhealthy packaged snacks.

In response, JSS introduced healthy snacks along with one fruit into the Phulwari nutrition plan. These included banana and potato chips, puffed rice, and til laddoos. Mothers were actively involved in preparing these snacks, enabling them to learn simple, low-cost techniques and replicate healthier alternatives at home. As a result, nine mothers across Phulwaris have started preparing banana or potato chips at home as substitutes for packaged junk foods.

Building on this initiative, JSS introduced puffed rice and chana laddoos thrice a week as evening snacks for all enrolled children, along with one banana per week in the Phulwari meal plan.

Analysis of cohort data over one year showed that the proportion of **SAM** children remained nearly constant at around **5%**. During the same period, the proportion of **moderately malnourished** children fluctuated slightly between **24% and 21%**, while the proportion of children in the normal nutritional category ranged between 70% and 74%.

RESEARCH

Indian J Med Res 159, March & April, 2024, pp 339-346
DOI: 10.25259/ijmr_3300_21

1. Sickle cell anaemia control mission: Implementation of a comprehensive care model in Anuppur, Madhya Pradesh

Sickle Cell Anaemia Control Mission Technical Group*

Jan Swasthya Sahyog, Village Ganiyari, Bilaspur, Chattisgarh, India

Received November 11, 2021

Background & objectives: Sickle cell disease (SCD) is a common genetic disorder, predominantly found in the tribal population of India. The examples of models providing comprehensive care and management to individuals with SCD in public health facilities are sparse. The Sickle Cell Anaemia Control Mission is one such model implemented by Jan Swasthya Sahyog, a non-profit organization in collaboration with the National Health Mission in the Anuppur district of Madhya Pradesh. This article aimed to identify the key learnings from this programme that can guide the public health system strengthening with respect to SCD.

Methods: The Sickle Cell Anemia Control Mission Programme included door to door screening for anaemia, SCD and blood group. SCD cases were included in the programme and other individuals with Anemia were referred for further care. Care for individuals with SCD included counselling, provision of hydroxyurea, regular follow up of clinical parameters and management of complications. Care for individuals with SCD was provided through monthly patient support group (PSG) meetings and regular outpatient /in-patient care at public health facilities. Quantitative data on programme design, screening and patient management collected during programme implementation were used for analysis.

Results: A total of 39421 persons were screened in 18 months (August 2018-March 2020). Of these 81.9 per cent persons were anaemic, 16.9 per cent had sickle cell trait and 779 (1.98%) had SCD. Eighty-six already diagnosed individuals joined the programme for care. People from all caste categories were diagnosed with SCD. Out of 865 individuals with SCD, 157 underwent regular 9-11 months follow up and showed improvement in clinical symptoms and drug compliance.

Interpretation & conclusions: Central India has a significant burden of anaemia and SCD. This study found that SCD is present in non-tribals as well. PSGs are an efficient way to deliver non-emergency care for chronic diseases such as SCD.

