POPULATION RESEARCH CENTRE

DEPARTMENT OF ECONOMICS,

UNIVERSITY OF KASHMIR, NAAC ACCREDITED GRADE "A+" SRINAGAR J & K

CONCURRENT EVALUATION OF

HEALTH AND WELLNESS CENTRES

IN

JAMMU AND KASHMIR

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SYED KHURSHEED AHMAD
MUNEER AHMAD

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CONTENTS

LIST OF ABBREVIATIONS

AB	Ayushman Bharath
ANM	Auxiliary Nurse Midwife
AWCs	Anganwadi Centres
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BCC	Behaviour Change Communication
BMO	Block Medical Officer
BPM	Block Programme Manager
CHC	Community Health Centre
CHO	Community Health Officer
COPD	Chronic Obstructive Pulmonary Disease
CPHC	Comprehensive Primary Health Care
DH	District Hospital
DPM	District Programme Manager
EML	Essential Medicines List
FRU	First Referral Unit
GNM	General Nursing and Midwifery
HR	Human Resource
HC	Health Centres
HWCs	Health and Wellness Centres
IEC	Information Education Communication
MAS	Mahila Arogya Samiti
MLHP	Mid-level Health Provider
MMUs	Mobile Medical Units
MO	Medical Officer
MPW	Multi-Purpose Worker
NACO	National Aids Control Organisation
NGO	Non-Governmental Organisation
OOPE	Out of Pocket Expenditure
OPD	Out Patient Department
PBS	Population Based Screening
PHC	Primary Health Centre
RCH	Reproductive and Child Health
SBA	Skilled Birth Attendant
SHGs	Self Help Groups
UHC	Universal Health Coverage
UHND	Urban Health and Nutrition Day
ULB	Urban Local Body
UPHC	Urban Primary Health Centre
VHSNC	Village Health Sanitation and Nutrition Committee
UT	Union Territory

PREFACE

It is an established fact that Primary Health Care has been selective and limited to RCH and Communicable Diseases and address only about 20 percent of health care needs. Besides, various studies this low utilization of public health facilities has also been established by NSSO data (71st Round) which shows that 28 percent in rural areas and 21 percent in urban areas have sought care in the public sector; of which only 11 percent and 3 percent respectively sought any form of care at a level below the CHC. It has also been established that Health care is fragmented as it disrupts continuity of care and impacts on clinical outcomes and leads to high Out of Pocket Expenditure (OOPE). There has been an epidemiologic transition and death from the four major Non-Communicable Diseases (NCDs) –Cancer, Cardio-Vascular Disease (CVD), Diabetes, and Respiratory Diseases accounts for nearly 62 percent of all mortality among men and 52 percent among women of which 56 percent is premature. There is global evidence that Primary Health Care is critical to improving health outcomes. It has an important role in the primary and secondary prevention of several disease conditions, including non-communicable diseases. The provision of Comprehensive Primary Health Care reduces morbidity and mortality at much lower costs. For primary health care to be comprehensive, it needs to span preventive, promotive, curative, rehabilitative and palliative aspects of care. In India, the need for and emphasis on strengthening Primary Health Care was firstly articulated in the Bhore Committee Report 1946 and subsequently in the First and Second National Health Policy statements (1983 and 2002). The National Health Policy, 2017 recommended strengthening 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 thirds of the health budget to primary health care. Keeping in view the above-mentioned facts, Government of India (GoI) initiated the World's largest health care scheme-Ayushman Bharat Yojana or Pradhan Mantri Jan Arogya Yojana (PMJAY) or National Health Protection Scheme which was launched in 2018, for a New India -2022. The scheme aims at making interventions in primary, secondary and tertiary care systems, covering both preventive and pro-motive health, to address healthcare holistically. Ayushman Bharat is an attempt to move from a selective approach to health care to deliver comprehensive range of services spanning preventive, promotive, curative (both outpatient and hospitalization) rehabilitative and palliative care. It aims to undertake path breaking interventions to holistically address health at primary, secondary and tertiary level. It is perhaps the single most important reform measure of Government of India, to address the major challenges of ensuring Continuum of Care, Two-way referral, and Gatekeeping.

In view of the National Health Policy, 2017 which recommended strengthening the delivery of primary health care, through establishment of "Health and Wellness Centers" (HWCs) as the platform to deliver Comprehensive Primary Health Care (CPHC) and called for a commitment of two thirds of the health budget to primary health care. In February 2018, the Government of India announced that, 1,50,000 Health and Wellness Centers would be created by transforming existing Sub Centers (SCs) and Primary Health Centers (PHCs) to deliver Comprehensive Primary Health care (CPHC) as one of the key components of Ayushman Bharat. Under this 1.5 lakh HWCs are being setup to provide comprehensive health care, including for non-communicable diseases and maternal and child health services, apart from free essential drugs and diagnostic services.

The government has already started upgrading existing SCs and PHCs to Wellness Centres. The list of Services to be provided at Health and Wellness Centre include: Pregnancy care and maternal health services, Neonatal and infant health services, Child health, Chronic communicable diseases, Non-communicable diseases, Management of mental illness, Dental care, Eye care, Geriatric care and Emergency medicine.

Ayushman Bharat was launched in Jammu and Kashmir on December, 1st 2018 and the UT has so far established a large number of HWCs in all the 20 districts (including 2 aspirational districts) at the primary health care facilities. The UT has a target of converting a total of 2722 primary level health facilities which include, 2068 SHCs, 605 PHCs, and 49 UPHCs in to H&WCs by 2022. The UT of Jammu and Kashmir has a target to make 517 SCs, 151 PHCs, and 12 UPHCs as H&WCs by March, 2020 and so far, (31st Dec, 2019) 165 SCs, 139 PHCs and all the 12 UPHCs have been made operational in various districts of the state. So far against a total of 1222 proposed HWCs since 2018-19 to 2019-20, the UT has been able to make operational only 316 (26 percent) HWCs. Various districts have also not been able to set-up the proposed HWCs in a time bound manner. The UT has a target to make 680 HWCs operational by March, 2020. The UT is in the process of formulation of a "vision document for operationalization of H&WCs" with timelines and projections of resources estimated to convert all primary care health facilities in to HWCs in Jammu and Kashmir. Keeping in view the above-mentioned facts we found it as the right time to have a concurrent evaluation of these HWCs so that mid-way corrections can be made to make these centres more effective and productive. The data collection was done during the month of December, 2019 to March, 2020.

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 conduct this study. We thank our Director Prof. Effat Yasmeen for her support and encouragement at all stages of this study. We thank our colleagues at the PRC, especially Mr. Bashir Ahmad Bhat, Mr. Imtiyaz Ahmad, Mrs. Farida, Mr. Jaweed Ahmad, Mr. Tahir Nabi, Mrs. Shahida and Mrs. Samina for their constant support and encouragement during all phases of this study. Special thanks are due to Chief Medical Officers and District Nodal Officers of Srinagar, Jammu, Udhampur, Anantnag, and Baramulla, and BMOs of all the selected blocks that we visited, officials of all the HWCs for their support and sparing their precious time and sharing with us their experiences. We also appreciate the cooperation rendered to us by MLHPs, MPWs, ASHAs, Community Leaders, and other officials of selected HWCs. Last but not the least credit goes to all OPD patients, and all those persons who spent their valuable time and responded with tremendous patience to our questions.

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Syed Khursheed Ahmad
Muneer Ahmad

1. EXECUTIVE SUMMARY

The results of the study are based on a total of 5 districts, 30 H&WCs (5 each from Srinagar and Anantnag, 8 from Jammu, and 6 each from Udhampur and Baramulla), 14 medical blocks, 25 community leaders/groups, 46 OPD patients, 13 MLHPS, 39 ASHAs, and 25 MPWs. Executive

State/UT Profile

- Out of a total of 1222 proposed HWCs since 2018-19 to 2019-20, the UT has been able to make operational only 316 (26 percent) HWCs till 31st December, 2019 which include 165 SCs, 139 PHCs and all the 12 UPHCs.
- The UT has a target to make 680 HWCs (517 SCs, 151 PHCs, and 12 UPHCs) operational by March, 2020 which seems to be next to impossible given the time constraint and harsh weather conditions of the UT.
- The UT has a target of converting a total of 2722 primary level health care facilities in to HWCs by 2022 and 900 such health facilities during 2020-21.
- In case of selection of UPHCs not any particular criterion is being followed by the UT, as almost all the UPHCs have been proposed to be converted into HWCs by the year 2021.

Human Resource

Programme Management

- Nodal officers for CPHC have been identified for state as well as all the districts and their orientation has also been completed while as orientation of block programme management units has not yet been taken-up. CPHC orientation in case of primary health care team has been initiated and partially completed.
- Review meetings are being conducted at the state level on regular basis but such activities hardly take place at district and block level.
- The state has established 10 Program Study Centres (PSCs) in various districts of the UT and the total intake capacity of all these PSCs is 500.
- The selection of MLHPs is done by the Mission Director and recruitment of candidates is now only done for fresh candidates only (as it was found that in the beginning some in-service candidates were also recruited as MLHPs).
- Posting of MLHPs is mainly done on the locality basis and most of the MLHPs are posted in their home districts.
- Overall a total of 247 MLHPs have been posted at various SCs in the UT till December, 31st 2019. No staff nurses have been proposed for NCDs at PHC level in the UT. Out of these, 10 MLHPs were posted in Srinagar district, 18 in Jammu and 8 MLHPs in Baramulla.
- A total of 485 MLHPs were undergoing CPHC training at different places in the UT for the June, 2019 session.

Training

- More than 3000 ASHAs, about 1000 MPWs, 150 staff nurses, and about 250 MOs have been trained in NCD in the UT. Such trainings have been given to a large majority of above-mentioned health professionals during 2019-20 in the selected districts also.
- Training in other packages like, oral health, ENT, eye care, mental health etc. has not been imparted at the UT level. Targets set by SHS/district for training were not shared with us.
- Though the SHS maintained that the guidelines regarding duration of training were followed strictly but, in the field, it was found that the guidelines were not properly followed by some districts in terms of number of days and trainers, thus compromising with quality of trainings.

Expanded Service Delivery

- Population enumeration has been initiated in all the districts and more than 2000 SCs have started this activity in their respective districts.

- The filling-up of CBAC forms has also been initiated and about 110 SCs are filling up the CBAC forms and all the selected districts reported that such activity is taking place in their respective districts also.
- Universal screening for NCD is also going on in more than 900 SHCs but the frequency of OPDs, camps etc. remains to be an issue.

Work done during the last two quarters

- Overall, during the last two quarters, more than 75000 suspected cases were screened for hypertension in the UT and out of these about 5000 (6 percent) were identified positive and were presently on treatment.
- Similarly, about 74000 suspected cases of diabetes were screened and about 2700 (4 percent) were found positive. Currently 5500 cases (including follow-up cases) were on medication.
- Overall a total of 728 (4 percent) cases of various types of cancer cases were detected but only 157 cases were on treatment in various health facilities.

Drugs Diagnostics and Infrastructure

- The UT of Jammu and Kashmir has made some minor changes in EML in order to incorporate the local health issues. At PHC level HWC, there are 71 drugs in the EML while at SC level HWC, the UT has made a list of 23 free drugs which include few drugs for NCDs also.
- The indenting of blocks varies from district to district but by and large such indenting is done by blocks on monthly basis.
- The SHS officials maintain that district drug stores have started receiving separate indents for SC-HWCs but it was found that such indenting is in the initial phase and only three districts (out of 5 selected districts) have initiated the process.
- Medicines for hypertension and diabetes are supplied to SC-HWCs, but in various districts it was found that their quantity and choice of drugs was very limited.
- Essential list of diagnostics was found missing in all the visited HWCs in the UT. DVMDS indenting has not yet been taken-up at any level.
- Diagnostic facilities have not been brought under PPP mode at any level but the strengthening of in-house labs is taking place at few places.
- In order to strengthen the infrastructure for HWCs, the UT has taken the task on priority and an amount of Rs. Seven lacs are provided to a SC-HWC for infrastructure development while as Rs one lac is given to SC-HWC for equipment.
- Similarly, for PHC-HWC, an amount of Rs. Four lacs are given for infrastructure development while an additional one lac is for equipment to bring these facilities to the standards as laid down in the guidelines.
- Each UPHC-HWC is given Rs one lac each for infrastructure development and equipment.
- The gap analysis of facilities has been done but in all the selected districts it was found that such process is still underway or has not yet been initiated.
- Infrastructure upgradation and branding of functional HWCs has been done in most of the districts and for new HWCs, such process is underway in all the selected districts.
- Overall, the UT has completed the process of upgradation of infrastructure/refurbishment in 315 HWCs in various districts (as on 31st December, 2019). This process has been completed in 32 HWCs in Jammu, 43 in Udhampur, and 51 HWCs in Baramulla district but there are still some unresolved issues in various HWCs.

IT System and Telehealth

- In terms of IT system, the UT of Jammu and Kashmir has not done much but intend to use OPEX model for the purpose.
- None of the has ASHA been given any smart phone while the number of MLHPs/MPWs, who have received Tablets across the UT is almost negligible.

- Very few PHCs/MOs have been given desktops/laptops to create digital data base. The desktops were found available in Udhampur and Baramulla but it was found that such facility was already available with them before their upgradation.
- The internet suspension post 5th August, 2019 affected the overall working of HWCs as they could not upload their data on the national portals.
- Teleconsultation has not yet been initiated in any of the districts of the UT and ECHO model has not yet been implemented for training the service providers.

IEC, Community Outreach and Health Promotions

- In order to improve the IEC activities in community regarding expanded range of services, it was found that not much has been done by the UT or the districts as such the activities are carried-out by different HWCs as per the previous schedule of VHNDs only.
- As far as yoga/physical exercise sessions are concerned, the activity has been initiated by the UT and some selected districts have also conducted such sessions. The major issue for conducting such sessions remains to "the space and identified instructors".

Financing

- The SHS has distributed funds to the districts as per the allocation and it was found that in all the selected districts the major chunk of funds was yet to be utilized for the last three years.
- The funding (received and utilized) by the SHS was not provided to us for one or the other pretext thus, giving us no chance to analyse the funds position in the UT.
- In terms of release and expenditure of funds, except for Srinagar, no other district has been able to utilize the released funds in a time bound manner during the last two financial years.
- Udhampur district lags behind and has been able to spent only 14 percent and 52 percent of the released funds respectively during 2018-19 and 2019-20.
- Performance based incentives to various health functionaries associated with HWCs not yet been released by the SHS for any districts till date. However, some districts reported that recently funds have been released for ASHAs on CBAC assessment and mobilization only @ Rs. 10/form but yet ASHAs have not received the same at any level.

Partnership

- Partnerships with private agencies, SHGs, NGOs etc. has not been initiated by the UT or any of the selected districts for any knowledge generation, diagnostics, treatment or other purposes.

HEALTH AND WELLNESS CENTERS (HWCs)

Basic information

- The analysis is based on a total of 30 HWCs taken from five districts of the UT. Overall, 14 SC-HWCs, 6 PHCs, 5 UPHCs, and five 24X7 PHCs were visited for this evaluation exercise.
- Most of the HWCs have been established in government buildings but out of the total HWCs visited in Baramulla 33 percent (one UPHC and one SC) were in private rented buildings.
- Further, the data reveals that 40 percent each HWC in Srinagar district covers a population of >5000-7000 and more than 10000 respectively. In Udhampur, 67 percent HWCs cover a population of >5000-7000 while in Anantnag 80 percent HWCs cover a population of 3000-5000.
- In Udhampur, 83 percent HWCs have DH or 24X7 PHCs as referral facilities while in Srinagar district, 80 percent HWCs had DH or 24X7 PHC as referral facility. In Baramulla all the HWCs reported that their FRU was the nearest CHC while in Jammu, 63 percent HWCs had PHC as their FRU.
- The average time to travel to FRU for most of the HWCs in all the districts varies between 10-30 minutes but in case of Udhampur, Jammu and Anantnag districts the average travel time was up to 45 minutes.

- Since the SC-HWCs have primarily nearest PHC as the FRU but most of the patients ask them for referral to at least CHC level and thus breaks the primary health care chain and the burden is again shifted to the higher-level facilities.

Human Resource

- All the sanctioned positions of one MO in PHCs is in-position while as none of the PHC has two MOs in position. In 24X7 PHCs, 80 percent have two MOs in-position while in case of UPHCs, 40 percent have 2 MOs in-position.
- Overall, one-third of PHCs are without a MO. One SC-HWC has also a doctor attached in it.
- Only 17 percent PHC-HWCs have a SN in position while as 80 percent of such 24X7 PHCs and UPHCs have one or more SNs in position.
- Overall, 14 percent SCs, 33 percent PHCs, 60 percent UPHCs and another sixty percent 24X7 PHC type HWCs have at least one lab technician in-position while as 17 percent PHCs, 20 percent UPHCs and 60 percent 24X7 PHC type HWCs have 2 lab technicians in-position.
- Seventy-one percent SCs, 67 percent PHCs, 60 percent UPHCs and 40 percent 24X7 PHC type HWCs have one pharmacist in position.
- The sanctioned position of LHV are very limited in the selected HWCs and only one-third of PHCs, and 60 percent 24X7 PHCs have any sanctioned position of LHV and out of these, only 17 PHCs and 60 percent 24X7 PHC type HWCs have such posts filled-in.
- MLHP at the SC-HWCs were found in-position in all the 14 selected SC-HWCs and out of these, 43 percent each had BAMS and GNM as their basic qualification while as 14 percent MLHPs were BUMS qualified.
- Most of them (71 percent) were appointed during June, 2019 to December, 2019 after completion of 6 months' bridge course.
- Most of the MLHPs appointed during 2018, were taken from in-service quota in some districts of the UT.
- As far as MPW-F is concerned, UT has appointed one MPW-F in almost all SC-HWCs under NHM but it was found that some of these have been moved from their original place of posting.
- MPW-F from regular side is sanctioned in all the SC-HWCs but in only 71 percent SC-HWCs both the MPWs-F were in position. Baring 2 PHC/UPHC-HWCs, at least one MPW-F is sanctioned in all other selected facilities.
- One or more MPWs are in position in all the selected HWCs in UT.
- The number of ASHAs sanctioned and in-position ranges from at least one ASHA to 14 ASHAs per HWC and about 40 percent of the selected HWCs (mostly UPHCs, and PHCs) need some more ASHAs for their areas.

Skills and Competencies of Human Resource

- All the MLHPs who have been posted in HWCs have successfully completed their six months' bridge course but during our interaction with some MLHPs, it was found that the 6 months course at some places was not run for the maximum period.
- UT has recently initiated training under HWCs for MOs but other trainings like BEmoc, family planning, other national programmes, safe abortion etc. have been received by a sizable number of MOs also.
- Out of 10 SNs in position at various selected HWCs, only half of them have received any training on family planning or safe abortion. Out of 16 lab technicians in position, only five have received some training while in case of MLHPs, in addition to their six-month bridge course, they have received three days training on population-based screening on NCDs at some places only.

- As per the latest information (as on 10th March, 2020), all the selected districts have imparted training on PBS of NCDs for MPWs, ASHA Facilitators and ASHAs while as training in this regard for MOs, and SNs is going-on and will be completed soon.

Infrastructure and Resources Available

- Out of 14 selected SC-HWCs, repair and upgradation work has been completed while as in 21 percent cases repair work has not taken place and in one each SC-HWC repair work has partially taken place and not started yet.
- In all the PHCs and 24X7 PHCs, repair work has been completed in selected districts while as in one UPHC-HWC no repair or renovation work has been initiated till date.
- Overall, 36 percent SC-HWCs, 33 percent PHCs, and 20 percent UPHCs do not have 24X7 power back-up while as 24X7 water supply is available in almost all the selected HWCs.
- OP consultation room is not available in 29 percent SC-HWCs, and half of the selected PHCs while as all the UPHCs and 24X7 PHCs have sufficient space for OP consultation.
- Patient waiting area is available in most of the HWCs but it was observed that this space is either in open or in the corridors of the facility without any heating or cooling arrangement.
- Sixty-four percent SC-HWCs, and half of the PHC-HWCs have designated limited space for lab and dispensation of medicines but such space is very limited for drug dispensation as most of them do not have a lab.
- In one of the SC-HWC, it was found that they have converted one old wash room in to a lab where they are able to conduct the few specified rapid tests. Space of sterilization is not available in 43 percent SC-HWCs.
- Facility for labour room and NBCC is available in all those HWCs which have been designated as delivery points, though hardly any delivery take place in most of these HWCs.
- Overall, 29 percent SC-HWCs, half of the PHC-HWCs and 20 percent UPHCs have not yet installed any purifier or filter for safe drinking water.
- Approach road to all the HWCs is almost good, facility for separate wash rooms for males/females/patients, and staff have been made functional as at least two washrooms were found available in 57 percent SC-HWCs, 68 percent PHC-HWCs and 60 percent UPHC-HWCs
- Appropriate drainage and arrangement for waste disposal has been made in only 36 percent SC-HWCs, 67 percent of PHC-HWCs, 80 percent UPHC-HWCs and all the 24X7 PHCs across the selected districts.
- Establishment of yoga rooms or provision of yoga services was still found to be available in limited HWCs especially in SC, UPHC and PHC level HWCs due to lack of space. Overall, 29 percent SC-HWCs, half of PHC-HWCs, 20 percent UPHC-HWCs and 60 percent 24X7 PHC-HWCs have established yoga rooms or have made provision for such activities in their locality.
- Furniture and equipment were found to be limited in various facilities though, efforts have been made by the SHS to provide requisite equipment and furniture to HWCs as per the CPHC guidelines.
- Rain water harvesting, state of art waste disposal management, and establishment of herbal garden was found in some selected HWCs of Udhampur district only.

IT Support and Teleconsultation Services

- Overall, only one-third of the selected HWCs were given Desktops for MOs/health facilities and in Udhampur all the facilities were given desktops to maintain the records digitally while as it was observed in some other districts that desktops were already available at these facilities (especially at PHCs, UPHC and 24X7 PHCs) even before they were converted into HWCs.
- Majority of MLHPs had received tablets initially but they were found faulty and were withdrawn immediately by the SHS. However, no new tablets were given to them later.

- The information further collected in this regard shows that 20 percent of each HWCs in Srinagar and Anantnag and one-third of HWCs in Baramulla have received tablets while in all other SC-HWCs tablets have not yet been given to MLHPs.
- None of the ASHAs have received a smart phone in any selected health facility so far across the UT. Similarly, almost all the HWCs in the selected districts reported that no one has received any training in use of IT systems.
- The information on HMIS, RCH, ANMOL, and Nikshay is mostly submitted to block headquarters on hard copies and the same is uploaded on relevant websites by them only.
- Most of the ASHAs were found filling-up population enumeration and CBAC data manually as no smart phone have been provided to them and secondly, such activities in most of the selected districts have been started late.
- Trainings and capacity building of an ASHA to do this exercise was also an impediment to pick-up this exercise and the data is not also being digitized and entered on tablets by MPWs or MLHPs due to non-availability of internet and tablets with them but where-ever tablets are available this data is digitized in offline mode.
- None of the PHC/UPH/24X7 PHC is yet connected with the tele-consultation hub in any district as such facility has not yet been established by the SHS in the UT.

Medicines and Diagnostics

- As per EML, free drug list for SC/NTPHC-HWC contains a total of 23 drugs (which does not include drugs on ophthalmology or ENT) and while the drug list for PHC/UPHC-HWCs contain 71 drugs.
- Up to 23 drugs were found in 21 percent SC-HWCs, 24-30 drugs were found in half of the SC-HWCs and more than 30 drugs were found in 28 percent SC-HWCs.
- Overall, half of the PHC-HWCs had 41-60 drugs, and rest of them had less than 40 drugs available. Similarly, at UPHC-HWC, 60 percent had more than 40 drugs available in their health facilities. All the 24X7 PHC-HWCs had at-least more than 40 drugs available for patients.
- Drugs for chronic diseases like hypertension, diabetes, COPD etc. are also included in these EMLs but it was found that the indents for HWCs have not yet been issued separately by the officials.
- Supply of medicines for NCDs to HWCs ranges from less than 4 medicines to 10 medicines or more to each HWC.
- At some HWCs in Jammu district, most of the MLHPs of HWCs reported that they have very few medicines available and the choice of drugs and multi salt-drugs were not available to them for NCDs and were of the opinion that a full range of drugs for NCDs in sufficient quantity should be made available at all the HWCs.
- The drugs supplied to HWCs are limited in quantity and none of the HWC was able to provide a one-month dosage of drug to any patient.
- All the SC-HWCs conduct only rapid lab tests ranging from one test to 7 tests which include, Hb, Pregnancy test, Sugar test, measure BP, urine dip stick, slide preparation for malaria smear, and sputum test.
- In case of PHC-HWCs the range of tests varies from 17 tests to 40 tests as some UPHC and 24X7 PHC-HWCs are able to carry 28-40 lab tests.
- Almost three-fourth of SC-HWCs have no in-house lab while one third of PHC and 20 percent UPHC-HWCs also do not have any laboratory.

Functional Coordination Amongst the Primary Care Team

- Almost all (except one SC-HWC which is very new) the SC level HWCs have distributed the work amongst themselves under the overall supervision of MLHP. The field coordination and challenges are being discussed at the SC-HWC by MLHPS/MPWs/ASHAs on regular basis and sorted out but such mechanism was found in very initial stages.

- ASHAs are referring suspected cases to SC-HWC after she visits the households to fill-up the family and individual folders. On specified screening day for NCDs, MLHP along with MPWs attend all the referral cases sent by the ASHA and screen them.
- PHC/UPHC/24X7 PHCs-HWCs MOs at these facilities attend the referral cases of SC-HWC priority and provide them all possible facilities available at their disposal but it was found that most of the patients if found with any NCD (who are screened at SC-HWC) prefer to go to higher level health facility for treatment/conformation of disease instead, of going to PHC level HWCs due to lack of specialized general medicine doctor.
- Communication between MOs and MLHPs for continuation of treatment plan and follow-up care was found satisfactory while as the communication by MLHPs/MPWs for community level follow-up by ASHAs was also poor at PHC/UPHC/24X7 PHC-HWC level but at SC-HWC, it was better.

Functionality and Service Delivery

- There has been a definite increase in the average footfall at the OPD in some SC-HWCs. The last month OP footfall for more than one-third of SC-HWCs was between 500-1500 and for most of the PHC/UPHC/24X7 PHC-HWC the average footfall for the last month was from 500 to 2000 patients.
- About 100-700 patients (71 percent) were new cases and between 100-300 had come for the follow-up at SC-HWC.
- The performance of PHC-HWC has also been encouraging though some major services which are included in the CPHC are yet to be started at various levels.
- The total number of cases in some SC-HWCs has increased up to 1500 after it became a HWC though it is too early to say as to what extent there has been an increase or decrease in the number of patients coming to these HWCs as some of the selected HWCs are 2-3 months old only.
- Monthly basis special clinics on fixed day are organised for PMSMA at all the PHC and higher-level health facility on 9th of every month while ANC services in most of the HWCs are provided on routine basis.
- Frequency of immunization sessions ranges from once in a week at 24X7 PHCs to once in a month at SC-HWC level across the UT.
- Most of HWCs have conducted some NCD screening and such screening is scheduled on every Saturday at all the HWCs, but it was found that such screening sessions are not yet held on regular basis at most the HWCs.

Community Level Outreach and Health Promotion Activities

- In Jammu and Kashmir, all the primary care health facilities have been involved in community outreach though VHNDs. Except for one selected PHC, all the selected HWCs have carried-out VHNDs in their respective areas. The frequency of holding these VHNDs is once in a week for all these facilities.
- Though VHND sessions are held against the planned sessions, but due to some disturbances after 5th August, 2019 (when the reorganization of State of J&K took place), some HWCs could not undertake this task for quite some time.
- About one-third of HWCs have not yet conducted any screening camps in their localities while as two-third of HWCs have started this activity in their areas. The frequency of conducting the NCD screening camps varies from weekly for 36 percent to 43 percent among SC-HWCs.
- The screening for 0-18 years is normally done by the mobile teams of RBSK at schools, AWCs, delivery points and in govt. aided private schools also but the role of various levels of health facilities remains limited and if after screening there are some children with some minor ailments, they are sent to nearest SC, PHCs or 24X7 PHCs for treatment.

- Various health facilities at all levels do screen 0-18-year population in routine OPD and in this regard about 47 percent selected health facility have screened this population and have also referred them for further treatment/management to higher level health facilities.

