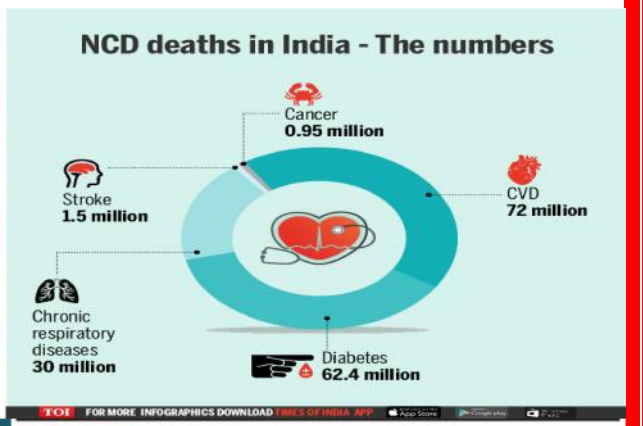
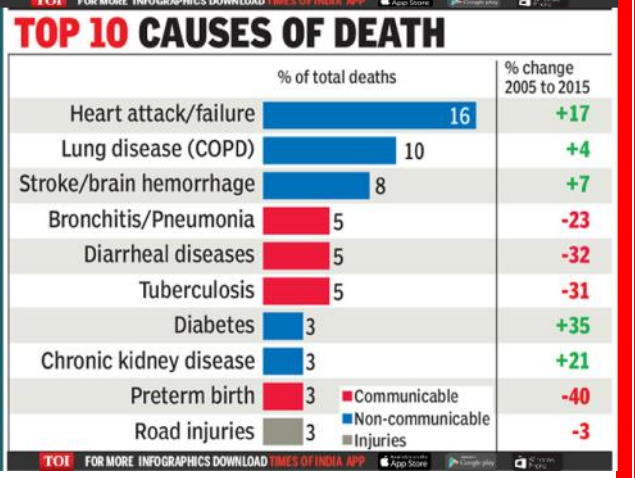
Concurrent Evaluation of the Implementation of Prevention, Screening and Control of Non-Communicable Diseases by Health and Wellness Centres in Jammu and Kashmir





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PREFACE

India is experiencing rapid demographic and epidemiological transitions with NCDs causing significant disability, morbidity and mortality both in urban and rural populations and across all socioeconomic strata. According to the ICMR State Level Disease Burden Initiative, in 2016, NCDs accounted to an estimated 6.0 million deaths, constituting 62 percent of the total mortality of that year. The four NCDs - Cardiovascular Diseases, Cancers, Diabetes and Chronic Respiratory Diseases - contributed to nearly 58 percent of the premature mortality in the age group 30-69 years. ICMR–INDIAB study has estimated prevalence of diabetes as 7.3 percent and there are nearly 3,460 million people suffering from diabetes. Prevalence of Hypertension which is the principal risk for CVDs, has considerably increased in Indian population in last two decades. Tobacco use is a leading risk factor for NCDs attributable to nearly 1.3 million deaths every year. About 28.6 percent of adults use tobacco products in some form.

India is one among the developing countries which took an early initiative to control the epidemic of non communicable diseases in 2010, when it launched the National Programmes for the Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) scheme. In order to ensure comprehensive primary health care, close to where people live, Sub-Centres are being strengthened as Health and Wellness Centres (H&WC), staffed by appropriately trained primary health care team. These HWCS have to play a key role in the Prevention, Screening and Control of Non-Communicable Diseases. Here the focus is not only on building the knowledge and skills of the ASHAs, MPWs and CHOs in undertaking population based screening but also on identification of cases for referral, follow up, recognition of complications, prevention, ensuring continuity of care, health promotion and improving recording and reporting of information.

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The programme of the community based screening for NCDs through AB-HWCS in various districts of J&K is still in the infancy stage and as a new programme, the implementers may be facing few challenges and barriers in its implementation. MOHFW desired that the implementation of NCD screening in Jammu and Kashmir be evaluated by PRC Srinagar. PRC completed this evaluation exercise in 5 districts of J&K and this report presents the findings of the evaluation exercise conducted in the districts of Anantnag, Budgam, Kupwara, Samba and Udhampur.

The study was successfully accomplished due to the efforts, involvement, cooperation, support and guidance of a number of officials and individuals. We wish to express our thanks to the Ministry of Health and Family Welfare, Government of India for giving

us an opportunity to be part of this evaluation exercise of national importance. Shri. D.K Ohja Deputy Director General, and Mrs. Anjali Rawat, Director (Statistics Division) MOHFW encouraged us to take up this study and we are highly thankful to both of them for their encouragement and support at every stage of completing this evaluation exercise. Our special thanks are due to Dr. Bhupinder Kumar, Mission Director NHM Jammu & Kashmir and his team for his cooperation and support rendered to the PRC in conducting this monitoring exercise. Chief Medical Officers of District Anantnag, Budgam, Kupwara, Samba and Udhampur extended desired cooperation in data collection. They deserve our special appreciation. We also appreciate the cooperation rendered to us by the Block Medical Officers and NCD Programme Management Units of various blocks for their cooperation and help in the collection of information. Special thanks are also to staff of AB-Health and Wellness Centres and ASHAs who spent their valuable time and responded with tremendous patience to our questions.

I thank my colleagues namely Mr. Syed Khursheed Ahmad, Mr. Imtiyaz Ahmad Bhat and Jaweed Ahmad Mir for their help and support in data collection and data entry. It is hoped that the findings of this study will be helpful to both the Union Ministry of Health and Family Welfare and the State Government in taking necessary changes.

Bashir Ahmad Bhat

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The objectives of this evaluation study are to study whether functional HWCs have been equipped with requisite inputs like, infrastructure, human resource, trainings, equipments, drugs and other logistics required for screening and reporting of NCDs as per the guidelines. Another objective was to evaluate the performance of HWCs with specific reference to community mobilization, creation of individual health records, Health Promotion, Community Based NCD Screening, referrals, follow up, record keeping and coordination with ASHA and suggest remedial measures that can be undertaken to improve the process of implementation of community based screening of NCDs through AB-HWCs in the State.

The study was conducted in 5 districts of Jammu and Kashmir namely Anantnag, Budgam, Kupwara, Samba and Udhampur. From each district, we collected information from five facilities which have been upgraded to AB-HWCs. Information was collected from the Medical Officer and the MPW in case the facility was a PHC AB-HWC and MLHP and MPW in case the facility was a SHC AB-HWC. We also collected information from one ASHA from each of the Health and Wellness Centre except Udhampur as the ASHAs during our visit to Udhampur were involved in some training.

Important findings of this evaluation exercise are as under:

Infrastructure

The districts have initiated up gradation and branding of the easily doable facilities for achieving the short term goals, while doing so, the quality of up gradation has been compromised. Some of the Sub Health Centre AB-HWCs lack even the basic facilities like electricity, water, proper toilets, sanitation, pit for bio medical waste, adequate patient waiting area, space for examination, etc. Uniform guidelines for branding of HWCs have not been implemented. Samba and Udhampur districts have upgraded the infrastructure of AB-HWCs more efficiently and Budgam districts seems to have not properly utilized the funding provided to it for up gradation.

Manpower

Although the State has started to recruit MLHPs and few batches have completed the bridge course and have been posted at HWCs, but most of the SHC AB-HWCs are without MLHPs. Further some of the SHC AB HWCs are functioning with only one MPW. Some PHC AB HWCs are without SNs and Lab Technicians. It was also found that State has not yet finalized the mechanism for performance linked payments to MLHPs as State is waiting for uploading of performance of HWCs data.

Training

Various districts have initiated training for Medical Officers, Staff Nurses, MPWs and ASHAs under NCD in the State. But it appears that the districts have not followed proper guidelines for imparting training to MPWs and ASHAs and quality of training seems to have been compromised. Further, it was found that trainings mostly focused on NCD screening and proper attention has not been given on filling CBAC forms and promoting health lifestyles. As most of the VHNC members have not been oriented about their roles and responsibilities, this has restricted their participation in making NCDs a success.

Diagnostic Equipment

Information collected from the HWCs regarding the availability of equipments for screening of NCDs and oral cancers shows that Glucometers, strips for Glucometer and BP apparatus is available in almost all the HWCS. Measuring tap and Torch in working condition is also available in most of the facilities. Torch Examination lamp with white light, Autoclave, Cusco's speculum and Dental Mouth Mirrors is not available in about 40 percent of AB-HWCs.

Information Technology

It was found that due to the delay in procurement, issues with both hardware and software and issues in distribution, Desktops/Laptops and Smart Phones have not yet been provided to most of the HWCs. Even if they were provided to few HWCs that were upgraded in the first phase in the districts of Udhampur, Samba and Kupwara, they were unable to use the NCD portal due to the non availability of internet facility and other issues with software.

Drugs

It was observed that there is no structured policy for procurement of drugs and reagents and other lab consumables. Some drugs are provided by Jammu and Kashmir Medical Supplies Corporation (JKSML), some are provided by the BMOs and some are purchased locally. Irregular and shortage of NCD drugs both at SHC and PHCs is a common feature across all facilities in the State. This is substantiated by the fact that a significant number of AB-HWCs had only 1 or 2 NCD drugs. Inability to ensure uninterrupted and regular supply of medicines, diagnostics is affecting the continuum of care as well as the utilization of AB-HWCs by community.

All the HSC AB-HWCs except those located in Udhampur District mentioned that the NCD drugs supplied to them are not provided to them in adequate quantities. None of the facilities had a stock of available that could last for three months.

Diagnostics

The facility of random blood sugar, blood pressure and Hb investigation is available at almost all the HWCs. The facilities which do not have HB testing facility available are Zahooma, Wadipora and Wavoora. However, all facilities reported inadequate supply of blood sugar strips. So far as screening of common cancers is concerned, the AB-HWCs are not able to screen patients for common cancers due to lack of training and other logistics.

IEC

Some of the districts like Budgam, Samba and Anantnag have not yet developed IEC material for health promotion as 14 of the 25 HWCs have not displayed any message related to NCD or health promotion. Although some facilities have displayed IEC messages, but they have covered only few aspects of NCD and health promotion. None of the facilities from Budgam and Samba have displayed any message related to NCDs.

Community Involvement

It was found that there is no clear strategy for community mobilization in the State. As Panchayats are not properly functioning, so involvement of PRIs is a more complicated task. Further, the blocks have not yet initiated training of VHNC members under NCDs, so they are not well aware about their roles and responsibilities. Therefore, AB-HWCs have not yet been able to market the preventive and primitive services involving the community, particularly in Kashmir division, where PRI members hesitate to work for various government programmes

Community Based Assessment Check list

ASHAs have started to collect information on CBAC forms for persons age 30 and above but filling up of CBAC forms is in infancy in some districts particularly in Budgam district.

Quality of CBAC Forms

We checked at least 5 CBAC Forms of each ASHA and it was found that all the ASHAs had made major mistakes in filling up the forms. The responses of some of the questions were not circled in 15 percent of the CBAC forms. Personal details were also missing in few forms. It was found that ASHAs have not been provided any training regarding calculation of age and they were simply accepting any age reported by the client. It was noticed that they were not reading the full text of the questions and were not fully probing smoking and drinking behavior. Therefore the information contained in these forms does not depict the actual health score of the individuals.

The MPWs and MLHPs are supposed to review the completed CBAC filled by the ASHA in her coverage area to ensure that it is filled correctly but it was observed that

till date nobody has taken the pains to review these forms or at least accompany the ASHA to see how they ask the questions and how they fill the responses.

Screening

Almost all the facilities have started population based screening for diabetes and hypertension and screening takes place once a week. But it was found that the screening of these two morbidities is also in the infancy. Blood sugar is rarely measured for general population due to limited number of blood sugar strips supplied to HWCs. Therefore opportunistic screening is not taking place at HWCs.

Record keeping of the details of NCD screening is very poor in Budgam, Kupwara and few facilities in Samba. Some facilities maintain information about person who are hypertensive and diabetic and not about the total number screened. Some record information about hypertension only even though the person is diagnosed for diabetes also. In two of the facilities more than 95 percent of the individuals screened are female. Due to these data limitation, it was not possible to get clear cut information about overall screening or prevalence of Diabetes and Hypertension.

Follow up

Although both MPWs and ASHAs should conduct follow up visits of NCD patients, but it was seen that ANM/MPWs do not undertake follow up visits. Community Follow up of NCD case is done by ASHAs only. They are making visits to enable positive behaviour modifications, treatment compliance, and encouraging patients to go the Sub Health Centre for regular check-up of BP/blood glucose. The ASHAs, MPWs and MOs mentioned that follow up and failure to ensure continuity of treatment is a major challenge due to supply issues and public perception that the drugs available at the health facilities are sub standard.

Shifting of Patients from Private to Public facilities

ANMs/ASHAs are also required to identify the patients who are already on treatment under the care of a private practitioner and advise and motivate them to visit the AB-HWCs for treatment. They are to be offered the choice of taking drugs from the public health system, after appropriate confirmation. None of the patients from 13 AB-HWCs had shifted to public health care facilities for treatment or drugs.. It was reported by the MPWs and ANMs that they find it difficult to motivate the patients to shift from private sector to public due to the irregular and non availability of drugs prescribed to them by private practitioners and a perception among patients that the drugs available at SCs and PHCs are sub standard.

Referral

Referral linkages between SHC AB-HWCs and Primary Health Centres and higher facilities for managing complicated cases is missing, because PHC and other higher facilities are not clear about their roles and responsibilities. There is also lack of coordination among service providers at SC and PHC level. Further the MPWs/MLHPs mentioned that once a person is diagnosed with Hypertension or Diabetes and is referred to PHC for confirmation, the patients instead of visiting a PHC generally visits a private doctor/clinic or District/State hospital for confirmation and subsequent treatment as they do not have much faith on Primary Health Care facilities.

Monitoring

Sr. Officials from State, District and Block offices are required to review the progress of the NCD regularly more so in the early stages of the implementation of NCD screening and identify the problems in the implementation and suggest ways to rectify the issues. But it was found that monitoring of NCD programme is week as monitoring visits are not frequent. Some of the monitors have not given any feedback at all to the HWCS thus restricting the efficiency of these visits. Review of NCD programme should be an integral a part of monthly review meetings but monitoring of NCDs was not in the agenda of the last monthly review meeting in case of majority of HWCs.

