COMPREHENSIVE PRIMARY HEALTH CARE THROUGH FAMILY HEALTH CENTRES

State Health Systems Resource Centre
Kerala

GOVERNMENT OF KERALA

K K SHAILAJA TEACHER

Minister for
Health, Social Justice,
Women & Child Development

MESSAGE

Thiruvananthapuram,
February 19, 2019.

The Government of Kerala is committed to providing affordable health care for all as part of "Aardram Mission". Even though Kerala has the best health indices in the country newer health problems are emerging. The concept of Family Health Centres (FHC) has been envisaged to improve the quality of service at the primary level with emphasis on prevention, promotion, treatment, rehabilitation and palliative care at local settings.

Transformation in infrastructure, human resources, timings and provision of services along with intervention in social determinants of health would definitely help the state to achieve its sustainable development goals which will ultimately improve the overall health outcome and thus cut down the out of pocket expenditure for health.

The FHC would also be following standard guidelines for comprehensive mangement of common medical conditions. The standards will be followed in not only treating the patients but also in proper referral and rehabilitation along with the preventive and promotive activities.

A document with detailed description of the concept is very essential for whoever is involved with the implementation of FHCs as well as for general reading. I am confident that this document would give the reader a detailed description on various aspects of the envisaged Family Health Centres, it's services and the role of various players in the implementation and sustenance. I congratulate team SHSRC, experts, academicians and staff in Department of Health services for their valuable contribution in developing the unique concept for the State.

K K Shailaja Teacher

Contributors

WRITTEN BY

Dr. Vijayakumar K
Hon. Consultant Aardram & Prof. and HOD, Dept of Community Medicine, AIMS, Kochi

Dr. Anitha S S
Asst. Professor, Dept. of CM, Pariyaram

Dr. Arya L R
Junior Resident, Dept. of CM, Pariyaram

Dr. Sanjeev
Rtd. Asst. Surgeon

Dr. Ajan M J
JAMO, Planning, DHS, TVPM

Dr. Divya V S
Staff Nodal Officer Training, NHM, TVPM

Dr. Joy John
Asst. Surgeon, PHC Kuttichal, TVPM

Dr. Anjali Krishna
Asst. Surgeon, PHC Aanikkad, Pathanamthitta

Dr. Manu M S
JC, Respiraotry Medicine, STDC

Dr. Pradeesh
DTO, Malappuram

Dr. Devraj R
Asst.Pro.Gov.Medical College, Idukki

Dr. Minu Mohan
Asst.Pro.Gov.Medical College, Idukki

Dr. Shabna Basheer
SMCSI, Medical College, Karakkonam

Dr. Sethulekshmi Surendran
Asst. Surgeon, PHC, Kulanada

Dr. Prajitha C Pillai
Junior Resident, Dep. of CM - MC, Tvm

Dr. Abin Sebastian
Senior Resident, Dep. of CM - MC, Tvm

Dr. Betsy A Jose
Senior Resident

Dr. Harsha Lais
Resident, Dept. of Community Medicine, AIMS

Dr. Amrita Das M
Resident, Dept. of Community Medicine, AIMS

Dr. Yamini Thankachi
CMO, W&C, TVPM

Dr. Kiran P S
SNO, Mental Health, Trivandrum

Dr. Mahesh N
Asst. Surgeon, CHC Perumkadavila, Trivandrum

Mr. Sibi Augustine
Health Supervisor, PHC Nettoor, Ernakulam

Mr. Manoj
Health Inspector, FHC Thirunnavaya, Malappuram

Mr. Geoffery Jacob
Health Inspector, FHC Vattamkulam, Malappuram

Mr. Dinesh
Health Inspector, PHC Keezhattur, Malappuram

REVIEWED BY

Mr. Rajeev Sadanandan (Retd. IAS)
Former Addl. Chief Secretary, (H & FW), Govt. of Kerala

Dr. Shinu K S
Principal, KSHIFW & Executive Director, SHSRC

Dr. Jameela P K
State Consultant Aardram, Former DHS, Govt. of Kerala

Dr. Jagadeesan C K
Deputy Director, DHS

EDITED BY

Dr. Rekha M Ravindran
Sr. Research Officer, SHSRC-K, TVPM

LANGUAGE EDITING

Ms. Maya C
Reporter Hindhu

TECHNICAL SUPPORT

Mr. Arun Babu
Consultant CP & Documentation SHSRC-K, TVPM

TYPING AND LAYOUT

Sowmya M V
Data Entry Operator, SHSRC-K, TVPM

Content

Abbreviations

ADD	-	Acute Diarrhoeal Disorder
ADS	-	Area Development Society
AEFI	-	Adverse Event Following Immunisation
AIDS	-	Acquired Immuno Deficiency Syndrome
AIDS	-	Acquired Immuno Deficiency Syndrome
ARI	-	Acute Respiratory Infection
ART	-	Anti Retroviral Therapy
ART	-	Anti Retroviral Therapy
ASHA	-	Accredited Social Health Activist
ASHA	-	Accredited Social Health Activist
AYUSH	-	Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathy
AYUSH	-	Ayurveda, Unani, Siddha, Homeopathy
BSE	-	Breast Self Examination
CAD	-	Coronary Artery Disease
CBNAAT	-	Cartridge Based Nucleic Acid Amplification Test.
CBPC	-	Community Based Palliative Care
CDS	-	Community Development Society
CPHC	-	Comprehensive Primary Health Care
CPHC	-	Comprehensive Primary Health Care
DEIC	-	District Early Intervention Centre
DM	-	Diabetes Mellitus
DM	-	Diabetes Mellitus
DMFT	-	Decayed Missed Filled Index
DMHP	-	District Mental Health Program
DMHP	-	District Mental Health Program
FBS	-	Fasting Blood Sugar
FHC	-	Family Health Centre
FHC	-	Family Health Centre
FICTC	-	Strategic Information Management System
GDM	-	Gestational Diabetes Mellitus
HIV	-	Human Immunodeficiency Virus
HT	-	Hypertension
HTN	-	Hypertension
IDSP	-	Integrated Disease Surveillance Program
IDSP	-	Integrated Disease Surveillence Program
IEC/BCC	-	Information Education Campaign / Behavioral Change Communication

IEC/BCC	-	Information Education Campaign / Behavioral Change communication
IFA	-	Iron and Folic Acid
IMR	-	Infant Mortality Rate
IMR	-	Infant Mortality Rate
LFT	-	Liver Function Test
LGBT	-	Lesbian Gay Bisexual Transgender
LIFE	-	Livelihood Inclusion and Financial Empowerment
LSG	-	Local Self Government
LSG	-	Local Self Government
MB	-	Multi Bacillary
MMR	-	Maternal Mortality Ratio
MMR	-	Maternal Mortality Ratio
NCD	-	Non communicable Diseases
NCD	-	Non Communicable Diseases
NGO	-	Non Governmental Organisation
NGO	-	Non Governmental Organisation
NMR	-	Neonatal Mortality Rate
NMR	-	Neonatal Mortality Rate
NSS	-	National Service Scheme
NTD	-	Neglected Tropical Disease
NTD	-	Nitrate Tropical Disease
OPD	-	Out Patient Department
PB	-	Pauci Bacillary
PHC	-	Primary Health Centre
RTA	-	Road Traffic Accidents
SC/ST	-	Scheduled Caste/Scheduled Tribe
SDG	-	Sustainable Development Goals
SDG	-	Sustainable Development Goals
SJD	-	Social Justice Department
SSM	-	Social Security Mission
SWAAS	-	Stepwise Approach to Airway Diseases
SWAAS	-	Stepwise Approach to Airway Diseases
TB	-	Tuberculosis
TB	-	Tuberculosis
U5MR	-	Under 5 Mortality Rate
U5MR	-	Under 5 Mortality Rate
UN	-	United Nations
UN	-	United Nations
UTI	-	Urinary Tract Infection
VIA	-	Visual Inspection with Acetic Acid
VPD	-	Vaccine Preventable Diseases
WHSNC	-	Ward Health Sanitation and Nutrition Committee
WHSNC	-	Ward Health Sanitation, Nutrition Committee
WIFS	-	Weekly Iron and Folic Acid

EXECUTIVE SUMMARY

Kerala's public health system has attracted international attention for its remarkable achievements even though the State's progress on the economic front has been relatively modest. However, it has hardly kept up with the epidemiological and demographic transitions that have happened in the State in the last three decades. With the increasing burden of non communicable diseases and issues of an ageing population taking a toll on the State's health system, the Government has now decided to revamp the health system by turning its focus firmly back on the primary health care system through delivery of Comprehensive Primary Health Care.

Mission 'Aardram'

The Government of Kerala, as part of its 'Navakerala Karma Padhadhi', had announced the launch of four key Missions namely, LIFE (Livelihood Inclusion and Financial Empowerment), Comprehensive program for the rejuvenation of the public education system, Haritha Keralam and Aardram, which it thought was crucial to the State's future progress and development. The main goal of Mission Aardram is the transformation of the State's public health system into one which is not just patient-friendly but one which delivers equitable, affordable and quality care to the public.

At the Sustainable Development Summit in 2015, the UN adopted a set of 17 Sustainable Development Goals (SDGs) to end poverty, fight inequality and injustice, and tackle climate change by 2030. Out of the 17 goals, Goal no. 3 dealt with "Good Health and Well Being". With the help of 22 expert groups on various aspects of health, Kerala has formulated its own health goals, in sync with the UN's SDGs (short term goals to be met in 2020 and long-term goals to be met in 2030) and has been incorporated into the State's 13th Five Year Plan. Mission 'Aardram', launched in 2017 February, has been conceived as one of the vehicles which will lead Kerala to its SDG goals thus reducing the out of pocket expenditure for health in the state.

Components of Aardram Mission

1. People friendly transformation of out patient department
2. Transformation of Primary Health Centres (PHC) to Family Health Centres (FHC)
4. Provision of specialty services in at least one hospital in every District/Taluk; introduction of super specialty services in District hospitals
5. Provision of basic health care services to backward tribal, coastal and migrant communities in the State.

Family Health Centres

Family Health Centres, an integral part of Mission Aardram, proposes to revamp primary care services to ensure equitable, affordable and quality care to all. The aim is to provide comprehensive health care including

preventive, promotive, curative, rehabilitative and palliative care aspects.

Vision : To provide comprehensive primary health care services for each and every individual residing within its jurisdiction.

Mission : To achieve SDG 2020 and 2030 targets through provision of equitable, affordable and quality care for all

Strategies: Strengthening primary health care by improving quality of services, addressing social determinants of health and enhancing community participation.

Services

An FHC will be more than just a hospital and will function as a centre for the promotion of good health and well being. It should have a welcoming environment, appropriate infrastructure and the staff should be pleasant and affable. An FHC will not be just a hospital which alleviates sickness but it should be an institution which promotes health and wellness. It should be friendly to the people with its amiable infrastructure, environment and pleasant attitude of the employees.

The quality of services at FHCs will be ensured by improving the standards of care through the provision of patient-friendly infrastructure, adequate equipments and implementation of guidelines for clinical care. Continuity of care between different levels of care in the public health system and different time periods will also be ensured through the implementation of e-health. FHCs will also function as the nodal centre for community based interventions for addressing social determinants of health. FHCs will take the lead in planning the activities of the Panchayat with community participation and intention to achieve Sustainable Development Goals of the State.

One of the prime strategies for improving the quality of healthcare delivery through the new FHCs involves redefining the service packages to suit the requirements of the target population. Curative services (OP services, emergency, laboratory and referral services), field-level activities, institutional services (hostels, schools, offices and work places), and specific services for marginalized and vulnerable population will be provided by incorporating appropriate social security schemes.

FHCs will strictly follow the Comprehensive Primary Health Care (CPHC) treatment guidelines for managing patients attending the out patient (OP) clinics. Patients who may require treatment at a higher level will be identified and referred early to the appropriate level of institution in accordance with the treatment guidelines. FHCs will also follow up all cases which are referred back from Taluk or District hospitals.

In order to provide comprehensive primary health care, service packages have been re-defined. Improving the services qualitatively and quantitatively, strengthening the sub centers, addressing the social determinants of health, ensuring effective convergence and community participation are some of the planned strategies.

Health care service delivery plan

A health care service delivery plan should be prepared for every individual registered under an FHC based on the health care needs recorded in the family health register. Similar plans to suit the needs of every family under an FHC as well as service delivery plans for the entire ward and panchayat should be drawn up.

Four types of service delivery packages

are conceived for the population in a Panchayat at four different levels. Individual service packages are defined set of services for an individual based on the age, gender, physiological and disease condition. Family health care service delivery plan consists of specific needs of the family including social determinants of health. Ward and Panchayat health service delivery plan will consider the needs of the whole population. After mapping the health needs, responsibility mapping should also be carried out. Service delivery from the FHC should be based on the defined health plan of the state and health service delivery plan conceived for the FHC.

Individual packages

The individual packages are **35** in number and are categorized based on age, gender, physiological and morbidity status. Each package ensures comprehensive health care for the concerned category:-

a. There are nine packages based on **age and gender (demographical):** Newborn, infants, under 5 children, children 5 to 10 years, Adolescents (10-19 years), Apparently healthy adult men (19-60 years), women (19-60 years), older persons (men and women) (60 years and above)

b. Packages based on **physiological conditions:** Antenatal and post-natal

c. Packages based on **prevention and risk reduction:** Obesity, substance abuse, underweight, diet, NCD diet, physical inactivity, oral health and immunization

d. Packages based on **disease conditions:** Non Communicable Diseases [Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Coronery Artery Disease (CAD), Stroke, Mental illness, Cancer care], Palliative care, Leprosy and Tuberculosis (TB).