Health Promotion and Prevention Activities

- Overall, 36 percent SC-HWC, two-third among PHCs, 40 percent among 24X7 PHCs, and 20 percent UPHC-HWCs have not so far carried-out any activity for health promotion and prevention activities for wellness.
- Most of SC-HWCs have formed one or more than one Patient Support Group (PSG) in their area but only half of them have conducted any meeting of PSG till date. In case of 24X7 PHC-HWCs, 60 percent of them have formed patient support groups and have also conducted meetings with them.
- Almost all the HWCs have organised awareness camps for life style modification, sanitation drives, outbreak prevention activities in their respective areas.
- About two-third of the SC-HWCs have started yoga sessions while in case of PHC-HWCs, only half of them have conducted yoga sessions and in case of 24X7 PHC-HWCs only 20 percent have started such sessions in their respective facilities/area.
- Frequency of conducting these sessions vary from "once a week" to "sometimes only" across the districts but it was observed that such sessions hardly take place. It was found that such session at their facility was conducted only on the World Yoga Day.
- Most of SC-HWCs do not have any space for such type of activities but some MLHPs have conducted very few yoga sessions at panchayat house or in open space during summers.
- Coordination between the staff of HWCs and the VHSNC was not found so good and their meetings do not take place on regular basis.

Reports on Service Delivery

- The data uploading also varies from individual level to the state level. In the UT of Jammu and Kashmir data on various portals is uploaded by blocks or districts and in some cases, facilities also upload their data on the relevant portals.
- HMIS formats are filled-up by the health facilities (hard copy) and is uploaded by BPMU on the portal while as RCH registers are updated manually on the facilities on daily basis and later uploaded by BPMU.
- CPHC-NCD and HWC data is being uploaded by the concerned facilities (presently in offline mode wherever the tabs have been given as the internet facility was shut in the UT since 5th August, 2019).
- Overall, about 30 percent SC-HWCs are uploading data on various portals at the facility level while as half of the PHC-HWCs, 40 percent UPHCs and 60 percent 24X7 PHC-HWCs also upload the data on various portals at the facility level.
- In SC-HWCs, 80 percent have done around 1000 or less lab tests during the last one year which means that they have conducted less than 100 lab investigations on monthly basis while as most of the 24X7 PHC-HWCs have conducted between 15000-20000 diagnostic test during one year while as majority of PHC and UPHC-HWCs have conducted up to 3000 diagnostic tests in the current financial year.
- None of the selected HWC has been able to provide at least one-month refill of medicines to those patients who are suffering from chronic illnesses. Very few HWCs have been able to provide medicines to such patients for a maximum of 15 days due to limited supplies.

Programme Management Functions

- About 80 percent SC-HWCs organise monthly meetings regularly while in case of PHC-HWC, only 67 percent such HWCs have organised the monthly meeting while as all the 24X7 PHC-HWCs, organise monthly meetings on regular basis.

- The monthly meeting with frontline functionaries at SC-HWC is a regular feature and all SC-HWCs have organised such meetings and most of the HWCs (84 percent) discuss the overall activities of their facilities.
- Such meetings are also regularly organised by PHC, UPHC, and 24X7 PHC-HWCs and mostly discuss the overall functioning of their health facilities. At PHC-HWC level meetings some MOs also conduct technical sessions for trainings as was reported by the various facilities.
- Only at 24X7 level PHCs (out these, some are block headquarters), the concerned BMO were found actively involved with the establishment, upgradation and working of HWCs and use their good-offices to facilitate and extend all help to the core staff of SC-HWC in their respective areas.

Management of Untied Funds

- overall 86 percent SC-HWCs have received united funds during the last year. Similarly, all the UPHC and 24X7 PHC-HWCs have also received untied funds.
- Most of these HWCs use these funds for various activities which include renovation of facility, acquiring drugs, equipment and reagents, etc.
- The decision on expenditures at PHC level HWCs is mostly made by the concerned RKS while as in case of SC-HWCs such decisions are made by the team of the health facility or by the concerned BMO.

Perspective of ASHAs/MPWs/MLHPs about HWCs

- ASHAs irrespective of their place of posting opined that their workload has increased manifold.
- Though ASHAs maintained that they received additional training on NCD for 3-5 days in various districts but the authorities reported that 5 days training on population-based screening on NCDs was given to most of ASHAs.
- There has been a positive feedback from the community to ASHAs for establishing HWC and posting a trained MLHP in their locality. It was also reported by ASHAs that there is a remarkable increase in OPD footfall at their respective health facilities.
- ASHAs are getting help from MLHPs to maintain their day to day record and sharing of workload in a better way.
- Majority of ASHAs were of the opinion that working for NCD screening and treatment has increased manifold due to introduction of HWC and MLHPs.
- A sizable number of ASHAs have filled-up the CBAC forms but their comprehension was not so good and, in some cases, they could not fill-up the CBAC forms due to their low level of literacy and took help from their relatives and MPWs.
- None of the ASHA has yet received any incentive for filling-up the CBAC form or for any other activity of HWC.

Perspective of MPWs/ANMs

- MPWs reported that some major changes have taken place at SC level in terms of manpower, branding in terms of painting and construction/renovation of washrooms, additional supplies of medicines especially for NCDs, infrastructure, diagnostic facility, and NCD screening.
- Most of the MPWs were of the view that their workload has increased in terms of OPD patients, ANC, immunization, NCD screening and other field work.
- Overall training for population-based screening on NCDs was given to all the MPWs ranging from 2-3 days. However, the quality of training was reported to be poor by all the MPWs.
- MPWs reported that the availability of MOs and MLHPs at the designated health facilities have facilitated screening for NCDs, enhanced diagnostic facility, availability of medicine and referral facility for the needy patients at their doorstep.

Perspective of Selected MLHPs

- Most of the MLHPs were of the opinion that their experience of serving at SHCs is very good and were of the view that "this is the best way of serving people at grassroots level".
- Regarding mentoring support from PHC level MOs, MLHPs reported that it was not so encouraging but help from respective BMO was good.
- Cooperation from front line workers by MLHPs depict that majority of them were highly satisfied or satisfied in gaining support for their activities at HWC.
- None of the MLHPs had received any performance-based incentives till date though their performance was reported good by all the BMOs. The non-payment of incentives has given a negative feeling to MLHPs.
- Most of the MLHPs were of the opinion that support system needs to be enhanced to make the very concept of HWC success.
-

Perspective of Patients

- Most of the patients had come to HWC for various of reasons which include immunization of children, ANC services, treatment for minor ailments etc.
- Patients were found happy with the intervention of HWC and posting of MLHPs at SC level. Most of the patients get the treatment for minor ailments from these HWCs and also get limited quantity of free medicines.
- Now people are coming for NCD screening and also the confirmed cases of hypertension and diabetes get medicines from these HWCs. A sizable number of patients (already on medicines) reported that the drugs prescribed to them for hypertension or diabetes by the doctors are not available and there is a need that such drugs should be kept for them.
- Those getting drugs from the HWC, reported that they get drugs for a maximum of 10 days from the HWC due to limited supplies.
- More than two third of the patients were treated at their respective HWCs but a sizable number of patients were referred to other facilities from various districts.

Perspective of Community

- At SC level HWCs, the community participation, interest and faith has increased after upgrading these facilities. The common ailments in the respective areas that were brought in our notice, included, thyroid, orthopedic problems, neurological disorders, NCDs, common ailments and seasonal ailments.
- Majority of people in rural areas prefer to go to higher level facilities for treatment of various chronic diseases while as for common ailments and seasonal diseases, they prefer the local health facility. For immunization of children and ANC registration almost all villagers get such facilities at their local SCs.
- ASHAs remain to be in limelight to most of the villagers as she has frequent contacts with the local population since HBNC was introduced and now for NCD screening and filling of CBAC forms.
- The information on Ayushman Bharat was not given to all and some members were also complained that their name does not exist in the list of golden card holders though they were fulfilling the criteria. The community at most of the places has been informed about the services available at their respective HWCs through IEC material and by concerned health workers also. The perception of community about the existing services at HWCs found satisfactory but were of the view that there is a need for more inputs in terms of manpower, equipment, medicines and diagnostic facilities.

2. INTRODUCTION

The National Health Mission (NHM), the country's flagship health systems strengthening programme, particularly for primary and secondary health care envisages "attainment of universal access to equitable, affordable and quality health care which is accountable and responsive to the needs of people". Investments during the life of the NHM in its earlier phases were targeted to strengthen Reproductive and Child Health (RCH) services and contain the increasing burden of communicable diseases such as Tuberculosis, HIV/AIDS and Vector Borne Diseases (VBDs). While such a focus on selective primary health care interventions, enabled improvements in key indicators related to RCH and select communicable diseases, the range of services delivered at the primary care level did not consider increasing disease burden and rising costs of care on account of chronic diseases [1].

Studies and surveys conducted by various government and non-governmental organizations have found that Primary Health Care is selective and limited to RCH and Communicable Diseases and addresses only about 20 percent of health care needs. This Low utilization of public health facilities has also been established by the National Sample Survey Organization (NSSO) data (71st Round) which shows that 28 percent in rural areas and 21 percent in urban areas have sought care in the public sector; of which only 11 percent and 3 percent respectively sought any form of care at a level below the CHC (other than child birth related services). It has also been established that Health care is fragmented as it disrupts continuity of care and impacts on clinical outcomes and leads to high Out of Pocket Expenditure (OOPE). High Costs are incurred because of lack of gate keeping function which raises the load on secondary and tertiary care facilities and compromises quality. There has been an Epidemiologic Transition and Death from the four major Non-Communicable Diseases (NCDs) –Cancer, Cardio-Vascular Disease (CVD), Diabetes, and Respiratory Diseases accounts for nearly 62 percent of all mortality among men and 52 percent among women of which 56 percent is premature. National Sample Survey (NSS) estimates for the period-2004 to 2014 show a 10 percent increase in households facing catastrophic healthcare expenditures. This could be attributed to the fact that private sector remains the major provider of health services in the country and caters to over 75 percent and 62 percent of outpatient and in-patient care respectively [1].

There is global evidence that Primary Health Care is critical to improving health outcomes. It has an important role in the primary and secondary prevention of several disease conditions, including non-communicable diseases. The provision of Comprehensive Primary Health Care reduces morbidity and mortality at much lower costs and significantly reduces the need for secondary and tertiary care. 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 [1].

1. ***Ayushman Bharat, Comprehensive Primary Health Care through Health and Wellness Centers Operational Guidelines, NHRC, National Institute of Health and Family Welfare, New Delhi.***

In India, the need for and emphasis on strengthening Primary Health Care was firstly articulated in the Bhore Committee Report 1946 and subsequently in the First and Second National Health Policy statements (1983and 2002). India is also a signatory to the Alma Ata declaration for Health for All in 1978. The Twelfth Five Year Plan Identified Universal Health Coverage as a key goal and based on the recommendations of the High- Level Expert Group Report on UHC had called for 70 percent budgetary allocation to Primary Health Care in pursuit of UHC for India. The National Health Policy, 2017 recommended strengthening 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 thirds of the health budget to primary health care.

Keeping in view the above-mentioned facts, Government of India(GoI) initiated the World's largest health care scheme-Ayushman Bharat Yojana or Pradhan Mantri Jan Arogya Yojana (PMJAY) or National Health Protection Scheme or Modi-Care- a centrally sponsored scheme which was launched in 2018, under the Ayushman Bharat Mission of Ministry of Health and Family Welfare (MoHFW) for a New India -2022. The scheme aims at making interventions in primary, secondary and tertiary care systems, covering both preventive and pro-motive health, to address healthcare holistically. It is an umbrella of two major health initiatives namely, Health and Wellness centres and National Health Protection Scheme (NHPS). The scheme has been formed by subsuming multiple schemes including Rashtriya Swasthya Bima Yojana, Senior citizen health Insurance Scheme (SCHIS), etc. Further, the National Health Policy, 2017 has envisioned Health and Wellness Centres as the foundation of India's health system which the scheme aims to establish.

Ayushman Bharat (AB) is an attempt to move from a selective approach to health care to deliver comprehensive range of services spanning preventive, promotive, curative (both outpatient and hospitalization) rehabilitative and palliative care. It aims to undertake path breaking interventions to holistically address health at primary, secondary and tertiary level. It is perhaps the single most important reform measure of Government of India, to address the major challenges of ensuring Continuum of Care, Two-way referral, and Gatekeeping [2].

In view of the National Health Policy, 2017 which recommended strengthening the delivery of primary health care, through establishment of "Health and Wellness Centers" (H&WCs) as the platform to deliver Comprehensive Primary Health Care (CPHC) and called for a commitment of two thirds of the health budget to primary health care. In February 2018, the Government of India announced that, 1,50,000 Health and Wellness Centers would be created by transforming existing Sub Centers (SCs) and Primary Health Centers (PHCs) to deliver Comprehensive Primary Health care (CPHC) as one of the key components of Ayushman Bharat [3].

2. ***Manual for 1st Orientation Workshop of Population Research Centres 30th - 31st May, 2019 Vigyan Bhawan, New Delhi – 110011, Government of India, Ministry of Health and Family Welfare, New Delhi.***
3. ***Ayushman Bharat, Comprehensive Primary Health Care through Health and Wellness Centers Operational Guidelines, NHRC, National Institute of Health and Family Welfare, New Delhi.***

Under this 1.5 lakh HWCs are being setup to provide comprehensive health care, including for non-communicable diseases and maternal and child health services, apart from free essential drugs and diagnostic services. The government has already started upgrading existing SCs and PHCs to Wellness Centres. The list of Services to be provided at Health and Wellness Centre include: Pregnancy care and maternal health services, Neonatal and infant health services, Child health, Chronic communicable diseases, Non-communicable diseases, Management of mental illness, Dental care, Eye care, Geriatric care and Emergency medicine. The delivery of Comprehensive Primary Health Care (CPHC) through HWCs rests substantially on the institutional mechanisms, governance structures, and systems created under the National Health Mission (NHM). The delivery of comprehensive primary health care through HWCs envisages a gatekeeping function, and a two-way referral system- that links to secondary and tertiary care and also follow up care [4]. It is expected that the scheme can prove as a game changer in the health sector and will provide better services to the population at their door-step and reduce the out of pocket expenses to the needy people.

Ayushman Bharat was officially launched in Jammu and Kashmir on December, 1st 2018 by the State Governor at Jammu and all the districts of the State were geared-up to start as the basic homework in this regard was initiated by the districts from June, 2018. The State in the first phase has established and have made functional a sizable number of Health and Wellness Centres (HWCs) in various districts and upgradation of more such Centres is under process. The districts covered in the very first phase include Udhampur, Jammu, Doda, Pulwama, other high focus districts and two aspirational districts namely Baramulla and Kupwara. As per the discussions with the State and some district authorities it is learnt that at least 10 HWCs from each district have been made fully functional in terms of manpower, infrastructure, equipment, drugs and other necessary interventions in the first phase and the process of making functional other HWCs in all the districts of the State is in progress. It is therefore, right time to have a concurrent evaluation of these HWCs so that mid-way corrections can be made to make these centres more effective and productive.

Objectives

The main objective of this study is to have a concurrent evaluation of HWCs established under Ayushman Bharat in selected district of Jammu and Kashmir.

Specific Objectives are:

- To examine the field level implementation of CPHC through Ayushman Bharat by H&WCs.
- To examine whether the necessary inputs which include manpower, logistics, infrastructure, service package, IT support, Use of Telemedicine/Tele-mentoring, Capacity Building, Health Promotion and Community Mobilization and requisite financing for making HWCs fully functional are in place (the expanded range of services),
- To evaluate the performance of essential output indicators which include HWC Data Base, Family Health Folders, and Increased Access to Services,

4. ***Manual for 1st Orientation Workshop of Population Research Centres 30th - 31st May, 2019 Vigyan Bhawan, New Delhi – 110011, Government of India, Ministry of Health and Family Welfare, New Delhi.***

- To evaluate Outcomes which include service delivery (physical performance), Improved population coverage, reduced out of pocket expenditure.
- To make some suggestions for mid-way interventions that can help HWCs in maximizing the service delivery and improve quality of services at primary health care level.

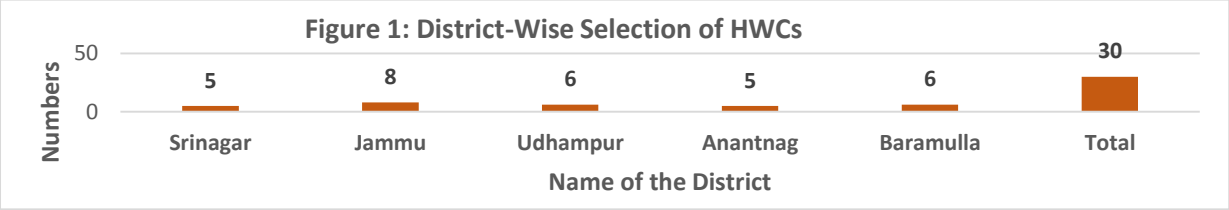
Methodology and Data Collection

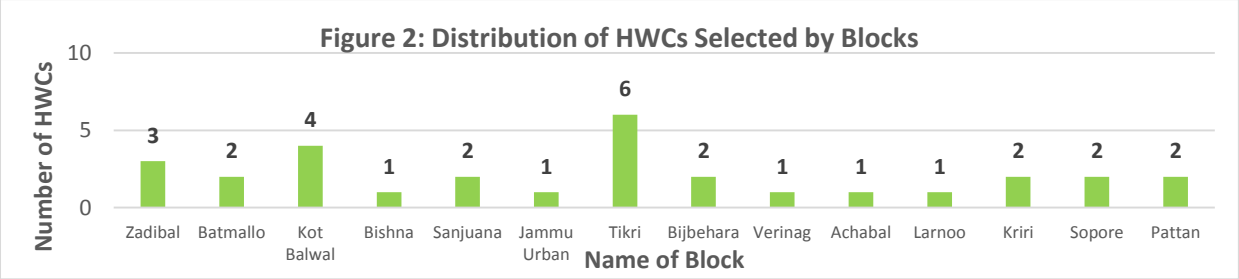
Initially we had proposed that this study will be carried-out in one of the aspirational districts (Baramulla district) of Jammu and Kashmir, but after submitting the proposal to the ministry, a common methodology was asked to be adopted by all the PRCs who have submitted any proposals related to HWCs. As per the directions of the ministry, the study was supposed to be carried-out in five districts by each of the PRC in their respective areas and from each district five HWCs were to be taken. Thus, a total of 25 HWCs were asked to be evaluated by each of the Population Research Centre (PRC). In this background our PRC selected five districts in Jammu and Kashmir for evaluation in consultation with the Mission Director (MD), NHM J&K and from each district 5-7 HWCs were selected for this study. The districts that were taken for the study include Jammu, and Udhampur from Jammu division and Srinagar, Baramulla and Anantnag from Kashmir division. Various criterion was followed to select the districts to make the sample selection a representative one. Sixty percent districts were taken from the UT which were allotted to us under PIP monitoring keeping in the representation of UPHCs, region, population covered by the districts, etc. In addition to these, one (out of two) aspirational district was taken to accommodate at least one aspirational district. One more district, Udhampur was taken to give adequate representation to Jammu division. The HWC selection was made on various criteria, which include the type of health facility converted in to HWC, distance from the district headquarter, representation to various blocks, appointment of MLHP at SC level, and branding of the HWCs. During the field work some of the selected HWCs in Anantnag district, it was reported that some of the selected health facilities were undergoing reorganization and were being brought under the control of a new medical college and the staff was either shifted or was not available in their respective health facilities and thus we could not get all the requisite information from these HWCs in the said district. Keeping in view this issue, some additional HWCs were taken from other districts to make the sample representative. The results of the study are based on a total of 5 districts, 30 HWCs (5 each from Srinagar and Anantnag, 8 from Jammu, and 6 each from Udhampur and Baramulla), 14 medical blocks, 25 community leaders/groups, 46 OPD patients, 13 MLHPS, 39 ASHAs, and 25 MPWs.

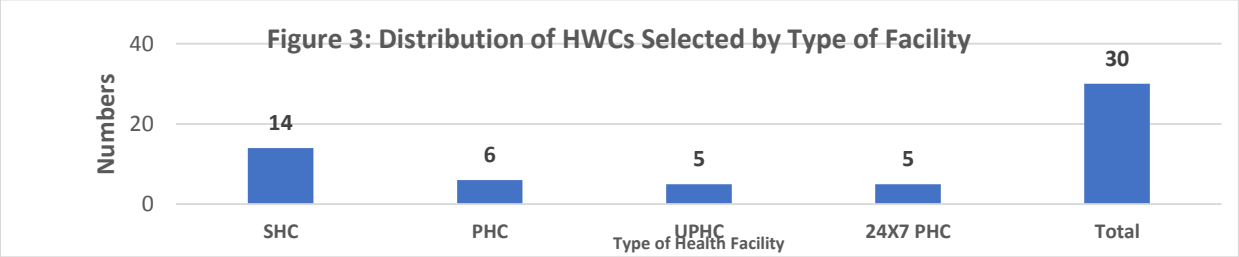
The checklists for the State officials, District officials, HWCs, ASHAs, MPWs, MLHPs, Community and OPD Patients were prepared by the concerned division in the ministry and were sent to our PRC. Since this was the very first exercise in this direction, therefore, no local changes were made in those checklists and were canvassed at all the levels separately. These checklists include information on various components to be covered in HWC like type of building, manpower, logistics, infrastructure, medicines, IT support, capacity building, etc.

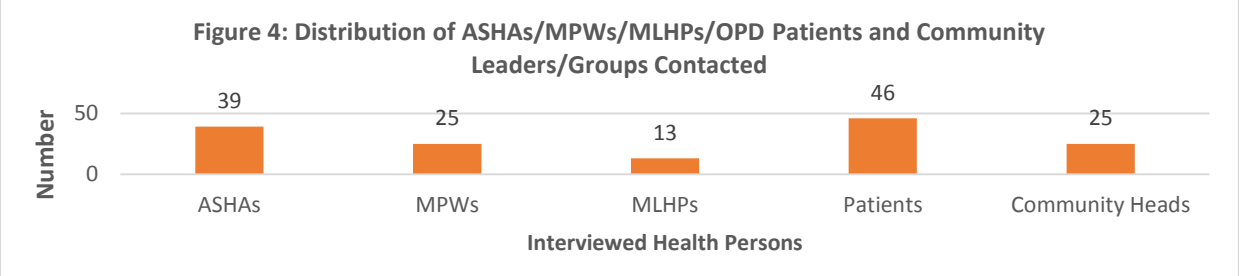
A schedule of visit was prepared for this evaluation exercise and accordingly the information from all the stake-holders was gathered in the selected districts during December, 2019-

February, 2020. The State level checklist was discussed with the State Nodal Officer and information was gathered on most of the data elements. Similarly, the district checklist was discussed and canvassed at the district level to the concerned CMO and district level nodal officer for getting the requisite information. The HWC checklist was filled at the selected facility when we visited these HWCs. At SC-HWC, the information was taken from the MLHP while as at PHC/UPHC level HWCs, the information was collected from the MOs or other staff. Further, ASHAs, MPWs, MLHPs and others were interviewed regarding their perception on converting their health facility in to HWC. Group discussions were held at various places with the community to extract their perception regarding establishment of HWCs in their areas. Formal and informal discussions were also held with community, VHSC members, AWWs at the village level, BMOs, MOs of PHCs, at the block level and DM, CMO, Nodal Officer at the District level and State Nodal Officer at the State level. All the patients at the OPD who were present on the day of our visit were also interviewed as per the checklist. The data entry was made at the PRC office and tables and graphs were generated using SPSS-25. The details of the sample taken from various districts is shown below in figures 1-4:









3. RESULTS AND DISCUSSION

3.1: STATE/UT PROFILE

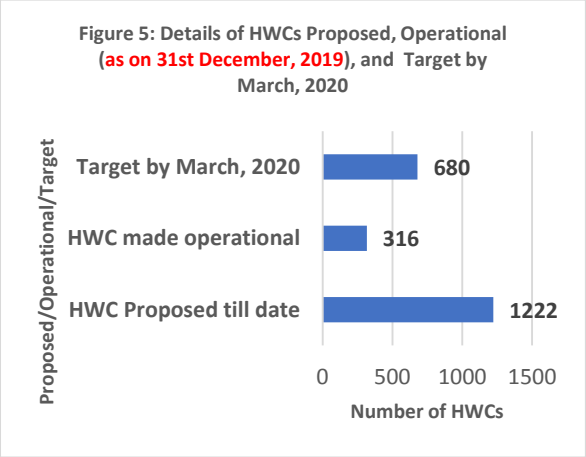
After the bifurcation of the State of Jammu and Kashmir on 5th August, 2019 into two Union Territories (J&K), Jammu and Kashmir which is situated in the north of India, occupies a position of strategic importance with its borders touching the neighbouring countries of Afghanistan, Pakistan, China and Tibet. The total geographical area of the J&K is 42241 square kilometres and presently comprises of 20 districts in two divisions namely Jammu, and Kashmir. According to 2011 Census, Jammu and Kashmir has a population of 12.30 million, accounting roughly for one percent of the total population of the Country. The sex ratio of the population (number of females per 1,000 males) in the J&K according to 2011 census was 872, which is much lower than for the country as a whole (940). Twenty- seven percent of the total population lives in urban areas which is almost the same as at the National level. Overall Scheduled Castes (SC) account for 8 percent and Scheduled Tribe (ST) population accounts for 11 percent of the total population of the J&K. As per 2011 census, the literacy rate among population age 7 and above was 69 percent as compared to 74 percent at the National level. The population density of Jammu and Kashmir is 56 persons per square kilometres. As per NFHS-4, the erstwhile State has improved a lot in the critical health care indicators. The data shows that the State has an infant mortality rate (IMR) of 32 as compared to 45 during NFHS-3. Similarly, there is a decline (as per NFHS-4) in under 5 mortality rate as compared to NFHS-3 results as it has come down to 38 from 51. NFHS-4 further shows that the use of any family planning method has also increased from 53 percent (during NFHS-3) to 57 percent. Similarly, the total unmet need for family planning in the State has decreased from 16 percent to 12 percent. The percentage of institutional deliveries has gone up to 86 percent in the State. Similarly, the percentage of fully immunized children has gone up to 75 percent as compared to 67 percent during NFHS-3.

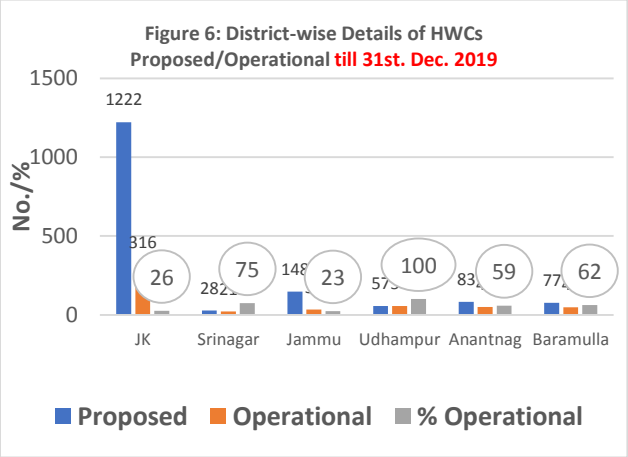
The delivery of CPHC through HWCs rests substantially on the institutional mechanisms, governance structures, and systems created under the National Health Mission (NHM). NHM, as part of health system reform in the country, has supported states to create several platforms for delivery of community-based health systems, expanding Human Resources for Health and infrastructure towards strengthening primary and secondary care. Though largely limited to a few conditions, NHM created mechanisms for expanded coverage and reach, and developed systems for improved delivery of medicines, diagnostics and improved reporting. About seven years ago, these components were also introduced in urban areas. Although the delivery of universal Comprehensive Primary Health Care, through HWCs builds on existing systems, it will need change in management and systems design at various levels, to realize its full potential. The other component of Ayushman Bharat, namely the Pradhan Mantri Jan Arogya Yojana (PMJAY) aims to provide financial protection for secondary and tertiary care to about 40 percent of India's households. Its success and affordability rests substantially on the effectiveness of provision of Comprehensive Primary Health Care through HWCs. Together, the two components of Ayushman Bharat will enable the realization of the aspiration for Universal Health Coverage.

