Abstract

Background : Non communicable diseases (NCDs) are emerging global pandemic with changing life style and environment. Programmes and interventions were introduced globally to combat it. Screening and Health promotion are major strategies of prevention of NCDs. Assessment of community level coverage of those programmes is mandate for planning for new interventions based on successfulness of implemented programmes as it reflects both gaps in service delivery and population health literacy.

Objective : The purpose of the study is to determine the coverage of the different service provisions for non-communicable diseases screening in the medical officer of health (MOH) area Kuruwita.

Methodology : A descriptive cross sectional study was conducted in 35 to 65 aged cohort lived in Kuruwita MOH area. Two stage cluster sampling was implemented to recruit 360 participants out of them. Primary sampling unit was Grama Niladhari (GN) divisions, 30 out of 39 GN divisions were selected by random sampling. Secondary sampling unit included 35 – 65 years aged individuals. Interviewer administered questionnaire that contain socio demographic data, direct observational check list and questions to assess the level of behavioral change based on HICDARM model was used. Percentage population coverage for selected NCD related services were calculated.

Results : Out of the total population 37.4% (CI 32.3-39.9) was diagnosed as having one or more NCDs, 26.1% (CI 21.5-30.66)) was never screened and rest was screened negative population. About 8.4% (CI 5.51-11.28) reach health system 5 times but full screening package is delivered only on 0.06% (CI -1.5 – 1.6). More than half of the population screened on hypertension (58.4%, CI 51.7 – 65.0) and diabetes (50.3%, CI 43.6-56.9) at least once in their life time. Majority (93.5%, CI 88.0-98.9) had never undergone clinical oral examination. Only 27.8% (CI 21.3 – 34.3) of the population received systematic screening while 32.3% (CI 25.7 – 38.8) got opportunistic screening.

The level of behavioral change varied from highest; abstinence from alcohol as healthy behavior (m = 43.84, SD = 25.58) and lowest; regular exercise for 30 minutes (m = 19.11, SD = 19.57) as a healthy behavior, when analyzed by modified Likert scale based on HICDARM model.

Conclusion and recommendation : NCD screening progrmme should be modified with new strategies to catch the remained one-fourth of the population and opportunistic/systematic single package should be introduced. Gaps of behavioral change regarding NCD related lifestyle risk factors should be filled and reasons for not adhearing the behaviors should be further evaluated.

Key words : Non communicable diseases, Screening, Coverage, HICDARM model, behavioral change analysis.