सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

INDUCTION TRAINING MODULE FOR COMMUNITY HEALTH OFFICERS

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Induction Training Module for
Community Health Officers

ABOUT THIS INDUCTION MODULE

As part of Ayushman Bharat the Community Health Officers (CHOs) are a new cadre of non- physician health workers. CHOs will play a critical role in provision of expanded range of essential package of services as a part of Comprehensive Primary Health Care. They are expected to lead the primary care team at Sub Centre-Health and Wellness Centre, provide clinical management & ambulatory care to the community and serve as an important coordination link to ensure the continuum of care.

This Induction Module will help you to understand the main functions of a Community Health Officers and develop clarity on work coordination with your primary care team. This module will build your capacity in estimating your beneficiaries, knowing your population, health promotion & prevention activities and monitoring & supervision. Thus, training in this induction module will be useful in commencing your work at Health and Wellness Centres as a Community Health Officer.

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Check-ups
ANM	Auxiliary Nurse Midwives
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CBAC	Community Based Assessment Checklist
CHC	Community Health Centre
CHO	Community Health Officer
CPHC	Comprehensive Primary Health Care
DH	District Hospital
ECD	Early Childhood Development
FRU	First Referral Unit
HWC	Health and Wellness Centres
ICDS	Integrated Child Development Services
IFA	Iron Folic Acid
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IYCF	Infant Young Child Feeding
LBW	Low Birth Weight
MAS	Mahila Aarogya Samiti
MDR-TB	Multi Drug Resistant-Tuberculosis
MLHP	Mid-Level Health Provider
MMU	Medical Mobile Units
MNCH	Maternal Newborn and Child Health

MPW	Multi-Purpose Worker
NCD	Non-Communicable Disease
NMR	Neonatal Mortality Rate
NRC	Nutrition Rehabilitation Centre
OOPE	Out of Pocket Expenditure
PHC	Primary Health Centre
PMJAY	Pradhan Mantri Jan Aarogya Yojana
PRI	Panchayati Raj Institutions
PSG	Patient Support Group
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
SHC	Sub Health Centre
SHG	Self Help Groups
SoE	Statement of Expenditure
SNCU	Special Newborn Care Unit
SRS	Sample Registration System
STI	Sexually Transmitted Infections
THR	Take Home Ration
ULB	Urban Local Bodies
VHSND	Village Health Sanitation and Nutrition Day
VPD	Vaccine Preventable Diseases
WASH	Water Sanitation and Hygiene

CHAPTER 1

CURRENT SCENARIO AND NEED FOR COMPREHENSIVE PRIMARY HEALTH CARE

1.1 CURRENT SCENARIO OF HEALTH IN INDIA

In last few decades, our country has witnessed major changes in the disease burden. You know that India has made good progress in reducing maternal and child mortality in the last fifteen years. The Under-five Mortality has come down to 39/1000 live births in 2016 in comparison to 74.3 in 2005 (SRS 2007 and 2016). Infant Mortality Rate is 33/1000 live births in 2016 and used to be 58/1000 live births in 2005. Similar reduction is visible in Maternal Mortality Ratio that has declined from 234/one lakh live births in 2004-06 (SRS 2008) to 130/one lakh live births in 2014-16 (SRS, 2018). This decrease is visible on account of various initiatives by the government such as- the universal immunization program, several initiatives for improving maternal, child and reproductive health under the National Health Mission etc.

Ten to fifteen years ago communicable diseases along with maternal and nutritional disorders contributed to the major disease burden. We are now seeing a change in this disease pattern. Death from the four major NCDs–Cancer, Cardio Vascular Diseases (CVD), Diabetes, and Respiratory Diseases accounts for nearly 62% of all mortality among men and 52% among women – *of which 56% is premature.*

However, high levels of maternal and child mortality continue to exists in many states and Tuberculosis including MDR-TB, Hepatitis and rising burden of Dengue, Chikungunya are continuing to be challenge for improving population health. (Annexure 1)

Despite the changing disease pattern, the public health care delivery system focussed only on provision of care related to reproductive, maternal, new born and child health and few communicable diseases under the disease control programmes. These conditions together represent merely 15% of all morbidities. Further, majority health care is sought at the level of District Hospitals as primary health centres and sub-centres are not providing a wider range of services. For the rest of the services people are availing care from the private sector that leads to high Out of Pocket Expenditure (OOPE) on healthcare. Today about 15-17% households in India face impoverishment on account of OOPE on health care.

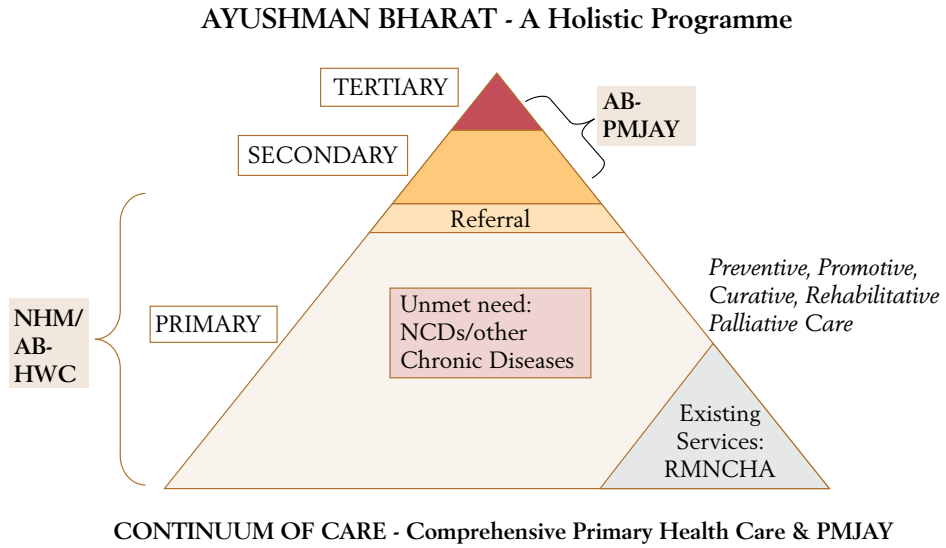
1.2 NEED FOR COMPREHENSIVE PRIMARY HEALTH CARE

To completely address the morbidity burden, reduce OOPE, improving the utilization of government health facilities and for ensuring continuum of care; the Government of India has recently implemented the holistic programme of the "Ayushman Bharat". It comprises of two inter-related components. The first component involves upgrading of 1.5 lakh Sub Health Centres (SHCs) and Primary Health Centres (PHCs) to Ayushman Bharat Health and Wellness Centres for the delivery of CPHC. The second component comprises of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) which aims to provide financial protection of up to Rs. 5.0 lakh per annum for secondary and tertiary care to about 40% of India's socially vulnerable and low-income households. Thus, together, the two components of Ayushman Bharat will enable the country to achieve Universal Health Coverage and eventually "Health for All".

The HWCs will provide expanded range of services beyond selective package of health care for pregnant women, children, reproductive health and communicable diseases. HWCs will also deliver **Preventive, Promotive, Curative, Rehabilitative and Palliative** care for wider range of services close to communities. To achieve this, you will need to be sensitive and understand local health needs, cultural traditions and socio-economic status of the HWC population you will serve. You should be able to provide care for most common ailments, enable referral for doctor or specialist consultations and undertake follow-up.

FIGURE 1

Continuum of Care- Comprehensive Primary Health Care and PMJAY



1.3 CONTRIBUTION OF NATIONAL HEALTH MISSION

The National Health Mission (NHM) led to major health systems strengthening efforts in the last fifteen years. In the last fifteen years there has been substantial efforts towards strengthening of District Hospitals/Secondary care facilities. NHM also led to- massive expansion of health workforce and strengthened outreach services through Sub Centres or Multi-Purpose Workers (MPWs) in rural and urban areas.

NHM developed the cadre of one million AHSAs to expand outreach, promote mobilization, and provide home based care and counselling services. Systems for registration, tracking and follow up of target groups for Maternal Newborn and Child Health (MNCH), Family Planning, including high risk for anaemia, Low Birth Weight babies (LBW) and Nutrition Rehabilitation Centre (NRC) have been established. Mechanisms for referral and transport established for MNCH, systems for capacity building, Free Drugs and Diagnostics Service Initiative and Procurement and logistics systems have also been implemented. The Health and Wellness Centres will leverage the above efforts of NHM for providing the expanded range of services.

CHAPTER 2

INTRODUCTION TO HEALTH & WELLNESS CENTRES

2.1 DEFINING HEALTH AND WELLNESS CENTRES

In order to ensure delivery of Comprehensive Primary Health Care (CPHC), all the existing Sub Health Centres and Primary Health Centres (both Rural and Urban) are being upgraded to Health Wellness Centres (HWCs). The Medical Officer of the PHC ensures that CPHC services will be provided to population falling under the service area of both PHC and the linked SHCs. Thus, enabling a network of HWCs to deliver CPHC services.

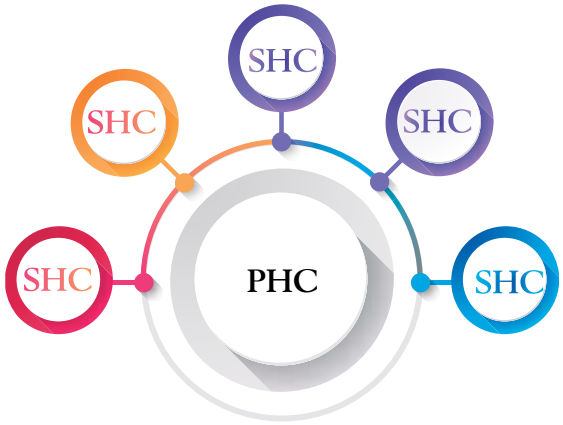
2.2 KEY PRINCIPLES OF HEALTH AND WELLNESS CENTRES

A HWC

1. Provides people-centered, holistic, health care that is sensitive to the health care needs of marginalized and vulnerable sections.
2. Reaches every section of the community through a process of population empanelment, regular home visits, community interactions and people's participation.
3. Delivers high-quality care addressing health risks and disease conditions through-a commensurate expansion of medicines and diagnostics, use of

FIGURE 2

Network of HWCs for CPHC



standard treatment and referral protocols and IT systems to enable continuum of care and maintenance of health records.

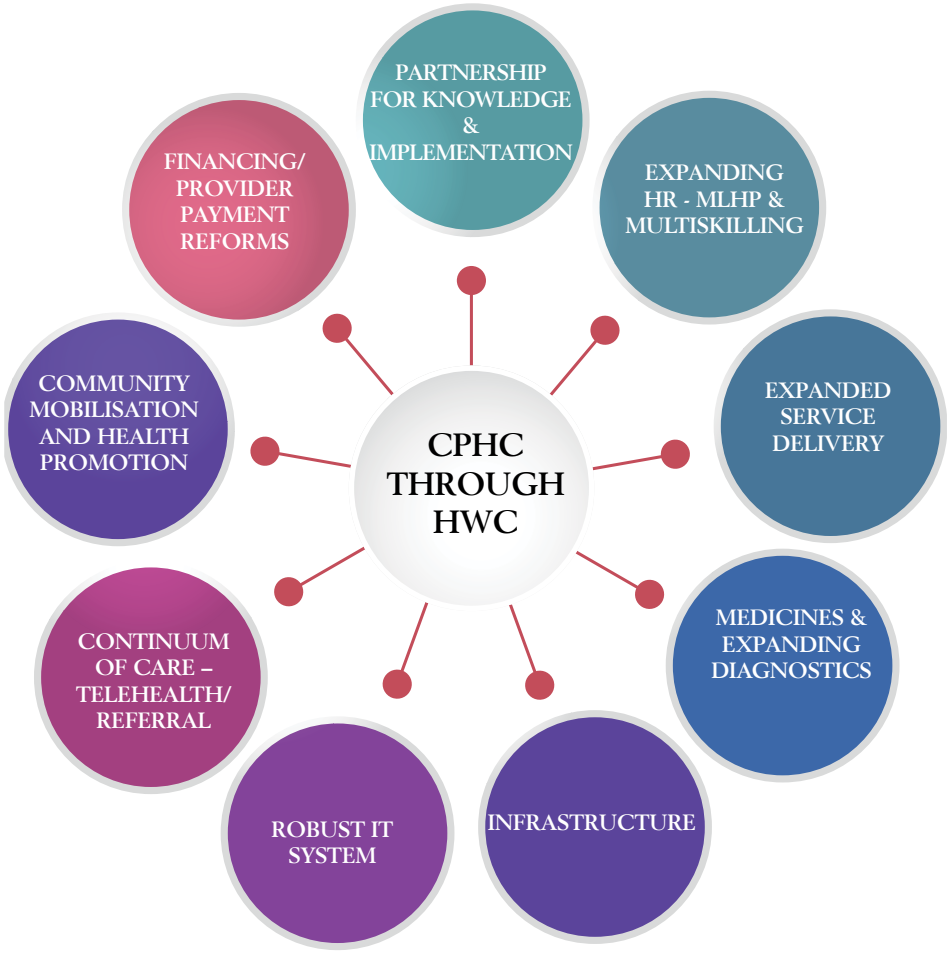
4. Uses a team-based approach in delivery of quality health care encompassing: Preventive, Promotive, Curative, Rehabilitative and Palliative Care.
5. Ensures continuity of care with a two-way referral system and follow up support.
6. Undertakes health promotion (including through school education and individual centric approach) and promotes public health action through active engagement and capacity building of community platforms and individual volunteers.
7. Integrates Yoga, AYUSH services etc as appropriate to people's needs for wellness activities.

2.3 KEY ELEMENTS OF HEALTH AND WELLNESS CENTRES

For PHCs and SHCs are being upgraded to HWCs with certain key inputs (Figure 3) mentioned below:

FIGURE 3

Key Elements to roll out Comprehensive Primary Health Care



1. **Primary health care team** to deliver the expanded range of services.

   a. The HWC at the **Sub Health Centre** is equipped and staffed by an appropriately trained Primary Health Care team, comprising of:

      - One Mid-Level Health Provider (MLHP)/ Community Health Officer (CHO)
      - One or two Multi-Purpose Health Workers (MPWs)- Commonly known as Auxiliary Nurse Midwife.
      - One health worker (male) (optional)
      - ASHAs (one per 1000 population)

   b. **Primary Health centres upgraded** to HWC are staffed by the regular staff of the PHC. In 24x7 PHCs having inpatient care, an additional nurse can also be posted where cervical cancer screening is being undertaken/ planned if desired by the state.

   c. **In urban areas,** other than U-PHC staff the team consists of the MPW-F (for 10,000 population) and the ASHAs (one per 2500 population).

   d. **Logistics:** HWC have expanded list of essential medicines and diagnostics to address the wider range of services particularly NCDs. Adequate availability of essential medicines will need to be ensured to enable HWC teams to resolve more and refer less.

2. **Infrastructure:** The infrastructure of HWC shave sufficient space for - outpatient care, for dispensing medicines, diagnostic services, adequate spaces for display of communication material of health messages, including audio visual aids and appropriate community spaces for wellness activities, including the practice of Yoga and physical exercises.

3. **Digitization:** Primary Care Teams at HWC will use Tablets/Smart Phones to serve a range of functions such as - Population enumeration and empanelment, maintain patient records, enable quality follow up, and facilitate referral/ continuity of care.

4. **Use of Telemedicine/IT Platforms:** At all levels, teleconsultation would be used to improve referral advice, seek clarifications, and undertake virtual training including case management support by specialists.

5. **Capacity Building:** You have already been trained in a set of primary health care and public health competencies through Certificate Programme in Community Health. Other members of the team at HWC like ASHAs, MPWs at SHC and Medical Officers and Staff Nurses at PHC, will also be trained appropriately to deliver the expanded range of services.

6. **Health Promotion:** HWC team will bring about behavior change communication to address life style related risk factors and organize collective action for reducing risk exposure, improved care seeking and effective utilization of primary health

care services. HWC team will also engage- Village Health Sanitation and Nutrition Committee (VHSNCs) and use health ambassadors in schools for community level health prevention and promotion activities.

7. **Community Mobilization:** Community Mobilization through multi-sectoral convergence to address social and environmental determinants of health will be undertaken to ensure delivery of universal and equitable Comprehensive Primary Health Care for all.
8. **Linkages with Mobile Medical Units:** To ensure that no individual is left out or denied care, your districts can also develop linkages with Mobile Medical Units (MMU) to improve access and coverage in remote and under served areas where there is difficulty in establishing HWCs. In such cases, medicines and other support could be provided to frontline workers, with periodic MMU visits.

2.4 EXPANDED RANGE OF SERVICES TO BE PROVIDED AT THE HEALTH AND WELLNESS CENTRES

The Health and Wellness Centres need to provide a set of twelve essential services. A set of these services are needed by specific population sub-groups and remaining services are required to be delivered for the entire population.

These services will be delivered at the level of households and outreach sites in the community with the help of suitably trained frontline workers (ASHAs and MPWs) in the primary health care team.

List of Essential Services for Specific Population sub-groups

Care in Pregnancy and Child-birth

Neonatal and Infant Health Care Services

Childhood & Adolescent Health Care Services

Family Planning, Contraceptives services & other Reproductive Health Care Services

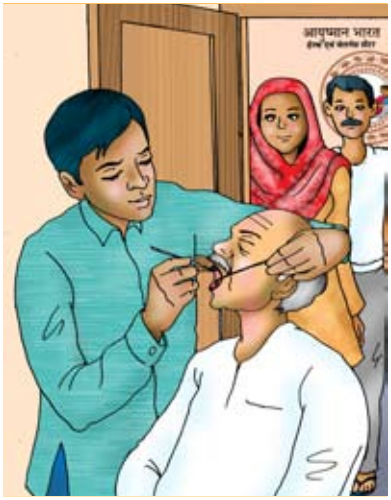
Screening, Prevention, control and management of Non-Communicable diseases for above 30 years age group

Elderly and Palliative health care services

List of Essential Services for Health and Wellness Centre Population

Management of Communicable diseases including National Health Programs

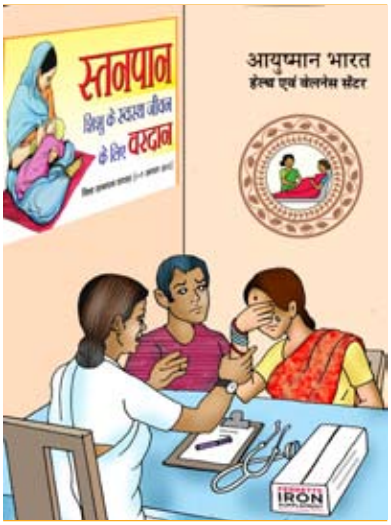
Management of common Communicable diseases and outpatient care for acute simple illnesses & minor ailments



Basic Oral Health Care Services

Care for Eye, Ear & Nose and Throat problems

Emergency Medical Services



Screening and Basic Management of Mental Health problems

CHAPTER 3

ROLES AND RESPONSIBILITIES OF A COMMUNITY HEALTH OFFICER

3.1 RATIONALE AND NEED FOR A COMMUNITY HEALTH OFFICER

From the previous chapters you would have understood that a CHO is one of the most important additions to the Primary Health Care Team at the Sub Health Centre-HWC. States are deploying individuals with professional backgrounds such as *BSc. in Community Health or a Nurse (GNM or B.SC) or an Ayurveda practitioner,* trained and certified through IGNOU/other State Public Health/Medical Universities at HWCs. You are one amongst them.

You have been appointed at HWCs with the vision to:

- Improve access to healthcare in rural/remote areas for the marginalized and vulnerable families.
- Reduce OOPE being incurred by families on healthcare.
- Increase the utilization of public health services at primary care level.
- Reduce fragmentation of care.
- Reduce work load of secondary and tertiary care facilities.

You will achieve these objectives by:

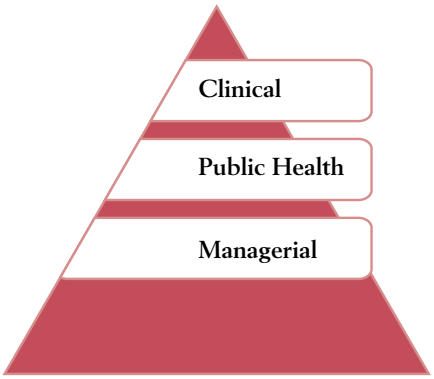
1. Improving the capacity of the HWC to offer expanded range of services closer to the community, thus improving access and coverage with a commensurate reduction in OOPE.
2. Improving clinical management, care coordination and ensure continuity of care through regular follow up, dispensing of medicines, early identification of complications, and undertaking basic diagnostic tests.
3. Strengthening public health activities related to preventive and promotive health and the measurement of health outcomes for the population served by the HWC.

3.2 ROLES AND RESPONSIBILITIES OF THE CHO

As a CHO you will be the first point of care or source of information for the health-related issues for the community by the virtue of the proximity of HWCs to its catchment population. Therefore, it is essential for you to understand the population in your service area and identify its common health needs. In order to achieve this, you will need to win over the trust and confidence of the people from the area you serve.

You are broadly expected to perform the following three functions

- Clinical functions to provide ambulatory (out-patient) care and management.
- Public health functions for health promotion, prevention and disease surveillance.
- Managerial functions for efficient functioning of the Health and Wellness Centres.



The specific roles and responsibilities of CHOs for each of these functions are as follows:

A. Clinical functions for ambulatory care and management

You will provide clinical care as specified in the care pathways and standard treatment guidelines for the range of services expected at the HWC. Your six-months training in Certificate Programme in Community Health has already covered in detail the clinical functions that you are expected to undertake at HWCs.