2. Background

In the last ten years, India has seen many improvements in the health of women and children which include an increase in institutional deliveries, immunization coverage, improvements in maternal and child health, and reductions in maternal and child deaths. However, with improvements in maternal and child health, India is also witnessing an epidemiological and demographic transition, where non-communicable diseases such as cardiovascular diseases, diabetes, cancer, respiratory, and other chronic diseases, account for over 60 percent of the total deaths. The four major causes of NCD deaths are: Coronary Heart Disease, Stroke, and Hypertension (45 percent), Chronic respiratory Disease (22 percent), Cancers (12 percent) and Diabetes (3 percent). The three most commonly occurring cancers in India are those of the breast, uterine cervix and lip/oral cavity. Together, they account for approximately 34 percent of all cancers in India, and constitute a public health priority. Breast cancer has emerged as one of the leading causes of cancer among women (14.3 percent) in India with 1,44,937 new cases and 70,218 deaths reported in 2012 (Globocan 2012). Cervical cancer in India is the second most common cancer in women (12 percent). Every year, around 1.23 lakh new women are diagnosed with cervical cancer and 67,500 of these women die of the disease in India (Globocan 2012). Oral cancer accounts for around 7 percent of all cancers in India with 77,003 new cases and 52,067 deaths reported in 2012 (Globocan 2012). One of the most serious concerns about Non-Communicable Diseases is that they affect people in the productive years of their life.

However, there is global evidence that Comprehensive Primary Health Care (CPHC) is critical to improving health outcomes particularly in the primary and secondary prevention of several disease conditions, including non-communicable diseases. The provision of CPHC reduces morbidity and mortality at much lower costs and significantly reduces the need for secondary and tertiary care. But for primary health care to be comprehensive, it needs to span preventive, promotive, curative, rehabilitative and palliative aspects of care. Primary Health Care goes beyond first contact care, and is expected to mediate a two-way referral support to higher level facilities (from first level care provider through specialist care and back) and ensure follow up support for individual and population health interventions.

In India, the need for and emphasis on strengthening Primary Health Care was articulated in the Bhore Committee Report 1946, First and Second National Health Policy statements (1983 and 2002), Twelfth Five Year Plan and the National Health Policy, 2017. National Health Policy, 2017 recommended strengthening of the delivery of Primary Health Care, through establishment of Health and Wellness Centres (HWCs) as the platform to deliver Comprehensive Primary Health Care and called for a commitment of two third of the health budget to primary health care. In February

2018, the Government announced that 1,50,000 Health & Wellness Centres (HWCs) would be created by transforming existing Sub Health Centres (SHCs) and Primary Health Centres (PHCs) to deliver Comprehensive Primary Health Care and declared this as one of the two components of Ayushman Bharat (AB). This was the first step in the conversion of policy articulations to a budgetary commitment. The Report of the Primary Health Care Task Force provides valuable insights into structure and processes that are required in health systems to enable Comprehensive Primary Health Care. The delivery of CPHC through HWCs rests substantially on the institutional mechanisms, governance structures, and systems created under the National Health Mission (NHM).

As part of the CPHC, the government has been implementing the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) under NHM. In this programme, an important component is the Opportunistic Screening i.e examination of all individuals for hypertension, diabetes and selected cancers who came to the health care facilities. The government has now expanded the scope of the NPCDCS to undertake Population Based Screening (PBS) i.e. screening of all healthy women and men 30 years of age and above in the community) through Ayushman Bharat-Health and Wellness Centres (AB-HWCs). Multi-Purpose Workers (MPW) and Accredited Social Health Activists (ASHAs) have to play a very important role in undertaking population based screening of common non-communicable diseases such as hypertension, diabetes and three common cancers namely cervical, breast and oral cancer. Here the focus is not only on building the knowledge and skills of the ASHAs, MPWs and CHOs/MLHPs in undertaking population based screening but also on identification of cases for referral, follow up, recognition of complications, prevention, ensuring continuity of care, health promotion and improving recording and reporting of information .

Government of Jammu and Kashmir has approved population based screening as part of NPCDCs in all districts through AB-HWCs and in the first phase it was rolled out in 6 districts (Jammu, Udhampur, Doda, Anantnag, Baramulla and Kupwara) in 2018-19 and remaining districts have been added during 2019-20. During 2018-19, 341 HWCs have been made operational. State has set a target of 15 percent of population age 30+ to be covered for PBS during 2019-20. Information provided by the State NHM office also shows that the State had set a target of 7.8 lac population to be covered under PBS and has been in a position to screen 7.1 lac population, thus achieving a target of 91 percent.

2.1 Rational of the Study

The programme of the community based screening for NCDs through AB-HWCs in various districts of J&K is still in the infancy stage and as a new programme, the

implementers may be facing few challenges and barriers in its implementation. Although the programme is monitored by the State NHM but no concurrent evaluation study has been conducted to assess the progress of the scheme and study the reasons for its tardy implementation. There is, therefore, a need to evaluate the progress of the implementation of the NCD screening at this stage and understand the challenges and barriers in its implementation so that suitable mid-course corrective actions can be undertaken to smoothen the process of implementation of community based screening of NCDs by AB-HWCs in the State and ensuring that the intended benefits of the scheme reach the target population.

2.2 Objectives

The objectives of this evaluation study are to:

a. Study whether functional HWCs have been equipped with requisite inputs like, infrastructure, human resource, trainings, equipments, drugs and other logistics required for screening and reporting of NCDs as per the guidelines.
b. Evaluate the performance of HWCs with specific reference to community mobilization, creation of individual health records, health promotion, community based NCD screening, referrals, follow up, record keeping and coordination between ASHAs, MPWs, MLHPs and PHC Medical Officer.
c. Suggest remedial measures that can be undertaken to improve the process of implementation of community based screening of NCDs in the State.

2.3 Data and Methods

PRC had desired to evaluate the process on NCD screening in two districts of Jammu and Kashmir. However, the NCD Programme Division at the Ministry of Health and Family Welfare, desired to conduct the study in 5 districts of Jammu and Kashmir along with the Monitoring of National Health Mission, State Programme Implementation Plan (PIP) and accordingly we randomly selected 5 districts in J&K out of 10 districts that were allocated to PRC Srinagar for PIP monitoring during 2019-20. The districts selected were Anantnag, Budgam, Kupwara, Samba and Udhampur. From each district, it was planned to select 5 health facilities, which have been upgraded to Health and Wellness Centres from different health blocks. The list of the health facilities upgraded to H&WCs in 2018-19 was collected from the Office of the Mission Director, National Health Mission, Jammu and Kashmir. A glance at the list of health facilities upgraded to H&WCs in the selected districts during 2018-19 revealed that districts had upgraded H&WCs only from a few health blocks. Further some districts like Samba and Udhampur have only 2 or 3 medical blocks. So it was not possible to select H&WCs from 5 different medical blocks in a district. However, where ever it was possible, H&WCs were selected from different Medical Blocks.

We also planned to select a mix of Sub Health Centres and Primary Health Centres and it was decided to select at least 3 SHCs and 2 PHCs from each district. However, from Udhampur due to the landslides and road blockade it was not possible to reach one of the PHCs and that PHC was replaced by a nearby Sub Health Centre. The list of the Health and Wellness Centres selected for evaluation is presented in Table 1.

Information was collected from the Medical Officer and the SN/MPW in case the facility was a PHC AB-HWC and MLHP and MPW in case the facility was a SHC AB-HWC. We also collected information from one ASHA in each of the selected Health and Wellness Centre except Udhampur as the ASHAs during our visit to Udhampur were involved in some training.

Table No 1: List of the Selected Health and Wellness Centre for Evaluation of NCDs in Jammu and Kashmir

District	Block	CHC	PHC	Name of Facility	Type of Facility
Anantnag	Bijbehara	Bijbehara	Marhama	Sathar	Sub Health Centre
Anantnag	Sallar	Bijbehara	Sallar	Wallerhama	Sub Health Centre
Anantnag	Sallar	Bijbehara	Sallar	Liver	Sub Health Centre
Anantnag	Bijbehara	Bijbehara	Veeri	Veeri	Primary Health Centre
Anantnag	Verinag	Dooru	Verinag	Veerinag	Primary Health Centre
Budgam	Chadoora	Chadoora	Panzan	Namthal	Sub Health Centre
Budgam	Chadoora	Chadoora	Zahooma	Zahooma	NTPHC
Budgam	Chadoora	Chadoora	Surisyar	Bonen	Sub Health Centre
Budgam	Chadoora	Chadoora	Wadipora	Wadipora	NTPHC
Budgam	Chadoora	Chadoora	Bogam	Chak Sardar	Sub Health Centre
Kupwara	Kupwara	Kupwara	Trehgam	Trehgam	Primary Health Centre
Kupwara	Sogam	Sogam	Maidanpura	Vawoora	Sub Health Centre
Kupwara	Kupwara	Kupwara	Drugmulla	Waterkhai	Sub Health Centre
Kupwara	Kralpora	Kralpora	Kralpora	Shaloora	Sub Health Centre
Kupwara	Langate	Langate	Yunsoo	Yunsoo	NTPHC
Samba	Ramgarh	Ramgarh	Nand Pur	Chattaka Chak	Sub Health Centre
Samba	Purmandal	Ramgarh	Purmandal	Birpur	Sub Health Centre
Samba	Purmandal	Ramgarh	Rai	Palli	Sub Health Centre
Samba	Purmandal	Ramgarh	Bassi Kala	Bassi Kalan	NTPHC
Samba	Ramgarh	Ramgarh	Nandpur	Nandpur	Primary Health Centre
Udhampur	Ramnagar	Udhampur	Tikri	Tikri	Primary Health Centre
Udhampur	Udhampur	Udhampur	Garhi	Roundomail	Sub Health Centre
Udhampur	Udhampur	Udhampur	Hatrijan	Jib	Sub Health Centre
Udhampur	Udhampur	Udhampur	Garhi	Sanasoo	Sub Health Centre
Udhampur	Udhampur	Udhampur	Tikri	Mand	Sub Health Centre

3. Key Findings

3.1 Infrastructure

Ensuring adequate infrastructure and human resource as per IPHS norms is essential for providing CPHC services through Ayushman Bharat Health and Wellness Centres. The Government of India is supporting the States/UTs for strengthening and upgrading of existing health infrastructure as well as branding of AB-HWCs. In this regard, model payout plans for construction of new AB-HWCs and branding of existing health facilities have been prepared and shared with the States. As per the AB-HWCs guidelines, the essential requirements for strengthening a health facility to serve as a AB-HWC are as under:

- 24 hours electricity
- 24 hours water supply
- Well ventilated Room for OP Consultation
- Examination Area with adequate privacy
- Patient Waiting Area covered to accommodate 8-10 patients
- Designated space for Lab and Dispensation of Medicines
- Space for Sterilization
- Adequate provision for Cold chain maintenance
- If the facility is a Delivery Point-Labour room/NBCC available as per IPHS
- Facilities for safe Drinking Water
- Suitable Approach Road
- Separate Male/Female Toilets for staff/Patients/both
- Proper system for Drainage
- Deep burial pit for Bio Medical Waste Management
- Wellness room or provision of Yoga services
- Furniture/Fixtures and Equipment as per CPHC Guidelines
- Citizen's Charter & Display of IEC for Community Awareness on services available

The State Government has directed all the districts to identify the infrastructure gaps in the health facilities and prioritize with timelines the facilities for up gradation of these facilities to AB-HWCs. Based on the reports submitted by the districts, the office of NHM has identified about 170 health facilities in the State for upgrading during 2018-19. The State Government has allocated an amount of Rs. 750000 for upgrading a SC to HWCs and Rs. 450000 for branding of PHCs and undertaking necessary repairs in conformity with the requirements under AB-HWCs branding. It was seen that different districts have allocated the work of branding of HWCs to various construction agencies. For example the work of branding in Kupwara has been assigned to Urban Housing Board, while as in Budgam; the branding was executed by Public Works

Department. Consequently, there is no uniformity in the branding and signage of HWCs across districts. The districts have initiated up gradation and branding of the easily doable facilities for achieving the short term goals, while doing so, the quality of up gradation has been compromised. This is substantiated by the fact that almost all the districts in the first phase have identified the SCs housed in government buildings for up gradation to HWCs. The infrastructure developed also varies greatly within the districts. For example, while the SHC Namtihaal in Budgam has been upgraded with most of the facilities but HWC Bonen probably presents the worst example of up gradation as it lakes most of the facilities. We collected information about the availability of various infrastructural facilities in AB-HWCs and the same is presented in Table 2 and Table 2A.

Table No 2: Availability of Infrastructure Facilities in Health and Wellness Centres in Jammu and Kashmir

District	Total No of Facilities	24 hours Electricity	24 hours Water supply	Room for OP Consultation	Examination Area with adequate privacy	Patient Waiting Area	Designated space for Lab and Dispensation of Medicines	Adequate provision for Cold chain maintenance	Labour room/ NBCC available
		No	No	No	No	No	No	No	No
SHC-AB-HWCS									
Anantnag	3	0	2	2	2	2	2	0	0
Budgam	3	0	1	3	2	0	2	2	0
Kupwara	3	0	1	3	3	3	1	0	0
Samba	3	3	3	3	3	3	3	2	0
Udhampur	4	3	3	4	4	3	4	1	1
Total SCs	16	6	10	15	14	11	12	5	1
PHC-AB-HWCS									
Anantnag	2	0	2	2	2	2	2	2	2
Budgam	2	0	1	2	2	1	2	1	0
Kupwara	2	1	1	2	2	2	2	2	2
Samba	2	2	2	2	2	2	2	2	2
Udhampur	1	1	1	1	1	1	1	1	1
Total PHCs	9	4	7	9	9	8	9	8	7
G. Total	25	10	17	24	23	19	21	13	1

3.1.1 Electricity

As per the requirements all the HWCs should have regular electric supply linked to main line or solar source and should have a back up in the form of an inverter or generator. Table 3 shows that most of the SCs upgraded to HWCs do not have regular power supply and only 6 have uninterrupted electric supply. None of the SCs located in the 3 districts of Kashmir Division (Anantnag, Kupwara and Budgam) have regular power supply. In fact 2 of the HWCs located in Budgam district namely Wadipora and Bonen have no electricity at all. Of the 9 PHCs, only 4 have regular electric back up. Two of these PHCs are in Samba, and 1 each is in Udhampur and Kupwara. Thus none of the upgraded HWCs in Budgam and Anantnag have uninterrupted electric supply.