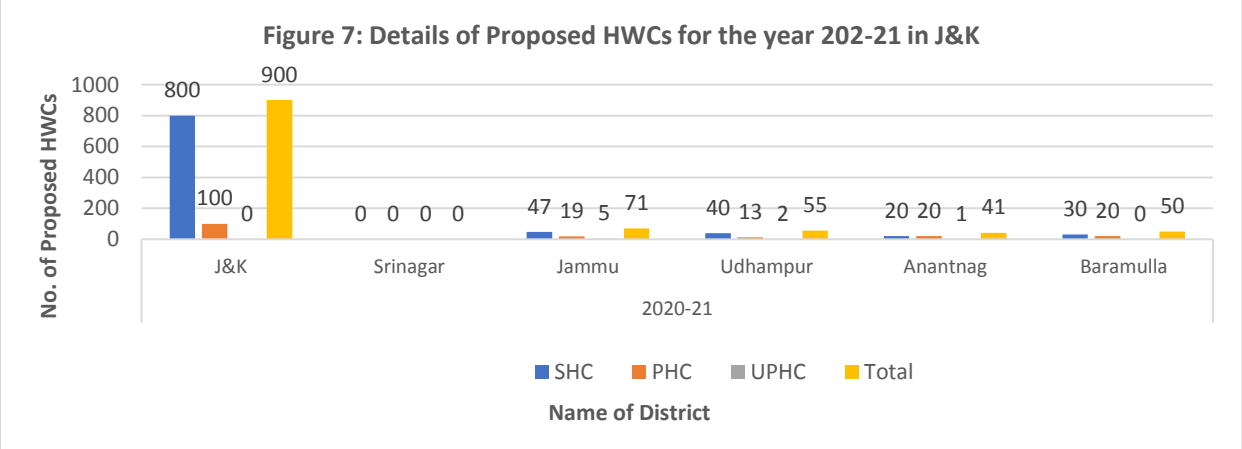
The first HWC was inaugurated by the Honorable Prime Minister at Jaangla, Bijapur Chhattisgarh on 14th April 2018 and as per the plan, the government of India has a target of operationalizing 1.5 Lakh Health and Wellness Centres across the country by 2022. The operational guidelines on Comprehensive Primary Health Care (CPHC) were disseminated to all states in July 2018 and any changes from time to time are shared with the states as per the requirement. The operationalization of Health and Wellness centre relies on a set of functionality criteria viz, availability of requisite HR, completion of training on NCDs, ensuring supply of medicines and diagnostics and branding, to ensure quality of services. As already mentioned, Ayushman Bharat was officially launched in Jammu and Kashmir on December, 1st 2018. The state in the first phase established and made functional a sizable number of Health and Wellness Centres (HWCs) in six districts and later extended it to all the 20 districts of the UT. The discussions held with the top officials of the J&K reported that they are in the process of formulation of a "vision document for operationalization of HWCs" with timelines and projections of resources estimated to convert all primary care health facilities in to H&WCs in Jammu and Kashmir.

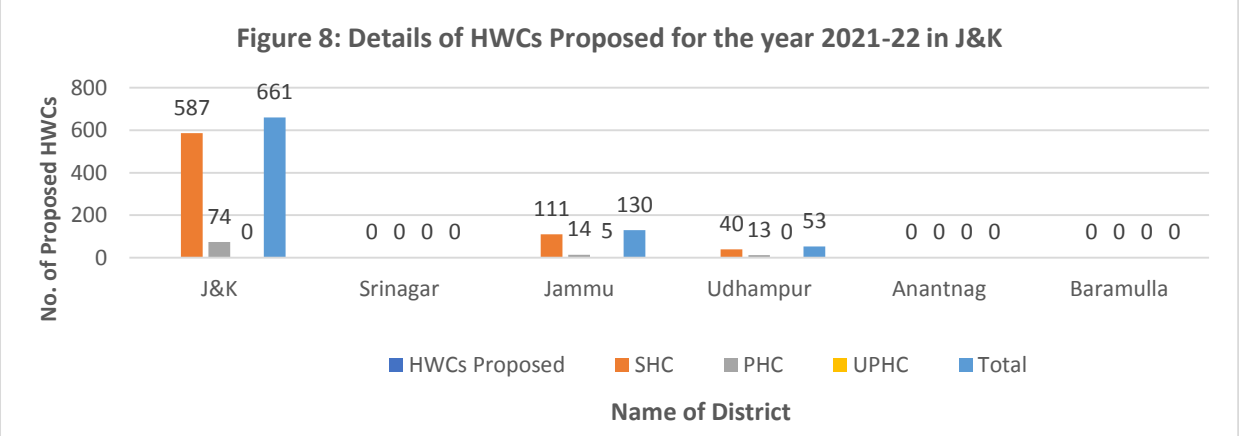
The UT of Jammu and Kashmir has so far established a large number of HWCs in all the 20 districts (including 2 aspirational districts) at the primary health care facilities. The J&K has a target of converting a total of 2722 primary level health facilities which include, 2068 SHCs, 605 PHCs, and 49 UPHCs in to HWCs by 2022. Initially six districts were taken for this exercise by J&K and later in 2018-19 the process was extended to all the 20 districts. The information collected from the SHS shows that J&K has a target to make 517 SCs, 151 PHCs, and 12 UPHCs as HWCs by March, 2020 and so far, (31st Dec, 2019) 165 SCs, 139 PHCs and all the 12 UPHCs have been made operational in various districts of the state. The information provided by the SHS, shows that against a total of 1222 proposed HWCs since 2018-19 to 2019-20, the UT has been able to make operational only 316 (26 percent) HWCs. Various districts have also not been able to set-up the proposed HWCs in a time bound manner. The UT has a target to make 680 HWCs operational by March, 2020 which seems to be next to impossible given the time constraint of only three months. The details of information on number of various primary level health facilities proposed and operationalized since 2017-18 to 2019-20 (till 31st December, 2019) provided by the state and the selected districts is shown below.

The information further provided by the State officials reveals that they have proposed a total of 900 primary level health facilities to be converted into HWCs during 2020-21, which include 800 SCs and 100 PHCs. Further, during 2021-22, state has a plan to convert a total of 661 remaining primary level health facilities into HWCs which include 587 SCs and 74 PHCs. In this regard various selected districts have also proposed to upgrade such health facilities into HWCs during the next two financial years but it was revealed by some districts that such type of planning is only done by the state authorities. The details in this regard is given shown below in figure 5-8.









In terms of selection of districts all the districts have been covered irrespective of the guidelines laid down in this regard by the ministry. As far as the selection of blocks is concerned, it was reported by the state as well as by the district authorities that various criteria are followed for the selection which include HR and infrastructure availability at CHC, availability of referral transport, and population based screening while as the selection of SCs/PHCs is identified by the state in consultation with the districts keeping in view various criteria like availability of infrastructure, requisite HR, facilities under universal screening of NCDs, and SCs with population less than 1500. Further in case of UPHCs not any particular criteria are being followed by the state as almost all the UPHCs have been proposed to be converted into HWCs by the year 2021.

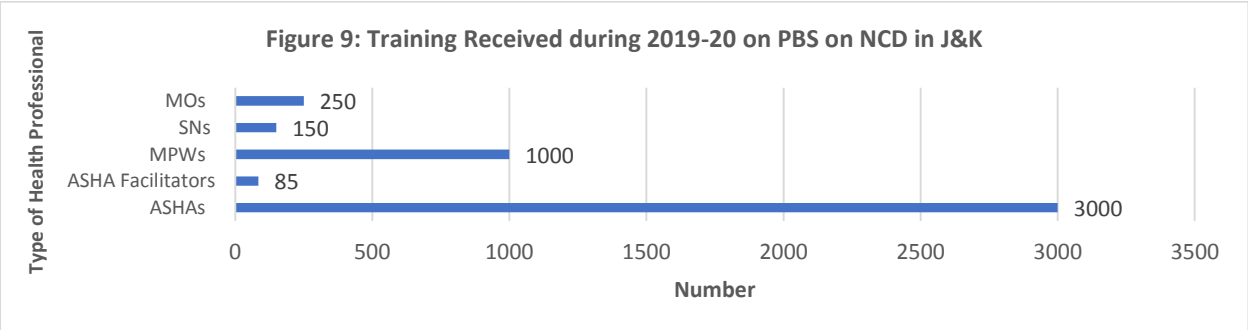
Human Resource

Programme Management

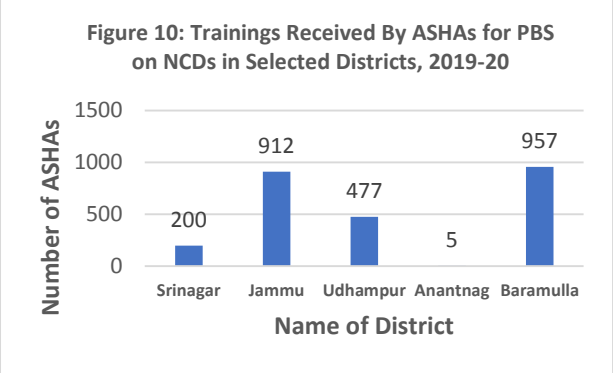
The information collected from the state shows that nodal officers for CPHC have been identified for state as well as all the districts and their orientation has also been completed. However, the orientation of block programme management has not yet been taken-up while as CPHC orientation in case of primary health care team has been initiated and partially completed. Review meetings are being conducted at the state level on regular basis but such activities hardly take place at district level. Field visits and review meetings are held to monitor the programme at state as well as the district level. The state has established 10 Program Study Centres (PSCs) in various districts of the UT and the total intake capacity of all these PSCs is 500. The selection of MLHPs is done by the Mission Director and recruitment of candidates is now only done for fresh candidates only (as it was found that in the beginning some in-service candidates were also recruited as MLHPs). The selection process is done through a transparent system consisting of theory, objective type and skill-based assessment. Posting of MLHPs is mainly done on the locality basis and most of the MLHPs are posted in their home districts. The information collected further reveals that a total of 93 MLHPs were posted during January, 2018 to December, 2018 in various districts of the UT. Out of these, 10 MLHPs were posted in Srinagar district, 18 in Jammu and 8 MLHPs in Baramulla district. Overall, 485 MLHPs were undergoing CPHC training at different places in the UT for the June, 2019 session. Overall, 247 MLHPs have been posted at various SCs in the UT till December, 31st 2019. So far, no staff nurses have been proposed for NCDs at PHC level in the UT.

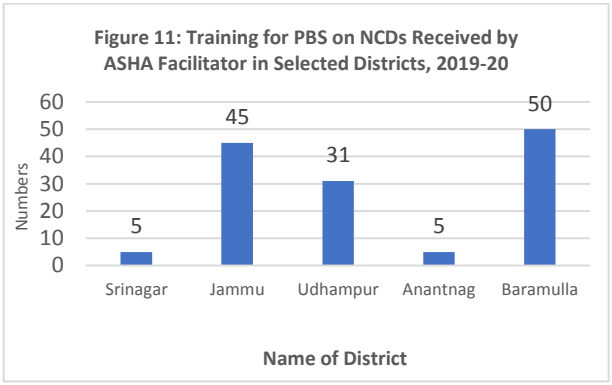
Training

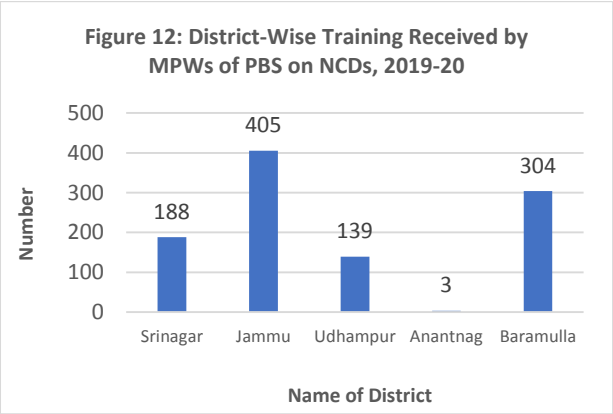
The information collected from the SHS reveals that more than 3000 ASHAs, about 1000 MPWs, 150 staff nurses, and about 250 MOs have been trained in NCD. Training in other packages like, oral health, ENT, eye care, mental health etc. has not been imparted at the state level. The information collected from the selected districts also shows that such trainings have been given to a large majority of above-mentioned health professionals during 2019-20. Though the SHS maintained that the guidelines regarding duration of training were followed strictly but, in the field, it was found that the guidelines were not properly followed by some districts in the initial phase. The detailed information on training of the selected districts is shown below in Fig.9-13.

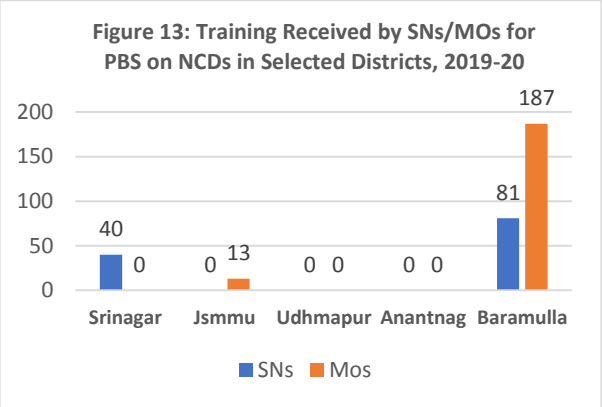


Note: Since both UT and district officials were asked to report on training against the targets set by them but such information was not provided by the districts as all of them reported that such targets are being fixed by the SHS. The matter was repeatedly taken up with the concerned Nodal officer of the SHS but they failed to provide us such information till the last.



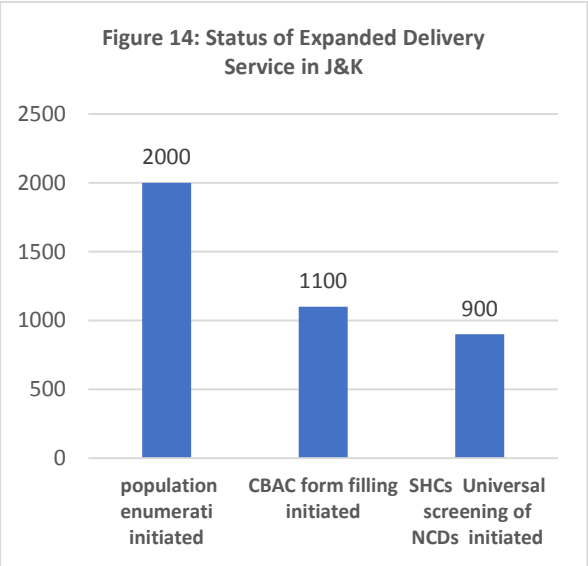


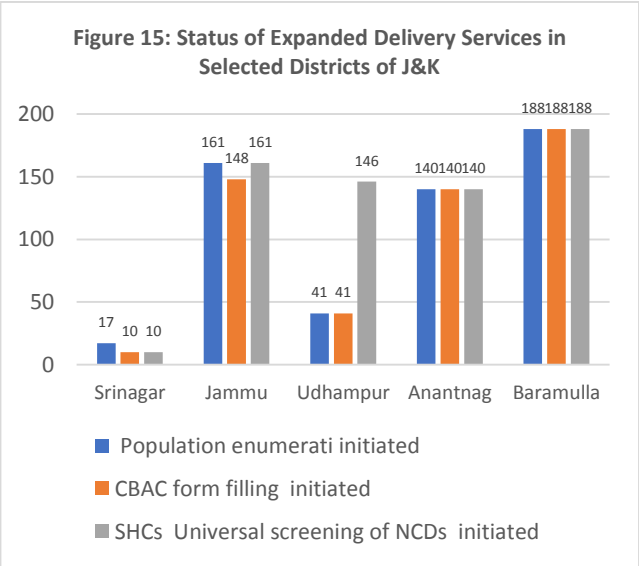




Expanded Service Delivery

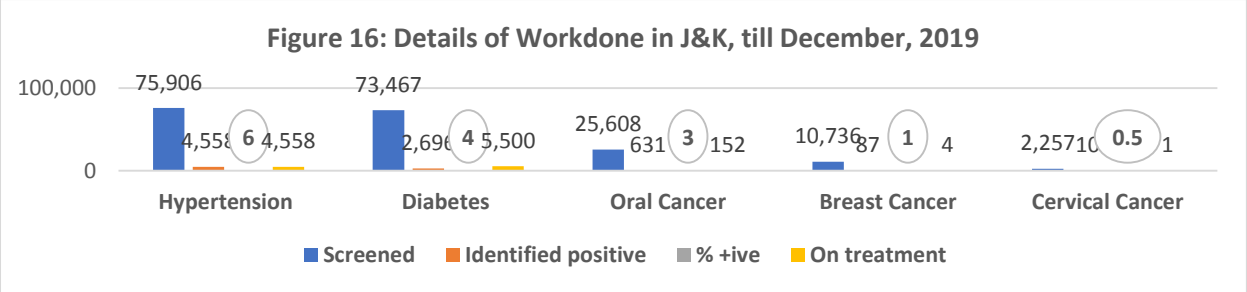
Population enumeration has been initiated in all the districts of the UT and more than 2000 SCs have started this activity in their respective districts. The information collected from the selected districts shows that such activity is in full swing. The filling-up of CBAC forms has also been initiated and about 1100 SCs are filling up the CBAC forms in the UT. All the selected districts also reported that such activity is taking place in their respective districts also but failed to provide us information on the targets they have achieved. Universal screening for NCD is also going on in about more than 900 SHCs in the UT. The detailed information is shown in fig. 14-15.

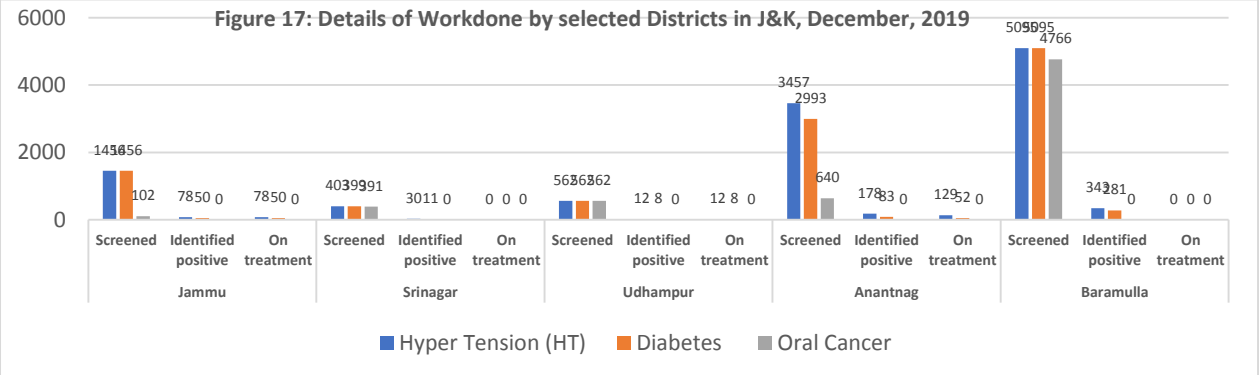




Work Done During Last Two Quarters

The information collected from the SHS regarding work-done during the last two quarters reveals that more than 75000 suspected cases were screened for hypertension in the UT and out of these about 5000 (six percent) were found hypertensive and were presently on treatment. Similarly, about 74000 suspected cases of diabetes were screened and about 2700 (four percent) were found positive. Currently 5500 cases (including follow-up cases) were on medication in the UT. Further, the data collected shows that overall a total of 728 cases of various types of cancers were detected in the UT but only 157 cases were on treatment in various health facilities. The details of various selected districts are represented below in figure 16 and 17:





Drugs Diagnostics and Infrastructure

HWCs are supposed to keep adequate availability of essential medicines and diagnostics to support the expanded range of services, to resolve more and refer less at the local levels, and to enable dispensation of medicines for chronic care as close to communities as possible. The ministry has issued Essential Medicine List (EML) for various levels of health facilities to include drugs for expanded service delivery at HWCs. In this regard, the ministry had given some free hand to the states to include or exclude any drugs as per their local needs. The UT of Jammu and Kashmir has made some minor changes in the EML in order to incorporate the local health issues. At PHC level HWC, there are 71 drugs in the EML while as for SC level HWC, the UT has made a list of 23 free drugs which include few drugs for NCDs also. The information collected from selected districts shows that the indenting of blocks varies from district to district but by and large such indenting is done by blocks on monthly basis. The SHS officials maintain that district drug stores have started receiving separate indents for SC- HWCs and the information collected from the selected districts also shows that such indenting has been started in around three

districts (out of 5 selected districts). Medicines for hypertension and diabetes are supplied to SC-HWCs but in various districts, it was found that their quantity and variety was very limited.

As per the guidelines, the states are supposed to have facility wise essential list of diagnostics in place and in this regard, the SHS reported that they have such lists available for each facility in the UT and same was also confirmed by the selected districts. In this regard, such essential list of diagnostics was found missing in all the visited HWCs in the UT. DVMDS indenting has not yet been taken-up in the UT while as the diagnostic facilities have not been brought under PPP mode at any level but the strengthening of in-house labs is taking place at few places.

In order to strengthen the infrastructure for HWCs, Government of India is providing funds generously to the states and as per the guidelines to create sufficient space for expanded service delivery, for medicine dispensation, diagnostics organized, space for wellness related activities including the practice of yoga etc. with adequate spaces for display of communication material of health messages, including audio visual aid and branding of the HWCs. In this regard, the UT has taken the task on priority and an amount of Rs. Seven lacs are provided to a SC-HWC for infrastructure development while as Rs one lac is given to SC-HWC for equipment. Similarly, for PHC-HWC, an amount of Rs. Four lacs are given for infrastructure development while an additional one lac is for equipment to bring these facilities to the standards as laid down in the guidelines. Each UPHC-HWC is given Rs one lac each for infrastructure development and equipment. as per the information received from the SHS, gap analysis of facilities has been done but in all the selected districts it was found that such process is still underway or has not yet been initiated. Infrastructure upgradation and branding of functional HWCs has been done in most of the districts and for new HWCs, such process is underway in all the selected districts of the UT. The information provided by the SHS, shows that the UT has completed the process of upgradation of infrastructure/refurbishment in 315 HWCs in various districts (as on 31st December, 2019). Such process has been completed in 32 HWCs in Jammu, 43 in Udhampur, and 51 HWCs in Baramulla district.

IT System and Telehealth

As per guidelines, HWC team is supposed to be equipped with Tablets at SCs and Laptop/ Desktop at PHC level to create electronic health record of the population covered by HWCs. Developing a robust IT system for Population Enumeration through household surveys, and empanel families to a HWC, enable ASHAs to undertake risk assessments, be able to track patients for treatment adherence and follow up, to provide population based analytics, service records, and to ensure continuity of care across levels and facilities, and enable performance linked payments. The states are supposed to use teleconsultation at all levels to improve referral advice, seek clarifications, and undertake virtual training including case management support by specialists. In this regard the UT of Jammu and Kashmir has not done much but intend to use OPEX model for the purpose. None of the ASHA been given any smart phone while the number of MLHPs/MPWs, who have received Tablets across the UT is very small. Similarly, very few PHCs/MOs have been given desktops/laptops to create digital data base. The desktops were found available in Udhampur and Baramulla but it was found that such facility was already

available with them since long. The biggest issue for the UT was internet suspension post 5th August, 2019 which affected the overall working of HWCs as they could not upload their performance on the national portals. Teleconsultation has not yet been initiated in any of the districts of the UT and ECHO model has not yet been implemented for training the service providers.

IEC, Community Outreach and Health Promotions

IEC activities, community outreach and health promotion need to be facilitated through engagement of community level collectives such as–VHSNCs, MAS and SHGs. Community mobilization, for action on social and environmental determinants, would build on the accountability initiatives under NHM to ensure that there is no denial of health care and universality and equity are respected. In order improve the IEC activities in community regarding expanded range of services, it was found that not much has been done by the UT or the districts as such the activities are carried-out by different HWCs as per the previous schedule of VHNDs only. As far as yoga/physical exercise sessions are concerned, the activity has been initiated by the UT and some selected districts are also conducting such sessions. The information in this regard collected from the selected districts shows that only districts of Jammu and Srinagar have conducted such session. The major issue for conducting such sessions remains to the space problem at most of the SC-HWCs but some HWCs have identified the space for this exercise in local panchayats and schools. So far, no honorarium has been given to any trainer for these activities in the UT.

Financing

Except for three selected districts namely Srinagar, Udhampur and Baramulla, none of the districts could provide us any details about the funding positions in their respective districts. The funding from the SHS was also not provided to us on one or the other pretext thus, giving us no chance to analyse the funds position in the UT or in selected districts. As far as the release and expenditure of funds in Srinagar, Udhampur and Baramulla is concerned, the information provided by these districts shows that except for Srinagar, no other district has been able to utilize the released funds in a time bound manner during the last two financial years. In this regard, Udhampur district lags behind and has been able to spent only 14 percent and 52 percent of the released funds respectively during 2018-19 and 2019-20. Baramulla has done better during 2019-20 as compared to 2018-19. Table 3.1

Table 3.1: Details of Funds Approved, Released and their Expenditure in Jammu and Kashmir

	J&K		**Srinagar**		**Jammu**		**Udhampur**		**Anantnag**		**Baramulla**	
	2018-19	**2019-20**	**2018-19**	**2019-20**	**2018-19**	**2019-20**	**2018-19**	**2019-20**	**2018-19**	**2019-20**	**2018-19**	**2019-20**
Approved	NA	NA	63 Lakhs	1.43 Crores	NA	NA	NA	NA	NA	NA	1.85 Crores	3.10 Crores
Released	NA	NA	100%	63%	NA	NA	1.57 crores	3.14 Crores	NA	NA	100%	100%
% Expend.	**NA**	**NA**	**100%**	**95%**	**NA**	**NA**	**14%**	**52%**	**NA**	**NA**	**58%**	**83%**

NA =Not Available (Was not Provided by concerned officials on repeated requests)

As per the guidelines for HWCs, there is a provision to provide performance based incentives to various health functionaries associated with HWCs which include MLHPs on institutional basis, team based for ASHAs and MPWs, ASHAs for CBAC assessment and mobilization for screening and follow-up but it was found that no such incentives have been released by the SHS for any districts of the UT till date however, some districts reported that very recently funds have been released for ASHAs on CBAC assessment and mobilization only @ Rs. 10/form but yet ASHAs have not received the same at any level.

Partnership

Partnerships with private agencies, SHGs, NGOs etc. has not been initiated by the UT or any of the selected districts for any knowledge generation, diagnostics, treatment or other purposes.

3.2: HEALTH AND WELLNESS CENTERS (HWCs)

Basic information

In order to give representation to various types of primary level health facilities that have been converted into HWCs in each district, it was decided to select 2-3 SC-HWCs, 1-2 UPHCs, 1-2 PHCs, and at least one 24X7 PHC (where ever converted into HWC) from each district. The analysis is based on a total of 30 HWCs taken from five districts of the UT. Overall a 14 SC-HWCs, 6 PHCs, 5 UPHCs, and 5 24X7 PHCs were visited for this evaluation exercise.

