Training and Digital Care Coordination for Improved Prevention of Type 2 Diabetes (T2D) and Cardiovascular Diseases (CVD) by Primary Health Care Teams in Bangladesh: Testing the Proof of Concept

Date: 22 August to 31 August 2021 | **Duration:** 09 days

Number of Participants: 10 (1 Research Medical Officer, 1 Medical Technologists, 5 Research Assistants, 3 Data Collectors)

Facilitators:

- Dr Rina Rani Paul, Consultant, BRAC JPGSPH
- Md. Mokbul Hossain, Analyst Statistics, BRAC JPGSPH
- Professor Malay Kanti Mridha, Director, CNCDN, BRAC JPGSPH

Study launched: 01 September 2021

Study Sites(s): Chandipur and Manmathpur Unions of Parbatipur Sub-district, Dinajpur

Brief: Although 67% of deaths in Bangladesh are attributed to non-communicable diseases (NCD), NCD management is not yet a priority in the country's primary health care (PHC) system. The government of Bangladesh, the World Health Organization (WHO) and the Non-government organizations (NGO) are looking forward to the digitalization of health service delivery. Centre for Non-Communicable Diseases and Nutrition (CNCDN), BRAC JPGSPH has recently

developed a digital care coordination platform to support the PHCs in improving the prevention and management of type-2 diabetes (T2D) cardiovascular diseases and launched the piloting of the application. In this piloting, we are simulating the government PHC system from the community to the Upazilla health complex (UHC) to understand the readiness of this digital platform and ways to improve the functionality of the platform further. The study will also help us to document challenges and opportunities for future scaling-up of the digital platform.

In this study, Community Health Workers (CHW) will register around 2,300 people aged 40+ from the catchment area of 3 selected community clinics of the Chandipur and Manmathpur unions of the Parbatipur sub-district in Dinajpur district. From this population-based assessment, we look forward to identifying and enrolling 800 hypertensive and 180 diabetic patients. CHWs will screen the participants for behavioural risk factors, counsel, and refer them to a community clinic like a health centre for further assessment if needed. In a community clinic like a health centre, a Community Care Provider (CCP) will verify identification and measure height, weight, blood pressure, the blood sugar of the referred patients. They will estimate and communicate 10-years CVD risk using the WHO nonlaboratory-based CVD risk chart and will screen for hypertension and T2D and refer the identified hypertensive and T2D patients to an NCD corner-like set up for confirmation of the diagnosis of hypertension and T2D. In the NCD corner life set up, a medical officer will confirm hypertension/T2D, generate a prescription, perform additional diagnostic tests if needed, estimate and communicate 10-years CVD risk, counsel for treatment adherence, complications, and refer to the specialist care if required. Through this piloting, we will generate data and information to further improve the NCD management in the primary health care system of Bangladesh.

Implementing by: Centre of Excellence for Non-Communicable Diseases and Nutrition (CNCDN)

Organized by: Centre of Excellence for Non-Communicable Diseases and Nutrition (CNCDN)