3.1.2 Assured Water Supply

All the Sub Health Centres upgraded to HWCs do not have assured water supply. The facilities which do not have any water facility are PHC Yunsoo, Vawoora and Waterkhai in Kupwara, Bonen and Wadipora in Budgam and Sanasoo in Udhampur. Of the 9 PHCs, 2 PHCs are also without regular water supply.

3.1.3 Room for OP Consultation and Examination

Room for OP consultation and examination area with adequate privacy is available at all the health facilities except SC Sethhar in Anantnag district which is located in a rented building. Although OP consultation room is available at SC Bonen but despite having a two storey building, it does not have a proper space for examination with adequate privacy.

3.1.4 Patient Waiting Area

Adequate waiting area for at least 10 patients is available in most of the HWCs located in Samba, Udhampur and Kupwara districts. None of the HWCs in Budgam have adequate waiting area available for patients. SCs located in Kashmir division where waiting area is available, however, do not have any sitting arrangement for patients.

3.1.5 Designated space for Lab and Dispensation of Medicines

HWCs should have designated space for laboratory and dispensation of medicines. This facility is available in the PHCs. But of the 16 SHC-HWCS, only 12 have adequate space for laboratory and dispensation of medicines. The SCs where adequate space for lab and dispensation of medicines is not available are located in Kashmir region. Further it was found that even if the facilities have earmarked space for lab, but the lab investigations are generally conducted in the OPD room.

3.1.6 Adequate Provision for Cold Chain Maintenance

HWCs should have adequate provision for cold chain maintenance. But it was found that adequate provision for cold chain maintenance is available only in a few HWCs. Only vaccine carriers are available in most of the HWCs. Adequate provision for cold

chain maintenance is available in 8 of the 9 PHCs. The PHC where this facility is not available is Wadipora in Budgam district.

3.1.7 Availability of Labour Room and NBCC

Deliveries are generally not conducted in SCs and PHCs in Jammu and Kashmir, although some of the SCs and PHCs have been provided delivery tables few years back under untied funds. Of the 16 SCs, the facility of Labour Room and NBCC is available in Mund SC in Udhampur district. All the PHCs except the two located in Budgam do not have labour rooms.

Table No 2A: Availability of Various Facilities in H&WCs in J&K

District	Total No of Facilities	Facilities for safe Drinking Water	Suitable Approach Road	Separate Male/Female Toilets	Appropriate Drainage	Appropriate Waste Disposal	Room or provision of Yoga services	Furniture as per CPHC Guidelines	Citizen's Charter & Display of IEC	Visible Sign Board
		No	No	No	No	No	No	No	No	No
Sub Health Centres										
Anantnag	3	1	3	2	1	0	0	3	2	3
Budgam	3	0	2	2	2	1	1	0	1	3
Kupwara	3	1	3	2	2	1	2	2	3	2
Samba	3	2	3	3	3	2	3	2	3	3
Udhampur	4	0	3	4	2	3	3	3	4	4
Total SCs	16	4	14	13	10	7	9	10	13	15
Primary Health Centres										
Anantnag	2	2	2	2	2	1	2	2	2	2
Budgam	2	0	2	2	1	2	2	0	1	2
Kupwara	2	1	1	2	1	2	2	1	2	2
Samba	2	2	2	2	2	1	2	2	2	2
Udhampur	1	1	1	1	1	1	1	1	1	1
Total PHCs	9	6	8	9	7	7	9	6	8	9
G. Total	25	10	22	22	17	14	18	16	21	24

3.1.8 Facilities for Safe Drinking Water

All the facilities upgraded to HWCs should have the facility for safe drinking water. It was found that provision of safe drinking water is a neglected area and no attention has been provided to make provision for safe drinking water facility in SCs during up gradation. None of the facilities in Budgam have facility of safe drinking water. Of the 16 SCs, only 4 have the facility for safe drinking water. None of the visited SCs in Budgam and Udhampur and 2 each in Anantnag and Kupwara have provision for safe drinking water. Both the PHCs in Budgam and PHC Yunsoo in Kupwara also have issues with safe drinking water facilities.

3.1.9 Approach Road

HWCs should have a suitable approach road so that patients do not have any difficulty in reaching the health facility. But it was found that the land allocated by the community for the construction of Sub Health Centres is located at isolated places without any approach road. While few such Centres have been planned for up gradation but no provision has been made to provide suitable approach roads to such health centres. For example the PHC Wadipora and SC Bonen do not have suitable approach roads.

3.1.10 Separate Male/Female Toilets

While upgrading the existing SCs to HWCs, a provision has been made to construct/renovate toilets separately for male and female patients and for the staff. It was found that most of the SCs upgraded to HWCs have been provided separate male and female toilets. But it was observed that due to space constraints, toilets at some centres are unusable. There are some SCs where only a common toilet has been constructed/renovated. For example SC Bonen and Vawoora do not have separate male and female toilets. Even if the toilets are available, few SCs do not have water facility or appropriate drainage facility and are therefore unusable.

3.1.11 Drainage

Proper system for drainage is another essential requirement of the HWCs but it was found that during the process of up gradation, efforts have not been made to provide/upgrade drainage system of the health and Wellness Centres which had no drainage. Six of the 16 SCs and 2 PHCs were without any appropriate drainage before up gradation and they continue to be without any drainage even after up gradation. A pit which was dug for the drainage in SC Bonen has been left incomplete and has become a nuisance for the HWC.

3.1.12 Deep Burial Pit for Bio Medical Waste Management

All the health facilities should have proper mechanism for segregation of Bio Medical Waste and its proper disposal. To this direction, the facilities should have color coded bins and a deep burial pit for the disposal of bio medical waste. It was found that all the facilities have color coded bins in place but 9 SCs and 2 PHCs do not have any proper mechanism for the management of bio medical waste. Deep burial pits for bio medical waste management are not available in any of the health facilities. However, some facilities mostly PHCs have outsourced the disposal of bio medical waste to a private agency, which lifts it once or twice a week.

3.1.13 Wellness Room or Provision of Yoga Services

The HWCS are also envisaged to promote wellness activities by regularly organizing yoga events and for this appropriate support has been provided to make space in the

HWCs for Wellness Rooms or Yoga Services. It was found that almost all the PHCs have a wellness room for yoga services. But of the 16 SCs, Wellness Room is available in 9 facilities. Most of the SCs in Budgam, Kupwara and Anantnag do not have wellness rooms due to space constraints.

3.1.14 Furniture/Fixtures and Equipment as per CPHC Guidelines

Ten SCs and 6 PHCs have been equipped with some furniture. Few of the SCs upgraded to HWCs in Udhampur have purchased some furniture out of untied funds. But none of the facilities in Budgam have been provided any additional furniture.

3.1.15 Display of Citizen's Charter & IEC for Community Awareness on Services Available

As per the AB-HWCs guidelines all facilities upgraded to HWCs should prominently display Citizen's Charter and IEC for community awareness about the services available at the facility. It was found that 13 SCs and 8 PHCs had displayed the Citizen's Charter and availability of services. But such information was not available in 2 SCs and 1 PHC located in Budgam district. Sign Board displaying the name of the HWC was not available in SC Waterkhai of Kupwara District.

3.2 Manpower

As we move towards improved and patient centered Comprehensive Primary Health Care (CPHC), having robust and responsive human resource for health is essential. In an effort to promote Comprehensive Primary Health Care, GOI decided to have a key addition to the Primary Health Care team at the Sub Health Centre AB-HWCs in the form of Mid Level Health Provider (MLHP) who are trained for 6 months on a certificate programme in Community Health. The MLHP will lead the team of existing Multipurpose Workers and ASHAs to provide the expanded range of services including screening, early detection and address issues of changing lifestyles and treatment adherence.

In order to train the required number of MLHPs, the State Government has recruited both Ayurveda as well as Unani Practitioners for 6 month Certificate programme in community health. These programmes are conducted by State Health Society in partnership with IGNOU and State Universities. Few batches have already completed the certificate programme and have been posted at HWCs.

Thus upgraded AB-HWCs should ideally have the following Team:

- 1 Multi Level Health Provider (MLHP) – Team Leader
- 2 Multi Purpose Health Worker (Male & Female / 2 Females)
- All ASHAs in the catchment area

A look at the Table 3 reveals that of the 16 HWCs, MLHPs were posted at 13 Sub Health Centres. All the selected HWCS in Anantnag, Udhampur and Samba had a MLHP in place. MLHPs were also posted at 2 HWCS in Kupwara. Till date only 2 MLHPs have been posted in Budgam district and one of them is posted at HWC Bonen. HWC Waterkhai located in Kupwara district is functioning without a MLHP. An upgraded AB-HWC should have 2 MPHWs in place but it was found that of the 16 SCs only 12 have required number of MPHWs available. Once again all the SCs in Samba and Udhampur have both the positions of MPWs in place. SC Waterkhai is managed by a single FMPHW and as the post of MLHP is also vacant, therefore this HWC is almost non functional. HWC Bonen also has only one MPHW in place. Of the 3 HWCs located in Anantnag only Wullarhama has the required staff. Thus overall, of the 16 HWC, only 10 have the required staff and 7 of them are in Jammu division and only 3 in districts located in Kashmir region. Performance linked payments to MLHPS are yet to start in all districts as the State is waiting for uploading of data.

Table No 3: Availability of Human Resource in Selected Health and Wellness Centers in Jammu and Kashmir

District	No of Facilities	MO	NHM	AYUSH MO	DS	MLHP	SN	LT	Phar	LHV	2 ANMS
Sub Health Centres											
Anantnag	3	-	-	-	-	3	-	-	0	-	1
Budgam	3	-	-	-	-	1	-	-	0	-	2
Kupwara	3	-	-	-	-	2	-	-	2	-	2
Samba	3	-	-	-	-	3	-	-	1	-	3
Udhampur	4	-	-	-	-	4	--	-	2	-	4
Total	16	-	-	-	-	13	-	-	5	-	12
Primary Health Centres											
Anantnag	2	2	1	1	0	0	2	2	2	1	1
Budgam	2	2	0	0	0	0	0	0	0	0	2
Kupwara	2	2	1	2	2	0	2	2	2	0	0
Samba	2	2	0	1	0	0	1	2	2	0	1
Udhampur	1	1	0	1	0	0	1	1	1	1	1
Total PHCs	9	9	2	5	2	0	6	7	7	2	5
Total	25	9	2	5	2	13	6	7	12	2	17

Primary Health Centres which have been upgraded to AB-HWCs have to function as first referral units for the Sub Health Centres and therefore it is envisaged that these PHCs should have at least 1 Medical Officer in place. It was found that MBBS Medical Officers were in place at all the 9 PHCs. Further, 2 PHCs had additional position of

MO from NHM side. AYUSH MOs from NHM side were also posted in 5 PHCs. Dental Surgeons are posted in 2 PHCs. By and large the position of Medical Officers in PHCs is satisfactory. Except Budgam, Staff Nurses, Lab Technicians and Pharmacists are posted in various PHCs under study. Thus it may be concluded that both SCs and PHCs upgraded to HWCs in Budgam are poorly staffed.

3.3 Human Resource Development

The health professionals and health care providers at various AB-HWCS would be trained for health promotion, NCD prevention, early detection and management of Cancer, Diabetes, CVDs and Stroke. For imparting training both for the programme management and for specialized training for diagnosis, treatment of cancer, diabetes, CVDs and strokes, the nodal agency/agencies will be identified to develop the training material, organize training of health care providers at different levels and for monitoring the quality of the training. Structured training programmes will be developed to provide quality training with appropriate curriculum to various categories of staff.

The scheme envisages that ANMs/MPWs would be trained in a three day module for HT/DM and screening of oral and breast cancers, and ASHAs in a five day module, with one day of overlap for integrated training, so that they are able to better function as a team. The contents would cover: the process of enumeration and family folder creation, signs, symptoms and sequelae of NCDs, early symptoms of hypoglycemia, presentations of common cancers, heart attacks and strokes, skills of measurement of Blood pressure and blood glucose, history taking/ completion of forms for community based assessment, recognizing oral lesions, breast palpation, organizing work processes during screening days, referral, follow up to ensure continuity of care, drugs and side effects, and documentation and reporting. ANM's in selected SHCs, Staff Nurses and LHVs will require two weeks training at a DH/ tertiary care institutions for Visual inspection using Acetic Acid (VIA) for cervical cancer screening. MOs will need training for a period of five days in a tertiary care setting. For HT/DM, MOs to be (re) trained in a one-day module covering programmatic elements, supportive supervision, standard treatment guidelines, cardio vascular risk assessments, (use telemedicine/consultation with internal medicine specialists CHC/DH), assessment for complications, etc. A one-day orientation and training of VHSNC members on NCD: risk factors and to review preventable deaths – as a form of community monitoring, will be undertaken. Further, one day Orientation of Programme Officers and BPM/DPM would be required so that they are in synergy with the programme features and understand the roles and responsibilities related to support (including availability of drugs and consumables), monitoring (reports, records) and supervision.

Table No 4: Distribution of Health and Wellness Centers by 3 day NCD Training attended by ANM/MPWs							
District	T. No of Facilities	No. of ANMs attended HPT and Diabetes training			No. of ANMs attended Oral & Breast cancer Training		
		0	1	2	0	1	2
	Sub Health Centres						
Anantnag	3	0	3	0	3	0	0
Budgam	3	0	2	1	3	0	0
Kupwara	3	0	2	1	1	2	0
Samba	3	0	0	3	0	0	3
Udhampur	4	0	1	3	0	2	2
Total SCs	16	0	8	8	7	4	5
	Primary Health Centres						
Anantnag	2	0	2	0	2	0	0
Budgam	2	1	1	0	2	0	0
Kupwara	2	2	0	0	2	0	0
Samba	2	0	1	1	0	1	1
Udhampur	1	0	0	1	0	0	1
Total PHCs	9	3	4	2	6	1	2
Total	25	3	12	10	13	5	7

Training for the screening for HT/DM and oral and breast cancers for ANMs/MPWs has been initiated in all the 6 districts and at least one MPW/ANM has received this training (Table 4). There are 8 Sub Centers where both the ANMs/MPWs have received 3 days module training. Both the MPWs working in SCs in Udhampur and Samba have participated in HT/DM Training, while as in Kupwara Budgam only one of the two ANMs working in HWCs have received this training. However not all ANMs working at PHCs had participated in this type of training. Of the 9 PHCs, none of the ANMS from 3 PHCs had attended NCD screening training. Both the MPWs working at 2 PHCs had attended NCD training. It was further mentioned by the ANMs that the duration of the training was only 2 days and not much attention was paid on record keeping.