The data collected shows that most of the HWCs have been established in government buildings but out of the total HWCs visited in Baramulla 33 percent (one UPHC and one SC) were in private rented buildings. Further, the data reveals that 40 percent each HWC in Srinagar district covers a population of 5000-7000 and more than 10000 respectively. Similarly, in Udhampur, 67 percent HWCs cover a population of 5000-7000 while in Anantnag 80 percent HWCs cover a population of 3000-5000. Out of the total selected HWCs in Udhampur 83 percent HWCs have DH or 24X7 PHCs as referral facilities while in Srinagar district, 80 percent HWCs had DH or 24X7 PHC as referral facility. In Baramulla all the HWCs reported that their FRU was the nearest CHC while in Jammu, 63 percent HWCs had PHC as their FRU. Overall, the average time to travel to the FRU for most of the HWCs in all the districts varies between 10-30 minutes but in case of Udhampur, Jammu and Anantnag districts the average travel time was up to 45 minutes. *During our field visit it was observed that SC-HWCs have primarily nearest PHC as the FRU but most of the patients ask them for referral to at least CHC level and thus breaks the primary health care chain and the burden is again shifted to the higher-level facilities and thus kills the basic concept of CPHC*. The district-wise details are given in table below:

Table 3.2: Details of Basic Information of Selected HWCs in J&K											
		Name of District									
		Srinagar		Jammu		Udhampur		Anantnag		Baramulla	
		No	%	No	%	No	%	No	%	No	%
Type of Facility	SHC	2	40%	4	50%	4	67%	1	20%	3	50%
	PHC	0	0%	2	25%	0	0%	2	40%	2	33%
	UPHC	3	60%	1	13%	0	0%	0	0%	1	17%
	24X7 PHC	0	0%	1	13%	2	33%	2	40%	0	0%
Type of Building	Old/Govt.	3	60%	4	50%	5	83%	2	40%	3	50%
	New/Govt.	2	40%	4	50%	1	17%	2	40%	1	17%
	Private Rented	0	0%	0	0%	0	0%	1	20%	2	33%
Population Covered	Up-to 2000	0	0%	0	0%	0	0%	1	20%	0	0%
	2001-3000	1	20%	1	13%	0	0%	0	0%	2	33%
	3001-5000	0	0%	2	25%	1	17%	4	80%	0	0%
	5001-7000	2	40%	3	38%	4	67%	0	0%	2	33%
	7001-10000	0	0%	1	13%	1	17%	0	0%	0	0%
	> 10000	2	40%	1	13%	0	0%	0	0%	2	33%
Linked FRU	PHC	1	20%	5	63%	1	17%	0	0%	0	0%
	CHC	0	0%	1	13%	0	0%	4	80%	6	100%
	DH	2	40%	2	25%	2	33%	1	20%	0	0%
	24X7 PHC	2	40%	0	0%	3	50%	0	0%	0	0%
Travel Time to FRU in Minutes	Up-to 20 Minutes	3	60%	2	25%	0	0%	0	0%	1	17%
	>20-30 Minutes	2	40%	2	25%	2	33%	0	0%	4	67%
	>30-45 Minutes	0	0%	3	38%	4	67%	4	80%	1	17%
	>45- 1 Hour	0	0%	1	13%	0	0%	1	20%	0	0%
	> 1 Hour	0	0%	0	0%	0	0%	0	0%	0	0%
	Total	**5**	**100**	**8**	**100%**	**6**	**100%**	**5**	**100%**	**6**	**100%**

Human Resource

In order to provide CPHC through HWCs, it is important to have requisite manpower at various levels of primary health care facilities. The guidelines in this regard have recommended that at SHC- A team of at least three service providers (one Mid-level provider- trained in 6 months Certificate Programme in Community Health, two Multi-Purpose Workers – Male/ Female) and team of ASHAs (one per 1000) is required, while at **PHC** –PHC team as per IPHS standards led by a Medical Officer. In addition, at PHCs where cervical cancer screening is being planned an additional staff nurse can be posted. In this regard, the information was collected from all the selected HWCs in the selected districts shows that MOs ranging from 1-3 were sanctioned in all the PHCs, UPHCs and 24X7 PHCs while MLHPs have not yet been appointed in all the HWCs in the UT. Out of total selected PHCs, half of them have at least one sanctioned MO while in case of UPHCs, 60 percent have two sanctioned positions of MOs and in case of 24X7 PHCs, 80 percent

have two or three sanctioned positions of MOs. All the sanctioned positions of one MO in PHCs is in-position while as none of the PHC has two MOs in position. In 24X7 PHCs, 80 percent have two MOs in-position while in case of UPHCs, 40 percent have 2 MOs in-position. Further, the information collected shows that 33 percent PHCs are without a MO. Further, the data collected shows that 83 percent PHC-HWCs, 20 percent UPHCs, and another 20 percent 24X7 PHC-HWCs do not have any sanctioned positions of staff nurses among the selected HWCs while as surprisingly three selected SC-HWCs has one or more sanctioned SNs position. Only 17 percent PHC-HWCs have a SN in position while as 80 percent of such 24X7 PHCs and UPHCs have one or more SNs in position. The information collected shows that 86 percent SC-HWCs, 33 percent PHC-HWCs, and 20 percent UPHC-HWCs do not have any sanctioned post of lab technician in the selected HWCs in J&K. Further, the data shows that more than two-third of PHC-HWCs, 80 percent such type of UPHCs, and all the 24X7 PHC type HWCs have one or more sanctioned positions of lab technicians in the UT. Overall, 14 percent SCs, 33 percent PHCs, 60 percent UPHCs and another sixty percent 24X7 PHC type HWCs have at least one lab technician in-position while as 17 percent PHCs, 20 percent UPHCs and 60 percent 24X7 PHC type HWCs have 2 lab technicians in-position. Overall, about 30 SCs, and 17 percent PHC type HWCs have no sanctioned position of pharmacist while all other selected HWCs have one or two sanctioned posts of pharmacists. Seventy-one percent SCs, 67 percent PHCs, 60 percent UPHCs and 40 percent 24X7 PHC type HWCs have one pharmacist in position in the selected health facilities in UT. The sanctioned position of LHV are very limited in the selected HWCs and only one-third of PHCs, and 60 percent 24X7 PHCs have any sanctioned position of LHV and out of these, only 17 PHCs and 60 percent 24X7 PHC type HWCs have such posts filled-in.

The team leader (MLHP) at the SC-HWC were found in-position in all the 14 selected SC-HWCs and out of these, 43 percent each had BAMS and GNM as their basic qualification while as 14 percent MLHPs were BUMS qualified. Most of them (71 percent) were appointed during June, 2019 to December, 2019 after completion of 6 months' bridge course. Most of the MLHPs appointed during 2018, were taken from in-service quota in some districts of the UT. As far as MPW-F is concerned, UT has appointed one MPW-F in almost all SC-HWCs under NHM but it was found that some of these have been moved from their original place of posting. As far as the data collected regarding the sanction and in position of MPWs is concerned, it was found that MPW-F from regular side is sanctioned in all the SC-HWCs but in only 71 percent SC-HWCs both the MPWs-F were in position while in around 30 percent SCs only one MPW-F was in position. Baring 2 PHC/UPHC-HWCs, at least one MPW-F is sanctioned in all other selected facilities. Further, the information collected shows that one or more MPWs are in position in all the selected HWCs in UT. The information collected on sanctioned and in-position MPW-M, out of only four sanctioned positions, three are filled-in. The UT has a huge network of ASHAs and almost all the health facilities in the UT have enough number of ASHAs. The process of engaging ASHAs in urban blocks is still on as the officials do not get the requisite number of ASHAs needed in UPHCs-HWCs. The number of ASHAs sanctioned and in-position ranges from at least one ASHA to 14 ASHAs per HWCs and about 40 percent of the selected HWCs (mostly UPHCs, and PHCs) need some more ASHAs for their areas. The detailed information on number of sanctioned posts/in-position post for various categories is given below in table 3.3.

Table 3.3: Details of Human Resource of Selected HWCs in J&K									
Various categories of sanctioned staff	**Number**	**Type of HWC**							
		SHC		**PHC**		**UPHC**		**24X7 PHC**	
		No	**%**	**No**	**%**	**No**	**%**	**No**	**%**
MOs in sanctioned	None	0	0%	0	0%	0	0%	0	0%
	1	0	0%	3	50%	1	20%	1	20%
	2	0	0%	2	33%	3	60%	2	40%
	3	0	0%	1	17%	1	20%	2	40%
	NA	14	100%	0	0%	0	0%	0	0%
MOs in Position	0	0	0%	2	33%	1	20%	0	0%
	1	1	100%	3	50%	2	40%	1	20%
	2	0	0%	0	0%	1	20%	4	80%
	3	0	0%	1	17%	1	20%	0	0%
Sanctioned Staff Nurse	0	11	79%	5	83%	1	20%	1	20%
	1	1	7%	0	0%	1	20%	3	60%
	2	2	14%	1	17%	2	40%	0	0%
	3	0	0%	0	0%	1	20%	1	20%
In Position Staff Nurse	0	12	86%	4	67%	2	40%	1	20%
	1	2	14%	1	17%	2	40%	3	60%
	2	0	0%	1	17%	1	20%	1	20%
Sanctioned Lab Technician	0	12	86%	2	33%	1	20%	0	0%
	1	2	14%	3	50%	2	40%	4	80%
	2	0	0%	1	17%	2	40%	1	20%
In Position Lab Technician	0	12	86%	3	50%	1	20%	0	0%
	1	2	14%	2	33%	3	60%	3	60%
	2	0	0%	1	17%	1	20%	2	40%
Sanctioned Pharmacist	0	4	29%	1	17%	0	0%	0	0%
	1	10	71%	5	83%	3	60%	3	60%
	2	0	0%	0	0%	2	40%	2	40%
In Position Pharmacist	0	4	29%	1	17%	0	0%	0	0%
	1	10	71%	4	67%	3	60%	2	40%
	2	0	0%	1	17%	1	20%	2	40%
	5	0	0%	0	0%	1	20%	1	20%
Sanctioned LHV	0	14	100%	4	67%	5	100%	2	40%
	1	0	0%	1	17%	0	0%	2	40%
	2	0	0%	1	17%	0	0%	1	20%
In Position LHV	0	12	100%	4	67%	2	100%	2	40%
	1	0	0%	1	17%	0	0%	2	40%
	2	0	0%	1	17%	0	0%	1	20%
In Position MLHP	None	0	0%	0	0%	0	0%	0	0%
	Yes	14	100%	0	0%	0	0%	0	0%
	No	0	0%	0	0%	0	0%	0	0%
	NA	0	0%	6	100%	5	100%	5	100%
Qualification	BAMS	6	43%	0	0%	0	0%	0	0%
	BUMS	2	14%	0	0%	0	0%	0	0%
	GNM	6	43%	0	0%	0	0%	0	0%
Appointment, Year	2018	4	29%	0	0%	0	0%	0	0%
	2019	10	71%	0	0%	0	0%	0	0%

Continue……Table 3.3: Details of Human Resource of Selected HWCs in J&K									
Various categories of sanctioned staff	**Number**	**Type of HWC**							
		SHC		**PHC**		**UPHC**		**24X7 PHC**	
		No	**%**	**No**	**%**	**No**	**%**	**No**	**%**
MPW Female Sanctioned	None	0	0%	1	17%	0	0%	1	20%
	1	1	7%	1	17%	2	40%	0	0%
	2	13	93%	4	67%	2	40%	2	40%
	3	0	0%	0	0%	1	20%	2	40%
MPW Female In-position	None	0	0%	0	0%	0	0%	0	0%
	1	4	29%	3	50%	3	60%	1	20%
	2	10	71%	2	33%	1	20%	1	20%
	3	0	0%	0	0%	1	20%	2	40%
	6	0	0%	0	0%	1	20%	0	0%
MPW Male Sanctioned	None	12	86%	5	83%	4	80%	5	100%
	Yes	2	14%	1	17%	1	20%	0	0%
	No	0	0%	0	0%	0	0%	0	0%
MPW Male In position	0	1	7%	0	0%	0	0%	0	0%
	1	1	7%	1	17%	1	20%	0	0%
ASHA/Link Worker Sanctioned	1	0	0%	0	0%	1	20%	0	0%
	2	2	14%	0	0%	1	20%	0	0%
	3	3	21%	1	17%	2	40%	1	20%
	4	2	14%	0	0%	0	0%	3	60%
	5	2	14%	1	17%	0	0%	0	0%
	6	4	29%	0	0%	0	0%	0	0%
	7 or More	1	7%	4	67%	1	20%	1	20%
ASHA/Link Worker In position	None	0	0%	0	0%	0	0%	0	0%
	1	0	0%	0	0%	1	20%	0	0%
	2	3	21%	0	0%	1	20%	1	20%
	3	3	21%	1	17%	2	40%	2	40%
	4	2	14%	0	0%	0	0%	1	20%
	5	1	7%	1	17%	0	0%	0	0%
	6	4	29%	1	17%	0	0%	0	0%
	7	1	7%	2	33%	0	0%	0	0%
	8	0	0%	0	0%	0	0%	1	20%
	14	0	0%	1	17%	1	20%	0	0%
Villages need more ASHAs	None	10	71%	5	83%	1	20%	2	40%
	1 or more	4	29%	1	17%	4	80%	3	60%
Total		**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

Skills and Competencies of Human Resource

As per the guidelines, the Mid-Level Health providers should be trained in either Certificate Programme in Community Health, managed and certified by IGNOU/ state universities or have a B.Sc. degree in Community Health. To improve training quality, all the states need to institutionalize District Level Committee of Observers to monitor these trainings. These committees can submit feedback to State NHM/District Health Officers/CMHOs on improvement areas if any. In addition, states are supposed to create a strong mentorship programme including

programmes like ECHO (Extension for Community Health Care Outcomes) for supporting the MLHPs through handholding, trouble shooting, problem solving, to enable building of technical competencies and sustaining motivation. Frontline workers, and Service Providers posted at all levels are also to be multi-skilled to address the mismatch in the services to be provided and various levels of training of primary care team members. The key principle is that as many skills as possible and appropriate at that level should be available within the team at the HWC, so that the services are assured to the population and the team is able to resolve more at their level including through telehealth with fewer referrals. MPW (M & F) need skills to function as paramedics for undertaking laboratory, pharmacy and counselling functions. Similarly, at the HWC-PHC level, staff is supposed to be appropriately skilled to function as ophthalmic technicians, dental hygienists, physiotherapists, etc. there is a provision of Massive Open Online Courses, also. States are supposed to enter into partnerships with a range of academic and training organizations to help deliver such multi-skilling on an ongoing basis. In this background, we canvassed some questions on trainings received by various categories of health professionals working in selected HWCs in Jammu and Kashmir. The information in this regard collected shows that all the MLHPs who have been posted in HWCs have successfully completed their six months' bridge course through SHS to make them competent to work more effectively, but during our interaction with some MLHPs, it was found that the 6 months course at some places was not run for the maximum period but some shortcuts were made due to unknown reasons and were posted in the field but were found highly motivated to work. The information collected on trainings received by MOs working in HWCs shows that population-based screening training on NCDs has been received by very limited number of MOs as the UT has not yet initiated training for MOs in this regard in all the districts and is under process. Other trainings like BEmoc, family planning, other national programmes, safe abortion etc. have been received by a sizable number of MOs also. Out of 10 SNs in position at various selected HWCs, only half of them have received any training on family planning or safe abortion. Further, the information collected shows that out of 16 lab technicians in position, only five have received some training while in case of MLHPs, in addition to their six-month bridge course, they have received three days training on population-based screening on NCDs recently in some selected districts. Further, the information collected on trainings received by them shows that they have received trainings on various programmes from time to time but recently almost all the MPWs have received a three-day training of PBS on NCDs in various selected districts of the UT. The training and orientation of ASHAs is a continuous process but the application of such trainings in the field has always been a problem as has been established by many studies in this regard from time to time. Various reasons for such issues are their educational level, quality of training, and above all the monitoring and support system under which they are working. Recently ASHAs in various districts have received five days training on PBS of NCDs but during our interaction with them in the field, a sizable number of them were not able to explain more on NCDs and were also not able to fill-up the CBAC forms due to low educational level. As per the latest information (as on 10th March, 2020), all the selected districts have imparted training on PBS of NCDs for MPWs, ASHA Facilitators and ASHAs while as training in this regard for MOs, and SNs is going-on and will be completed soon. The details of trainings of various categories of human resource in selected HWCs is given below in table 3.4.

Table 3.4: Details of Skills and Competencies of Human Resource in selected HWCs of J&K during 2019-20									
Training Received by	**Type of Training**	**Type of HWC**							
		SHC		**PHC**		**UPHC**		**24X7 PHC**	
		No	**%**	**No**	**%**	**No**	**%**	**No**	**%**
MO1	None	0	0%	1	20%	0	0%	2	40%
	IMNCI	1	7%	0	0%	0	0%	0	0%
	BEmOnc	0	0%	0	0%	0	0%	2	40%
	Family Planning	0	0%	3	60%	1	20%	0	0%
	PBS on NCDs	0	0%	0	0%	1	20%	1	20%
	Other Program	0	0%	0	0%	2	40%	0	0%
	Not Applicable	13	93%	1	20%	1	20%	0	0%
MO2	None	0	0%	0	0%	0	0%	1	20%
	Family Planning	1	8%	0	0%	1	20%	3	60%
	Safe Abortion	0	0%	1	20%	0	0%	0	0%
	Other Program	0	0%	0	0%	1	20%	0	0%
MO3	None	0	0%	0	0%	0	0%	1	20%
	BEmOnc	0	0%	0	0%	1	20%	0	0%
	PBS on NCDs	0	0%	1	20%	0	0%	0	0%
Staff Nurse	No Training	1	7%	1	17%	0	0%	3	60%
	SBA	0	0%	0	0%	1	20%	1	20%
	Family Planning	1	7%	1	0%	1	20%	0	0%
Lab Tech	None	3	21%	2	33%	1	20%	5	100%
	Other Program	1	7%	1	17%	3	60%	0	0%
	Not Applicable	10	71%	3	50%	1	20%	0	0%
LHVs	None	1	7%	2	33%	1	20%	4	80%
	Family Planning	0	0%	1	17%	0	0%	0	0%
	Not Applicable	13	93%	3	50%	4	80%	1	20%
MLHP	None	2	14%	1	17%	0	0%	1	20%
	IMNCI	1	7%	0	0%	0	0%	0	0%
	PBS on NCDs	11	79%	0	0%	1	20%	2	40%
	Not Applicable	0	0%	5	83%	4	80%	2	40%
MPW Female	None	0	0%	0	0%	1	20%	1	20%
	Family Planning	0	0%	0	0%	1	20%	0	0%
	PBS on NCDs	13	93%	2	33%	3	60%	2	40%
	Other Program	1	7%	2	33%	0	0%	0	0%
	Not Applicable	0	0%	2	33%	0	0%	2	40%
MPW Male	None	1	7%	1	17%	1	20%	2	40%
	PBS on NCDs	0	0%	1	17%	1	20%	0	0%
	Not Applicable	13	93%	4	67%	3	60%	3	60%
ASHAs	None	0	0%	0	0%	2	40%	0	0%
	IMNCI	6	43%	2	33%	2	40%	1	20%
	PBS on NCDs	8	57%	4	67%	1	20%	4	80%
Total		**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

***Note**: The reference period for various trainings was not included in the schedule provided by the Ministry though training on PBS on NCDs has been initiated only on 2019-20 as mentioned in the beginning of this report also. The objective for collecting this information from the selected health facility staff was to only assess their skill and technical competence, thus no reference period was mentioned in the schedule.*

Infrastructure and Resources Available

Ensuring adequate infrastructure for the delivery of Comprehensive Primary Health Care (CPHC) at Health and Wellness Centres would need to cater to a population size as per IPHS norms for Sub Health Centers. As per the guidelines, major civil infrastructure upgrade is required for developing the Sub Health Centres as Health and Wellness Centre. Essential requirements for strengthening a SHC to serve as a Health and Wellness Centres are: A well-ventilated clinic room with examination space and office space for Mid-Level Health Provider/Community Health Officer, Storage space for storing medicines, equipment, documents, health cards and registers, Designated space for lab/diagnostic, Separate male and female toilets, Deep burial pit for Bio Medical Waste Management, Proper system for drainage, Assured water supply that can be drawn and stored locally, Electricity supply linked to main lines or adequate solar source, inverter or back-up generator as appropriate, Patient waiting area covered to accommodate at least 20-25 chairs, Repairs of roofs and walls, plastering, painting and tiling of floors to be undertaken as per requirement, Space/room for Yoga if adequate space for expansion is available, Adequate residential facilities for the service providers, and Rain water harvesting facilities should be planned if required. For a PHC- HWC, infrastructure would be as per current Indian Public Health Standards. States and district need to earmark fund support of 7 lakh/SHC-HWC or 4 lakh PHC-HWC as a pooled grant rather than fixed grant per facility for infrastructure modification. In terms of branding all the HWCs are supposed to: Colour Code the facility, fix display boards, citizen charter, referral arrangements, names and contact details of the primary care team, jurisdiction of gram panchayat/ urban local body representatives etc. In this background we tried to get the information from the visited health facilities and also tried to observe whether such initiatives have been taken by the HWCs in selected districts of Jammu and Kashmir. The information collected in this regard shows that out of 14 selected SC-HWCs repair and upgradation work has been completed while as in 21 percent cases repair work has not taken place and in one each SC-HWC repair work has been partially taken place and not started yet. In all the PHC and 24X7 PHCs repair work has been completed in all the selected districts while as in one UPHC-HWC no repair or renovation work has been initiated till date. Further, the data collected shows that out of the selected HWCs, 36 percent SC-HWCs, 33 percent PHCs, and 20 percent UPHCs do not have 24X7 power back-up while as 24X7 water supply is available in almost all the selected HWCs. OP consultation room is not available in 29 percent SC-HWCs, and half of the selected PHCs while as all the UPHCs and 24X7 PHCs have sufficient space for OP consultation. Patient waiting area is available in most of the HWCs but it was observed that this space is in the corridors of the facility and has not heating or cooling arrangement. Further, it was found that 64 percent SC-HWCs, and half of the PHC-HWCs have designated space for lab and dispensation of medicines but it was observed that in SC-HWC such space is very limited for drug dispensation as most of them do not have a lab. In one of the SC-HWC, it was found that they have converted one old wash room in to a lab where they are able to conduct the specified 6-7 rapid tests. Space of sterilization is not available in 43 percent SC-HWCs among the selected health facilities. Facility for labour room and NBCC is adequate in all those HWCs which have been designated as delivery points. The information collected further shows that a sizable number of HWCs have made arrangements for safe drinking water in their facilities but still 29 percent SC-HWCs, half of the PHC-HWCs and 20 percent UPHCs have not installed any purifier or

filter for safe drinking water. Approach road to all the HWCs is almost good but in one of the SC-HWC work was in progress to make the approach road better. Facility of separate wash rooms for males/females/patients, and staff have been made functional in sizable number of HWCs as at least two washrooms were found available in 57 percent SC-HWCs, 68 percent PHC-HWCs and 60 percent UPHC-HWCs in the selected districts of the UT. Appropriate drainage and arrangement for waste disposal has not yet been taken seriously and it was found that such arrangements were made in only 36 percent SC-HWCs, 67 percent of PHC-HWCs, 80 percent UPHC-HWCs and all the 24X7 PHCs across the selected districts. The information on establishment of yoga rooms or provision of yoga services was still found to be available in limited HWCs especially in SC, UPHC and PHC level HWCs due to lack of space as such facilities have very limited space in this regard but these HWCs have also taken community in confidence to get the space for this activity. Overall, 29 percent SC-HWCs, half of PHC-HWCs, 20 percent UPHC-HWCs and 60 percent 24X7 PHC-HWCs have established yoga rooms or have made provision for such activities in their locality in the selected districts of the UT. It was further observed that such activities have not yet been taken seriously by the selected HWCs also. Furniture and equipment were found to be limited in various facilities though, efforts have been made by the SHS to provide requisite equipment and furniture to HWCs as per the CPHC guidelines to all the HWCs. Only few selected HWCs reported that they have furniture or equipment available as per the CPHC guidelines. Display of citizen charter was found to be on display in majority of the selected HWCs in all the districts of the UT. In addition to this, rain water harvesting, state of art waste disposal management, and establishment of herbal garden was found in some selected HWCs of Udhampur district only. Table 3.5

Table 3.5: Details of Infrastructure and Resources Available in selected HWCs of J&K

		Type of HWC							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Repairs and upgradation Completed	Yes	9	64.30%	6	100%	4	80.00%	5	100%
	No	3	21.40%	0	0.00%	1	20.00%	0	0.00%
	Partial	1	7.10%	0	0.00%	0	0.00%	0	0.00%
	Not yet	1	7.10%	0	0.00%	0	0.00%	0	0.00%
24 hours electricity	Yes	9	64.30%	4	66.70%	4	80.00%	5	100%
	No	5	35.70%	2	33.30%	1	20.00%	0	0.00%
24 hours water supply	Yes	12	85.70%	6	100%	5	100%	5	100%
	No	2	14.30%	0	0.00%	0	0.00%	0	0.00%
Room for OP Consultation	Yes	10	71.40%	3	50.00%	5	100%	5	100%
	No	4	28.60%	3	50.00%	0	0.00%	0	0.00%
Examination Area adequate	Yes	8	57.10%	3	50.00%	4	80.00%	5	100%
	No	6	42.90%	3	50.00%	1	20.00%	0	0.00%
Patient Waiting Area	Yes	12	85.70%	5	83.30%	4	80.00%	5	100%
	No	2	14.30%	1	16.70%	1	20.00%	0	0.00%
Designated space for Lab and Dispensation of Medicines	Yes	9	64.30%	3	50.00%	5	100%	5	100%
	No	5	35.70%	3	50.00%	0	0.00%	0	0.00%

Continue ……. Table 3.5: Details of Infrastructure and Resources Available in selected HWCs of J&K									
		Type of HWC							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Space for Sterilization	Yes	8	57.10%	5	83.30%	5	100%	5	100%
	No	6	42.90%	1	16.70%	0	0.00%	0	0.00%
Facility Delivery Point-Labour room/NBCC available	Yes	1	7.10%	2	33.30%	2	40.00%	5	100%
	Not Applicable	13	92.90%	4	66.70%	3	60.00%	0	0.00%
Facilities for safe Drinking Water	Yes	10	71.40%	3	50.00%	4	80.00%	5	100%
	No	4	28.60%	3	50.00%	1	20.00%	0	0.00%
Suitable Approach Road	Yes	10	71.40%	5	83.30%	4	80.00%	5	100%
	No	4	28.60%	1	16.70%	1	20.00%	0	0.00%
Separate Male/Female Toilets for staff /Patients/both	Yes	8	57.10%	4	66.70%	3	60.00%	5	100%
	No	6	42.90%	2	33.30%	2	40.00%	0	0.00%
Appropriate Drainage and Arrangement for Waste Disposal	Yes	5	35.70%	4	66.70%	4	80.00%	5	100%
	No	9	64.30%	2	33.30%	1	20.00%	0	0.00%
Wellness room or provision of Yoga services	Yes	4	28.60%	3	50.00%	1	20.00%	3	60.00%
	No	10	71.40%	3	50.00%	4	80.00%	2	40.00%
Furnitures and Equipment as per CPHC Guidelines	Yes	1	7.10%	2	33.30%	1	20.00%	2	40.00%
	No	3	21.40%	2	33.30%	0	0.00%	0	0.00%
	Partial	10	71.40%	2	33.30%	4	80.00%	3	60.00%
Citizen's Charter and Display of IEC	Yes	11	78.60%	5	83.30%	4	80.00%	4	80.00%
	No	3	21.40%	1	16.70%	1	20.00%	1	20.00%
Total		**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

IT Support and Teleconsultation Services

As per the guidelines, the use of standardized digital health record and establishing a seamless flow of information across all levels of health care facilities is an aspirational goal. IT system has been envisioned at the Health and Wellness Centres and will need to be inter-operable with the overall e- health architecture plans at the national and state level. Use of Information Technology would be essential to enable efficient delivery of services at the HWCs. IT tool would support the HWC team in recording the services delivered, in enabling follow up of service users, in reporting to higher functionaries, and in population-based analytics. The Key Functions of the IT system are: Empanel all individuals and families in the catchment area and update this database regularly when there is a new entrant into this area, or someone exits, facilitate identification and registration of beneficiaries/ families for Pradhan Mantri Jan Arogya Yojana as per laid down criteria, ensure that every family and individual have been allotted and are aware of their unique Health ID - which would also be used to seek services under various programmes such as RCH/ RNTCP/ NVBDCP etc. and support beneficiaries to seek services under the PMJAY, link the unique health ID with the AADHAAR ID at the back end, identify and merge duplicates by verifying IDs

and create a longitudinal health record of each empaneled individual. In case of service delivery: record all services that are delivered at the HWC under different programmes, enable follow up of services that individual patients are receiving by recording relevant parameters, diagnostic results, medication given etc. and send SMS/ reminders to individuals about the follow up visits. Also facilitate clinical decision making for the service providers, track and support upward and downward referrals to support continuity of care, ability to print key summary and prescription based on individual's requirement ability to provide standardized prescription, discharge summary and/or referral note which can be scanned/photographed or printed and uploaded as per requirement and capture, store and transmit images to support teleconsultation, referral and follow up. Further management of service delivery includes: capturing service delivery coverage and measure health outcomes using population-based analytics, generate work plans for the teams with alert and reminder feature for services providers to support scheduling of appointments, follow up home visits and outreach activities, use the service delivery data to validate use of services and enable Direct Bank Transfers to beneficiaries wherever required, support birth and death registrations and disease surveillance, capture record of other preventive and promotive services delivered, like vector control etc. and send appropriate IEC/BCC messages. In this regard initially it has been decided to provide a laptop/desktop to MO/facility, tablet to MLHP/MPW/facility and smart phones to ASHAs for carrying out the above-mentioned activities in a better way. In this background, the information was collected on various indicators from the selected HWCs in all the five districts of UT to ascertain as to what extent such facilities have been provided to various level of HWCs. The data collected shows that only one-third of the selected HWCs were given Desktops for MOs/health facilities and in Udhampur all the facilities were given desktops to maintain the records digitally while as in Anantnag district none of the health facility had desktops. In some other districts, we were informed that desktops were already available at these facilities (especially at PHCs, UPHC and 24X7 PHCs) even before they were converted into HWCs. In case of tablets to SC-HWCs, we were told by majority of MLHPs that initially they were given tablets but they were found faulty and not working and were withdrawn immediately by the SHS. However, no new tablets were given to them later. The information further collected in this regard shows that 20 percent each HWCs in Srinagar and Anantnag and one-third of HWCs in Baramulla have received tablets while in all other SC-HWCs tablets have not yet been given to MLHPs. None of the ASHAs have received a smart phone in any selected health facility so far across the UT. Similarly, almost all the HWCs in the selected districts reported that no one has received any training in use of IT systems. The information on HMIS, RCH, ANMOL, and Nikshay is mostly submitted to block headquarters on hard copies and the same is uploaded on relevant websites by them only. But in some selected HWCs such uploading is done at the facility level by the out-sourced data entry operators also. Uploading on CPHC-NCD application, HWC portal is supposed to be done by the HWCs and initially it was started in some facilities where tablets or desktops were available but later it was not done due to non-availability of internet facility (post 5th August, 2019). Now as per latest reports, facilities in Jammu division have started uploading the data as internet has been restored in various areas of the UT. Most of the ASHAs were found filling-up population enumeration and CBAC data manually as already mentioned that no smart phone has been provided to them and secondly, such activities in most of the selected districts have been started

late. Further, trainings and capacity of an ASHA to do this exercise was also an impediment to pick-up this exercise. This manual data is not also being digitized and entered on tablets by MPWs or MLHPs due to non-availability of internet and tablets with them but where-ever tablets are available this data is digitized in offline mode on tablets as was reported by the officials at selected HWCs. None of the PHC/UPH/24X7 PHC is yet connected with the tele-consultation hub in any district as such facility has not yet been established by the SHS in the UT. Table 3.6

