QUARTERLY JOURNAL OF CMAI

# CMJI

## CHRISTIAN MEDICAL JOURNAL OF INDIA

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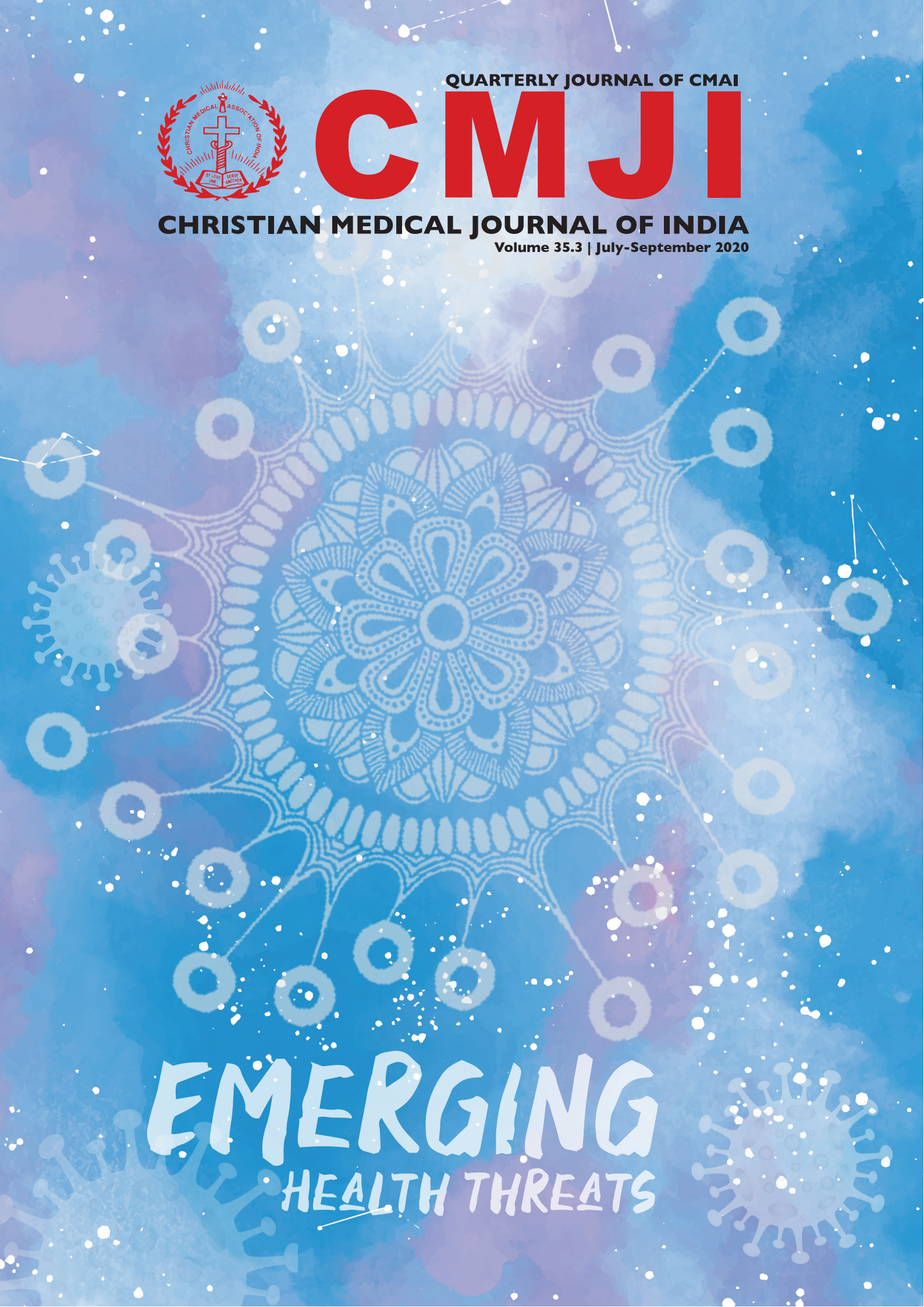

# Join Hands with us in the Healing Ministry

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CMAI is a national network of health professionals and institutions promoting a just and healthy society for all irrespective of religion, caste, economic status, gender or language

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- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
- CMAI is the health arm of the National Council of Churches in India(NCCI).

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- Work closely with the churches, civil society and the government
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- Christian Medical Journal of India (Perspective)
- Life for All (Newsletter)
- Footsteps (Development) English & Hindi (A Tearfund publication distributed by CMAI)

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COME JOIN US AS MEMBERS

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*Building a just and healthy society*

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# CMJI

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## LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: cmai@cmai.org

# Guidelines for Contributors

### SPECIAL ARTICLES

CMAI welcomes original articles on any topic relevant to CMAI membership - no plagiarism please.

- Articles must be not more than 1500 words.
- All articles must preferably be submitted in soft copy format. The soft copy can be sent by e-mail; alternatively it can be sent in a CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
- Articles submitted to CMAI should not have been simultaneously submitted to any other newspaper, journal or website for publication.
- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
- Articles accepted for publication can take up to six to eight months from the date of acceptance to appear in the CMJI. However, every effort is made to ensure early publication.
- The decision of the Editor is final and binding.

### LETTERS

- Readers of CMJI are encouraged to send comments and suggestions (300-400 words) on published articles for the 'Letters to the Editor' column. All letters should have the writer's full name and postal address.

### GENERAL GUIDELINES

- Authors are requested to provide full details for correspondence: postal and e-mail address and daytime phone numbers.
- Authors are requested to send the article in Microsoft Word format. Authors are encouraged to use UK English spellings.
- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged immediately on receipt with a reference number. Please quote this number when making enquiries.


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**EDITORIAL**

# Healthcare OR Health

We who are in the ministry of healing tend to equate 'health' and 'healthcare' often. In a close reading one can understand quickly that there is a huge gap between these two terms. Health encompasses the wholistic wellbeing of individuals, people groups, nations and the nature. Instead of keeping health as our focus, we are guilty that we have kept healthcare as our keyword.

Even in healthcare, most often focus is on treating illnesses of people. Many institutions, organisations, establishments, hospitals, clinics, pharmaceuticals, insurance companies and medical industries which claim to work for healthcare actually work for sick-care. It is important therefore to understand the difference and to commit ourselves for the health of the nations. To understand and experience the function of the Healing God and to align ourselves to the same function is, therefore, our calling as individuals and as institutions.

Articles in this issue invite us to pay attention to the emerging health threats and the way we need to address them for the sake of health of the nations. It is not enough to talk about healthcare. We need to identify the factors contributing and hindering health. Even the healthcare systems should include in their agenda what is their response to the emerging threat to health in our land.

We are also grateful for two senior health professionals who have given interviews in this issue regarding how they have been working towards health and healing of people.

During this season of Advent, may we wish you all a meaningful and appropriate Christmas celebrations. May the sacrificing God who voluntarily chose to become one among us brighten our lives so that we find and experience salvation. We also want to wish you a blessed and healthy new year 2021. May Christ's radiating love flow through our lives as we make steps through our institutions to bring forth healing and wholeness to people.

***Rev Dr Arul Dhas T***
***Editor***

***Rev. Arul Dhas T.***

# EHA NURSES AT THE FRONTLINES, PLAYING A VITAL ROLE DURING THE INTERNATIONAL HEALTH CRISIS, COVID-19

With the recent outbreak of Covid-19, healthcare related communities have been working tirelessly. And an irreplaceable role has been played by nurses. Despite not often being in the limelight they have showed determination, selflessness and care for the world.

The World Health Organization declared 2020 to be the "Year of the Nurse and Midwife" a celebration of the 200th birthday of Florence Nightingale (1820–1910). It was completely unexpected that this would also be the year of an International Health Crisis, a Covid-19 pandemic! This has brought out the need for more nurses in the country. They have been the leading soldiers in this time of this crisis, fighting the pandemic out in the front line. It is a time that we need to be together to fight this Covid-19 crisis.

**Mr. Vinay John**

The Covid-19 pandemic in India is part of the worldwide epidemic of coronavirus disease 2019 (Covid-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first case of Covid-19 in India, which originated from China, was reported on January 30, 2020.

The Emmanuel Hospital Association hospitals (EHA) are located in the below-mentioned States of India, the number of corona cases may vary in each district but I have retrieved State-wise data on Covid-19 from MyGov dashboard on July 23, 2020. EHA is a Fellowship of Christian individuals and institutions committed to the ministry of healing in the name and spirit of Jesus Christ. Today EHA manages 21 Hospitals, 6 Nursing Schools, Palliative Care Services, and 40+ Community Health and Development Projects in some districts of Assam, Bihar, Chhattisgarh, Delhi, Jharkhand, Madhya Pradesh, Maharashtra, Uttarakhand, and Uttar Pradesh. The Vision Statement of EHA is summarized as: "Fellowship for Transformation Through Caring."

The Nursing Department of Christian Hospital Chhatarpur, one of the Emmanuel Hospital Association units, implemented a series of efficient and meaningful measures to obtain good results in Covid-19 transmission control. I am sharing my experience, observation, and involvement as a member of the nursing team.

### Preparation and Quarantine Measures

The management of Christian Hospital Chhatarpur held a meeting in March 2020. Following this, they immediately established a Covid-19 transmission control leadership team with the medical, nursing, and administration leaders. The Principal, Nursing Superintendent, Nursing Tutors, Ward in-charges and Staff Nurses took it seriously and started the preparations and training programme for Covid-19 transmission control. As the nursing professionals' leader, the Principal and Nursing Superintendent immediately conducted an awareness programme about the Covid-19 transmission control measures, uses of the masks, handwashing techniques, social distancing, and uses of the sanitizers and health education pamphlets to teach the patients and their relatives. The nurses were divided into two groups with seven days of continuous work followed by seven quarantine days, which was an additional protective measure for the staff. This provided the staff time for recovery and decreased the risks of direct exposure.