1. Early detection, screening and first level management

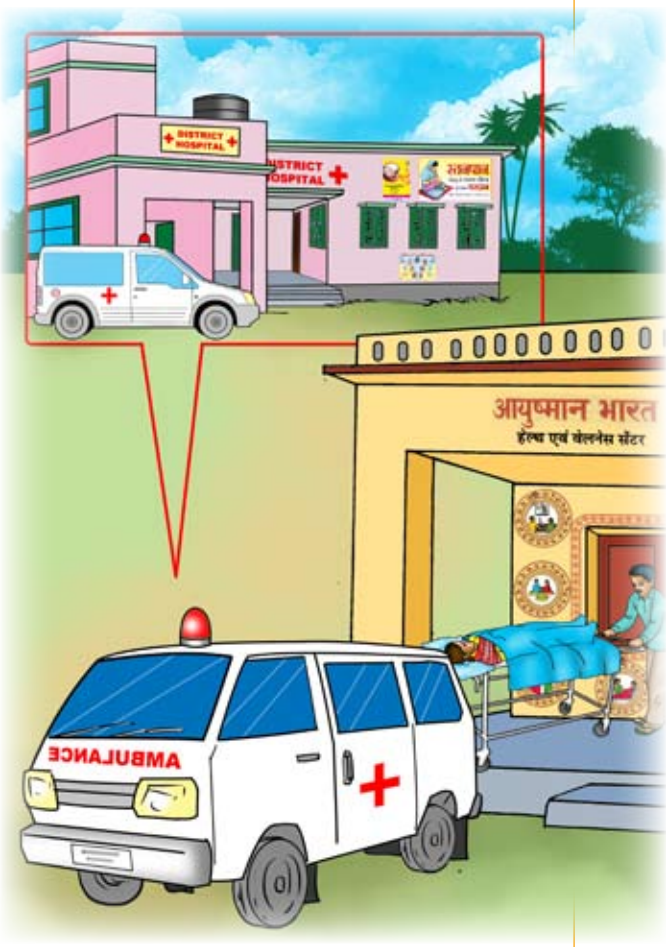
You will:

- Undertake detailed history, physical examination of patients to assess general signs and symptoms for identifying a disease condition.
- Identify and provide the first level management for all conditions covered under the 12 essential packages of services and various national health programmes. The details of the activities that will be undertaken as part of your clinical functions have been discussed in Chapter 6.

2. Undertake referral to enable continuum of care

Your key role will be to coordinate referrals for continuum of care. This would require entering patient case records in referral slip/IT application, providing information on the closest and most appropriate health facility for seeking care, informing the service providers at referral centres, arranging referral transport and providing pre-referral

stabilization if required. Few examples where you will be required to provide active referral support are:



- High risks cases, complications, medical emergencies and trauma.
- Cases screened positive for NCDs, chronic infectious diseases requiring confirmation of diagnosis and initiation of treatment plan.
- Refractory and serious cases related to common communicable diseases and acute illnesses etc.
- Women in need of safe abortion services, eligible couples opting for limiting method of contraception/injectable contraceptives.
- Children 0-18 years age to mobile health teams for assessment of four Ds-Diseases, Disability, Defects and Developmental delays, cases for deaddiction – tobacco/ alcohol/substance abuse.
- Cases in need of rehabilitative care e.g. provision of physiotherapy, crutches, MCR foot ware, etc.
- Cases with tertiary or secondary care under PMJAY.

3. Provide follow up care

Like timely referrals, provision of follow up care is critical to ensure continuum of care. The follow up care can be provided when patient visit HWCs or with support from ASHAs and MPWs when they undertake their household visits. You will follow up for the patients who were treated by you as well as patients who were referred to higher centres for treatment. Key examples for which follow up care is essential are:

- Individuals such as high-risk pregnant women, post-natal mothers, LBW/ SNCU/NRC discharged children, children suffering from common childhood illnesses etc.
- Individuals suffering from chronic illnesses-Hypertension, Diabetes, TB, Leprosy etc to assess- treatment compliance, review of parameters (such as-Blood sugar, Blood Pressure,) adherence to life style modifications, timely detection of complications etc.
- Individuals requiring palliative care need regular home visits for treatment adherence as well as for counselling.
- Individuals requiring post- surgical follow up to detect surgical complications and compliance to maintain post- surgical care in case of surgeries related to cataract, hernia, trauma etc.

4. Provide counselling support for the following

Counselling is a means of assisting people to understand, and cope, more effectively with their problems, improve health seeking behaviour, bring about life style modifications etc. Counselling is an important means to share information related disease management, enabling treatment compliance, educate individuals and families for primary and secondary prevention and support in necessary health promotion. Few examples where counselling is most commonly required are:

- Antenatal Care (ANC), Postnatal Care (PNC), Essential Newborn Care, Infant Young Child Feeding (IYCF), Nutrition counselling, Iron Folic acid tablet (IFA) use, Water Sanitation and Hygiene (WASH), Childhood Immunization, enabling Early Childhood Development (ECD), registration in government sponsored Maternity benefit schemes etc.

- Prevention of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs), health risk behaviours related to-substance abuse, diet, exercise, injury, violence, sexual and reproductive health, hygienic practices, social drop outs, menstrual hygiene, etc in adolescents.
- Adoption of Contraceptive for specific case, and facilitation for safe abortion services, post abortion follow- up care.
- Prevention, of vector borne diseases, prevention of infectious diseases such as TB, Leprosy, HIV/AIDS, STI/RTIs etc and for self-care, treatment compliance, identification of complications related to each of these conditions.
- Lifestyle modification, addressing risk factors and treatment for NCDs.
- Psychosocial support for mental health, awareness and stigma reduction activities and address the myths related to Mental/ neurological illnesses.

5. Facilitate Teleconsultation

You will also use Teleconsultation as part of your clinical functions to:

- Confirm continuation of treatment from your PHC Medical Officer-especially useful during the first follow up visit of the individual who has been recently initiated on treatment for Diabetes/ Hypertension.

- Seek clarifications regarding provision of care when the condition is not serious and patient's time can be saved by obtaining treatment decision from the PHC Medical Officer. For example- you can facilitate teleconsultation for skin rash with PHC MO along with case details and obtain a treatment decision.
- Seek advice to start pre-referral stabilization/first aid where timely interventions are necessary for prevention adverse outcomes.

B. Public health functions for health promotion, prevention and disease surveillance

You will undertake the following activities as part of your public health functions:

1. Ensure collection of population-based data and planning for organizing services at HWCs:

- Ensure that all households/population in your service area are listed, individuals are empanelled at your HWC for seeking health care services and a database is maintained- in digital format of CPHC-IT application/paper format as required by the state.
- Support and supervise the collection of population-based data by frontline workers, collate and analyse data for planning and reporting data to the next level in an accurate and timely fashion. For example- data related to pregnant mothers or children under five will be used to prepare micro birth plans or micro planning needed for Universal Immunization Programme. Likewise, data on population above 30 years of age will be used to plan schedule of NCD screening, fix monthly targets for your HWC and monitor coverage.
- 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.

2. Community level action for health promotion prevention

- Coordinate with VHSNCs and work closely with PRI/ULB, to address social determinants of health and promote behaviour change for improved health outcomes.
- Address issues of social and environmental determinants of health with extension workers of other departments related to gender-based violence, education, safe

potable water, sanitation, safe collection of refuse, proper disposal of waste water, indoor air pollution, and on specific environmental hazards such as fluorosis, silicosis, arsenic contamination, etc.

- Guide and be actively engaged in community level health promotion activities including behaviour change communication being undertaken by ASHAs/MPWs.
- Plan and undertake monthly health promotion activities/campaigns to improve community awareness and uptake of services for- sanitation, nutrition rehabilitation, substance use, life style modifications, eating right and eating safe, control of communicable diseases TB, leprosy, HIV/AIDS, vector borne illnesses, family planning etc.
- Conduct monthly VHSND & VHSNC meetings for monitoring of community level activities for health promotion.
- Organize at least 30 Heath promotion campaigns in a year on different themes.

3. Disease surveillance

An "epidemic" or "outbreak" is the sudden occurrence of disease in greater numbers than what you would normally expect to see in the HWC area. If you normally see about 15 cases of respiratory infection per month among children under five in a village in the rainy season, and this year you see 18 cases, it may not be an outbreak. But if you see 50 cases, which is clearly greater than what you would expect in that village in the rainy season, it would constitute an outbreak, or "epidemic" of respiratory infection. Your main role will be to coordinate and lead local response to disease outbreaks, emergencies and disaster situations and support the medical team or joint investigation teams for disease outbreaks. The investigation of an outbreak or epidemic is an important step in controlling disease which may cause a lot of adverse consequences, if allowed to spread rapidly. You will undertake the following steps in investigating an outbreak:

- Ascertain the diagnosis of the condition. Example of outbreak is– measles, gastroenteritis.
- Verify the existence of an "epidemic/Outbreak" by comparing the count of the cases reported currently with what is usually seen in the area at the same period.
- Inform the PHC medical officer and other authorities if the number of cases is higher than expected. This will enable assistance to reach, so that the outbreak can be handled correctly and promptly.
- Search for cases and listing- Since the cases that come to the notice of the health department are always less than the actual numbers of cases which occur, HWC

staff must look for the "hidden" part of the outbreak, by looking for cases in the villages/community. List the cases with some basic information including age, sex, onset of disease, key symptoms, any treatment taken, when the disease stopped (if it stopped) and outcome.

- Participate in the control activity which is initiated by the PHC/other health staff. You must actively participate in all control activity, like setting up treatment centres, education to the unaffected population, environmental action if required, and other activity.

C. Managerial Functions for efficient functioning of HWCs:

As a team leader of the HWC Team you will also be responsible for undertaking managerial and administrative functions of the HWC such as inventory management, upkeep and maintenance, and management of untied funds. Details of the activities to be undertaken for each of these tasks are as follows:

1. Recording, reporting and monitoring of service delivery

- Support MPWs in maintaining updated information for all sub centre level reporting formats required to assess service delivery under the various national health programmes.
- Maintain records on delivery of services at HWCs-OPD/ Investigations conducted/services provided.
- Maintain patient records, family health folders, health risk assessment data, and treatment details for enrolled patients of HWC in a computerized data base.
- Ensure accurate and timely completion/updation of various health information systems such as-HMIS, RCH Portal, CPHC NCD Application, NIKSHAY etc.

- Submit monthly performance report for the HWCs to PHC MO to enable disbursement of the Performance Linked Payments to HWC-Team.
- Use the information available in the various reporting formats to assess service delivery improvements, identify key gaps, assess reasons for the gaps and support ASHAs and MPWs in improving performance.

2. Undertake administrative functions of HWCs

- Inventory management to assess availability of medicines, reagents and consumables at HWC.
- Timely indenting to maintain adequate stocks. Display the list of essential medicines and diagnostic services that will be available at your HWC will be provided by your state NHM.
- Ensure proper upkeep and maintenance of equipment, furniture and fixture at HWCs.

- Proper utilization of HWC-untied fund (Rs. 50,000/HWC) in consensus with MPWs and maintain records and account book for internal Controls, payments and expenditure, prepare statement of Expenditure (SoE) and Utilization Certificate (UC) for annual submission to PHC MO.

3. Supportive Supervision of HWC Team: Supportive supervision of the HWC team will be undertaken through the following:

- Conducting monthly HWC meetings with MPWs and ASHAs for:
  a. Assessing progress on coverage of beneficiaries for various services.
  b. Identifying and addressing gaps. The gaps could be on account of team members knowledge or skill that can be either resolved on the spot or facilitation of additional trainings.
  c. Discuss common issues and problems being faced by ASHAs and MPWs.
  d. Identifying actions that need to be highlighted to PHC-Medical Officer.
  e. Refreshing skills and knowledge of ASHAs and MPWs.
  f. Keeping the team updated about the new programme guidelines and technical details.
- Conducting visits to beneficiary households where ASHAs and MPWs need additional support in motivating families to adopt healthy behaviours, utilize services at HWCs, in ensuring treatment compliance etc.
- Monitoring the conduction of community/village level meetings such as VHSND, VHSNCs or campaigns under various national health programmes.
- Facilitate multi-sectoral convergence for action by ASHA/MPW and VHSNCs on social determinants of health, health promotion and prevention activities.

CHAPTER 4
KNOWING YOUR POPULATION AND DISEASE PATTERN

4.1 DEMOGRAPHIC STRUCTURE OF YOUR POPULATION

The usual population under the catchment area of a SCH-HWC is 5000. People from different groups with respect to age, gender etc. have different health needs. As a Community Health Officer, you will have to understand, predict and cater to the health needs of your population. But for that you need to first understand-**What constitutes your population?**

Given below is the Table 1 depicting age group wise composition of your population *(Source: Census Report 2011)*.

Table 1: Demographic Composition of Population

Age Groups	Percentage	Formula	Total population in a catchment area of 5000
0-1 years of age	3	3 x 5000/100	150
0-4 years of age	9.7	9.7 x 5000/100	485
1-5 years of age	11.2	11.2 x 5000/100	560
5-9 years of age	9.2	9.2 x 5000/100	460
10-14 years of age	10.5	10.5 x 5000/100	525
0-14 years of age	29.5	29.5 x 5000/100	1475
10-19 years of age	18.4	18.4 x 5000/100	920
15-49 years women of reproductive age group	24	24 x 5000/100	1200
15-59 years of age	62.5	62.5 x 5000/100	3125
30 years & above	37	37 x 5000/100	1850
60 years & above	8	8 x 5000/100	400
65 years & above	5.3	5.3 x 5000/100	265

4.2 CALCULATING THE BENEFICIARIES

It is important for you to estimate the number of beneficiaries who should avail services at your HWC. This would help in improving coverage of population with essential services and improve access to healthcare for the marginalized and vulnerable groups.

To calculate some of the key beneficiaries in your area, you will need to know the population covered by your HWC-SHC and the Birth Rate. The PHC-Medical Officer, your MPWs have the recent count of the population of your HWC. This will need to be updated by a household survey at the beginning of the year by MPWs and ASHAs during Population Enumeration.

Some of the important calculations that you may need while serving as CHO at HWC-SHC are given in Table 2:

Table 2: Calculations of key Beneficiaries

1. Estimated Number of Pregnant women in HWC area
Birth rate of your state = 20.2/1000 population *(Source-SRS 2019)*
Population under each SHC-HWC = 5000
Therefore, expected number of live-births = (20.2 x 5000)/1000 = 101 births
*Correction factor = 10% of live births (i.e. [10/100] x 101) = 10.1
Therefore, total number of expected Pregnant women in a year under one HWC = 101 + 10.1 = 111.1=111 per year.
*As some of the pregnancies may not result in a live-birth (i.e. abortions and stillbirths may occur), the expected number of live births is an underestimation of the total number of pregnancies. Hence, a correction factor of 10% is required, i.e. add 10% to the figure obtained above. This will give the total number of expected pregnancies.
2. Number of Live Births/Estimated Newborns in HWC area
Expected number of live-births = (20.2 x 5000)/1000 = 101 births
Hence number of newborns per month = 101/12 = 8-9/month in a population of 5000.
3. Estimated Number of Pregnant mothers with complications
Estimated Maternal Complications is 15% approx. Hence number of mothers with complications in Pregnancy, Delivery and Post-Partum are:
Number of pregnant women x 15%.
Number of pregnant women with under one HWC-SHC = 111
Number of pregnant women with complications = 111 x 15% = 16 to 17 annually
4. Eligible couples: 17% of total population
Total number of Eligible couples in HWC-SHC= (5000 x 17/100) = 850 eligible couples/5000 population
5. Sick newborns- 10% to 12% of total live births
Total number of live-births in SHC-HWC = 101 births
Number of sick newborns in SHC-HWC= (101x12/100) = 12-13 sick newborns

6. Estimation of beneficiaries for common Non-Communicable Diseases
Population ABOVE 30 years is 37% of the total population i.e 1850
No. of men above 30 years-51% of the total above 30 age group = 944
No. of women above 30 years-49% of the total above 30 age group = 906
For hypertension and diabetes cases annually = 1850
For oral cancer –for men and women per year= 370
Breast cancer & cervical cancer per year= 182

Other important calculations

7. Number of Neonatal/Infant Deaths
IMR in your area: 33/1000 live births
NMR can be approximately calculated as 2/3rd of the IMR;
Hence NMR: 2/3*33 =22 approx.
Annual live births in a year at 5000 population or under one HWC-SHC= 101
Hence the number of infant's deaths is equal to number of births annually x IMR divided by 1000 = 101 x 33/1000 = 3.33; thus 3-4infant deaths annually at a HWC-SHC.
Total number of births annually x NMR and divided by 1000=
=101 x22/1000= 2.2 Thus, 2-3 neo natal deaths annually at a HWC-SHC.
8. Ante Natal Care Coverage
Percentage of pregnancies in the area that received ANC: = (No. of pregnancies received ANC/Total number of pregnancies) x 100.

4.3 KNOWING THE DISEASE PATTERN RELEVANT IN YOUR HWC POPULATION

If you have to ensure population health it is vital to know following:

- Burden of disease.
- Areas where the health problem is majorly present.
- Population groups that are most affected.

Occurrence of disease can be measured using rates or proportions. *Rates* tell us how fast the disease is occurring in a population; *proportions* tell us what fraction of the population is affected. Let us turn to how we use rates and proportions for expressing the extent of disease in a community or other population.

Incidence is defined as occurrence of new cases of disease in a population over a specified period of time.

Incidence rate is defined as the number of new cases of a disease divided by the population at risk for developing the disease.

For example, 5 women develop breast cancer in one year in a population of 906 women age above 30 years in your HWC area. The incidence is 5/906=0.0055 and the incidence rate per 2000 population is 0.0055x2000=11.

Thus, the incidence rate of breast cancer in your HWC is 11 cases per 2000 of women population above 30 years per year.

Prevalence is defined as the number of affected persons (both old and new cases) present in the population at a specific time divided by the number of persons in the population at that time, that is, what proportion of the population is affected by the disease at that time?

For example, in your HWC area, there are 906 women aged 30 years & above and 280 of these women are newly diagnosed as diabetic and 100 old cases of diabetes are already present. Prevalence is (280+100/906)*100=42%. So, approx. 42% of women in your HWC are diabetic.

The table given below describes the average number of disease specific cases in India and HWC. These are the minimum number of cases estimated annually. The number of cases might be increased in some diseases such as tuberculosis, malaria, leprosy, chikungunya, filariasis etc. due to seasonal variations. You have to be alert if you are working in such disease endemic areas and plan interventions together with your PHC-MO to manage the disease.

Indicator	Number of cases in India	Number of cases in HWC	Source
Incidence of Tuberculosis cases	2.8 million (Incidence rate-211/100000)	5-10 cases	Global TB report 2017
Number of Malaria cases	0.84 million *API-0.64/1000	3-4 cases	NVBDCP report
Incidence of Leprosy cases	0.13 million (Prevalence is 0.67/10000)	Less than 1 case (depends upon state specific prevalence)*	NLEP Annual Report 2016-2017
Percentage of Malnourished children	Underweight-35.7% Stunted- 38.4% Wasted- 21%		NFHS 4

**Annual Parasite Incidence- (Confirmed cases during one year/population under surveillance) x1000*

**Some states has leprosy prevalence of 1 or 2/1000 and some has more than 5.*

4.4 POPULATION ENUMERATION AND EMPANELMENT OF FAMILIES AT HWC

Once the HWCs have been made operational, the first activity you will undertake with support from the ASHA will be population enumeration to facilitate empanelment. This will help you know your community and your community to identify you, their MPW and ASHAs.

The primary health care team would prepare a population-based household lists and undertake registration of all individuals and families residing within the catchment area of a HWC in the **Family Folder** (Annexure 2). This process is called empanelment of individuals and families at HWCs. Once empanelled through these **family folders**, this data will be transferred to the IT systems in place at the SHC and thus will serve as record of all the population under your HWC.

Along with the population empanelment, the second task of ASHA is to fill the Community Based Assessment Checklist (CBAC). CBAC aims to collect details of all individuals 30 years and above, on the risk factors pertaining to diseases like hypertension, Diabetes, cancers like oral, breasts or cervical, tuberculosis, leprosy etc.

The purpose of CBAC is not only to gather data related to individuals but also to:

a. Aware community on the easily identifiable risk factors of the common diseases.

b. Aware community about the newer services that are being provided at their Sub-Centre which is now upgraded to Health and Wellness Centres.

c. Provide ASHA a platform to develop interpersonal relationship with the community.

d. Helps identify those who must be prioritized to attend the screening day.

e. Community Mobilization

CBAC covers questions pertaining to-duration of signs and symptoms, behavioural factors like tobacco and alcohol consumption, amount of physical activity, measurement of waist circumference, family history of high blood pressure, diabetes, heart disease and presence of common symptoms for common cancers, epilepsy and respiratory diseases have been asked in CBAC (Annexure 2).

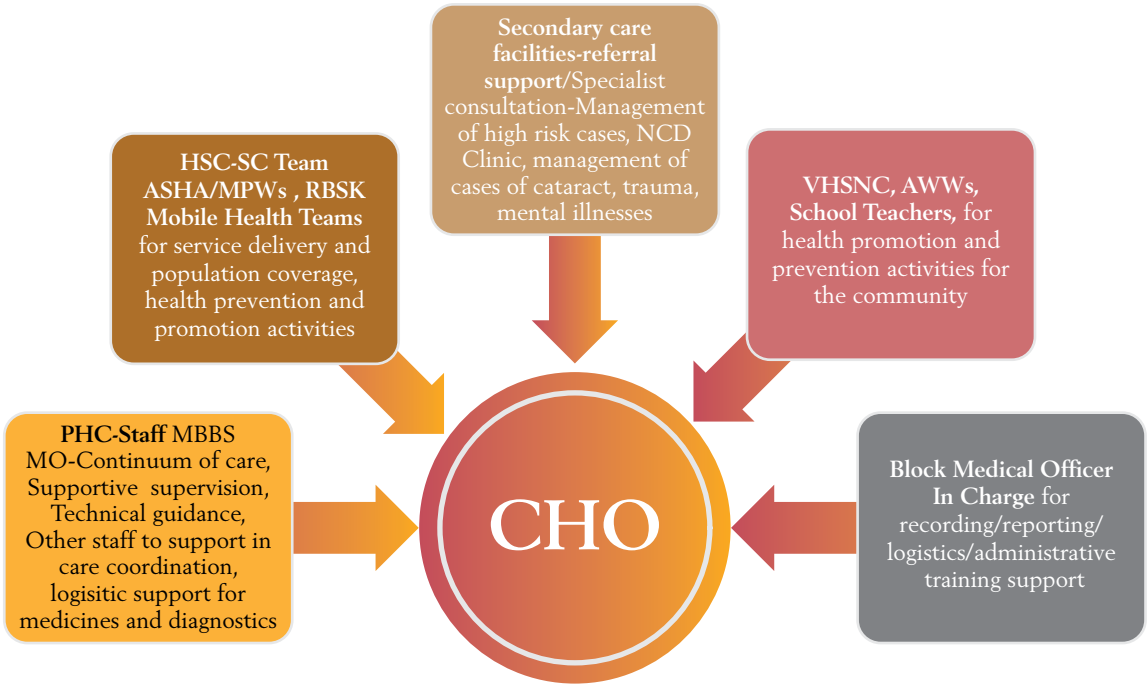
Individuals with a CBAC score of 4 and above will need to be prioritized for screening. Your task as a CHO is to review the completed CBAC filled by the ASHA and verified by MPWs in your coverage area to ensure that it is filled and correct.