Family packages

The family package addresses the needs of all members of the family and other health needs of the family which do not directly come under the individual packages such as quality and quantity of drinking water, rearing pets/ cattles, well chlorination, indoor air quality, household waste disposal and kitchen garden.

Ensuring green protocol in family function and at the household level, rain water harvesting and well- water recharge, provisions to decrease indoor air pollution-chimney/smokeless chulha/ avoiding smoking and burning of waste is also part of family service package. Ensure adequate ventilation and lighting inside the house, encourage the practice of kitchen garden, promote healthy relations between family members and protective mechanisms to prevent domestic accidents/injuries.

Ward level packages

The ward and panchayat packages cater to those needs which should be provided at a community level and on a larger scale, such as provision of safe drinking water, solid and liquid waste management, spaces for promoting physical activity & recreation, setting up of kitchen garden, ensuring social security, elderly-friendly social environment and organized, social interventions to prevent social evils like domestic violence and alcoholism. The responsibility for arranging the ward level services rests with WHSNC, ASHA, Kudumbasree Health Volunteer, Anganwaadi worker, SC/ST promoter and Arogyasena, under the leader ship of an elected representative of the locality. They will be acting in collaboration with the health system functionaries of the locality.

Panchayat-level packages

Panchayat-level packages involve creating physical or social structures to nurture comprehensive primary health care, over and above ward level package. Some examples are: management of non-biodegradable waste, establishing common spaces like library, walkways, office space for self help groups, judicious utilization of idle buildings as venues for sub centers, senior citizen gathering places, vocational training points, health clubs etc., preparing a plan of action for addressing issues of destitutes and ensuring the enforcement of public health laws to protect the rights of people.

Institutional mechanism for providing Comprehensive Primary Health Care

Family health centres along with the Sub centres, Anganwaadi centres, other related institutions like Ward Health Sanitation and Nutrition Committee (WHSNC) play a crucial role in delivering the above package of serivce.

Role of LSG in FHCs

Health for all should be the motto of all local self- governments in attaining the Sustainable Development Goals. LSGs should develop specific targets to be achieved by the panchayat. They should adopt a proactive role in identifying potential issues which could affect the health care delivery and utilization, and in rectifying them in advance. Local self-governments should play a leadership role in the planning, funding, implementation, maintenance, monitoring and evaluation of family health centers. Improving the health status of the community can considerably reduce the expenditure on treatment, which can be channeled to preventive and promotive services as well as other developmental activities. Functions of LSG in the context of FHCs can be broadly divided into the following domains — stewardship, provider, community mobilization, mobilization of resources and convergence

Monitoring and Evaluation

Monitoring should act as a tool that helps in speeding up the development processes. Continuous monitoring, right from the planning stage is necessary for the effective implementation of any program. Multi-level monitoring, both administrative and social, should be the way forward. Social auditing is also essential for maintaining transparency and equity in the activities and this shall be led by the LSG and executed by a group representing all sections of society. The monitoring committee should be constituted at different levels as ward, sub centre, FHC and panchayat. Social monitoring and evaluation should be addressed by local self government.

Conclusion

The FHCs, as envisaged, will be one of the important vehicles for the State to achieve the short-term and long-term SDG goals for 2020 and 2030 respectively. Through this program the Government aims at bringing down the morbidity amongst the population and preventing catastrophic health expenditure, which could go a long way in promoting social and economic growth.

Chapter 1
INTRODUCTION

The outstanding achievements of Kerala in the area of public health have attracted much international attention, even though its progress on the economic front has been quite modest. However, the epidemiological and demographic transition of the past three decades seems to have over whelmed the State's public health system, rendering it unable to handle the new health challenges that the State is currently facing. A total revamp of the health system, with a firm focus on primary care, is the way forward. This has to start by re-working the primary health care system and making it better equipped.

Mission Aardram

The Government of Kerala has launched four missions under its Nava Kerala Karma Padhadhi. Mission Aardram, aimed at revamping and transforming the public health sector, is one of the key missions, which has been launched in the backdrop of UN's Sustainable Development Goals 2030

The other missions – "Livelihood Inclusion and Financial Empowerment" (LIFE), "Comprehensive Public Education Rejuvenation" (for universal education) and "Haritha Keralam" (for water and food safety, sanitation and safe disposal of waste, and sustainable development of water resources) are also indirectly linked to Mission Aardram, as these deal with various social determinants of health like education, safe drinking water, sanitation or safe disposal of waste. The Sustainable Development Goals 2030, an all-encompassing and inclusive development agenda, was declared by the UN in 2015.

An expert working group on health has charted out the State's agenda in the health sector for the next five years, with specific goals and targets, in sync with the targets under SDGs. While the SDGs have set 2030 as the time target, Kerala, through Mission Aardram will primarily focus on what it can achieve in the next five years; by 2020 .This has been incorporated into the 13th Five Year Plan of the State. Given below is the state target for 2030 and 2020.

നവകേരള കർമ്മപദ്ധതി

ആർദ്രം

Table : 1

Sustainable Development Goals

Sl. No	National Target 2030	State Target 2020
SDG Target 1 Maternal Mortality Ratio	By 2030, reduce the Maternal Mortality Ratio (MMR) to less than 70 per 100,000 live births	➢ To reduce the Maternal Mortality Ratio from 66 to 30 per 100,000 live births by 2020 and to 20 per 100,000 live births by 2030.
SDG Target 2 IMR, NMR, U5MR	By 2030 end preventable deaths of newborns and children under 5 years of age, reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	➢ To reduce IMR from 12 per 1000 live births to 8 per 1000 live births by 2020 i.e. 2/3rd reduction ➢ To reduce NMR from 7 to 5 by 2020 ➢ To reduce under 5 mortality (U5MR) from 14 to 9 per 1000 live births
SDG Target 3 Communi-cable Diseases	By 2030, end the epidemics of AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases and combat Hepatitis, Water-borne diseases and other Communicable diseases	
	1. Hepatitis	➢ To ensure 95 % new born vaccination coverage for Hep B ➢ To identify 100% high risk groups of Hep B ➢ To provide drug therapy to >50% confirmed cases of Hepatitis C cases

	2. Leprosy	➢ Reduce the prevalence rate from 0.169 to < 0.1 at all levels-District, Block and Panchayat. ➢ Child cases of leprosy from 1.17/million to < 0.6/million ➢ Rate of child case with zero disability to be sustained (SDG target). ➢ Grade 2 deformity from 1.2/million to < 1/ million (SDG target)
	3. Lymphatic Filaria	➢ Reducing Microfilaria prevalence below 1% in all districts by 2020 ➢ Ensuring availability of recommended minimum package of care for all patients with Lymphoedema, acute attack and Hydrocoele by 2020
	4. Malaria	➢ To bring down the incidence of Indigenous Malaria to zero in all 14 districts by 2020 ➢ To prevent the transition of imported Malaria cases to Indigenous Malaria cases in Kerala by 2020
	5. Tuberculosis	➢ Reduce mortality by 35% by 2020 and by 90% by 2030 ➢ Reduce incidence by 20% by 2020 and by 80% by 2030 ➢ Zero catastrophic costs due to TB
	6. HIV/AIDS	➢ All eligible persons are put and maintained on Anti Retroviral Treatment (ART) by 2020 ➢ No incidence of HIV infection by 2025
	7. Kala Azar	➢ Elimination of Kala-Azar (<1/10,000 block population) from Kerala by 2020
SDG Target 4 Non-Communi-cable Diseases	1. By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well being	➢ Halt increase in prevalence of raised Blood Pressure (HT) 30 - 40 % among those above 30 years of age ➢ Halt the rise in prevalence of Diabetes (DM) 18 – 20 % prevalence above 30 years ➢ To maintain the present prevalence of obesity and diabetes in the general population ➢ 30% relative reduction in current tobacco use ➢ 20% relative hike in people consuming 5 servings of fruits & vegetables ➢ 10% relative reduction in mean intake of salt ➢ 50% increase in drug therapy to prevent heart attacks and stroke ➢ 5% relative reduction from current alcohol use ➢ Early detection of 60% high risk individuals

		➢ 10% reduction in insufficient physical activity ➢ Availability of essential NCD medicines & basic technologies to treat NCDs in at least 80% of public facilities ➢ 50% reduction in household use of solid fuels to combat COPD
	2. Cancer	➢ To reduce smoking in males to ≤ 20%, and tobacco chewing by 5% among males and females ➢ To diagnose 50% of oral, breast and cervical cancers in localized stages (Stages I and II for oral cancer; stages I and II A for breast and cervix cancers) ➢ To increase the compliance to prescribed course of treatment from 76% to 90%. (for first year following the date of diagnosis) ➢ To reduce the catastrophic health expenditure on cancer treatment to 15% by ensuring 85 % of cancer treatment through government funded or private pre-payment schemes.
	3. Mental Health	➢ To reduce the emotional and behavioural problems in school children from 30% to <10% ➢ To reduce the suicide rate from 24.9/- per lakh(2014) to <16 per lakh ➢ To reduce morbidity due to depression from 5.8% for men and 9.5% for women to <3% in men and <5% in women ➢ To achieve 50% of rehabilitation for mental patients in remission ➢ To expand Community Mental Health Program to Block and Panchayat level
	4. Alcohol/ Substance Abuse	➢ To reduce the per capita consumption of alcohol by 5% ➢ To reduce percentage of people with harmful alcohol use by 10% and < 10% use in young adults (<25 yrs) ➢ To double the number of enrolment to oral substitution therapy centres to treat drug abuse ➢ To double the number of cases registered against illicit trafficking and use of narcotic drugs

SDG Target 5 Road Traffic Accidents	By 2030, halve the number of deaths and injuries	To reduce mortality and morbidity due to RTA and other injuries by 50% of the current incidence by 2020
SDG Target 6 Reproductive Sexual Health	By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs	➢ To reduce the percentage of adolescent pregnancies from 2.8% to zero by 2020 ➢ To reduce the low birth weight from 11.6% to 9% ➢ To reduce the unmet need of spacing from 11.6 % to 8% ➢ To reduce primary LSCS from 23% to 20% ➢ To start "Well women clinics for geriatric problems among women ➢ To establish One Stop Crisis Cell in all major health institutions in the State with access to all services (medical, legal, rehabilitative) to address gender issues and violence ➢ To screen 60% of post-menopausal woman for prolapse uterus and offer 80% coverage to surgical care for the detected
SDG Target 7 Universal Health Coverage	Achieve universal health coverage, including financial risk protection, access to safe, effective, quality and affordable essential health care services	➢ Ensure that 80% of the population is covered under a pre-paid scheme for financial protection by 2020 ➢ By 2020 the percentage of persons availing health care from Government Hospitals is increased from 34% to 50% ➢ Ensuring availability of essential medicines and diagnostics in all public health facilities.
SDG Target 8	1. Dental Health	➢ To reduce prevalence of dental caries among 6-12 year old children by 10 % (45% - 55% to 35% - 45%) and to retain the mean DMFT (Decay Missing Filled Teeth) index at ≤ 3 ➢ To reduce prevalence of Periodontal disease among 35-44 year olds by 10%
	2. Eye Health	➢ To reduce the prevalence of blindness due to cataract, uncorrected refractive errors, trauma and diabetic retinopathy by 25 %.

SDG Target 8	3. Palliative Care	➢ CBPC Units in 100% Panchayat of Kerala conducting regular home care program, for all those who are needy ➢ Integrated care for palliative, geriatric and mentally ill in 100% of Panchayat. ➢ Family level empowerment training for care conducted at ward level in at least 70% of Panchayats of Kerala. ➢ Establishment of SWAAS clinics in 100% Family Health Centres in Kerala ➢ Doctor with morphine license available at 100% Taluk hospitals. ➢ Physiotherapy services for COPD, Stroke, neuromuscular conditions and prevention of fall among older persons available at 100% CHCs ➢ Rehabilitation for paraplegia and mentally ill at Block level in 75% Blocks. ➢ Provision for temporary hospitalization of palliative care patients in every CHC with doctors &nurses specialized in palliative care services to support the community based palliative care

Key Focus Areas of Aardram mission to attain SDG

1. Transformation of OP services in public hospitals: The aim is to change the hospital administration and processes so that hospitals are more people-friendly and hospitable. Improvement of patient amenities and introduction of conveniences such as advance booking of doctor's appointment so that hospital visits are hassle-free.
2. Revamp of Primary Health Centres as Family Health Centres
3. Provision of specialty services in at least one hospital in 17 District/Taluk; introduction of super specialty services in District hospitals
4. Provision of basic health care services to backward tribal, coastal and migrant communities in the State.

Being the concept document for Family Health Centres this hand book will be dealing with the process and operationalisation for transformation of Primary Health Centres.

Chapter 2

FAMILY HEALTH CENTRES

FAMILY HEALTH CENTRES

Though the Primary Health Centres were set up to provide Comprehensive Primary Health Care, somewhere along the line, the accent on primary care was lost and these institutions were delivering mostly curative care. These centres which were supposed to take a lead in providing preventive and promotive services to the public did not completely succeed in making an impact. With Non Communicable Diseases (NCDs) emerging as a significant and growing health challenge in the State, it is imperative that our PHCs are equipped to provide primary and preventive care to those with lifestyle diseases and to ensure that they are followed up regularly to prevent them from developing complications. This is where the concept of Family Health Centres come in.

What is a Family Health Centre?

Family Health Centres will be an integral part of Aardram Mission which will provide Comprehensive Primary Health Care (Preventive, Promotive, Curative, Rehabilitative and Palliative) to all the people residing in the defined geographical area. The focus being on improving quality of care and service delivery at the primary care-level, FHCs will have better equipment, facilities and infrastructure than PHCs. Clinical guidelines for various disease conditions will be developed and put in place to ensure that definitive standards of care are met.