ANM's in selected SHCs, Staff Nurses and LHVs should have attended two weeks training at a DH/ tertiary care institutions for training in VIA. Table 5 shows that ANM working in 16 facilities mostly in Kashmir region have not attended in VIA training. At least 1 ANM in 3 facilities have attended VIA training and both ANMS at 6 facilities (Samba and Udhampur) have attended VIA training. Staff Nurses working in 8 PHCs have also not attended VIA training. It appears that the districts have not yet focused on VIA training. As VIA training of SNs and ANMS for screening of cervical cancer

has not yet been undertaken, therefore screening of cervical cancer is not yet taking place in large majority of SHC AB-HWCs in J&K.

Table No 5: Distribution of HWCS by VIA Training Attended by ANMS and Staff Nurses in Jammu and Kashmir						
District	**ANM**				**Staff Nurse**	
	Total	None	1	2	None	1
Anantnag	3	3	0	0		
Budgam	3	3	0	0		
Kupwara	3	3	0	0		
Samba	3	1	1	1		
Udhampur	4	1	0	3		
Total SCs	16	11	1	4		
Anantnag	2	1	1	0	2	0
Budgam	2	2	0	0	2	0
Kupwara	2	1	0	1	2	0
Samba	2	0	1	1	1	1
Udhampur	1	1	0	0	1	0
Total PHCs	9	5	2	2	8	1
Grand Total	25	16	3	6	8	1

The scheme also envisages that PHC Medical Officers will be trained for a period of five days in a tertiary care setting. For HT/DM, MOs will be (re) trained in a one-day module covering programmatic elements, supportive supervision, standard treatment guidelines, cardio vascular risk assessments, (use telemedicine/consultation with internal medicine specialists CHC/DH), assessment for complications, etc.

Table No 6: Distribution of HWCS by 5 day NCD Training Attended by Medical Officers in Jammu and Kashmir				
	Total PHCs	**No. of Medical Officer attended NCD Training**		
		None	1	2
Anantnag	2	1	0	1
Budgam	2	2	0	0
Kupwara	2	1	1	0
Samba	2	1	1	0
Udhampur	1	0	1	0
Total	9	5	3	1

Information presented in Table 6 shows that of the 9 PHCs, MOs of only 4 PHC have attended five days NCD training in a tertiary care setting. This training seems to have not been initiated in Budgam.

Training for the screening for HT/DM for ASHAs has been initiated in all the 6 districts and this training has been organized at block levels. A look at Table 7 shows that all the facilities reported that at least some ASHAs have attended NCD training. In fact it was found that of the 25 facilities, all AHAs at 21 facilities have attended NCD training. In the remaining facilities at least 1 ASHA has undergone NCD training. All ASHAs working in Samba and Udhampur have participated in NCD training.

Table No 7: Distribution of HWCs by NCD Training Attended by ASHAs

	Total	NCD Training by ASHAs	
	1	All	Some
Anantnag	3	2	1
Budgam	3	2	1
Kupwara	3	2	1
Samba	3	3	0
Udhampur	4	4	0
Total SCs	16	13	3
Anantnag	2	2	0
Budgam	2	1	1
Kupwara	2	2	0
Samba	2	2	0
Udhampur	1	1	0
Total PHCs	9	8	1
Total	25	21	4

During the survey we contacted two ASHAs at each facility in the districts of Anantnag, Budgam, Kupwara and Samba and collected information from these ASHAS regarding the topics discussed during the training. The results are presented in Table 8.

Among the various topics that are part of the training programme the process of enumeration and family folder creation, history taking/ completion of forms for community based assessment, signs, symptoms and sequelae of NCDs, was reported by most of the ASHAs who attended training (Table 9). Very few ASHAs mentioned that skills of measurement of blood pressure and blood glucose and recognizing oral lesions were also part of the training programme. Roughly half of the ASHAs also mentioned

that other topics like drugs and side effects, presentations of common cancers, heart attacks and strokes, breast palpation, organizing work processes during screening days, early symptoms of hypoglycemia, referral and follow up to ensure continuity of care, and documentation and reporting were in the agenda of the training. Our interaction with the ASHAs revealed that most of the ASHAs had not attended the training for all 5 days. In fact ASHAs in Budgam, Kupwara and Anantnag mentioned that they attended the training for 2-3 days only.

Table No 8: Distribution of ASHA by Topics Taught During Training

Topic of Training	J&K	District			
		Anantnag	Budgam	Kupwara	Samba
	No	No	No	No	No
The process of enumeration and family folder creation	18	5	4	4	5
History taking/ completion of forms for community based assessment	18	5	4	4	5
Signs, symptoms and sequelae of NCDs	15	5	4	4	2
Early symptoms of hypoglycemia	13	5	3	2	3
Presentations of common cancers, heart attacks and strokes	11	2	4	2	3
Skills of measurement of Blood pressure and blood glucose	9	2	2	3	2
Recognizing oral lesions	7	3	1	2	1
Breast palpation	12	3	3	2	4
Organizing work processes during screening days	12	5	2	4	1
Referral	14	5	2	4	3
Follow up to ensure continuity of care, drugs and side effects	14	4	4	3	3
Documentation and reporting	10	5	1	3	1
Total	19	5	5	4	5

3.3.1 Training of VHNC Members

VHNC members have to play a very important role in raising community awareness about NCD screening. Therefore it is imperative that they should be aware about their role and responsibilities. To this effect the scheme envisages that a one-day orientation and training of VHSNC members on NCD risk factors and their role in community awareness be organized.

Table No 9: Distribution of HWC whose VSHNC Members attended NCD Training			
	Total	NCD Training organized for VHSNC members	
		Yes	No
Anantnag	5	0	5
Budgam	5	0	5
Kupwara	5	0	5
Samba	5	2	3
Udhampur	5	1	4
Total	25	3	22

Information presented in Table 9 reveals that Anantnag, Kupwara and Budgam districts have not organized any orientation/training programme for VHNC members related to NCD. Even in Samba and Udhampur only 1 or 2 facilities have organized NCD training for VHNC members.

3.4 Diagnostic Equipment

As the HWCs have to undertake community based screening for NCDs and selected cancers and to conduct such screening, the team at the HWCs would need to have a glucometer, sufficient strips, a BP apparatus, a tape measure, and a torch in working condition. Equipment for screening of cancers that should be available at the HWCs include examination lamp with white light, autoclave, Cusco's speculum, Dental Mouth Mirrors and torch with white light.

Information collected from the HWCs regarding the availability of equipments for screening of NCDs and oral cancers presented in Table 10 shows that CBAC forms, glucometer, strips for glucometer and BP apparatus is available in almost all the HWCS. Measuring tap and Torch in working condition is also available in 19 facilities. Torch is available in 11 SCs and 8 PHCs. All the SCs in Anantnag and Budgam and all the PHCs except one in Anantnag have a Torch available.

Examination lamp with white light, Autoclave, Cusco's speculum and Dental Mouth Mirrors are available in 14 facilities. None of the SCs in Samba has been provided these four items. Both the PHCs in Budgam and Kupwara have all these four items. Torch with white light is available in less than half of the facilities. Less than 30 percent of the SCs under study have torch with white lamp available. Torch with white light is available in only one of the 3 SCs in Budgam, Kupwara and Udhampur.

Table No 10: Distribution of Health and Wellness Centers by Availability of Diagnostic Equipments for Screening of NCDs in J&K												
District	No of facilities	CBAC Form	Glucometer	Strips	BP apparatus	Tape	Torch	Examination lamp with white light	Autoclave	Cusco's speculum	Dental Mouth Mirrors	torch with white light
	Sub Health Centres											
Anantnag	3	3	3	3	3	2	3	2	1	3	2	2
Budgam	3	3	3	3	3	2	3	3	2	2	2	1
Kupwara	3	3	3	3	3	3	1	1	3	2	2	1
Samba	3	3	3	3	3	3	1	0	0	0	0	0
Udhampur	4	4	4	4	4	3	3	1	1	0	0	1
Total SCs	16	16	16	16	16	13	11	7	7	7	6	5
	Primary Health Centres											
Anantnag	2	2	2	2	2	2	1	1	1	2	2	1
Budgam	2	2	2	2	2	0	2	2	2	2	2	2
Kupwara	2	2	2	2	2	1	2	2	2	2	2	2
Samba	2	2	2	1	1	2	2	1	1	1	1	1
Udhampur	1	1	1	1	1	1	1	1	1	0	1	1
Total PHCs	9	9	9	8	8	6	8	7	7	7	8	7
Total	25	25	25	24	24	19	19	14	14	14	14	12

3.5 Information Technology

Use of Information Technology (IT) to its full potential can bring radical changes in the delivery of health care in both rural and urban areas. Realizing the importance of Information Technology, Government of India is taking significant efforts to streamline its use across primary, secondary and tertiary care health facilities. In this regard, it is mandated to have a robust IT system at AB-HWCs.

Essential components of this robust IT system are:

- Functional laptop/desktop at PHC/UPHC level AB-HWC
- Functional Tablet with MLHP and MPW at SHC AB-HWC.
- Functional Smart Phone for each ASHA
- Internet Connection
- NCD application
- Daily entry of service statistics in AB-HWCs portal
- Tele consultation services.

Table No 11: Distribution of H&WCS in Jammu and Kashmir by Availability of IT Infrastructure						
District	**Total Centres**	Laptops/Desktops available with Medical Officer	Tablets for MLHPs and MPWs	Smart Phones with ASHAs	H&WC staff trained in use of IT systems	ASHAs started filling CBAC data in CPHC application in smart phones
	NO	NO	NO	NO	NO	NO
Anantnag	5	0	2	0	0	5
Budgam	5	0	2	0	0	5
Kupwara	5	0	1	0	0	5
Samba	5	2	3	0	2	5
Udhampur	5	5	0	0	1	5
Total	**25**	**7**	**8**	**0**	**3**	**25**

It was found that due to the delay in procurement, issues with both hardware and software and issues in distribution, Desktops/Laptops and smart Phones have not yet been provided to HWCs. Few HWCs in Udhampur, Samba and Kupwara which were upgraded in the first phase were provided tablets but due to hardware, internet issues and limited number of laptops, and issues in distribution, these were never put to use. Information collected regarding the IT support available for NCD screening at AB-HWC at the selected health facilities is presented in Table 11. None of the 15 AB-HWCSs in Kashmir region have been provided with Desktops/Laptops. Only 2 of the 5 Centers in Samba have desktops available. All the 5 HWCs in Udhampur have been provided with desktops. A total of 8 facilities reported to have received Tablets. None of the facilities in Udhampur have laptops. Smart Phones have not yet been distributed among ASHAs in the State. It was mandated under the scheme that all the staff of AB-HWCs would be trained in the use of IT but this training seems to have not yet been initiated in Kashmir region as all the facilities mentioned that none of their staff has been trained in the use of IT. Even in Samba and Udhampur, staff of only one or two facilities has participated in IT training. As the IT system in J&K is still in infancy and smart phones have not been given to ASHAs and neither have they been trained to use the CPHC application, therefore, ASHAs are manually filling up the CBAC forms.

3.6 Drugs

Provision of CPHC services through AB-HWCs rests on the availability of essential medicines and diagnostics for a range of health care needs of the population. This is one of the essential components of the upgraded AB-HWCs as it will reduce the out of pocket expenditure and increase the footfalls in the public health care facilities duly enhancing the health seeking behavior of the population.

In light with this paradigm shift, the AB-HWCs will provide a broader range of services and this necessitates expanding the list of essential medicines and diagnostics services currently available at these transformed SHCs and PHCs. Along with the medicines hitherto listed in EDL for SCHs, additional list of medicines like drugs for Hypertension, Diabetes, Mental disorders etc, will be required at the AB-HWCs.

For a patient suspected of common chronic diseases such as Hypertension and Diabetes Mellitus etc, confirmation and imitation of treatment will be done by the Medical Officer at the PHC AB-HWC or a higher referral facility. However, for continuation of treatment as per the prescription by the Medical Officer, medicines will be dispensed at the Sub Health Centre AB-HWC by MLHP to avoid patient hardship and to ensure that the clinical condition is monitored regularly i.e. treatment adherence, close to home without any additional travel involved.

Table No 12: Distribution of H&WCS by Number of Drugs Available for Treatment of Hypertension and Diabetes at Health and Wellness Centres in J&K

District	Total	No. of Medicines Available					
		0	1	2	3	4	5
Anantnag	5	0	2	0	1	2	0
Budgam	5	1	1	2	0	0	1
Kupwara	5	0	1	0	2	2	0
Samba	5	0	0	0	2	1	2
Udhampur	5	0	0	0	4	1	0
Total	25	1	4	2	9	6	3

It was observed that there is no structured policy for procurement of drugs and reagents and other lab consumables. Some drugs are provided by Jammu and Kashmir Medical Supplies Corporation (JKSML), some are provided by the BMOs and some are purchased locally. Irregular supply and shortage of NCD drugs both at SHC and PHCs is a common feature across all facilities in the State. This is substantiated by the fact that a significant number of AB-HWCs had only 1 or 2 NCD drugs (Table 12). One of the facilities in Budgam district namely Bonen has never been provided any medicines for the treatment of Hypertension and Diabetes, despite the fact that this is the lone HWC in whole Budgam district which has MLHP in place. The MLHP mentioned that despite many requests no drugs for NCDs were provided to the Centre during the last 6 months. Four facilities all located in Kashmir had just one medicine available and 2 facilities both located in Budgam had only 2 drugs available for NCDs. The only facility in Budgam district which had 5 drugs available is PHC Zahooma. About half of the facilities in Anantnag and Kupwara district had 3-4 NCD medicines available, while as 80 percent of facilities in Samba and Udhampur had 3-4 NCD drugs available.

What are the common drugs available for the treatment of hypertension and Diabetes Mellitus at AB-HWCs. It was found that the SHC AB-HWCS do not properly maintain stock registers of medicines. Further, it was also noted that indenting of drugs do not take place on a daily basis.