CHAPTER 5

PRIMARY HEALTH CARE TEAM, WORK COORDINATION AND ACTIVITY PLAN OF A COMMUNITY HEALTH OFFICER

FIGURE 5

Work Coordination of a Community Health Officer



As a CHO, you will need to work in close coordination with:

- Team of ASHAs and MPWs at your HWCs.
- Service providers of your linked PHC.
- Block Medical Officer In-charge.

- Service providers at secondary care facilities for referral support, RBSK Teams, VHSNCs, AWWs, School teachers for the delivery of CPHC.

For an effective care coordination, it is important for you to understand the broad roles and responsibilities of MPWs and ASHAs. Their specific functions related to essential package of services under CPHC will be covered in detail in your training in respective modules for each of the services. There is some overlap in roles and responsibilities of CHO and MPWs at the HWCs in the delivery of CPHC services. However, based on the local context and population coverage you and MPWs will need to plan each other's work distribution through mutual discussion and in consultation with your Medical Officer. The work distribution involving common functions for both should be so planned that specified essential services can be provided both at the HWC and community level.

5.1 ROLES OF AN ASHA IN COMMUNITY LEVEL PROVISION OF SERVICES

Broadly the roles and responsibilities of an ASHA include the functions of a healthcare facilitator, a service provider and a health activist. Her functions involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services; participation in health campaigns and enabling people to claim health entitlements.

Her roles and responsibilities are as follows:

- ASHA takes steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living, life style modifications, and working conditions, information on existing health services and the need for timely use of health services.
- She will counsel women and families on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA mobilizes the community and facilitate people's access to health and health related services available at the village/HWC-sub-centre/HWC-Primary health centres, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided under CPHC by the government.
- She works with the Village Health, Sanitation and Nutrition Committee to develop a comprehensive village health plan, and promote convergent action by the committee on social determinants of health. In support with VHSNC, ASHAs also assist and mobilize the community for action against gender-based violence.

- She arranges/escorts/accompanies pregnant women & children requiring treatment/admission to the nearest pre- identified health facility i.e. HWC- Health Centre/First Referral Unit (PHC/CHC/FRU).
- ASHA also provides community level curative care for minor ailments such as diarrhoea, fever, care for the normal and sick newborn, childhood illnesses and first aid. She is a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She also acts as a depot holder for essential health products appropriate to local community needs. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. These will be updated from time to time, States can add to the list as appropriate.
- The ASHA's role as a care provider will also be enhanced through based on state needs and roll out of services under CPHC. ASHAs role will expand through graded training in new service packages such as NCD, Oral, Eye, ENT, Elderly, Palliative care, Mental health, medical emergencies and trauma, Early childhood development, childhood disability, and others.
- The ASHA undertakes annual household surveys for population enumeration, maintains a village health records and provides information on about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.
- She promotes construction of household toilets under Swachh Bharat Mission.

The ASHA fulfils her role through five activities:

1. **Home Visits:** For up to two hours every day, for at least four or five days a week, the ASHA should visit the families living in her catchment area, with first priority being accorded to marginalized families. Home visits are intended for health promotion, preventive care and follow up services for ensuring treatment compliance. They are important not only for the services that ASHA provides for reproductive, maternal, newborn, child health or communicable diseases interventions, but also for new services packages such as non-communicable diseases, Eye, ENT, Elderly, Palliative, Mental Health etc. The ASHA should prioritize homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child. Home visits to these households should take place at least once in a month. Where there is a new born in the house, a series of

six visits or more becomes essential. ASHAs are now also expected to provide additional visits at 3rd, 6th, 9th, 12th and 15th months of age for young infants as part of the Home-Based Care for the young child.

2. **Attending the Village Health Sanitation and Nutrition Day (VHSND):** The ASHA promotes attendance at the monthly Village Health and Nutrition Day by those who need Anganwadi or MPW/Auxiliary Nurse Midwife (MPW) services and help with counselling, health education and access to services.
3. **Visits to the health facility:** This usually involves accompanying a pregnant woman, sick child, or members needing screening services for facility-based care. The ASHA is expected to attend the monthly review meeting held at the PHC.
4. **Holding village level meeting:** As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), the ASHA helps in convening the monthly meeting of the VHSNC and provide leadership and guidance to its functioning. These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.
5. **Maintain records:** Maintaining records which help her in organizing her work and help her to plan better for the health of the people.

The first three activities relate to facilitation or provision of healthcare, the fourth is mobilization and fifth is supportive of other roles.

5.2 ROLE OF MULTI-PURPOSE WORKERS (FEMALES AND MALES)

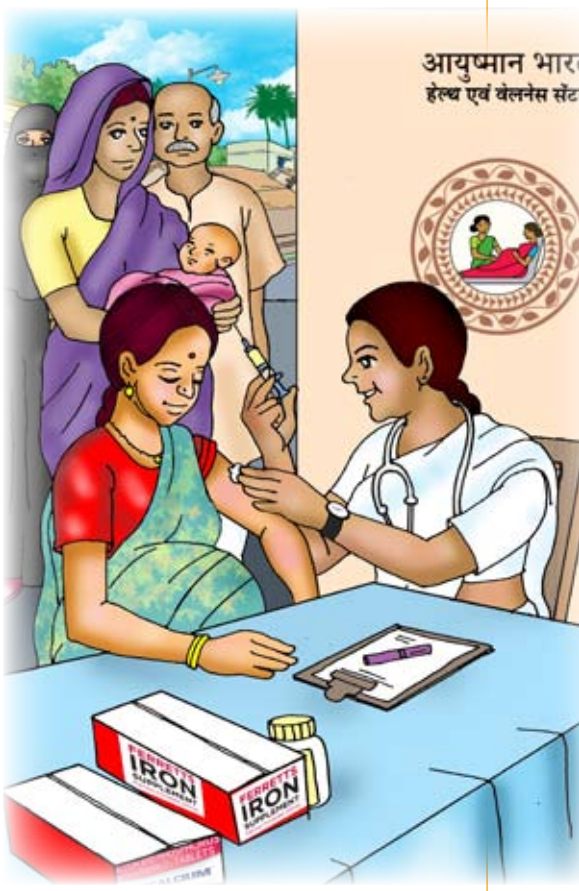
Broadly the functions of **Multi-purpose workers, both females and males are as follows:**

i. Functions at the sub-centre-HWC

- General OPD services when available in the Health Sub-centre HWC and support CHO in treating common ailments-fever, cough, diarrhoea, worm infestation, minor injuries, RTI/STI & others, any acute fever for which blood smear/RD test must be done, and anti-malarial given or referral made as indicated.
- Attending to those who missed the immunization outreach services or VHSND and therefore could not avail of the services offered there

(ANC registration & check-up, immunization, IFA tablets, access to contraceptives etc.) and also report serious AEFI.

- Midwifery Services in Sub Centres only where institutional deliveries have been allowed by the state governments.
- Attend to beneficiaries coming for special family planning needs - e.g. emergency contraceptives, IUD insertion, oral contraceptives, condoms etc.
- Help ASHA with replenishment of drugs in her kit.
- Undertake Diagnostic Services- Pregnancy Test, Haemoglobin, Urine Test, Blood Sugar and other point of care diagnostic services specified for different service packages.
- Organize Special "Day Clinics" along with CHOs and ASHAs to enhance attendance for ambulatory outpatient services. Each of these could be held once a week: Adolescent wellness clinic/session, Family Planning counselling clinic, chronic illness clinic, Elderly care session, ANC clinic, Immunization days etc.



- Identification and referral of common mental illnesses, substance use and Epilepsy cases for treatment and follow them up in community.
- IEC Activities for prevention and early detection of hearing impairment/deafness, visual impairments at the level of health facility, community and schools.
- Motivation for quitting and referrals to Tobacco Cassation Centre at District Hospital/Medical College.

ii. Functions for Provision of Outreach Services to population covered by the sub-centre

(a) Organize **Village Health Sanitation and Nutrition Day (VHSND)** to deliver outreach services for:

- Routine immunization, Antenatal care (all components), Postnatal care (all components), issue of IFA tablets to all, Delivery of condoms or pills, Counselling on family planning.
- Treatment of patients with any minor illness, who come to seek her services.
- Follow-up visit for any chronic illness who come to seek care (in remote and inaccessible areas).
- Making blood slides/doing RD tests on any patient with fever and giving treatment if required.

- Growth monitoring and counselling on nutrition, breast feeding, especially for pregnant women and children.

(b) **Undertake Field/Home visits for:**

- Prioritized visit to pregnant women who did not attend their regular ANCs in the monthly ANC clinics/ VHSND, especially if they are in their 9th month of pregnancy and bring them back to the system -motivate them for institutional deliveries.
- Midwifery services to pregnant women along with visits to post-partum mothers for home-based services and providing care - either as indicated by ASHA after a home visit, or if ASHA is not there, or if they failed to attend VHSND.
- Identify children who missed their immunization sessions and ensure that they get vaccinated during next immunization session/campaigns.
- Visit sick new born/low-birth weight babies and children who need referral but are unable to go, as indicated by ASHA and malnourished children who did not go for the medical reference - ensure they get care at a higher centre.
- Motivate Families with whom ASHA is having difficulty in motivating for changing health-seeking behaviours, adopting family planning methods and who did not come to VHSND.
- Patients having chronic illnesses, who have not reported for follow-up at the sub centre or VHSND and encourage them to attend special-day clinics
- Prioritized visits in areas where Fever Treatment Depots/ASHAs have not been deployed - Collecting blood smears or performs RDTs from suspected malaria cases during domiciliary visits and maintains records. Providing treatment to positive cases.
- Support ASHA to ensure home based care for new born and young children. In cases where ASHA is not able to manage with

home-based care, MPW (F) should provide appropriate treatment or refer to higher centres.

- Distribution and utilization of LLIN Bed Nets; facilitate and ensure quality spray in households and insecticide treatment of community-owned bed nets.
- Verbal autopsy/or at least preliminary inquiry into any maternal or child death. During a visit clusters of families or beneficiaries may be collected and locally relevant health issues discussed or necessary counselling given.
- Surveillance for unusually high incidence of cases of diarrhoeas, dysentery, fever, jaundice, diphtheria, whooping cough, tetanus, polio and other communicable disease and notify CHO and PHC-MO.
- Identify, screen and refer all cases of visual impairment, blindness, loss of hearing, deafness, mental illness, epilepsy and disability to the nearest higher centre also ensure identification and referral of infants with birth defects, sick neonates and children with deficiency conditions and developmental delays.
- Ensuring regular Testing of salt at household level for presence of Iodine through Salt Testing Kits by ASHAs.
- Undertake household survey with ASHAs for detailed mapping, enumeration and enrolment of population being covered in HWC, identifying population at risk, estimating RCH needs etc.
- CHO helps in formation of Patient support groups for different diseases.

iii. Functions for Health Education of the community

Educate the community on:

- Danger signs during pregnancy, Importance of institutional delivery and where to go for delivery and Importance of seeking post-natal care.
- Nutrition
- Importance of Exclusive Breastfeeding and Weaning and complementary feeding.
- Care during diarrhoea, use of ORS with Zinc, signs of dehydration.
- Care during acute respiratory infections (Signs of Pneumonia and Respiratory Distress).
- Prevention of malaria, TB, leprosy and other communicable and locally endemic diseases (e.g. Kala-Azar, encephalitis).
- Information and Prevention of RTIs, STIs, HIV/AIDS.
- Importance of safe drinking water/Personal hygiene/ household Sanitation etc.

- Family Planning/Education of children/Dangers of sex selection/Age at marriage/ Information on/Disease outbreak/Disaster management/Adolescent Health.
- IEC to prevent fluorosis.
- Life style modifications needed for non-communicable diseases like Hypertension and Diabetes.
- Importance of regular follow up visits to Health and Wellness Centre or other facilities for NCDs and ensuring adherence to treatment plans.
- Oral Health education especially to antenatal and lactating mothers, school children and adolescent, first aid and referral of cases with oral problems.

iv. Functions of Reporting and Record Maintenance

- In addition, to all the above work, MPWs will devote sufficient time for register entries and housekeeping work, data entry; report preparation and review meetings.
- The main purpose of records should be to improve the quality of care provided to service users and to measure and plan for service needs and health outcomes in the population. The use of records to monitor her work, should flow from this priority rather than dictate the design of registers and their use. HMIS/RCH data should also be regularly updated and maintained.
- In addition, she would also ensure timely documentation and registration of all births and deaths under the jurisdiction of Sub Centre.
- Support CHO in enabling every HWC to have a folder for every family that should be ideally in a digitized form but even a manual register to begin with two pages dedicated to every family member will also suffice for the time being.
- They should maintain this register using population enumeration data and with help of the ASHA and must have detailed records e.g. name-based list of children who require immunization, line listing of high- risk pregnant women, adults above 30 years of age for screening of NCDs (CBAC) etc.
- The information for every family should have:
  - MCP card for all mothers and children.
  - Simple card/register to line-list all the health events.
  - Separate card for anyone on a TB/HIV/Leprosy/Kala-azar treatment protocol.
  - Separate card for anyone attending the special clinics – adolescent wellness, family planning, chronic illness etc. or being followed up at home for any chronic illness.
- Attend VHSNC meetings as far as possible and ensure that the minutes of the meetings are recorded and maintained. MPWs will support CHO in ensuring that the untied funds are utilized as per the rules and guidelines.
- Making and timely submission of reports for various programs i.e. RCH Portal, NCD, HMIS, IDSP, NIKSHAY etc.

5.3 ROLE OF PHC MEDICAL OFFICER

The PHC Medical Officer at the HWC-PHC will monitor, support and supervise the delivery of comprehensive primary health care through the network of SHC-HWCs.

You will work in the overall supervision of the PHC Medical Officer. The PHC MO will support you in delivery of services at HWC-SCs by:

- Reviewing and managing all cases referred by CHOs/MPWs as per Standard Treatment Guidelines.
- Ensuring continuum of care for patients as per standard referral pathways to ensure timely diagnoses and management of disease conditions at higher level facilities.
- Supporting the primary health care team at HWC- SHCs through telehealth and undertake teleconsultation with specialists at higher-level facilities wherever required.
- Systematically documenting health conditions, treatment plan, disease progression and detailed instructions for follow up management by HWC-SHC Teams or referral to higher facilities.
- Ensuring timely submission of updated monthly records and reports for programme monitoring and strategic planning.
- Reviewing reports to assess service delivery coverage especially to marginalized population and planning activities for improvement with the HWC-Primary Health Care team.
- Assessing the performance of Primary Health Care Team at SHC-HWCs on a monthly basis based on the performance monitoring criteria shared by state NHM.
- Ensuring timely submission of performance report to Block and District level Officer for CPHC, Chief Medical Health Officer for the release of monthly performance-based incentives to the members of HWC team.
- Ensuring regular supply and sufficient stocks of medicines, equipment and reagents at the PHC and at all the SHC-HWCs as per national/state list of Essential medicines/Diagnostics for the HWC-SC and PHC
- Apart from the Medicines listed in the Essential List of SHCs, a PHC Medical Officer should ensure availability of adequate stocks of the medicines that can be dispensed by CHOs
- Providing support and supervision to the Primary Health Care team at HWC-SC and HWC-PHC by undertaking monthly visits to HWC-SC and holding PHC review meetings for- technical handholding of CHOs, assessing progress on coverage of beneficiaries under various services, identifying and addressing gaps.
- Providing facilitation for additional trainings.
- Discuss and resolve common issues and problems being faced by ASHAs and MPWs.

5.4 ROLE OF BLOCK MEDICAL OFFICER IN CHARGE

The HWC team at the SHCs and PHC will work under the overall supervision of the Block Medical Officer-In Charge. The BMO-IC supports the delivery of CPHC by the following functions:

- Roll out of activities at block level; manage, monitor and support the work for delivery of CPHC through HWCs.
- Develop-PHC/SHC-HWC wise detailed plan for activities such as Population Enumeration/CBAC, Screening, and health campaigns for the delivery of National Health Programmes.
- Undertake gap analysis for all essential inputs of HWCs such as- infrastructure strengthening and ensure availability supplies and adequate stocks of requisite medicines, clinical and laboratory equipment, reagents and other consumables at the SHC-HWCs and the referral PHCs.
- Undertake field visits to address challenges in project implementation and appraise District/State Nodal Officer on progress.
- Coordinate with PHC MOs, BPMs and CHOs to gather service delivery data and generate block and facility wise analytical reports.
- Submit monthly and quarterly reports in prescribed format to District Programme Officers.
- Implement mechanisms of assess performance-based incentives to CHOs and team- based incentives to other Primary Health Care Team.
- Coordinate with Zilla-Panchayat and Gram Panchayats/Urban Local Bodies in ensuring IEC for awareness about HWCs/CPHC, organizing health promotion campaigns, camps under various national health programmes.
- Ensure periodic review meeting with the Primary Health Care Teams at the PHCs or SHCs.

5.5 PLANNING OF ACTIVITIES TO PROVIDE CPHC SERVICES FOR POPULATION IN HWC SERVICE AREA

To ensure that population in the service area of HWC is able to obtain CPHC services, it will be useful for you to develop a weekly plan of activities for the primary health care team. An illustrative weekly calendar in Table 3 is described below. You can modify this plan based on your state/district specific context.

Table 3: Illustrative weekly calendar for primary health care team at HSC-HWC

Days	9 am -1 pm	2-4 pm
Monday	**Immunization Day**	
	OPD by CHO + MPW -1 Home visits by MPW-2	OPD by CHO + MPW-1 Home visits by MPW-2
Tuesday	**ANC Day**	
	OPD by CHO and MPW-2 Home visits by MPW-1	OPD by CHO and MPW-2 Home visits by MPW-1
Wednesday	**NCD screening Day**	
	OPD by CHO + MPW -1 Home visits by MPW -2	OPD by CHO + MPW -1 Home visits by MPW -2
Thursday	**VHSND Day**	
	OPD by CHO or MPW- 1 or One VHSND by each MPW or One VHSND each by MPW -1 and CHO	OPD by CHO or MPW- 1 or Home Visits by two MPWs or Home Visits by MPW-1 and CHO
Friday	Outreach activities by CHO (NCD screening camp or participation in RBSK camps and school/AWC visit etc may be planned based on roll out of new service packages and local requirements)	OPD by MPW-1 1st Friday- VHSNC meeting by CHO 2nd Friday- VHSNC meeting or Patient Support Group meeting by CHO 3rd Friday- SHC monthly meeting by CHO 4th Friday- PHC Monthly meeting
Saturday	Wellness Activity – (e.g.-Yoga supported by two MPWs and ASHAs) OPD by CHO	Weekly review meeting at SHC team

CHAPTER 6

SERVICE DELIVERY FRAMEWORK & CONTINUUM OF CARE FOR CPHC

6.1 ORGANIZATION OF SERVICES

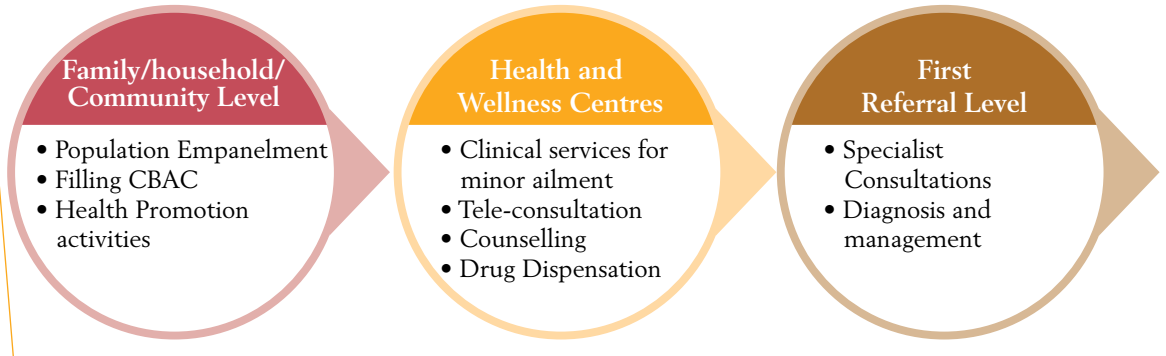
Delivery of an expanded range of services, closer to the community at HWCs would require re-organization of the existing workflow processes. The delivery of services would be at three levels:

- Family/Household and community levels
- Health and Wellness Centres and
- Referral Facilities/Sites.

Figure 6, depicts how the delivery of service will be spread across various levels.