Once the e-Health project implementation is complete, continuity of care of patients through primary to tertiary care at various hospitals or at different points in time can be ensured. The social determinants of health (safe drinking water, environment, cleanliness, sanitation etc) being crucial to the health of a community, the FHCs will also take a lead role in organising community-led interventions for improving the same.

Vision

To provide comprehensive and complete primary health care service for each and every individual.

Mission

Achieving SDG 2020 targets by ensuring access to affordable and quality healthcare for all.

Strategies

- Strengthening primary health care
- Improving quality of services at institutional level and field level
- Addressing social determinants of health
- Strengthening of sub centers
- Improving community participation

Activities for strengthening primary health care

Increasing trend of emerging & reemerging communicable diseases, non communicable diseases and issues of older persons pose a major challenge to the Health system. To some extent, strengthening the primary health care can prevent the emergence of these diseases.

- Every individual and family should be registered under the local FHC and their data stored in the electronic data base of e-health network
- Every individual should receive defined health care services — promotive, preventive, curative, rehabilitative and palliative care services
- Families of the differently abled and those on palliative care should be given adequate support services
- All communicable diseases in a panchayat should be notified. The data should be aggregated and sufficient control measures launched
- Prevention and control of non-communicable diseases
- Strengthening sub-centres by improving the facilities and services.

◆ Preventive services

Focusing on prevention rather than treatment of diseases will ensure social and economic protection for the patients and family. FHCs will make sure the following activities in order to prevent illnesses

- Activities for preventing healthy people from contracting illness
- Activities to prevent spread of disease from an infected person to others in the society
- Activities to avoid the circumstances enabling spread of the disease
- Prompt notification of all communicable diseases in a panchayat followed by sufficient control measures
- Activities to improve the lifestyle of the population to prevent non communicable diseases
- Activities to identify and control the risk factors of life style disorders

◆ Promotive services

FHCs will be focusing on improving the health of entire population by cultivating a healthy culture among them. Activities include

- Providing IEC/BCC
- Developing subcentres into nodal centres where the public can learn and practice healthy habits
- Create a secure and enabling environment for promoting health with community participation and support of LSG

◆ Curative Services

Providing quality treatment at the primary care level will decrease the number of cases referred to higher care centres and thus reducing overcrowding at higher centres. This ensures financial protection for the patients as well.

- Identifying the illness at the earliest and providing treatment as per the guidelines
- Referring the patients to the appropriate centres without any delay as per guidelines
- Follow up treatment to all patients

referred back from higher centres as per referral care plan.

- Interventions to reduce out of pocket expenditure by providing quality lab services, ensuring uninterrupted supply of medicines, arranging transport services during referral, and by ensuring follow up treatment

◆ Rehabilitative care

FHCs will provide rehabilitative care services to differently abled, older persons, chronically ill and those in need. There should be interventions for provision of physical, social and mental support to the patients as well as their families. Measures will be taken to ensure social security to all the needy.

- Activities to identify the needy, define services to each and ensure provision of appropriate services
- Integration with other departments and agencies/NGOs for service provision
- Activities to ensure social security measures

◆ Palliative care

FHCs will provide palliative care services to all in need. Quality pain management should be the aim by provision of quality services for patient as well as the care takers.

- Activities to identify the needy, define services to each and ensure provision of appropriate services
- Developing palliative home care teams with the support of LSG, NGOs and community participation
- Strengthening the existing palliative home services
- Families of the differently abled and those on palliative care should be given adequate support services
- Effective pain management for patients with chronic illness

Activities for improving quality of services

Improving quality of services delivered through public hospitals will reduce the over dependency of population on private hospitals for basic health needs, which will in turn reduce the out of pocket expenditure for health.

- Standardisation of FHCs by improving infrastructure and facilities
- Improving human resources in FHCs
- Extending the working hours of FHCs
- Capacity building of staff to deliver the objectives of FHCs
- Behavioral change modification to improve the attitude and communication skills of the staff in FHCs
- Ensuring continuity of care through e-Health
- Provision of quality care by ensuring that all patients are treated / referred according to the Comprehensive Primary Health Care clinical guidelines for the management of common conditions
- Improving Pharmacy services
- Ensuring the uninterrupted supply of essential medicines listed under the clinical guidelines for various conditions.
- Improving access to diagnostic services by creating lab facilities in all FHCs for delivering a prescribed set of diagnostic services.

Activities for addressing social determinants of health

Social determinants are factors that do not come under the direct control of health services but has indirect effect on the health of the people. Addressing social determinants is essential for prevention and control of several illnesses.

- Implementation of LSG projects addressing social determinants of health
- Convergence with other departments and other national/state/Panchayat programmes

Activities for strengthening sub-centres

Strengthening of subcentres by strengthening the management committee and WHSNC is very important to ensure the proper functioning of sub centres and WHSNCs.

- Standardisation of subcentres by improving infrastructure and services offered.
- Capacity building of staff, elected representatives, ASHA, Anganwadi workers, Kudumbasree, Arogya sena and members of other organisations.
- Periodic monitoring of activities of these committees

Activities for ensuring community participation

LSGs are responsible for facilitating the smooth and effective functioning of FHCs by providing the right infrastructure, human resources and logistics. Community partnership and participation in various health programmes are essential for promoting health and well being of any community especially in the context of lifestyle modification and convergence. Ensuring the partnership as well as participation of the community should be the reponsibility of LSGs. Setting up of "Arogyasena" in every panchayat for improving community participation is the responsibility of LSGI. All existing social networks like Ward Health Sanitation and Nutrition Committees, Kudumbasree, ASHA and Anganwadis should be made use of in building bridges with the community and implementing health activities at the grassroot. Social monitoring and auditing should be brought in to improve the quality of service and to bring in accountability at all levels.

Services offered in FHCs

FHCs will provide institution-based and field-level services. Curative care, patient counselling, health education, immunisation, medico-legal, pharmacy and diagnostics are the services which will be provided at the FHCs. The field-level activities carried out by FHCs include the out-reach programmes carried out for various public health programmes as well as the routine services provided by health workers. The promotive, preventive, curative, rehabilitative and palliative care aspects should be taken care of when providing services.

Outpatient care will be available at FHC, seven days a week;

Monday to Saturday	:	9.00 AM to 1.30 PM and 1.30 PM to 6.00 PM
Sunday	:	9.00 AM to 1.30 PM

Curative services

Treatment should be provided for all patients attending the outpatient clinics of FHCs and the Comprehensive Primary Health Care treatment guidelines should be adhered to. Patients who may require care at a higher-level should be identified by following the red flag signs and referred early to the appropriate level of institution

Management of common symptoms

All cases are to be managed as per clinical guidelines, including identification of red flag signs early referral to appropriate levels, counseling regarding preventive measures and follow up of patients including those referred back from higher centers wherever required.

◆ Fever :

- Screening for common causes of fever and treatment according to the CPHC treatment guidelines & National guidelines

◆ Cough :

- Identification & treatment of common conditions causing cough
- Treatment of acute cough
- Screening of patients with cough for Tuberculosis

◆ Joint pain:

- Identification and treatment of common causes of joint pain
- Pain relief using adequate analgesics
- Advice regarding therapeutic exercises or physiotherapy to relieve pain

◆ Abdominal pain

- Diagnosis & treatment of common conditions causing abdominal pain

◆ Headache

- Differentiation of primary and secondary headaches
- Screening of all patients with headache for visual defects
- Diagnosis and treatment of common causes of headache
- Provision of prophylaxis for conditions like Migraine

◆ Anaemia

- Screening of patients for anaemia
- Identification and treatment of iron-deficiency anaemia
- Deworming, iron and folic acid supplementation for high risk groups

◆ Jaundice

- Identification of the cause of jaundice
- Screening of all cases of jaundice for assessing severity of the infection
- Differentiation of acute and chronic liver disease
- Identification of signs of hepatic failure

Communicable diseases

◆ Dengue Fever

- Identification of a probable case of Dengue fever
- Classification of illness as mild, moderate or severe, based on clinical features and laboratory investigations
- Provision of home/PHC-based treatment for mild cases of dengue

fever as per clinical guidelines including counselling on red flag signs.

- Early referral of cases of Dengue fever with complications
- Advice regarding prevention of infection to other family members.

◆ Leptospirosis

- Identification of a probable case of leptospirosis
- Initiation of early treatment of leptospirosis cases as per clinical guidelines and referral of complicated cases.
- Provision of doxycycline prophylaxis to high risk groups

◆ H1N1

- Identification of a probable case of Influenza-like-Illness /Acute Respiratory Infection
- Classification of illness and provision of treatment according to the ABC guidelines for H1N1
- Screening of high risk groups especially antenatal women, elderly, diabetes patients and early treatment with Oseltamivir

◆ Malaria

- Diagnosis of malaria cases by identification of malarial parasite using microscopy/bivalent antigen-based RDT
- Provision of treatment for malaria as per national guidelines
- Follow up of all patients under treatment as per guidelines

◆ Scrub typhus

- Identification of a probable case of Scrub typhus
- Provision of treatment for uncomplicated cases of scrub typhus as per treatment guidelines

◆ Tuberculosis

- Identification of a probable case of Tuberculosis
- Confirmation of diagnosis of suspected cases of Pulmonary tuberculosis by referral to designated microscopic centres and getting positive cases screened for MDR TB using CBNAAT.
- Identification of possible extra-pulmonary tuberculosis patients and referral of cases if necessary
- Provision of treatment as DOTS according to RNTCP guidelines
- Follow up of all patients under treatment as per RNTCP guidelines
- Routine screening of high risk groups including contacts for signs or symptoms of tuberculosis

◆ Community-acquired Pneumonia

- Identification of a case of pneumonia based on clinical features
- Assessment of severity based on CRB65 scores
- Provision of appropriate treatment as per guidelines

◆ Reproductive Tract Infections (RTI)/Sexually Tract Infections (STI)

- Identifiation of various RTI/STI syndromes based on clinical features
- Provision of treatment based on Syndromic management of RTI/STI
- Screening of partners for RTI/STI

- Advice regarding screening and testing of patient and partners for HIV
- Provision of health education to patients and partners regarding RTI/ STI, HIV and safe sex practices

◆ Hansen's disease

- Routine screening and referral of patients with signs/symptoms suggestive of Leprosy
- Identification of a probable case of Leprosy including neuritic type
- Provision of multi drug therapy as per guidelines
- Follow up of all patients for the entire duration of treatment; two years in PB cases and five years for MB cases
- Contact survey
- Identification of complications and provision of appropriate treatment or referral if necessary
- Identification and grading of disability if present
- Advice regarding rehabilitative measures and correction of disability

◆ Lymphatic Filariasis

- Early detection of microfilaria cases
- Treatment of acute lymphangitis
- Referral for surgical conditions like hydrocoele
- Morbidity management of lymphoedema

Non communicable diseases

◆ Diabetes mellitus

- Screening of all persons above 30 years for Diabetes mellitus
- Identification of a probable case of Diabetes Mellitus based on symptoms
- Confirmation of diagnosis by blood sugar estimation
- Advice regarding life style modifications, diet, exercise and foot care
- Provision of treatment as per guidelines
- Routine follow up and evaluation of glycemic status of persons put on treatment to ensure that the desired parameters are achieved and maintained
- Follow up of women with history of Gestational Diabetes Mellitus (GDM)
- Screening of all patients for complications of Diabetes like neuropathy, retinopathy and nephropathy according to the guidelines
- Early identification and management of complications; referral if necessary

◆ Hypertension

- Screening of all persons above 18 years for hypertension
- Identification of a probable case of hypertension based on symptoms
- Confirmation of diagnosis by blood pressure measurement
- Advice regarding diet, exercise and other lifestyle modifications
- Provision of treatment as per guidelines
- Routine follow up and evaluation of blood pressure of persons put on treatment
- Follow up of women with history of

Pregnancy-Induced Hypertension (PIH)

- Screening of all patients for complications of hypertension
- Early identification and management of complications; referral if necessary

◆ Coronary Artery Disease (CAD)

- Identification of a probable case of Angina or Myocardial infarction based on clinical features and ECG findings
- Stabilisation of the patient, by starting loading dose of antiplatelet drugs and statins and referral to an appropriate higher center immediately
- Follow up of all patients with CAD/ Angina at frequent intervals
- Screening of all patients with CAD for other NCDs like Hypertension, Diabetes and Dyslipidemia
- Advice advice regarding tobacco, diet, exercise and other lifestyle modifications

◆ Stroke

- Identification of risk factors for stroke like Hypertension, Diabetes mellitus, dyslipidaemia
- Identification of a case of stroke based on symptoms and signs
- Early referral of all stroke cases to a tertiary centre identified where management of stroke is available
- Follow up of all cases of stroke at frequent intervals
- Advice regarding tobacco, diet, exercise and other lifestyle modifications
- Provision of rehabilitative support such as physiotherapy or mobility aids
- Palliative care services for bedridden patients

◆ Cancer

- Routine screening for oral, breast and cervix cancers
- Advise patients regarding signs/ symptoms of cancer
- Advise patients regarding oral self examination and advise women on how a breast self examination may be done
- Identification of a probable case of cancer based on signs/symptoms
- Advice regarding tobacco, diet, exercise and other lifestyle modifications
- Referral of all probable cases of cancer detected through screening for expert care
- Follow up of all patients referred back from higher centres
- Provision of palliative care wherever necessary

◆ Chronic Obstructive Pulmonary Disease (COPD) and Bronchial Asthma

- Identification of a probable case of COPD/Asthma based on clinical features
- Staging of illness by Spirometry as per SWAAS guidelines
- Screening of all COPD patients for tuberculosis as per RNTCP guidelines
- Provision of treatment for minor exacerbations
- Identification of red flag signs and early referral

- Follow up of all COPD/Asthma patients at frequent intervals
- Advice on correct use of inhalers
- Advice on lifestyle modifications, smoking cessation and vaccination