Table 3.6: Details of IT Support and Teleconsultation Services in J&K

Particulars	Response	Name of District									
		Srinagar		Jammu		Udhampur		Anantnag		Baramulla	
		No	%	No	%	No	%	No	%	No	%
Desktops/Laptop for MO/Facility	Yes	2	40%	1	13%	6	100%	0	0%	1	17%
	No	3	60%	7	88%	0	0%	5	100%	5	83%
Tablets for MLHP, MPWs	Yes	1	20%	0	0%	0	0%	1	20%	2	33%
	No	4	80%	8	100%	6	100%	4	80%	4	67%
Smart Phones for ASHA	Yes	0	0%	0	0%	0	0%	0	0%	0	0%
	No	5	100%	8	100%	6	100%	5	100%	6	100%
Training in use of IT systems complete for Staff	Yes	0	0%	0	0%	0	0%	0	0%	1	17%
	No	5	100%	8	100%	6	100%	5	100%	5	83%
RCH Portal	Yes	1	20%	1	13%	1	17%	2	40%	1	17%
	No	4	80%	7	88%	5	83%	3	60%	5	83%
HMIS	Yes	1	20%	1	13%	1	17%	2	40%	1	17%
	No	4	80%	7	88%	5	83%	3	60%	5	83%
CPHC-NCD Application	Yes	0	0%	0	0%	0	0%	2	40%	0	0%
	No	5	100%	8	100%	6	100%	3	60%	6	100%
H&WC Portal	Yes	0	0%	1	13%	0	0%	2	40%	1	17%
	No	5	100%	7	88%	6	100%	3	60%	5	83%
Nikshay	Yes	1	20%	0	0%	1	17%	2	40%	1	17%
	No	4	80%	8	100%	5	83%	3	60%	5	83%
ANMOL by MPWs	Yes	0	0%	0	0%	0	0%	0	0%	1	17%
	No	5	100%	8	100%	6	100%	5	100%	5	83%
E-Hospital	No	5	100%	8	100%	6	100%	5	100%	6	100%
ASHAs filling population enumeration and CBAC data in CPHC application in smartphones	No	0	0%	0	0%	0	0%	1	20%	1	17%
	Manual	5	100%	8	100%	6	100%	4	80%	5	83%
CBAC data in digitized and entered in tablets with MLHP/MPWs	Yes	1	20%	0	0%	0	0%	0	0%	0	0%
	No	4	80%	8	100%	6	100%	5	100%	6	100%
Connectivity of PHC with Tele-consultation Hub established	Yes	0	0%	3	38%	0	0%	0	0%	0	0%
	No	5	100%	5	63%	6	100%	5	100%	6	100%
Total		**5**	**100%**	**8**	**100%**	**6**	**100%**	**5**	**100%**	**6**	**100%**

Medicines and Diagnostics

The credibility of HWCs rests on the availability of essential medicines and diagnostics for a wide range of health care needs of the population served by the HWC. In line with the paradigm shift envisaged, the HWC are supposed to provide a broader range of services and this has necessitated to expand the list of essential medicines and diagnostic services currently available. Medicines listed as per essential list of medicines for a PHC/Sub health Centre need to be ensured at respective HWCs. Additional medicines are required at the HWC as the range of services expands. The indicative list of medicines is as per National List of Essential Medicines (NLM) 2015, can be updated periodically based on new protocols and states will have the flexibility to adapt the list as appropriate. As per the guidelines, certain medicines for treatment of identified patients with chronic diseases (Hypertension, Diabetes Mellitus, Epilepsy, Chronic Obstructive Pulmonary Disease, Mental Disorders, and patients requiring palliative care) can be indented by the Mid-Level Health Provider, from the PHC/referral center essential medicine list. For a patient suspected of a chronic disease, confirmation and initiation of treatment will be given by the Medical Officer at the PHC or a higher referral centre. However, for continuation of treatment, medicines are to be dispensed at SHC-HWCs by MLHP to avoid patient hardship and ensure that the clinical condition is monitored regularly.

Based on the records in the health folder, the MLHP can generate each month, a list of patients on treatment for chronic illnesses in the population served by HWC. According to the patient list, the MLHP can indent medicines from PHC- EML/ referral centre- EML for a three - month period per patient. The medicines are provided every month to the patient. Patients are to be encouraged to come to the HWC so that their health status can be monitored. Home based distribution is recommended only for patients who are not able to travel. In this regard, the states have been given a free hand to make necessary changes in the drug list as per their local needs and come-up with EMLs for various types of HWCs.

Keeping in view the guidelines, the UT of Jammu and Kashmir has also made some necessary changes in the EMLs and as per the list, free drug list for SC/NTPHC-HWC contains a total of 23 drugs (which does not include drugs on ophthalmology or ENT) and while the drug list for PHC/UPHC-HWCs contain 71 drugs. Besides, these some other drugs are also provided to various types of health facilities by their respective directorates in the two divisions of UT. The information collected in this regard from the selected HWCs of various types shows that up to 23 drugs were found in 21 percent SC-HWCs, 24-30 drugs were found in half of the SC-HWCs and more than 30 drugs were found in 28 percent SC-HWCs. Further, it was found that half of the selected PHC-HWCs had 41-60 drugs, and rest of them had less than 40 drugs available at the time of our visit. Similarly, at UPHC-HWC, 60 percent had more than 40 drugs available in their health facilities. The information collected further shows that all the selected 24X7 PHC-HWCs had at-least more than 40 drugs available for patients. Drugs for chronic diseases like hypertension, diabetes, COPD etc. are also included in these EMLs but it was found that the indents for HWCs have not yet been issued separately by the officials. Supply of medicines for NCDs to HWCs ranges from less than 4 medicines to 10 medicines or more medicines to each HWC.

Table 3.7: Details of Medicines and Diagnostics in Selected HWCs in J&K									
		Type of HWC							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Number of Medicines Available in the Facility as per State List	Up to 23	3	21%	0	0%	1	20%	0	0%
	24-30	7	50%	1	17%	0	0%	0	0%
	31-40	1	8%	2	33%	1	20%	0	0%
	41-60	3	21%	3	50%	3	60%	5	100
Number of Medicines Available for management of NCDs	< 4	1	7%	0	0%	1	20%	1	20%
	5-8	11	79%	3	50%	3	60%	1	20%
	More than 8	2	14%	3	50%	1	20%	3	60%
Number and Type of Medicines that are not in adequate stock for minimum three months usage	None	9	64%	4	67%	1	20%	5	100
	1-4	5	36%	2	33%	4	80%	0	0%
Reasons for Stock Out	None	2	14%	2	33%	0	0%	2	40%
	sufficient supply	2	14%	2	33%	0	0%	1	20%
	Sufficient supplies as per demand	3	21%	0	0%	3	60%	0	0%
	When needed get from BMO	7	50%	2	33%	2	40%	2	40%
Number of Diagnostics Tests/Lab Investigations being conducted	4	3	21%	2	33%	1	20%	0	0%
	7	11	79%	3	50%	0	0%	0	0%
	16	0	0%	0	0%	0	0%	1	20%
	28	0	0%	1	17%	4	80%	2	40%
	40	0	0%	0	0%	0	0%	2	40%
Reasons for Non- Availability of Lab Investigations	Lack of Reagents /consumables	2	14%	0	0%	1	20%	1	20%
	Lack/Non-Functional Equip	0	0%	0	0%	3	60%	1	20%
	Lack of Lab Tech	0	0%	2	33%	0	0%	0	0%
	Other Reasons	0	0%	1	17%	0	0%	3	60%
	No Lab	12	86%	3	50%	1	20%	0	0%
consumables have frequent stock outs?	None	11	79%	5	83%	2	40%	5	100 %
	Sugar test Strips	1	7%	0	0%	0	0%	0	0%
	Grouping, CBC etc	2	14%	1	17%	3	60%	0	0%
Report on Functionality of Equipment/Maintenance	Yes	14	100	6	100	4	80%	5	100
Comment on the accuracy of investigations	Near Accurate	3	21%	2	33%	3	60%	1	20%
	Accurate	11	79%	4	67%	1	20%	4	80%
Are the untied funds being utilized for local procurement based on rate contracting at the state level	Yes	14	100 %	6	100 %	5	100 %	5	100 %
Is the facility having DVDMS/E Aushadhi or other MIS for Drug and Vaccine Logistics	Yes	0	0%	0	0%	0	0%	1	20%
	No	14	100 %	6	100 %	5	100 %	4	80%
Total		**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

At some HWCs in Jammu district, most of the MLHPs of HWCs reported that they have very few medicines available and the choice of drugs and multi salt-drugs were not available to them for NCDs but in various other districts such issue was not raised by any HWC. As far as the adequacy of drugs is concerned, it was found that most of the HWCs have received drugs supply recently

and those who are working for NCDs and other communicable diseases for a longer time had problem of sufficient stock. Further, the drugs supplied to HWCs are limited in quantity and none of the HWC was able to provide a one-month dosage of drug to any patient who has been identified for chronic disease and has been put on drugs by MOs at any level. In case of any stock-out, most of the various types of HWCs report to the concerned BMO and get the required drugs. The information collected on number of lab investigations conducted by each HWC, shows that all the SC-HWCs conduct only rapid lab tests ranging from one test to 7 tests which include, Hb, Pregnancy test, Sugar test, measure BP, urine dip stick, slide preparation for malaria smear, and sputum test. In case of PHC-HWCs the range of tests varies from 17 tests to 40 tests as some UPHC and 24X7 PHC-HWCs are able to carry lab tests between 28-40 tests. It was found that almost three-fourth of the HWCs have no in-house lab while one third of PHC and 20 percent UPHC-HWCs also do not have any laboratory. Some of the HWCs were found either short of equipment or had no reagents to carry-out the full range of lab investigations. By and large, it was observed that lab testing facilities are better in PHC/UPHC/24X7 PHC level HWCs in the selected districts of Jammu and Kashmir. All the HWC report on functionality of equipment and maintenance to the concerned authorities on regular basis. Further, the information collected shows that all the selected HWCs use their Untied Funds for local procurement based on rate contracting at the state level. Table 3.7

Functional Coordination Amongst the Primary Care Team

Functional coordination between the members of primary care teams at SC and PHC-HWC is an important part of success for CPHC. The MLHP is supposed to be a torch bearer at the SC level team and needs to work in a coordinated manner with the MPWs and ASHAs and extend support to them so as to make this concept of HWC a success. Similarly, at PHC or higher-level referrals, the concerned MOs are supposed to entertain the referrals from lower level HWCs at OPDs and other help. There is a need that both MOs and MLHPs should remain in-touch for further follow-ups of patients so that CPHC can be made a success story. Monthly review meetings and other means of communication need to be made available for frequent interaction between the primary care team to resolve issues in a time bound manner. The information collected from the selected HWCs shows that almost all (except one SC-HWC which is very new) the SC level HWCs have distributed the work amongst themselves under the overall supervision of MLHP. The field coordination and challenges if any are being discussed at the SC-HWC by MLHPS/MPWs/ASHAs on regular basis and the challenges are being sorted out in a time bound manner. The information collected shows that most of the ASHAs are referring suspected cases to SC-HWC after she visits the households to fill-up the family and individual folders. As most of the SC-HWCs have kept one day in a week for NCD screening and thus the MLHP along with MPWs attend all the referral cases sent by the ASHA and screen them. Further, the data collected from PHC/UPHC/24X7 PHCs-HWCs shows that MOs at these facilities attend the referral cases of SC-HWC on priority and provide them all possible facilities available at his disposal but it was observed that most of the patients if found with any NCD (who are screened at SC-HWC) prefer to go to higher level health facility for treatment/conformation of disease instead, of going to PHC level HWCs. Communication between MOs and MLHPs for continuation of treatment plan and follow-up care was found satisfactory in almost all the selected HWCs in Jammu and Kashmir.

The data further shows that the communication by MLHPs/MPWs for community level follow-up by ASHAs was poor at PHC/UPHC/24X7 PHC-HWC level but at SC-HWC, it was found comparatively better. The details in this regard are given below in table 3. 8.

Section 3.8: Details of Functional Coordination Amongst the Primary Care Team of HWCs in J&K									
		Type of HWC							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Work distribution between MLHPs and MPWs Females and Males	Yes	13	93%	0	0%	0	0%	0	0%
	No	1	7%	0	0%	0	0%	0	0%
	NA	0	0%	6	100	5	100	5	100
Assess Field Level coordination and challenges if any in functions of MLHPs/MPWs and ASHAs	Yes	13	93%	0	0%	0	0%	0	0%
	No	1	7%	0	0%	0	0%	0	0%
	NA	0	0%	6	100	5	100	5	100
ASHAs referring cases for screening/management of cases at SHC-HWC	Yes	13	93%	0	0%	0	0%	0	0%
	No	1	7%	0	0%	0	0%	0	0%
	NA	0	0%	6	100	5	100	5	100
MLHPs attending to cases referred by ASHAs	Yes	12	86%	0	0%	0	0%	0	0%
	No	2	14%	0	0%	0	0%	0	0%
	NA	0	0%	6	100	5	100	5	100
PHC Medical Officer attending upward referral by MLHP/MPWs for diagnosis, complication management and initiation of Treatment plan	Yes	0	0%	5	83%	4	80%	5	100
	No	0	0%	1	17%	1	20%	0	0%
	NA	14	100	0	0%	0	0%	0	0%
Communication by PHC Medical Officer to MLHP/MPW for continuation of treatment plan and follow up care at SHC-HWC	Yes	13	93%	3	50%	4	80%	5	100 %
	No	1	7%	3	50%	1	20%	0	0%
Communication by MLHPs/MPWs for Community level follow up by ASHAs	Yes	8	57%	1	17%	1	20%	1	20%
	No	2	14%	0	0%	0	0%	0	0%
	NA	4	29%	5	83%	4	80%	4	80%
Total		**14**	**100**	**6**	**100**	**5**	**100**	**5**	**100**

Functionality and Service Delivery

Delivery of an expanded range of services, closer to the community at HWCs require re-organization of the existing workflow processes. The delivery of services as per the guidelines would be at three levels i.e., i) Family/Household and community levels, ii) Health and Wellness Centres and iii) and Referral Facilities/Sites. Delivery of services closer to the community and close monitoring enables increased coverage and help in addressing issues of marginalization and exclusion of specific population groups. The services envisaged at the HWC level includes early identification, basic management, counselling, ensuring treatment adherence, follow up care, ensuing continuity of care by appropriate referrals, optimal home and community follow up, and health promotion and prevention for the expanded range of services. The primary health care team led by the Mid-level health provider is supposed to be trained to provide first level of management and triage i.e. refer the patient to the appropriate health facility for treatment and follow up.

Care provision at every level should be provided as per clinical pathways and standard treatment guidelines. This facilitates the decongestion of the secondary and tertiary care facilities as the primary care services would be made available at the HWC level closer to the community with adequate referral linkages and early identification and management will prevent disease progression that would require secondary/ tertiary care interventions. Thus, the HWC team needs to play the critical role of coordination by assisting people in navigation of the health system and mobilizing the support for timely access to specialist services when required. It is expected that such a strong mechanism will definitely make a strong foundation for primary health care for the people. In order to find the answers to such queries a set of questions was framed about the service delivery at the HWC to ascertain as to what extent HWC are working in this direction. The information collected in this regard form the selected HWCs in the UT shows that there has been a definite increase in the average footfall at the OPD as was told by the patients and community during our interaction with them on the day of our visit to these facilities. The last month OP footfall for some SC-HWCs (35 percent) was between 500-1500 and for most of the PHC/UPHC/24X7 PHC-HWC the average footfall for the last month was from 500 up to 2000 patients. Out of these, 100-700 patients (71 percent) were new cases and between 100-300 (71 percent) had come for the follow-up at SC-HWC. The performance of PHC-HWC has also been encouraging in the selected districts though some major services which are included in the CPHC are yet to be started at various levels. The total number of cases in some SC-HWCs has increased up to 1500 after it became a HWC though it is too early to say as to what extent there has been an increase or decrease in the number of patients coming to these HWCs as some of the selected HWCs are 2-3 months old only. Fixed day on weekly basis special clinics are organised for PMSMA at all the PHC and higher-level health facility on every 9th of the month while ANC services in most of the HWCs is a routine matter for all the days in these HWCs. Similarly, the frequency of immunization sessions ranges from once in a week at 24X7 PHCs to once in a month at SC-HWC level across the UT. Though, most of HWCs reported that they have conducted some NCD screening and such is scheduled on every Saturday at all the HWCs, though the information given by the HWCs is depicted in the table below but it was found that such screening sessions are not yet held on regular basis at most the HWCs. This statement was also substantiated by the village committee members and the OPD patients of these HWCs in the selected districts.

Table 3.9: Details Regarding Functionality and Service Delivery of HWCs in J&K

		Type of Facility							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Total OP Footfalls in last month	< 100	1	7%	1	17%	0	0%	0	0%
	100-300	6	44%	3	49%	1	20%	0	0%
	301-500	2	14%	0	0%	1	20%	0	0%
	501-700	2	14%	0	0%	0	0%	1	20%
	701-1000	2	14%	0	0%	1	20%	1	20%
	1001-1500	1	7%	1	17%	0	0%	1	20%
	1501-2000	0	0%	1	17%	1	20%	0	0%
	> 2000	0	0%	0	0%	1	20%	2	40%

Continue……. Table 3.9: Details Regarding Functionality and Service Delivery of HWCs in J&K									
		Type of Facility							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
New Cases	< 100	4	29%	3	49%	0	0%	0	0%
	100-300	8	57%	1	17%	2	40%	2	40%
	301-500	0	0%	0	0%	1	20%	0	0%
	501-700	2	14%	1	17%	0	0%	1	20%
	701-1000	0	0%	0	0%	1	20%	0	0%
	1001-1500	0	0%	1	17%	0	0%	1	20%
	1501-2000	0	0%	0	0%	1	20%	0	0%
	> 2000	0	0%	0	0%	0	0%	1	20%
Old Cases	< 100	6	43%	3	49%	1	20%	0	0%
	100-300	4	29%	1	17%	1	20%	0	0%
	301-500	1	7%	0	0%	1	20%	1	20%
	501-700	3	21%	1	17%	0	0%	2	40%
	701-1000	0	0%	1	17%	1	20%	0	0%
	1001-1500	0	0%	0	0%	0	0%	1	20%
	1501-2000	0	0%	0	0%	1	20%	0	0%
	> 2000	0	0%	0	0%	0	0%	1	20%
Total Cases Attended post operationalization as HWC	< 100	2	14%	0	0%	0	0%	0	0%
	100-300	5	36%	4	66%	1	20%	1	20%
	301-500	1	7%	0	0%	1	20%	0	0%
	501-700	4	29%	1	17%	0	0%	0	0%
	701-1000	0	0%	0	0%	0	0%	0	0%
	1001-1500	2	14%	0	0%	1	20%	1	20%
	1501-2000	0	0%	0	0%	1	20%	1	20%
	> 2000	0	0%	1	17%	1	20%	2	40%
Average OP Footfall Month	< 100	2	14%	1	17%	0	0%	0	0%
	100-300	7	50%	3	50%	2	40%	0	0%
	301-500	1	7%	0	0%	0	0%	0	0%
	501-700	2	14%	0	0%	0	0%	2	40%
	701-1000	0	0%	0	0%	1	20%	1	20%
	1001-1500	2	14%	2	33%	1	20%	0	0%
	1501-2000	0	0%	0	0%	0	0%	0	0%
	> 2000	0	0%	0	0%	1	20%	2	40%
Fixed Day Weekly Special Clinics Organized	Yes	14	100%	6	100%	5	100%	5	100%
ANC/PMSMA Per week	2	1	7%	2	33%	0	0%	0	0%
	6	13	93%	4	67%	5	100%	5	100%
Immunization Sessions per week/month	1	12	86%	5	83%	2	40%	2	40%
	2	2	14%	1	17%	3	60%	3	60%
NCD Screening	1	14	100%	6	100%	4	80%	5	100%
	6	0	0%	0	0%	1	20%	0	0%
Total		**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

Community Level Outreach and Health Promotion Activities

Health promotion and information provision at the community level is an integral part of the expanded range of services under Comprehensive Primary Health Care. Health is affected by various social and environmental determinants and actions to address these issues often do not fall in the purview of health systems alone and therefore requires intersectoral convergence and people's participation. Activities like organizing VHNDs, NCD screening camps, collaboration with RBSK teams, organizing meetings and programmes with VHSCs etc. could be a source of connect with the community and their participation. Other programmes can also be organised at school/AWC level and provide IEC to the community. Formation of patient support groups, organizing awareness camps for life style modification, sanitation drive and involvement of SHGs, NGOs, and VHSCs in various programmes can on one hand be a strong source of community connect and on the other hand will in health promotion and prevention activities. The following paragraph gives us the details regarding the community outreach, and health promotion carried out by selected HWCs in Jammu and Kashmir.

In Jammu and Kashmir, all the primary care health facilities have been involved in community outreach though as per the guidelines issued from time to time by the ministry, only SHCs are supposed to carry-out VHNDs in their catchment areas but in case of J&K all the primary care facilities, which include HSC, PHCs, UPHCs, and some 24X7 PHCs are carrying such activities even before they were upgraded as HWCs. The information collected from the selected HWCs in this regard shows that except for one selected PHC, all the selected HWCs have carried-out VHNDs in their respective areas. The frequency of holding these VHNDs is once in a week for all these facilities. As far as the information on VHND sessions held against the planned sessions, it was found that such sessions have been carried-out by the HWCs as per the plan but due to some disturbances after 5th August, 2019 (when the reorganization of State of J&K took place), some HWCs could not undertake this task for quite some time. Further, the information collected shows that about one-third of the selected HWCs have not yet conducted any screening camps in their localities while as two-third of HWCs have started this activity in their areas. The frequency of conducting the NCD screening camps varies from weekly for 36 percent to 43 percent among SC-HWCs while in case of PHC/UPHC-HWCs most of them have not yet started this activity. In the UT of Jammu and Kashmir, the screening for 0-18 years is normally done by the mobile teams of RBSK at schools, AWCs, delivery points and in govt. aided private schools also but the role of various levels of health facilities remains limited and if after screening there are some children with some minor ailments, they are sent to nearest SC, PHCs or 24X7 PHCs. The major chunk of referral by the RBSK team remains to be the DEIC at the District Hospital level. However, various health facilities at all levels do screen 0-18-year population in routine OPD and in this regard the information collected shows that about 47 percent selected health facility have screened this population and have also referred them for further treatment/management to higher level health facilities. The detailed information is given below in table 3.10 below.

Table 3.10: Details of Community Level Outreach of Selected HWCs in J&K									
		Type of Facility							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Community Level Outreach	Yes	14	100%	5	83%	5	100%	5	100%
	No	0	0%	1	17%	0	0%	0	0%
VHND Sessions Planed	0	0	0%	1	17%	0	0%	0	0%
	40	0	0%	0	0%	1	20%	0	0%
	48	14	100%	5	83%	4	80%	5	100%
VHND Session Held against Planned for the current FY 2019-20	0	0	0%	1	17%	0	0%	0	0%
	24-36	5	35%	2	34%	1	20%	4	80%
	38	0	0%	1	17%	0	0%	0	0%
	40-48	9	63%	2	33%	4	80%	1	20%
NCD Screening Camps conducted	0	1	7%	4	67%	4	80%	1	20%
	1-5	7	49%	2	34%	1	20%	3	60%
	6-9	4	28%	0	0%	0	0%	0	0%
	10 or more	2	14%	0	0%	0	0%	1	20%
Specified Frequency of Screening Camps	weekly	5	36%	0	0%	1	20%	1	20%
	Monthly	6	43%	1	17%	0	0%	2	40%
	Occasional	2	14%	1	17%	0	0%	1	20%
	Not yet	1	7%	4	67%	4	80%	1	20%
Screening for 0-18 years by RBSK Teams	By RBSK	9	64%	3	50%	4	80%	1	20%
	On routine	5	36%	3	50%	1	20%	4	80%
Number of Children screened and referred	< 30	3	21%	0	0%	1	20%	1	20%
	30-250	0	0%	1	17%	0	0%	2	40%
	> 250	2	14%	2	34%	0	0%	1	20%
	Total	**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

Health Promotion and Prevention Activities

Formation of Patient support groups (PSGs) is to be facilitated by the MPWs/ASHA or other frontline workers around particular disease conditions to improve treatment compliance and engaging not only those with the disease condition but also family member. They would prove a useful mechanism to improve treatment compliance and engaging not only those with the disease condition but also family members. PSGs can provide a platform wherein patients with similar illness and their family members or care-givers can have an open discussion about the disease, challenges associated with the illness and its treatment. The ASHAs are supposed to be actively engaged in facilitating these group discussions and must ensure that individuals from marginalized groups with the same disease condition are supported to become part of these groups. Inter-sectoral converge is one of the important tools for awareness and coordination with different departments can also help in control of various other diseases in the area. Further, there is a need to identify a pool of local Yoga Instructors at the HWC level. These could be an ASHA, ASHA Facilitator, Physical Instructor from village school, representatives from VHSNC, or other NGO groups active in community.

Table 3.11: Details of Health Promotion and Prevention Activities for Wellness in J&K									
		Type of Facility							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Health Promotion and Prevention Activities for Wellness	None	5	36%	4	67%	1	20%	2	40%
	Yes	8	57%	1	17%	0	0%	3	60%
	No	1	7%	1	17%	4	80%	0	0%
Number of Patient Support Groups Formed	0	7	50%	5	83%	5	100%	2	40%
	1	6	43%	1	17%	0	0%	0	0%
	2 or more	1	7%	0	0%	0	0%	3	60%
Patient Support Group Meetings Conducted	None	0	0%	0	0%	2	40%	0	0%
	Yes	7	50%	1	17%	0	0%	3	100%
	No	7	50%	5	83%	3	60%	0	0%
Awareness Camps for Life Style Modification	None	1	7%	0	0%	0	0%	0	0%
	Yes	13	93%	6	100%	5	100%	5	100%
Vector Control Activities	None	1	7%	0	0%	0	0%	0	0%
	Yes	13	93%	6	100%	4	80%	5	100%
	No	0	0%	0	0%	1	20%	0	0%
Sanitation Drive/Outbreak prevention activities conducted	Yes	13	93%	6	100%	5	100%	5	100%
	No	1	7%	0	0%	0	0%	0	0%
Yoga/physical exercise sessions conducted	None	1	7%	0	0%	0	0%	0	0%
	Yes	9	64%	3	50%	0	0%	1	20%
	No	4	29%	3	50%	5	100%	4	80%
Details of sessions	None	1	7%	1	17%	3	60%	1	20%
	once a week	5	36%	0	0%	0	0%	1	20%
	sometimes	3	21%	3	50%	0	0%	0	0%
	No Space	2	14%	2	33%	2	40%	3	60%
	New HWC	3	21%	0	0%	0	0%	0	0%
Involvement of HWC-PHC/SHC staff in VHSNC meetings	Yes	14	100%	6	100%	5	100%	5	100%
Total		**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

The information collected on various promotional activities being carried-out by selected HWCs shows that 36 percent SC-HWC, two-third among PHCs, 40 percent among 24X7 PHCs, and 20 percent UPHC-HWCs have not so far carried-out any activity for health promotional and prevention activities for wellness. Further, the data collected shows that most of SC-HWCs have formed one or more than one patient support group in their area but only half of them have conducted any meeting of PSG till date. Similarly, in case of 24X7 PHC-HWCs, 60 percent of them

have formed patient support groups and have also conducted meetings with them. Information collected from the selected HWCs about other activities carried-out by them shows that almost all of them have organised awareness camps for life style modification, sanitation drives, outbreak prevention activities in their respective areas.