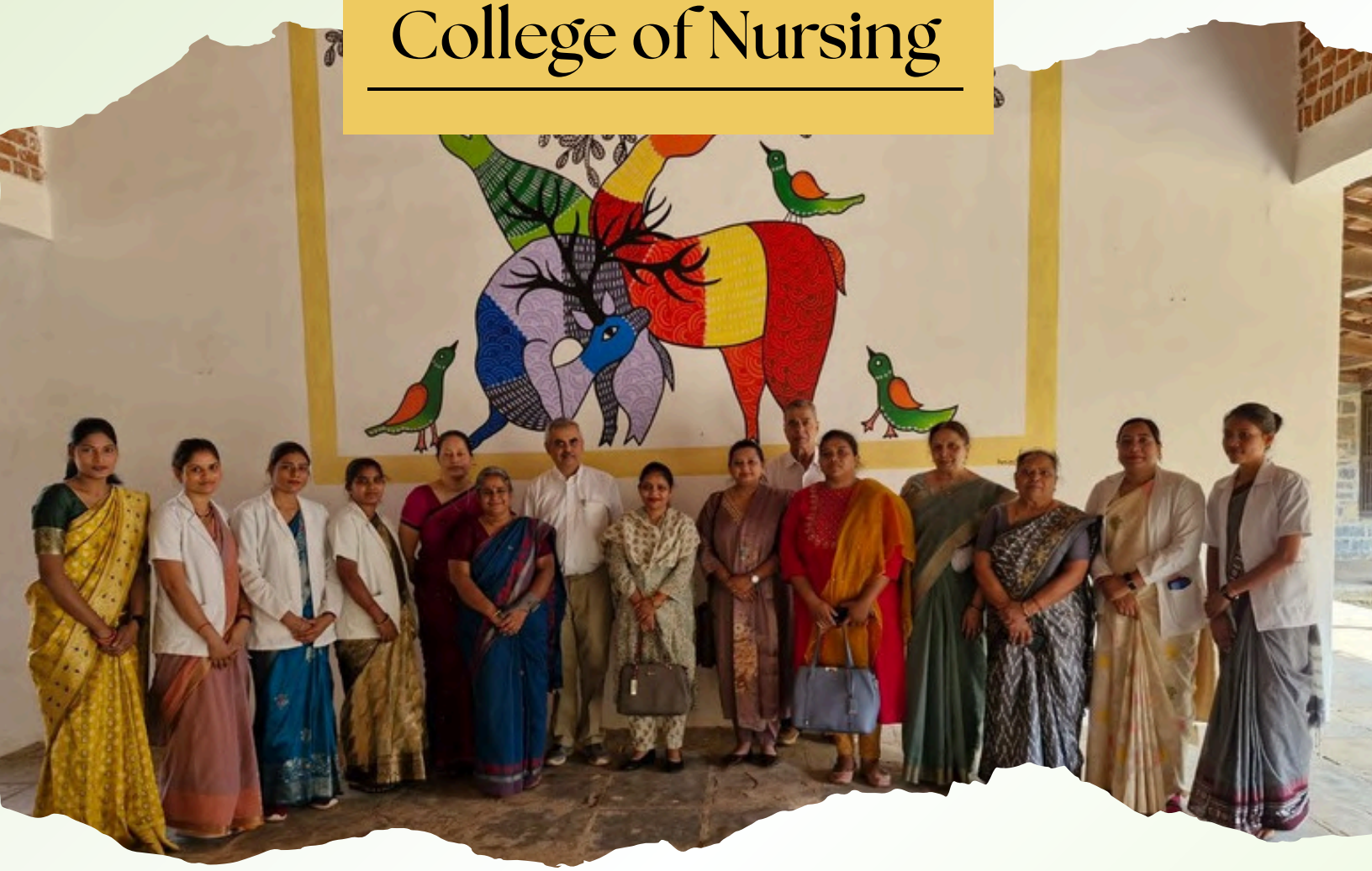
2. **Digitalizing food assistance:** Political economy, governance, and food security effects across the Global North South divide - Phase 2 started from March 2025, focus on farm law, connectivity in the villages and MGNREGA in later stage.

3. **Elderly care** – Assessing and addressing barriers to improve access to health care and social security programmes by the geriatric population in 43 programme villages in rural and tribal Chhattisgarh- Completed data collection and analysis, intervention phase of one year started for last 2 months.

4. **Study of Enhanced TB Package** (Active case Finding, Intensified Protocol Based Follow Up and Nutritional Supplementation to Family) for Particularly Vulnerable Tribal Groups (PVTG)- An Implementation Research in Rural Central India- Screening completed, Follow up of diagnosed patients has started - medicines, labs and food packet distribution started as per requirement.

TB X-Ray in the field

College of Nursing



Nursing and Paramedical training were in full swing through the year with a total of 69 BSc Nursing students in 3 batches (1st, 2nd and 3rd years) and 15 students of the Operation Theatre Technician course. In February 2025, the first batch of the Pathology Lab Technician students also commenced their training, having been granted approval from the Chhattisgarh Paramedical Council for said course this year. The majority of the students receive merit-cum-means scholarships to ensure that the candidates and their families do not have to bear any financial burden. For most, this also covers the cost of their boarding and lodging, uniform, exam fees, books & stationery, etc. We are hopeful that the sponsors of these scholarships will continue to support this initiative.

Their performance in the semester exams speaks volumes for the quality of education imparted and their motivation levels. In order to encourage and mentor girls from tribal and poor rural communities, we conduct a month long residential training program named 'Abhilasha'. Through this, we hope that the girls would get motivated to pursue a career in Nursing and would be prepared to face the state level entrance exam for this.

The School of Nursing observed ***World Mental Health Day*** at Sendari Psychiatric Hospital. Students performed a skit on mental health, raising awareness about the importance of mental wellbeing.