◆ Mental illness

- Screening of patients for depression and other psychiatric illness based on clinical features
- Identification counselling and treatment of minor psychiatric illnesses
- Referral of other patients to Psychiatrist for expert management
- Follow up of all patients referred back from District Mental Health Centres (DMHP)/ Mental Health Centres/ psychiatrists
- Advice regarding stress management, mental health maintenance and avoiding alcohol or other substance abuse
- Referral to de-addiction centres if necessary

Surgical conditions

◆ Injuries and accidents

- Treatment of minor injuries
- Administration of tetanus prophylaxis in case of injuries
- Primary survey (preliminary assessment) and resuscitation of critically injured patients
- Provision of initial treatment for stabilisation and wound management
- Identification of red flag signs and early referral
- Follow up of all patients referred back from higher centres

◆ Burns

- Initial assessment and classification of burns into minor or major
- Assessment of percentage of burns
- Treatment of minor burns with $<10\%$ body surface area
- Referral of all deep burns, burns $>10\%$ body surface area, burns in children and elderly for expert management after stabilisation

◆ Minor surgical procedures

- Incision and drainage of minor abscesses
- Management of minor injuries, suturing of small wounds
- Treatment of ulcers including diabetic foot and bed sores
- Removal of superficial foreign bodies
- Removal of finger and toe nail if indicated
- Identification and treatment of cellulitis

◆ Thyroid Diseases

- Identification of cases of hyperthyroidism or hypothyroidism based on clinical features
- Diagnosis of hyper/hypothyroidism through thyroid function tests (utilizing lab network services)
- Treatment of uncomplicated cases of Hypothyroidism
- Referral of all patients with Hyperthyroidism and children,

elderly and pregnant women with Hypothyroidism for expert management

- Follow up of all patients with Hypo/ Hyperthyroidism

Paediatrics

◆ Acute Respiratory Infection (ARI)

- Identification of children with Acute Respiratory Infection
- Classification of ARI based on signs/ symptoms
- Treatment of ARI according to State/ National guidelines
- Identification of danger signs and early referral
- Follow up of patients referred back from higher centres

◆ Acute Diarrhoeal Diseases

- Assessment of the severity of dehydration in a child with acute diarrhoea
- Provision of appropriate treatment according to the severity of diarrhoea /dehydration as per National guidelines including ORS
- Identification of danger signs and early referral
- Follow up of patients referred back from higher centres
- Advice regarding measures to prevent diarrhoeal diseases

◆ Congenital malformations & developmental delays

- Screening of all infants and children for identifying delays in developmental milestones
- Early identification of children with congenital anomalies or developmental delays and referral to District Early Intervention Centre/ higher centre
- Follow up of all children referred back from higher centres
- Advice regarding schemes like Rashtriya Bal Swasthya Karyakram (RBSK)/Arogya Kiranam (AK)

Adolescent Friendly health services

- Identification and management of common health problems
- Referral of cases that require management by a specialist
- Identification of risk behaviors
- Health education and Counseling services

Obstetrics & Gynaecology

◆ Antenatal and Postnatal care

- Diagnosis of pregnancy by urine pregnancy test
- Registration of all antenatal women and issue of Mother Child Protection (MCP) card
- Provision of routine antenatal care till 28th week as per guidelines
- Identification of high risk pregnancies and early referral
- Screening of all antenatal women for GDM, PIH, Anaemia and STIs
- Provision of TT immunisation, Iron-Folic acid supplementation to all pregnant women
- Advice regarding proper diet, exercise and rest during antenatal period

- Identification and treatment of common complications during antenatal period; referral if required
- Referral of all antenatal women beyond 28 weeks to a centre where delivery services are available
- Provision of postnatal care after discharge from hospital
- Management of common postnatal problems/complaints including mental health
- Early identification of complications and referral
- Advice regarding diet, breast feeding, postnatal exercises and immunisation
- Iron folic acid and calcium supplementation to all lactating women
- Detection of danger signs in new born and early referral
- Advice regarding spacing/sterilisation services
- Advice regarding schemes like Janani Shishu Suraksha Karyakram (JSSK), Janani Suraksha Yojna (JSY), Pradhan Manthri Surakshith Mathritva Abhiyan (PMSMA)

◆ Gynaecology

- Initial management and referral of abnormal vaginal bleeding in all age groups
- Management of dysmenorrhoea in all age groups
- Referral of primary and secondary amenorrhoea if necessary
- Treatment of decubitus ulcer and referral for mass descending per vaginum
- Diagnosis and treatment of uncomplicated cases of Urinary tract infection
- Diagnosis of stress urinary incontinence and referral for evaluation
- Management of vaginal discharge in all age groups and referral if required
- Follow up of all patients referred back from higher centres

Dermatology

◆ Fungal Infections

- Identification and treatment of common fungal infections like Taenia and Onychomycosis
- Management of Candidal intertrigo, oral or genital candidiasis

◆ Bacterial infections

- Identification and treatment of common bacterial infections like impetigo, furuncle, carbuncle and cellulitis

◆ Viral infections

- Identification and treatment of viral infections like Herpes zoster, Herpes simplex, Varicella, Hand Foot and Mouth Disease (HFMD), Molluscum etc

◆ Other conditions

- Management of other skin conditions like Urticaria, Eczema, Acne and Dermatitis
- Identification and treatment of Scabies

ENT

◆ Ear complaints

- Evaluation of common ear complaints like discharge, pain, ear block, swelling around ear, tinnitus, trauma to ear etc
- Removal of superficial foreign bodies of ear
- Treatment of uncomplicated cases of Acute Suppurative Otitis Media (ASOM), Otitis externa
- Follow up of patients with Chronic Suppurative Otitis Media (CSOM)
- Identification of red flag signs in CSOM and early referral
- Assessment of a patient with hearing loss and referral for evaluation

◆ Nasal complaints

- Evaluation of common nasal complaints like discharge, nasal block, headache, sneezing etc
- Treatment of minor cases of epistaxis
- Removal of visible foreign body nose in adults
- Treatment of allergic rhinitis
- Identification of nasal polyps, deviated nasal septum (DNS) etc and referral for surgery
- Treatment of uncomplicated cases of sinusitis
- Management of minor cases of trauma

◆ Oral cavity & Throat complaints

- Management of acute pharyngitis and acute tonsillitis
- Identification of red flag signs in tonsillitis, diphtheria and referral
- Identification of emergencies like acute epiglottitis, stridor, foreign body larynx and early referral
- Diagnosis of acute and chronic dysphagia, odynophagia and referral for evaluation

Ophthalmology

- Routine screening of patients for diminished vision or eye complaints
- Provision of prescription for spectacles
- Identification of conditions like cataract, diabetic retinopathy, glaucoma etc and early referral
- Evaluation of eye strain and headache
- Treatment of conjunctivitis and redness of eyes
- Treatment of hordeolum; referral if required
- Evaluation of eye injuries; referral if required
- Removal of conjunctival foreign bodies
- Identification of red flag signs and early referral

Dental

- Identification of common dental conditions like dental caries, Periodontitis, Gingivitis etc
- Routine screening of patients for pre-malignant conditions of oral cavity and other dental conditions
- Referral of patients requiring expert management

Emergency care

- In emergency situations, the patient will be provided first aid and stabilised before referral to appropriate centres
- Provision of Tetanus Toxoid & anti-rabies vaccine in cases of dog and

other animal bites; referral for Rabies immunoglobulin in Class III wounds

- Identification of patient with anaphylaxis and initial treatment before referral
- Provision of first aid in conditions like snake bite, poisoning, heat stroke, seizures etc before referral to higher centre

Laboratory services

Essential lab services on all six days (Monday to Saturday): 8.30 am to 4.30 pm (If only one lab technician is available.)

If there is more than one technician, the second person would work from 10.30 am to 6.30 pm)

◆ Blood

- Haematology
- HB, TC, DC, ESR, PCV, Platelet

count, BT, CT

◆ Biochemistry

- Blood sugar-RBS/PPBS/FBS/ GCT
- Blood urea
- S Creatinine
- S Bilirubin
- S cholesterol
- HbA1c

◆ Serology

- Rapid tests VDRL/RPR, HbsAg and Widal

a) Urine analysis
   - Routine examination with dipsticks and microscopy
   - Bile salt and bile pigment
   - Micro albumin

b) Stool analysis
   - Routine microscopy and occult blood

c) All tests related to National programs as per guidelines at FHC level

Pharmacy services

Pharmacy services on all seven days

Monday to Saturday: 09.00 am to 6.00 pm
Sundays: 9.00 am to 1.30 pm

- Medicines as per the CPHC treatment guidelines should be dispensed from FHC

- Information on drug use including how to take it (whether on empty stomach/ full stomach, timings, dosage), its side effects, interaction with other drugs, method of using nasal spray, inhalers, rota halers etc should be explained

Counselling, Health education and guidance services

- Expectant women (Counselling on diet, nutrition, child care and growth monitoring, contraceptives, spacing, mental health including depression and suicide prevention)
- Post-natal women (Counselling on diet, nutrition, child care including injury prevention and growth monitoring, contraceptives, spacing, mental health including depression and suicide prevention)
- Eligible couples (Counselling on family planning, child birth, child care)
- Adolescents (Counselling on diet, exercise, anti- tobacco, alcohol, substance abuse, menstrual hygiene, reproductive health, gender sensitization, mental health including depression and suicide prevention)
- Life style diseases (Counselling on diet, exercise, tobacco cessation, alcohol, stress management)
- Counselling on diet, exercise, prevention of falls and mental health for older persons including Counselling on postmenopausal problems and osteoporosis for older women.
- Chronically ill patients (Counselling on diet, exercise, treatment compliance, mental health)
- High risk behaviour and substance abuse (Counselling on diet, exercise, mental health, de-addiction)
- Smoking cessation/de-addiction services: Counselling and support services; referral of cases to smoking cessation clinics or de-addiction centres in cases of alcohol addiction
- Care, counselling and referral in cases of domestic violence to Jagrata Samiti/ One Stop Crisis Management Centres (Bhoomika)
- Counselling for care givers of the chronically ill, mentally challenged and differently abled patients

Public Health Services

- Implementation of all National and State Health Programs.
- Implementation of Universal Immunisation Program
- Prevention, screening and control of communicable diseases, non communicable diseases and mental illness
- Integrated Disease surveillance Project (IDSP), vector surveillance and preparation of annual epidemic prevention plan
- Family Health Survey and preparation of health service delivery plan for individual, family, ward and panchayat
- Counselling services
- Prevention and control of tobacco, alcohol and substance abuse
- Dangerous & Offensive trade inspection and Public Health Act implementation
- Institution-based services (anganwadis, schools, hostels, orphanages, old age home, other government institutions, day care centres etc)
- Domiciliary services including palliative care in areas where necessary

- Special service packages for the differently abled, tribal, migrant, urban and coastal population
- Addressing social determinants of health by coordination with LSG and concerned departments/agencies

Rehabilitative Services

- Screening for persons with disability through anganwadi centres and camps
- Referral of cases to DEIC at the earliest
- Follow up of people living with disability in the community
- Provision of medical & other supportive care at domiciliary level; distribution of assistive devices like wheel chairs, crutches etc. through linkages with Social Justice department
- Intersectoral coordination: with Social Justice department and NGOs to identify people living with disability, ensure availability of social security measures including disability pension
- Provision of vocational & social rehabilitation for the differently abled with the help of Panchayat & other voluntary organizations.
- Detection of children with intellectual or mental challenges, those with visual impairment, speech and hearing impairment and facilitation of rehabilitative services/care
- Provision of medical support to day care centres established by Social Justice Department or Local Self Government Department
- Provision of health services to the "Aashraya" beneficiaries
- Prevention of NCDs and other illness among the disabled
- Training for caretakers of the chronically ill, mentally challenged and people living with disability

Palliative services

- Provision of home care for bedridden patients and other patients requiring palliative care
- Provision of pain relief for patients with terminal illness using oral morphine or other analgesics as and when required

- Dressing of ulcers and bed sores
- Care of tracheostomy, colostomy, oral and bladder care
- Improvement of the general well being of the patient by providing symptomatic management of associated conditions like constipation, diarrhoea, breathlessness etc
- Provision of end-of-life care and support to family in case of bereavement
- OP care for those who are mobile
- Medicines for patients under palliation
- Provision of supportive care for improving quality of life (Ryles tube, catheterization, care of chronic wounds, physiotherapy, mobilisation)
- Training and support for caretakers
- Provision of assistive devices (wheelchair, crutches etc through Palliative care projects)

Medico-legal services

- Services to all Medico legal cases
- Services related to Public Health Acts, COTPA, PNDT Act, POCSO, Protection of women against domestic violence act 2005 etc

Issue of certificates

- Medical and fitness certificate
- Age certificate
- Certificate for availing financial aid for treatment
- Certificate of Health
- Certificate of Health for food handlers
- Sanitation Certificate
- Accident cum wound certificate
- Treatment Certificate
- Certificate of Potency
- Drunkenness certificate
- Certificates to beneficiaries of various social security and benefit schemes as and when requested

SWAAS Program

To address the rising incidence of Chronic Obstructive Pulmonary Disease (COPD) and Asthma in Kerala a program named Step Wise Approach to Airway diseases (SWAAS) is initiated in all Family Health Centres. It is a structured program for

diagnosis and treatment of COPD and Asthma starting from primary care to tertiary level This program is the first of its kind in India and intends to

- Identify COPD and Asthma in early stages of disease
- Develop a system for generating information on disease burden of COPD, health seeking behavior, and health system needs which will aid in further planning and strategizing for COPD management in Kerala
- Use the opportunity of pulmonary

rehabilitation using available resources and by developing indigenously acceptable pulmonary rehabilitation techniques