The data collected from the selected HWCs on the sessions conducted for yoga/physical exercise shows that out of selected SC-HWC, about two-third of them have started these sessions while in case of PHC-HWCs, only half of them have conducted yoga sessions and in case of 24X7 PHC-HWCs only 20 percent have started such sessions in their respective facilities/area. The information on the frequency of conducting these sessions vary from "once a week" to "sometimes only" across the districts but it was observed that such sessions hardly take place in selected HWCs. In fact, a sizable number of HWCs reported that such session at their facility was conducted only on the World Yoga Day. Further, it was also found that most of SC-HWCs do not have any space for such type of activities but some MLHPs reported that they have conducted few yoga sessions at panchayat house and few it was conducted in open space during summers. There is a good coordination between the staff of HWCs and the VHSNC and the staff also attend their meetings on regular basis. The facility type-wise information is given above in table 3.11.

Reports on Service Delivery

All the health facilities including HWCs are supposed to report on service delivery of essential package of services which they provide in their respective health facilities. in this regard, there are a number of portals which have been developed by the ministry for uploading the data (work done) either on monthly or daily basis. These portals include, HMIS portal where the data is updated on monthly basis on a large number of indicators and pertains to facility-based data, RCH portal is to be updated on daily basis and contains area-based data. Similarly, there are other portals for different programmes being run by the government which include CPCH-NCD application, HWC portal, Nikshay, ANMOL, E-Hospital, Rathkosh etc. All these portals are being used for analysis of data and besides, MoHFW, various other ministries, NITI Ayoug, and PMO use this data for policy making and planning. The data uploading also varies from individual level to the state level. In the UT of Jammu and Kashmir data on various portals is uploaded by blocks or districts and in some cases, facilities also upload their data on the relevant portals. The latest additions in this regard are the HWC portal and CPHC-NCD portals. The information in this regard collected from the selected HWCs shows that HMIS formats are filled-up by the health facilities on monthly basis and are sent to BPMU for uploading it on the portal while as RCH registers are updated manually on the facilities on daily basis and later sent to BPMU for uploading. CPHC-NCD and HWC data is being uploaded by the concerned facilities (presently in offline mode wherever the tabs have been given as the internet facility was shut in the UT since 5th August, 2019). The information collected shows that about 30 percent SC-HWCs are uploading data on various portals at the facility level while as about two-third of them do it manually and send it to the concerned BPMU for uploading the data on the concerned portal. Similarly, half of the selected PHC-HWCs upload the data at the facility while as 40 percent UPHCC and 60 percent 24X7 PHC-HWCs also upload the data on various portals at the facility level.

Table 3.12: Details of Reporting on Service Delivery by Selected HWCs in J&K									
		Type of Facility							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Report on Service Delivery for Essential Package of Services	Yes	4	29%	3	50%	2	40%	3	60%
	Manual	10	71%	3	50%	3	60%	2	40%
Total Lab Investigations Conducted in current financial year as on date	< 1000	11	79%	3	50%	3	60%	1	20%
	1000-2000	3	21%	1	17%	1	20%	0	0%
	2001-5000	0	0%	1	17%	0	0%	1	20%
	5001-7000	0	0%	0	0%	0	0%	0	0%
	7001-10000	0	0%	1	17%	0	0%	0	0%
	10001-15000	0	0%	0	0%	0	0%	0	0%
	15001-20000	0	0%	0	0%	1	20%	0	0%
	> 20000	0	0%	0	0%	0	0%	3	60%
Average Monthly Investigations conducted	< 100	11	79%	4	67%	3	60%	1	20%
	100-300	3	21%	1	17%	1	20%	1	20%
	301-500	0	0%	1	17%	0	0%	1	20%
	501-700	0	0%	0	0%	0	0%	0	0%
	701-1000	0	0%	0	0%	0	0%	0	0%
	1001-1500	0	0%	0	0%	0	0%	1	20%
	1501-2000	0	0%	0	0%	0	0%	0	0%
	> 2000	0	0%	0	0%	1	20%	1	20%
patients suffering from chronic illnesses provided at least one- month refill of medicines	For 1 week	3	21%	2	33%	1	20%	1	20%
	For 10 Days	8	57%	4	67%	2	40%	3	60%
	For 15 Days	3	21%	0	0%	2	40%	1	20%
	Total	**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

As already mentioned above, the HWC should have the capacity to deliver a minimum range of basic diagnostics and screening capabilities for conditions that are mandated to be screened/treated at this level. Diagnostic services as per the Guidelines for National Free Diagnostic Initiative need to be available at HWC (SHC-7 and PHC-19 investigations). There is a plethora of diagnostics, several of them are "point of care" that are currently available. However, the choice of those that need to be included should be taken after validation and Health Technology Assessment (HTA). On completion of HTA, states can consider use of the innovative diagnostics solutions from those empanelled through Government E-Market Place. With regards to the diagnostic services at the HWC, the primary objective is to minimize the movement of the patient and improve the timeliness of reporting. This can be achieved by following the hub and spoke model by creating the hub (Central Diagnostic Unit) at CHC or block level PHC for 20-30 HWCs, depending on the distance and population served. State will need to define context specific protocols for peripheral collection of samples from HWCs. At the level of PHC- HWC, availability of diagnostics and medicine would be ensured as per the existing IPHS and Essential Medicine List PHC. In this background, it was observed that in the UT of Jammu and Kashmir

testing facility at the level of PHC/UPHC/24X7 PHC is better than various other states of the country. The information collected on total number of lab tests conducted by various HWCs in the current financial year shows that in selected SC-HWCs, 80 percent have done around 1000 or less than that which means that they have conducted less than 100 lab investigations on monthly basis. The data collected further shows that most of the 24X7 PHC-HWCs have conducted between 15000-20000 diagnostic test during the same period while as majority of PHC and UPHC-HWCs have conducted up to 3000 diagnostic tests in the current financial year. None of the selected HWC has been able to provide at least one-month refill of medicines to those patients who are suffering from chronic illnesses. Very few HWCs have been able to provide medicines to such patients for a maximum of 15 days. The major reason behind this scenario was the inadequate supply of medicines for such ailments by the authorities. However, it was observed that the choice of medicines was also not satisfactory for a sizable number of patients in some selected HWCs. Table 3.12

Programme Management Functions

The basic unit for success of any programme is always dependent on programme management functions. Robust and effective management strategies need to be adopted to facilitate among other things, re-organization of health care services, and intersectoral convergence. Since the CPHC approach relies primarily on integration of existing service delivery structures of various programme components under the NHM and intersectoral convergence, it is important that the nodal officers of different programmes need to work in a coordinated manner. The designated programme management team at state and district level would be responsible for overall monitoring and supervision of the HWCs. Clinical care provision would include coordinating for care/ case management for chronic illnesses based on the diagnosis and treatment plan made by the Medical Officer/specialists who will initiate treatment for chronic diseases, dispense drugs as per standing orders by the medical officer. Such coordination needs to be facilitated through processes such as telehealth. MLHP is supposed to coordinate, support and supervise the collection of population-based data by frontline workers, collate and analyse data for planning and report the data to the next level in an accurate and timely fashion. Use HWC and population data to understand key causes of mortality, morbidity in the community and work with the team to develop a local action plan with measurable targets, including a particular focus on vulnerable communities. Coordinate and lead local response to diseases outbreaks, emergencies and disaster situations and support the medical team or joint investigation teams for disease outbreaks. MLHP is also supposed to support the team of MPWs and ASHAs on their tasks, including on the job mentoring, support and supervision and undertaking the monitoring, management, reporting and administrative functions of the HWC. The MOs of the referral health facilities are supposed to be in touch with the SC-HWC team for management of the patients. MO is also supposed to have frequent meetings with the MLHP to coordinate and manage various issues pertaining to HWCs and resolve them. Hence, CPHC imitative needs to be team effort at the primary care level health facilities to resolve issues in a time bound manner and avoid any unnecessary trouble to the patients.

Table 3.13: Details of Programme Management Functions of Selected HWCs in J&K									
		Type of Facility							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
Monthly Meetings Held	Yes	11	79%	4	67%	2	40%	5	100%
	No	3	21%	2	33%	3	60%	0	0%
Meetings with Frontline Functionaries Team organized every month at SHC-HWC	Yes	13	93%						
	No	1	7%						
Meetings with Frontline Functionaries Team organized every month at the SHC-HWC	On overall activities of H&WC	11	84%						
	Progress on NCD activities	2	16%						
At SHC-HWC MLHP discuss, resolve issues and support MPWs/ ASHAs to improve se	Yes	12	92%						
	No	1	8%						
Meetings with Frontline Functionaries and SHC Team organized every month at the PHC-HWC	Yes	11	92%	5	100%	3	60%	5	100%
	No	1	8%	0	0%	0	0%	0	0%
	Some Times	0	0%	0	0%	2	40%	0	0%
Agenda/Purpose of the meetings	On overall activities	12	100%	5	100%	3	60%	5	100%
	DK	0	0%	0	0%	2	40%	0	0%
At PHC-HWC are trainings on technical sessions conducted by MO during meeting	Yes	7	50%	3	50%	2	40%	5	100%
	No	7	50%	3	50%	3	60%	0	0%
MO using this forum to discuss, resolve issues and support MPWs/ ASHAs to improve coverage of services	Yes	8	57%	3	50%	2	40%	5	100%
	No	3	21%	3	50%	3	60%	0	0%
	Some Times	3	21%	0	0%	0	0%	0	0%
	Total	**14**	**100%**	**6**	**100%**	**5**	**100%**	**5**	**100%**

In this background a set of questions were asked to all the visited HWCs to know as to what extent the programme management units are functioning to improve the quality of working of HWCs. The data collected from the selected HWCs shows that about 80 percent SC-HWCs organise monthly meetings regularly while in case of PHC-HWC, only 67 percent such HWCs have organised the monthly meeting. Further, the information collected that all the 24X7 PHC-HWCs, organise monthly meetings on regular basis while as at UPHC level only 40 percent such health

facilities are organizing these meetings. The monthly meeting with frontline functionaries at SC-HWC is a regular feature and all (except one new HWC) SC-HWCs have organised such meetings and of the HWCs (84 percent) discuss the overall activities of their facilities. Such meetings are also regularly organised by PHC, UPHC, and 24X7 PHC-HWCs and mostly discuss the overall functioning of their health facilities. At PHC-HWC level meetings some MOs also conduct technical sessions for trainings as was reported by the various facilities but it was observed that PHC level HWCs have not yet taken the concept of HWC seriously and as such no proper attention as per the guidelines is being given on the working of HWCs. It was further observed that only at 24X7 level PHCs (out these, some are block headquarters), the concerned BMO were found actively involved with the establishment, upgradation and working of HWCs and use their good-offices to facilitate and extend all help to the core staff of SC-HWC in their respective areas. Table 3.13

Management of Untied Funds

Under NHM all the health facilities are entitled to get untied funds for the overall development of health facilities in terms of infrastructure, equipment, medicines, and other necessary renovations.

Table 3.14: Details of Management of Untied Funds of Selected HWCs in J&K

*Multiple Response		Type of Facility							
		SHC		PHC		UPHC		24X7 PHC	
		No	%	No	%	No	%	No	%
UF received in last year	Yes	12	86%	4	67%	5	100	5	100
	No	2	14%	2	33%	0	0%	0	0%
*Activities for which untied fund was spent	Medicine/Equipment/Reagent	2	14%	0	0%	0	0%	0	0%
	Renovation of Facility	1	7%	1	17%	0	0%	0	0%
	Infrastructure	7	50%	1	17%	3	60%	2	40%
	Need Based Activities	2	14%	2	33%	2	40%	3	60%
	Account Freeze	2	14%	2	34%	0	0%	0	0%
*Procedure followed for decision about untied fund expenditure	Approved by Facility	3	21%	0	0%	0	0%	0	0%
	Approved by RKS	0	0%	1	17%	3	60%	4	80%
	Approved by BMO	2	14%	0	0%	2	40%	0	0%
	Approved by VHSC and HWC	6	43%	1	17%	0	0%	1	20%
	Others	2	14%	2	33%	0	0%	0	0%
	Purchase Committee	1	7%	2	33%	0	0%	0	0%
Signing authority	BMO/ZMO	2	14%	1	20%	4	80%	3	60%
	Both MPW and Village Head	11	79%	1	20%	0	0%	0	0%
	Incharge MO	1	7%	3	60%	1	20%	2	40%
Involvement of SHC-HWC team	Yes	14	100	5	83%	3	60%	5	100
	No	0	0%	1	17%	0	0%	0	0%
	Some Times	0	0%	0	0%	2	40%	0	0%
Total		**14**	**100**	**6**	**100**	**5**	**100**	**5**	**100**

In order to know as to how the HWCs manage these funds some questions were asked to all the selected HWCs and in this regard the information collected shows that 86 percent SC-HWCs have

received united funds during the last year as two selected HWCs have not received the same due to the fact that their account was blocked for some reason. Similarly, one-third of PHC-HWCs had not received untied funds during the same year while as all the UPHC and 24X7 PHC-HWCs have received untied funds during the last year. Most of these selected HWCs reported that they use these funds for various activities which include renovation of facility, acquiring drugs, equipment and reagents, etc. The decision on expenditures at PHC level HWCs is mostly made by the concerned RKS while as in case of SC-HWCs such decisions are made by the team of the health facility or by the concerned BMO. The details about the management of untied funds received by the selected HWCs during the last year is given above in table 3.14.

4. PERSPECTIVE OF ASHAs/MPWs/MLHPs/OPD PATIENTs AND COMMUNITY

Perspective of Selected ASHAs

Overall a total of 39 ASHAs working in various HWCs at different levels like SHC, PHC, UPHC and 24x7 PHCs in the five selected districts of Jammu and Kashmir were contacted during our field work to know their perception about the establishment of HWCs and the impact on their job profile. In order to ascertain their views a set of questions were canvassed to them which were framed by the Ministry of Health and Family Welfare to collect the information regarding the type of change felt by them after the facility started working as H&WC. An effort was made to interview at least one-two ASHAs from each selected HWC in all the five districts of the UT of Jammu and Kashmir. The information was sought on their perception for service delivery, posting of MLHPs and benefits to the community as a whole. Multiple responses were recorded for most of the questions that were asked to ASHAs. The information collected from the selected ASHAs shows that all the ASHAs irrespective of their place of posting in all the five districts opined that their workload has increased. In Jammu district 39 percent ASHAs said that their interaction with people has increased followed by Srinagar district (22 percent). The response in this regard was less than 20 percent for three other districts. The additional training received on NCD was reported by 46 percent ASHAs in Jammu district followed by 31 percent in Srinagar and 15 percent in Udhampur. However, none of ASHAs in Baramulla reported that they had received any training on NCD though the district authorities maintained that a 3-5-day training on population-based screening on NCDs was given to most of ASHAs. Further the information collected shows that one-half of the ASHAs in Jammu and about one-third in Srinagar revealed that they expect to get more incentives and such response was almost negligible in other three districts. All the ASHAs posted at SC-HWCs opined that people are happy with the posting of MLHPs as they get consultation facility at local level for the first time by a doctor on various health issues including NCD on daily basis.

The information was also sought from the ASHAs working at selected HWCs regarding the posting of MLHPs at SC-HWCs and its impact on their routine work. The information collected in this regard shows that most of the ASHAs were of the opinion that there is a remarkable increase in OPD footfall at their respective health facilities and this was substantiated by the fact that around one-half (47 percent) of the ASHAs in Jammu, 21 percent in Srinagar and 16 percent each in Udhampur and Baramulla districts said that OPD footfall has increased after their SC was

upgraded to HWC. A large percentage of ASHAs in Jammu district (about two-third of ASHAs) opined that people are happy with the introduction of MLHPs at Sub centre level; however, this percentage was around 10-20 percent in other districts. The ASHAs reported that they are getting positive help form MLHPs to maintain their day to day record and sharing of workload in a better way. The information collected in this regard shows that more than two-third of ASHAs in in Jammu district and one-third in Srinagar, in this regard responded in affirmative. The information further reveals that working for NCD screening and treatment has increased manifold due to introduction of MLHPs. Eighty-three percent ASHAs in Jammu and 17 percent in Udhampur backed that the increase in NCD working. Table 4.1 to 4.3

The ASHAs were further asked to report about the type of benefits availed by beneficiaries with the introduction of HWCs and in this regard multiple responses were recorded from ASHAs. From all the five districts, ASHAs opined that getting a trained doctor at the lower health facility has benefited the society in the form of MOs or MLHPs. In this regard 37 percent ASHAs from Jammu, 21 percent each from Srinagar and Baramulla and 16 percent from Udhampur district attributed the benefit introduction of HWCs to the society. Other benefits to the society mentioned by ASHAs include their NCD screening and availability of testing facility for NCDs. The benefit of referrals was backed by 31 percent ASHAs in Jammu, 23 percent in Srinagar and 15 percent each in Anantnag, Baramulla and Udhampur districts.

During our informal discussions with ASHAs, it was found that a large number of ASHAs have been trained for Population Based Screening on NCDs but their comprehension was not up to mark and could not answer few simple queries which we tried to clarify from them. This can mainly be attributed to the quality of training imparted to them. Secondly, it was also found that a large number of ASHAs are underqualified and have not been able to fill the CBAC forms in their respective areas and in this regard some ASHAs told us that they took help of their qualified kin to fill-up these forms and still have not been paid any incentive for this exercise. During our group discussion the ASHAs revealed their views as "We had lost our credibility in the society due to many reasons like non availability of staff, lack of diagnostic facilities at most of the PHCs and SCs. Now after the establishment of HWCs our acceptance in society has improved due to posting of more staff, screening for NCD, availability of drugs, testing facility and posting of MLHPs at SC level. Now the people are experiencing positive changes in service delivery, therefore, HWCs should be further strengthened." In some of the health facilities there is shortage of ASHAs, Therefore, some of the ASHAs reported that they are supposed to cover more population than the permissible quota especially in urban areas, and hence not able to do justice with their duties. At some places ASHAs revealed that they have completed survey in their respective areas and filled almost 80-90 percent CBAC forms, but no incentive has been released in their favour so far. ASHAs at UPHC/24x7 PHC-HWCs expressed that more doctors are now available from different disciplines on selected days during a month at the facility, which has definitely improved the service delivery in their respective health facilities.

Table 4.1: Perspective of ASHAs Regarding HWCs in J&K										
Type of Change after this facility became HWC * Multiple Response	**Name of District**									
	Srinagar		**Jammu**		**Udhampur**		**Anantnag**		**Baramulla**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Workload increased	3	23%	3	23%	3	23%	1	8%	3	23%
More Interaction with People	5	22%	9	39%	3	13%	2	9%	4	17%
People Responding more	3	33%	3	23%	3	23%	2	15%	4	31%
NCD training received	4	31%	6	46%	2	15%	1	8%	0	0%
Incentives on for working more	3	30%	5	50%	1	10%	1	10%	0	0%
People Happy For getting MLHP	4	31%	6	46%	1	8%	0	0%	2	15%
Total	**9**	**23%**	**14**	**36%**	**6**	**15%**	**3**	**8%**	**7**	**18%**

Table 4.2: Perspective of ASHAs Regarding HWCs in J&K										
Posting of MLHP at H&WC affected your work *Multiple Res	**Name of District**									
	Srinagar		**Jammu**		**Udhampur**		**Anantnag**		**Baramulla**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Increased OPD Footfall	4	21%	9	47%	3	16%	0	0%	3	16%
People are Happy	1	10%	6	60%	1	10%	0	0%	2	20%
Increase in Workload	1	100%	0	0%	0	0%	0	0%	0	0%
Working for NCD	0	0%	5	83%	1	17%	0	0%	0	0%
Facility renovated and space created	1	13%	2	25%	2	25%	0	0%	3	38%
Sharing of workload in better way	1	33%	2	67%	0	0%	0	0%	0	0%
Total	**9**	**23%**	**14**	**36%**	**6**	**15%**	**3**	**8%**	**7**	**18%**

Table 4.3: Perspective of ASHAs Regarding HWCs in J&K										
Benefits of H&WC to Community Multiple Response	**Name of District**									
	Srinagar		**Jammu**		**Udhampur**		**Anantnag**		**Baramulla**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Getting Trained doctor at doorstep	4	21%	7	37%	3	16%	1	5%	4	21%
Getting some Tests for NCD	4	27%	6	40%	3	20%	1	7%	1	7%
Screened for NCDs	6	22%	10	37%	5	19%	2	7%	4	15%
Getting More Medicines	5	20%	10	40%	4	16%	1	4%	5	20%
Getting Referral to higher facilities	3	23%	4	31%	2	15%	2	15%	2	15%
Total	**9**	**23%**	**14**	**36%**	**6**	**15%**	**3**	**8%**	**7**	**18%**

Perspective of selected MPWs/ANMs

In order to extract the information from MPWs from the selected HWCs, at total of 25 MPWs were contacted during our field visits and information was sought from them on various types of changes observed at different health facilities since the introduction of HWCs in Jammu and Kashmir. All the questions were asked to all the contacted MPWs irrespective of their place of

posting. Most of the MPWs posted at UPHCs and 24x7 PHCs were of the opinion that no major change has been witnessed at these facilities after the introduction of HWCs in terms of manpower. However, branding in terms of painting and construction/renovation of washrooms has been done at these higher-level health HWCs. It was also reported that additional supplies of medicines especially for NCDs have been provided to these facilities but the supply does not fully match with the demand created at these health facilities. However, during our field visits an improvement was observed in terms of manpower, infrastructure, diagnostic facility, availability of drugs and NCD screening, in at least SC/PHC-HWC level in all the selected districts.

Further, the data collected about the views of MPWs regarding the changes felt by them after these centres who were converted in HWCs. Shows that the workload of MPWs working at HWCs has increased in terms of OPD patients, ANC, immunization, NCD screening and field work. The information collected shows that 38 percent MPWs each in Jammu and Baramulla districts followed by 13 percent each in Srinagar and Udhampur districts opined that their work load has increased. It was also reported by all the selected MPWs that their interaction with people (especially local population) has increased significantly as more health care facilities are available now at HWCs. Overall training for population-based screening on NCDs was given to all the MPWs and as such most of them have received this training ranging from 2-3 days. However, the quality of training was reported as poor by all the MPWs. It was further revealed by MPWs that posting of MLHPs at SC-HWC level has brought a feeling of hope in people for better service delivery. It was opined by all the MPWs that they have not so far received any incentives for HWC related work as is envisaged in the guidelines.

All the MPWs in the selected districts irrespective of their place of posting defended the posting of MLHPs at HWCs as a positive step. They were of the opinion that the work-culture has changed and improved after the introduction of HWCs. Forty percent MPWs in Jammu opined that OPD footfall has increased, followed by 20 percent each in Srinagar, Udhampur and Baramulla districts. Similarly, working for NCD and increase in workload was also felt by all the MPWs. Further, all the MPWs revealed that all the HWCs have been renovated in terms of branding and toilet facility for male and female have been almost provided at all the HWCs.

The benefits of HWCs to community were also discussed with MPWs of selected HWCs and in response to this, the benefits revealed by MPWs was availability of MOs and MLHPs at the designated health facilities which has facilitated screening for NCDs, enhanced diagnostic facility, availability of medicine and referral facility for the needy patients at their doorstep. In this regard 39 percent MPWs in Jammu said that they got a trained MO/MLHP at the health facility. Similarly, 33 percent each from Srinagar, Udhampur and Baramulla said people get screening facility. The referral facility has also helped the people but in most of the PHCs due to non-availability of MOs, people face lot of difficulties. There are also some of the PHCs where the laboratory facility is not available. *It was further observed during our visit to PHC/UPHC-HWCs that MOs were found least concerned about the activities as per the HWC guidelines and as such were found busy with their routine work. Further, it was found that the connect between the MOs of PHCs and MLHP was also missing. Table 4.4 to 4.6*

Table 4.4: Perspective of MPWs Regarding HWCs in J&K										
Type of Change after facility Made HWC (*Multiple Response)	**Name of District**									
	Srinagar		**Jammu**		**Udhampur**		**Anantnag**		**Baramulla**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
SHC	4	29%	4	29%	3	21%	0	0%	3	21%
PHC	0	0%	5	50%	2	20%	0	0%	3	30%
UPHC	1	100%	0	0%	0	0%	0	0%	0	0%
24X7 PHC	0	0%	0	0%	0	0%	0	0%	0	0%
Total	5	20%	9	36%	5	20%	0	0%	6	24%
Workload increased	1	13%	3	38%	1	13%	0	0%	3	38%
More Interaction with People	4	29%	4	29%	4	29%	0	0%	2	14%
NCD training received	3	21%	5	36%	4	29%	0	0%	2	14%
Incentives on work	0	0%	1	100%	0	0%	0	0%	0	0%
People Happy For getting MLHP	3	21%	6	43%	2	14%	0	0%	3	21%
Total	**5**	**20%**	**9**	**36%**	**5**	**20%**	**0**	**0%**	**6**	**24%**

Table 4.5: Perspective of MPWs Regarding HWCs in J&K											
***(Multiple Response)**		**Name of District**									
		Srinagar		**Jammu**		**Udhampur**		**Anantnag**		**Baramulla**	
		No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Posting of MLHP at H&WC	Yes	3	23%	4	31%	3	23%	0	0%	3	23%
	Not Applicable	2	20%	5	50%	2	20%	0	0%	1	10%
*Posting of MLHP at H&WC affected your work	Increased OPD Footfall	2	20%	4	40%	2	20%	0	0%	2	20%
	People are Happy	1	50%	0	0%	0	0%	0	0%	1	50%
	Increase in Workload	1	25%	1	25%	1	25%	0	0%	1	25%
	Working for NCD	1	20%	2	40%	1	20%	0	0%	1	20%
	Health Facility renovated	3	27%	3	27%	2	18%	0	0%	3	27%
Total		**5**	**20%**	**9**	**36%**	**5**	**20%**	**0**	**0%**	**6**	**24%**

Table 4.6: Perspective of MPWs Regarding HWCs in J&K											
Benefits of H&WC to Community (Multiple Response)		**Name of District**									
		Srinagar		**Jammu**		**Udhampur**		**Anantnag**		**Baramulla**	
		No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Getting a Trained doctor		4	17%	9	39%	4	17%	0	0%	6	26%
Tests for NCD		1	50%	0	0%	1	50%	0	0%	0	0%
Screened for NCDs		1	33%	0	0%	1	33%	0	0%	1	33%
Getting More Medicines		1	14%	1	14%	2	29%	0	0%	3	43%
Getting Referral		3	30%	1	10%	3	30%	0	0%	3	30%
Total		**5**	**20%**	**9**	**36%**	**5**	**20%**	**0**	**0%**	**6**	**24%**

While talking to MPWs/ANMs during our group discussion these health workers revealed that now medicines and diagnostic facilities are available for diabetic and hypertensive patients, both at PHC and SC level HWCs, and are able to provide some free tests, medicines for diabetic and hypertensive patients at least for 10 days to such patients but still we are not able to provide them the quantity of medicines as per the guidelines. Majority of MPWs were of the view that Infrastructure has upgraded at some places in terms of fresh furniture, branding of building, construction/repairment of wash rooms etc. but at most of the SC-HWCs still have space constraint. They further added that poor and elderly people are benefited after the introduction of HWCs, they are getting treatment at their doorstep and are able to save time and money. They also mentioned that people had to go to district hospitals for minor ailments, now this scenario is changing steadily. Some of the MPWs expressed their views during these discussions on some of the problems which they face which include lack of staff under NHM, as some of the designated HWCs were not provided recommended staff as per norms. Further, a major issue which was brought in to our notice by almost all the MPWs in different districts that they are being put on night duties at least for four nights in a month at CHC, 24X7 PHCs and thus are not able to perform their duties at HWCs as per norms.