### Opening of Flu Clinic and Respiratory Ward

The management of Christian Hospital Chhatarpur has selected Community Health and Development Projects staff (Prerana and Kishangarh Watershed Programme) to do Triaging and run the Flu Clinic at the hospital entrance. The registration department was moved near the Flu Clinic so that all the patients coming to the OPD

| India States | EHA Hospitals | Confirmed Cases | Deceased | Mortality (%) |
|---|---|---|---|---|
| Assam | 3 | 26,772 | 64 | 0.23 |
| Bihar | 2 | 30369 | 217 | 0.71 |
| Chhattisgarh | 2 | 5968 | 29 | 0.48 |
| Delhi | 1 | 126323 | 3719 | 2.94 |
| Jharkhand | 2 | 6485 | 64 | 0.98 |
| Madhya Pradesh | 2 | 24842 | 770 | 3.09 |
| Maharashtra | 2 | 337607 | 12556 | 3.71 |
| Uttarakhand | 2 | 5300 | 57 | 1.07 |
| Uttar Pradesh | 5 | 55588 | 1263 | 2.27 |

would have to register at the entrance gate. The recording of their history, and their assessments were done in the Flu Clinic. Patients having any symptoms of fever, cough, breathing difficulties, and if they had a travel history, were sent to the respiratory ward for further evaluation by the Consultants/Medical Officers. The rest of the patients who did not exhibit such symptoms were sent to the regular Out-Patients Department.

### Selecting Nursing Staff

While selecting the nurses for the respiratory ward, the nursing department prioritized the nurses who have experience managing a department. In addition to this, they were required to have a minimum of one-year work experience, good physical health and are expected to be good in nursing techniques and skills. Nurses are currently managing suspected cases in the respiratory ward, but in the future, confirmed cases would be admitted in the Covid-19 dedicated ward. Nursing staff who have experience in managing a department will be working in the Covid-19 dedicated ward. At the later stages, after the training, all nurses should be able to work in the Covid-19 dedicated ward as per the schedule.

### Planning for a Good Support System

It looks like Covid-19 transmission will continue until the government finds vaccines or treatment for the coronavirus. Nurses in the general ward, maternity ward, and respiratory ward are going to have a massive workload, and due to this overwork, some nurses may experience burnout. To ensure sufficient nursing staff to provide quality care in the Covid-19 dedicated ward, the nursing department will have to reassess the workload and personnel requirements in the entire hospital. The nursing department is thinking of establishing a good staffing pattern, a good number of skill-mixed staff, and several senior or specialized nurses to work in the Covid-19 dedicated ward. Any nurse experiencing discomfort would be replaced after reporting to the people concerned.

### Online and On-Site Training

Presently, there is no effective treatment regimen for Covid-19, and the number of suspected or confirmed patients is increasing. The nursing department needs to regularly conduct intensive training for all nurses, irrespective of their area of duty. This will provide future nurses who will be placed in the respiratory ward or next Covid-19 dedicated ward. Due to social distancing, few nurses need to receive on-site training in the present situation while other nurses should receive online training. Thus, all nurses will be ready to start working as and when required.

### Safety of the Nursing Staff

When first entering the Covid-19 dedicated ward, new nurses need to be accompanied by nurses with working experience in the respiratory ward or covid-19 dedicated ward. For every shift, a nurse from the hospital will be responsible for supervising disinfection and protection work in the ward. Besides, the head nurse should do night ward rounds, thereby ensuring the proper protection of nurses.

### Priorities

The Flu Clinic, Respiratory Ward, and Covid-19 dedicated ward are the first-line regions in Covid-19 transmission control hospitals. A budget and supplies plan needs to be formulated, and stocks need to be appropriately maintained. Medical equipment and supplies, especially Personal Protective Equipment (N95 masks, latex/nitrile gloves, goggles, protective face shields, and scrubs), sanitizers, disinfectants, need to be restocked timely according to the requirements.

### Encouragement

Given this situation, the nursing department heads have to lead from the front and encourage nursing staff at the frontline every day. We are aware of the nurses' difficulties, such as long working hours resulting in a dry throat, long periods of mask-wearing resulting in chest tightness, allergy to the protective gown, and about the risk of infection to their family members. Despite these challenges, we make an effort to keep their spirits high through motivation, devotion, and constant prayer.

## Conclusion

As nurses with considerable expertise in health care, we are very proud of EHA nurses everywhere as they provide services during the current pandemic. And while nurses are our most valuable asset during this crisis, they are not exempted from experiencing unintended consequences such as accidental exposure to the virus or physical and psychological fatigue. Efforts are underway to ensure that all nurses have the proper Personal Protective Equipment to care for patients while protecting themselves.

Nurses will always be on the front lines caring for the community in a significant way beyond our current pandemic. Nursing's presence is a real cause for celebration, both during and beyond the Year of the Nurse and Midwife 2020.

I am grateful to my colleagues who comprise the dedicated team of leaders, the Principal, Mrs. Rekha John, the Nursing Superintendent, Mrs. Elizabeth Johnson, Mr. Jone Wills, the Managing Director, and Dr. Tony Vikas Bishwas, the Medical Superintendent and the Doctors' and Nurses' group at Christian Hospital Chhatarpur.

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***Mr. Vinay John, M.Sc.(N)., MBA***
***Nursing Director EHA***

# THE DIRECT IMPACT OF COVID-19 ON TUBERCULOSIS RESPONSE

**Ms. Blessina Kumar**

The year 2020 started off like a science fiction movie. As news of Corona emerged along with news that was many times unfounded, panic loomed large. Added to this was the whatsapp messages and social media platforms like facebook which became our 'CDC' and 'ICMR' news bulletins.

Going back a couple of years to 2018 when the landmark UN high-level meeting at the UN General assembly on TB had very ambitious commitments from heads of state. Ending TB by 2030 seemed somewhat possible. India, the country with the highest TB burden with 2.9 million people diagnosed with TB each year decided to End TB by 2025 and announced it to the world.

The recently launched [1]WHO Global TB Report is sobering and highlights the lack of progress by countries with South East Asia having the highest burden and India topping the list.

Presently, the world struggling to come to terms with the new normal and everything that goes with it, work from home, virtual health care, virtual class rooms, and an awful lack of mechanisms to cope with social isolation slowly reflecting in increasing issues of mental health. While the cost of this is still being measured, we are seeing the increasing damage due to the way COVID-19 was and is being addressed. The maximum impact of this pandemic is falling on the poor and the marginalised starting with the migrations, reverse migration, human trafficking, malnutrition, health facilities and resources diverted to Covid, to name a few. It is still continuing.

A global survey[2] conducted by Civil Society and community partners, with a focus on TB, clearly delineated the impact of COVID 19 on people affected by TB.

The findings of the survey offer a grassroots perspective of how COVID-19 is impacting five key stakeholder groups: people with TB, frontline healthcare workers, program and policy officers, TB researchers, and TB advocates.

### People with TB:

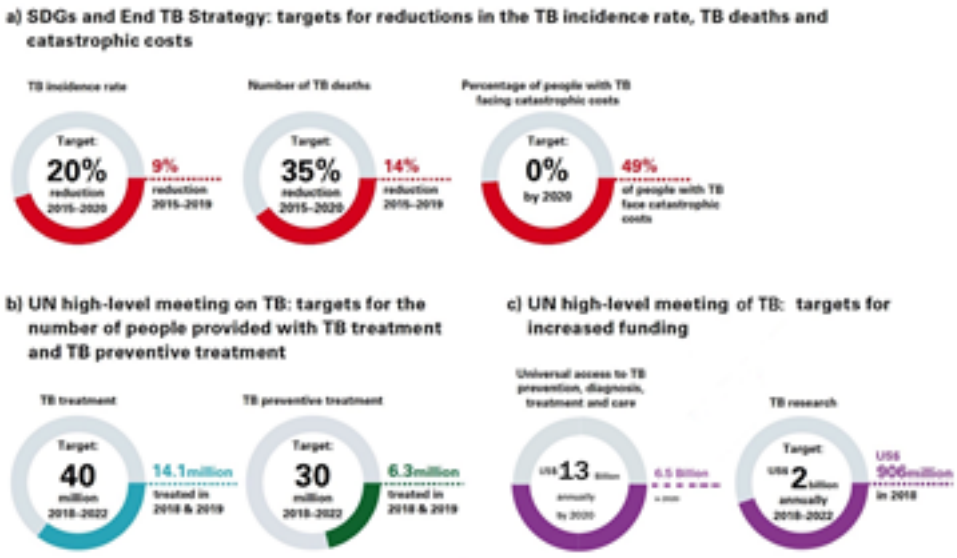
Kenya (n= 159) and India (n= 58) reported significant challenges in accessing TB services during the pandemic and associated lockdowns. Difficulty in finding transport to access TB care, changes in TB services, and fear of contracting COVID-19 during a healthcare visit were presented as key barriers. People with TB also reported experiencing increased stigma because of the similar symptoms of both respiratory diseases. While in most cases people with TB have been given additional TB medicines to continue treatment at home, they expressed a clear and urgent need for immediate non-medical support, including nutritional, economic and psychosocial support.

### Frontline Healthcare Workers:

TB frontline healthcare workers (n=150) reported significant reductions in TB care due to the pandemic. Main reasons for interruptions were related to the redeployment of essential resources and personnel to respond to the public health crisis at hand and generally weak health systems struggling to cope with an influx in demand on services. Participants from around the world reported a lack of personal protective equipment (PPE) and shared how the unsafe and challenging working conditions were resulting in low morale and mental health issues. There is an urgent need for increased support including investment in PPE, personnel, supplies, and tools, as well as innovations in programming to offer quality digital and community based care.

### Policy and Program Officers:

Responses from policy and program officers (n = 115) revealed that TB services and program resources have significantly reduced because of the pandemic. TB notifications have drastically decreased and personnel are being redeployed to respond to COVID-19. Participants from the US and Global Fund implementing countries reported decreases in people with TB accessing care, as well as increases in stock-outs or delays of TB medicines. Contributing factors to interruptions of TB programs included programmatic capacity, stigma and fear, human rights violations, and other psychosocial factors that impeded people with TB from accessing TB services.