However whatever information was available at HWCs it was found that Amlodipin is available in all the HSC AB-HWCs except Bonen and PHC AB-HWC Wadipora in Budgam district and Wallerhama SC in Anantnag (Table 13). Atnenoal is available in 16 Facilities. Atnenol is available in all the facilities in Udhampur. Telmisartan is available in 11 facilities (6 SCs and 5 PHCs). Telmisartan is not available in any of the AB-HWCs in Budgam and Udhampur. Atarvastin is available at 2 PHC AB-HWCs in Anantnag. Atarvastin is available at 1 of the PHC-AB HWCs in Budgam.

Table No 13: Distribution of VHNCs by Type of Drugs Available for Treatment of Hypertension and Diabetes in H&WCS in J&K

	J&K	Name of Drug							
		Amlodipin	Atenolol	Telmisartan	Atarvastin	Isosorbide	Metforminin	Glimepride	Insulin
District	No	No	No	No	No	No	No	No	No
	Sub Health Centres								
Anantnag	3	2	2	1	0	0	0	0	0
Budgam	2	0	2	0	0	0	0	0	2
Kupwara	3	3	2	2	0	0	0	0	0
Samba	3	3	1	2	0	0	3	3	0
Udhampur	4	4	4	0	0	0	3	2	0
Total SCs	**15**	**12**	**11**	**5**	**0**	**0**	**6**	**5**	**2**
	Primary Health Centres								
Anantnag	2	2	0	2	2	0	1	0	1
Budgam	2	1	1	0	0	1	2	0	1
Kupwara	2	2	1	1	0	0	2	1	0
Samba	2	2	2	2	0	0	1	1	0
Udhampur	1	1	1	0	0	0	1	0	0
Total PHCs	**9**	**8**	**5**	**5**	**2**	**1**	**7**	**2**	**2**
Total	24	20	16	10	2	1	14	7	4

As far as diabetic drugs are concerned, 14 facilities mentioned availability of metforminin. These include 7 SC AB-HWCs and 7 PHC AB-HWCs. None of the SC AB-HWCs in Anantnag, Kupwara and Budgam have metforminin available. Almost all the SCs in Samba and Udhampur mentioned availability of metforminin. Metforminin is available in all PHC except 2 PHCs (one each in Anantnag and Samba). Glimipride tablets for control of diabetes are available in 7 AB-HWCS. These include 5 SCs and 2

PHCs. Glimipride is available in all SC located in Samba and two in Udhampur. None of the SCs in Kashmir region reported availability of Glimipride. A total of 2 PHCs and 2 SCs reported availability of Insulin. It is not available in any of the facilities located in Jammu region. Thus overall availability of drugs for hypertension is better than diabetes. Two drugs namely Amlodipine and Atnenol are more commonly available than other hypertensive drugs. Further, facilities located in Jammu have better availability of NCD drugs than the facilities in Kashmir region.

3.6.1 Stock Out

All the HSC AB-HWCs except those located in Udhampur District mentioned that the NCD drugs supplied to them are not provided to them in adequate quantities. None of the facilities had a stock of available drugs that could last for three months. Few facilities particularly in Budgam, Anantnag, Kupwara and Samba had supplies that would last not for more than a month. Facilities which had Insulin available mentioned that there is no demand for this supply. The only drug that was found to be available in adequate quantity in few facilities is Amlodipin.

3.7 Diagnostics Facilities

An important objective of upgrading SCs and PHCS to AB-HWCs is to screen all individuals who came to the health care facilities for hypertension, diabetes and selected cancers. The government has expanded the scope of the NPCDCS to undertake Population-based Screening i.e screening of all healthy women and men 30 years of age and above in the community or in a health facility nearby. For this the AB HWCs should have a functional Glucometer and Blood Sugar Monitoring Apparatus. Further the facilities should also have regular supply of blood sugar strips. As already mentioned above that all the AB-HWCs have been provided with BP apparatus and Glucometers. Blood Sugar strips are also available in all the facilities. It was found that facility of random blood sugar facility is available at all the HWCs (Table 14). The facility of Blood Sugar fasting is also available in all the PHCs except Wadipora. Blood pressure measurement is also done in all the facilities. HP testing facility is available in 22 facilities. The facilities which do not have HB testing facility available are Zahooma, Wadipora and Wavoora. So far as screening of common cancers is concerned, the AB-HWCs are not able to screen patients for common cancers due to lack of training and other logistics.

Table No 14: Distribution of H&WCS by Availability of Diagnostic facilities at H&WCs				
District	Total facilities	Diabetes test	Blood Pressure Measurement	HB test
	No	No	No	No
Anantnag	5	5	5	5
Budgam	5	5	5	3
Kupwara	5	5	5	4
Samba	5	5	5	5
Udhampur	5	5	5	5
Total	25	25	25	22

3.7.1 Stock out of Laboratory Consumables

Facilities were also requested to report whether they have experienced any stock pout of lab supplies like blood sugar and HB strips and reagents used for diagnostics of fasting blood sugar. It was found around half of the facilities had experienced stock outs of blood sugar strips (Table 15). None of the facilities in Budgam and Samba had any issues with lab consumables. Almost all the facilities in Udhampur and Kupwara had faced stock out of BS strips.

Table No 15: Distribution of H&WCS in Jammu and Kashmir by Stock out of lab Consumables during Last 3 Months			
	Total	Any Stock Out of Diagnostic Consumables	
District		Yes	No
Anantnag	5	3	2
Budgam	5	0	5
Kupwara	5	4	1
Samba	5	0	5
Udhampur	5	5	0
Total	25	12	13

3.8 IEC on Health Promotion

Promoting healthy behaviours to effect lifestyle behavior change is critical for prevention and control of hypertension and diabetes and some other forms of non-communicable disease. It is the responsibility of HWC Team including the ASHA and other community level organizations to undertake health promotion activities. Promoting healthy behaviours is to support and motivate individuals, families, and communities to make necessary changes in improving their lifestyles. This includes cessation of tobacco and alcohol use, poor dietary habits, and lack of physical exercise,

and participating in screening programmes regularly. In this context States/ Districts have been given the responsibility to develop context specific strategies for lifestyle modification and for promoting healthy behaviours for primary prevention. Such strategies would need to be targeted at individuals, families, and communities. The district NCD cell will collect information on locally available healthy foodstuffs that should be encouraged and use this in the development of messages for healthy lifestyles. The IEC messages so developed by the State/NCD Cells are to be displayed prominently at AB-HWCs.

We collected information regarding the IEC material related to NCDs and health promotion displayed by the AB-HWCs. Information was collected on 9 issues. Table 16 shows that 14 HWCs have not displayed any message related to NCD or health promotion. Two facilities each had displayed 4, 5 and 6 messages. Only 5 facilities had displayed all the 9 messages and all these facilities are from Udhampur. None of the facilities from Budgam and Samba have displayed any message related to NCDs.

Table No 16 : No of IEC Messages Related to Health Promotion Displayed by HWCs in Jammu and Kashmir

	Total	None	4	5	6	All
	No	No	No	No	No	No
Anantnag	3	2	1	0	0	0
Budgam	3	3	0	0	0	0
Kupwara	3	0	0	2	1	0
Samba	3	3	0	0	0	0
Udhampur	4	0	0	0	0	4
Total SCs	16	8	1	2	1	4
Anantnag	2	1	1	0	0	0
Budgam	2	2	0	0	0	0
Kupwara	2	1	0	0	1	0
Samba	2	2	0	0	0	0
Udhampur	1	0	0	0	0	1
Total PHCs	9	6	1	0	1	1
Total	25	14	2	2	2	5

Table 17 presents details of the IEC messages displayed by various health and Wellness Centres. As mentioned above none of the facilities in Budgam and Samba have displayed any message related to NCDs or about promotion of healthy behaviours. In fact there are only two districts namely Kupwara and Udhampur which have taken an initiative to promote positive health behaviours by displaying IEC material at HWCS. Only two facilities in Anantnag have also displayed banners displaying some messages on health promotion and NCD risk factors.

Table 17: Distribution of Health and Wellness Centers by Availability of IEC material for Promotion of Health Behaviors in J&K										
	J&K	No. of Facilities which have following IEC material displayed								
District		Awareness on risk factors of NCDs	Healthy Lifestyle	Benefits of screening.	Benefits of cessation of tobacco	Avoiding substance abuse	Harmful use of alcohol	Poor dietary habits/dietary advice	Benefits of exercise	Compliance with treatment.
	Number of Facilities									
Anantnag	3	1	1	0	0	0	0	1	1	0
Budgam	3	0	0	0	0	0	0	0	0	0
Kupwara	3	3	3	3	0	0	3	3	0	1
Samba	3	0	0	0	0	0	0	0	0	0
Udhampur	4	4	4	4	4	4	4	4	4	4
Total SCs	**16**	**8**	**8**	**7**	**4**	**4**	**7**	**8**	**5**	**5**
Anantnag	2	1	1	0	0	0	0	1	1	0
Budgam	2	0	0	0	0	0	0	0	0	0
Kupwara	2	1	1	1	0	0	1	1	0	1
Samba	2	0	0	0	0	0	0	0	0	0
Udhampur	1	1	1	1	1	1	1	1	1	1
Total PHCs	**9**	**3**	**3**	**2**	**1**	**1**	**2**	**3**	**2**	**2**
Total	**25**	**11**	**11**	**9**	**5**	**5**	**9**	**11**	**7**	**7**

Overall, 11 facilities have displayed awareness messages related to NCD risk factors and healthy lifestyle (Table 17). Information related to benefits of NCD screening are displayed by 9 HWCs. Benefits of cessation of tobacco and harmful use of alcohol were seen displayed only in HWCs located Udhampur district. Messages related to poor dietary habits/dietary advice was included in the IEC material of 11 HWCs. All the SC AB-HWCs located in Udhampur and Kupwara had included it in their IEC. Information pertaining to benefits of regular exercise and compliance with treatment was seen displayed at 7 facilities mostly in Udhampur. Thus it appears that AB-HWCs have not yet given much emphasis on promoting healthy behaviours through the use of IEC.

3.9 Community Involvement

The Village Health Sanitation and Nutrition Committees (VHSNC), Mahila Arogya Samiti (MAS), members of PRIs and ULBs have to play an important role in raising community awareness about NCD screening among community leaders and influencers. Similar to the role in the Village Health and Nutrition Day, the VHSNC/MAS members have to support the ASHA and ANM during the screening day to help manage patient flows, support and direct referrals. In addition, the VHSNC would advocate with the block/district administration with the support of other community groups and influential leaders to heighten public understanding of the benefits of regular exercise and Yoga and create public parks and other spaces for exercise and encourage physical activity in schools. Further VHSNCs can also support the AB-HWC Team in arranging referral transport to higher facility.

Table No 18: Distribution of VHSNCs involved in Community Awareness about NCDs in J&K

	Nature of Involvement							
	Total Facilities	Community awareness about NCDs	Support to ANM/ASHA during screening	Creating awareness about benefits of regular exercise	Create public parks and other spaces for exercise	Encourage physical activity in schools.	Support for referral to higher facility	Not involved
District	**Number of Facilities whose VHSNCs Members are involved in Community Awareness**							
	Sub Health Centres							
Anantnag	3	2	2	0	0	1	3	0
Budgam	3	1	1	0	0	0	1	2
Kupwara	3	3	3	1	0	1	2	0
Samba	3	2	1	1	3	2	2	0
Udhampur	4	4	4	4	4	4	4	0
Total SCs	16	12	11	6	7	8	12	2
	Primary Health Centres							
Anantnag	2	1	1	0	0	1	0	1
Budgam	2	0	0	0	0	0	0	2
Kupwara	2	1	0	0	0	0	0	1
Samba	2	2	1	1	2	1	0	0
Udhampur	1	1	1	1	1	1	0	0
Total PHCs	9	5	3	2	3	3	0	4
Total	25	17	14	8	10	11	12	6

Information was collected from the health facilities whether the members of VHSNC and MAS are involved in raising community awareness about NCD screening among community and whether they have helped in creating public parks and other spaces for exercise and encourage physical activity in schools. It was found that there is no clear

strategy for community mobilization in the State. As Panchayats are not properly functioning, so involvement of PRIs is a more complicated task. Further, the blocks have not yet initiated training of VHNC members under NCDs, so they are not well aware about their roles and responsibilities. MAS do not exist in the State. AB-HWCs have not yet been able to market the preventive and primitive services involving the community, particularly in Kashmir division, where PRI members hesitate to work for various government programmes

It was reported by 6 facilities (2 SCs and 4 PHCs) that the local VHSNCs do not take any part in raising community awareness about NCD screening among community (Table 18). Four of these facilities are located in Budgam.

Of the various activities in which VHSNCs are involved, 17 undertake community awareness about NCDs and 14 support ANM/ASHA during NCD screening (Table 18). Eight VHNSCs are also helping HWCs in creating awareness about benefits of regular exercise. The number of facilities where the VHNCs/PRI are involved in creating public parks and other spaces for exercise is 10. Eleven VHSNCs have encouraged physical activity in schools and 12 are also providing support to HWCs in arranging referral transport to higher facilities. The VHSNCs located in Udhampur and Samba have played their role in various NCD related activities. In Kashmir region, these committees have played very limited role particularly in Budgam and Anantnag. The experience from Kupwara is mixed.

3.10 Coordination

Key tasks on the screening day include: community awareness and active mobilization, organizing the venue, history taking, management of patient flow, recording, feedback to patients, monitoring of already diagnosed cases, and referral advice. This needs a coordinated team effort netween ANM, ASHA, ASHA facilitator and, AWW. For this the work distribution between MLHP and MPWs (Male and Female) should be clearly demarcated. As the MLHPs have recently joined and there is not yet clear demarcation of the roles and responsibilities of the MLHPs and MPWs. Further, it was seen that MOs at the PHCs are also not well versed their roles and responsibilities pertaining to NCD screening and treatment and referral. However, ASHAs have started referring cases for screening of NCDs and MLHPs where ever they are posted are attending these cases. MLHPs have also started referring cases to the PHC Medical Officer, but ASHAs and MPWs reported that once a patient is diagnosed with diabetes or hypertension, they generally prefer to visit tertiary care facilities or district hospital or a private health clinic for confirmation and further treatment.