Perspective of Selected MLHPs

All the MLHPs posted at various SHCs in the selected districts were contacted and information was sought on various issues, like their experience of serving at HWCs, receiving support from MOs at PHC level and block level, cooperation from frontline health functionaries and receipt of performance-based incentives. In this regard multiple responses were collected from the selected MLHPs. The information collected in this regard shows that their experience of serving at SHCs is very good and were of the view that "this is the best way of serving people at grass root level". Regarding mentoring support from PHC level MOs, MLHPs posted in district Srinagar mentioned it as satisfactory. However, MLHPs from other districts like Jammu, Udhampur and Baramulla gave a mixed response as satisfactory or highly satisfactory. The information sought on cooperation from front line workers by MLHPs depict that majority of them were highly satisfied or satisfied in gaining support for their activities at their respective health facility. None of the MLHPS had received any performance-based incentives in any of the selected districts for any activity. Table 4.7 *It was observed that all the MLHPs were found extremely unhappy as they have not received any incentives as is envisaged in the guidelines. It was further observed that the non-receipt of incentives has brought down the level of enthusiasm among the majority of MLHPs.*

During our discussions with the selected MLHPs they were of the view that people are now able to get at least screened for NCDs, get diagnostic facility and medicines at SHC level otherwise they had to go to higher level/private facilities for the treatment. Now the elderly and poor people are able to save their time and money and get treatment at their doorstep. Regarding the problems, they are facing included data entry and reporting difficulties from as per norms as most of the HWCs/MPWs have not been provided Tablets and none of the ASHAs have been given smart phone. In addition to this, the non-availability of internet facility has added to the miseries. Although, some of the FMPHW and MLHPs received some Tabs, were not able upload their data

due to non-availability or poor network connectivity after August 2019. They further added that they fail to understand as to why the government is not releasing their performance-based incentives. They were also of the opinion that further trainings should be imparted to all the stakeholders for HWCs. Some MLHPs with degree in AYUSH were of the view that they should be allowed to prescribe AYUSH drugs and be allowed to treat patients who come to their HWCs as they hold the degree and have also undergone 6 months' additional course before they were appointed at HWCs. During our discussions with MLHPs and few doctors it was found that limited supply of essential drugs is an issue with these HWCs as only few limited drugs for NCDs which include Amlodipine, Telmisartan, Metformin, and Glimepiride, were available with them. Multi-drug choice for chronic patients was also found missing in most of the SC level HWCs.

Table 4.7: Perspective of MLHPs Regarding HWCs in J&K

		Name of District									
		Srinagar		Jammu		Udhampur		Anantnag		Baramulla	
		No	%	No	%	No	%	No	%	No	%
Experience of Serving H&WC	Very Good	1	17%	2	33%	2	33%	0	0%	1	17%
	Best way to Serve people	1	17%	2	33%	1	17%	0	0%	2	33%
Mentoring Support from PHC Mo/Block	Satisfactory	2	33%	2	33%	1	17%	0	0%	1	17%
	Highly Satisfactory	0	0%	2	40%	1	20%	0	0%	2	40%
	Cannot Say yet	0	0%	1	50%	1	50%	0	0%	0	0%
Cooperation from Frontline Functionaries	Satisfactory	1	14%	3	43%	2	29%	0	0%	1	14%
	Highly Satisfactory	1	25%	2	50%	1	25%	0	0%	0	0%
	Can't Say yet	0	0%	0	0%	0	0%	0	0%	2	100%
Received Incentives	No	2	15%	5	38%	3	23%	0	0%	3	23%
Total		**2**	**15%**	**5**	**38%**	**3**	**23%**	**0**	**0%**	**3**	**23%**

Perspective of OPD Patients

During our field visits to various HWCs in all the five selected districts of Jammu and Kashmir a total of forty-six patients were interviewed who attended the OPD on the day of our visit for availing various health services. The objective was to know the type of service which they availed and their perception on the type and quality of services being given to them. Multiple responses were received from patients. The information collected in this regard shows that more than one-half (54 percent) of the patients contacted from Baramulla district and 46 percent each from Srinagar and Jammu districts had visited the HWC for availing ANC and child immunization related services. All the respondents opined that they got the services easily from these facilities. Most of the patients from Srinagar and Jammu district who attended the OPDs at the H&WCs was related to NCD services (both screening and receipt of drugs for diabetes and hypertension). It was healthy to note that all the patients reported that they got the required services from selected HWCs. The visited patients were also asked to report whether they were referred to higher facilities when they visited these centers. More than two third of the patients were treated at their respective health facilities while as 28 percent each were referred to other

facilities from Jammu and Baramulla districts followed by 21 percent and 15 percent from Srinagar and Udhampur.

Table 4.8: Perspective of OPD Patients Regarding HWCs in J&K											
		Name of District									
		Srinagar		Jammu		Udhampur		Anantnag		Baramulla	
		No	%	No	%	No	%	No	%	No	%
Type of Facility	SHC	7	30%	7	30%	4	17%	0	0%	5	22%
	PHC	0	0%	7	37%	3	16%	3	16%	6	32%
	UPHC	4	100	0	0%	0	0%	0	0%	0	0%
	24X7 PHC	0	0%	0	0%	0	0%	0	0%	0	0%
Your health complaint for which you visited HWC	ANC Related	2	15%	4	31%	2	15%	1	8%	4	31%
	Child immunization	4	31%	2	15%	3	23%	1	8%	3	23%
	Self-Sick	3	30%	2	20%	1	10%	1	10%	3	30%
	Child Sick	0	0%	2	67%	1	33%	0	0%	0	0%
	NCD Related	2	40%	3	60%	0	0%	0	0%	0	0%
	NCD Drugs	0	0%	1	50%	0	0%	0	0%	1	50%
Treatment received for your complaint	ANC service Received	2	15%	4	31%	2	15%	1	8%	4	31%
	Child Immunized	4	31%	2	15%	3	23%	1	8%	3	23%
	Treatment for Sickness	3	30%	2	20%	1	10%	1	10%	3	30%
	Treatment of Child Sickness	0	0%	2	67%	1	33%	0	0%	0	0%
	Screened for NCDs	2	40%	3	60%	0	0%	0	0%	0	0%
	Got Drugs for NCD	0	0%	1	50%	0	0%	0	0%	1	50%
Referred to any other facility for further treatment	Yes	0	0%	2	67%	1	33%	0	0%	0	0%
	No	8	21%	11	28%	6	15%	3	8%	11	28%
	Not Needed	3	75%	1	25%	0	0%	0	0%	0	0%
Pay for any service at HWC	Yes	2	25%	1	13%	0	0%	3	38%	2	25%
	No	9	24%	13	34%	7	18%	0	0%	9	24%
Distance to facility from your residence	Same village	10	33%	7	23%	3	10%	1	3%	9	30%
	Other Village	1	6%	7	44%	4	25%	2	13%	2	13%
Is there any change in the services delivered at HWC	Yes	11	24%	13	29%	7	16%	3	7%	11	24%
	No	0	0%	1	100	0	0%	0	0%	0	0%
Informed about services available	Yes	9	20%	14	32%	7	16%	3	7%	11	25%
	No	2	100	0	0%	0	0%	0	0%	0	0%
Satisfied with behaviour of staff	Yes	11	24%	14	30%	7	15%	3	7%	11	24%
	No	0	0%	0	0%	0	0%	0	0%	0	0%
Satisfied with the treatment provided	Yes	7	20%	11	31%	5	14%	3	9%	9	26%
	No	4	36%	3	27%	2	18%	0	0%	2	18%
Total		**11**	**24%**	**14**	**30%**	**7**	**15%**	**3**	**7%**	**11**	**24%**

It was found that all the contacted service seekers reported in affirmative when they were asked about "whether they observed any change after these facilities were changed into H&WCs?" almost all the patients reported that they were informed about the additional facilities available at these health facilities. Further all the people who attended the health facilities were satisfied with the behavior of the health staff. However, most of the respondents were not fully satisfied with the type of treatment they received from these HWCs. The major cause of dissatisfaction was related to lack of testing facilities and non-availability of drugs especially at HSC and NTPHC level. Table 4.8

Perspective of Community/Community Leaders

In order to get some feedback from the community about the establishment of HWCs in their locality, placing of MLHPs at SC level HWCs, testing facilities, free medicines, increased outreach, screening of NCDs and other related issues, community group discussions and individual interview of community leaders were held at about 25 places that we visited. It was found that at SC level HWCs, the community participation, interest and faith has increased after upgrading these facilities. At some places group discussions were held with a large number of villagers and some healthy discussions were held with them. The common ailments in the respective areas that were brought in our notice, included, thyroid, orthopedic problems, neurological disorders, NCDs, common ailments and seasonal ailments. A majority of people in rural areas prefer to go to higher level facilities for treatment of various chronic diseases while as for common ailments and seasonal diseases, they prefer the local health facility.

For immunization of children and ANC registration almost all villagers get such facilities at their local SCs but for further investigations during ANCs, women go to CHCs, DHs, and other private clinics. ASHAs remain to be in limelight to most of the villagers as she has frequent contacts with the local population since HBNC was introduced and now for NCD screening and filling of CBAC forms. Since most of the community members were found aware of NCDs and a sizable number of them was also on medication for hypertension or diabetes and CVDs but now some were getting medicines from the local HWC but majority were of the view that they do not get the medicine from the HWC which the doctor has prescribed them as such supply of medicines was not available at these HWCs.

The information on Ayushman Bharat was not given to all the community members and some members were also complained that their name does not exist in the list of golden card holders though they were fulfilling the criteria. The community at most of the places has been informed about the services available at their respective HWCs through IEC material and by concerned health workers also. The perception of community about the existing services at HWCs in terms of OPD timings, availability of nurse/doctor/other staff, user charges, availability of medicines, lab investigations, behaviour of the staff were found satisfied but were of the view that there is a need for more inputs in terms of manpower, equipment, medicines and diagnostic facilities. VHSCs or MAS are formed in all the villages/urban slums but not much is being done to involve them for various activities and programmes which are being conducted by the NHM or health department.

5. CONCLUSION SUGGESTIONS AND RECOMMENDATIONS

Based on our analysis of the findings of this study, discussions with all the stakeholders including Nodal Officers, CMOs, BMOs, MOs, MPWs, MLHPs, ASHAs, OPD Patients, and Community Leaders during the field survey and on the basis of observations from the field, we suggest the following few points for policy makers and programme implementing agencies for further improvement in establishing HWCs so as to ensure quality Comprehensive Primary Health Care (CPHC) to the targeted population in more effective manner.

The UT of Jammu and Kashmir is doing its best to make this noble programme a success at all levels and has been able to move forward and has established a good number of HWCs operational with most of the inputs in place, though there are still some gaps at many levels in terms of branding, equipment, manpower, infrastructure, medicines, lab testing, trainings, monitoring and IT. The UT is in the process of shaping-up things in the right direction but still there is a long way to go in making these HWCs as the basic units of services for primary health care a reality. The UT of Jammu and Kashmir has always proved to be a role model for the rest of the country in implementing various national level programmes from time to time and have always achieved desired goals. Therefore, it is expected that UT will implement this programme with the same enthusiasm and vigor as has been done in the past, though the magnitude of this programme is huge and needs some good time to settle down. There is a huge gap between the number of proposed HWCs and operational HWCs across the UT, as till date (31st December, 2019), only 26 percent of the proposed HWCs have been made operational. On the other hand, UT has an ambitious plan of converting 680 health facilities (517 SCs, 151 PHCs, and 12 UPHCs) into HWCs by 31st March, 2020. Since there are various issues which the UT is confronted with, which include: Trained manpower of MLHPs is available in limited numbers and secondly rented buildings may be used to make more HWCs functional where the infrastructure and other related issues will be a huge challenge.

In order to provide CPHC through HWCs, it is important to have requisite manpower at various levels of primary health care facilities. But it was found that besides, MLHP and ASHAs, only 71 percent HWCs had two MPWs in position. Similarly, in case of PHCs, we could not find the requisite manpower as per the IPHS standards. None of the PHCs has been provided an additional SN for cervical cancer screening. Further, it was also brought into our notice at most of the HWCs that MPWs, SNs, MOs, and other staff is put on roster duties in various higher-level health facilities in their respective blocks and districts and thus obstructing the routine work of their HWCs. *It is therefore, suggested that all the staff of HWCs must be exempted from roster duties and the staff to these wellness centres should be provided as per the guidelines to make it a success story.*

UT has identified nodal officers at various levels and necessary orientation has also been given to them but their effectiveness at various levels was found missing. Similarly, about 250 MLHPs, 1000 MPWs, 3000 ASHAs, 150 SNs, and about 250 doctors have been trained for population based NCD screening but during our interaction with MPWs and ASHAs, it was found that the

quality of training was not satisfactory and has been compromised at some places and the protocols as per the guidelines in terms of trainers, their monitoring during training and duration of training has not been followed strictly. *Therefore, it is suggested to hire the services of some reputed experts for training and monitoring who can contribute in a better way and provide quality training to all the stakeholders.*

Filling of CBAC forms and population enumeration has also been initiated in a large number of HWCs across the UT, but it was found that the filling-up of CBAC forms was given independently to the ASHAs without keeping in view their educational qualifications and other limitations, as such activities need a coordinated effort by the team of each HWC team. *In this regard, all the MLHPs and MPWs need to be directed to coordinate such activities as a team so that quality out-puts can be gained.*

Besides, other normal work which include ANC services, immunization, FP services, care for minor ailments, VHNDs etc., all the HWCs have started some additional work which include identification and screening of suspected cases of NCDs, some additional lab tests, yoga sessions etc. but it was found that a very small percentage of population has been screened so far as the role of PHC and UPHC level HWCs was found to be limited and have not shown proactive approach. Overall, only about six percent of patients with hypertension, four percent each with diabetes and various cancers have been identified (which is very low as compared to various large-scale surveys have established) and put on medicines in the UT which shows that a lot more needs to be done. *It is suggested to reorient and refresh the staff of these HWCs to expedite the process of screening the population for various NCDs and provide them medicines and counselling so that the high level of mortality due to NCDs can be reduced by timely interventions.*

Infrastructure has been strengthened in most of HWCs by providing them equipment, furniture, furnishing, branding etc. in this regard, the UT has so far done a good job but effective monitoring mechanism for carrying-out such interventions in HWCs was found inadequate as in some HWCs such interventions were found either incomplete or not up to the mark. *It is therefore, suggested to constitute a taskforce of experts from diverse field which include engineers, doctors, and administrators to monitor and audit the quality of work executed in the above-mentioned areas in HWCs.* UT has approved the EML with some minor changes and have started supplying drugs to HWCs though the indenting of drugs to HWCs as per the list has been started recently but the it was observed that limited supply of essential drugs is an issue which these HWCs are facing as only few limited drugs for NCDs which include Amlodipine, Telmisartan, Metformin, and Glimepiride, were found available at most of the HWCs. Multi-drug choice for chronic patients was also found missing in most of the SC level HWCs thus giving little choice to old patients to get their drug supplies from HWCs. Due to limited supply of drugs, none of the HWC was in a position to give a one-month refill of drugs to any of the patients suffering from NCDs as envisaged in the guidelines. *It is therefore, recommended to establish a dedicated supply chain network of drugs for all the HWCs so that these centers do not fall short of any medicines at any point of time and no patient will suffer due to non-availability of medicines at their nearest HWC and may not be compelled to get such drugs from market which is bound to put more pressure*

on them in terms of OOPEs. Additional diagnostic equipment has been also supplied to various HWCs and some rapid diagnostic tests are also conducted at SC-HWCs but it was found that at some places the lab technician was not in place, HWCs were found short of space to establish a separate laboratory and drug dispensation counter. *It is thus suggested to ensure the posting of at least one pharmacist and a lab technician at each of the PHC and above level HWCs. There is also need to explore the possibility to create some additional space for establishment of lab and drug dispensation (wherever, it is not available).* The yoga/physical exercise constitutes an integral part of NCD activities but it has virtually been a non-starter (though some HWCs have started and are working on it) due to two major reasons which include, lack of space and non-availability of Yoga instructors. *It is therefore, suggested to involve at least one yoga instructor in each district for carrying out such activities in HWCs and the space constraint issue can be taken-up with the local panchayats at higher level to use their panchayat grehs for carrying-out yoga sessions on specified days.*

Information Technology is considered to be the basis for any programme to sustain and succeed but it was observed that the UT has not done much but are in the process to use OPEX model for telehealth and other related purposes. None of the ASHAs have been given smart phone, tablets have been given to very limited number of MPWs/MLHPs, and desktops have not been given to all the MOs for maintenance of records and uploading their work done. Similarly, the teleconsultation has not been started in the UT. *Therefore, it is suggested that the UT should hire some multinational IT consulting agency to establish a robust system of IT and make the system more transparent at all the levels in terms of quality of data, timely capturing and uploading of data (by providing laptops, tablets, and smart phones) and above all make the teleconsultation operational at the earliest so that the community gets benefitted.*

In order to make any programme successful the role of Information, Education and Communication (IEC) plays a vital role as has been seen in the past for various health programmes. The IEC, community outreach, and health promotion practices were found to limited in case of HWCs at all the levels in the UT though few HWCs have put on various type of IEC material in their respective HWCs but most of HWCs were still going by the VHNDs and providing very limited information on expanded range of services. Similarly, PHC level HWCs do not show much enthusiasm in this regard. *Separate, intense IEC campaign is the need of the hour to establish a healthy link with the community and provide them the services at their door-steps. In this regard, it is suggested to involve the VHSCs, NGOs, school managements, AWCs, and other relevant institutions and platforms to reach to the people.*

Since the magnitude of financing in terms of receipt of funds, their utilization at various levels, procurement of lab and IT equipment, drugs, branding of HWCs, constructions, renovations, repairs, etc. is enormous *and needs a separate full-fledged finance section at all levels to ensure transparent and time-bound manner procurement/completion of all requirements.*

Incentive issue has seriously affected the working of HWCs as no incentives have been disbursed so far to any of the staff working in these HWCs. As per the guidelines, the MLHPs are supposed

to get an amount of 15000 INR as incentive in addition to their basic salary on the basis of institutional performance on certain indicators. Similarly, SNs, MOs, ASHAs and other staff is also supposed to get incentives by fulfilling certain criteria, though the SHS officials have very recently released some amount for incentives for ASHAs but still districts have not disbursed the same. *It is therefore, suggested that after due clearance from the concerned monitoring authorities at various levels the release of performance based incentives should be disbursed to the people working in various HWCs across the UT to boost their morale and make them work more efficiently in terms of productive output lines, as salary is the main motivating factor to any individual under any given circumstances.*

Since the UT has engaged the services of a large number AYUSH doctors under NHM for RBSK and PHCs and as such, they have been successful to a large extent to fill the gap at PHCs in the absence of an allopathic doctor. Keeping in view this fact, the services of MLHPs can also be utilized in a better way at SC-HWCs as a large majority of MLHPs are trained AYUSH doctors and have been trained additionally for six months and as such can handle any emergency at their respective HWCs. *It is therefore, suggested that these AYUSH degree holder MLHPs besides, their fundamental duty at the HWCs should also be allowed to take OPDs as per the guidelines for AYUSH at their respective HWCs to prove their competence. In this regard some limited supplies of AYUSH drugs can also be made available to them to ensure real wellness, preventive and palliative care under holistic AYUSH approach.*

The functional coordination between the members of primary health care team was found satisfactory at SC-HWCs but such coordination was found missing in most of the PHC-HWCs and MOs were found least interested in working for the HWCs activities and remain confined to OPDs and other administrative matters. The coordination between the MO of referral PHC and SC-HWC staff was also found missing. *It is therefore, suggested to make the concerned MOs of PHCs and MLHPs answerable on regular basis to their concerned higher officials at block and district level to achieve the desired results under CPHC. It is further suggested to appoint a dedicated specialist general medicine doctor at the PHC level under this scheme so that the patients referred by the HWCs can be taken due and appropriate care at this level which will in real sense give an extraordinary boost to the CPHC and will definitely, on one hand, reduce the higher level referrals and decongest the higher level institutions and on the other hand reduce the OOPEs of the people to a great extent.*

Keeping in view the above-mentioned facts, our suggestions and above all the concept of establishing HWCs, which is of extra-ordinary importance and most viable in terms of strengthening the primary health care system and provide quality health care services through these HWCs. *It is therefore, recommended to make a pause of six months or one year and allow the UT to consolidate and concentrate on strengthening the already established HWCs in terms of their infrastructure, manpower, equipment, labs, supply of medicines, services envisaged in the guidelines, monitoring and supervision, and other related issues. The process of establishing more HWCs can be made later in a very systematic manner so that no gaps are left.*

REFERENCES

- *Ayushman Bharat, Comprehensive Primary Health Care through Health and Wellness Centers Operational Guidelines, NHRC, National Institute of Health and Family Welfare, New Delhi.*
- *CPHC NCD Solution, NCD Application ANM User Manual, Government of India, Ministry of Health and Family Welfare, New Delhi.*
- *Comprehensive Primary Health Care: Design Features and Strategic Approaches: PPT presented at 1st Orientation Workshop of Population Research Centres 30th - 31st May, 2019 Vigyan Bhawan, New Delhi – 110011, Government of India, Ministry of Health and Family Welfare, New Delhi.*
- *Manual for 1st Orientation Workshop of Population Research Centres 30th - 31st May, 2019 Vigyan Bhawan, New Delhi – 110011, Government of India, Ministry of Health and Family Welfare, New Delhi.*
- *Module for Multi-Purpose Workers (MPW) - Female/Male on Prevention, Screening and Control of Common Non-Communicable Diseases, Government of India, Ministry of Health and Family Welfare, New Delhi*
- *National Health Profile 2018, 13th Issue, Central Bureau of Health Intelligence Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India.*

ANNEXURES-1 (CHECKLISTS/SCHEDULES)

Concurrent Monitoring Checklist to Assess Field Level Implementation of CPHC Through Ayushman Bharat HWCs (State Level)

Part A State Level Planning and Readiness to Roll Out CPHC

(Kindly provide the District-wise list of H&WCs along with their present status)

Name of the State
Date of Visit:
Total number of districts:
Number of Primary Health Care Facilities:
• SHCs-
• PHCs-
• UPHCs-
Total-

A) Planning of HWCs

1. Does the state have a plan with timelines and projection of resources estimated to convert all sub centres/PHCs/Urban PHCs to HWCs and ensure the provision of care as close to community as possible? Assess the planning with respect to following criteria for selection/prioritization of districts/blocks and health facilities. (Tick where appropriate)

Selection of districts	Aspirational districts are included (write number)	
	Districts where universal screening of NCDs has been initiated in 2017-18 and 2018-19 are included (write number)	
	All districts included	
	Number of districts where HWCs are functional/planned-	
Selection of blocks	HR availability at CHC	
	Availability of referral transport	
	Infrastructure availability at CHC	
	Other criteria used for selection	
	Has state followed block saturation principle?	
Selection of facilities-SHCs and PHCs	Infrastructure availability	
	Availability of HR at SHCs- MPW-F/ Availability of MBBS-MO at PHC	
	SHCs at a distance of more than 30 minutes' walk from nearest referral centre- PHC/CHC/SDH/DH	
	SHCs/PHCs under universal screening of NCDs	
	SHCs catering to villages with relatively poor health indicators	
	SHCs catering to villages with vulnerable population- tribal/ marginalized etc.	
	SHCs with population less than 1500	
	Has state followed sector saturation principle?	
Selection of UPHCs	Distance of the UPHC from DH/Medical college	
	Availability of full time MBBS MO	
	Infrastructure availability- Gov. owned/rented	

2. What is the district involvement in planning of HWCs? *
   identifies the Health facilities to be upgraded as HWCs.
3. Number of HWCs operationalized and planned

	2017-18	**2018-19**	**2019-20**
HWCs proposed			
SHC			
PHC			
UPHC			
HWCs operationalized			
SHC			
PHC			
UPHC			

	2020-21	**2021-22**
HWCs planned		
SHC		
PHC		
UPHC		

B) Human Resources:

(1) Program Management

State level team composition	
Is CPHC orientation of state nodal officers completed?	Yes/No
CPHC orientation of district nodal officers planned/completed?	Completed/Planned
Are review meetings conducted at state for district officers? Details- frequency, are planning and implementation issues discussed, any other platform used for interaction?	
What is the mechanism for monitoring of the program at state and district level? (field visits, review meetings etc.)	

(2) Service delivery HR: Mid-Level Health Providers- ***(Refer to CPCH checklist for assessing the Program Study Centre in a district)***

	State
1. Number of Program Study Centres (PSCs)	
2. Total capacity of all PSCs per session	

1. Planning of MLHPs-

Whether selection of candidates is at state level or is decentralized- at district level?	
Recruitment is from in-service employees or open recruitment or both	

Selection of MLHPs in accordance with number of SHCs proposed-

	State
Number of SHCs proposed in current FY	
Number of MLHPs expected to be posted in current FY	

2. Selection procedure for candidates-

Examination • Theory • Skill based	
Weightage for any other criteria 1. 2.	