Program adaptations are being made and need further financial support to increase and sustain the innovative mechanisms being deployed, such as telemedicine and family/community based care. Significant investments that being made now to respond to COVID-19 should be leveraged to strengthen the TB response.

### TB advocates:

Individuals employed with civil society or non-governmental organizations working to end TB, or who identified as a TB advocate or TB survivor from Global Fund implementing countries (n = 270) expressed much concern for TB advocacy and people with TB because of the pandemic. Diverted attention to COVID-19 from politicians and media was reported to be seriously affecting advocacy work. Participants also raised alarm bells about people with TB not being able to access care and social support, and community support groups not being able to reach affected communities during lockdowns. Human rights issues, including stigma, economic inequalities, food insecurity, and fear were raised as key challenges in responding to COVID-19 and TB. To respond to the challenges at hand, advocates called for a strengthening of TB affected communities' capacity and engagement in the fight to end both the epidemic and pandemic.

**The biggest difference is that COVID does not differentiate between the rich and poor, upper class and middle or lower class and caste. Unfortunately TB does. It affects the poor and undernourished, people living in crowded settings, all leading to the reason for the decades of lack of attention to TB.**

### TB Researchers:

TB researchers from around the world (n = 73) reported significant interruptions in TB research related to a diversion of personnel, equipment, and funding to COVID-19 over TB. Survey participants repeatedly noted existing lab space and infrastructure being closed during lockdowns or repurposed for COVID-19. Similarly, respondents experienced reduced access to research participants due to immobility during lockdowns. There is a unified demand from TB researchers for additional and continued resources for TB, and for research investments in COVID-19 to be leveraged for TB. TB research and infrastructure is currently being leveraged for COVID-19 related research.

### Moving Forward

Covid-19 has impacted TB services but also provides opportunities. The need is to leverage the attention and response for COVID to work for TB. Both are similar in many ways. The biggest difference is that COVID does not differentiate between the rich and poor, upper class and middle or lower class and caste. Unfortunately TB does. It affects the poor and undernourished, people living in crowded settings, all leading to the reason for the decades of lack of attention to TB. The headline of a recent article read, 'The biggest monster is spreading and it is not the Corona virus!'. TB remains the biggest killer.

The 10 priority recommendations of the UN Secretary General's 2020 progress report on TB for actions needed to accelerate progress towards global TB targets very clearly articulate the resource needs. And for the very first time combating stigma and discrimination as well as promoting human rights are a part of the End TB narratve along with meaningful engagement of civil society, communities and people affected by TB. Recently I had the opportunity of being

**Countries need to be supported to report data accurately without worrying about being seen as failures. Countries are trying to adopt MAF and fill in the checklist but need guidance and support in moving forward to action.**

the keynote speaker at the UN General Assembly side event on TB. I summarised the speech with 3 asks and one crosscutting issue.

**Funding- Invest invest invest!!!**

TB funding has reduced significantly, specially in the past 6-8 months, and in the same time Billions of dollars have been made available for COVID. This is great but not at the cost of TB! We cannot turn away from TB, not now not for anything else. TB remains the biggest killer, and as leaders, do not shift your focus away from TB. Lives depend on it.

Civil Society and Communities can be part of the decisions on how, who and where this investments are most needed.

2. Research- I heard recently that in the past 6 months there have been more

than 70,000 papers on COVID, 5000 clinical trials for COVID. We cannot allow TB being left behind. Rapid research and new tools are urgently needed. Newer safer oral drugs to replace the painful injections with terrible side effects and a rapid uptake of the ones already available. Despite WHO guidance to do away with injections, in TB we are moving at snails pace and every minute delayed is a life lost!

3. Support to countries- The Health Systems around the world are weak and ill equipped to simultaneously respond to TB and COVID epidemics.

Countries need to be supported to report data accurately without worrying about being seen as failures. Countries are trying to adopt MAF and fill in the checklist but need guidance and support in moving forward to action. We have seen encouraging progress from Indonesia in terms of the TB budget which increased by a threefold and there has been some progress in EECA region as well.

Crosscutting - The biggest cross cutting barrier to progress is STIGMA. We need you at the highest level to be actively engaged in stigma reduction.

If we truly want to realise our collective dream of ending TB in the near future we need to hold ourselves accountable to the commitments made and follow them upwith strong ACTIONS!

I would like to end with a paraphrase of a quote from Mahatma Gandhi,

“Recall the face of the poorest and weakest person you have seen, and ask yourself if the step you contemplate is going to be of any use to him/her, will he or she gain anything by it, will it restore to him or her a control over his/ her own life and destiny.”

I call on you to recall the face of a TB patient when you take your next step.

***Ms. Blessina Kumar***
***CEO Global Coalition of TB Activities***

# JOB OPPORTUNITIES WITH THE LEPROSY MISSION TRUST INDIA

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TLMTI is the oldest and largest leprosy-focused non-governmental organisation in India and is headquartered in New Delhi. The organisation works with people affected by leprosy and other neglected tropical diseases (NTDs), people with disabilities, and marginalised communities, especially women.

TLMTI has a diverse set of programmes – Healthcare, Sustainable Livelihood, Community Empowerment, Advocacy and Communication, and Research and Training. These programmes are implemented through 14 hospitals, six vocational training centres, five residential care homes for elderly persons affected by leprosy, nine community empowerment projects, and a molecular biology research laboratory spread across 10 states of India. www.leprosymission.in

At TLMTI, we believe that only by working together with people affected by leprosy, people with disabilities, underserved communities and our supporters and partners, we can bring holistic healing, social inclusion and dignity for all. Hence, we implement our programmes across the country working with various partners. They include Central and state governments, the World Health Organization (WHO), International Federation of Anti-Leprosy Associations (ILEP), corporates, faith communities, grassroots-level organisations think-tanks, and national and international development and research bodies.

## HOW TO APPLY

Applications are invited from qualified, experienced and committed candidates. Please send your application to Mr. Melvin Moras, Head-HR at jobs@leprosymission.in along with full details of qualifications and experience latest by 30th November 2020. Interviews are planned to take place between 01st to 15th December 2020. Compensation package is one of the best in NGOs/development sector.

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# COVID-19 PANDEMIC ACCELERATING NEED FOR PERSON CENTRED CONTINUUM OF CARE AND PATIENT ENGAGEMENT

**CARE**: **C**ovid-19 pandemic **A**ccelerating need for person centred **C**ontinuum of care and patient **E**ngagement

**Dr. Oommen John**

India enforced a strict nation-wide lockdown starting 24th March with an aim to reduce the spread of infection and prepare the health systems capacity for the pandemic. The Government of India issued advisory for those with chronic conditions to avoid visits to healthcare facilities for non-emergency consultations, as the risk of complications and deaths due to COVID-19 was higher among those with underlying co-mordbidies. The World Health Organization has highlighted that restrictive measures and travel restrictions to reduce the spread of infection during epidemics impact specifically the people living with NCDs by limiting their activity, ability to secure healthy foods, and access to preventive or health promotion services. Some of the challenges faced by health authorities during the early phases of a pandemic caused by an emerging infectious disease agent such as the novel corona virus or SARS COV 2 are the uncertainties and unpredictability of its impact on health delivery systems. Since this novel virus belonged to the family of corona virus that primarily presented as an influenza like illness, the health care delivery systems were geared to treat a viral illness that predominantly presented with classical manifestations of a flu like illness and the anticipated complications were respiratory distress syndrome, multi organ failure and sepsis. These assumptions therefore informed the policy around health systems preparedness resulting in the rush for increasing intensive care beds and procuring ventilators.

### Capacities in Rural Hospitals:

Most hospitals located in rural and underserved areas often do not have the luxury of modern day ICUs that rely on probes, piped oxygen, continuous monitoring gadgets and machines designed to prolong life while draining families of their entire lifetime earnings. They rely on human hands for palpating the pulse, eyes that read the pain on the face and words to comfort when modern medicine nothing much to offer in certain conditions or terminal stage of a malignancy. As these remotely located hospitals are not capable of attracting super specialists or retaining them long term, care delivery is through locally available healthcare professionals who through years of learning to listen to the patients have mastered the art of caring. Surprisingly enough, many of the disease-causing agents seem to vacate their human abode when they notice their hosts (persons whom they have infected) receiving respect and care with dignity. In essence, what most rural mission hospitals offer is personalized care that results in a superior personal user experience in the place of the “packaged” super specialist delivered care that their urban counterparts sell.

### Expectations and Surprises:

COVID-19 illness caused by the SARS COV2 virus like its cousins was expected to cause an influenza like illness lasting a fortnight to a month and rendering those infected protected for the future as antibodies against the virus were developed during the course of the illness. However, among those with high-risk health conditions such as diabetes, hypertension, and cardiovascular diseases the clinical course was expected to be stormy. These conditions collectively and conveniently termed as co-mordbities predisposed them to a metabolic milieu that rendered a fertile ground and as a runaway for the cytokine mediated inflammatory responses to take off. Enhancement of the surge capacities in healthcare delivery settings was aimed that those needing high dependency care and ventilator support in those developing respiratory distress syndrome. While the policy makers were concerned, the health and other multi-disciplinary experts with rich experience of delivering acute episodic, compartmentalized and organ focused care developed novel strategies such as large camps for delivering oxygen for those diagnosed with hypoxia, mass production of ventilators etc. A large majority of those

infected by the SARS COV2 virus remain asymptomatic and similarly majority of those with symptoms experience a clinically mild course of disease and were advised to manage at home. It was anticipated that most people who had mild symptoms would recover quick and would bounce back to their normal routines as they would from about of viral fever or flu as it is popularly known. However, a small number of persons approximately 10%, who had a mild form of COVID19 disease continue to experience a range of symptoms ranging from lack of energy, disturbances of sleep, extreme fatigue, difficulty in carrying out routine tasks, hair fall, joint pains, mood disturbances and some of them even experiencing memory loss. As per the current definitions, those who complete 14 days after initially testing positive with or with a repeat testing are considered as recovered. Though labelled as recovered, an estimated 7 Lakh Indians are likely to be experiencing these long term symptoms after an acute infection by SARS COV2 virus, these symptoms collectively are being recognized as "Long Covid" a term coined by patients who are experiencing these.