FIGURE 6

Organization of Services to ensure continuum of care



6.2 SERVICE DELIVERY FRAMEWORK

With the above structure of delivery in mind, let us now understand in depth the activities/ tasks that needs to be undertaken under each service package under CPHC. Table 4 below illustrates the delivery of services under each package at these three levels:

Table 4: Service Delivery Framework

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
Care in pregnancy and child birth 	• Early diagnosis of pregnancy • Ensuring four antenatal care checks • Counselling regarding care during pregnancy including information about nutritional requirements • Facilitating institutional delivery and supporting birth planning • Post- partum care visits • Identifying high risk pregnancies, child births and post-partum cases and facilitating timely referrals • Enabling access to Take home ration from Anganwadi centre • Follow up to ensure compliance to IFA in normal and anaemic cases • Sensitization of community regarding entitlements provided by government under various national programs	• Early registration of pregnancy and issuing of ID number and Mother and Child protection card. • Antenatal check-up including screening of Hypertension, Diabetes, Anaemia, Immunization for pregnant woman-TT, IFA and Calcium supplementation • Identifying high risk pregnancies, child births and post-partum cases and referral to higher facilities • Screening, referral and follow up care in cases of Gestational Diabetes, and Syphilis during pregnancy • Normal vaginal delivery in specified delivery sites as per state context - where Mid-level provider or MPW (F) is trained as Skill Birth Attendant (Type B SHC) • Provide first aid treatment and referral for obstetric emergencies, e.g. eclampsia, PPH, Sepsis, and prompt referral (Type B SHC) • Sensitization of community regarding entitlements provided by government under various national programs	• Antenatal and postnatal care of high-risk cases • Blood grouping and Rh typing and blood cross matching • Linkage with nearest ICTC/ PPTCT centre for voluntary testing for HIV and PPTCT services • Normal vaginal delivery and Assisted vaginal delivery • Surgical interventions like Caesarean section, • Management of all complications including ante-partum and post-partum haemorrhage, eclampsia, puerperal sepsis, obstructed labour, retained placenta, shock, severe anaemia, breast abscess. • Blood transfusion facilities

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
Neonatal and infant Health 	• Home based new-born care through 7 visits in case of home delivery and 6 visits in case of institutional delivery • Identification and care of high risk newborn - low birth weight/preterm newborn and sick newborn (with referral as required), • Counselling and support for early breast feeding, improved weaning practices, • Identification of birth asphyxia, sepsis and referral after initial management • Identification of congenital anomalies and appropriate referral • Family/community education for prevention of infections and keeping the baby warm • Identification of ARI/Diarrhoea-identification, initiation of treatment-ORS and timely referral as required • Mobilization and follow up for immunization services	• Identification and management of high risk newborn - low birth weight/ preterm/sick newborn and sepsis (with referral as required), • Management of birth asphyxia (Type B SHC) • Identification, appropriate referral and follow up of congenital anomalies • Management of ARI/Diarrhoea and other common illness and referral of severe cases. • Screening, referral and follow up for disabilities and developmental delays • Complete immunization • Vitamin A supplementation • Identification and follow up, referral andreporting of Adverse Events Following Immunization (AEFI).	• Care for low birth weight newborns (<1800gms) • Treatment of asphyxia and neonatal sepsis, • Treatment of severe ARI and Diarrhoea/dehydration cases • Vitamin K for premature babies. • Management of all emergency and complication cases
Childhood and Adolescent health care services including immunization	• Growth Monitoring, Infant and Young Child Feeding counselling and enable access to food supplementation - all linked to ICDS	• Complete immunization • Detection and treatment of Anaemia and other deficiencies in children and adolescents.	• NRC Services • Management of SAM children, severe anaemia or persistent malnutrition

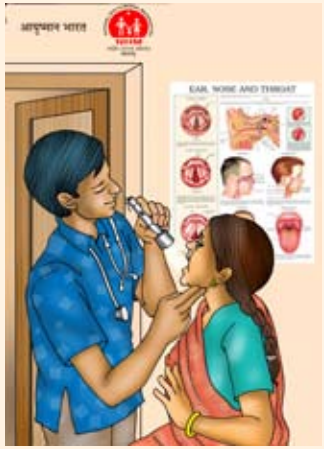
Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
	• Detection of SAM, referral and follow up care for SAM. • Prevention of Anaemia, iron supplementation and deworming • Prevention of diarrhoea/ARI, prompt and appropriate treatment of diarrhoea/ ARI with referral where needed. • Pre-school and School Child Health: Biannual Screening, School Health Records, Eye care, De-worming; • Screening of children under Rashtriya Bal Swasthya Karyakaram **Adolescent Health** Counselling on: ❖ Improving nutrition ❖ Sexual and reproductive health ❖ Enhancing mental health/Promoting favourable attitudes for preventing injuries and violence ❖ Prevent substance misuse ❖ Promote healthy lifestyle ❖ Personal hygiene- Oral Hygiene and Menstrual hygiene	• Identification and management of vaccine preventable diseases in children such as Diphtheria, Pertussis and Measles. • Early detection of growth abnormalities, delays in development and disability and referral • Prompt Management of ARI, acute diarrhoea and fever with referral as needed • Management (with timely referral as needed) of ear, eye and throat problems, skin infections, worm infestations, febrile seizure, poisoning, injuries/accidents, insect and animal bites • Detection of SAM, referral and follow up care for SAM. • Adolescent health- counselling • Detection for cases of substance abuse, referral and follow up • Detection and Treatment of Anaemia and other deficiencies in adolescents • Detection and referral for growth abnormality and disabilities, with referral as required	• Severe Diarrhoea and ARI management • Management of all ear, eye and throat problems, skin infections, worm infestations, febrile seizure, poisoning, injuries/accidents, insect and animal bites • Diagnosis and treatment for disability, deficiencies and development delays • Surgeries for any congenital anomalies like cleft lips and cleft palates, club foot etc. • Screening for hormonal imbalances and treatment with referral if required • Management of growth abnormality and disabilities, with referral as required • Management including rehabilitation and counselling services in cases of substance abuse. • Counselling at Adolescent Friendly Health Clinics (AFHC)

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
	• Peer counselling and Life skills education and • Prevention of Anaemia, identification and management, with referral if needed • Provision of IFA under Weekly Iron and Folic Acid Supplementation Programme (WIFS)		
Family planning, contraceptive services and other reproductive care services 	• Counselling for creating awareness about early marriage and delaying early pregnancy • Identifying and registration of eligible couples • Motivating for family planning (Delaying first child and spacing between 2 children for at least 3 years), • Provision of condom, oral contraceptive pills and emergency contraceptive pills • Follow up with contraceptive users **Other reproductive care services** • Counselling and facilitation of safe abortion services • Post abortion contraceptive counselling • Follow up for any complication after abortion and appropriate referral if needed	• Insertion of IUCD • Removal of IUCD • Provision of condoms, oral contraceptive pills and emergency contraceptive pills • Counselling and facilitation for safe abortion services • Medical methods of abortion (up to 7 weeks of pregnancy) on fix days at the HWC by PHC MO • Post abortion contraceptive counselling • Follow up for any complication after abortion and appropriate referral if needed • First aid for GBV related injuries - link to referral centre and legal support centre • Identification and management of RTIs/ STIs	• Insertion of IUCD and Post-Partum IUCD • Removal of IUCD • Male sterilization including Non-scalpel Vasectomy • Female sterilization (Mini-Lap and Laparoscopic Tubectomy) • Management of all complications • Medical methods of abortion (up to 7 weeks of pregnancy) with referral linkages MVA up to 8 weeks • Referral linkages with higher centre for cases beyond 8 weeks of pregnancy up to 20 weeks

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
	• Education and mobilizing of community for action on violence against women-based violence • Counselling on prevention of RTI/STI • Identification and referral of RTI/STI cases • Follow up and support PLHA (People Living with HIV/AIDS) groups • Ensure regular treatment and follow of diagnosed cases • Counselling on maintaining the personal hygiene care	• Identification, management (with referral as needed) in cases of dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse. • Counselling on maintaining the personal hygiene care	• Treatment of incomplete/ Inevitable/Spontaneous Abortions • Second trimester MTP as per MTP Act and Guidelines • Management of all post abortion complications • Management of survivors of sexual violence as per medico legal protocols. • Management of GBV related injuries and facilitating linkage to legal support centre • Management of hormonal and menstrual disorders and cases of dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse. • Provision of diagnostic tests services (VDRL, HIV) • Management of RTIs/STIs using syndromic approach • PPTCT at district level

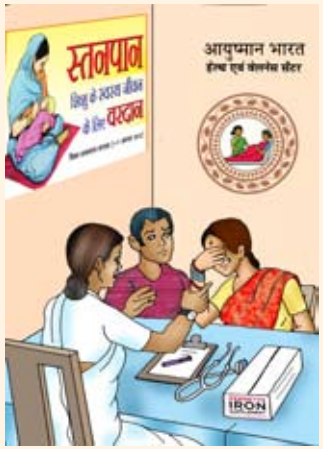
Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
Management of Communicable diseases and General Outpatient care for acute simple illness and minor ailments 	• Symptomatic care for fevers, URIs, LRIs, body aches and headaches, with referral as needed • Identification of danger signs and symptoms of communicable diseases • Identify and refer in case of skin infections and abscesses. • Preventive action and primary care for waterborne disease, like diarrhoea, (cholera, other enteritis) and dysentery, typhoid, hepatitis (A and E) • Creating awareness about prevention, early identification and referral in cases of helminthiasis and rabies • Preventive and promotive measures to address musculo-skeletal disorders-mainly osteoporosis, arthritis and referral or follow up as indicated • Providing symptomatic care for aches and pains – joint pain, back pain etc	• Identification and management of common fevers, ARIs, diarrhoea, and skin infections. (scabies and abscess) • Identification and management (with referral as needed) in cases of cholera, dysentery, typhoid, hepatitis, rabies and helminthiasis. • Management of common aches, joint pains, and common skin conditions, (rash/urticaria)	• Diagnosis and management of all complicated cases (requiring admission) of fevers, gastroenteritis, skin infections, typhoid, rabies, helminthiasis, patitis acute • Specialist consultation for diagnostics and management of musculo-skeletal disorders, e.g.- arthritis
Management of Communicable diseases: National Health Programmes (Tuberculosis, Leprosy, Hepatitis, HIV-	• Community awareness for prevention and control measures • Screening, Identification, prompt treatment initiation and referral as appropriate and specified for that level of care	• Diagnosis, (or sample collection) treatment (as appropriate for that level of care) and follow up care for vector borne diseases – Malaria, Dengue, Chikungunya, Filaria, Kalazar, Japanese Encephalitis, TB and Leprosy.	• Confirmatory diagnosis and initiation of treatment • Management of Complications, • Rehabilitative surgery in case of leprosy

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
AIDS, Malaria, Kala-azar, Filariasis and Other vector borne diseases) 	• Ensure follow up medication compliance • Mass drug administration in case of filariasis and facilitate immunization for Japanese encephalitis • Collection of blood slides in case of fever outbreak in malaria prone areas • Provision of DOTS/ensuring treatment adherence as per protocols in cases of TB	• Provision of DOTS for TB and MDT for leprosy • HIV Screening (in Type B SHC), appropriate referral and support for HIV treatment. • Referral and follow up of complicated cases • In case of any outbreak, report in S form on weekly basis	
Prevention, Screening and Management of Non-Communicable diseases	• Population empanelment, support screening for universal screening for population – age 30 years and above for Hypertension, Diabetes, and three common cancers – Oral, Breast and Cervical Cancer • Health promotion activities – to promote healthy lifestyle and address risk factors • Early detection and referral for - Respiratory disorders – COPD, Epilepsy, Cancer, Diabetes, Hypertension and occupational diseases (Pneumoconiosis, dermatitis, lead poisoning) and Fluorosis	• Screening and treatment compliance for Hypertension and Diabetes, with referral if needed. • Screening and follow up care for occupational diseases (Pneumoconiosis, dermatitis, lead poisoning); fluorosis; respiratory disorders (COPD and asthma) and epilepsy • Cancer – screening for oral, breast and cervical cancer and referral for suspected cases of other cancers.	• Diagnosis, treatment and management of complications of Hypertension and Diabetes • Diagnosis, treatment and follow up of cancers (esp. Cervical, Breast, Oral) • Diagnosis and management of occupational diseases such as Silicosis, Fluorosis and respiratory disorders (COPD and asthma) and epilepsy

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
	• Mobilization activities at village level, schools and other community based institutions – for primary and secondary prevention. • Treatment compliance and follow up for positive cases. • Counselling on steps to perform self-examination of breast • Use of IEC material regarding prevention of NCDs in community	• Confirmation and referral for Deaddiction – tobacco/alcohol/substance abuse • Treatment compliance and follow up for all diagnosed cases. • Linking with specialists and undertaking two-way referral for complications • Sensitization of community to form patient support groups • Conduct yoga sessions	
Care for Common Ophthalmic and ENT problems 	• Screening for blindness and refractive errors. • Recognizing and treating acute suppurative otitis media and other common ENT problems • Counselling and support for care seeking for blindness, other eye disorders • Community screening for congenital disorders and referral • First aid for nosebleeds • Screening by the Mobile Health Team/ RBSK for congenital deafness and other birth defects related to eye and ENT problems	• Diagnosis of Screening for blindness and refractive errors • Identification and treatment of common eye problems –conjunctivitis, acute red eye, trachoma; spring catarrh, xeropthalmia as per the STG • Screening for visual acuity, cataract and for refractive errors, • Management of common colds, ASOM, injuries, pharyngitis, laryngitis, rhinitis, URI, sinusitis, epistaxis. • Early detection of hearing impairment and deafness with referral.	• Management of all Acute and chronic eyes, ear, nose and throat problems. • Surgical care for ear, nose, throat and eye • Management of Cataract, Glaucoma, Diabetic retinopathy and corneal ulcers. • Diagnosis and management of blindness, hearing and speech impairment • Management including nasal packing, tracheostomy, foreign body removal etc

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
		• Diagnosis and treatment services for common diseases like otomycosis, otitis externa, and ear discharge etc. • Manage common throat complaints (tonsillitis, pharyngitis, laryngitis, sinusitis) • First aid for injuries/stabilization and then referral. Removal of Foreign Body. (Eye, Ear, Nose and throat). • Identification and referral of thyroid swelling, discharging ear, blocked nose, hoarseness and dysphagia	
Basic oral health care 	• Education about Oral Hygiene • Create awareness about fluorosis, early detection and referral • Recognition and referral for other common oral problems like caries, gingivitis and tooth loss etc • Symptomatic care for tooth ache and first aid for tooth trauma, with referrals • Mobilization for screening of oral cancer on screening day • Creating awareness about ill effects of Substance Abuse like tobacco, beetle and areca nut, smoking, reverse smoking and alcohol	• Screening for gingivitis, periodontitis, malocclusion, dental caries, dental fluorosis and oral cancers, with referral • Oral health education about dental caries, maintaining oral hygiene, periodontal diseases, malocclusion and oral cancers • Management of conditions like apthous ulcers, candidiasis and glossitis, with referral for underlying disease • Symptomatic care for tooth ache and first aid for tooth trauma, with referral • Counselling for tobacco cessation and referral to Tobacco Cessation Centres	• Diagnosis and management of oral cancer • Management of malocclusion, trauma cases, Tooth abscess, dental caries, • Surgical and prosthetic care

Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
Elderly and palliative health care services 	• Identification of high-risk groups • Support to family in palliative care • Home visits for care to home bound/ bedridden elderly, disabled elderly persons • Support family in identifying behavioural changes in elderly and providing care. • Linkage with other support groups and day care centres etc. operational in the area. • Community mobilization on promotional, preventive and rehabilitative aspects of elderly. • Community awareness on various social security schemes for elderly • Identify and report elderly abuse cases, and provide family counselling.	• Arrange for suitable supportive devices from higher centres to the elderly/ disabled persons to make them ambulatory. • Referral for diseases needing further investigation and treatment, to PHC/ CHC/DH. • Management of common geriatric ailments; counselling, supportive treatment • Pain Management and provision of palliative care with support of ASHA • Counselling on Yoga and meditation • Awareness regarding benefits under national programs such as provision of glasses, dentures, hearing aids etc.	• Diagnosis, treatment and referral for complications • Surgical care • Rehabilitation through physiotherapy and counselling • Comprehensive geriatric assessment tool
Emergency Medical Services, including for Trauma and Burns 	• First aid for trauma including management of minor injuries, fractures, animal bites and poisoning and follow up of cases • Emergency care in case of disaster	• Stabilization care and first aid before referral in cases of - poisoning, trauma, minor injury, burns, respiratory arrest and cardiac arrest, fractures, shock, chocking, fits, drowning, animal bites and haemorrhage, infections (abscess and cellulitis), acute gastro intestinal conditions and acute genito urinary condition. • Identify and refer cases for surgical correction - lumps and bumps (cysts/ lipoma/haemangioma/ganglion); anorectal problems, haemorrhoids, rectal	• Triage and management of trauma cases • Management of poisoning, • Management of simple fractures and poly trauma • Basic surgery and surgical emergencies (Hernia, Hydrocele, Appendicitis, Haemorrhoids, Fistula, and stitching of injuries) etc.

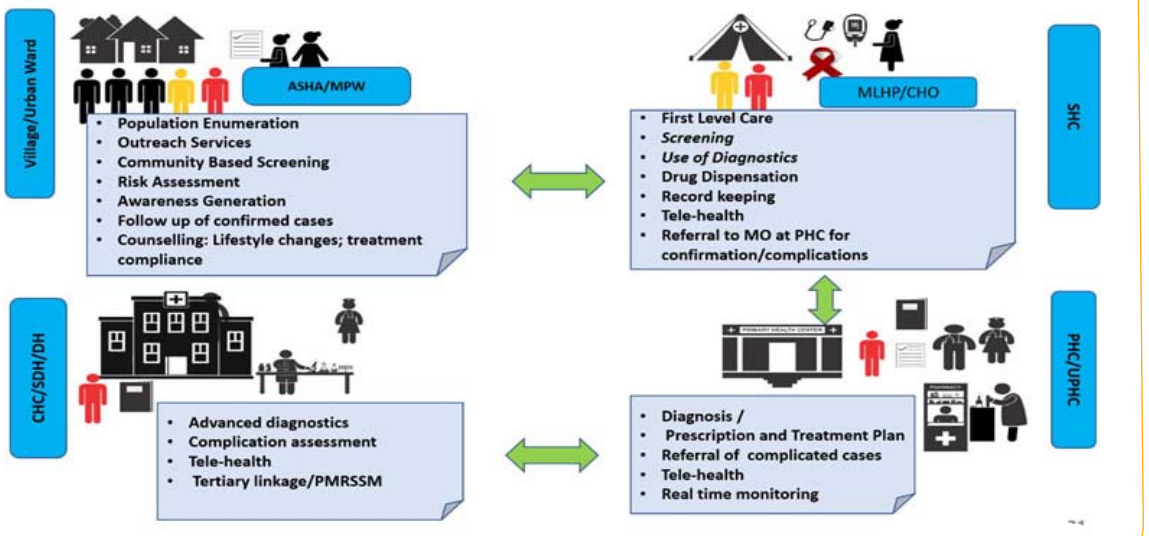
Health Care Services	Care at Community Level	Care at the Health and Wellness Centre-Sub Health Centres	Care at the Referral Site**
		prolapse, hernia, hydrocele, varicoele, epidymo-orchitis, lymphedema, varicose veins, genital ulcers, bed ulcers, lower urinary tract symptoms (Phimosis, paraphimosis), & atrophic vaginitis.	• Handling of all emergencies like animal bite, Congestive Heart Failure, Left Ventricular Failure, acute respiratory conditions, burns, shock, acute dehydration etc.
Screening and Basic management of Mental health ailments 	• Screening for mental illness- using screening questionnaires/tools • Community awareness about mental disorders (Psychosis, Depression, Neurosis, Dementia, Mental Retardation, Autism, Epilepsy and Substance Abuse related disorders) • Identification and referral to the HWC/ PHC for diagnosis • Ensure treatment compliance and follow up of patients with Severe Mental Disorders • Support home-based care by regular home visits to patients of Severe Mental Disorders • Facilitate access to support groups, day care centres and higher education/ vocational skills • Awareness to prevent stigma regarding mental disorders • Counselling on gender based violence • Community based follow up of cases discharged from deaddiction centres	• Detection and referral of patients with severe mental disorders • Confirmation and referral to deaddiction centres • Dispense follow up medication as prescribed by the Medical officer at PHC/ CHC or by the Psychiatrist at DH • Counselling and follow up of patients with Severe Mental Disorders • Management of Violence related concerns • Stress management	• Diagnosis and Treatment of mental illness. • Provision of out -patient and in -patient services • Counselling services to patients (and family if available)

6.3 CONTINUUM OF CARE

Continuity of care is one of the key tenets of Primary Health Care which spans for the individuals from the same facility to her/his home and community, and across levels of care- primary, secondary and tertiary. Care must be ensured from the level of the family/ community to the facility level. (Figure.7)

FIGURE 7

Continuum of Care at all levels



- **At Community/Household:** The ASHA would undertake home visits to ensure that the patient is taking actions for risk factor modification, provides counselling and support, including reminders for follow up appointments at HWC and collection of medicines. The population empanelment undertaken by the ASHA in the catchment area of HWC will facilitate gate keeping, as it will help families in identifying their closest health facility.
- **At Health and Wellness Centres PHC & SHC:** Dispensation of medicines, repeat diagnostics as required, identification of complications and facilitating referrals at a higher-level facility/teleconsultation with a specialist as required are undertaken at the HWC, including maintenance of records. The last activity would enable HWC team to identify stable patients, and to organize community level supportive activities to improve adherence to care protocols and reduction of exposure to risk factors.
- **Planning of Referral Linkages with Secondary care facilities:** In effect, every existing HWC providing the expanded range of services, would manage the largest proportion of disease conditions and organize referral for consultation and follow up with an MBBS doctor at the linked Primary Health Centre- HWC.

  The referring HWC uses a clear referral format to provide information on reason for referral and care already being provided and other details as necessary

(especially on insurance coverage). The referring HWC will refer to an appropriate a centre where specialists are available and facilitate the referral appointment. Therefore, the provider at the HWC should decide the referral site based on the case. For instance- cases of acute simple illness need not be referred to DH/FRU and handled at PHC itself. On the other hand, high-risk pregnancy, sick new born, care for serious mental health ailments may be referred directly to a District Hospital.

When you are appointed as CHO it will be useful to undertake the mapping of referral facilities to ensure continuum of care. You will be required to obtain details from your PHC Medical Officers of the secondary care facilities where referral would need to be undertaken for emergency situations.

- **Referral linkages with Higher:** level facility such as CHC/DH or even Medical College- The referred medical officer or specialists would examine the patient and develop/modify the treatment plan, including instructions for the patient as well as a note to the provider at the HWC, indicating the need for change. Systems need to be in place so that a medicine prescribed by a specialist is made available to the patient at the HWC where she/he is empanelled. Periodic meetings (whether in person or through virtual platforms) between HWC team and the specialists/medical officers referred to, are also essential to ensure that they all function as one team and ensure care continuum.
- **Ensuring two-way referrals between various facility levels:** The delivery of Comprehensive Primary Health Care particularly for chronic conditions requires periodic specialist referral. Treatment for chronic conditions will be initiated by MO at PHC, in consultation with concerned specialist at secondary/tertiary care facilities like CHC/DH. An IT system/teleconsultation can considerably facilitate this process. The Medical Officer would share the treatment plan with you to enable follow up care for the positively diagnosed cases.

Enabling Continuum of Care under PM-JAY

In chapter 1, you learnt about the second component of Ayushman Bharat-The Pradhan Mantri Jan Aarogya Yojana (PM-JAY). For ensuring continuum of care, you will also create awareness about the services included in this scheme for hospitalized care. This would require you to facilitate the enrollment of individuals under PM-JAY by giving information regarding the centers where e-cards are provided. You can use the PM-JAY application (https://www.pmjay.gov.in) to identify the closest empaneled public or private hospitals and share this information with people needing care for serious illness such as cancers, ischemic heart diseases, surgical care etc. You will need to provide follow up care to PM-JAY discharged patients based on the information alerts shared by your PHC medical officer. Your future trainings will further build your capacity in ensuring continuum of care through HWCs and PM-JAY.

CHAPTER 7
HEALTH PROMOTION AND PREVENTION

Health Promotion is the process of empowering people to gain control over their health and enable them to improve the health outcomes. Health promotion is more relevant today than ever in addressing public health problems. We have unfinished agenda of improving outcomes of maternal and child health, malnutrition, emerging communicable diseases and rise of non-communicable/chronic diseases.

Objectives of Health Promotion are

- To empower individuals, families and communities to engage in healthy behaviours and make positive changes in the living and working conditions that affect their health;
- To motivate people to make behavioural and lifestyle changes that reduce the risk of developing chronic diseases thus reducing premature deaths;
- To motivate behavioural change to prevent disease complications among those who are already diagnosed with diseases;
- To finally reduce the out of pocket expense by focusing on prevention and also enabling early diagnosis and management.