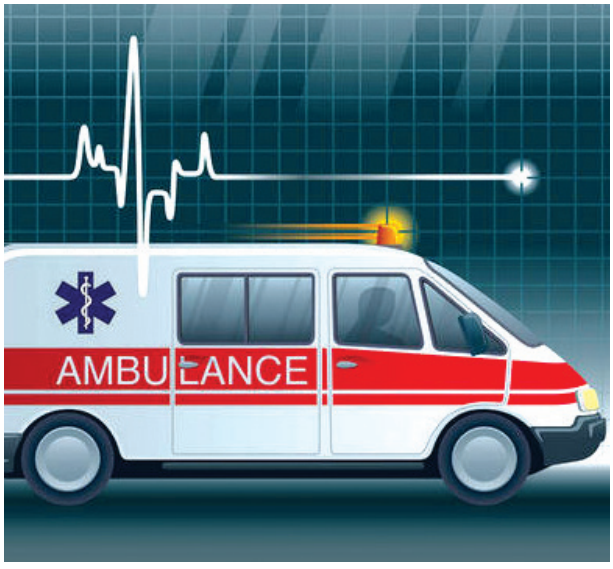
ASWASAM Program

This program envisages early detection, management and referral services of depression at Primary care level. Nurses and field staff will be given training to identify and screen for depression. Specific trainings

will be given to doctors for identifying and treating the patients and to refer the cases appropriately. The components of the program include:

1. Screening by field staff in community and staff nurses in FHCs
2. Providing psychological first aid by staff nurse in FHC, by JHIs, JPHNs in the community
3. Confirmation of the diagnosis and initiation of treatment by the Medical Officer- Psychosocial intervention alone for mild depression and medical treatment along with psychosocial intervention for moderate and severe depression
4. Follow up of the cases in the community for one year by the health workers to ensure the treatment compliance and deliver psychosocial interventions.
5. IEC/BCC activities
   - At Panchayath and district level co-ordinated by DMHP at the district level
   - Awareness classes in the community for ASHA workers, Anganwadi teachers, Kudumbashree members, National Service Scheme volunteers, Residence Association
6. Building social support system – Religious/faith organisations, existing social organisations, NGOs
7. Collaboration with other departments like AYUSH

Referral services



Forward and backward referral services will be improved and strengthened by linking the Family Health Centres, Taluk, District/ General Hospitals and Medical Colleges. The treatments that have to be carried out at different levels of care will be standardised based on the treatment guidelines. The doctors, nurses and other staff will be trained to deliver these services. Measures will be taken to ensure that the guidelines are adhered to. The stage at which a patient has to be referred and where to refer are detailed in the guidelines. After stabilising and managing

the acute stage at a higher centre, the patient has to be referred back to the Family Health Centre for further follow up and management. The details regarding the follow up and continuity of care of the patient has to be accurately informed to the concerned FHC. Implementation of eHealth will enable access to the patient details at all levels and thus ensure continuity and portability of care. In emergency situations transport facility has to be arranged and a responsible person should accompany the patient. The concerned field staff is responsible to make sure that the patient is receiving the necessary services as per the guidelines.

Outreach institutional services

There are defined services offered to institutions like schools, buds schools, hostels, orphanages, old age home, other government institutions, day care centres and other workplaces situated within the geographical area of an FHC. The nurses in FHCs who have obtained training are responsible for providing these services including medical camps, preventive promotive rehabilitative and palliative services, health education and other relevant interventions.

Field based services

The activities of an FHC are designed on the basis of the social, economic and health status of the population residing in the defined area. The data to devise these strategies and activities are collected and compiled by the multipurpose workers from the field. Continuous surveillance on the disease causing agents is necessary for preventing several illnesses. The delivery of services to all the beneficiaries as per the service package is possible only through efficient field based activities. Field based activities are required for executing the following services effectively

Implementation of all National and State Health Programs.

- Prevention, screening and control of communicable diseases, non communicable diseases and mental illness
- Integrated Disease surveillance Project (IDSP), vector surveillance and preparation of annual epidemic prevention plan
- Family Health Survey and preparation of health service delivery plan for individual, family, ward and panchayat
- Prevention and control of tobacco,

alcohol and substance abuse

- Dangerous & Offensive trade inspection and Public Health Act implementation
- Domiciliary services in areas where necessary
- Special service packages for the differently abled, tribal, migrant, urban and coastal population

People friendly transformation of FHCs

Creating better patient amenities in all public sector health care institutions and making hospital visits a comfortable and stress-free experience for patients and caretakers is one of the main objectives of Aardram Mission. FHCs are envisaged as comprehensive health care and wellness centres, with pleasing infrastructure, amenities and warm & courteous staff.

Improvement in infrastructure

Better ambience of an institution reflects its quality and enhances its acceptance and confidence among the public.

- Anyone who comes in to an FHC seeking medical care is registered in the system and assigned a unique patient identification number.
- Token systems would be put in place at the registration/lab/pharmacy counters to reduce crowding.
- Comfortable waiting areas with good seating arrangements and facilities like drinking water, reading material and radio or television for entertainment would thus be a feature of all FHCs.
- Toilets that are women/older person/ differently abled/ transgender friendly will be provided in FHCs
- Visible and appropriate sign boards will be placed to make it easy for the public to access the FHC.
- The whole infrastructure will become barrier free and accessible to all.
- Layout and signages will be displayed for the public to identify different facilities
- Implementation of eHealth will connect the different facilities starting from registration, precheck, consultation room, observation room, pharmacy, laboratory, and post check facilities.
- The staff nurses are expected to do the initial triaging during the pre-diagnosis assessment and record the vital signs, patient history and current symptoms, before handing over to the primary care physician. This will provide more time for the doctor to examine the patients.
- The patient consultation rooms will have adequate privacy. After consulting the doctor, the patient is directed to the observation room/laboratory/pharmacy

or post-consultation counselling room as the case may be or he/she could be referred to a higher centre of care.

- The facilities will be arranged in an order so that a flow will be maintained from entry to exit and there will not be crossing of patients.
- The immunisation rooms will be transformed to baby friendly rooms and a separate room will be provided for breast feeding.
- There will be provision for relief garden and aquarium.
- A conference hall should be there for conducting meetings and for health education.
- The waste management will be scientific and green protocol will be maintained in all centres.

eHealth

eHealth is a robust and sustainable IT solution to ensure efficient service delivery to the common citizen and provide a centralized database of healthcare information allowing close monitoring and control measures.

eHealth supports nearly 50,000 healthcare service personnel consisting of Doctors, Paramedical and other non-clinical staff at the Primary, Secondary and Tertiary care centres maintained by the State Government.

The ultimate vision is building an Integrated Healthcare Cloud which will hold the complete healthcare data about all the citizens in the state.

eHealth system is unique in that it covers patient care services at hospital and preventive care services handled at primary care level and integrates both. This include services through hospitals, through national programs and schemes, insurance schemes and other welfare schemes sponsored by state and central governments, services by field staff of health department. It is scalable to include private health care providers who agree to partner with government in the provision of RSBY or Universal Health Care.

All the field activities are managed by hand held Tablet PCs. The data captured is geo-tagged ensuring that the health worker actually visits the field, delivers service and collect the data.

There is seamless integration of field data as well as data gathered in hospitals. Everything is aggregated centrally and stored with a Unique Health Identification

number[UHID] as EHR. This is available across the state for use by the patient in any hospital he may chose to visit.

Major features of eHealth Hospital Information System

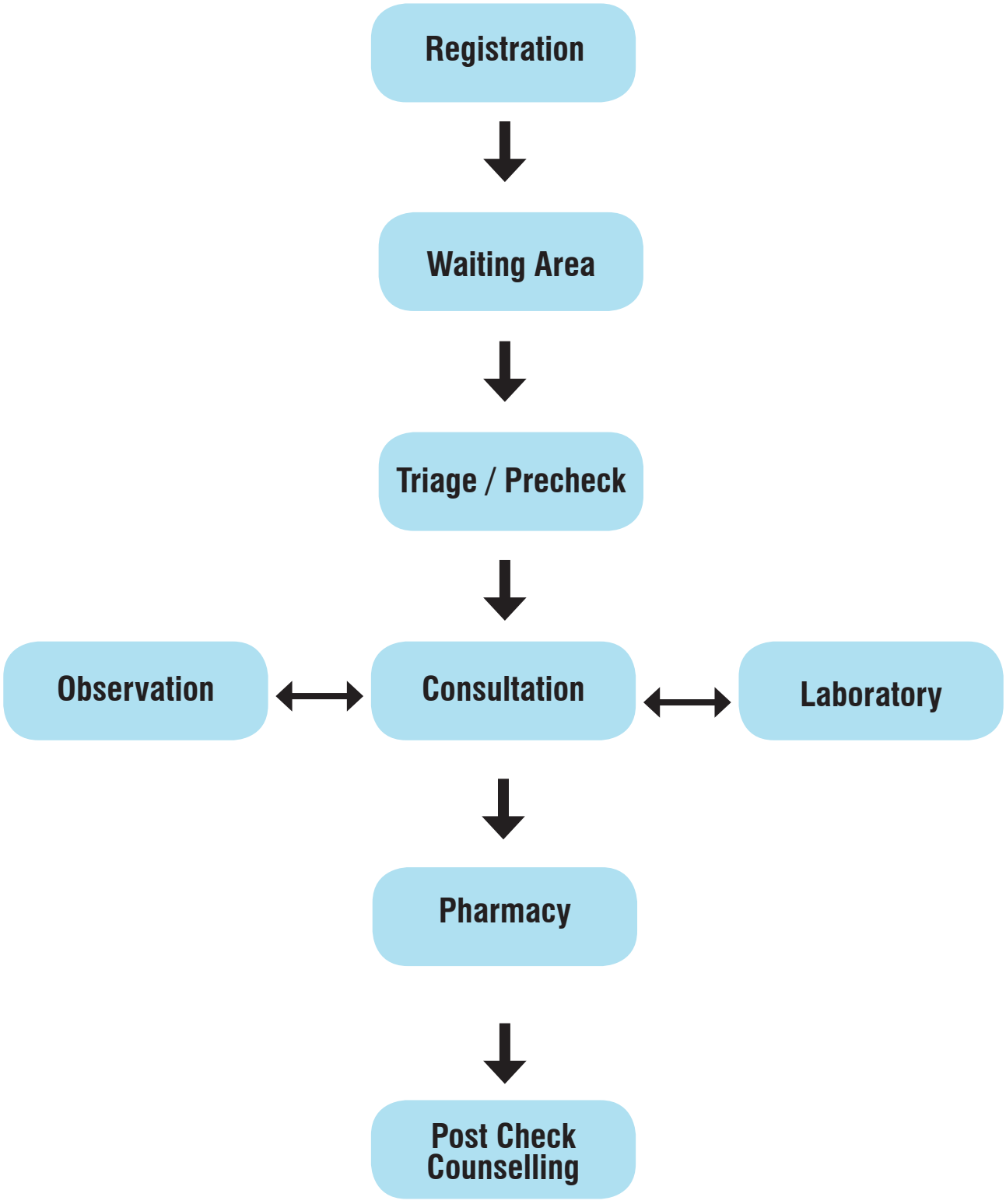
- One citizen - one EHR
- End to end transformation of health Care
- Adherence to Standards prescribed by GoI, WHO and other international organisations - SNOMED CT coding for diseases, LOINC, HL7 etc
- Integrated solution for hospital and public health management
- Comprehensive web portal for citizens to access services through single window
- Administrative modules covering administration of doctors and paramedical staff, purchase of drugs and equipment, cold chain management etc
- Biomedical equipment maintenance and facility management systems with automatic intimations at appropriate levels
- Direct integration with legacy systems like MCTS, HMIS, IDSP, CBHI, NLEP, NPCB, RNTCP etc
- Strengthens health care service at grass root level by using mHealth (mobile health application in Tablet) and empowers health workers for data capture, retrieval, analysis and instantaneous reporting.
- Introduces concept of paperless root level health workers by eliminating field diary and registers
- Generates work plan and alerts for health workers, schedule of service for antenatal care, immunisation etc
- Public health database serves as inputs to various researches
- Entire demographic and health information in electronic form, fully integrated
- Huge central data repository containing household and demographic health data and hospital information
- Electronic Health Record [EHR]
- The health record of each individual is generated in digital form and is stored against a Unique Health Identification number [UHID]. This is known as EHR (Electronic Health Record). Each individual will have his/her own unique EHR. Health data captured from field and hospital are stored in the same EHR and hence data is available at both ends as and when required.
- EHR is created for a person for the first time when he/she is registered for primary care service delivery by JPHN or JHI or when the person visits the hospital for treatment for the first time.

Improvement in quality of services

Improving the quality and efficiency of service delivery based on the need and expectation of the public will improve the trust on public institutions. Improvement in human resources, standardisation of services, laboratories and treatment, uninterrupted supply of medicines, continuous skill based training for all category staff are some of the strategies. Family Health Centres will provide mental support , palliation, confidence and privacy to the patients and bystanders

Patient flow in an FHC.

Fig : 1



Transformation of Subcentres

Sub-centres are the first contact point of the health system with the public which will ensure comprehensive health care to all. They act as extension centres for provision of preventive, promotive, rehabilitative, palliative services and to some extend curative services.

As part of Aardram, the basic infrastructure of the sub centres will be improved in convergence with the LSG. Panchayat specific goals to achieve the short and long term goals of the state will be developed based on the health issues specific for that locality. Sub centres will coordinate the activities in the locality through Ward Health Nutrition and Sanitation Committee involving ASHA, AWW, Kudumbasree and Health Volunteers. The data gathered by these groups will be analysed and activities will be charted out based on that. Action plan for each ward coming under the subcentre will be prepared which will inturn become the action plan for the subcenter together with action plans of other wards. Action plan of all subcentres will finally form the action plan for the FHC.