However, ASHAs/MPWs also reported that all the cases they referred to PHC were attended by the MO but the PHCs generally do not communicate back to the SCs about

diagnostic and continuation of treatment plan. ASHAs further mentioned that they themselves keep track with the patients for follow-up and continuation of treatment. While analyzing this information regarding coordination, it was found that the coordination between various team members is the best in Udhampur and followed by Samba. There seems to be lack of coordination among various team members in Kashmir region and there is a need to orient the team members of their roles and responsibilities as far as NCD screening and treatment is concerned.

4.1 Community Based Assessment Checklist

The CBAC is designed to collect details related to history of symptoms and behavioral factors. They include tobacco and alcohol consumption, amount of physical activity, measurement of waist circumference, family history of high blood pressure, diabetes, heart disease and presence of common symptoms for common cancers, epilepsy and respiratory diseases. The ASHA is responsible for filling the CBAC for all women and men aged 30 years and above. CBAC is helpful to the ASHAs to remember the key risk factors, helps identify those who must be prioritized to attend the screening day and refer the individuals. People with a CBAC score of 4 and above will need to be prioritized for screening. MPW has to review the completed CBAC filled by the ASHA in her coverage area to ensure that it is filled correctly. The ASHA facilitator can also undertake this task.

It was found that CBAC formats were available with all the ASHAs and almost all the ASHAs in the selected HWCs had started the task of filling the CBAC for women and men aged 30 years and above. ASHAs who are illiterate or who had less education mentioned that they take help either from their children or from other persons to fill up these forms.

Table No 19: Distribution of ASHAs by Percentage of Population age 30+ whose Community Based Check list is Completed

	Total	Percentage of CBAC Completed		
		20-40	40-60	60-80
	No	No	No	No
Anantnag	5	1	3	1
Budgam	5	3	0	2
Kupwara	5	2	3	0
Samba	5	1	3	1
Total	20	7	9	4

Although we tried to collect the information from the HWCs regarding the number of households enumerated and the number of CBAC forms completed for persons age 30 and above but hardly does any HWC maintain information about the number of completed CBAC forms, or number of persons with a CBAC score of 4 or more. It was found that once the ASHAs fill up these forms they either keep them with themselves or hand them over to MPWs. Therefore we thought it prudent to collect information about the number of CBAC forms filled by the ASHAs from the ASHAs itself. It was found that of the 20 ASHAs, 7 had completed CBAC forms for less than 40 percent of the population age 30 and above, 9 ASHAs had completed it for 40-60 percent and another 4 had completed it for 60-80 percent (Table 19). It was also found that 4 of the

5 ASHAs in Samba and Anantnag had completed CBAC forms for more than 50 percent of target population. Filling up of CBAC forms is in infancy in Budgam district.

4.1.1 Quality of CBAC Forms

We checked at least 5 CBAC forms completed by each of the 20 ASHAs and it was found that all the ASHAs had made major mistakes in filling up the forms. All the questions were not circled in 15 percent of the CBAC forms. Personal details like age and sex were also missing in few forms. We also asked ASHAs to fill up at least 1 CBAC form in our presence. It was found that ASHAs have not been provided any training regarding calculation of age and they were simply accepting any age reported by the client. It was noticed that they were not reading the full text of the questions and were not fully probing smoking and drinking behavior. None of the ASHAs while asking the question about Drinking Alcohol used the word "DAILY". Similarly, questions pertaining to physical activity and family history are not asked the way they need to be asked. Therefore the information contained in these forms does not depict the actual health score of the individuals. The photographs in the Photo Gallery of this report clearly depict the magnitude of mistakes in the CBAC forms filled in by the ASHAs.

The MPWs and MLHPs are supposed to review the completed CBAC filled by the ASHA in their coverage area to ensure that it is filled correctly but it was observed that till date nobody has taken the pains to review these forms or at least accompany the ASHA to see how they ask the questions and how they fill the responses.

4.2 Screening

Screening is a process of identifying a disease condition among apparently healthy individuals, who may be at increased risk of a disease or condition. Screening programmes can both be undertaken for a population at large, or targeting high-risk groups. Presently, HWCs have to target the NCD screening for population who are at elevated risk of NCDs. The CBAC forms completed by the ASHAs forms the basis of identifying individuals with high risk behaviors.

Screening requires careful planning and implementation. All the individuals who have a disease condition or are at increased risk of a NCD are to be motivated by the ASHA to go the AB-HWC, PHC or CHC for screening. ASHAs mentioned once they complete the CBAC form, they motivate all those individuals to go for screening who have a CBAC score of 4 or more. Screening takes place at all HWCs on weekly basis on every Saturday. But it was found that very few people have visited the AB-HWCs for screening of Hypertension and Diabetes.

Although we visited 25 health facilities and found people visiting the facilities for various ailments and BP of some of these patients is measured but it is not recorded. Blood sugar is rarely measured for general population. Therefore opportunistic screening is not taking place at HWCs.

We tried to get information from the HWCs regarding the number of individuals screened on fixed days but it was found that except HWCS located in Udhampur and a few in Samba and Anantnag, the facilities generally do not maintain information about the total population screened. Record keeping is very poor in Budgam, Kupwara and few facilities in Samba. Due to the poor quality of information pertaining to screening for Hypertension and diabetes it was not possible to get a clear cut picture about the number of individuals screened. For example the 3 SHC AB-HWCs in Anantnag have shown that all the individuals whose CBAC is complete have been screened for Hypertension and Diabetes. Same story was found in Kupwara. PHC Zoohama has maintained information about the individuals who have been diagnosed with high blood pressure. Further most of the facilities in Budgam and Kupwara have maintained some information about individuals who have been diagnosed with diabetes. In two of the facilities more than 95 percent of the individuals screened are female. Thus it may be concluded that although AB-HWCs have started screening but it is still in the infancy and recording keeping is very poor. Further, hardly any monitoring has examined this issue.

4.3 Treatment

Once the diagnosis of HT/Diabetes is established, the patient must receive at least a month's supply of drugs from the PHC. Once the condition is stable, the state could also decide to provide the patient with a three-month supply, with the ANM/ASHA visiting the patient each month for ensuring compliance, checking on diet and life style modification, and measuring the blood pressure/ blood glucose. Alternatively, a three-month drug supply could be stocked with the ANM at Sub Health Centre, to be given each month. Either way, sufficient drug supplies need to be made available at the PHC.

We tried to collect information about the pattern of treatment and frequency of the drugs provided to the patients who are confirmed with hypertension and diabetes. The details are presented in Table 20. All the Sub Cenres-AB-HWCs mentioned that they are not supposed to provide drugs unless they are prescribed by a PHC Doctor. Three such facilities mentioned they do not provide drugs to such patients at all. Seventeen facilities mentioned that they provide drugs fortnightly and remaining 5 facilities provide once a month.

When asked for how many days the facilities provide medicines at a time and it was mentioned by 10 facilities that to ensure compliance with the treatment they provide drugs for only 10 days at a time. All the facilities in Udhampur provide drugs only for 10 days at a time. Four facilities mentioned they provide it for 15 days and 8 facilities provide it for 20 days.

Table No 20: Frequency of supply of drugs for those diagnosed with HT/Diabetes and Days for which Drugs are provided

	Frequency of supply of drugs for those diagnosed with HT/Diabetes				No. of Days for which drugs are provided		
District	No. of Facilities	Do not provide Medicines at Facility	Fortnightly	Monthly	10 days	15 days	20 days
		No	No	No	No	No	No
Anantnag	5	0	5	0	0	2	3
Budgam	5	2	3	0	2	0	1
Kupwara	5	1	3	1	2	0	2
Samba	5	0	2	3	1	2	2
Udhampur	5	0	4	1	5	0	0
Total	25	3	17	5	10	4	8

4.4 Supply of Drugs

As per the scheme all providers should be aware in the use of standard treatment guidelines for diagnosis and treatment of common NCDs. The ANM and ASHA should also be aware of the complete treatment protocol. Once the diagnosis of HT/Diabetes is established, the patient must receive at least a month's supply of drugs from the PHC. Once the condition is stable, the state could also decide to provide the patient with a three-month supply, with the ANM/ASHA visiting the patient each month for ensuring compliance, checking on diet and life style modification, and measuring the blood pressure/ blood glucose. Alternatively, a three-month drug supply could be stocked with the ANM at Sub Health Centre, to be given each month. Either way, sufficient drug supplies need to be made available at the PHC. The scheme stipulates that patient need to go the PHC for the first follow up at the end of the first three months after diagnosis, and sooner if required. It was however found that there is no structured policy for procurement of drugs and therefore irregular and shortage of NCD drugs is a common feature across all facilities in the State. Therefore they are not in a position to provide drugs to the patients as per the stated policy. Some diabetic patients need insulin of different combinations, but either the facilities do not have the insulin or do not have the required combination which is prescribed by Medical Officers.

4.5 Follow-up

Once the patient is put on treatment, there is a need for regular follow up of the patients by ASHA/ANM. The patients are also encouraged to visit the facilities once the first pack of medicines is exhausted. Such follow ups are necessary for ensuring compliance, checking on diet and life style modification, and measuring the blood pressure/ blood glucose.

The patient will need to go the PHC for the first follow up at the end of the first three months after diagnosis, and sooner if required. An annual specialist consultation at the nearest nodal CHC with an NCD clinic, is also recommended, based on the decision of the MO at the PHC.

Table No 21: Distribution of H&WCS by Timing of First Follow Up after Diagnosis of Hypertension or Diabetes

District	No. of Facilities	Timing of First follow up	
		After 1 Week	After 2 Weeks
Anantnag	5	4	1
Budgam	5	2	3
Kupwara	5	3	2
Samba	5	4	1
Udhampur	5	3	2
Total	25	16	9

Information presented in Table 21 shows that most of the facilities (16) reported that once the patient starts taking medicines, they generally advise the patient to visit the facility after one week. Further, 9 facilities advise the patients to visit for follow up after 15 days. Most of the facilities in Anantnag and Samba advise the patients to visit after 1 week.

Although MPWs should also visits the patients for follow up, but it was seen that ANM/MPWs do not undertake follow up visits. Community Follow up of NCD cases is done by ASHAs only. They are making visits to enable positive behaviour modifications, treatment compliance, and encouraging patients to go the Sub Health Centre for regular check-up of BP/blood glucose.

Information collected regarding the timing of follow up visit by ASHAs presented in Table 22 reveals that ASHAs of 10 facilities conduct follow up of NCD patients once in two weeks. Facilities of 7 ASHAs mentioned that such visits are conducted once in 10 days and in 8 facilities ASHAs generally visit for follow up on a weekly basis. The ASHAs are prioritizing those households where there are treatment defaulters or those who experience complications. The ASHAs, MPWs and MOs mentioned that follow

up and failure to ensure continuity of treatment is a major challenge due to supply issues and public perception that the drugs available at the health facilities are sub standard.

Table No 22: Distribution of HWCS by Frequency of ASHA Visiting the Patient for Ensuring Compliance with Treatment				
District	No. of Facilities	frequency of ASHA visiting the patient for ensuring compliance		
		Weekly	Once in 10 days	Fortnightly
Anantnag	5	1	0	4
Budgam	5	2	1	2
Kupwara	5	2	2	1
Samba	5	1	1	3
Udhampur	5	2	3	0
Total	25	8	7	10

What are the activities that ASHAs undertake during follow up visits. It was mentioned by all ASHAs of all the 25 facilities that during the follow up visit they are encouraging patients to go the health facility for regular check-up of BP/blood glucose (Table 23). ASHAS of about 22 facilities also mentioned that they ensure treatment compliance and enable positive behavior modifications.

Table No 23: Distribution of HWCS by Nature of Activities Undertaken by ASHAS During Follow up Visits				
District	Total	For positive behaviour modifications	Treatment compliance	Encouraging patients to go the health facility for regular check-up of BP/blood glucose.
Anantnag	5	5	5	5
Budgam	5	5	5	5
Kupwara	5	3	4	5
Samba	5	4	4	5
Udhampur	5	5	5	5
Total	25	22	23	25

ANMs/ASHAs are also required to identify the patients who are already on treatment under the care of a private practitioner and advise and motivate them to visit the AB-HWCs for treatment. They are to be offered the choice of taking drugs from the public health system, after appropriate confirmation. We collected information about this aspect also to ascertain the numbers of patients who are already on treatment under the care of a private practitioner have shifted to public health system for drugs and the

information is presented in Table 24. None of the patients had shifted to public health care facilities for treatment or drugs in case of 13 HWCs. It was also observed that the HWCs where patients had started taking drugs from the HWCs but these Centres have not maintained separate information about patients who have shifted to public health care facilities for treatment or drugs. Of the 5 facilities in Anantnag, patients from private sector had shifted to public health care in case of 1 HWC. In Samba district, patients from four facilities and in Kathua patients from 2 facilities have started taking drugs from the HWCs. Some information maintained about the number of patients who had shifted to public health facilities show that the number of such patients is not more than 10 in any of these Centres.

Table NO 24: Distribution of H&WCS by Shifting of Patients from Private to Public Facilities for Taking Drugs/Treatment

District	No. of Facilities	Facilities where Patients Shifted from Private to Public Facilities for Treatment of NCDs		
		Shifted for medicines	Shifted for Check up	None
Anantnag	5	1	0	4
Budgam	5	1	1	3
Kupwara	5	2	0	3
Samba	5	4	0	1
Udhampur	5	2	1	2
Total	25	10	2	13

4.6 Referral

The scheme envisages that all individuals screened at SC AB-HWCs with a systolic BP of over 140 and a diastolic BP of over 90 mm of Hg, or random blood sugar of 140 mg/dl and above) would be referred to a Medical Officer (MBBS), at the PHC/CHC, for confirmation, conducting relevant laboratory investigations, and initiation of treatment. It was found that the staff of the HWCs had adequate information about the place of referral of NCD patients. But it was found that referral linkages between SHC AB-HWCs and Primary Health Centres and higher facilities for managing complicated cases is missing, because PHC and other higher facilities are not clear about their roles and responsibilities. There is also lack of coordination among service providers at SC and PHC level. Further the MPWs/MLHPs mentioned that once a person is diagnosed with Hypertension or Diabetes and we refer him/her to PHC for confirmation but the patients instead of visiting PHC generally visit a private doctor/clinic or District/State hospital for confirmation and subsequent treatment as they do not have much faith on Primary Health Care facilities. Inability to ensure uninterrupted and regular supply of

medicines, diagnostics is affecting the continuum of care as well as the utilization of AB-HWCs by community.