Moving beyond Acute and Chronic disease focus to Continuum of Care:

Healthcare delivery systems in India and in most other low and middle income countries are fragmented and narrowly focused on disease centred acute episodic care delivery. With increasing life expectancy and effective medical interventions that help people diagnosed with many life threating illness to live longer, there is a growing population of people who live with chronic conditions that require long term care. Further, many persons with chronic conditions have multiple morbidities and in most settings, people with chronic conditions seek care from hospitals or in the urban context from standalone specialty centers. A person with multiple chronic conditions therefore would need to meet several specialists in the same hospital or make several hospital or specialty clinic visits, resulting in multiple medications leading to polypharmacy. These add a huge burden to people who are aging and live on limited resources. Also in the context of the emerging economic situation that threatens livelihoods especially in rural areas, health care delivery cost optimization would be a priority for hospitals to consider.

The ongoing pandemic has clearly demonstrated that the current models of care delivery are not capable of meeting emerging health threats. Moreover, these models are expensive, inefficient and unsustainable in the long term. This calls for a paradigm shift in the current thinking and operational strategy of healthcare establishments. It also provides opportunity to venture into reimaging health care delivery services, using co-design approaches through learning about the expectations from people who use the healthcare delivery services to develop newer care pathways for chronic conditions.

Towards a new normal in healthcare:

As people experiencing the long terms effects of COVID19 infection start seeking care in hospitals, would the current care delivery mechanisms be able to provide any solace? Especially as many of these symptoms are non-specific and therefore are unlikely to be diagnosed through the traditional reductionist approaches or routine laboratory and imaging based work ups. As the emerging body of evidence suggests, the SARS COV2 infection itself and the lived experiences of those having diagnosed with COVID19 appear to be etching devastating scars on the very fabric of the lives of those who have gone through the anxiety, uncertainty and unpredictability of the clinical course. "Brain Fog" as some have labelled it is yet another concern among many others such as increased risk for blood clotting (thrombotic) events. Some of them might probably need home based care and comforting reassurances over several months may be even years and maybe even rehabilitation and reskilling and adapt to a new reality of their state of health. These persons need more than a diagnostic test to identify the root cause or a diagnostic label or be grouped it into a known "syndromic cluster" or "manifestation" of an organ damage, they need a listening ear, a caring reassurance and a shoulder to lean on while they limp along to full recovery. Would the mission hospitals rethink how the unspoken needs of these silent suffers could be met? Would the clinicians have the humility to admit that they don't really know what exactly the pathological mechanisms are or that they don't have all the answers to the clinical challenges in front of them. Admit that they feel as vulnerable as those experiencing these symptoms do. In doing so, the network of rural and remote health delivery establishments might be rewriting the fundamental principles of care in a healthcare delivery ecosystem that is devoid of trust or transparency and thereby establishing the new normal that has been the aspiration of everyone.

***Dr Oommen John is an Internal Medicine Specialist and Public Health Researcher. He grew up on a mission hospital campus in South India. He is an alumnus of CMC Ludhiana and served with The Leprosy Mission in India and Nepal.***

# IMPACT OF LOCKDOWN ON MIGRANTS IN BIHAR

**Mr Abraham Dennyson**

At 20:00 hrs, on the 24 March 2020, the Prime Minister of India announced a 21-day lockdown of the country beginning midnight, in an attempt to stop the spread of the Covid19. The four-hour notice resulted in unprecedented migrant (labourers') distress. COVID-19 and the total lockdown impacted the lives in obvious and hidden manner. Within a week of lockdown tens and thousands of migrants were on the road, trekking back to their homes, hundreds of kilometres away from their workplace. This demonstrated the immediate distress of job loss and insecurity with none to defend. Once they reached their respective states the impact seemed to have disappeared from the consciousness of the country. The media had done its bit and moved on to the next story. Several NGOs including our network were at ground working with the migrants and their families, addressing their needs.

In the past 10 years of my experience in Bihar, I have noticed every second home among the lowercase community has a migrant worker in their family. This is due to lack of employment opportunities in rural Bihar, coupled with increasing labour markets in other parts of the country. Underdevelopment and backwardness of the State is reflected in the higher dependency on agriculture, lower agricultural output, skewed distribution of land, higher incidence of landlessness and lack of industrialization.

**Underdevelopment and backwardness of the State is reflected in the higher dependency on agriculture, lower agricultural output, skewed distribution of land, higher incidence of landlessness and lack of industrialization.**

By early June 2020, government sources noted that about 3.5 million migrants had returned to Bihar. By mid July 2020, we members of the Arukah Network (CHGN)-Bihar Cluster have supported close to 55,000 families with cash transfer/ food relief, sanitary and hygiene kits in over 500 villages across Bihar. Arukah Network (CHGN)-Bihar Cluster is group of people who work collaboratively to serve their communities. Cluster members work to build relationships, support one another, share in training, and form partnerships. The aim is to increase the health, wellbeing and happiness of our communities, and ultimately, to inspire wider systems and social change. We celebrate local strengths rather than pinpointing weaknesses. We recognise that we all have something to offer, and so development need no longer be about 'donors & beneficiaries', 'haves & have-nots', or 'us & them'. In the cluster network, there is only 'us'.

We as core group when reviewing the migrant crisis felt the need for concerted medium to long term interventions to help the migrant community. To plan the strategy, we decided to do a joint needs assessment across the state. Members were invited to be part of the survey; World Vision India (WVI), Gospel Echoing Missionary Society (GEMS), Evangelical Fellowship of India Commission on Relief (EFICOR), Emmanuel Hospital Association (EHA), Children United for Action, The Leprosy Mission (CUFA TLM), and Forum for Social Initiatives, Archdiocese of Patna, participated in the survey by collecting the data. This was a typical example of what the network could achieve; data was collected from 25 blocks in 15 districts. In a matter of two weeks members were able to collect 1183 survey responses.

This study found 66% male migrated for work alone and about 6% migrated as family. Industrial centres in North India have become preferred destination compared to earlier agricultural centres. The survey showed that 51% of the migrant labour were returning from 4 destination states Gujarat, Maharashtra, Delhi, and Haryana. I have witnessed this during my Community Health work with EHA in Madhepura Christian Hospital, that able-bodied men seek work after the local agriculture season and set on a circular migration. This temporary migration leaves them as well as the family

left behind, highly vulnerable. Due to regulatory and admirative procedures, they are rarely full citizens in destination states or workplace.

Children left behind are vulnerable to violence, abuse, or exploitation. Fear, anger, and feelings of rejection are common among such children. Children lose the guidance, care, and authority of their parent/s. The gross enrolment ratio (GER) of the scheduled caste youth in higher education stands at 9.3%. For example, Uttar Pradesh has 6491 colleges in the state, while Bihar has only 744. (AISHE, 2015-16). In Bihar 33.1% of population belong to the socially disadvantaged groups, Muslims, Scheduled Castes and Scheduled Tribes. The dysfunctional educational system puts higher education out of reach for these disadvantaged groups. Many children dropout of school and end up becoming unskilled labourers. There are number of stories of household with chronically sick or differently abled, that are willing to send their young children for work to support their family.

Of migrants who returned during lockdown three quarters worked as unskilled labourers. 20% do skilled work like masonry, carpentry, cooking, driving, electrician etc. Among the skilled group only 1% have had formal training. Since returning, 40% of them said they have no idea how they will tide over this pandemic -jobless situation and a similar number wanted to go back to agriculture or agriculture labourers. About 15% wanted to be self-employed in trades like carpentry, tailoring, electrician, vegetable vending, grocery/petty, and barber shops. There is shifting of people towards agricultural farming job which increased by 5%, now at 12% as main source of income. Another 12% of them are jobless and only 1% of them see MGNREGA as main income source.

71% (n=836) of the respondents use WhatsApp. 47% (n=560) use more 2 or more social media apps on their smart phones. Migrants come back with skills and experience which can be used for community transformation and accessing their entitlements for their community. Very often it takes the leadership of one person to mobilise the community or make a difference in the village.

98% of the migrants have Aadhar card, 45% have more than one type identity cards (e.g. Aadhar + Voter Card). Less than half, 41% possessed voter cards. It will be important to help migrants involved in the political process so that their voice is heard, and their issue becomes priority for the policymakers.

The survey found that 10% is not planning to return while a total of 70% would return to destination for work within a year. This indicates serious lack of employment opportunities in rural Bihar. All main income source for the migrants has diminished including labour opportunities.

It was found that since the lock down hunger increased among the migrant families. Before the lockdown 89% of migrant families used to take three meals a day, since lockdown, this is reduced more than half (41%). 8 families had one meal a day before lockdown and this has gone up more than four times since lockdown to 36 families having only one meal a day.

**Bihar Government by middle of April 2020 claimed they had transferred Rs.1000/- each to 94.85 lakh ration card holders of across the state, however 72% of migrants surveyed did not receive this amount and 33% did not receive the 5Kg free grain (PM Garib Kalyan Ann Yojana) promised by the central government.**

Since lockdown, the number of families who had no access to any type of health care increased eight times (n = 106) and those opting health care from traditional healers and “Jholachap” doctors has increased by two times (n =207).

53% of them received the ex-gratia payment of Rs 500 in their women’s Jan Dhan account. 23% of migrants reported that they received the Rs. 1000/- monetary assistance for stranded migrants from Bihar government. 40% of them said they were not aware of such provision.