Improvement of infrastructure and improvement of quality and quantity of service provision is the need of the hour for strengthening of subcentres. Specific standards for infrastructure, equipments and services of subcentres have been defined. As far as possible subcentres should function in own buildings. It should be accessible and

approachable to the population it cateres. In difficult rural/tribal/coastal areas there should be quarters facility for the JPHN. The environment and infrastructure should be people friendly and barrier free with adequate direction boards, compound wall, waiting area (sufficient chairs, drinking water, audio visual aids, adequate lighting and ventilation, display of IEC/BCC materials), consultation room, office room, play area, acquarium, separate toilets for men/women/disabled. Proper measures should be taken to scientifically manage the waste materials. Facility for running water, electricity and net connection should be ensured. Equipments, furniture and consumables should be arranged as per the set standards.

In its new form, the sub centres will provide services six days a week. Even though the different clinics are fixed on specific days of the week, all services, except immunization, can be provided on all days according to request. PHN and HI should ensure that all scheduled clinics are functioning without any hassles and should also conduct clinics on their own. Apart from conduction of clinics sub centres have to perform several routine activities in the field. Subcentres will also be implement all National/State/Panchayat programs and projects at the grassroot level.

Subcentre level services/activities

- Surveillence, prevention and control of communicable diseases and its reporting.
- Screening, prevention and control and referral of non-communicable diseases.
- e-health activities
- Implementation of Public Health Act
- Curative services for minor illness and first aid for injuries
- IEC/BCC activities
- Linkage with social justice department and social security mission
- Integrating services of ASHA, Arograsena
- Activities of WHSNC
- Rehabilitative services
- Palliative care services
- Referral and follow-up services of SWAAS, ASWAAS clinics
- Forward and Backward Reporting
- Periodic reporting
- Integration with LSG, line department and other systems of medicine
- Maintaining important registers and records

Table : 2

Sub Centre Clinics and Service Provision

CLINICS	BENEFICIARIES	SERVICES PROVIDED	IN CHARGE	SUPER-VISION
WOMEN CLINIC	Women including girls	**1. Adolescent** ➢ Screening for reproductive health problems ➢ iron and folic acid supplementation. ➢ Deworming ➢ Screening for depression ➢ Health education- menstrual hygiene, sex education, STD/RTI, substance abuse including tobacco and alcohol, diet and physical activity ➢ Life skill education and awareness programme (LEAP) **2. Reproductive age group (18 -49)** ➢ Family planning services ➢ iron and folic acid supplementation. ➢ Symptomatic screening for gynaecological disorders (fibroid, PID, STD) ➢ Cancer screening (breast examination for women >30 yrs) ➢ Screening for depression ➢ Health education-family planning, menstrual hygiene, sex education, STD/RTI, diet, physical activity, substance abuse including tobacco and alcohol, GBV ➢ Referral of GBV cases to Bhoomika	JPHN	PHN

NCD	1) Adults of age >30 years 2) Diagnosed cases of NCD	1) Screening - BP, Height, Weight, BMI, GRBS 2) Screening for depression 3) Periodic monitoring of BP, Ht, Wt, BMI, GRBS for follow up cases according to the guidelines 4) Dispensing medicines for follow up cases of NCDs such as DM, HTN, dyslipidemia, CAD 5) Referral services 6) Health education (diet, stress, alcohol, tobacco, physical activity, diabetic foot care, self care) 7) Foot care, C & D of wound and ulcer 8) Physiotherapy 9) Use of AYUSH facilities wherever possible	JHI/ JPHN	HI/PHN
SWAAS Clinic		1) Pulmonary rehabilitation 2) Follow up of COPD & asthma cases		
ASWASAM Clinic		1) Screening for depression		
GERIATRIC Clinic	1) Elderly of age >60yrs	1. Symptomatic screening for urinary tract - related diseases 2. Screening for cancers 3. Health education - self care, falls, wound management, foot care 5. Referral services 6. Physiotherapy 7. Information regarding health and social welfare schemes 8. Use of AYUSH facilities wherever possible	Male geriatric clinic- JHI Female geriatric clinic- JPHN	PHN/HI

IMMUNI SATION Clinic & ANTENATAL / POSTNATAL Clinic	1) Children less than 15 years 2) Antenatal 3) Postnatal	• Routine immunization • Detection of pregnancy (UPT kit) • Routine checkup (Registration, TT immunization, IFA and Calcium supplementation) • Health education-diet, pregnancy-related complications like GDM, PIH, personal hygiene, exposure to infection, exposure to radiation and drugs, family planning, child rearing and feeding, exclusive breastfeeding\ • Screening for depression Post natal • Health education- family planning, child rearing and feeding, exclusive breast feeding, diet of the mother and child. • Family planning services • Follow up for complicated pregnancies with PIH, GDM, anaemia.	JPHN & JHI	HI / PHN
Life style education and health awareness	General public	1) Screening-Ht, Wt 2) Periodic monitoring of Wt 3) Health education (diet, stress, alcohol, tobacco, physical activity, diabetic foot care, self care) 4) Providing information regarding support services for women against domestic violence (Jagratha Samithi, Bhoomika)	ASHA with the help of Arogyasena	JPHN & JHI

Ward Health Sanitation and Nutrition Committee (WHSNC)

This committee is expected to take collective action on issues related to health and its social determinants at the ward level. In the context of strengthening the sub centres, these committees have to be revamped and strengthened. WHSNCs have a role in

- Coordination of preventive and promotive activities in the community ensuring community participation
- Constituting the Arogyasena incorporating all classes of people in the society
- Implementing Arogyajagratha in the ward
- In getting attention of the concerned and ensuring that proper action has been taken in the following situations
    - Any communicable diseases in the community
    - Any circumstances potential to instigate an illness
- Helping the deserved in availing several social security measures
- Ensuring proper functioning of the protective mechanisms for security of women, child and elderly in the society
- Supporting the Panchayat in addressing social determinants of health
- Supporting the LSGI in preparing Health Status Report and projects based on it to achieve short and long term goals of the panchayat
- Integrating, monitoring and evaluating activities of ASHA, AWW, Kudumbasree, Arogyasena and any other volunteers in the locality to improve the service delivery

Community participation through Arogyasena

Apart from the ASHA, AWW, Kudumbasree and any other volunteer working in an FHC area, there will be one health volunteer for every twenty household, around 25 for a ward and around 500 for a Panchayat. Any person with a strong commitment and interest in addressing the social issues of the community, who is influential and acceptable to the community and ready to volunteer, can join Arogyasena. LSG along with WHSNC is responsible for selection of Arogyasena ensuring male participation.

The responsibilities of Arogyasena:

- Notifying diseases and disease causing environment in their respective localities to the concerned
- Providing health education for prevention and control of Non communicable diseases
- Ensuring preventive, promotive, rehabilitative and palliative care services to each and every one residing in the Panchayat
- Indentifying issues related to social determinants of health and notifying to the concerned
- Ensuring proper implementation of field based activities
- Ensuring community participation
- Work in co-ordination with health workers and LSG for smooth functioning of FHCs.

Table 3
Differences between PHC and FHC

Services	PHC	FHC
OP hours	9 am to 2 pm	Extended: 9 am to 6 pm
Laboratory services	Only in few centres	Standardized services available at all centres
SWAAS program (COPD & Asthma)	Not in place	At all centres
ASWAASAM program for Depression	Not in place	At all centres
Subcentre functioning	Limited service only	Clinics on 6 days/week
Institutional out reach program	Limited	Services to institutions like old age homes, orphanages, schools, offices and other workplaces becomes regular by revising the duties of staff nurse
Services for vulnerable & marginalized	Inadequate attention	Special attention ensured
Referral and follow up	Limited compliance to patient referral	Forward & backward referral and follow up standardised as per CPHC guidelines
Introduction of Service packages	Not in place	Service delivery to each and every person residing in the concerned geographical area based on the packages defined for each age group and disease condition.
Quality of care	Insufficient	Improved with CPHC guidelines ensuring preventive, promotive, curative, rehabilitative, palliative care services Continuous training of all functionaries to ensure quality of service delivery Scientific waste management and infection control

Infrastructure	Not standardized	Standardized infrastructure • Patient friendly reception and registration • Token system • Waiting areas with improved amenities • Display boards and signages • Consultation rooms with adequate privacy • Barrier free environment • Pre check assessment and post check counseling handled by staff nurses • Advance online appointment system
Human resources	1-2 doctors, 0-1 staff nurse, 0-1 lab technician	At least 3 doctors,4 staff nurses,1-2 pharmacists and 1 lab technician
Equipments	Not standardised	Standardised as per the Government order
Renewed role for nurses	Nursing care limited to clinical services	• Nurses play an active role in triaging and initial assessment of patients and their work-up and in post consultation counseling. • They will also help manage chronic patients without any complications • Follow up of patients • Providing necessary information over the telephone • Conducting SWAAS and ASWAASAM programs • Institution based services
Health and medical records	Records are maintained manually and with limited accessibility	Prepared for everyone and made accessible at different levels of health care through e-Health
Community participation	Inadequate	Ensuring community participation through ASHA, AWW, WHNSC, Kudumbasree and Arogyasena
Addressing social determinants	Inadequate	Through better intersectoral coordination
Social security services	Not always	Ensuring integration of services
Field level activities	Mostly restricted to RCH and CD prevention	Extended field activities covering NCD and mental health

Chapter 3
SERVICE DELIVERY FRAME WORK FOR FAMILY HEALTH CENTRES

Table : 4

HEALTH CARE SERVICES	COMMUNITY	SUB-CENTRE	FHC	MONITORING INDICATORS AND SOURCE OF DATA * ALL DATA SHOULD BE F OR THE REPORTING MONTH
NON-COMMUNICABLE DISEASES (AmruthumArogyam)	• Population based screening • Health promotion and NCD awareness activities • Promotion of physical activities • Diet modification • Other lifestyle modifications • Defaulter tracking and ensuring treatment • Support groups for physical activity promotion, rehabilitation(counselling) • Creating spaces for physical activity, Yoga, sports and outdoor games, exercise etc in association with LSGD/other agencies • School and workplace interventions (nurses outreach)	• Screening, NCD Registration • Weekly NCD Clinics • Counselling regarding diet, physical activity promotion, tobacco cessation, alcohol use • Default tracking (with register) • Early identification of complications • Integration for rehabilitative services	• Screening, Diagnosis Management • Early identification of complications , -Nayanamritham for retinopathy - CKD - Foot ulcers - Other systemic • complications • Ensuring drug supply • Referral and follow up • Monitoring of defaulter tracking • Follow up of GDM/ GHTN cases • Identification of depression	• Percentage of 18+ population screened for Hypertension (e health) • Percentage of HTN patients with controlled Blood Pressure (e health) • Percentage of 30+ population screened for Diabetes (e health) • Percentage of Diabetic patients under control (e health) • Percentage of HTN /Diabetes or both screened for Retinopathy (e health)

MENTAL HEALTH	• Screening for mental illness using screening questionnaires as per "sampoornamanasikarogyam"/ "AASWAS"/ "Ammamanasu" guidelines and referran • Ensuring treatment compliance and follow up of patients with mental disorders. • Defaulter tracking • Facilitate access to support groups.	• Screening, detection and referral of patients with mental disorders. • Line listing of "AASWAS" and "SampoornaManasikaArogyam" Cases • Ensuring treatment compliance and default case tracking • Counselling services for patients and care takers	• Screening, management and referral of patients with mental disorders. • Mental health clinics ("SampoornaManasikaArogyam" / "AASWAS"/ "Ammamanasu") Clinic • Drug distribution • District mental health program camps and referral	• Number of new depression cases detected in ASWASAM (e health) • Number of psychiatric cases brought under treatment through SAMPOORNA MANASIKAROGYAM (e health) • Number of default cases of mental illness tracked (e health)
COPD/ ASTHMA	• Vulnerability mapping, identification, mobilisation, treatment compliance follow up and referral of COPD/Asthma cases to FHC • Tobacco cessation activities and COTPA • IEC/BCC activities at community and schools level for primary and secondary prevention	• Identification and line listing of COPD/ Asthma cases and referral • Treatment compliance & follow-up of all diagnosed • Tobacco Cessation through sub centre clinics	• Identification, diagnosis, management of COPD/Asthma cases • Management through SWAAS clinics (Spirometry, Inhaler therapy) • Referral and follow up • Tobacco Cessation Clinics	• Number of patients screened under SWAAS programme (e health) • Number of patients put on inhaler medication (e health)

HEALTH CARE SERVICES	COMMUNITY	SUB-CENTRE	FHC	MONITORING INDICATORS AND SOURCE OF DATA * ALL DATA SHOULD BE F OR THE REPORTING MONTH
Geriatric Care(Age above 60 years)	• Identification of high-risk groups like persons living alone, widows, persons with co morbid conditions, addictions, bed ridden patients etc • Home based health care services to elderly	• Line listing and registration of elderly in the area • Conduct weekly geriatric clinics and follow up • Planning and implementation of elderly health care programs	• FHC based comprehensive clinical care services for elderly • Prioritising and triaging of needy patients • Referral to higher centres if needed	• Number of patients attended the subcentres Geriatric clinics (e health)
Palliative Care	• Identification patients requiring palliative care • Providing household and community level palliative care services including psychological support • Linkage with other support groups, NGOs and day care centres • Community based resource mobilisation for palliative care	• Identification of new cases and line listing • Ensuring quality home-based palliative care coordinating with the palliative care nurse and other community level volunteers • Integration with LSGD, SJD and KSSM to prepare individual care plans for rehabilitation • Referral service	• Planning and implementation of home-based palliative care. • FHC level management of palliative patients and drug distribution • Training for the caretakers • Referral services • Planning and implementation of LSG projects	• Number of patients received palliative care services (Report to be generated from monthly palliative care report)