4.7 Monitoring

The overall responsibility for monitoring and supervision of field activities is with the Primary Health Centre Medical Officer. Review of the programme should be an integral a part of monthly review meetings, field supervision, and data monitoring. Recording and reporting at all levels is also to be aligned with NPCDCS guidelines.

During the survey we collected information about the monitoring of HWCs during the last 3 months by Sr. officials from the office of National Health Mission, Chief Medical Officer and Block Medical Officer. It was found that none of the officials from any of these offices had visited 6 HWCS for monitoring of NCD activities (Table 25). Of the facilities which are not visited by sr. Officials for monitoring two each are located in Budgam and Samba and one each in Kupwara and Anantnag. All the facilities in Udhampur have been visited for monitoring of NCD activities.

Table No 25: Distribution of H&WCS by No. of Monitoring Visits by Sr. Officials During Last 3 Months

	Total	No. of Monitoring Visits			
		0	1	2-3	4-5
Anantnag	5	1	2	2	0
Budgam	5	2	2	1	0
Kupwara	5	1	1	3	0
Samba	5	2	1	1	1
Udhampur	5	0	0	0	5
Total	25	6	6	7	6

Those facilities which were monitored by sr. officials were further asked about the number of monitoring visits paid by the Sr. Officials. It was found 6 facilities were visited 5 times during the last three months and 4-5 of these facilities are located in Udhampur and 1 is in Samba district. Further, 7 facilities were monitored 2-3 times and 3 of these were from Kupwara 2 from Anantnag and 1 each from Samba and Budgam. The number of facilities which were monitored only once during the last three months is 6 and 2 each of these are from Anantnag and Budgam. Thus NCD monitoring is strong in Udhampur followed by Kupwara.

Health and Wellness Centres that were monitored by Sr. Officials during the last three months were asked to report what type of feedback they gave to the HWCS after completing their monitoring visit and multiple responses were recorded (Table 26). It was reported by 9 facilities that the monitors after mentoring did not provide any feed back to the facilities. Staff of 6 HWCs mentioned that the monitors suggested them to

improve the recording and reporting of NCD information. Similarly 9 facilities were advised to improve screening. The number of facilities that were asked to speed up the CBAC is 6. Monitors of 5 facilities found the overall performance of NCDs weak and were suggested to improve it. It was also reported by 4 facilities that monitors found the training component of the ANMs/ASHAs weak and suggested to improve their training skills. District wise feedback given by the monitors reveal that the visits of monitors were effective in Udhampur district as all facilities have been given feedback on various issues related to NCDs. Monitoring visits seem to be least effective in Budgam.

Table No 26: Distribution of H&WCS by Type of Feed Back Given by Monitoring Officials After Monitoring

	Total monitored	Type of Feed Back Given by Monitoring Officials					
		None	Reporting	Screening	CBAC	Performance	Training
Anantnag	4	0	1	2	0	1	1
Budgam	3	1	0	1	1	0	1
Kupwara	4	2	1	0	2	2	1
Samba	3	1	1	2	0	0	1
Udhampur	5	5	3	4	3	2	0
Total	19	9	6	9	6	5	4

Review of NCD programme is an integral a part of monthly review meetings and the Block Medical Officers are required to review the progress of the NCD and identify the problems in the implementation and suggest ways to rectify the issues. Therefore we tried to evaluate whether the implementation of NCDs by AB HWCs is reviewed in the monthly meetings at the block level and the issues which were discussed in the last monthly meeting. Information presented in Table 27 shows that monitoring of NCDs was not in the agenda of the last monthly review meeting in case of majority of HWCs. NCDs issues have not been discussed in the last monthly meeting in Anantnag. NCD is also of least priority in case of most of the health blocks in Kupwara and Budgam also. Officials of only 12 HWCs mentioned that NCD was discussed in the last monthly review meetings at block level. Information was also collected on the range of NCD issues that were discussed in the last monthly meeting. Issues related to completion of CBAC were mainly stressed in such meeting. Supplies of drugs and record keeping were also discussed in some block. Performance of NCD screening was discussed in only 4 blocks. Each of these issues was reported to have been discussed by HWCs located in Udhampur and Samba districts.

Table No 27: Distribution of H&WCs by Nature of Discussion in Monthly Review Meetings at Block Level							
	J&K	NCD Discussed in Monthly Meeting		NCD Issues Discussed in the Last Monthly Meeting			
		Yes	No	Supplies	Record	Performance	CBAC
District	No	No	N0	No	No	No	No
Anantnag	5	0	5	0	0	0	0
Budgam	5	2	3	1	1	0	2
Kupwara	5	1	4	0	1	0	2
Samba	5	4	1	3	4	0	3
Udhampur	5	5	0	3	3	4	2
Total	25	12	13	7	9	4	9

5. Conclusion and Way Forward

The districts have initiated up gradation and branding of the easily doable facilities for achieving the short term goals, while doing so, the quality of up gradation has been compromised. Districts need to ensure proper planning while selecting the facilities to be upgraded to AB-HWCs through a detailed gap assessment of various parameters of functionality. Districts should follow proper AB-HWCs branding guidelines to maintain uniformity across the State. Those of the Sub Centres which are located in rented building, but adhere to specified infrastructure norms could be prioritized to serve as SHC AB-HWCs.

Although the State has started the process to recruit MLHPs but most of the SHC AB-HWCs are without MLHPs and some are functioning with only one FMPHW. Due to the lack of adequate number of MLHPs, the districts are following piecemeal approach in operationalization of AB HWCs. It was also found that State has not yet finalized the mechanism for performance linked payments to MLHPs and this is discouraging the MLHPs to work with vigor and enthusiasm. It is also essential to plan for the career progression and performance based incentives to ensure retention of the trained MLHPs.

Various districts have initiated training for Medical Officers, Staff Nurses, FMPHWs and ASHAs under NCD in the State. But it appears that the districts have not followed proper guidelines for imparting training to MPWs and ASHAs and therefore there is no clarity among staff of various categories about their roles and responsibilities and the whole process of implementation of NCD screening, diagnostics, treatment, follow-up etc. There is therefore a need to discuss the NCD screening in the monthly meetings and clarify all doubts the staff has regarding its proper implementation. It is also important to plan for capacity building and multi skilling of the staff so that they are better equipped to address the health needs of the population and deliver the NCD services.

Information collected from the HWCs regarding the availability of equipments for screening of NCDs and oral cancers reveals that Glucometers, strips for Glucometer and BP apparatus is available in almost all the HWCS. But some equipment for detection of common cancers are not available in about 40 percent of facilities.. NCD screening is limited to Hypertension and Diabetes in almost all the AB-HWCs and screening for common cancers is yet to start due to limited capacities and infrastructure. There is also a need to make available auto analysers at PHC AB-HWCS.

All the HSC AB-HWCs except those located in Udhampur District mentioned that the NCD drugs are not provided to them in adequate quantities. None of the facilities had a stock of available drugs that could last for three months. Inability to ensure uninterrupted and regular supply of medicines and diagnostics is affecting the continuum of care as well as the utilization of AB-HWCs by community. There is a need to make available NCD drugs of different brands with different combinations including Insulin. There is also a need to maintain a buffer stock of drugs for at least 3 months.

Due to the delay in procurement, issues with both hardware and software and issues in distribution, Desktops/Laptops and Smart Phones have not yet been provided to HWCs. Few HWCs in Udhampur, Samba and Kupwara which were upgraded in the first phase were provided tablets but due to hardware, snapping of internet facilities in J&K, these were never put to use. There is a need to provide necessary hardware to various HWCs and resolve the issues in NCD software and also restore 4G Internet services in the State, so that IT can used to ease the use of telemedicine, data capturing, recording and reporting.

It was found that there is no clear strategy for community mobilization in the State. As Panchayats are not properly functioning, so involvement of PRIs is a more complicated task. Consequently, AB-HWCs have not yet been able to market the preventive and primitive services involving the community, particularly in Kashmir division, where PRI members hesitate to work for various government programmes. There is a need to create awareness towards supply of assured availability of quality of services including quality of drugs at HWCs among the community at large.

The information contained in the CBAC is very poor, making redundant the whole process of health assessment of individuals. There are two reasons for poor quality of CBAC filled in forms. One is defective training and the second is poor monitoring. Districts need to address both these issues.

Referral linkages between SHC AB-HWCs and Primary Health Centres and higher facilities for managing complicated cases is missing, because PHC and other higher facilities are not clear about their roles and responsibilities. There is also lack of coordination among service providers at SHC and PHC level. Streamlining referral linkages by tracking referrals, setting up of help desks at receiving facilities, priority management of referral cases and nominating a nodal person at the referring and receiving facilities can help in managing referral cases.

Most of the facilities do not have a good system of recording information regarding screening of treatment, referral and follow up of NCDs. This issue can be tackled by proper monitoring and mentoring. NCD should be an integral part of monthly meetings. Further Community Health Officers, who visit the facilities for monitoring of other activities should also monitor NCD activities.


PHOTO GALLERY


आयुष्मान भारत


WELLNESS CENTRE
BLOCK-PURMANDAL
हेल्थ एंव वैलनेस सेण्टर


MONDAY & THURSDAY
TUESDAY & FRIDAY
GREEN
WEDNESDAY & SATURDAY
PINK
BLUE


AN BHARAT
S CENTRE BIRPUR
MAN BHARAT
WELLNESS CENTRE
BLOCK-PURMANDAL


HEALTH AND WELLNESS CENTRE
BASSI KALAN
NO SMOKING

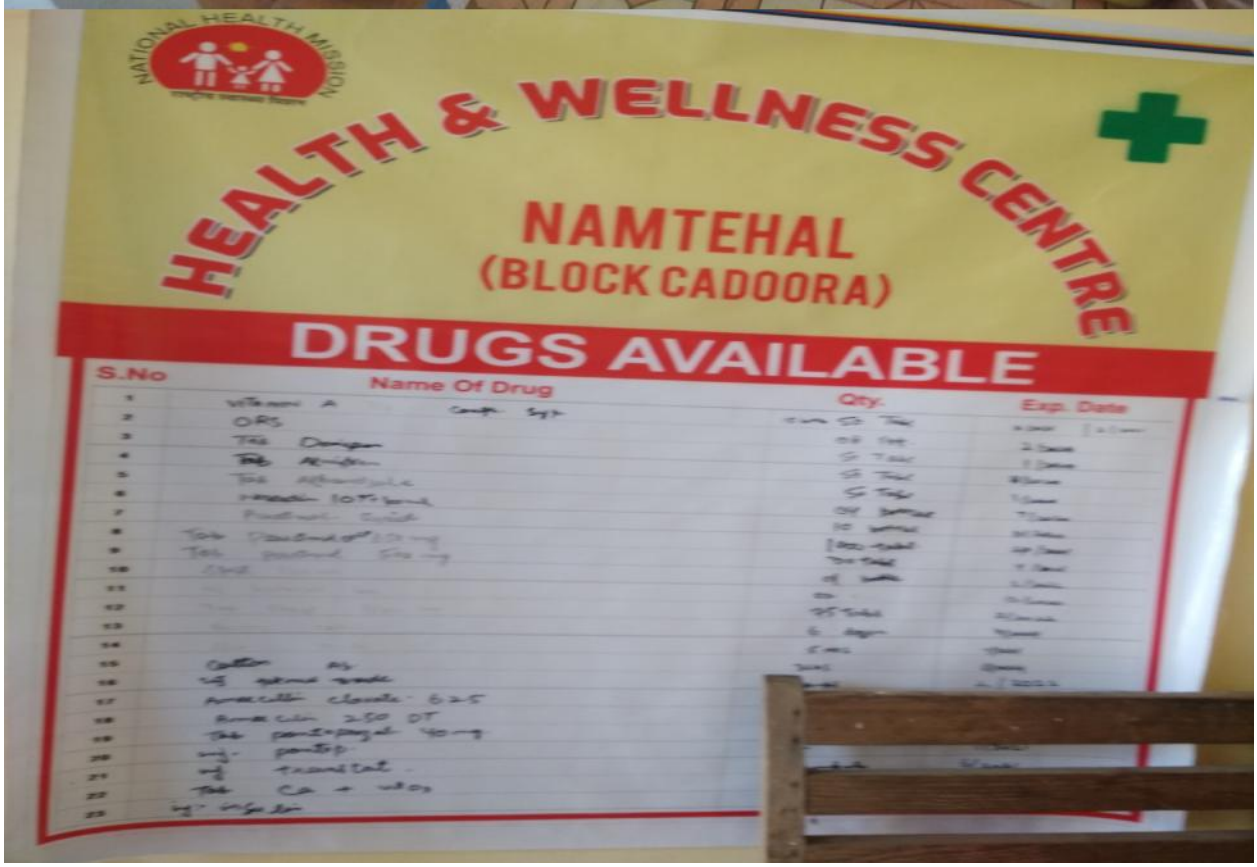

AYUSHMAN BHARAT
HEALTH AND WELLNESS CENTRE
آیوشمان بھارت


AYUSHMAN BHARAT
HEALTH AND WELLNESS CENTRE
آیوش مان بھارت

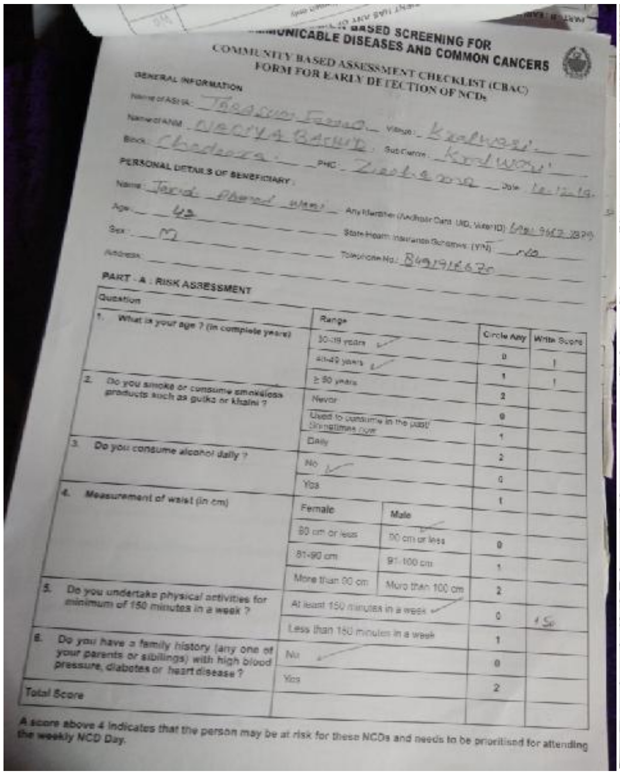

AYUSHMAN BHARAT
HEALTH AND WELLNESS CENTRE
BLOCK CHADOORA
NTPHC
PRIMARY HEALTH CENTRE


PRIMARY HEALTH CENTRE


STAFF TOILET


NATIONAL HEALTH MISSION
HEALTH & WELLNESS CENTRE
NAMTEHAL
(BLOCK CADOORA)
DRUGS AVAILABLE
S.No
Name Of Drug
Qty.
Exp. Date