Health Prevention on the other hand aims at reducing the risk or threats to health through various interventions. Broadly categorized as:

1. **Primordial Prevention:** The actions that restrict development of risk factors in population where they have not yet appeared. For example, many adult health problems (e.g., obesity, hypertension) have their early origins in childhood, because this is the time when lifestyles are formed (for example, smoking, eating patterns, physical exercise). Exclusive breastfeeding, wearing of helmets are important examples of primordial prevention.
2. **Primary prevention:** The actions taken prior to the onset of disease, which removes the possibility that the disease will ever occur. It signifies intervention in the pre-pathogenesis phase of a disease or health problem. For instance: Total avoidance of smoking and tobacco consumption, immunization to all children,

enforcement to ban or control the use of hazardous products like tobacco etc. or education about healthy and safe habits (e.g. eating well, exercising regularly).

3. **Secondary prevention:** The actions that halt the progress of a disease at its incipient stage and prevents complications." The specific interventions are: early diagnosis (e.g. screening tests, and case finding program) and adequate treatment. Secondary prevention attempts to arrest the disease process, restore health by seeking out unrecognized disease, treating it before irreversible pathological changes take place and reverse communicability of infectious diseases. Screening tests are an excellent example of secondary prevention.
4. **Tertiary prevention:** It is used when the disease process has advanced beyond its early stages. It is defined as "all the measures available to reduce or limit impairments and disabilities, and to promote the patients' adjustment to irremediable conditions." Intervention that should be accomplished in the stage of tertiary prevention are disability limitation, and rehabilitation. This is a last resort, effort to improve patient's quality of life and restore their ability to function and rehabilitate them.

Typical activities for health promotion and disease prevention include:

- **Communication:** Raising awareness about healthy behaviors for the general public. Examples of communication strategies include public announcements, health fairs, mass media campaigns, community level campaigns distributing newsletters etc.
- **Education:** Empowering behavior change and actions through increased knowledge of the population. Examples of health education strategies include courses, trainings, and support groups.
- **Policy changes, Systems, and Environment:** Making systematic changes – through improved laws, rules, and regulations (policy), functional organizational components (systems), and economic, social, or physical environment – to encourage, make available, and enable healthy choices.

7.1 APPROACHES TO HEALTH PROMOTION

As a CHO, you can use various approaches for health promotion such as campaigns, inter-personal communication (IPC), and community level IEC activities.

While keeping the principles of communication in mind, it should be also remembered that the messages for health promotion will vary for different target groups. In the catchment area of Health and

Figure 9 Health Promotion using the 'T A L K' approach

T – TELL About healthy life style

A – ADVISE how to reduce risk factors and adopt healthy lifestyles

L – LEAD Collective community action for reducing risk factors by working with community-based organizations, VHSNCs/Self-help groups.

K – KNOW more about health promotion and healthy life style to reduce risk.

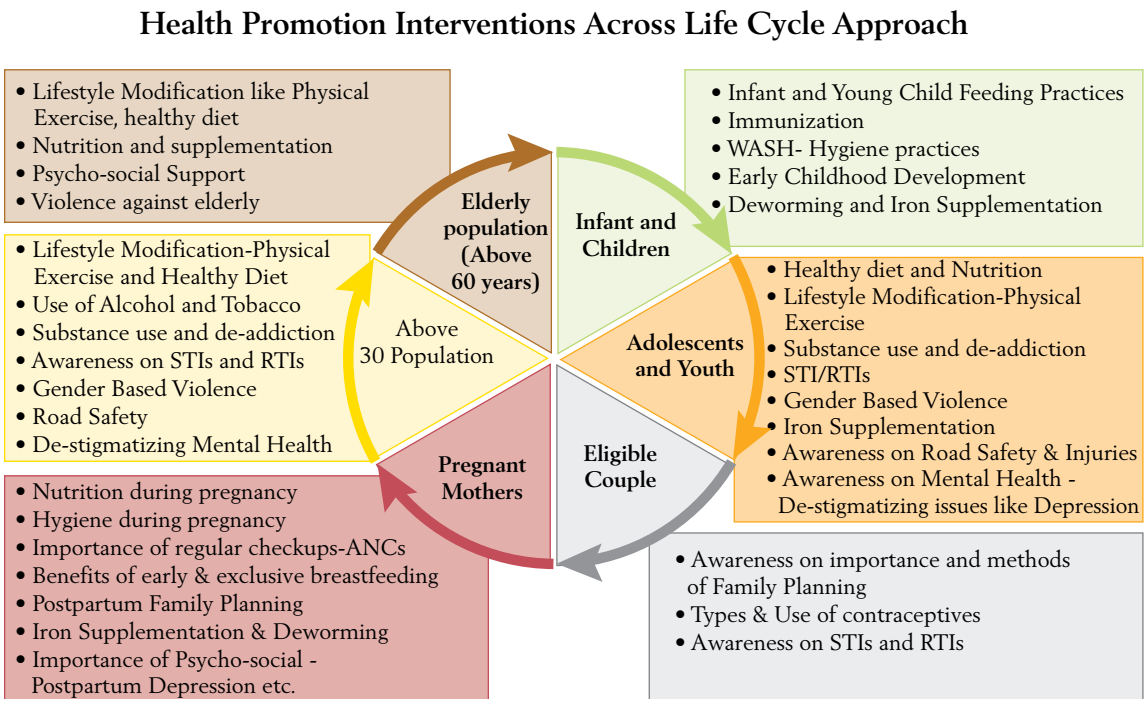
Wellness Centre, health promotion messages will need to be modified based on the population you are addressing. In order to plan strategies for health promotion, two approaches can be adopted and are mentioned below:

1. Life course approach- Age wise classifications of groups for health promotion

Each age group has different set of issues that needs to be addressed through proper health promotion interventions. For instance, in children immunization is pertinent to reduce vaccine preventable diseases and thus the subsequent mortalities. Similarly, adolescents need to be counselled on substance use. As a Community Health Officer, once you have identified the demographic make-up of your population, you can plan health promotion interventions for each age group. The Figure 8, illustrates major age groups and their key issues that you will need to address in your catchment area.

FIGURE 8

Health Promotion Interventions across Life Course



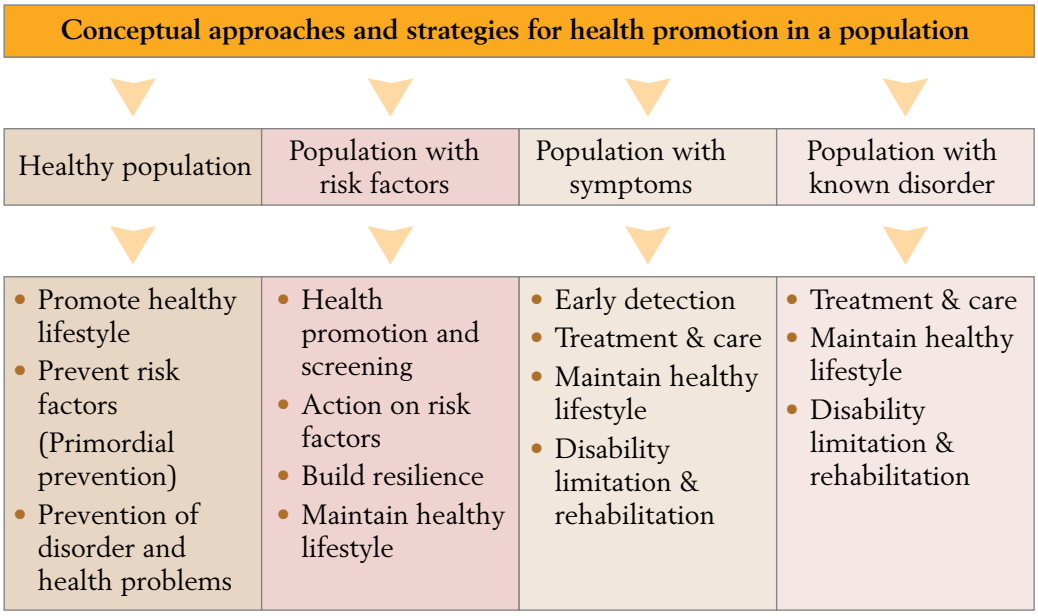
2. Health status approach

The second approach is based on the current health condition of the population. The framework[1] below (Figure 9) summarizes the approaches to health promotion in population sub-groups in various health status.

1. Sanjiv Kumar and GS Preetha, Health Promotion: An Effective Tool for Global Health, Indian J Community Med. 2012 Jan-Mar; 37(1): 5–12.

FIGURE 9

Approaches to health promotion in different population sub-groups



7.2 RESOURCES FOR HEALTH PROMOTION

You will roll out the health promotion and prevention activities at the HWCs using the following resources:

1. Patient Support Groups
2. ASHA
3. AWW
4. VHSNC
5. Monthly Community Level Campaigns
6. Multi-sectoral convergence
7. VHSND

1. Patient Support Groups (PSGs)

Formation of PSGs is helpful in ensuring treatment compliance by reducing social stigmas and increasing acceptance towards the disease. With the increasing prevalence of chronic ailments, the concept of patient support group may really help you in health promotion for population suffering from similar illnesses and addressing their common concerns. Some of the key advantages of PSGs are:

- **Helping the patients:** realizing that they are not alone- to boost the social support and acceptance towards one's disease. This realization will bring relief, and further encouragement to seek care.
- **Creating awareness:** these support groups may act as a platform for IEC sessions on topics relevant to that group. The added advantage of such platforms is that it will offer lots of practical tips and resources for coping up.
- **Reducing distress:** As the patient discusses her/his query in a group, this reduces stress and anxiety about the outcomes.
- **Increased self-understanding:** with more and more IEC, there is a scope to learn more effective ways to cope and handle situations.

How to create the PSG

As a CHO, your primary task will be to understand your population and map the disease burden. Once this is done, you may identify issues/diseases with high prevalence and make patient support group with the help of ASHA. Key steps on creating Patients Support Groups are:

- Identify disease conditions and members through data record or home/community visits, weekly NCD clinics, who are keen to form such groups to help them in better management of their own disease.
- While you promote people to join inform that sharing of experience by others with disease will help them- in identifying complications early, in taking support for treatment compliance, sharing additional information about the disease, also they may be of help in planning hospital visits for review together in case the family members are busy. Removes the stigma and helps them feel that they are not the only ones in this fight against these long-term diseases. Ensure inclusion of marginalized and vulnerable.
- The group can be formed by Friends, Families/relatives, Frontline or sometimes patients themselves even if not known to each other.
- Once the group is formed, you with the support of ASHA should plan a venue and time for the meeting which is convenient for members to attend specifically those from marginalized communities (e.g. distant hamlets).

Location should be flexible-in house of a group member, or arranged after VHSNC/VHSND meetings in the same venue or even after NCD clinics. Can also be arranged if space is not a constraint in SHC/AWC/Panchayat Bhawans/ Community Halls.

Key principles to be followed by ASHA for conducting PSGs

- PSG meetings should be open to all members of the community
- Method of discussion should be facilitation, not didactic or teaching
- Use the already learnt skills of communication and leadership to facilitate the sessions and use their potential to influence the group.
- Care and sympathy for members should never be overlooked
- At the start of the first meeting, introduce and encourage all participants to introduce themselves, while ensuring that no one gets left out and discuss your new role as a PSG facilitator.
- Ask the group to talk about how they see their role as a member of the PSG. Some examples include:
  - Attending meetings voluntarily.
  - Helping each other and the wider community.
  - Haring their knowledge and experiences with others.
  - Listening to and respecting the opinions of others.
  - Working together to solve problems.
  - Participating and helping health functionaries in health promotion for NCDs as and when convenient.
- When there are increased demands to support and provide information, which may arise at a point when the group is mature and few months old, it will be necessary to structure facilitation of support groups in such a way that forges partnerships, and co-ownership between participants and facilitators.

AT THE START OF EACH MEETING

- Informally chat with the participants and other members of the community.
- Encourage the participants to sit together.
- Welcome the participants and thank them for coming.

AT THE END OF EACH MEETING…

- Summarize the learning from the meeting.
- Ask the group members about what they liked or disliked about the meeting and what they learnt.
- Confirm the date, time and meeting place for the next meeting.

- Inform the group about the content of the next meeting if possible and ask them to come prepared for sharing their information.
- Informally chat with the participants and other members of the community.
- Thank the participants for attending the meeting.
- Make sure all necessary information is noted down.

2. ASHA

ASHAs have been an important resource at the community level to improve access to health care services in the areas of RCH and communicable diseases. Recently, with the shift from Selective to Comprehensive Primary Health Care, there has been many additions in roles that ASHA will play as a member of Primary Health Care Team at HWCs.

ASHAs support you in health promotion activities by:

- Listing the target population.
- Identifying individuals with health risks.
- Community mobilization for services such as screening.
- Supporting the HWC team in organizing monthly campaigns, screening camps, organizing VHSNDs.
- Identify and reaching the marginalized to attend these events and services at HWC.
- Support treatment compliance through periodic follow ups of her existing beneficiaries (pregnant women, new born and TB/Leprosy patients), NCD patients, those suffering from mental illness, cases in need of elderly palliative care etc.
- Inter personal communication and holding village level meetings for bringing about
- Life style modifications.
- Playing a lead role in supporting you in formation and functioning of disease specific patient support groups.
- Supporting the Village Health Sanitation and Nutrition Committees in community level planning, action and building accountability measures at the community level.

3. AWW

The AWWs play a key role in health promotion for early childhood development, nutrition related action for pregnant, lactating mothers and children in 0-6 years age group. You will coordinate with AWW in health promotion interventions related to

- **Supplementary nutrition:** For children below six years, and for pregnant and lactating Mothers. This could be a cooked meal, or in the form of Take Home

Rations (THR). Malnourished children are given additional food supplements. Adolescent girls (10 years to 19 years) are also given Weekly Iron and Folic Acid Supplement and tablets for de-worming.

- **Growth monitoring:** Involves weighing of all children below 5 years of age, but especially those who are under 3 years of age, growth monitoring through growth charts, tracking malnourished children and referral for children who are severely malnourished.
- **Pre-school non-formal education:** Includes activities for playful learning and providing a stimulating environment, with inputs for growth and development especially for children between three to six years of age.

The AWWs do:

- Monthly weighing of pregnant mothers and infants.
- Recording weight and filling the growth chart given in the MCP card.
- Identifying underweight and wasting in children and taking appropriate action.
- Counselling regarding growth monitoring.
- Counselling mothers for exclusive breast feeding from birth to 6 months of age.
- Checking for developmental delays.
- Distributing 'Take Home Ration' to lactating mothers and nutrition-specific counselling to mothers/caregivers for their children.
- Providing supplementary food from Anganwadi Centre (AWC).
- Counselling regarding age-appropriate complementary feeding on completion of 6 months of age.
- Counselling for deworming of children above 1 year of age.

4. Village Health Sanitation and Nutrition Committees

VHSNCs have been established under National Health Mission (NHM), mandated as the village level institutional platform, for 'local level community action for health', with focus on social determinants of health.

VHSNCs are expected to:

- Act as platform for building awareness of community for health programmes and improve the access to services by ensuring their participation in planning and implementation. VHSNC will conduct

regular monthly village meetings, and undertake collective health education drives, and health campaigns etc. to achieve this.

- Serve as a platform for convergent community action on social determinants and public services related directly or indirectly related to health. VHSNC has to build systems to support and monitor delivery of public services for sanitation, nutrition, clean and safe drinking water, etc.
- Act as platform for community to voice, needs, experiences and grievances on access to health services, on which service providers and panchayat can respond. VHSNCs will help in empowering panchayats to understand and act on issues of health, and undertake collective action.
- Provide community level support to frontline workers of health and related services.
- Support in developing village health plans with specific focus to the local health needs

Every VHSNC receives an untied fund of Rs. 10000 per year from NHM. VHSNCs are also mandated to work as the standing committee or sub-committee of the Gram Panchayats. Panchayats are constitutionally mandated as third level of government, with Health and its Social Determinants being key elements of their mandate and role.

VHSNC comprises of frontline workers of health and allied departments, PRI representatives, beneficiaries from marginalized and vulnerable households, and women groups. It is mandatory for every VHSNC to have 50% women members, and emphasis is on greater participation of women at community level, to enable gender equity and promoting women's health issues.

How CHOs can support and supervise VHSNC

The first step would be to do a status update on VHSNCs under its area – their constitution, status of bank accounts, involvement of Chairperson and Member Secretary, regularity of monthly meetings, quality of discussions and records of meetings and the decisions taken.

As per the guidelines, the CHO has to attend at-least two VHSNC monthly meetings under his/her area. The checkpoints that CHO needs to review while supervising the monthly meetings of VHSNCs are listed below:

- Time and venue of the meeting has been clearly and effectively communicated to each member, at-least a week in advance.
- Minimum quorum of 7-8 VHSNC members are present in the meeting and there is equal participation in the discussions.
- Actions have been undertaken on the decisions of previous month and issues addressed.
- Agenda items to be discussed in meeting, are listed and shared in the beginning of the discussions.

- Attendance register of the meeting is signed by all members in the beginning of the meeting itself.
- VHSNC completes review of public services and programmes such as-health services at HWC, ICDS, drinking water supply, sanitation, mid-day meals for school children, individual household toilets etc.
- Records and account of expenses incurred from untied/other funds, in previous month is discussed. Account of expenses is explained to all in simple language, and matching bills and vouchers are also presented. No account be submitted without bills.
- **Decisions of the meeting, are recorded clearly & completely and counter sign by Chairperson of VHSNC and ASHA. You should keep one copy with yourself and submit one copy to PHC-MO on monthly basis.**
- With regard to the decisions taken, plan of action is clearly shared, and responsibilities are given for each task.

5. Monthly health Promotion campaigns

As a CHO you will need to follow an annual calendar of health promotion activities so as to organize at least 30 disease/national health programme specific awareness or health promotion campaigns every year. The campaigns will be conducted for every village and will need to be planned out with stakeholders from AWW/VHSNC/the Gram Panchayat/tribal groups etc.

Steps of organizing health campaigns

- Conduct a situation analysis of the village using your information from population enumeration, village health register, CBAC, ASHA Diary, VHSNC record of minutes, RCH register etc to identify key challenges and list of priorities for the campaign.
- Prepare a 'social and resource map' of the village with HWC/VHSNC teams to identify locations or hamlets, vulnerable sections of the village in which problem is widespread.

- Prepare a draft Campaign Plan including the list of the activities that will be conducted in campaign days with allocation of responsibilities among primary care team members and the members of community.
- Conduct meeting of HWC team with stakeholders such as panchayat representatives, local decision makers, religious leaders, traditional healers, ICDS functionaries etc to finalize the tentative plan of action for the campaign and finalize the date for the roll out of the campaign.*
- Finalize mechanisms required for coordination with other concerned government departments.
- Ask your MPWs and ASHAs to disseminate the information regarding the date of the campaign through small group meetings, and household visits, for a larger participation.
- Gather/Prepare appropriate Information Education and Communication (IEC) and Inter Personal Communication (IPC) material required for the campaign.
- Invite an influential person to talk on the theme of the campaign on the day of roll out.
- Support and supervise members and community volunteers with responsibility related to different activities of the campaign.

**Note In case roll out of the campaign requires active mass participation of the community in executing field-based activities of the campaign you will need to conduct an additional meeting to plan the campaign roll out at the village. This meeting can be conducted either in HWC Panchayat Bhavan Anganwadi Centre or a school where all villagers can gather easily and there is space available for a large village level meeting. Your ASHAs and MPWs will need to make sure that large number of community members and stakeholders in the village participate in the meeting. These meetings will be useful for campaigns such as VISHWAS Swachh Bharat Campaigns Health Melas etc. These meetings would be useful in identifying volunteer to support in the campaign roll out.*

Illustrative list of themes for Health Promotion Campaigns

- *Nutrition screening of malnourished children, adolescent girls, women etc.*
- *WASH*
- *Eat right/eat safe*
- *Deaddiction and preventing use of alcohol, tobacco other substance abuse*
- *Control of indoor and outdoor air pollution*
- *Case detection campaigns for infectious diseases-TB/Leprosy*
- *Screening campaigns for control of non-communicable diseases*
- *Childhood illnesses-diarrhoea/pneumonia*
- *Prevention of early childhood marriages, violence against women*

6. Multi-Sectoral Convergence for Health Promotion

Convergence is central for the success of health promotion strategies and require close coordination of health with other allied departments. Some examples of convergence are given below:

School Health programme: Under Ayushman Bharat, about 2.2 million **Health and Wellness/Ayushman Ambassadors** in 1.1 million public schools have been envisaged for prevention and promotion of diseases among school children. You may need to coordinate with the Ayushman Ambassadors or the Health and Wellness Ambassadors who are schoolteachers (one male and one female) and are responsible for age appropriate learning for promotion of healthy behaviour and prevention of various diseases at the school level. You can leverage this initiative in your area by identifying schools and organizing training sessions for school children. The health promotion messages will focus on the health issues and strategies in improving healthy behaviours. The students will act as **Health and Wellness Messengers** in the society.

Other than Ayushman Ambassadors convergence from education should be leveraged to help in promoting better cooking practices for Mid- Day Meal programmes, training of MDM cooks, for enabling mandatory School Nutrition Clubs and competitions around health awareness for High fat, sugar and salty foods.

Convergence initiatives to address spread of outbreaks of communicable diseases such as dengue, chikungunya, malaria for sanitation drives, vector control, controlling water coagulation, through cleaning of drains etc. are observed with rural development or panchayats.

Ensuring Wellness and Health Promotion through YOGA and mainstreaming of AYUSH

In your HWC, to commence with the wellness activities, you may:

i. Identify a pool of Local Yoga Instructors at the HWC level. These could be an ASHA, ASHA Facilitator and Physical Instructor from village school, representatives from VHSNC, or other NGO groups active in community.

ii. Fix and widely disseminate weekly/ monthly schedule of classes for Community Yoga Training at the HWCs.

7. Village Health Sanitation and Nutrition Day

The Village Health Sanitation and Nutrition Day, is organised once every month at the level of village with an aim to improve access to Maternal New born and Child Health (MNCH), nutrition and sanitation services at the local level. The day can be decided by the VHSNC in each Village at anyone of the Anganwadi Centres (AWCs) in that village. Preferably, all the AWCs should be covered by rotation. On the appointed day, AWW and other VHSNC members will mobilize all the villagers, especially the women and children to assemble at the nearest Anganwadi centre.

CHAPTER 8

RECORDS, REPORTS AND INFORMATION SYSTEMS FOR HWCs

8.1 RECORDS AND REPORTS

Health record keeping is necessary for assessing the health situation in the SHC-HWC. It helps in decision making; in management of HWC by enabling planning, organising and reviewing health care services at the local level itself.