Communicable diseases – General activities	• Identify and inform symptomatic cases to nearest health worker and facilitate medical care • Active case search/ survey during an outbreak. • Suchitwa mapping and hot spots identification • Linkage with WHSNC, LSG, other line departments, NGOs and Harithakeralammission to address social determinants of health	• Initial management of symptomatic cases and referral. • Syndromic reporting • Online data entry • Line listing of cases • Plan and implement epidemic control activities. (arogya-jagratha) • Enforcement of public health laws • Collection of blood slides in fever symptomatic	• Detection, reporting, sample collection/ testing and management of cases as per guidelines • Identify red flag signs and Referral if indicated • Identify early warning signals • Collection of surveillance data from private clinics/hospitals/ nursing homes/other systems • Outbreak investigation and response • Planning and implementation of annual epidemic prevention activities (Arogya-Jagratha)	• Number of D & O trade inspections done (To be generated from institution monthly report)
Communicable Diseases – Specific Activities Airborne (eg. H1N1, CAP, ChickenPox, Measles, etc.)	• Awareness on airborne infections, cough hygiene and hand washing, need for isolation. • Immunisation • High risk screening,	• Immunization • Health education • Provision of personal protective measures for patients and contacts	• Detection, reporting, sample collection/ testing and management as per guidelines	

Waterborne (eg. ADD, Viral Hepatitis, Enteric Fever, etc.)	• Sanitary survey of drinking water sources and ensuring chlorination • Periodic water quality monitoring. • Maintaining ORS Depot • Activities in connection with enforcement of public health and food safety laws	• Water sampling, quality testing • Enforcement of public health laws • Maintaining ORS stock • Line listing of cases during an outbreak	• Detection, reporting, sample collection/ testing and management as per guidelines • ORT Corner • Plan A & B management and referral services • Stool examination	• Number of drinking water sources chlorinated (To be generated from the institution monthly report) • • Number of ADD cases reported per 1000 under 5 children (IDSP)
Vectorborne (eg. Dengue, Malaria, JE, Filariasis and Kala Azar etc.)	• Integrated Vector Management activities • Migrant screening • Active blood smear collection for detection of Malaria &Filaria. • Mass and contact survey of malaria cases. • Morbidity management of lymphatic filariasis • MDA -TAS activities	• Line listing of cases during an outbreak • Rapid Diagnostic Test for Malaria • Initiation of management and referral services • morbidity management of Lymphactic Filariasis • JE vaccination in selected districts	• Detection, reporting, sample collection/ testing and management as per guidelines • Passive surveillance of • Malaria cases • Lab confirmation of malaria • JE vaccination • Morbidity management for LF	• Total number of Malaria cases (IDSP) • Total number of indigenous malaria (IDSP) • Annual blood examination rate for the month (To be generated) • Number of suspected dengue cases (IDSP) • Number of confirmed dengue cases (IDSP) • Number of patients received morbidity management services for Lymphoedema (To be generated)

Leptospirosis	• Doxy prophylaxis for high risk groups (handling domestic animals, fishing, farming etc) • Rodent control activities	• Line listing of cases during an outbreak	• Detection, reporting, sample collection/ testing and management as per guidelines • Identification of red flag signs • Referral services if needed	• Number of persons received Prophylactic Doxycycline (To be generated)
Leprosy	• Identification, mobilisation and screening of individuals with hypo/erythematous patches and other symptoms suggestive of leprosy (Aswamedham) • Periodic screening of school children and migrants • Mobilisation of close contacts of leprosy patients for screening • Ensuring treatment compliance	• Opportunistic screening and detection of cases through various sub centre clinics • Linelisting, registration and ensuring treatment compliance • Planning and implementation of screening camps in schools, labour camps and in Aswamedham program	• Screening and referral services • Early Identification of patients with disability and referral for management/disability reduction • Registration of leprosy patients • Screening of close contacts • Ensuring treatment compliance and default tracking	• Number of new Leprosy cases detected through ASWAMEDHAM/opportunistic screening (NLEP report/NIKUSHT)

HEALTH CARE SERVICES	COMMUNITY	SUB-CENTRE	FHC	MONITORING INDICATORS AND SOURCE OF DATA * ALL DATA SHOULD BE F OR THE REPORTING MONTH
RNTCP	• Vulnerable population mapping • Identification of cases with cough more than two weeks/weight loss/ prolonged unexplained fever and referral to FHC for Sputum AFB • Identify and train DOTS provider • Promote HIV and diabetes screening in TB cases • Ensure treatment compliance, identify adverse drug reactions and refer	• Identification suspicious cases of TB and referral to FHC • Line listing of TB cases • Ensure treatment compliance, follow up and defaulter tracking • Documentation, Reporting &Nikshay entry of TB cases • Ensure chemoprophylaxis for child contacts and special attention for immune compromised contacts • Tobacco cessation through sub-centre clinics	• Identification of suspicious cases, diagnosis , initiation of treatment as per RNTCP guidelines, follow up and referral if needed • Sputum AFB, Chest X-ray, CBNAAT and other investigations as necessary • Notification of TB cases • Documentation, Reporting &Nikshay entry of TB cases • Detection and treatment of co-morbidities • Referral of MDR-TB cases to higher centre • Provide chemoprophylaxis for child contacts • Ensure support through social security schemes	• Percentage of vulnerable population screened for TB (NIKSHAY) • Number of new cases put on treatment (NIKSHAY)

Care in Pre-pregnancy, child birth and post-natal care	• Identifying high risk pregnancies and follow up • Follow up to ensure prophylactic and therapeutic compliance of IFA • Post- partum care visits	• Premarital counselling of eligible couples and Support for planning of pregnancy • Pre-conception supply of folic acid to prevent NTD • Early detection, registration of pregnancy and issuing of ID number and MCP Card • Antenatal check-up including screening of Hypertension, Diabetes, Anaemia etc • Immunization for pregnant woman-TD • IFA and Calcium supplementation • Transport entitlements • Follow-up of Gestational Diabetes Mellitus and Pregnancy Induced Hypertension.	• Ensuring quality antenatal and postnatal care • Blood grouping and Rh typing • HIV and PPTCT services and linkage with nearest ICTC for voluntary testing. • Detection, first-aid treatment and prompt referral of all high-risk cases. • Counselling and support for exclusive breast feeding • Linkage to delivery points • Referral to DMHP for suspected cases of depression (Amma Manassu)	• Percentage of pregnant mothers who received minimum 4 antenatal check up (RCH portal) • Percentage of high risk antenatal cases (RCH portal)

HEALTH CARE SERVICES	COMMUNITY	SUB-CENTRE	FHC	MONITORING INDICATORS AND SOURCE OF DATA * ALL DATA SHOULD BE F OR THE REPORTING MONTH
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 • Educating mother and family on new born danger signals. • Identification and care of high risk new-born - low birth weight, preterm and sick new-born (with referral as required) • Counselling and support for early and exclusive breast feeding complimentary feeding practices • Identification of congenital anomalies and appropriate referral to DEIC/FHC • Mobilization and follow up for immunization services • Reporting of neonatal death • Awareness about programs like Hridyam, New born screening (SalabhamJatakseva), SruthiTarangam, RBSK, Arogyakiranam and follow-up of beneficiaries	• Registration in RCH portal and MCP card. • Initiation and management of ARI/ Diarrhoea and other common illnesses and referral • Screening, referral (DIEC/FHC) and follow up/tracking for disabilities, developmental delays and behavioural abnormalities. • Ensuring full immunization coverage • Vitamin A supplementation • Reporting of Adverse Events Following Immunization (AEFI)	• Detection and management of minor problems in the newborn period and prompt referral of high risk cases • Treatment of ARI and Diarrhoea & dehydration cases and prompt referral • Childhood health care services including immunization, initial management of all emergency cases and referral. • Identification, referral and follow-up care of birth defects, behaviour abnormality, developmental delays.	• Number of infant deaths (RCH portal) • Percentage of low birth weight new born (RCH portal) • Percentage of fully immunized infants (RCH portal)

Childhood and Adolescent health care services including immunization	• Growth Monitoring, IYCF and food supplementation linked to ICDS • Identification of acute malnutrition referral and follow up care for SAM • Prevention of Anaemia - Iron supplementation and Deworming • Prevention of Diarrhoea/ ARI • Promotion of Home Available Fluids (HAF) and ORS • Pre-school and School level Child Health activities - Biannual screening, School health records, Eye care, De-wormingetc • Screening of children as per national and state programs to cover 4'D's Viz. Defect at birth, Deficiencies, Diseases, Development delay including disability (RBSK and Arogyakiranam) • Awareness creation on proper use of electronic gadgets like mobile phone, tab, TV etc • Promotion of physical activity and healthy food habits like reduced salt and sugar intake and increasing consumption of fruits and vegetables **Adolescent Health**	• Ensuring full immunization • Detection and treatment of Anaemia and other deficiencies • Identification and referral of vaccine preventable diseases • Early detection of growth abnormalities, delays in development and disability and referral • Prompt detection and referral of ARI, acute diarrhoea and fever • Detection, first-aid with timely referral as needed for ear, eye and throat problems, skin infections, worm infestations ,febrile seizure, poisoning, injuries/accidents, insect and animal bites • Detection of malnutrition referral and follow up care. • Adolescent health clinic and counselling services	• Detection, management and referral of nutritional deficiencies/SAM/MAM • 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 management for disability, deficiencies and development delays • Referral for any congenital anomalies • Identification of cases of hormonal imbalances, follow-up and referral if required • Management of growth abnormality and disabilities, with referral as required • Management, referral and follow up in cases of substance abuse.	• Total number of adolescents attended subcentre adolescent clinics (To be generated)

	• Awareness creation, Counselling and follow up on: - Improving nutrition - Sexual and reproductive health - Prevention of substance misuse (Vimukthi program) - Healthy life style promotion - prevention of Anaemia • Provision of IFA under National Program	• Detection for cases of substance abuse, referral and follow up with focus on vulnerable families • Identification and referral of behaviour abnormality and depression cases. • Detection and Treatment of Anaemia and other deficiencies in adolescents • Detection and referral for growth abnormality and disabilities, with referral as required • Hypertension screening for 18+.	• Identification, support and referral for further management of LGBTQ. • Counselling services for Adolescent Health	
Family planning, contraceptive services and other reproductive care services	• Identification of eligible couples for temporary and permanent methods • Follow up of contraceptive users • Counselling and facilitation of safe abortion services • Follow up for any complication after abortion and appropriate referral if needed • Awareness creation and referral services for infertility	• Registration of eligible couples • Provision of condoms, oral contraceptive pills and emergency contraceptive pills • Identification and referral of RTIs/STIs	• Insertion/removal of IUCD • Counselling services and facilitation of services for male and female sterilization • Provision of Injectable Contraceptives • Provision of emergency contraceptive pills and referral services for safe abortion.	

		• Identification and referral in case of dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse • Identification of infertility cases and referral • Facilitating male and female sterilization	• Management of survivors of sexual violence as per medico legal protocols. • Management of GBV related injuries and facilitating linkage to legal support centre (Bhoomika clinic, JagrataSamiti) • Management and referral if needed of hormonal and menstrual disorders and cases of dysmenorrhoea, vaginal discharge, mastitis, breast lump, pelvic pain, pelvic organ prolapse • Provision of diagnostic tests services such as (VDRL,HIV) and linkage with F-ICTCs • Management of RTIs/STIs • Linkage with PPTCT at district level	

Care for common ophthalmic problem	• Identification and referral of visual impairment or defects in general population. • Identification and referral of cases for cataract surgery • Promoting annual retinopathy screening for all diabetic and hypertensive patients.	• Administration of vitamin A prophylaxis • Facilitating annual retinopathy screening for all diabetic and hypertensive patients	• Establishing vision centre • Management of acute eye infection, foreign body and early referral • Screening of cataract, diabetic retinopathy glaucoma, corneal ulcers and referral • Identification and correction of refractive errors • Ensuring annual retinopathy screening for all diabetic and hypertensive patients	• Number of persons screened in vision centre (e health) • Number of Cataract cases detected through vision centre (e health)
Care for oral health	• Screening for common oral diseases/conditions and referral with special emphasis on geriatrics and palliative care patients. • Screening for oral cancer and premalignant conditions in high risk individuals and referral	• Counselling for tobacco cessation and referral • Screening for oral cancer and premalignant conditions in high risk individuals and referral	• Management of common oral conditions like apthous ulcers, candidiasis, glossitis etc. • Management of tooth ache and first aid for tooth trauma, with referral • Screening for oral cancer and premalignant conditions and referral	

Chapter 4
SERVICE DELIVERY PACKAGES WITH ACTIVITY MAPPING

A family health centre (FHC) has been conceived as a one-stop-centre which will provide primary, preventive, promotive and curative health care services, in addition to rehabilitative and palliative care services, to all families in a defined geographic area. The service packages which will be delivered by FHCs are derived from the comprehensive primary health care plan, which envisages improved health care service delivery and quality of care by strengthening sub centres, addressing the social determinants of health, by ensuring effective convergence and community participation.

The services provided at an FHC includes

- Activities for health promotion, prevention, rehabilitation & palliative care.
- Curative services (OP services, emergency, laboratory and referral services),
- Field-level activities
- Institution-based services (hostels, schools, offices and work places)
- Specific services for marginalised and vulnerable population, incorporating appropriate social security schemes.

Health care service delivery plan

The FHC team, on completion of the annual family health survey, should prepare the healthcare service delivery plan for the population concerned. The family health registers should be prepared on the e-health platform. All variables listed in the e-health database – demographic details, occupation, medical history, risk behaviours, anthropometry, blood sugar and blood pressure of individuals, details of household environment and other relevant details – should be entered in the health registers which has to be updated annually during January-February. Based on the data in the family health register, a healthcare service delivery plan should be prepared for every family under FHCs, accommodating the healthcare needs of every family member. From there, the health service delivery plan should be scaled up to the ward and panchayat-level, including the healthcare requirements of the entire population.