3. Posting of MLHPs

Interview and counselling at state level	
If locally selected candidates are posted in the same district	

4. MLHP current status

	July 2017-Dec 2017	**Jan 2018-June 2018**	**June 2018-Dec 2018**
MLHPs posted in state			

	Jan 2019-June 2019	**June 2019-Dec 2019**
MLHPs undergoing CPCH training in state		

Total MLHP posted at SHCs in the state-composition

Ayurveda graduates	
Nurses- BSc and GNM	
Others (mention)	

(3) Other HR

	State
PHCs without MBBS MO in position-	
In case of vacant positions, what is the planning of recruitment of MBBS MOs in PHCs to be proposed in next FY	
PHCs with vacant staff nurse positions	
Number of staff nurses proposed for NCD at PHC	
Number of staff nurses for NCD in position at PHC	
Number of PHCs without Lab technicians in position	
Number of PHCs without pharmacists in position	

(4) Training

1. Number of service providers trained

	State
ASHAs trained in NCD against the target	
AFs trained in NCD against the target	
MPWs trained in NCD against the target	
SNs trained in NCD against the target	
MOs trained in NCD against the target	
Staff nurses trained in VIA against the target	
Training in any other package (oral health/ENT-eye care/elderly/palliative/mental health)	MO- SN- MPW- ASHAs-

2. NCD training details

Whether duration of training is as per guidelines	
Trainer availability at state and district level	
Refresher trainings held	

C) Expanded service delivery (write data source in bracket)

	State
Number of SHCs where population enumeration has been initiated	
Number of SHCs where CBAC form filling has been initiated	
Total population enumerated in FY 2017-18	
CBAC assessment completed in 2017-18	
Total population enumerated in FY 2018-19	
CBAC assessment completed in 2018-19	
Number of SHCs where Universal screening of NCDs has been initiated	

Data from previous month - (write data source in bracket)

2. NCD training details

Whether duration of training is as per guidelines	
Trainer availability at state and district level	
Refresher trainings held	

C) Expanded service delivery (write data source in bracket)

	State
Number of SHCs where population enumeration has been initiated	
Number of SHCs where CBAC form filling has been initiated	
Total population enumerated in FY 2017-18	
CBAC assessment completed in 2017-18	
Total population enumerated in FY 2018-19	
CBAC assessment completed in 2018-19	
Number of SHCs where Universal screening of NCDs has been initiated	

Data from previous month - (write data source in bracket)

	Screened	**Identified positive**	**On treatment**
Hypertension			
Diabetes			
Oral Cancer			
Breast Cancer			
Cervical Cancer			
Hypertension			

Brief about planning of expanded service delivery and details if already being provided-

Oral health	
ENT/eye care	
Elderly/Palliative care	
Mental Health care	

D) Medicines

Has state revised the EML to include medicines for expanded service delivery at HWCs	
Availability of DVDMS is up to which level of facility?	
Stock out rates (HMIS)	

What is the frequency of indenting from PHCs? *	
Has the district drug store started receiving separate indents from HWC-SHCs or additional indenting is done by linked PHCs? *	
Are medicines for hypertension and diabetes, being supplied to SHC-HWCs? *	

E) Diagnostics

Does the state have facility wise essential list of diagnostics in place?	
Are consumables part of EML and being indented through DVDMS?	
If free diagnostic initiative is being implemented through in house lab strengthening/ PPP mode/ mixed?	
Has state implemented Hub and Spoke model?	
Whether hub is private or public- DH/SDH/CHC	
How many spokes are attached to a hub?	
Number of PHCs with vacant positions for LTs	

F) Infrastructure

	State
Status of gap analysis of facilities	
Status of infrastructure upgradation planning	
Status of branding	
Number of HWCs where upgradation of infrastructure- repair/refurbishment has been completed	
Planning of infrastructure upgradation in remaining facilities of block/district for next year	

G) IT system and Telehealth

	State
Issues in procurement, if any	
Number of SHCs where tablets are available against the target (ANMOL/CPHC/State specific application)	MPW- MLHP-
Number of SHCs where laptop/desktop is available against the target	
Number of PHCs where laptop/desktop is available against the target	
Number of ASHAs with smartphones against the target	
Whether ASHAs have started using CPHC application? (mention number if any)	
If support from TATA Trust is available for training in IT application at district level	
Number of MLHPs trained in CPHC IT application against the target	
Number of MPWs trained in CPHC IT application against the target	
Number of MOs trained in CPHC IT portal against the target	
Status of Internet connectivity at SHCs	
Status of internet connectivity at PHCs	
Plan for ensuring internet connectivity at HWCs	
Number of SHCs where CPHC application is being used	
Number of PHCs where CPHC portal is being used	
If state has existing IT application, what is the status of integration with CPHC application OR Whether all the required information is being captured in state application	
Has teleconsultation been initiated at HWCs?	
If yes, details about teleconsultation • Number of hubs identified- • Number and details of specialists identified per hub- • Honorarium payment to specialists-	

Is state implementing ECHO model for training service providers?	
If yes, number of ECHO hubs operational	
Number of spokes connected to the hub	
Total number of ECHO training sessions held	

(H) IEC, Community Outreach and Health Promotion

Plan for IEC activities in community regarding expanded range of services	
Are Yoga/physical exercise sessions being conducted at HWCs?	
Number of HWCs where yoga/physical exercise sessions are conducted	State -
Details about Yoga sessions • Identified place- • Frequency of sessions- • Sessions conducted by- • Honorarium paid to yoga instructor-	

(I) Financing

State funds for CPHC (State)

	2017-18	**2018-19**	**2019-20**
Approved			
Released			
Expenditure			

Has state institutionalized performance-based incentive for MLHP?	
If yes, details about the same Monitoring of indicators is done through- HMIS/CPHC IT application/State specific application? *	
Has state institutionalized team-based incentives for ASHA and MPWs?	
If yes, details about the same*	
Have ASHAs started receiving incentive for CBAC assessment and mobilization for screening (write rate at which incentive is received) *	
Have ASHAs started receiving incentive for follow up of individuals undergoing treatment for NCDs? (write rate at which incentive is received) *	

(J) Partnerships

1. Has the district-built partnerships for Knowledge generation/Technical Support for CPHC implementation?
2. Any facilities operating in PPP mode? – UPHC/PHC/SHC? Brief details about the same
   1) Private agency-
   2) Facility type-
   3) Number of facilities under PPP-
   4) PPP since when-
   5) Inputs from government-
   6) Inputs from private provider-
   7) Cost per facility-

3. Is the district team getting support from any external agency- NGO, development partner in CPHC implementation? *

Concurrent Monitoring Checklist to Assess Field Level Implementation of CPHC Through Ayushman Bharat HWCs (District Level)

Part A District Level Planning and Readiness to Roll Out CPHC

Name of the District-
Date of the Visit-
Is the district an Aspirational district? Yes/No
Total number of blocks-
Total population of the district-
Number of Primary Health Care facilities-
• SHCs-
• PHCs-
• UPHCs-
Total-

A) Planning of HWCs

4. Does the district have a plan with timelines and projection of resources estimated to convert all sub centres/PHCs/Urban PHCs to HWCs and ensure the provision of care as close to community as possible? **Yes/no/not decided yet**

Assess the planning with respect to following criteria for selection/prioritization of districts/blocks and health facilities. (Tick where appropriate)

Selection of blocks	HR availability at CHC	Yes/No
	Availability of referral transport	Yes/No
	Infrastructure availability at CHC	Yes/No
	Other criteria used for selection	Yes/No
	Has state followed block saturation principle?	Yes/No
Selection of facilities-SHCs and PHCs	Infrastructure availability	Yes/No
	Availability of HR at SHCs- MPW-F/ Availability of MBBS-MO at PHC	Yes/No
	SHCs at a distance of more than 30 minutes' walk from nearest referral centre- PHC/CHC/SDH/DH	Yes/No
	SHCs/PHCs under universal screening of NCDs	Yes/No
	SHCs catering to villages with relatively poor health indicators	Yes/No
	SHCs catering to villages with vulnerable population- tribal/ marginalized etc.	Yes/No
	SHCs with population less than 1500	Yes/No
	Has state followed sector saturation principle?	Yes/No
Selection of UPHCs	Distance of the UPHC from DH/Medical college	Yes/No
	Availability of full time MBBS MO	Yes/No
	Infrastructure availability- Gov. owned/rented	Yes/No

5. What is the district involvement in planning of HWCs? * _____

6. Number of HWCs operationalized and planned

	2017-18	**2018-19**	**2019-20**
HWCs proposed			
SHC			
PHC			
UPHC			

HWCs operationalized			
SHC			
PHC			
UPHC			

	2020-21	2021-22
HWCs planned		
SHC		
PHC		
UPHC		

B) Human Resources:

(1) Program Management

State level team composition	
Is district nodal officer identified for CPHC?	Yes/No
CPHC orientation of district nodal officers planned/completed?	Completed/Planned
CPHC orientation of block program management team by district nodal officer planned/completed? *	Completed/Planned
CPHC orientation of Primary Health Care team at SHCs and PHCs planned/completed? *	Completed/Planned
Are review meetings conducted at state for district officers? Details-frequency, are planning and implementation issues discussed, any other platform used for interaction?	
Are review meetings conducted at district level for block program management team?* Details-frequency, are planning and implementation issues discussed?	
What is the mechanism for monitoring of the program at state and district level? (field visits, review meetings etc.)	

(2) Service delivery HR: Mid-Level Health Providers-

	District
Number of Program Study Centres (PSCs)	
Total capacity of all PSCs per session	

Planning of MLHPs-

Whether selection of candidates is at state level or is decentralized- at district level?	
Recruitment is from in-service employees or open recruitment or both	

Selection of MLHPs in accordance with number of SHCs proposed-

	District
Number of SHCs proposed in current FY	
Number of MLHPs expected to be posted in current FY	

5. Posting of MLHPs

Interview and counselling at district level	
If locally selected candidates are posted in the same district	

6. MLHP current status

	July 2017-Dec 2017	Jan 2018-June 2018	June 2018-Dec 2018
MLHPs posted in district			

	Jan 2019-June 2019	June 2019-Dec 2019

MLHPs undergoing CPCH training from district		

(3) Other HR

	District
PHCs without MBBS MO in position-	
In case of vacant positions, what is the planning of recruitment of MBBS MOs in PHCs to be proposed in next FY	
PHCs with vacant staff nurse positions	
Number of staff nurses proposed for NCD at PHC	
Number of staff nurses for NCD in position at PHC	
Number of PHCs without Lab technicians in position	
Number of PHCs without pharmacists in position	

(4) Training

1. Number of service providers trained

	District
ASHAs trained in NCD against the target	
AFs trained in NCD against the target	
MPWs trained in NCD against the target	
SNs trained in NCD against the target	
MOs trained in NCD against the target	
Staff nurses trained in VIA against the target	
Training in any other package (oral health/ENT-eye care/elderly/palliative/mental health)	MO- __, SN- _____, MPW- __, ASHAs- ____

2. NCD training details

Whether duration of training is as per guidelines	
Trainer availability at state and district level	
Refresher trainings held	

C) Expanded service delivery (write data source in bracket)

	District
Number of SHCs where population enumeration has been initiated	
Number of SHCs where CBAC form filling has been initiated	
Total population enumerated in FY 2017-18	
CBAC assessment completed in 2017-18	
Total population enumerated in FY 2018-19	
CBAC assessment completed in 2018-19	
Number of SHCs where Universal screening of NCDs has been initiated	

Data from previous month - (write data source in bracket)

	Screened	**Identified positive**	**On treatment**
Hypertension			
Diabetes			
Oral Cancer			
Breast Cancer			
Cervical Cancer			
Hypertension			

Brief about planning of expanded service delivery and details if already being provided-

Oral health	
ENT/eye care	
Elderly/Palliative care	

D) Medicines

Has state revised the EML to include medicines for expanded service delivery at HWCs	
Availability of DVDMS is up to which level of facility?	
Stock out rates (HMIS)	
What is the frequency of indenting from PHCs? *	
Has the district drug store started receiving separate indents from HWC-SHCs or additional indenting is done by linked PHCs? *	
Are medicines for hypertension and diabetes, being supplied to SHC-HWCs? *	

E) Diagnostics

Does the state have facility wise essential list of diagnostics in place?	
Are consumables part of EML and being indented through DVDMS?	
If free diagnostic initiative is being implemented through in house lab strengthening/ PPP mode/ mixed?	
Has state implemented Hub and Spoke model?	
Whether hub is private or public- DH/SDH/CHC	
How many spokes are attached to a hub?	
Number of PHCs with vacant positions for LTs	

F) Infrastructure

	District
Status of gap analysis of facilities	
Status of infrastructure upgradation planning	
Status of branding	
Number of HWCs where upgradation of infrastructure- repair/refurbishment has been completed	
Planning of infrastructure upgradation in remaining facilities of block/district for next year	

G) IT system and Telehealth

	District
Issues in procurement, if any	
Number of SHCs where tablets are available against the target (ANMOL/CPHC/State specific application)	MPW- MLHP-
Number of SHCs where laptop/desktop is available against the target	
Number of PHCs where laptop/desktop is available against the target	
Number of ASHAs with smartphones against the target	
Whether ASHAs have started using CPHC application? (mention number if any)	
If support from TATA Trust is available for training in IT application at district level	
Number of MLHPs trained in CPHC IT application against the target	
Number of MPWs trained in CPHC IT application against the target	
Number of MOs trained in CPHC IT portal against the target	
Status of Internet connectivity at SHCs	
Status of internet connectivity at PHCs	
Plan for ensuring internet connectivity at HWCs	
Number of SHCs where CPHC application is being used	
Number of PHCs where CPHC portal is being used	
If state has existing IT application, what is the status of integration with CPHC application OR Whether all the required information is being captured in state application	
Has teleconsultation been initiated at HWCs?	
If yes, details about teleconsultation	

• Number of hubs identified- • Number and details of specialists identified per hub- • Honorarium payment to specialists-	
Is state implementing ECHO model for training service providers?	
If yes, number of ECHO hubs operational	
Number of spokes connected to the hub	
Total number of ECHO training sessions held	

(H) IEC, Community Outreach and Health Promotion

Plan for IEC activities in community regarding expanded range of services	
Are Yoga/physical exercise sessions being conducted at HWCs?	
Number of HWCs where yoga/physical exercise sessions are conducted	District-
Details about Yoga sessions • Identified place- • Frequency of sessions- • Sessions conducted by- • Honorarium paid to yoga instructor	

(I) Financing

State funds for CPHC

	2017-18	**2018-19**	**2019-20**
Approved			
Released			
Expenditure			

Has state institutionalized performance-based incentive for MLHP?	
If yes, details about the same Monitoring of indicators is done through- HMIS/CPHC IT application/State specific application? *	
Has state institutionalized team-based incentives for ASHA and MPWs?	
If yes, details about the same*	
Have ASHAs started receiving incentive for CBAC assessment and mobilization for screening (write rate at which incentive is received) *	
Have ASHAs started receiving incentive for follow up of individuals undergoing treatment for NCDs? (write rate at which incentive is received) *	

(J) Partnerships

3. Has the district-built partnerships for Knowledge generation/Technical Support for CPHC implementation? **Yes/No**
4. Any facilities operating in PPP mode? – UPHC/PHC/SHC? Brief details about the same

1) Private agency-
2) Facility type-
3) Number of facilities under PPP-
4) PPP since when-
5) Inputs from government-
6) Inputs from private provider-
7) Cost per facility-

4. Is the district team getting support from any external agency- NGO, development partner in CPHC implementation? *

Concurrent Monitoring Checklist to Assess Field Level Implementation of CPHC Through Ayushman Bharat HWCs

Part B Facility Readiness HWC-SHC/PHC

Persons Met: _____

Facility Name- _____ Date of the Visit- _____

Section 1: Basic Information		
Type of the facility (SHC/PHC/UPHC)		
1	Name of the facility Type of Building **Old----1, New-----2, Private-Rented-------3, Government-------4**	
2	Total Population in the catchment area of your facility	
3	Name of the village/Block/District	
4	Name of the Linked First Referral Centre-PHC/CHC as appropriate	
5	Travel Time to First Referral Centre-PHC/CHC through motorable transport	

Section 2: Human Resources Available (Enlist as per Facility Type)		
Type of the facility (SHC/PHC/UPHC)		
1.	MBBS Medical Officers	**Number-** **Date of Appointment** **Part Time/Full Time**
2.	AYUSH MO	**Qualification-**
3.	Other Paramedic Staff	
	• Staff Nurse • Lab Technician • Pharmacist • LHVs • Others	**Sanctioned/Available**
1	MLHP	**Date of Appointment** **Qualification-**BAMS/BSc-Nurse/GNM/Post Basic/BSc Community Health/equivalent
2	MPW Females	
3	MPW Male	
4	ASHAs	
5	Number of Villages not having an ASHA	

Section 3: Skills and Competencies of Human Resources (Enlist as per Facility Type)		
	Type of Personnel	**Trainings completed* and Duration of Training**
	Type of the facility (SHC/PHC/UPHC)	**Facility 1-**
1	MBBS Medical Officers	
2	AYUSH MO	
3	Other Paramedic Staff	
	Staff Nurse	

	Lab Technician Pharmacist LHVs Others _____	
4	MLHP	
5	MPW Females	
6	MPW Male	
7	ASHAs	

Include Trainings such as SBA, IMNCI, BEmOnC, Family Planning, Safe Abortion etc. Information necessarily required for Trainings on Universal Screening of NCDs, other new service packages and Trainings related to National Health Programmes

Section 4: Infrastructure and Resources Available		
	Type of the facility (SHC/PHC/UPHC)	
1.	Infrastructure	
a.	Repairs and upgradation for HWCs completed	Completed Underway Planned but not started yet
b.	**Has the facility been upgraded with the following inputs** • 24 hours' electricity • 24 hours' water supply • Room for OP Consultation • Examination Area with adequate Privacy • Patient Waiting Area (for at 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 IPHS • Facilities for safe Drinking Water • Suitable Approach Road • Separate Male/Female Toilets for staff/Patients/both • Appropriate Drainage and Arrangement for Waste Disposal • Wellness room or provision of Yoga services • Furniture/Fixtures and Equipment as per MoHFW CPHC Guidelines (Refer Annexure 1) • Citizen's Charter and Display of IEC to enable Community Awareness on services available at HWCs	

Section 5: IT Support and Teleconsultation Services		
	Type of the facility (SHC/PHC/UPHC)	
1.	**IT Support for HWC**	
a.	Desktops/Laptops for Medical Officer-Available-Yes/No	
b.	Tablets for MLHP, MPWs (Specify Numbers)	
c.	Smart Phones for ASHA	
d.	Training in use of IT systems complete for Staff -PHC and SHC	
e	Type of IT Applications in use • RCH Portal	

	• HMIS • CPHC-NCD application • HWC Portal • Nikshay • ANMOL by MPWs • E-Hospital • Any other application to support the delivery of National Health Programmes	
f.	Have ASHAs started filling population enumeration and CBAC data in CPHC application in smartphones? (applicable if ASHAs having smartphones)	
g	If not, is the CBAC data filled manually by ASHAs digitized and entered in tablets with MPWs/MLHP?	
h.	Connectivity of PHC with Tele-consultation Hub established (Yes/No)	
	• Pre-Fixed Schedule of Teleconsultation services displayed for the service users • Average number of Teleconsultations undertaken in day/week • Mention most common cases for which Teleconsultation services have been availed • Comment on usefulness/ challenges reported by PHC Medical Officer	
i.	Teleconsultation with PHC-MO established by MLHP and in use • Pre-Fixed Schedule of Teleconsultation services displayed for the service users • Average number of Teleconsultations undertaken per day/week • Mention most common cases for which Teleconsultation services have been availed • Comment on usefulness/ challenges reported by MLHP in using Tele-Consultation services	

Section 6: Medicines and Diagnostics		
Type of the facility (SHC/PHC/UPHC)		
a	Number of Medicines Available in the Facility as per State/National List of Essential Medicines (Refer Annexure 2)	
b	Number and Types of Medicines Available for management of NCDs	
c	Number and Type of Medicines that are not in adequate stock for minimum three months usage	
d	Reasons for Stock Out- • Track timeliness and adequacy of generation of indents • Does the SHC-HWC team submit demand of medicines and consumables to PHC ***OR*** these are supplied from PHC as per availability? • Is the indenting linked to Government Store/District Warehouse for supply of medicines? • Timelines of Receipt of consignments etc	

	• Knowledge of SHC-HWC team about medicines to be available at SHC-HWC as per Essential List of Medicines?	
e	Number of Diagnostics Tests/Lab Investigations being conducted as per MoHFW CPHC Guidelines (Refer Annexure 3)	
f.	Specify Lab Investigations not being Conducted	
g	Reasons for Non- Availability of Lab Investigations	
	- Lack of reagents and consumables - Non-Functional Equipment - Lack of Equipment - Lack of Training - Lack of Lab Technician* - Any other (specify)	
	- Is there any stock out of consumables currently? Which consumables have frequent stock outs?	
h	Report on Functionality of Equipment/Calibration/Maintenance	
i.	Comment on the accuracy of investigations	
j.	Are the untied funds being utilized for local procurement based on rate contracting at the state level	
k	Is the facility having DVDMS/E Aushadhi or other MIS for Drug and Vaccine Logistics	
l.	Availability and uptake of FP-LMIS	

***applicable only for HWC-PHC**

Section 7: Functional Coordination Amongst the Primary Care Team		
a.	Nature of work distribution between MLHPs and MPWs Females and Males	
b.	Assess Field Level coordination and challenges if any in functions of MLHPs/MPWs and ASHAs	
c.	Coordination of Care Delivery for Continuum of Care- 1. Are ASHAs referring cases for screening/management of cases at SHC-HWC 2. Are MLHPs attending to cases referred by ASHAs 3. Is the PHC Medical Officer attending upward referral by MLHP/MPWs for diagnosis, complication management and initiation of Treatment plan 4. Communication by PHC Medical Officer to MLHP/MPW for continuation of treatment plan and follow up care at SHC-HWC 5. Communication by MLHPs/MPWs for Community level follow up by ASHAs	

Section 8: Functionality and Service Delivery of HWC-PHC/SHC		
Type of the facility (SHC/PHC/UPHC)		
a.	**Opening Hours of the Facility**	
b.	**Total OP Footfalls in the previous month** New Cases Old Cases	
c.	Total Cases Attended post operationalization as HWC	
d.	Average OP Footfall/Day/Month	
e.	Fixed Day Weekly Special Clinics Organized for	

	- ANC/PMSMA	
	- Immunization	
	- NCD Screening	
	- Others (Specify)	
f.	**Community Level Outreach**	
	- VHND Session Held against Planned for the current FY	
	- NCD Screening Camps conducted against planned - Specified Frequency of Screening Camps	
	- Screening for 0-18 years by RBSK Teams in Schools/AWC (Visits Conducted/Planned) - Number of Children screened and referred for further management	
g.	**Health Promotion and Prevention Activities for Wellness**	
	- Number of Patient Support Groups Formed	
	- Patient Support Group Meetings Conducted since operationalization as HWC or in current FY - Awareness Camps for Life Style Modification - Vector Control Activities - Water Testing - Sanitation Drive/Outbreak prevention activities conducted in villages	
	-Are Yoga/physical exercise sessions conducted at HWC/ any identified place in the community	
	-Details of sessions	Frequency- Conducted by- Yoga instructor/PHC staff
	-Other IEC activities conducted by SHC-HWC team	
	-Involvement of HWC-PHC/SHC staff in VHSNC meetings	
h.	**Report on Service Delivery for Essential Package of Services as per Facility Records (OP/IP Register-HMIS; CPHC IT Application; Any other)** (Refer Annexure 4 for Recording information)	
i.	Total Lab Investigations Conducted in current financial year as on date	
j.	Average Monthly Investigations conducted	
k.	Are the patients suffering from chronic illnesses been provided at least one- month refill of medicines	
	Programme Management Functions	
l.	**Monthly meetings**	
	• Are meetings with Frontline Functionaries Team organized every month at the SHC-HWC? • Agenda/Purpose of the meetings • At SHC-HWC is the MLHP using this meeting to discuss, resolve issues and support MPWs/ASHAs to improve coverage of services such as- ANC, Immunization, Institutional Delivery, FP-Contraceptive Distribution, Screening of NCD, Treatment Compliance for chronic illness such as-NCDs, TB. Leprosy etc.	

	• Are meetings with Frontline Functionaries and SHC Team organized every month at the PHC-HWC? • Agenda/Purpose of the meetings • At PHC-HWC are trainings on technical sessions conducted by MO during the meeting? What are the topics discussed? • Is the MO using this forum to discuss, resolve issues and support MPWs/ASHAs to improve coverage of services	
m	**Management of untied funds**	
	Untied funds received in last year	
	Activities for which untied fund was spent	
	Procedure followed for decision about untied fund expenditure	
	Signing authority	
	Involvement of SHC-HWC team	

Section 9 Exit Interview with Patients (2-3 Patients)	
	1. What was your health complaint/condition for which you visited HWC? _____ 2. What treatment did you receive for your complaint? _____ 3. Are you referred to any other facility for further treatment? _____ 4. Did you pay for any service at HWC? (registration, medicines, consumables, diagnostics, any other) **Yes/No** 5. How far is this facility from your residence? How do you commute to the facility? _____ 6. Have you visited the HWC before? Is there any change in the services delivered at HWC-SHC? **Yes/No, (if yes any change) Yes/No** 7. Are you informed about the services that are/should be available at the facility? (through IEC/ Citizen charter, information provided by frontline workers etc.) **Yes/No** 8. Are you satisfied with behaviour of the staff? **Yes/No** 9. Are you satisfied with the treatment provided? **Yes/No**

Section 10 : Perspective From ASHA/MPW		
a.	Changes in service delivery post operationalization of HWCs	
b.	How has positioning of MLHPs at HWC affected your work	
c.	What have been the benefits of the HWCs to the community and service users	
d.	***From MLHP***	
e.	Experience of serving in SHC-HWC	
f.	Mentoring Support from PHC MO and Block Teams	
g.	Cooperation from Frontline Functionaries	
h.	Receipt of Performance Linked Incentives-Process, Validation, Frequency of disbursal (common to all)	

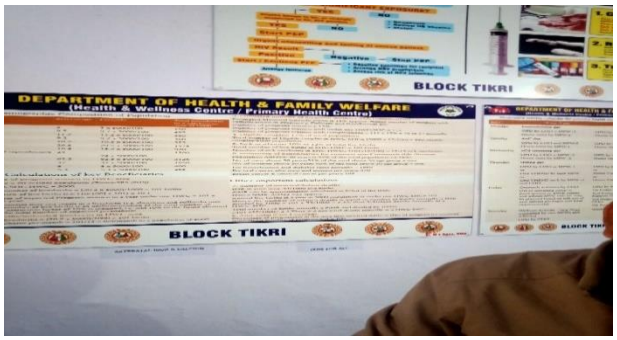
Section 11: FGD with Community

1. What are the common illnesses reported in the community among different age groups? _____
   _____
2. Which health facility is availed for these illnesses? **(public- SHC/PHC/CHC/SDH/DH/UPHC or private- clinic/hospital/pharmacy/RMP)**
3. Which is the nearest health provider to village? **(public- SHC/PHC/CHC/SDH/DH/UPHC or private- clinic/hospital/pharmacy/RMP) (ask for road connectivity, transport options)**
4. How far is the nearest SHC and PHC/UPHC from the village/ward? _____
5. Where do members go for immunization of children? _____
6. Where are ANC check-ups done? _____
7. **If the answer is SHC-HWC**, probe for other services availed at SHC. **(treatment for cough, cold, fever, skin allergies, diarrhoea etc.)**
8. Do they recall ASHA/ MPWs visiting household and filling a form to understand their life style (eg- physical activity), family history, measured waist circumference and asked about symptoms (like history of fits, cough for over 2 weeks etc.) _____
9. Are community members aware about non-communicable diseases? How many members are suffering from Hypertension and Diabetes in the village/ward? Where do members avail service for Hypertension/Diabetes? _____
10. Are they aware that as part of Ayushman Bharat a HWC is now operational close to their home? **Yes/No**
11. Are community members informed about the services to be available at SHC-HWC? (through IEC/ Citizen charter, information provided by frontline workers etc.) **Yes/No**
12. Have the ASHAs/ MPWs informed them about the services that will be provided at HWCs. **Yes/No**
13. Are they aware that they can now avail free screening services for of hypertension / diabetes/ oral /breast cancer at HWC? **Yes/No**
14. Are they aware that they can avail free treatment for common illnesses at SHC-HWC for which they earlier had to travel long distances? **Yes/No**
15. Community's perception about currently existing services at SHC-HWC and PHC-HWC (OPD timings, availability of nurse/doctor/other staff, user charges, availability of medicines, lab investigations, behaviour of the staff) Are the people suffering from Diabetes/Hypertension able to obtain one- month refill of medicines at HWC **Yes/N0**
16. Is there any change in human resources at SHC-HWC? Is there any change in services provided at SHC-HWC? **Yes/No** _____
17. Ask about member's knowledge about ASHA in the village and services provided by her. Have ASHAs visited their household? What are services provided to new-borns, pregnant women and others? What is the information asked by ASHAs? **Yes/No** _____
18. Is there a Village Health Sanitation and Nutrition Committee/ Mahila Arogya Samiti in the village/ward? What are the functions of this committee? (meetings held, activities conducted, participation of community members) **Yes/No** _____

ANNEXURE-2 PHOTO GALLERY


RAIN WATER
HARVESTING


LIQUID WASTE
TREATMENT


BLOCK TIKRI
DEPARTMENT OF HEALTH & FAMILY WELFARE
(Health & Wellness Centre / Primary Health Centre)
BLOCK TIKRI


कैंसर
कैंसर


HEALTH AND WELLNESS CENTRE
आयुष्मान भारत


HERBAL GARDEN


AYUSHMAN BHARAT


YOGA ASANAS


HEALTH & WELLNESS CENTRE
ROUN DOMAIL BLOCK


HEALTH & WELLNESS
SANSOO BLOCK


HEALTH & WELLNESS CENTRE
TIKRI


HEALTH & WELLNESS
CENTRE
NTPHC PALHALLAN
BLOCK PATTAN


URBAN PRIMARY
HEALTH CENTRE
CHANKHAN SOPORE


GOVT. SUB CENTRE
SANGRAMA


DIAGNOSTICS SERVICES
AVAILABLE AT
HEALTH AND WELLNESS CENTRE
NOWPORA BLOCK: KREERI
HAEMOGLOBIN
URINE PREGNANCY RIPID TEST
URINE DIPSTICK
BLOOD GLUCOSE-GLUCOMETER, COLLECTION
BLOOD GLUCOSE-GLUCOMETER, COLLECTION
PROCEDURE FOR DRIED BLOOD SPOT (DBS)
SLIDE PREPARATION FOR MALARIA SMEAR, RDK
SICKLE CELL RAPID TEST
COLLECTION FOR SPUTUM SAMPLES
WEIGHT MACHINES- FOR DIFFERENT AGE GROUPS
BLOOD PRESSURE STADIOMETERS FOR BODY MASS INDEX
BLOOD PRESSURE STADIOMETERS FOR BODY MASS INDEX
PEAK FLOW METER
QUESTIONNAIRE- FOR DETECTION OF RISK FACTORS E-G
SMOKING SUBSTANCS ABUSE, AND FOR CHRONIC
RESPIRATORY DISEASE (CBAC)
VISUAL INSPECTION THROUGH ACETIC ACID
QUESTIONNAIRE ALGORITHM FOR MENTAL DISORDER
DETECTION AND EPILEPSY
SNELLEN'S AND NEAR VISION CHART
WEIGHT CHART AND WEIGHING MACHINE
RBSK SCREENING TOOLS
QUESTIONNAIRES TO ASSESS REQUIRMENT.


Does Asha Know her incentives?


YOGA
ROOM


Health & Wellness Centre, Wagoora