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Out of the 900 children who were enrolled in ICDS, a high number of 76% did not receive the cash transfer. However, it has been reported that in some places the money is transferred to AWW and dry ration are been distributed among the children.

Only 9% (n=100) of migrants or their family members got employment under NREGA scheme since lockdown. 8%

**"Gap in food and nutritional requirements for women and children are obvious, service providers need respond in innovative ways during this time of pandemic."**

(92) of the migrants did not have job cards. 6% of the respondents said that the NREGA wages are disbursed in timely manner and 65% (n=773) felt that is not the case. 61% (n=724) of migrants said they did not receive the PM Kisan Samman Yojana, instalment of Rs 2000, while 26% said that either they are not registered or not eligible. Only 18% of migrants have access government health insurance (Ayushman Card – PMJAY).

Delivery of government relief and services during COVID-19 for among the migrant families, is something to be desired. Gap in food and nutritional requirements for women and children are obvious, service providers need respond in innovative ways during this time of pandemic. From among migrant returnees skilled personnel can be identified to advocate and work for improved access to government schemes. Skilled people also can be identified to be self-employed in their trade and create opportunities in their villages. Bihar is endowed with land, water, and human resources. Large portion of human resources is unskilled and work in unorganised sector. Agriculture sector is unable create enough employment opportunities in Bihar hence migration is unavoidable. Systems for safe migration needs to be ensured.

***Mr Abraham Dennyson***
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# NCDs IN THE TIME OF THE PANDEMIC: PERSPECTIVES FROM PRIMARY AND SECONDARY CARE SETTINGS IN RURAL TAMIL NADU

## Burden of NCDs and COVID in India

Ms Anu Oommen

India and many other Low- and Middle-Income Countries (LMICs) have been struggling with the double burden of disease, brought about by the epidemiological transition (change from traditional causes of premature mortality such as communicable, maternal, neonatal and nutritional diseases -CMNNDs, to Non-Communicable Diseases - NCDs). There is a wide variation within India, with certain states in more advanced stages of this transition (e.g. Tamil Nadu, Kerala) compared to others, with rapid changes even in those states with currently lower NCD levels. According to the Global Burden of Disease (GBD) data, NCDs contributed to 61.8% of all deaths in India, compared to 27.5% due to CMNNDs. Diabetes, Ischaemic Heart Disease, Chronic Respiratory Disease, Cerebrovascular Disease and Cancers contribute to most of the NCD related morbidity and mortality.

India is now reeling under the COVID-19 pandemic, superimposed on the 'epidemic' of NCDs. The high burden of NCDs, the growing COVID-19 pandemic and the ensuing nationwide and global lockdowns, have together created an immense healthcare burden on already struggling LMICs. India, as of September 2020, had the second highest number of reported COVID-19 cases, with a reported mortality rate of just under 2%. Due to its large population, even a small percent of infected, leads to large numbers of infections and deaths.

## Links between NCDs and COVID 19

Multiple studies have shown that People Living with NCDs (PLWNCDs) are at a higher risk of acquiring and dying from COVID-19, which may be causally or incidentally associated. As age is also associated with NCDs, it is not surprising that COVID-19 mortality is higher in the older age groups. Besides the disease itself, the public health responses to the pandemic, taken by governments (e.g. prolonged lockdowns), health facilities and communities also impact PLWNCDs.

The following are some of the ways in which there are associations between NCDs and COVID-19:

**Increased incidence of COVID-19, severity of illness and mortality due to COVID-19**, in those with NCDs. PLWNCDs are also more likely to experience increased stress due to multiple comorbidities, risk factors and fear of COVID-19.

## Disruption in all levels of intervention for NCDs.

**a) Primary prevention:**

Increase in behavioural risk factors such as alcohol/ tobacco use, physical inactivity, unhealthy diet and stress because of lockdowns, as well as lack of emphasis on preventing these risk factors (focus on prevention of COVID-19).

**b) Secondary prevention:**

Disruption of screening services (as screening of apparently well persons would not be a priority during an epidemic) will lead to late detection of chronic conditions such as cancer, diabetes etc.

**c) Tertiary prevention:**

-Disruption of treatment/continuation of care for chronic diseases due to transport issues, facilities overwhelmed by COVID-19, primary care disruption, escalating costs of treatment, loss of financial stability in many families, which could predictably to lead to increased deaths, complications and disabilities. Financial hardships due to the loss of wages and the looming recession will make it harder for those with chronic diseases to sustain treatment. A study by interns in RUHSA, among diabetic patients (unpublished), found that nearly two thirds had missed their routine appointments, with unavailability of transport being the most common reason.

-Disruption of palliative and rehabilitative care: the terminally ill and disabled are more likely to experience discontinuity of care due to the responses taken by governments and communities to the pandemic.

Mitigation of the combined effects of NCDs and the pandemic: a few examples

COVID-19 is an example of a dramatic, catastrophic public health emergency that has affected all countries worldwide, at around the same time, leading to unprecedented responses. In the face of sudden, unavoidable emergencies, mankind has risen to the situation by responding in different ways, with the wisdom and resilience that characterize man's image as being one like his Creator.

Some of the ways in which CMC's peripheral rural centres have tried to adapt to the situation, are outlined in Table 1. Similar measures and much more, have been taken by other primary and secondary health care settings across the country, in low resource settings, e.g. measures taken by LCECU, CMC Vellore (Primary Care for India's urban dwellers living in informal settlements during the COVID-19 pandemic, Abraham et al, September 2020, AJGP).

**Empowering communities for prevention to reduce the incidence of NCDs, can ensure that NCDs do not compound the effects of other disasters.**

The Community Health and Development (CHAD) program which serves the surrounding rural communities and a tribal area (Jawadhi hills), and the RUHSA (Rural Unit for Health and Social Affairs) department, CMC Vellore followed the underlying principle of ensuring that those with chronic diseases did not lose continuity of care during the lockdown and the ongoing pandemic, during which their increased vulnerability is widely recognized. Both these programs have a primary care component (routine village visits by health workers and nurses, with monthly mobile clinics), as well as a secondary care hospital. At a time when many private clinics and hospitals were shut down, these hospitals were kept open with precautions such as spacing waiting areas, guiding febrile patients to fever clinics, etc. Although there were financial difficulties in providing concessional treatment as was done previously, steps taken by CMC to cut costs and raise funds internally and externally, helped continue subsidised care to the neediest.

While home visits in the CHAD program have been stopped temporarily, mobile clinics have been functioning regularly, ensuring health education and necessary precautions to prevent COVID-19.

Home delivery of medicines including in a difficult to access tribal area, made possible due to the efforts of community volunteers and staff and the availability of a list of such patients, ensured that PLWNCDs did not miss their chronic medications. Having a system of *patient retained chronic disease cards* with names of medications, also enabled patients to obtain medicines at pharmacies or nearby clinics and to serve at least to some extent as a travel document for transport to hospital.

Palliative care in the CHAD program was provided through phone consultations, to assess need for medications (e.g. pain killers), as home visits were avoided to reduce transmission of COVID-19 through health care providers.

As PLWNCDs were also likely to be affected by lower access to food, CMC's three peripheral units (RUHSA, LCECU and the CHAD program) also responded by making provisions for supplying food grains/ cooked food to most vulnerable families.

Weaknesses in the health system exposed during this period indicate the pathways that are needed for the future, to ensure that we are better prepared for similar situations.

### Future directions

With increasing environmental changes and increasing man-environmental conflicts, it is very likely that there may be similar future threats to global health. Wars, natural disasters and disease outbreaks can have the same devastating consequences on the entire population, with higher effects on vulnerable populations. We need to learn lessons from this experience, by sharing our responses and planned recovery pathways, and together devise safety nets to help mitigate the effects of such situations.

*Primary prevention*

Empowering communities for prevention to reduce the incidence of NCDs, can ensure that NCDs do not compound the effects of other disasters. Lifestyle medicine approaches to enable healthy lifestyles, through exercise, healthy and sustainable dietary choices, and coping strategies (e.g. through investment in spiritual and emotional aspects of health), would decrease morbidity and mortality due to NCDs. Healthy settings at workplaces, home and the community will enable people to make the right choices for health. Awareness regarding the health, mental and economic losses due to addictions

to tobacco, drugs and alcohol also need to be stepped up. Secondary care hospitals with primary care outreach work, have the opportunity to do many these activities, that large tertiary hospitals cannot.

*Secondary prevention*

Ensuring regular screening for common NCDs including cancers, will help detect early disease and possibly lead to cure, leading to lower susceptibility to new infections. With screening now being available or meant to be available, through the national program for NCDs, it should be possible for all Indians everywhere to avail these services, and if not available, to raise the demand for them.

*Tertiary prevention*

Universal coverage for basic treatment, example access to medicines for those with stable NCDs, through well-functioning primary and secondary care settings, both public and private (such as mission hospitals and other charitable organisations), including mobile services for remote locations will ensure continuity of care. Leveraging digital and other technology for enabling chronic care, example through telemedicine, needs to be explored more in populations where these are now increasingly available and affordable. Maintaining patient databases including phone numbers, seems to be a necessary step for ensuring continuity of care and communication.

## Conclusions

It is exemplary how mission-run secondary hospitals and primary care programs have risen to the occasion compassionately, with God's guiding hands, protecting the interests of the marginalised and vulnerable populations around them, while handling their own struggles to stay afloat in this storm of health and economic torrents. It would be useful for organisations that have found practical solutions to share these with others in similar settings, to 'encourage one another for good works' and so that 'no one tires of doing good'.

***Ms. Anu Oommen, Professor,***
***Community Health Department, CMC***
***Vellore***

# YOUTH AND MENTAL HEALTH IN THE CONTEXT OF COVID-19: A PASTORAL PERSPECTIVE

**Rev. Dr. A Israel David**

As we deconstruct and decode the theme and Context of COVID-19 we realise that there are many very significant terminologies. Let us begin with the context of COVID-19 which has at least four stages; pre-COVID or lockdown, the lockdown period, unlocking stages and the post COVID. In the Indian context- COVID accompanied by locusts attack on agriculture, impact on economy, tension on Indo-China border, super cyclone, change of labour laws, tremors and much more has continued to cause disruption in our lives.