OT Technician students - 2nd Batch

Pathology Technician students - 1st Batch

Four new residents have joined this year - two each in DNB General Surgery and Diploma Family Medicine

Dr Killol, Senior Resident, General Surgery

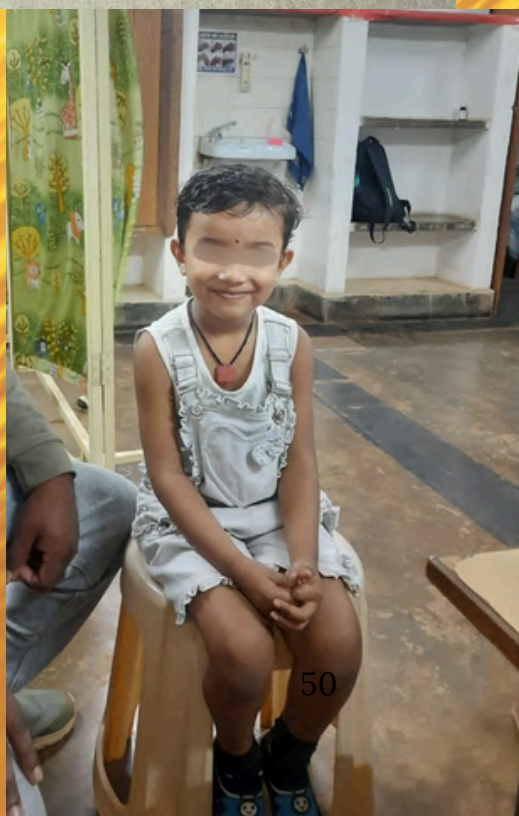
Although JSS was not my first choice, but what initially felt incidental gradually turned into one of the most defining phases of my journey in surgical training. My experience at JSS in surgical training imparted a true and substantial meaning to the word doctor.

From working as a Surgical Resident to taking on responsibilities as a Senior Resident, I found an environment that combined clinical rigor with a strong sense of purpose. The hospital's commitment to community care, including outreach and accessibility for patients from diverse backgrounds, gave me a deeper meaning of the responsibility we carry as surgeons.

The training here extended beyond general surgery, with exposure to multiple specialties that contributed to a more holistic approach to patient care. This interdisciplinary environment emphasized not just technical proficiency, but also clinical judgment, communication, and ethical decision-making. I learned that becoming a good surgeon is not defined solely by operative skills, but by consistency, empathy, teamwork, and the ability to make sound decisions in challenging situations. The support from colleagues, nursing staff, and mentors created a system where learning was continuous and responsibility was gradually entrusted, allowing both professional and personal growth.

One patient who left a lasting impression on me was Prem (pictured alongside), a 23-year-old from Sarguja, admitted during my first year of residency with uncontrolled Type 1 diabetes, severe protein-energy malnutrition, bed sores, and bilateral cataracts, along with depression. At admission, he had a BMI of 13 and weighed just 23 kg.

Over a hospital stay of more than two and a half months, he was managed with insulin, nutritional rehabilitation, wound care, and regular counselling, and also underwent successful bilateral cataract surgery. With sustained multidisciplinary care, he gained over 10 kg, regained strength, and was eventually discharged walking independently.



Another child, a 4-year-old girl (pictured alongside) who presented with prolonged abdominal pain and distension and was diagnosed with a Type I choledochal cyst. She underwent definitive surgical management and required close postoperative care. When I saw her seven months later as a healthy, active child preparing to start school, it was a powerful reminder of the impact of timely intervention and dedicated care.

What began as an inconsequential choice in my career ultimately became a place that shaped not only my surgical abilities, but also my understanding of compassionate and meaningful medical practice.

"JSS is a comfort zone where you are pushed out of your comfort zone everyday."

- Dr Killol Borad

Partnerships that Strengthened the Ecosystem

Forest Department: Approval of livelihood promotion, organic farming, bio-fencing in 10 core forest villages, construction of three bridges over the Maniyari River, and installation of network boosters in ATR villages to improve connectivity.

Alliance for Comprehensive Primary Health Care (CPHC): JSS joined this SWASTI-anchored alliance to design district-level strategies on healthcare design, governance, and financing, alongside partners such as USAID, Piramal Swasthya, CMS, and Crypto Relief Foundation.

Rural Crèche Initiative (Azim Premji Foundation): JSS will support implementation, capacity building, and technical guidance across tribal regions of Chhattisgarh.

When Community Voices Shifted Systems

Some of the most meaningful changes under the community program in this year emerged not from planned interventions, but from community voices amplified at critical moments.