Records: Records are the registers and formats in which the data is collected with respect to details of pregnant women, delivered women, children 0-5 years, eligible couples, population above 30 years of age and others in need of services. These registers and formats are available in sub-centre. These are meant for taking action at the local level. At sub-centre following registers are maintained:

Recording formats maintained by primary care team at SHC-HWC:

S. No.	Recording formats/registers	Who enters	Who Checks	Who sign
1	Reproductive and Child health register	MPW/CHO	CHO	CHO
2	Births and Deaths Register	MPW	CHO	CHO
3	Communicable diseases/Epidemic/ Outbreak Register	MPW/CHO	CHO	CHO/PHC-MO
4	Passive surveillance registers for malaria cases	MPW/CHO	CHO	CHO
5	Register for records pertaining to Janani Suraksha Yojana	MPW	CHO	CHO
6	Register for maintenance of accounts including untied funds	MPW/CHO	CHO	CHO/MPW
7	Register for water quality and sanitation	MPW-Male	CHO	CHO
8	NCD-Family folder and CBAC form	ASHA/MPW	CHO/MPW	CHO/MPW
9	OPD register	CHO/MPW	CHO	CHO

S. No.	Recording formats/registers	Who enters	Who Checks	Who sign
10	Stock register (Drug, Equipment Furniture and other accessories)	CHO/MPW	CHO	CHO
11	Due list for pregnant women and children (immunization)	ASHA	MPW/CHO	CHO/MPW
12	VHSND Supportive supervision format	CHO	PHC-MO	Counter signed by MPW and ASHA
13	NCD register	MPW/CHO	CHO	CHO
14	Monthly meeting register	MPW	CHO	CHO
15	Referral register	MPW/CHO	MPW/CHO	CHO

Reporting formats

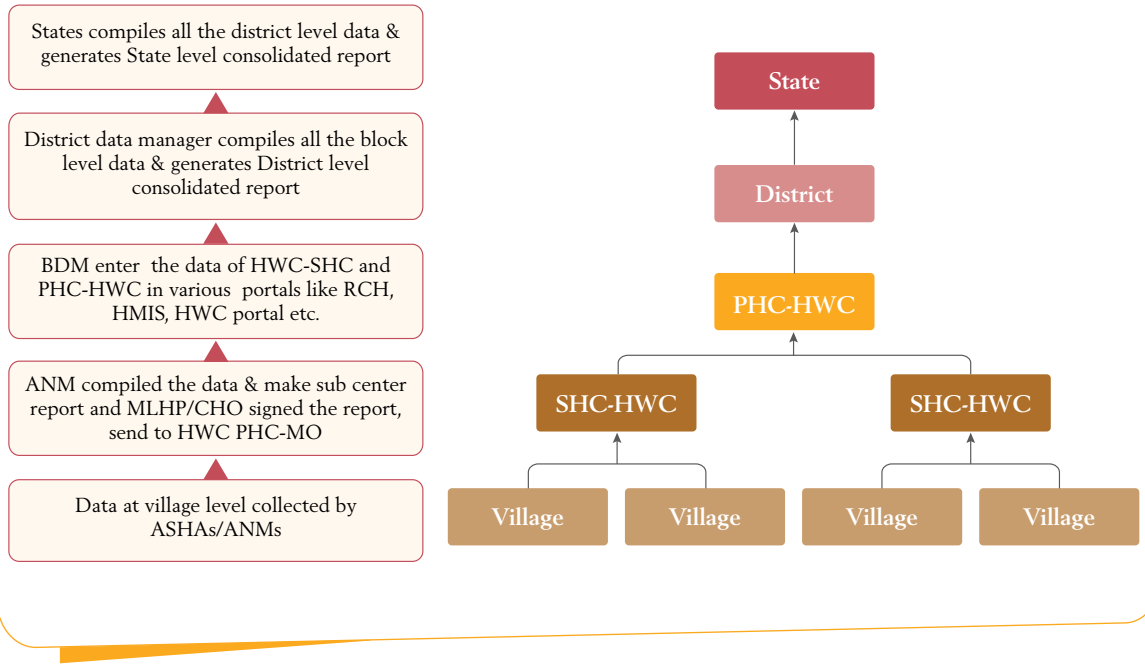
Reports are made from the records and are submitted to higher levels of programme management. Both the documents are necessary for information on a regular basis and for actions to be taken. The reporting formats of different facilities will contain data elements relevant to that level. The number and nature of data elements will vary depending upon the facility. The following reporting formats are available at SHC-HWC. The MLHP is responsible for collecting the monthly reports from their team members and sending it to the PHC-MO for review.

S. No.	Reporting Formats	Frequency of Reporting
1	HMIS sub-centre reporting format	Monthly
2	Maternal Death reporting format	Monthly
3	Child Death Reporting Format	Monthly
4	S-form for Outbreak reporting	Weekly
5	NPCDCS reporting format-1	Monthly
6	HWC-SHC reporting format	Monthly
7	Online reporting on HWC portal	Daily
8	VHSND reporting format	Monthly
9	National Program Reports (NVBDCP, NACP, NLEP, RNTCP, Blindness control, etc.)	Monthly
10	HMIS Annual reporting format	Annually
11	VHSNC format	Monthly

As you are the key person at HWC-SHC, you would be accountable for submitting performance reports of your primary care team. At field level, MPW/ASHAs will undertake all outreach activities as per protocols specified for each of the twelve essential service packages. The MPW/ASHAs will submit their reports to you on monthly basis. The data would be gathered and compiled in specific reporting formats. You will eventually submit these reports to HWC-PHC Medical officer in-charge on monthly/weekly basis to enable tracking of performance. The flow of data at various level shown in Figure 10:

FIGURE 10

Flow of data at various levels of health care system



8.2 IT APPLICATIONS/MANAGEMENT INFORMATION SYSTEMS

The HWC-SHCs is the source of origin for all the data/health information and ASHA/MPW/CHO will be responsible for the data collection and transmission. These data get aggregated at different levels. Many IT applications/Software's are used for transmission of information, recording of services, in enabling follow- up of service users, and are briefly explained below.

1. Health Management Information System (HMIS)

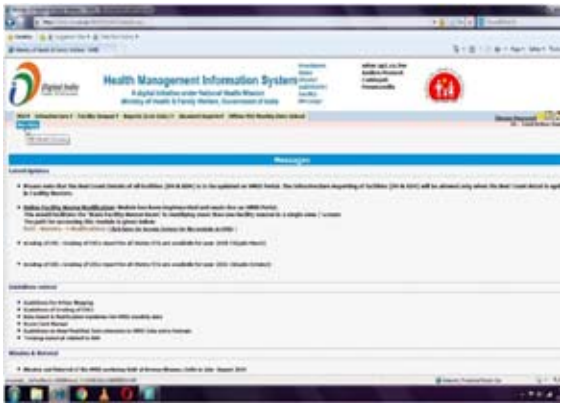
A HMIS is web-based management information system of Ministry of Health & Family Welfare. This portal has been established at http://nrhm-hmis.nic.in where the service users can log on and enter the data directly onto the portal. It captures data using online and offline mode regarding service delivery related to maternal health, child health, IPD, OPD, adolescent health and immunization activities on a monthly basis.

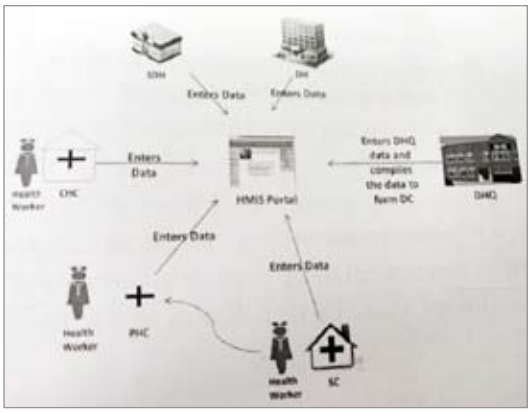
The MPW and CHO will fill the data in monthly HMIS sub-centre format and submit to the PHC-MO on monthly basis.

At every level, the operator can access the formats that need to be filled at their level. So long as entered data is in draft mode, you can edit the entry. Once the form is submitted, then it will no longer be accessible for editing, though you can see what you had submitted. You can view the data only for your facility.

FIGURE 11

(a) HMIS page (b) Flow of data of facility level reporting





2. RCH (Reproductive and Child Health Portal)

RCH portal has been designed to meet the requirements of the RMNCH program by incorporating additional functionality and features of the Mother and Child Tracking System (MCTS). Application facilitates to ensure timely delivery of full component of antenatal, postnatal & delivery services and tracking of children for complete immunization services.

The data is collected through household surveys by ASHA as well as through regular identification by MPW. After identification of beneficiaries, the MPW will immediately register each beneficiary in her integrated RCH register. The MPW will not provide any ID number to the beneficiary. In states where MPWOL application is available, MPWs enters data online in the application directly and data is automatically linked to RCH portal. After recording in the register, this data will be transferred to the RCH portal by Data Entry Operator at PHC, and once entered the RCH portal will generate a unique ID number for each beneficiary which will be written on the RCH register afterwards. The DEO ensures that data is received on time from all MPWs and give feedback to MPWs on incomplete, unclear, or unreadable information.

FIGURE 12

RCH Portal Web page

Integrated RCH register: The MPWs are using the Integrated RCH register to register beneficiaries and for updating services provided to each beneficiary. There is separate register for each village and if the MPW happens to be in charge of five villages she will be making five different registers. This register has the following parts:

- Village-wise information (Profile Entry)
- Section 1: Tracking of Eligible Couples and use of contraceptives
- Section 2: Tracking of Pregnant Women
- Section 3: Tracking of Children
- Section 4: Annexures

3. ANM Online (ANMOL)

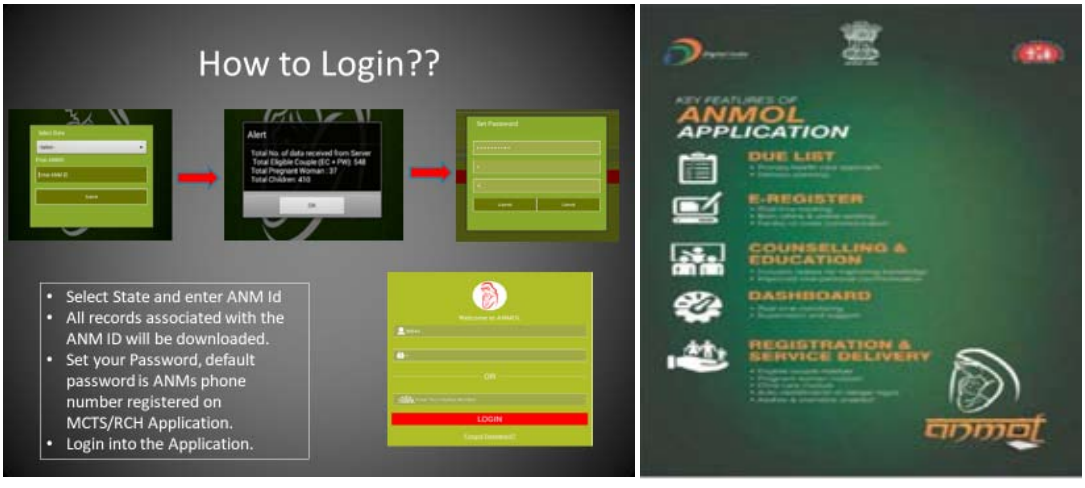
ANMOL is an android application incorporating all features of RCH register for MPWs. MPWOL like RCH application has six modules that facilitate data entry on 245 elements for Village Profile, Eligible couples, Registration and Tracking of pregnant women, child tracking through registration and profile entry, MPW/ASHA Registration to enable a directory of health providers.

It act as a job aid to the MPWs by providing them with readily available information such as due list, dashboard and guidance based on data entered etc. Videos/audios on subjects like high risk pregnancy, immunization, family planning etc. are also available in the application for use by MPWs. This application allows MPWs to enter and update the data of their jurisdiction.

ANMOL works in the offline mode when no internet connectivity is available. As soon as the internet connectivity is available, the data is synchronized with the central server. Another important component of ANMOL is audio and video counselling. This helps create awareness among beneficiaries about the various government schemes.

FIGURE 13

Login page of ANMOL application



4. IDSP (Integrated Disease Surveillance Programme)

Integrated Disease Surveillance Project (IDSP) is a decentralized, State based Disease Surveillance Programme intended to detect early warning signals of epidemic prone diseases. Web-based application package can be invoked using Internet Explorer browser only using the URL http://idsp.nic.in.

This is currently a paper based weekly reporting system. During outbreaks MPW has filled the data in 'S' form (Figure 14) and send to the PHC-MO. Even if there is no outbreak reported, MPW has to write NIL in the form and send it to the PHC. The data is aggregated at the district level and state level. During epidemics and monsoon season this is augmented by a daily telephonic reporting system.

FIGURE 14

Sub-centre Level 'S' form


Form S
Reporting Format for Syndromic Surveillance
(To be filled by Health Worker, Village Volunteer, Non-formal Practitioners)

State ..... District ..... Block ..... Year .....

Name of the health worker/Volunteer/Practitioner	Name of the Supervisor	Name of the Reporting Unit

ID No./Unique Identifier (To be filled by DSU_) | Reporting week | From dd mm yy | To dd mm yy

	a	b	c	d	e	f	g	h	i	j	k	l	m	n
	Cases							Deaths						
	Male			Female			Total	Male			Female			Total
	<5yr	≥5yr	Total	<5yr	≥5yr	Total		<5yr	≥5yr	Total	<5yr	≥5yr	Total	
1. Fever														
Fever <7 days														
1. Only Fever														
2. With Rash														
3. With Bleeding														
4. With Daze/Semiconsciousness/ unconsciousness														
Fever > 7 days														
2. Cough with or without fever														
<3 weeks														
>3 weeks														
3. Loose Watery Stools of Less Than 2 Weeks Duration														
With some/Much Dehydration														
With no Dehydration														
With Blood in Stool														
4. Jaundice cases of Less Than 4 Weeks Duration														
Cases of acute Jaundice														
5. Acute Flaccid Paralysis Cases in Less Than 15 Years of Age														
Cases of Acute Flaccid Paralysis														
6. Unusual Symptoms Leading to Death or Hospitalization that do not fit into the above.														

5. CPHC-IT Application

An IT application has been developed to support the planning, delivery and monitoring of the services at HWCs. This application comprises of following six applications:

- ASHA Mobile App
- SHC – HWC team - MPW/CHO Tablet App
- PHC MO Web Portal
- CHC Portal Web portal
- Administrator's Web Portal
- Health Officials Dashboard

The application designed for ASHAs and SHC team is an android based application that can work both on offline and online mode depending on availability of the internet connectivity. The application has been developed with the objective to support delivery of expanded range of services at the Health and Wellness Centres. Currently the NCD module of the IT application has been introduced to facilitate roll of universal screening of NCDs. As the roll out of expanded services is planned in an incremental manner, the application would include additional modules to capture delivery services v.i.z, Oral health, ENT, Eye care, mental health etc, which would be added in a phased manner. The CPHC – IT application would also integrate with all the applications and reporting portals explained above. Once the integration is completed it will significantly reduce the burden of reporting on various platforms/applications.

The *features for the level of SHC – HWC are listed below*

- ***Enrolment***: The application has the feature to capture details of families and create family folders. It can generate unique health IDs for each individual which facilitates enrolment/empanelment of the individual at the SHC- HWC. Provision of unique health ID allows to track the services sought by each individual across all levels of healthcare facilities eg- SHC or PHC or CHC. The application will help in creating health record for each individual i.e, the team can see the past illness history of the patient, treatment plan initiated by doctor and the follow up care needed by the patient.
- ***Screening***: At present the application captures all data pertaining of Community Based Assessment Checklist (CBAC) filled for individuals over 30 years of age. The application has provisions to capture details of screening on Hypertension, Diabetes and three cancers Oral, Breast and Cervical. Job aids have been included in the application to support the SHC- HWC team in taking appropriate decision for referral and providing counselling for life style modification.
- ***Refer and Follow up***: The application would allow the SHC- HWC team to refer any individual to higher level of health facility Eg- PHC/CHC. Once the patient visits the referral health facility, the application can record the diagnosis, treatment plan or management advice provide by the doctor at higher level, which can be accessed by SHC-HWC team. This would allow the team to provide follow up care to the patient, this may include dispensing of medicine as prescribed by the doctor.
- ***Dashboard***: A brief dashboard has been designed for the SHC- HWC team. This provides important information that can help the team review their performance and assess coverage of services delivered on a periodic basis.
- ***Work plan***: Generation of work plan is one of the key features of the application. Based on the data entered in the application the application can create a work plan for the SHC- HWC team on a calendar mode and send alerts to the team for a due upcoming task.
- ***Incentives***: As discussed earlier the SHC- HWC team would receive performance linked payments on identified list of indicators. The application will have a feature to capture team's performance and estimate the incentive due every month.

In addition to these features the application would be integrated with DVDMS (Drugs and Vaccines Distribution and Management Systems) IT system, which currently is operational up to the PHC level in most states. This would allow the SHC-HWC

team to estimate the requirements of medicines/consumables based on caseloads and send indents to the next level for initiating timely delivery and eliminate stock outs at the HWCs.

The application will also facilitate teleconsultation with the higher facilities i.e, SHC- HWC team may contact the doctors at PHC or any identified Hub to seek guidance for provision of care to patients. This would be achieved by integrating the application with a teleconsultation module.

6. Health and Wellness Centre Portal

A web-based portal - https://ab-hwc.nhp.gov.in has been developed with the objective to help the states and districts plan and monitor the operationalization of HWCs. The portal is based on National Identification Number (NIN) i.e, provides a unique identification number to all public health facilities. The portal allows the district/state users to identify the SHC/PHC/UPHC for upgradation as HWC. It captures details of every HWC on all important components v.i.z:

- Human Resources
- Training of HRH
- Medicines as per guidelines
- Diagnostics as per guidelines
- Upgradation of Infrastructure and Branding
- IT systems
- Teleconsultation services
- Wellness activities like yoga etc
- Service Delivery – Population Enumeration, Community Based Assessment Checklist and NCD screening

At present the portal has state and district level user IDs to update the information on the above mentioned areas on a regular basis. At the level of HWCs, user ids and passwords have been created to capture the following details on daily basis-OPD/footfalls, provision of medicines and provision of diagnostics and organization of wellness activities.

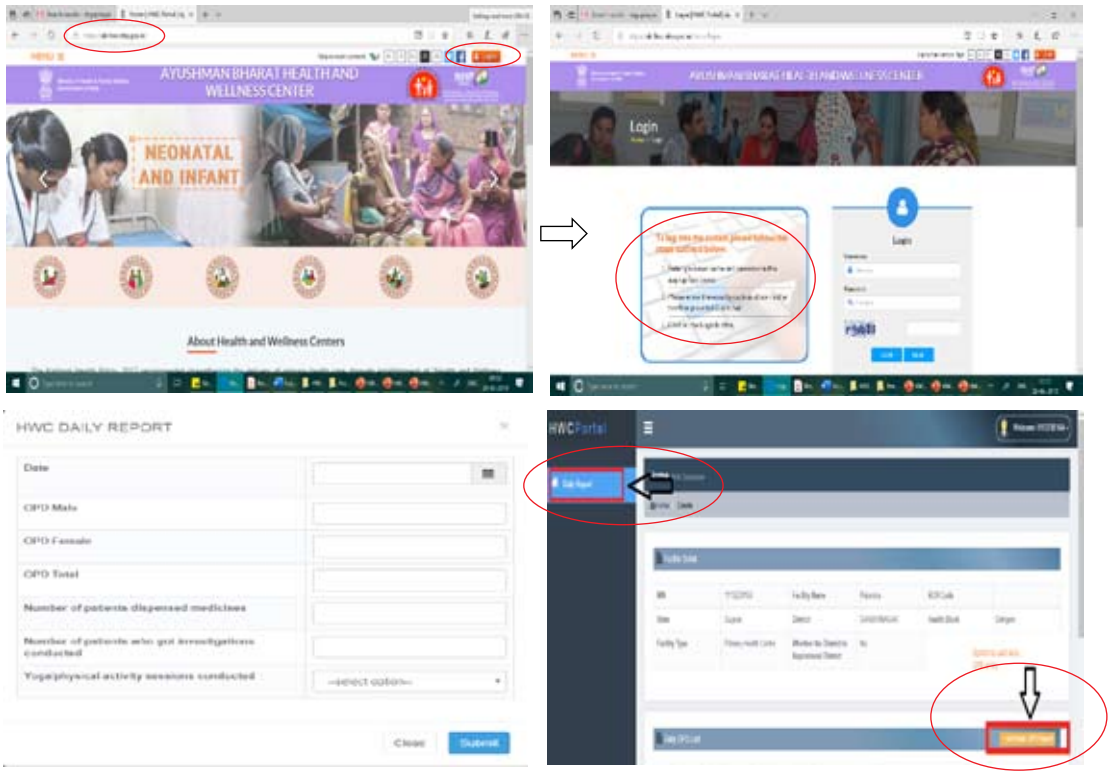
The OPD/Footfalls includes the services delivered at the HWC and during outreach. This will encompass all services delivered at the HWC ranging from NCD screening, ANC/PNC services, Immunization, counselling and management of illnesses etc. User ID and password for your SHC- HWC will be provided to you by the district nodal officers. You may follow the following steps to log in and fill the data on a daily basis.

Type the URL - https://ab-hwc.nhp.gov.in on the search engine (like Google or Bing etc) on any device available Eg- tablet or desktop or laptop provided at the HWC or even your own smart phone.

The portal will allow you to generate reports to assess the trends in service delivery i.e, whether the services delivered is increasing or decreasing. This information at the level

FIGURE 15

Health and Wellness Portal



of district and state will project an aggregate (total) picture of the trends in service delivery. Similarly, the service delivery form of the HWC portal covers details of NCD screening services provided at the HWCs. This form is to be filled at the district level for all HWCs, hence you are expected to maintain and submit the monthly reports in a timely manner to ensure data quality.

8.4 QUALITY OF DATA

Data quality is an important factor which determines whether it can be used effectively for planning and management of services. Quality is measured in three different aspects of completeness, timeliness and accuracy:

Completeness

For data to be of good quality, it has to be complete. Your role is to check the completeness of the data in the formats and handhold your team at regular intervals. Completion can be seen in twoways:

- Number of data elements reported among total data elements in a reporting format.
- The forms have to be assessed for zeros and blanks. If there is repeated omission of certain elements, reason has to be ascertained and if needed, amended.

- For example: Address is not recorded properly; sometimes difficult to trace; sometime beneficiaries don't have address proof to attach.