In this scenario, referring to the recent media stories and articles the huge impact on mental health is witnessed during lockdown and covid19. Mental Health is a state of well-being in which the individual realizes his or her abilities , can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community. It is pertinent to know what is the state of wellbeing, who are these individuals who are getting affected, what is the impact on their abilities and what can be the obstacles to help them realize these abilities. We should be aware that how can one cope up with the normal stress of life and yes if there is a new normal then how do we gauge it. We are aware of working joyfully, productively and fruitfully but today we also have to understand how the youth looks at productivity and is getting affected by the challenges.

Let us look at our youth, namely the youth who are able to 'Work from Home' and the Youth who 'Work For Home'. Hindustan Times newspaper on May 27th 2020 printed -Pandemic creating 'lockdown generation' as one in six youths stop work". These are the real fears of losing work opportunities, losing career options, the fear of being left behind and a massive increase in youth unemployment which affect the young men and women. The need of belongingness, the fear of missing out, loss of living space, forced to be present, in proximity and loss of mobility are some of the fears that trouble our young generation.

### The key notable points are:

The uncertainty to perform and the question of ability

a. Impact on Education due to the uncertainty of exams, results and promotion
b. Triple shock from the crisis of employment (lost), education (delayed) and training (unable to complete)
c. The impact of online classes and the digital divide

**The Anxiety of Losing the Youth-hood**

- Fear of prolonged impact on future
- The physiological impact due to gaining weight, eating disorders, skewed sleeping patterns and missing out of physical togetherness.

**The Issue of Productivity**

- Less work leading to alternative ways of spending time
- The peril of pornography and addiction to substance alcohol
- The pressure of productivity and quality

### Reaffirming the Youth

- The ekklesia which is in the process of rebooting itself should be aware of to which youth group they are called to respond first without ignoring the other
- Reaffirming the commitment to focus on the youth group who are 'work for home'- the marginalized, the subaltern, the so called outcaste, the migrants, the labours, found on the streets, the labelled and the so called 'sinners', the rural population
- The youth in the context of COVID-19 are not the ones do not belong to the community who flies in charted flights from Bhopal to Delhi and able to send their pets in flights from Delhi to Mumbai

- But who cycled 1200 kilometres with the ailing father, the Mashesh Jenas, the dying ones, those who lost their childhood and losing the youth-hood
- We are called out (Ekklesia) to reboot our focus towards these youth
- Preferential option for the poor and rural youth
- It is a call to the church to reboot her pastoral care towards these youth

### Companionship as PARADIGM for Pastoral Care

- Though, both groups need healing, the church needs to make an informed choice
- Pastoral community- from silence to presence - Safeguarding justice- Charity to solidarity- becoming a companion-creating the sense of availability
- Moving along with (not substituting) clinical response- Theological and biblical paradigms-Being informed by sociology, anthropology, psychology and theology
- Spiritual nurturing has to be emphasised. God as a companion
- Towards self-actualization-bring back hope- becoming the representative of the presence of divine

### Recommended Pastoral Practices

- Responding to social systems-the larger contexts- towards intra, interpersonal and social healing
- Focusing on constructive handling of conflicts- Responding to both internal and external conflicts
- Wholistic/wholeness- family as a system- not youth in isolation-
- Enabling the youth to respond to the present-moving from the past and leaving the future?
- Communication- Information to Influence- positive (may not be new normal-back to normalcy) –space for expression-Listening-talking- feeling
- Exploring-to feel safe –adapting not adjusting to changes –discovering alternatives
- Reassuring- answering- being practical –forgiveness
- Helping to help themselves-personal rational responsibility- shared responsibility
- The church needs more will power to move from ‘blaming’ to ‘understanding’ the youth
- Establish support groups –being close –digital resources
- ABCD model- Achieving a relationship- Boil down (deconstruction) the major problems- Constructive action plans (construction) - Develop on going plans

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***Rev. Dr. A. Israel David, Associate Professor of Pastoral Counselling, Faculty Dean and Dean of Doctoral Programme, Union Biblical Seminary***

# INTERVIEW OF DR KATUMALLA SHOBA

## Ophthalmologist, Mary Lott Lyles Hospital, Madanapalle, Chittoor, AP


**Introduction**

Mary Lott Lyles Hospital, Madanapalle was established in 1911 by Rev. Dr. Jacob Chamberlain. As a medical missionary from Reform Church of America, he came along with the Scudder's to Madanapalle in 1865 also bringing Christianity to the region. Like a medical missionary he conducted camps and worked in the towns. Mary Lott Lyles Hospital was established only for women and children.

Nursing school was established in 1912. It is a 220-bed hospital and the only hospital in the surrounding region making it one of the most famous hospital in the Southern Karnataka, Northern Tamilnadu and Madras presidency. From year 2000 to 2014 the hospital faced lot of crisis as it was without patients, during that period only 20 staff were working in the hospital. There were no doctors.

**At present what are the main services or work done by the hospitals?**

In 2014 a new Bishop requested us to help them to re-establish this hospital. Along with my husband we took over started with orthopedic, ophthalmology, Ob/Gynae and established a lab.

**Please tell us about the reach of the hospital to nearby villages and districts?**

We cover around 150 km in radius population because most of the people in Madanapalle and surrounding area would have been born here.

**When you joined how many doctors were there in the town around the hospital?**

We have 75 Nursing homes 150 doctors around, but this hospital is known for giving healthcare over the last 100 years.

**How did COVID effect the hospital?**

We were very fast in taking action, in December itself when it started in Wuhan, we were assured that it would

soon hit India. So, we started talking about its drugs etc. in the month of January and February 2020. We started with triaging our patients with sanitizer etc. even before it was announced in the country in March and were the first one to prepare our own sanitizer using the WHO formula because it was very expensive to buy from outside. We had thermal scanner before itself in the hospital. So, we had a small triaging area outside at the registration. So, whoever patients came in, we would take travel history of patients at that time and check with thermal scanner and put sanitizer. If we found anyone with fever etc., we use to keep them in a separate clinic called flu clinic.

In March it was complete lock down in AP and most of the hospitals and private nursing homes were also closed. May be all the doctors were worried at that time. But MLL was the only hospital that was running along with the government hospital.

**Please share your experience about the COVID block at your hospital.**

As the government didn't give permission till August ending to any private hospital to take COVID patients and till then only government hospitals were looking after the COVID patients. If they were sick the government hospital would refer the patient to Tirupati. But because of the number was high in August that's when the government gave permission to some of the hospitals who had the facilities. So, with the help of the local MLA & MPs we were able to create a separate block for COVID.

We have only separate blocks at the hospital and so about six months before we were planning to work on an ICU, so we put up a manifold for oxygen and cylinders which was of great use. We have established another new block with 40 beds and out of these 27 beds have oxygen support facility. We again invested in the COVID block, in less than a week's time it was and by September we started treating COVID patients.

Initially there was a decrease in number of patients due to social stigma, but once they came to know that COVID block is separated from the normal block they started coming to the hospital. Now the patients in the OPD have also increased, thankfully.

I am really very proud to share that our hospital is the best hospital in the entire Chittoor district. Out of the 25 hospitals working for COVID, Mary Lott Lyles Hospital has been always ranked in the first place.

**Kindly share some impact stories of individuals at Mary Lott Lyles Hospital.**

We had a retired judge living 60-km away from the hospital who along with his wife. After 5-6 days he became severely ill, and as we didn't have any COVID ICU, we told their children to shift him to a better hospital. However, the family insisted to continue the treatment as they had a lot of trust in us. Reminding us about how forty years ago when his wife had delivered all their children at this hospital which created a greater bond with the doctors and nurses. So, the whole night we did our best to treat him and by God's grace the next day he was alright. After 10 days both husband and wife were discharged, and they left retaining the same bond and trust with us.

Another story reminds us of a female patient who came along with 11 relatives who were diagnosed with COVID. That time in local hospitals and at small locations if a patient got fever, they won't even do the testing and they start giving drugs used for COVID as normal drugs like paracetamol. However, we treated all her relatives as per their needs and diagnosis. So some got home-quarantined and others So, this family too left happy and the fairness in the treatment they received.

**Did you get any opportunity to collaborate with a CMAI Member institution?**

Yes, we are a small mission hospital. Baptist Hospital and CMC Vellore are of great help to us. Dr Naveen Thomas in Baptist Hospital is my classmate and Dr David Peter is also my classmate. So, I look forward to them for any help and of course CMAI helped us with the PPEs which is of great use for us, I must thank you all for the effort. I also called Mr. Vijay to get more PPEs free of cost. We have also got 100 more PPEs from Baptist hospital.

Management protocol are all from CMC Vellore. We are in touch with Dr Priscilla Rupali who is a Professor in the Department of Infectious Diseases in CMC Vellore. We have their management COVID book, which is of great use beyond that also we call them more information.

Apart from Baptist and CMC there is one more hospital called RDT Hospital in Bathalapalli, AP which is not a member of CMAI they are also been a great help to us in terms of COVID.

**Please share of the challenges at the hospital.**

As you are aware that at small locations we always lack in human resources. So as soon as we started COVID block, we needed younger group of nurses, initially, people were not comfortable going to the COVID block, so I used to put myself on duty. Even though I am an ophthalmologist, but I used to go along with the medical officers during night duties.

Our own staff children who are into medical education like Nursing, BSc etc., but due to lockdown were contained at home. So, we trained them as a support staff in the

administration area and in food area etc. and paid on daily basis. So, we created work for them and utilized their abilities. We had other doctors and nurses also but then we required other staff also, so we used these young children. We trained them and used their expertise.