- **A bridge born from urgency:** A viral video of a snakebite patient being carried across the flooded Maniyari River converted a long-standing demand into administrative action. The district sanctioned a bridge between Bamhani and Niwaskhar villages, closing a life-threatening access gap. While the silver lining is seen in sanctioning the budget, the delay in initiation of construction carries and continues the usual threat to villagers posed every year.
- **Connectivity as a health enabler**: Demonstrating low-cost network boosters at a JSS sub-center led to installations in Chhaparwa village, with further plans for expansion.
- **Entitlements unlocked:** Sustained dialogue with district leadership resulted in documentation drives enabling access to ration cards, Ayushman Bharat card, Aadhaar, NREGA job cards, and land records—advancing the constitutional right to social security and dignity.

National Rural Surgeons Conference at JSS

1. We organised the National Conference ARSICON 2025 **(Annual Conference of the Association of Rural Surgeons of India)** in February drawing over 140 participants including experts, young medical students, rural surgeons, and allied health professionals across the length and breadth of the country - from Gujarat to Nagaland and Jammu to Kerala.

Prof. Ashok Jindal (Director, AIIMS Raipur) during the inaugural ceremony with senior members of the ARSI and the Organizing Team

Dr. Ravi Kannan (Cachar Cancer Hospital, Assam), Dr. Rosina Ahmed (Tata Medical Centre, Kolkata) and Dr. Sameer Bakhshi (Professor & Head, Medical Oncology, AIIMS Delhi) during a session discussing cancer care for rural India

Panel discussions on -

- 'Surgical training for rural India',
- 'Huge unmet need of cancer in rural India and way forward',
- 'Research relevant to resource constrained settings'

Dr. Regi & Dr Lalitha from the Tribal Health Initiative (THI), Sittilingi delivered the Dr. Balu Sankaran Oration urging young doctors to step beyond institutional bureaucracy and engage in meaningful activism for policy change

Lecture and panel discussion on Orthopedic problems in rural India with Prof. Shah Alam (AIIMS Delhi), Dr. Shekhar Bhojraj (The Spine Foundation), Prof. Alok Chandra Agarwal (HOD Orthopedics, AIIMS Raipur) and Dr. Sandeep Nema (Orthopedics, AIIMS Raipur)

Young surgeons at the Rural Urology workshop

(Left) Prof Dhruva Ghosh (CMC Ludhiana) at the panel on Research relevant for rural surgeons
(Right) Dr. Manish Ghosh on Plastic Surgery in resource constrained settings

Prof Gowri Dorairajan and Prof. LN Dorairajan Urology talking about obstetric emergencies and difficult urethral strictures in rural settings

The session on surgical training for rural India was really throught provoking and provided several insights.
Prof. Minu Bajpai (Vice President, National Board of Examinations) and Prof. George Mathew (Former Principal, CMC Vellore were centre stage.)

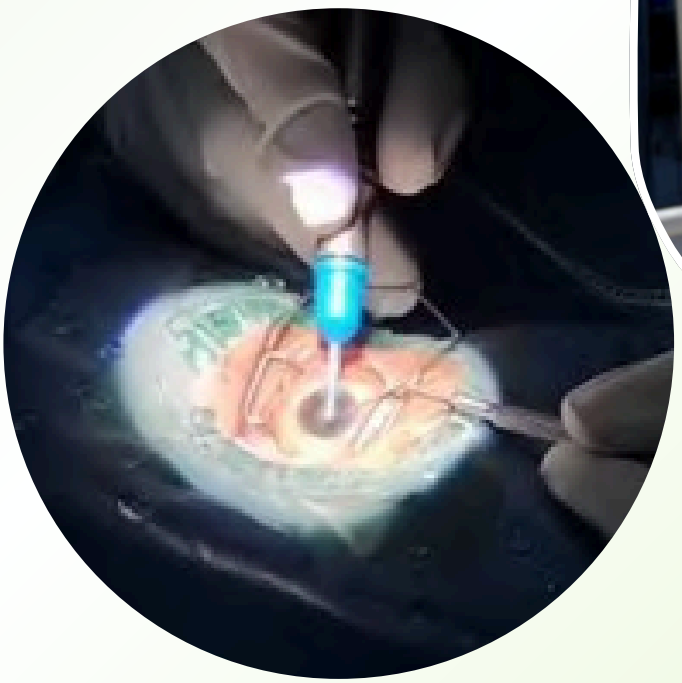
The 3 day conference with 2 days of pre conference workshops covered a wide range of topics and was a treat for young and old practitioners of surgery and rural surgery. The discussions remained grounded to rural realities.