Timeliness

For data to be useful, it has to be reported timely. Delayed reports will hinder accurate assessment and action. There is enough time given for the facilities to submit data after the month ends i.e. earliest being 5th of next month or 20th in case of quarterly report.

You should set an appropriate timeline with your team for the submission of the reports. Provide regular support to your team so that they should send report on time to you. As a team leader, you should also maintain your timeline for the submission of reports to the PHC-MO. Thus, if you are not maintaining the timelines, the reports will be automatically delayed at all levels and it will affect the functioning and status of District.

Accuracy

Data should measure what it is supposed to measure and be correct.

Error in data could arise due to:

- Gaps in understanding of data definitions and data collection methods
- Data recording and data entry errors
- Misreporting

Data entry errors can be reduced by

- **Visual scanning or eye balling:** This is just scanning of the document for any major deviation from the normal. It may be in the form of missing values, abnormal figure or calculation mistakes. For e.g. age of an antenatal mother written as 60 years.
- **Performing validation checks:** Validation is performed by comparing values of 2 (or more) data elements that are related. One (or more) data elements are placed on left side and other data element(s) are placed on right side with an operator separating both sides e.g. 'Early ANC registration' is a part of 'ANC registration' and it can be equal to 'ANC registration' or it will be less than or equal to 'ANC registration' but it cannot be greater than 'ANC registration.'

Validation tools that can be used regularly in these aspects

- Number of BCG given cannot be more than number of live births; unless there are children born outside the area who have come only for immunisation.
- Number of family planning users should be less than total eligible couples.
- Number of women receiving postnatal care should not be more than total deliveries.

CHAPTER 9

SUPPORTIVE SUPERVISION AND PERFORMANCE REVIEW

9.1 SUPPORTIVE SUPERVISION

Supportive Supervision is a process of helping staff to improve their work performance continuously. It is carried out in a respectful and non-authoritarian way by using supervisory visits to improve knowledge and skills of health staff. Supportive supervision encourages open, two-way communication, and builds team approaches that facilitate problem-solving.

Supportive supervision is helping to make things work, rather than checking to see what is wrong

As a team leader at SHC-HWC, your main role is to provide supportive supervision to ASHAs/MPWS. Be cautious and do not use traditional/autocratic supervision that is focused more on inspection and fault finding rather than on problem solving to improve performance. Use of a set of processes and tools such as checklists and protocols that will support in systematic performance assessment and provision of feedback.

You will need to find out the areas where your team needs support and provide guidance to ASHAs/MPWs through on the jobmentoring to improve their capacity and performance.

Supportive Supervision is done through the (i) Village visits (ii) Monthly Sub-centre meetings (iii) Monthly Review Meeting at Block level PHC.

1. Village visit

Preparation for a village visit is ideally done during a sub-centre level meeting, when you will have a chance to meet all the team members. In this meeting you will decide the convenient time and date for your household/VHSND visit in consultation with the primary care team. Work with team in identifying the households to be visited. You should inform your team in advance if there are any changes in the meeting schedule.

Household visits: On reaching the village, you must prioritize home visits to those households where MPWs/ASHAs need additional support in motivating such families to adopt healthy behaviours, utilize outreach services, or access referral. You may prioritize your visits as follows: For example- if there are three diabetic patients in the area, then the one who is suffering from diabetic complications such as diabetic foot, retinopathy should be prioritized over one who is diabetic with no complications. In the former case, the team can thus review the treatment plan, check whether the individual has been seen by a specialist for management of complication and advice on healthy lifestyle habits, physical activity and motivate for regular follow up at SHC-HWCs.

During the home visits, you should first allow MPW/ASHA to undertake counselling and advice, including demonstration as appropriate. You add those points that the MPW/ASHA may have missed or corrects any errors, in a manner that does not embarrass or humiliate them. Provide feedback only after the visit.

VHSND visit: During the VHSND session visits, you first allows the MPW/ASHAs to undertake all the activities such immunization, counselling, abdominal examination, BP measurement etc. Use the monitoring checklist (Annexure 3) to record/observe the activities.

Your role is to monitor the quality of services being provided and availability of drugs & diagnostics. After the completion of session, you should review the checklist and give the appropriate feedback to the team. The VHSND checklist should counter signed by MPW and ASHA. You should keep one copy of checklist with you and one copy submit to the PHC-MO on monthly basis to avail your monthly performance based incentive.

Meet the Panchayat representative in the village to enhance their awareness of the health situation, enable support for the ASHA and help them view the work in a positive way. The MPW will provide the copy of VHSND report to you and you will discuss the gaps/best practices identified at VHSND during PHC level monthly meeting with PHC-MO.

2. Conducting SHC-HWC meetings

You will organize a monthly meeting of primary care team for:

- Performance review
- Review of key performing Indicators to assess the functionality of HWC.
- Review of current month work plan
- Updating work plan for the next month
- Identifying common issues and problems
- Identifying actions that need to be discussed at monthly PHC review. meeting,
- Take at least one technical session for capacity building of primary care team.
- Obtaining data from the MPW/ASHA to enable consolidation of reports at the sub centre level and
- Updating HWC Team about new guidelines and other technical details about programmes

At the end of the meeting, you have to maintain the minutes of the meeting including discussions, decisions taken and action plan for the next month. The minutes should signed by you, MPW and ASHA. You should keep one copy of minutes with you and

submit one copy to PHC-MO on monthly basis to avail your performance linked incentive.

3. Monthly PHC-HWC meeting:

The Medical Officer at the PHC-HWC convenes this monthly meeting, to be attended by CHO, MPW/MPW, ASHAs, LHVs and the ASHA Facilitator. These meetings are an opportunity for the HWC team to interact with the PHC-MO and other CHOs of PHC area in a larger platform. You would need to carry monthly report of HWC-SHC and share the report with PHC-MO. Progress against KPIs needs to be shared during monthly review meetings at the PHC-HWC and inputs will be provided to address gaps that have been identified and corrective actions can be discussed and planned.

Monthly meetings serve as an additional forum for capacity building, trouble shooting, problem solving and motivation. You can also share any best practices/good work done by your team, so that others can replicate those good practices in their areas.

9.2 PROGRAMME MONITORING OF THE PRIMARY CARE TEAM FOR OUTCOMES AND FUNCTIONALITY

A Monitoring system has been developed to monitor the functionality as well as the outcomes of the primary care team. You have major role to play in the collection and consolidation of the data for monitoring.

The monitoring will be done at two levels (i) Monitoring of SHC-HWC by CHO (ii) Monitoring of HWC-SHC by PHC-MO/District/State officials.

Monitoring of SHC-HWC by CHO

As you are conducting the supervisory visits through monthly meetings, household visits, VHSND session monitoring, you have to monitor some of key indicators of different service packages under comprehensive primary health care. By doing this you will get to know the functionality status of your health and wellness- sub centre and performance of your team. This activity enables you to improve the quality of services being provided. The following indicators given in Table 5, as per service package for CPHC may be used for monitoring of HWC-SHC and outreach activities of your team:

Table 5: Indicators for Monitoring of HWC-SHC

Assessment Indicator	Definition	Means of verification/ Reporting
Indicators for Care during Pregnancy and Birth		
Proportion of estimated pregnancies registered	**Numerator:** Number of pregnant women registered for ANC **Denominator:** Total no. of estimated pregnancies	RCH register
Registered pregnant women who received full ANC (%)	**Definition of full ANC:** Full ANC is defined as four antenatal check-ups that include abdominal examination; checking for height and weight; haemoglobin estimation and urine test for protein and sugar during each check-up; two doses of tetanus toxoid; distribution of 180 IFA tablets; and counselling on diet, rest, birth preparedness, and family planning. **Numerator:** Total number of women who received full ANC **Denominator:** Total number of pregnant women who are registered for ANC	RCH register HMIS
Pregnant women line listed for severe anaemia out of total registered for ANC (%)	**Numerator:** Total number of pregnant women detected with severe anaemia **Denominator:** Total number of women registered for ANC	RCH register HMIS
All Maternal deaths in age group of 15-49 years (%)	**Numerator:** Total number of all maternal deaths reported in age group of 15-49 years **Denominator:** Total number of women in the age group of 15-49 years	MDR reporting format (Primary Informant Form)
Indicators for Neonatal and Infant Health		
Infants exclusively breastfed for six months (%)	**Numerator:** Total number of infants who were exclusively breastfed for six months **Denominator:** Total number of infants in your area	RCH register HBNC reporting format
Newborn having weight less than 2.5 kg (%)	**Numerator:** Total number of newborns having weight less than 2.5 kg **Denominator:** Total number of newborns/live births in your area	RCH register HBNC records
Sick newborns referred by ASHAs to higher facilities (%)	**Numerator:** Total number of sick newborns referred to higher facilities by ASHA **Denominator:** Number of total sick newborns identified by ASHA	ASHA records (HBNC register) Village RCH register

Assessment Indicator	Definition	Means of verification/ Reporting
Indicators for Child health		
Full Immunization rate	"Full immunization" coverage is defined as a child has received a BCG vaccination against tuberculosis; three doses of DPT vaccine to prevent diphtheria, pertussis, and tetanus (DPT)/ Pentavalent; at least three doses of polio vaccine; and one dose of measles vaccine **Numerator:** Total number of children age 12-23 months received the BCG, DPT/Pentavalent, OPV and Measles **Denominator:** Total number of children in the age of 12-23 months	HMIS MCP card Due list
Children with diarrhoea treated with ORS and zinc (%)	**Numerator:** Total number of children under-five treated for diarrhoea with ORS and zinc **Denominator:** Total number of children under-five diagnosed with diarrhoea	HMIS MPW/ASHA records
Children diagnosed with pneumonia	**Numerator:** Total number of children under-five children diagnosed with pneumonia **Denominator:** Total number of under five children under-five	HMIS MPW/ASHA records
Indicators for Family Planning and Reproductive Health		
Number of interval IUCDs inserted per trained provider* per month	**Definition:** Number of interval IUCDs inserted by each trained provider in the HWC during a month. (Trained service providers can be MLHPs and MPWs trained in SBA training/FP)	Training records, IUCD register, performance monitoring register
Utilization of condoms/OCPs/ECPs through ASHAs (%)	**Numerator:** Number of condoms/OCPs/ECPs utilized through ASHAs in the quarter **Denominator:** Number of condoms/OCPs/ECPs distributed to ASHAs in the quarter	ASHA stock register
Indicators for Management of Communicable Diseases		
Provision of DOTS for tuberculosis patients (%)	**Numerator:** Total number of TB patients received DOTS **Denominator:** Total number of patients diagnosed with TB	TB-MIS MPW/ASHA register
Provision of MDT for leprosy patients (%)	**Numerator:** Total number of leprosy patients received MDT **Denominator:** Total number of patients diagnosed with leprosy	HMIS

Assessment Indicator	Definition	Means of verification/ Reporting
NCD application and SHC-HWC register in means of verification column for all 7 indicators		
Proportion of above 30 years individuals screened for Hypertension (%)	**Numerator:** No. of individuals screened for Hypertension **Denominator:** Total population above 30 years of age	NCD application
Proportion of above 30 years individuals screened for Diabetes (%)	**Numerator:** No. of individuals screened for Diabetes **Denominator:** Total population above 30 years of age	NCD application
Proportion of Patient of HTN on treatment (%)	**Numerator**: No. of HTN patients who received follow up care **Denominator:** Total no. of HTN patients	NCD application
Proportion of Patient of DM on treatment (%)	**Numerator:** No. of DM patients who received follow up care **Denominator:** Total no. of DM/patients	NCD application
Proportion of above 30 years individuals screened for Oral cancer (%)	**Numerator:** No. of individuals screened for Oral cancer **Denominator:** Total population above 30 years of age	NCD application
Proportion of above 30 years women screened for Breast cancer (%)	**Numerator:** No. of women screened for Breast cancer **Denominator:** Total women above 30 years of age	NCD application
Proportion of above 30 years women screened for Cervical cancer (%)	**Numerator**: No. of women screened for Cervical cancer **Denominator:** Total women above 30 years of age	NCD application

Monitoring of SHC-HWC by PHC-MO/District/State officials

In addition, to regular supervision and monitoring by CHO; the block officials/PHC medical officer can also make independent monitoring visits to assess the effectiveness of expanded range of services provided at HWCs, evaluate the service delivery output, track improvements in health outcomes or for assessing the performance of HWCs team for the disbursal of team-based incentives. The performance of the team will be assessed on indicators that will be a mix of service utilization and coverage of population for essential services.

The selected indicators are those that are reported in the RCH portal, CPHC-NCD Application, and Nikshay. Monthly performance of the functionaries will be assessed on a set of 15 indicators and have been specified in **Annexure 4**.

1. **Distribution of Incentive Amount for each HWC-SHC team:** The monthly incentive to HWC-SHC team could follow the distribution listed below:
   - Rs. 15,000/MLHP/month
   - Rs. 3000/month for MPWs (Subject to a maximum of Rs. 1500/month/MPW)
   - Rs. 5000/month for ASHAs (Subject to a maximum of Rs. 1000/month/ASHA)

   Considering the above distribution, the maximum amount of incentive for MPWs and ASHAs would remain fixed @ Rs. 96,000/annum. The maximum amount allocated to MLHP would be 1,80,000/annum.
2. **Incentive Amount to be allocated for the indicators:** For ease of implementation in the early stages, all indicators are weighted equally, and the MLHP would receive Rs. 1000 per indicator, upto a maximum of Rs. 15,000. Similarly, the incentive of Rs. 3000/month and Rs. 5000/month for MPWs and ASHAs respectively will be equally allocated to each indicator.
3. **Service Delivery Output for incentive payment:** The service delivery outputs as included in Table 6, have been graded at two levels of achievement: 75% and 100% for 8 out 15 indicators. Performance linked payment that is to be disbursed for each indicator will correspond the level of achievement.

Table 6: Illustration for Calculation of incentives-*

Assessment Indicator	Definition	Source of Verification/ Reporting	Service Delivery Output to receive 75% of Incentive Payment	Service Delivery Output to receive 100% of Incentive Payment	Maximum incentive allocation for each personnel (Rs) at 75% achievement	Maximum incentive allocation for each personnel (Rs) at 100% achievement
Number of OPD cases in the month	No. of OPD cases including new and old cases	AB-HWC/ Portal/ HWC-SHC Register	Min. 300/month	400/ month	MLHP=750 MPW=75 ASHA=50	MLHP=1000 MPW=100 ASHA=67

Based on standard assumption that there fifteen indicators and monthly incentive allocated to each personnel has been distributed equally.

4. Key principles to assess performance

- Indicators for performance measurement of the primary care team are easily verifiable. The selection of indicators is such that report for these indicators can be verified from the existing information systems such as- RCH Portal/Registers, NCD Application of the CPHC IT system, NIKSHAY, IDSP reports, meeting records submitted to PHC Medical Officer.

- Ensuring that data is fed accurately and regularly in the information system at each level is a collective and individual responsibility of the HWC-SHC team.

5. Process

- The PHC Medical Officer under whose jurisdiction the HWC-SHC is assigned or (any other suitable representative as decided by the state) will be responsible for assessing the performance of the HWC-SHC team. He/She will:
  - Ensure that CHOs/MPWs are trained in using the CPHC IT system for online auto compilation and transmission of performance data for HWC-SHC team. However, till the time such a system is in place, CHOs will use the data entered in the respective information system to submit performance reports on service delivery outputs for the particular month in a standard format developed by the state.
  - Ensure release of performance- linked incentives within one month of submission of performance report by MLHPs.
  - Use the performance monitoring mechanism to identify the areas of improvement for the primary care team at the HWC-SHC and provide the necessary handholding and support to improving the performance and overall service delivery at HWCs.
  - Undertake monthly visits to every HWC for field level monitoring visits and use these visits to handhold and mentor HWC-SHC team.

6. Mode of Validation:

- **Local:** PHC-MO will assess and validate the records submitted by CHOs with the reports from information systems- RCH Portal/Registers, NCD Application of the CPHC IT system, NIKSHAY, IDSP reports, meeting records submitted for performance- linked payment.
- **External:** (i) Existing mechanisms of 104 Call Centre etc. can also be used to validate team performance data reported by CHOs. (ii) States can also opt to assess service use and satisfaction by random surveys of service users through telephone surveys, (iii) States may also opt for nominating an independent committee comprising of officials and civil society representative to validate the quantity and quality of service delivered by HWCs. This committee can evaluate the performance quarterly or bi annually to ensure that no conflict of interest arise, during the process of performance- linked payment.

7. Ensuring timely payments

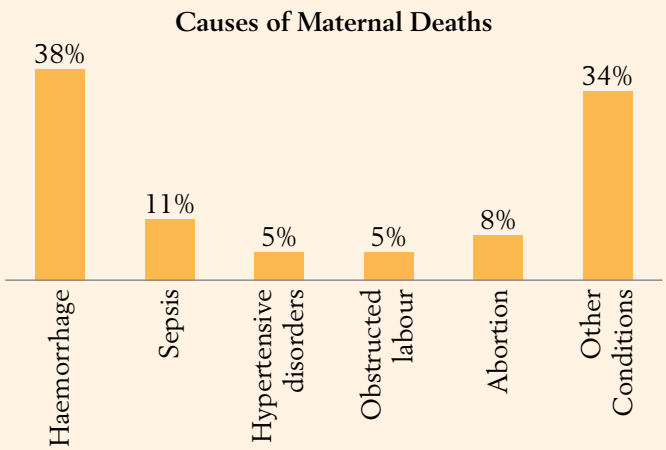
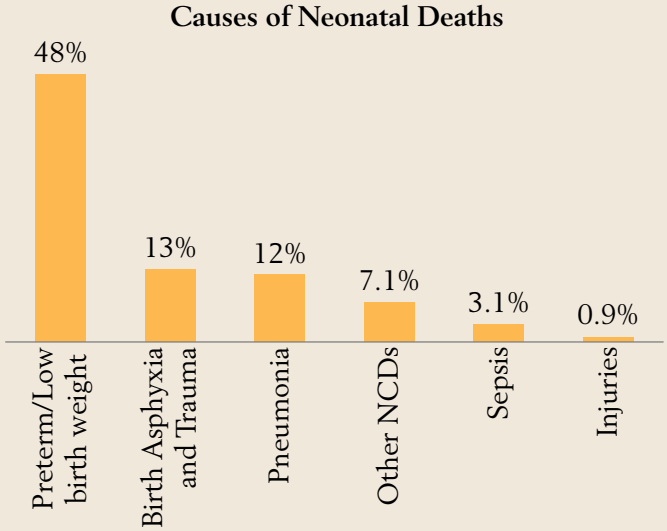
Though external validation is essential to check fraudulent reporting; in any given circumstance monthly payment of incentives to CHOs and frontline functionaries should not await call centre linked validations.

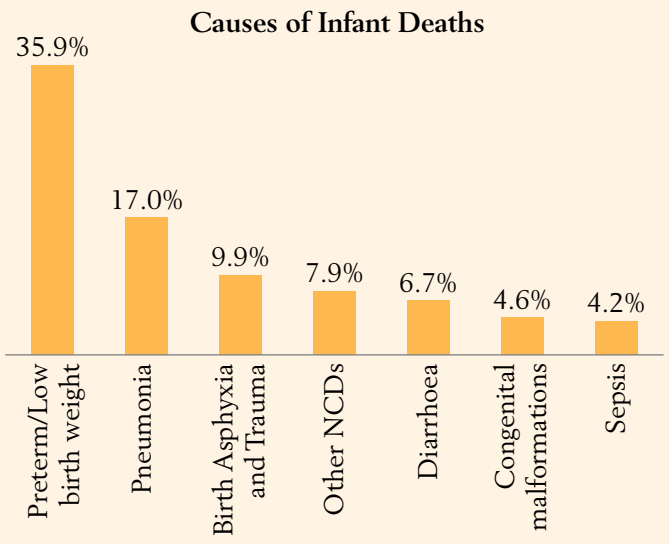
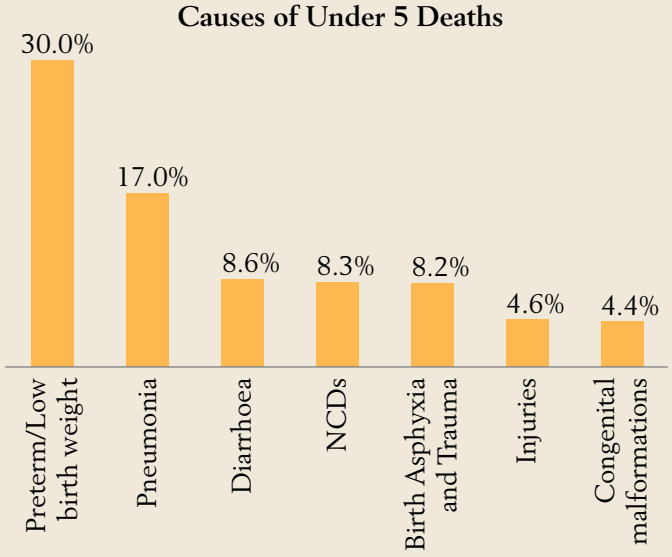
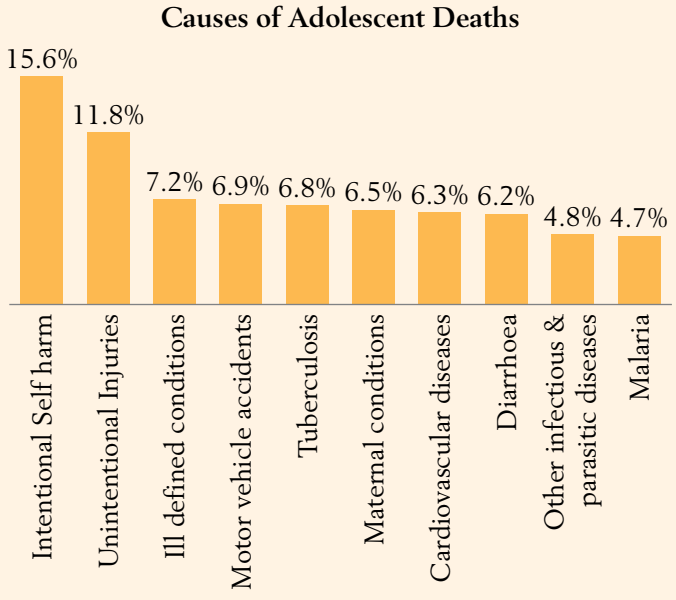
8. Possible Action for false reporting by CHOs

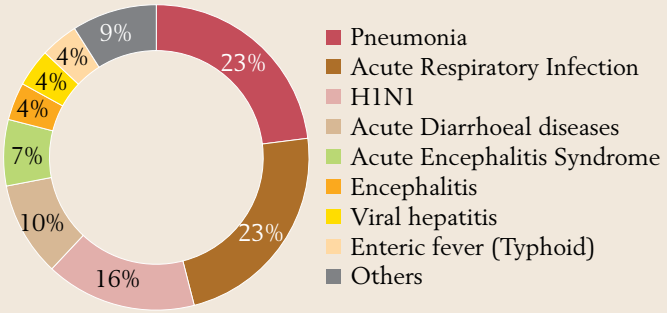
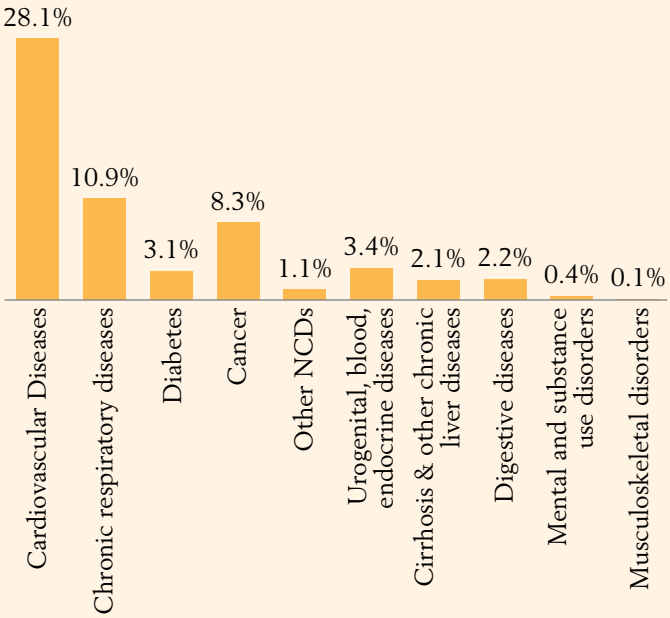
CHO as team leader would be accountable for submitting performance reports of HWC-SHC team. He/she should be given one warning if an instance of false reporting of performance indicators is identified from the call-linked validation of performance reports. Any repeat of falsification could result in deducting the amount from their salaries, and a third instance could lead to termination of service contracts of CHOs if continuous false reporting is observed despite warning.