**Anything more would you like to share.**

In the first 3 months i.e. March, April & May we couldn't give salaries to our staff on time because of the lockdown. Then when we started this COVID block in September & October with the help of local politicians we were able to cope up the situation. Lots of people are quite weary of the politicians and I am certain that they also realised if the hospital is working genuinely, then helping in time is also necessary.

## Heads up!!!

It's time
Open doors
Let in the light
Can't go on
Pretending
That everything's alright..

Storms in my head
Auras
Surreal
Beautiful
Pounders
Blinding pain
Lighting
Thunder
Rain..
I'm a migraneur
That's my new name...

Overwhelming anxiety
Feels as if
I'm unprepared
For life
And how it'll hit me..
Worrying
Ceaselessly
Trying to control
Everything
Everybody
Dreading
Tomorrow
And what it'd bring
Catastrophic thinking
Concerning everything..

Coping
Struggling
Easy days
And tough
Mood swings
Weepy spells
'Black dog'
Life under
A grey cloud..

Abysmal darkness
Unending tunnel
No glimmer
No flicker
Of light
Helpless
Hopeless
Given up
No end
In sight..

Severe pain
With nothing to show
No fracture to fix
No surgery required
Crazy behaviour
Hating myself
For being this way
Hurting myself
The ones that I love...

Unable to do
The simplest of tasks
Getting out of bed
Brushing my teeth
Taking a bath..
Everest like
Impossible
Tears unending
Sadness
Blackness
Just crying
And crying..

Being bombarded
Suicidal thoughts
Grotesque images
Of all sorts
Trying to function
Hold it together
Paste a smile
Wipe the tears
Blow the nose
One more time…

Half of me
Hating myself
Degenerated state
This shell of myself
While the other half
Unable to
Understand
Comprehend..

Treatment atlast
Medicines
Kind professionals
Diagnoses
Counseling

Cloud lifting
Able to breathe
Peace in my mind
Get back to me..

That part of me
Hidden away

Show off
My personality
Pretend
All's well
Multi-talented
Perfectly..

I mean I'm a doctor
Pathologist, please..
Evidence based
medicine
Not
'this is how I feel'..
I'm a wife
A mum
Many hats to wear
Perfection demands
Excellence
Everywhere..

But the anxiety
Right there
Can't think
Can't breathe
Mind like a washing
machine
Stuck
Endless repeats..
Spinning around
The same thoughts
'so much to do..'
'how will I do it all?'
And then
'so much time'
'what will I do?'
And dealing with people
And their personalities
How to prevent
Arguments
Criticism
Rubbing each other
The wrong way…
'help….
I don't know what to do..
Can't handle this…
Somebody help me
please…'

Now I'm older
Greyer
Wiser
Larger in size
Now I know
One life
We all get

Help each other
Not ostracize..

Needless suffering
Silent diseases
Afflicting our mind
We
Our children
Our loved ones
Are one of a kind
Can be affected
Any stage
Any time..

Help those
Who need it
Let them know
They're not mad..
No place for shame
There's help available
There's a name
For what
they're going through
Just an illness
Of the mind..
Not simply
A 'loose screw..'

My supportive
Spouse
Been there with me
In the tough times..
Prayed with me
Held me close
Wiped my tears
Never let me feel
I'm a kill joy
No matter what
Hung in with me
Down the lonely roads..

When Jesus walked
This world
Among the many
He healed
A demon possessed man
Cutting himself
Living in the tombstones
This man
Stands out in relief!!!!

Jesus healed him
Sweet release
The man begged

' Lord let me
Go with you..'
Jesus said
'My child, go,
tell the world
What has been done to you'

And I hear
Jesus
Looking at me
Tenderly
'You've been there
Living hell
You know
How it feels..
Go!!
Spread the news
Testify..
Speak out
Loud
Bold'

This is my story
All who read
Pass it on
Be safe places
Listen
Heed
The warning signs..
Lives are precious
Minds too
Gentle souls
Need love
His touch
Jesus the Healer
For
Bodies
Souls
Minds
For
Me and you…

Lisa Choudhrie

# INTERVIEW OF DR SEDEVI ANGAMI

## Christian Institute of Health Sciences and Research (CIHSR) Dimapur, Nagaland


**Introduction of the Member Institution**

The Christian Institute of Health Sciences and Research (CIHSR) is based in Dimapur, Nagaland. It's a public and private partnership institution. EHA, CMC Vellore and the Govt of Nagaland have partnered together to start this institute for a common cause. It is a secondary hospital with approximately 200 beds. It has educational courses like DNB PG courses in Family Medicine, surgery and Medicine, college of nursing and also has few Allied Health Sciences courses from which are with CMAI and some are with the Nagaland University.

CIHSR also partners with CMC Vellore for CLHCT and CHPC programmes and PGD Family medicine. They also run a small centre for Children with special needs in partnership with several organisation, churches and govt. We also have small palliative care unit and Community Health dept to do outreach work.

**Please share how this pandemic affected the hospital?**

COVID has brought a lot of difficulties to the us but also brought many opportunities. In the beginning, everyone was apprehensive hearing the news about the pandemic. However, we trained around twenty people from various areas as a Rapid Response Team. They in turn started training our other staff members which helped in spreading awareness about the pandemic. There were times when we faced difficulty in getting the PPE's and other materials. However, these trained staff helped in producing materials in-house also procuring the materials which were not easily available.

As there were no testing centres in Nagaland, we took initiative to start a COVID test centre in consultation with the government. In result of that we were able to have two centers, in our hospitals at Dimapur and Kohima.

Then we also created an isolation ward for the COVID -19 patients. As there was lot of panic in the community before the lockdown, we were able to conduct around 20 workshops in several parts of Dimapur with the help of several organization and churches, village councils, etc. We also developed educational materials to spread awareness about the quarantine centre, isolation centre, prevention, etc. We have been instrumental in providing support to the government in many ways like, setting up and running the quarantine centre, etc.

More than 50 staff were affected by COVID but all recovered in time. Due to which we had to close down the hospital for two weeks leading to deferment of salaries but we successfully reimbursed by the month of September

**What are the opportunities you had in this time?**

It raised fantastic opportunities like we got opportunities to engage with the government through which we also got lot of networking opportunities. We were able to demonstrate that as an institution can be of great help to the community and to the government and also to the churches. It gave the opportunity to develop training teams who could conduct workshops and further develop many more teams. This situation also helped us to think more about spiritual growth which helped us to create a team who can work on a strong spiritual curriculum for a dynamic spiritual growth.

**Reaction of the community when workshops were conducted?**

Right now, it will be difficult to share about the response from the community as we are yet to receive feedback about the programmes. However what we can say for sure is that overall these workshops were welcomed by everyone in the community.

**Please share in case you were able to collaborate with another member hospitals of CMAI during this time?**

Due to the lockdown period, we were unable to collaborate with other nearby hospitals. Although, there were times when we could take care of nearby hospitals and whenever the contact was possible. They required help like manpower etc. we were able to cater to such needs to Tezpur, Makunda, Alipur, etc.

**Any other experiences you can share with our readers?**

All the hospital staff who stayed in rented accommodations were asked to leave the house. This had led to a very sad situation as our staff suffered. So, we had to keep them in the hospital and provide with all the necessities. There was a lot of stigma and discrimination in the community. So, I addressed this matter and reached out to the Bishop and other authorities to explain that the situation in the community had potential to destroy the peace of the community. Simultaneously, we kept organizing activities making attempts to remove stigma by spreading awareness.

**What is the present situation at the hospital?**

We are elated to share that we are back to the normal situation. People are now confidently coming for their treatment. I definitely would like to commend the CMC courses which have been instrumental and helpful for our awareness programmes and also empower a lot of people in the process.

# PANCYTOPENIA: AN UNEXPECTED OUTCOME

## Introduction

Pancytopenia is a common haematological entity in which all three major formed elements of blood (red blood cells, white blood cells and platelets) are decreased in number [1]. It's encountered in our day-to-day clinical practice causing serious and life-threatening illnesses, ranging from megaloblastic anaemia, simple drug-induced bone marrow hypoplasia, to fatal leukemias and bone marrow aplasias [2]. Not only common causes but some of the other rare causes are hemophagocytic syndrome, Mycobacterium Avium complex, Tuberculosis (TB), among others [3, 4, 5]. Hence, it is critical to rule out the severity of pancytopenia and the underlying pathology to determine the management and prognosis of the patients. In view of extreme rarity, this paper focuses on a patient who presented as fever with pancytopenia, showed a myriad of haematological findings like extensive purpuric rashes all over the body and henceforth, was admitted under haematologist, with possibility of leukaemia and turned out to be TB.

## Case report

A young 24 year old male from Hyderabad, India was presented to the St. Theresa multispecialty hospital with a history of on and off high-grade fever for 3 months associated with evening raise, chills and rigors. He also had altered bowel movements for a month and epistaxis. He was previously admitted in other hospital for 5 days before coming to our hospital and developed petechiae in both upper and lower limbs and trunk in 3 days of admission. He also had hematuria, reduced urine output and nausea for 2 days. He received 2 units packed red blood cells (PRBC), 6 Units single donor platelets (SDP) transfusion and platelets were raised. He was suspected primarily of acute leukaemia, TB involving marrow, non-Hodgkin or Hodgkin lymphoma and conservatively managed with tetracycline and B- lactam antibiotics for broad spectrum coverage but found no improvement. He was advised referral to our hospital's haematology centre for further evaluation. In our ER department, the patient had Ecchymosis all over body, multiple Ecchymotic patches, splenomegaly on palpitation, nose bleed, and gum bleed (Fig:1). He had marked loss of appetite, and had lost weight. He denied long-standing cough, headache, altered sensorium or blurred vision. No chest pain, syncope, shortness of breath (SOB), cold or vomiting. There were no known comorbidities. His past medical history was unremarkable. He is a third year engineering student, and no history of smoking or drinking. He denied any family history, past history or contact history of tuberculosis.