The audience was involved in rich discussions

Dr. Shiv Singh conducting a workshop on pain management and nerve blocks in the perioperative period

New Developments

The new Eye OT is ready, equipped with a new Ophthalmic Surgical Microscope

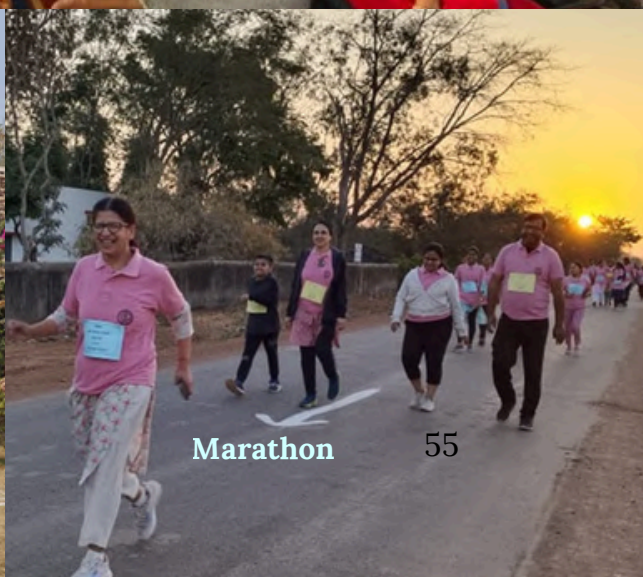


We are now able to perform cataract surgeries (pictured alongside), many of which are complicated by diabetes and hypertension - diseases which are increasingly common even among the rural and tribal communities in Chhattisgarh.

Silver Jubilee Celebrations

We celebrated our Silver Jubilee in February. Various activities were organized to commemorate the occasion, including a reflective session, games, sports like Kho-Kho, Cricket, Marathon, Painting competition and a Cultural programme.

Kho - Kho



Marathon

Achievements & Recognitions

Out of 81 nurses from across the country, our nurses (Maheshwari and Deepika) were among the **top 6 finalists** shortlisted for the prestigious IAPC Gold Medal for nurses.

Recognition: The initiative received the *"Innovative Farmers Award"* in the national conference on System of Crop Intensification for Climate-smart, Water, and Nutrient Efficient Agriculture by **ICAR-IIWM**, Bhubaneswar, Odisha, recognising its contribution to improved nutrition and groundwater conservation. The w**ork aligns closely with SDG 12 (Responsible Consumption and Production) and** SDG 15 (Life on Land).

A Phulwari worker from Karpiha was awarded a **Childcare Champion by FORCES** (Forum for Crèche and Child Care Services)

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, 2025

Particulars	Schedule	Year Ended March 31,2025 (Rs.)	Year Ended March 31,2024 (Rs.)
INCOME			
Receipts from activities	X	18,94,05,867	11,56,64,335
Donations		40,80,054	42,99,122
Grants Received		14,59,41,013	8,89,90,213
Interest Income		2,47,38,187	2,08,35,404
Interest on Income tax refund		21,98,507	-
Total Income		**36,63,63,627**	**22,97,89,074**
EXPENDITURE			
Drugs & Consumables	XI	5,64,16,348	4,55,55,240
Administrative Expenses	XII	1,66,75,945	1,43,31,157
Research & Development Expenses		23,66,765	11,51,453
Manpower Cost	XIII	14,63,68,801	12,55,45,885
Program & Community Welfare Expenses	XIV	3,30,36,113	2,75,12,604
Depreciation	IV	58,42,425	54,20,999
Total Expenditure		**26,07,06,397**	**21,95,17,338**
Excess of Income Over Expenditure		10,56,57,230	1,02,71,736
Add: Depreciation for the year transferred to Capital Fund		58,42,425	54,20,999
Less: Addition to Fixed Assets (including WIP)		(2,37,21,845)	(58,16,753)
Transferred to Reserve and Surplus		**8,77,77,809**	**98,75,982**

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

(Swarnjit Singh)
M.No. : 080388
Partner
Place : New Delhi
Date : 29-SEP-2025
UDIN : 25080388BMJKEF6773

Ved Jain and Associates * New Delhi * Chartered Accountants

For, Jan Swasthya Sahyog

(Dr. Raman Kataria) Secretary

(Dr. Surabhi Sharma) Treasurer

For, Jan Swasthya Sahyog

Treasurer

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 25 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 philanthropist, 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)