ANNEXURES

ANNEXURE 1: BURDEN OF DISEASES IN INDIA

Disease/Health condition	Causes of mortality/morbidity/disability	Source
Maternal Mortality		RGI-SRS 2001-2003/ NHM Website
Neonatal Mortality		RGI-SRS 2001-2003/ NHM Website

Disease/Health condition	Causes of mortality/morbidity/disability	Source
Infant Mortality		RGI-SRS 2001-2003/ NHM Website
Under five Mortality		RGI-SRS 2001-2003/ NHM Website
Adolescent mortality		Causes of death in India-Centre for Global Health Research (2001-2003)

Disease/Health condition	Causes of mortality/morbidity/disability	Source
Deaths due to Communicable diseases		National Health Profile 2018, CBHI, DGHS
Deaths due to Non–communicable diseases	**Deaths due to NCDs** 	India: Health of the Nations States: The Indian State level disease burden Initiative 2017
Eye problems (Prevalence)	Cataract (62.6%) Refractive Error (19.70%) Corneal Blindness (0.90%) Glaucoma (5.80%) Surgical Complication (1.20%) Posterior Capsular Opacification (0.90%) Posterior Segment Disorder (4.70%) Others (4.19%) Estimated National Prevalence of Childhood Blindness is 0.80 per thousand.	
ENT problems	From the data available from various community-level surveys in India, the burden of ENT related illnesses is around 4.3%. Out of these, Ear, Nose and Throat related disorders contribute to 60%, 27% and 13% burden respectively, thus making disorders leading to hearing loss a major public health concern. Adult-onset hearing loss ranks 15th amongst the leading causes of the Global Burden of Disease (GBD), and 2nd in the leading causes of Years Lived with a Disability (YLD) (WHO).	Global Burden of Diseases

Disease/Health condition	Causes of mortality/morbidity/disability			Source
Oral Health Problems	40-45% of population have dental caries More than 90% of the population have periodontal diseases. 19-32% of population aged more than 65 years is edentulous 12.6 per one lakh population have oral cancer.			Operational Guidelines for Oral Health
Prevalence of Mental Morbidity among adults 18+ years		Lifetime	Current	National Mental Health Survey of India, 2015-16
	F10-F19 - Mental and behavioural problems due to psychoactive substance use	**22.4**		
	F10 Alcohol use disorder	4.7		
	F11-19, except 17 Other substance use disorder	0.6		
	F17 Tobacco use disorders	20.9		
	F20 –F29 Schizophrenia, other psychotic disorders	1.4	0.4	
	F30-F39 Mood (Affective) disorders	5.61	2.84	
	F30-31 Bipolar Affective Disorders	0.50	0.30	
	F32-33 Depressive Disorder	5.25	2.68	
	F40-F48 Neurotic and stress related disorders	3.70	3.53	
	F40 Phobic anxiety disorders	1.91		
	F40.0 Agoraphobia	1.62		
	F40.1 Social Phobia	0.47		
	F41 Other anxiety disorders	1.34	1.15	
	F41.0 Panic disorder	0.50	0.28	
	F41.1 Generalized Anxiety Disorder	0.57	0.57	
	F41.9 Panic disorder with limited symptoms	0.33		
	F42 Obsessive Compulsive Disorder	0.76		
	F42.0 to 42.8 OCD current	0.32		
	F42.9 OCD NOS	0.76		
	F43 Reaction to severe stress and adjustment disorders	0.24		
	F43.1 PTSD	0.24		

ANNEXURE 2: FAMILY FOLDER AND COMMUNITY BASED ASSESSMENT CHECKLIST (CBAC) FORM

Annexure 2a: Reporting format for ASHA

ASHA Name: .....

Village Name: ..... **Hamlet Name:** .....

Subcentre Name:..... **PHC Name:**.....

Part A) Family folder

1. Household details	
i. Number/ID	Please specify
ii. Name of Head of the Household	
iii. Details of household amenities –	
a) Type of house *(Kuccha/Pucca with stone and mortar/Pucca with bricks and concrete/or any other specify)*	
b) Availability of toilet *(Flush toilet with running water/flush toilet without water/pit toilet with running water supply/pit toilet without water supply/or any other specify)*	
c) Source of drinking water *(Tap water/hand pump within house/hand pump outside of house/well/tank/ river/pond/ or any other specify)*	
d) Availability of electricity *(Electricity supply/generator/solar power/kerosene lamp/or any other specify)*	
e) Motorised vehicle *(Motor bike/Car/Tractor/or any other specify)*	
f) Type of fuel used for cooking *(Firewood/crop residue/cow dung cake/coal/kerosene/LPG/or any other specify)*	
g) Contactdetails for all individuals in the household *(Telephone number of head of the family)*	

S. No.	Individual Name	Aadhaar ID *(if Aadhaar id is not available please add details of other ids like Voter id or Ration card)*	Individual Health ID *(issued by SHC/ ANM)*	Sex	Date of Birth	Age	Marital Status	Beneficiary of any health insurance scheme		Current Status of residence	
								Yes/No	Details of the scheme (as applicable)	Staying at the house currently	Migrated temporarily for work

Part B) Individual Health Record

Individual Name .....

Individual ID .....

A. History (to be filled by ASHA)

Known Medical Illness for NCDs	Date of Diagnosis	Treatment		Any Complications	Others
		Currently under treatment	Discontinued		

B. Screening for NCD (to be filled by ANM/CHO)

Screened for (specify date on which screening was done)						Screening Result						Risk Factors	Other - Remarks
Hypertension	Diabetes	Oral Cancer	Breast Cancer	Cervical Cancer	COPD (Respiratory Disorders)	Hypertension	Diabetes	Oral Cancer	Breast Cancer	Cervical Cancer	COPD (Respiratory Disorders)		

C. Treatment Details

Condition	Date of Diagnosis	Treatment Initiation			Treatment Compliance - Currently on Treatment				Treatment Discontinued		Other - Remarks
		Health Facility	Date	Details	Health Facility	Date of Visit	Supply of Medicine Received– Monthly	Side Effects/ Complications (if any)	Reasons for Discontinuation	Date of Discontinuation	

Annexure 2b: Community Based Assessment Checklist (CBAC) Formfor all individuals above 30 years of age

General Information	
Name of ASHA	Village
Name of ANM/MPW	Sub Centre
PHC	Date
Personal Details	
Name	Any Identifier (Aadhar Card, UID, Voter ID)
Age	State Health Insurance Schemes: (Y/N)
Sex	Telephone No.
Address	

Part A: Risk Assessment

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

Part B: Early Detection: Ask if Patient has any of these Symptoms

B1: Women and Men	Yes/No		Yes/No
Shortness of breath		History of fits	
Coughing more than 2 weeks*		Difficulty in opening mouth	
Blood in sputum*		Ulcers/patch/growth in mouth that has not healed in two weeks	
Fever for > 2 weeks*		Any change in the tone of your voice	
Loss of weight*		Any patch or discoloration on skin	
Night Sweats*		Difficulty in holding objects with fingers	
Are you currently taking anti-TB drugs**		Loss of sensation for Cold/Hot objects in in palm or sole	
Anyone in family currently suffering from TB**			
History of TB *			
Lump in the breast		Bleeding after menopause	
Blood stained discharge from the nipple		Bleeding after intercourse	
Change in shape and size of breast		Foul smelling vaginal discharge	
Bleeding between periods			
In case of individual answers Yes to any one of the above-mentioned symptoms, refer the patient immediately to the nearest facility where a Medical Officer is available			
**If the response is Yes- action suggested: Sputum sample collection and transport to nearest TB testing center*			
*** If the answer is yes, tracing of all family members to be done by ANM/MPW*			

Part C: Circle all that Apply

Type of Fuel used for cooking – Firewood/Crop Residue/Cow dung cake/Coal/Kerosene
Occupational exposure – Crop residue burning/burning of garbage – leaves/working in industries with smoke, gas and dust exposure such as brick kilns and glass factories etc.

ANNEXURE 3: VILLAGE HEALTH SANITATION AND NUTRITION DAY SITE MONITORING CHECKLIST

Village Health, Sanitation and Nutrition Day Monitoring Format		
Section A: General Information		
Name of Sub Centre	Name of CHO:	
Name of Village:	Name of MPW/ANM:	
VHSND site Anganwadi Centre Code:	Name of ASHA:	
Date:	Name of Anganwadi worker:	
Name of supervisors 1:	Name of supervisors 2:	
Designation of supervisors 1:	Designation of supervisors 2:	
Section B: Planning		
Data Field	YES	NO
VHSND Held		
VHSND held as per microplan		
If not held, what are the reasons A_____ B_____ C _____ D_____		
ANM Present		
ASHA Present		
Anganwadi worker Present		
VHSND sessions attended by all (MPW-F/ANM, MPW-M, AWW, ASHA)		
VHSND sessions attended by the PRI officials		
Section C: Infrastructure		
Data Field	YES	NO
Organized in Anganwadi Centre		
Organized in Other building (specify)		
Drinking water available		
Toilet available		
Provision for Hand washing		
Provision of curtain for Privacy		
Section D: Logistics available		
Select whichever is applicable		
☐ BP Instrument	☐ Albendazole tablets	☐ Condoms
☐ Stethoscope	☐ Cotrimoxazole tablets	☐ Combined Oral Contraceptives
☐ Examination table	☐ IFA Tablets (Red)	☐ Injectable MPA sample

Village Health, Sanitation and Nutrition Day Monitoring Format		
☐ Inch tape	☐ IFA Tablets (Pink and Blue)	☐ IUCD -375 and 380 A sample
☐ Weighing scale (adult)	☐ IFA syrup	☐ Centchroman (Chhaya)
☐ Weighing scale (Infants)	☐ Paracetamol	☐ Nischay/Pregnancy testing kits
☐ Weighing scale (child)	☐ Urine testing kit/uristix	☐ Injectable MPA sample
☐ Foetoscope	☐ Blank MCP Cards	☐ Emergency contraceptive pills
☐ ORS Sachets	☐ Referral slips	☐ Due list of Beneficiaries
☐ Zinc tablets	☐ Digital hemoglobinometer	

Section E: Immunization		
Select whichever is applicable		
☐ Immunization session held with VHSND?	☐ All vaccines are available?	
☐ MR	☐ BCG	☐ JE Diluent (in endemic districts only)
☐ OPV	☐ MR Diluent	☐ JE (in endemic districts only)
☐ Hepatitis B (given within 24 hours of birth)	☐ BCG Diluent	☐ AEFI/Anaphylaxis Kit Available
☐ Penta	☐ Rota	☐ 5ml Disposable Syringes in adequate quantity
☐ Td	☐ DPT	☐ 0.5 Ml Syringe available in adequate quantity
☐ f-IPV	☐ PCV	☐ 0.1 Ml Syringe available in adequate quantity

Section F: Reproductive Health		
Data Field	YES	NO
Contraceptive material being distributed to beneficiaries		
Pregnancy confirmation test done		

Section G: Maternal Health		
Data Field	YES	NO
Privacy ensured during PA examination		
Conducting PA examination		
Conducting BP measurement		
IFA tablets distributed to PW IFA tablets distributed to Lactating mothers		

Village Health, Sanitation and Nutrition Day Monitoring Format		
Urine examination of pregnant woman (for proteinuria)		
Identification of Severe Anemia of mother		
Identifying high risk pregnancy		
Identification of danger signs of mother		
Weighing of PW/Lactating Mother is being done		
PW/Lactating Mother referred to higher facility		
Conducting counseling of mothers		
Section H: Newborn and Child Health		
Data Field	YES	NO
Weighing of newborn and children is being done		
Plotting of growth chart is being done		
Identifying MAM and SAM Identifying sick SAM child		
Identification of danger signs of newborn		
Underweight children received supplementary nutrition IFA syrup distributed to children 6 – 59 months Provision of Vitamin A solution		
Provision of ORS		
Provision of Zinc tablets		
Dietary counselling for children		
Newborn and children referred to higher facility as per requirement		
Section I: Adolescent Health		
Data Field	YES	NO
Adolescent girl received sanitary napkins		
Adolescent girls counseled on menstrual hygiene practices		
Adolescents received weekly IFA tablets		
Section J: Others		
Data Field	YES	NO
Provision of RDK for Malaria		

Village Health, Sanitation and Nutrition Day Monitoring Format		
Provision of Antimalarial drugs		
Beneficiaries tested with VDRL		
Beneficiaries tested for HIV		
Beneficiaries with suspected Leprosy lesions detected		
Section K: Counseling		
Select whichever is applicable		
☐ Antenatal Care	☐ Nutrition of pregnant & lactating mothers	
☐ Birth preparedness/complication readiness	☐ Spacing methods	
☐ Importance of institutional delivery	☐ Permanent methods	
☐ Postnatal Care of mother and newborn	☐ Postpartum family planning	
☐ Essential New born care	☐ Reproductive Tract Infections- RTI	
☐ Early initiation of breastfeeding and Exclusive Breast feeding	☐ Sexually Transmitted Infections- STI	
☐ Complementary feeding	☐ Hygiene and Sanitation	
☐ Feeding of sick child ☐ Micronutrients Supplementation (Vitamin A and IFA)	☐ Sex Selection	
☐ Early Childhood illnesses (Diarrhoea and ARI Management)	☐ Non Communicable Diseases (NCD)	
	☐ Age at marriage	
☐ Others(Specify)_____		
Section L: IEC Material		
Select whichever is applicable		
☐ Banner	☐ Wall writing	☐ Poster
☐ Flip charts	☐ Pamphlets	☐ None
☐ IEC materials as per Village counseling theme		
Signature: **CHO** **MPW** **ASHA**		
Δ *A = ANM and logistics available,* ***B*** *= Both ANM as well as logistics are not available* ***C*** *= ANM present but logistics not available* ***D*** *= Logistics available but ANM absent,* ***D****= Others (specify)* **Multiple responses may be applicable AVD= Alternate vaccine delivery*		

ANNEXURE 4: SUGGESTIVE LIST OF INDICATORS TO ASSESS MONTHLY PERFORMANCE OF HWC-SHC TEAM FOR SERVICE UTILIZATION

S. No.	Assessment Indicator	Definition	Source of Verification/ Reporting	Service Delivery Output to receive 75% of Incentive Payment	Service Delivery Output to receive 100% of Incentive Payment
1	Number of OPD[1] cases in the month	No. of OPD cases including new and old cases	AB-HWC Portal/HWC – SHC Register	300 per month for 5000 population Or 180 per month for 3000 population *(Estimated @ 60 cases per 1000 population)*	400 per month for 5000 population Or 240 per month for 3000 population *(Estimated @ 80 cases per 1000 population)*
2	Proportion of estimated pregnancies registered	Numerator: Number of pregnant women registered for ANC Denominator – Total no. of estimated pregnancies[2]	RCH Portal/HWC – SHC Register and HMIS	60% of the estimated pregnancies registered	80% of the estimated pregnancies registered
3	Proportion of Pregnant Women registered who received ANC	Numerator - No. of pregnant women who received ANC services (as per schedule) in a month Denominator - Total no. of registered pregnant women whose ANC is due that month	RCH portal/HWC – SHC Register	80% of the pregnant women received ANC as per schedule	100% of the pregnant women received ANC as per schedule
4	Proportion of Children up to 2 years of age who received immunization	Numerator - No. of children who received immunization (as per schedule) in a month Denominator - Total no. of registered children whose immunization was due that month	RCH portal/ HWC – SHC Register	90% of the children[3] received immunization as per schedule	100% of the children received immunization as per schedule

S. No.	Assessment Indicator	Definition	Source of Verification/ Reporting	Service Delivery Output to receive 75% of Incentive Payment	Service Delivery Output to receive 100% of Incentive Payment
5	Proportion of Newborns who received HBNC visits	Numerator - No. of newborns who received visits (as per schedule) as per HBNC schedule Denominator - Total no. of newborns	RCH portal/HWC – SHC Register	80% of newborn received HBNC visits	100% of newborn received HBNC visits
6	Proportion of above 30 years individuals screened for Hypertension[4]	Numerator - No. of individuals screened for Hypertension Denominator-Total population of 30 years and above of age	NCD- CPHC IT application/HWC-SHC Register	120 individuals over 30 years of age per 5000 population and 74 individuals over 30 years of age per 3000 population screened for HTN every month (Estimated to achieve 80% screening of individuals over 30 years over a period of one year)[5]	
7	Proportion of above 30 years individuals screened for Diabetes[4]	Numerator - No. of individuals screened for Diabetes Denominator-Total population above 30 years of age	NCD- CPHC IT application/HWC-SHC Register	120 individuals over 30 years of age for 5000 population and 74 individuals over 30 years of age for 3000 population screened for DM every month (Estimated to achieve 80% screening of individuals over 30 years over a period of one year)[5]	
8	Proportion of above 30 years individuals screened for Oral Cancers[6]	Numerator - No. of individuals screened for Oral Cancer Denominator-Total population above 30 years of age	NCD- CPHC IT application/HWC-SHC Register	120 individuals over 30 years of age for 5000 population and 74 individuals over 30 years of age for 3000 population screened for Oral Cancer every month (Estimated to achieve 80% screening of individuals over 30 years over a period of one year)[5]	
9	Proportion of Patient of HTN on treatment	Numerator - No. of HTN patients who received follow up care Denominator - Total no. of HTN/patients	NCD- CPHC IT application/HWC-SHC Register	30% of patients who received treatment	50% of patients who received treatment

S. No.	Assessment Indicator	Definition	Source of Verification/ Reporting	Service Delivery Output to receive 75% of Incentive Payment	Service Delivery Output to receive 100% of Incentive Payment
10	Proportion of Patient of DM on treatment	Numerator - No. of DM patients who received follow up care Denominator - Total no. of DM/ patients	NCD- CPHC IT application/HWC-SHC Register	30% of patients who received treatment	50% of patients who received treatment
11	Proportion of cases referred for TB screening	Numerator-Number of suspected TB cases referred for diagnosis/ Denominator- Total number of patients attended in OPD	Nikshay/SHC – HWC Register[7]	Minimum 3% cases identified from OPD should have been referred for screening of TB at a higher facility	
12	Notified TB patients who received treatment as per protocols[8]	Numerator - No. of TB patients who are on regular treatment as per protocol Denominator - Total no. of TB patients	Nikshay/TB treatment card/SHC – HWC Register DMC Register[9]	100% of patients on treatment	
13	VHND held against planned	Numerator - No. of VHND attended Denominator - Total no. of VHND held	Self- reported in CPHC-NCDapplication	MPWs and ASHAs will organize all VHND session as planned and CHO should monitor at least two VHNDs in a month for performance- linked incentive	
14	Village meetings (VHSNCs)/MAS held	Numerator - No. of VHSNC/ Village meetings attended as per plan Denominator - Total no. of VHSNC/Village meetings held		MPWs and ASHAs will organize all VHNC session as planned and CHO should monitor at least two VHNSC meeting in a month for performance- linked incentive	

S. No.	Assessment Indicator	Definition	Source of Verification/ Reporting	Service Delivery Output to receive 75% of Incentive Payment	Service Delivery Output to receive 100% of Incentive Payment
15	Monthly meetings held at SHC- HWCs	Organized monthly meeting with Primary Care Team at Sub centers HWCs to monitor the following- 1. Review of work plan for current month. 2. Updating work plan for the next month. 3. At least one technical session held for capacity building of the primary health care team.		One meeting held at the SHC- HWC and should be attended by MPWs and all ASHAs	

1. OPD includes outreach and facility-based services provided by HWC-SHC team. It encompasses all services delivered by the team with regards to NCD Screening, ANC/PNC services, Immunization, counselling and treatment of illnesses etc.
2. Denominator can be derived from HMIS.
3. In case of target beneficiaries being in the range of 7-9, achievement of 85% can be rounded off and equated as 90% achievement. If target beneficiaries are in the range of 4-6, the achievement of 75% can be equated as 90%.
4. Screening for HT and DM to be repeated every year.
5. Incentive may be provided to HWC- SHC team once the target of 80% screening is met irrespective of number of individuals screened in the remaining months of the year.
6. Screening for Oral Cancer to be repeated once in five years.
7. Senior Treatment Supervisor (STS) can verify the records.
8. If there are no cases of notified TB patients, this indicator will be marked as non-applicable. In such instances, extrapolation of incentives can be done based on 14 indicators in place of 15 indicators. Thus, the total entitlement of the incentives for that month will remain unchanged but the incentive amount to be disbursed will be calculated based on achievements on remaining 14 indicators.
9. Senior Treatment Supervisor (STS) can verify the records.

Note

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