SD
HIV-1/2 3.0
Ozocheck
SYPHILIS TP STRIP



POPULATION BASED SCREENING FOR NON COMMUNICABLE DISEASES AND COMMON CANCERS

COMMUNITY BASED ASSESSMENT CHECKLIST (CBAC) FORM FOR EARLY DETECTION OF NCDs

GENERAL INFORMATION

Name of ASHA:

Name of ANM:

Block:

PERSONAL DETAILS OF BENEFICIARY:

Name:

Age:

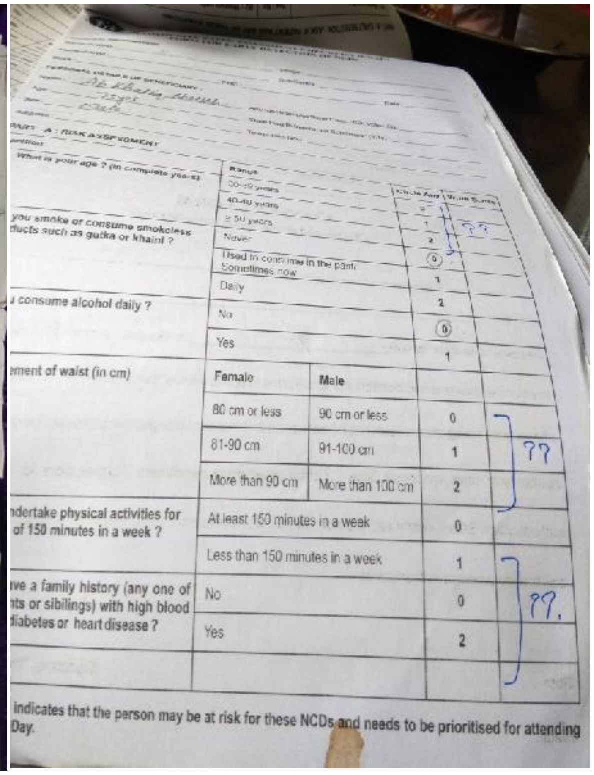
Sex:

Address:

PART - A : RISK ASSESSMENT

Question	Range		Circle Any	Write Score
1. What is your age ? (in complete years)	30-39 years		0	
	40-49 years		1	
	≥ 50 years		2	
2. Do you smoke or consume smokeless products such as gutka or khaini ?	Never		0	
	Used to consume in the past/ Sometimes now		1	
	Daily		2	
3. Do you consume alcohol daily ?	No		0	
	Yes		1	
4. Measurement of waist (in cm)	Female	Male		
	80 cm or less	90 cm or less	0	
	81-90 cm	91-100 cm	1	
	More than 90 cm	More than 100 cm	2	
5. Do you undertake physical activities for minimum of 150 minutes in a week ?	At least 150 minutes in a week		0	
	Less than 150 minutes in a week		1	
6. Do you have a family history (any one of your parents or siblings) with high blood pressure, diabetes or heart disease ?	No		0	
	Yes		2	
Total Score				

A score above 4 indicates that the person may be at risk for these NCDs and needs to be prioritised for attending the weekly NCD Day.



What is your age ? (in complete years)	30-39 years		0	
	40-49 years		1	
	≥ 50 years		2	
you smoke or consume smokeless ducts such as gutka or khaini ?	Never		0	
	Used to consume in the past/ Sometimes now		1	
	Daily		2	
consume alcohol daily ?	No		0	
	Yes		1	
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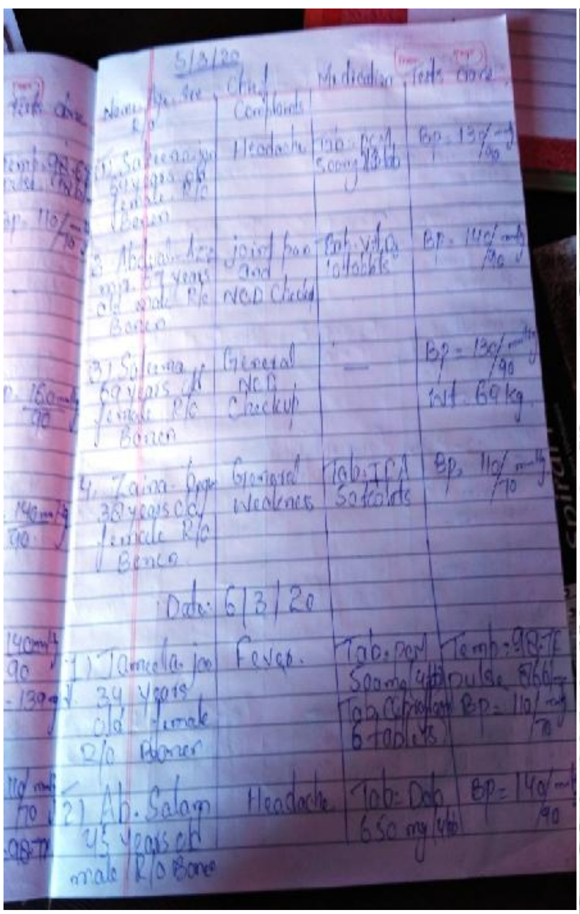
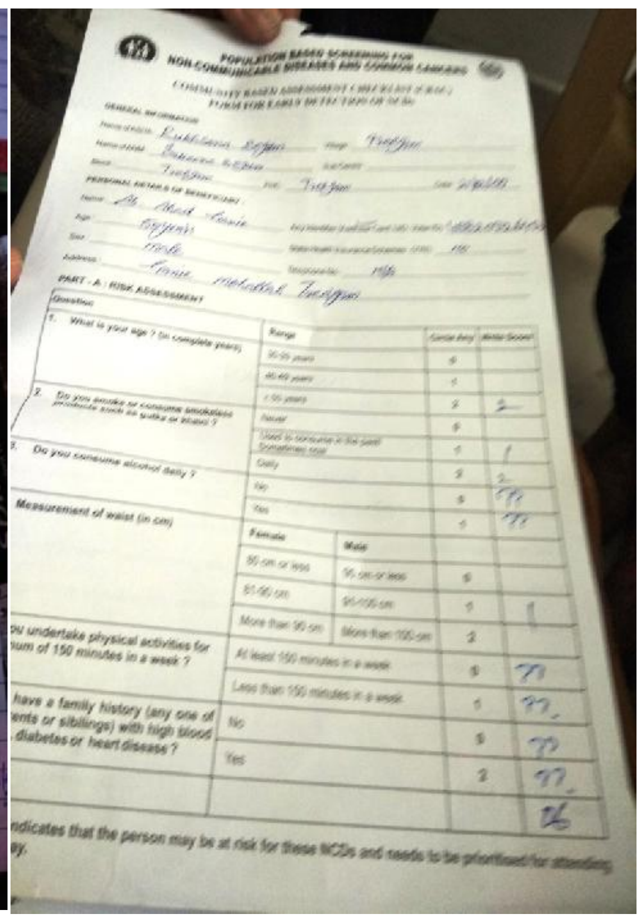
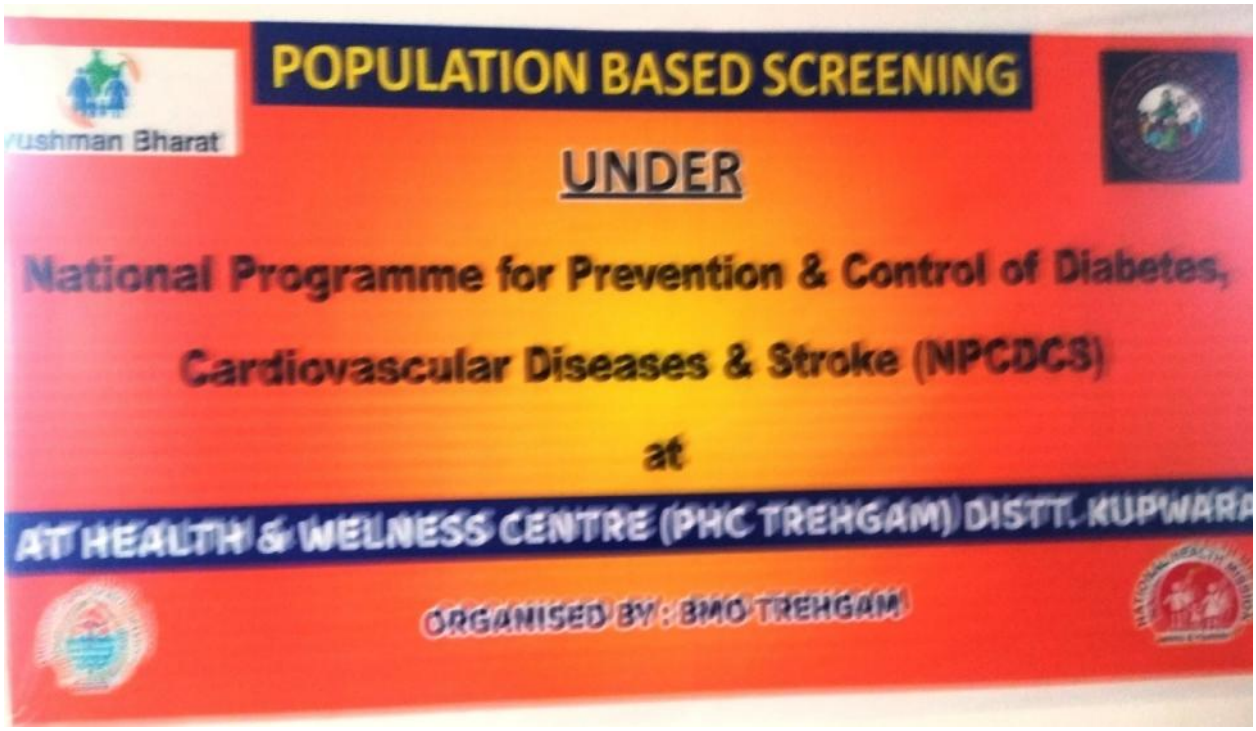
	80 cm or less	90 cm or less	0	
	81-90 cm	91-100 cm	1	
	More than 90 cm	More than 100 cm	2	
ndertake physical activities for of 150 minutes in a week ?	At least 150 minutes in a week		0	
	Less than 150 minutes in a week		1	
ve a family history (any one of nts or sibilings) with high blood diabetes or heart disease ?	No		0	
	Yes		2	

indicates that the person may be at risk for these NCDs and needs to be prioritised for attending Day.






Ayushman Bharat
POPULATION BASED SCREENING
UNDER
National Programme for Prevention & Control of Diabetes,
Cardiovascular Diseases & Stroke (NPCDCS)
at
AT HEALTH & WELNESS CENTRE (PHC TREHGAM) DISTT. KUPWARA
ORGANISED BY : BMO TREHGAM


TOP 5 CANCER - CAUSING FOODS
Fried Potatoes
Doughnuts
Sweetened Beverages
Burned Meat
Hot Dogs
TOP 5 ANTI - CANCER FOODS
Soni
Turmeric
Green Leafy Vegetables
Tomatoes
Sour - Sop
خطرے کے علامات
CAUTION
سبزیوں اور پھلوں کی اہمیت
ان میں پایا جاتا ہے:۔
ضروری غذائیت
حیاتین (وٹامن)
اور
جسمانی ورزش سے مہلک بیماریوں کی روک تھام
دل کی بیماریاں
ورزش:
ذیابیطس (شوگر کی بیماری)
ورزش:
بڑی انتڑیوں کے نچلے حصے کا کینسر
ورزش:
DIRECTORATE OF HEALTH SERVICES KASHMIR
CHIEF MEDICAL OFFICER KUPWARA (NCD KUPWARA)
NCDs

پستان (بریسٹ) کینسر کے علامات

- پستان میں گٹلی / گانٹھ۔
- پستان یا بغل میں مسلسل درد۔
- نپل کے گرد جلد میں سُرخی۔

- نپل کا اندر کی طرف دب جانا۔
- نپل سے خون یا پس نکلنا۔
- پستان کے سائز میں تبدیلی۔

خود اپنے پستان کی جانچ کریں۔

- ہر مہینے ماہواری بند ہونے کے بعد۔
- رجونورتی (**Menopause**) کے بعد ایک مخصوص دن اس کی جانچ کے لیئے رکھیں۔
- **Menopause**۔ (حیض کا بند ہونا)

آگاہ رہیں۔ کینسر سے بچیں

ISSUED IN PUBLIC INTEREST BY

Visited s/c wadipora on 18/12/18 @ 11 Am. FMPHW Shaheena and s/w Bashir were present. Mureesa (EMPHW) went to chakoora for official purpose.
All records & reports were maintained properly.

Fatima (HE)
18/12/18

Visited NTPHC Wadipora on 3/4/19 @ 10:30 Am. FMPHW Kaiser and s/w Bashir were present. Checked RCH register and Daily Immunization register. Adviced FMPHW to complete registers upto-date.

Fatima (HE)
3/4/19

Visited NTPHC Wadipora on 3/9/19 @ 12:00 Pm. All the employees were present. Centre was neat & clean. Checked all register, registers were maintained. Adviced FMPHW to update RCH register and daily imunization register.

Fatima (HE)
3/9/19

Visited NTPHC Wadipora on 11.10.19 @ 11:30 Am. FMPHW Kaiser jan was present, s/w Bashir Ahmad has N/D. Checked Delivery register, Birth register, VHND Regr, Daily immunization register & RCH register. All register were maintained up to date. ~~Afff~~ Total ANC = 26, child = 23 registered and uploaded.

Fatima (HE)
11.10.19