On examination, he had pallor and was mild icteric. He had temperature of 98.6°F at the time of admission. He had cervical lymphadenopathy. His cardiovascular and respiratory system examinations were unremarkable; his blood pressure was 110/80 mmHg and pulse of 136 beats per minute. Respiration rate was 20 breaths per minute and on auscultation found no abnormal breath sounds. His abdominal examination revealed a soft, non-tender abdomen with mild hepatosplenomegaly, soft in consistency. He did not have features of meningism. The results of his neurological examination, including higher functions, were unremarkable. His fundus examination was not done

On admission, patient was started on Normal saline 75ml per hour empirically after blood and urine were taken for cultures. He was treated with proton pump inhibitors (PPI), intravenous injection vitamin B12, ondensetron, cefoperazone and sulbactam, was subsequently added to the treatment regimen. He received 1 unit PRBC and 2 units SDP transfusion. He continued to have high fever spikes, and his condition deteriorated. Complete blood count revealed anaemia with haemoglobin of 7.3 g/dl (reference range 11.0–17.5), Total leucocyte count (TLC) 3100 (reference range 4000–10,000) with neutropenia of 72.3%, and a low platelet count of 1700µl (reference range 150–450). Pancytopenia and reactive lymphocytes with profound neutropenia and moderate thrombocytopenia were evident in the patient's blood workup. His C-reactive protein level was 1.14mg with an erythrocyte sedimentation rate of 135 mm in the first hour. His blood culture and urine cultures were sterile. His chest radiograph was unremarkable. His renal function was normal. He had a low serum albumin level (2.1 gm/dl) with a normal prothrombin time. Liver Function Test (LFT) showed mild hyperbilirubinemia. His liver enzymes were elevated (alanine aminotransferase 22 U/L, aspartate aminotransferase 45 U/L), and his serum bilirubin level was 1.24 mg/dl. His lactate dehydrogenase concentration was 1620 U/L.

His lipid profile showed serum LDH was 680 U/L, other parameters of iron profile was normal. Serum B12 was normal and was decrease in folic acid. His hepatitis profile, malaria film, dengue film, Widal test, Coombs test and human immunodeficiency virus serology was negative. Ultrasonography (USG) neck showed multiple left supra clavicular nodes, largest measuring 4x4cm. The high-resolution computed tomography (HRCT) chest was unremarkable.

On further evaluation, family history was taken again and found history of TB in the patients younger brother who died 2 years ago. A histological examination of lymph node biopsy was done (Fig/Table ).. The cartridge- based nucleic acid amplification test (CBNAAT) showed multi drug resistant TB (MDR TB). Cervical node biopsy showed rifampicin resistant strain of mycobacterium tuberculosis on CBNAAT sample. In addition, the result of his Mantoux test was positive. Patient was started on standard antituberculosis treatment (ATT) and made a rapid clinical improvement with improvement in the blood picture. The patient was started on standard MDR-TB regimen, including isoniazid, pyrazinamide, ethionamid, clofazamine, levofloxacin, and ethambutol and multiple SDP and PRBC transfusions in view of bleeding manifestations.

## Discussion

Tuberculosis (TB) is the third common cause of death in India [6]. Approximately, 3 out of 10 (27%) cases worldwide belongs to India [7]. This infection not only affects the lungs but can also affect other organs through lymphohematogenous spread. Extrapulmonary tuberculosis is often delayed in its diagnosis due to its nonspecific presentation and symptoms varying according to the affected site of infection [8]. This paper reports a case of a young boy with pyrexia of unknown origin (PUO) who presented with peripheral cytopenia and high inflammatory markers. He had positive Mantoux test results and negative chest radiograph. Our patient showed recovery with anti-tuberculosis treatment (ATT). This case report is quite unique in that it describes a rare but recognized presentation of disseminated tuberculosis with pancytopenia and an excellent response to the treatment following prompt diagnosis.

While the incidence of active pulmonary TB has declined due to prompt diagnosis and treatment, the incidence of extrapulmonary TB remains constant because of the delayed diagnosis owing to very nonspecific presentations [9]. Bone marrow examination is the best in confirmation of differential diagnoses of disseminated tuberculosis with absence of pulmonary lesion and presence of hematologic findings. Bone marrow biopsy may reveal granulomata in one half of cases, but anemia, leukopenia, and monocytosis show in 80% of cases [10]. TB is one of the most common causes of bone marrow granulomas constituting 6–48% of the cases where in cases of miliary tuberculosis its 33–100%; caseation is uncommon (29%), and presence of acid-fast bacilli detected by Ziehl-Neelsen staining is rare [11, 12].

Furthermore, as diagnosis remains a challenge to the treating physician due to protean manifestations of disseminated tuberculosis, history taking also plays a key role. A careful and detailed history helps in evaluating the possible outcome. Any patient who presents with PUO with peripheral cytopenia in an endemic region has to alert the physician to the possibility of TB, and prompt investigations including bone marrow need to be carried out [13, 14].

TB rarely presents with pancytopenia and thrombocytopenia is more common in patients with disseminated tuberculosis. Fast recovery of peripheral blood counts with ATT indicates no underlying haematological disease [15]. Aetiology of pancytopenia in disseminated or extrapulmonary tuberculosis can be due to hypersplenism, nutritional deficiency, malignancy, infiltration of the bone marrow by caseating or noncaseating granulomas, or hemophagocytic lymph histiocytosis (HLH), tumours causing reversible or irreversible fibrosis [16]. Mukherjee A, et al. reported that normocytic normochromic anaemia was the most common abnormality observed [17].

Another possible mechanism of pancytopenia in Tb is infiltration of the bone marrow by noncaseating or caseating granulomas causing reversible or irreversible fibrosis [18]. A study reported patients with disseminated or miliary tuberculosis with granulomas in the bone marrow had bone marrow histiomonocytosis, peripheral monocytopenia, and severe anaemia, in contrast to patients with disseminated or miliary tuberculosis without granulomas [19]. In addition, Pancytopenia in disseminated tuberculosis is multifactorial and can be due to hypersplenism, which was doubtful in our patient because his splenomegaly was mild and would not justify for such severe degree of pancytopenia. Maturation arrest due to disseminated tuberculosis is rarely known to cause pancytopenia [14]. Henceforth, identification of correct cause will help in applying appropriate therapy.

## Conclusions

Due to nonspecific remains disseminated tuberculosis stands as a diagnostic challenge. This case report presented a patient with fever with cytopenia, a normal chest radiograph, and positive Mantoux test. Poor prognosis of disseminated tuberculosis is due to delay in diagnosis owing to lack of specific clinical features. Wang *et al.* described that simultaneous culture and histopathological examination of bone marrow in diagnosing disseminated tuberculosis is more sensitive than just performing a mycobacterial blood culture [20]. The favorable outcome of our patient was probably due to good history taking and prompt diagnosis with early initiation of ATT. Hence, it is to remember, common diagnoses are commonly correct and rare diagnoses are rarely correct.

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***CMJI with this edition will engage with artists to commission them for creating the Cover Design. This work of art will add visual value to the theme. The original art piece will be available for purchase by an individual member or a member institution. For this edition, we spoke with Ms Rebecca Pearson who created this painting on Violence in Medical Field.***


**-Please tell us about yourself.**

I'm Rebecca Pearson, an artist, writer, and entrepreneur based in Bangalore. Creativity and communication are two of my biggest strengths and I've put the two together and founded a creative branding agency called Five Stones Media House, that helps brands 'create giant impact'.

**-What inspires you?**

People and nature inspire me most. To see the fullness and beauty of God's creation, especially in faces of people and flowers give me immense joy.

**-The artists love the beauty of Canvas and colors. It has its own space and yet the digital world embraces and promotes art more effectively today. Your thoughts please?**

I love that technology is a friend of art and it's given artists tools and platforms that they didn't have before. I think canvas and paints have their own charm and digital art its own. One isn't better than the other, they're equally creative and inspiring to me.

**-So, looking at the painting you've created for the cover page, tell us what came to your mind?**

Infectious diseases aren't the easiest subject to articulate through art. But I love drawing patterns and playing with watercolors, even digitally. The shapes of viruses depicted microscopically looked like beautiful patterns and so I used that as inspiration. Also, the colors blue and purple evoke confidence and security, something I believe we all really need this year.

**- CMAI is trying to promote artists through this publication. What would you like to tell your fellow Artists?**

Deeply touched by what CMAI is doing here with artists. I think Christian artists need a platform and a voice and I think the way CMAI is doing it is wonderful.

**- What does your process involve? Does the work evolve or your start with an idea and take it to the finish?**

Every artwork has a process that is a different story. Sometimes I struggle with a concept, sometimes it flows out of me easily. The key is to allow yourself to take time with the work that you're doing and not rush it.

**- Where can we find more about your work?**

I sell my paintings on www.beckyleepearson.com and also take commissioned orders for personalised artwork if reached out to directly on beckyleepearson@gmail.com

# *Are you looking for an opening in a mission hospital?*

***Advertise in the Classified Section in the CMAI newsletter – LIFE FOR ALL, and on our CMAI website: www.cmai.org***

Take bold steps for change. This is what Mahatma Gandhi taught us. Christian Medical Association of India, established in 1905, was one such bold step taken by the missionary doctors who dared to serve this country. Even today, young doctors, nurses, allied health professionals, administrators and chaplains have followed the trodden path of the missionary movement which was started 115 years ago.

One cannot do it alone. But together, we can. If you are a medical or nursing graduate, if you are a professional in the health sector or a theology graduate, you need fertile ground to sprout and bloom.

CMAI is a large Christian membership organisation in the Indian health sector. We offer training programmes, platforms for sharing knowledge, opportunities for leadership building, and avenues to excel in your career.

If you haven't become a member, become one today.

CMAI member institutions work in the remotest parts. You will see a different geography of India where people suffer due to lack of proper medical care, children die of malnutrition and young mothers who need education in rearing children.

Dare to reach out to the place where people with commitment such as yours are needed to make a change.

YES,
It possible! You are needed indeed.

**Write to us:**
Christian Medical Association of India
cmai@cmai.org