The role of community health volunteers, SC/ST Promoters, ASHA, Anganwadi worker, Field staff in the Health Services, Staff nurses and Medical officers in delivering the health services should be clearly delineated and the responsibility of each charted out. Activities linked to the improvement of the social determinants of health should be coordinated between the LSGs and other departments involved. The involvement of Hospital Management Committee (HMC), Ward Health Sanitation and Nutrition Committee, Area Development Society / Community Development Society, Jagrathasamithi, Oorukoottam and local NGOs in service delivery should also be ensured.

FHCs should deliver healthcare services as healthcare packages which have been designed in such a manner that each addresses a specific health issue in a comprehensive manner. There are four types of packages

I.Individual packages

There are 35 comprehensive individual packages categorised on the basis of age, gender, physiological and morbidity status

- **Individual service packages based on age group**
  - * Newborn
  - * Infants
  - * Children 1 to 5 years
  - * Children 5 to 10 years
  - * Adolescents (10-19 years)
  - * Apparently healthy men (19-60 years)
  - * Apparently healthy women (19-60 years)
  - * Older persons (60 years and above)
- **Individual service packages based on physiological condition**
  - * Antenatal
  - * Postnatal
- **Individual service packages based on prevention and risk reduction**
  - * Obesity
  - * Substance abuse
  - * Underweight
  - * Diet
  - * NCD diet
  - * Physical activity
  - * Immunization
- **Individual service packages based on the disease condition**
  - NCD
  - Diabetes
  - Hypertension
  - COPD/Bronchial Asthma
  - CAD
  - Stroke
  - Mental Health
  - Cancer
  - People with disability [PWD]
  - Palliative care
  - CD
  - Airborne infections
  - Waterborne infections
  - Vector borne infections
  - Leptospirosis
  - HIV/AIDS
  - RTI/STI
  - TB
  - Leprosy

1. NEW BORN

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Registration			✓			
2	Assessing hypothermia, cord care, jaundice and advice to attend health center if any			✓	✓	✓	
3	Management/referral of hypothermia, hypoglycemia, jaundice, seizures, incessant cry, breast feeding issues, respiratory issues, ADD and other common conditions	✓	✓	✓	✓		
4	Follow up of the newborn with the morbidity listed above		✓	✓		✓	
5	Educating mother on newborn care-breastfeeding, keeping the baby warm, cord care, importance of immunization		✓	✓	✓	✓	
6	Educating mother and family on new born danger signals- baby lethargic, inability to take breastfeeds, decreased urine output, jaundice, grunting, chest-in drawing and accidents/injuries	✓	✓	✓	✓		
7	Assessing weight gain of newborns and advice to attend health center if weight gain not adequate			✓	✓	✓	
8	Management/referral of babies with inadequate weight gain	✓					

9	Follow up of preterm babies and low birth weight babies			✓	✓		
10	Immunization • Mobilizing			✓	✓	✓	✓
	• Vaccinating			✓			
	• Identification and reporting of AEFI		✓	✓	✓	✓	
	• Management/referral of AEFI	✓					
	• Identifying drop-outs and mobilizing them			✓	✓	✓	✓
	• Motivating resistant cases and ensuring their vaccination	✓	✓	✓	✓	✓	✓
11	Ensuring routine neonatal screening including anthropometry, ocular and audiometric evaluation	✓	✓	✓			
12	Refer to DEIC in case of any birth defects	✓		✓			
13	Reporting of neonatal death in community			✓	✓	✓	✓
14	Detailed assessment of neonatal death - verbal autopsy	✓					

*** Treatment/referral of all diseases is as per CPHC clinical guidelines**
*** DEIC should serve as the nodal referral centre for all developmental defects**

2. INFANTS

Sl. No	Services	MO	SN	JPHN/ JHI	ASHA	AWW	CHV
1	Identifying infants in their area and registering in MCTS.			✓	✓	✓	
2	Treatment of common illness: fever, ARI, ADD, conjunctivitis and referral of severe cases	✓	✓	✓			
3	Treatment of common illness: skin disease, ear infection	✓					
4	Follow up of infants treated for common conditions		✓	✓	✓	✓	
5	Identification and treatment of babies with hypothyroidism, seizure disorder.	✓					
6	Identification and referral of babies with congenital malformations	✓	✓	✓	✓		
7	Identification and referral of surgical emergencies in children: intussusception, intestinal obstruction	✓					
8	Identifying the children with cerebral palsy- pneumonia, severe acute malnutrition, seizure and referral	✓	✓	✓			
9	Rehabilitation of infants with cerebral palsy and equipping the parents to address their specific needs		✓				

10	Promotion of exclusive breast feeding till 6 months of age and continuing breast feeding along with complementary feeding afterwards.	✓	✓	✓	✓	✓	✓
11	Monthly weight monitoring			✓	✓	✓	
12	Assessment of nutritional status: underweight and overweight and refer to health center			✓	✓	✓	✓
13	Identification of undernourished children/ children who are not under regular weight monitoring	✓	✓	✓	✓	✓	✓
14	Assessment of achievement of developmental mile stones and referral of babies with delay in development to health center		✓	✓	✓	✓	
15	Referral to DEIC	✓		✓			
16	Health education and nutrition education sessions for mothers with special emphasis on infant care.	✓	✓	✓	✓	✓	
17	Educate the mother on danger signals- grunting, inability to feed, decreased urine output, passage of blood in stool, seizure, delay in attaining developmental mile stones.	✓	✓	✓	✓	✓	✓
18	Health education on prevention of accidents/injuries, ADD- breast feeding, use of safe water, hand washing, food safety, use of latrine and safe disposal of stool, measles immunization	✓	✓	✓	✓	✓	✓
19	Health education to prevent ARI-improvement of nutrition, prevention of low birth weight and malnutrition, importance of immunization, control of indoor air pollution, exclusive breast feeding.	✓	✓	✓	✓	✓	✓

*** Treatment/referral of all diseases is as per CPHC clinical guidelines**

3. CHILDREN (1 - 5 YEARS)

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification of children in their area and ensure registration in MCTS.			✓	✓		
2	Immunization • Mobilizing		✓	✓	✓	✓	✓
	• Vaccinating				✓		
	• Identification and reporting of AEFI		✓	✓	✓	✓	
	• Management / referral of AEFI	✓					
	• Identifying drop-outs and mobilizing them	✓	✓	✓	✓	✓	✓
	• Motivating resistant cases and ensuring their vaccination	✓	✓	✓	✓	✓	✓
3	Vitamin A supplementation			✓			
4	Promoting physically active games, personal hygiene				✓	✓	✓

5	Treatment of common communicable diseases like short febrile illness, ARI, ADD, scabies	✓	✓	✓	✓		
6	Treatment of communicable diseases- Varicella, UTI, mumps, measles, diphtheria, malaria, dengue, pneumonia etc and referral of severe cases.	✓					
7	Treatment /referral of febrile seizures	✓					
8	Follow up of all children treated for common conditions at the centre		✓	✓	✓	✓	✓
9	Education on management of febrile seizures and identification of danger signs	✓	✓	✓			
10	Identification/referral and follow up of differently abled children	✓					
11	Identification and referral of ephritic syndrome, acute glomerulonephritis, infectious mononucleosis, Henoch schonlein purpura , idiopathic thrombocytopenic purpura,	✓					
12	First aid/ basic life support	✓	✓	✓	✓	✓	✓
13	Management of trauma	✓	✓	✓			
14	Referral of severe cases	✓					
15	Identification and referral of surgical emergencies- acute appendicitis, intestinal obstruction.	✓					
16	Early identification of children with defective vision and hearing impairment		✓	✓	✓	✓	
17	Referral of children with defective vision and hearing impairment	✓		✓			
18	Identification of children with locomotor disability and mental retardation		✓	✓	✓	✓	✓

19	Management/ referral of children with locomotor disability and mental retardation.	✓					
20	Monthly growth monitoring			✓		✓	
21	Assessment of nutritional status- underweight and overweight and		✓	✓		✓	
22	Management/ referral of under/over nutrition if required	✓					
23	Identification of underweight children and children not under regular growth monitoring			✓		✓	
24	Identification of refractive errors and dental health problems		✓	✓			
25	Administration of IFA and biannual deworming.			✓	✓	✓	
26	Identification and referral of dental caries.		✓	✓	✓	✓	
27	Identifying the health care needs of children with cerebral palsy- pneumonia, severe acute malnutrition, seizure and referral	✓	✓				
28	Health education to mothers to identify danger signals- grunting, wheeze, lethargy, inability to take feeds/water, decreased urine output, seizures, weight loss or no weight gain.	✓	✓	✓			
29	Nutrition education to mothers on selection of healthy food.			✓	✓	✓	✓
30	Education to mothers on promotion of physical activities among children, and decreasing sedentary habits among children				✓	✓	✓
31	Motivate the mothers and family to avail services from AWC.				✓	✓	✓

32	Psychological support to mothers of children with cerebral palsy and disabilities.		✓	✓	✓	✓	✓
33	Guidance and support to obtain disability certificate and to avail social security schemes.				✓	✓	✓
34	Health education on prevention of ADD- breast feeding, use of safe water, hand washing, food safety, use of latrine and safe disposal of stool	✓					
35	Health education to prevent ARI- improvement of nutrition, importance of immunization, control of indoor air pollution, breast feeding.			✓	✓	✓	✓
36	Educating mothers for prevention of domestic injuries		✓	✓	✓	✓	✓

4. CHILDREN (5 - 10 YEARS)

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification of 1-10yr old children in their area and ensure registration in MCTS			✓	✓		
2	Immunization • Mobilizing		✓	✓	✓	✓	✓
	• Vaccinating		✓				
	• Identification and reporting of AEFI		✓	✓	✓	✓	
	• Management/referral of AEFI	✓					
	• Identifying drop-outs and mobilizing them	✓	✓	✓	✓	✓	✓
	• Motivating resistant cases and ensuring their vaccination	✓	✓	✓	✓	✓	✓
3	Promoting physically active games, schooling, personal hygiene				✓	✓	✓
4	Treatment of common communicable diseases like short febrile illness, ARI, ADD, scabies	✓	✓	✓	✓		
5	Treatment of communicable diseases- Varicella, UTI, mumps, measles, diphtheria, malaria, dengue, pneumonia etc and referral of severe cases.	✓					

6	Follow up of all children treated for common conditions at the centre		✓	✓	✓	✓	✓
7	Identification of children with learning disability, mentally challenged, behavioral problems and locomotor disability.	✓	✓	✓	✓	✓	✓
8	Referral of differently abled children	✓					
9	Identification and referral of nephrotic syndrome, acute glomerulonephritis, infectious mononucleosis, Henoch schonlein purpura , idiopathic thrombocytopenic purpura,	✓					
10	First aid/ basic life support	✓	✓	✓	✓	✓	✓
11	Management of trauma	✓	✓	✓			
12	Referral of severe cases	✓					
13	Identification and referral of surgical emergencies- acute appendicitis, intestinal obstruction.	✓					
14	Early identification of children with defective vision and hearing impairment		✓	✓	✓	✓	
15	Referral of children with defective vision and hearing impairment	✓		✓			
16	Management/ referral of children with learning disability, mentally challenged, behavioral problems and locomotor disability.	✓					
17	Assessment of nutritional status- underweight and overweight and referral for evaluation and management.		✓	✓		✓	
18	Identification of underweight children and children not under regular growth monitoring				✓		✓
19	Annual health check-up –nutritional and health status, refractive errors, dental health, mental health at school		✓	✓			
20	Administration of IFA and biannual deworming.			✓	✓	✓	
21	Identification and referral of dental caries.		✓	✓	✓	✓	
22	Identifying the health care needs of children with cerebral palsy- pneumonia, severe acute malnutrition, seizure and referral	✓	✓				
23	Nutrition education to mothers on selection of healthy food.			✓	✓	✓	✓

24	Education to mothers on promotion of physical activities among children, and decreasing sedentary habits among children				✓	✓	✓
25	Psychological support to mothers of children with cerebral palsy and disabilities.		✓	✓	✓	✓	✓
26	Guidance and support to obtain disability certificate and to avail social security schemes.			✓	✓	✓	✓
27	Health education on prevention of ADD- use of safe water, hand washing, food safety, use of latrine			✓	✓	✓	✓
28	Health education to prevent ARI- improvement of nutrition, importance of immunization, control of indoor air pollution			✓	✓	✓	✓
29	Counseling for prevention of substance abuse		✓	✓			
30	Screening for dental cavity		✓	✓	✓	✓	

***Treatment/referral of all diseases is as per CPHC clinical guidelines**

5. ADOLESCENT (10 – 19 YEARS) HEALTH CARE

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Maintaining an adolescent register			✓			
2	Health education on puberty, pubertal changes and personal hygiene		✓	✓		✓	
3	Education on menarche and menstrual problems- irregular bleeding, menorrhagia, dysmenorrhea, menstrual hygiene, reproductive and sexual health (RSH)	✓	✓	✓			
4	Entering the data of girls with menstrual problems in the register			✓			
5	Detection and proper referral of RSH issues and UTI in adolescents	✓	✓	✓			
6	**Adolescent vaccines** • Education regarding Rubella, TT and HPV (optional).		✓	✓			
	• Ensuring vaccination			✓	✓	✓	✓
	• Providing vaccination			✓			
	• AEFI to be included						
	Adolescent counseling including premarital counseling	✓	✓	✓			

7	**Family planning services** • Cafeteria approach	✓		✓	✓		
	• Educating about the importance of family planning		✓	✓	✓	✓	
	• Identification and mobilization				✓		✓
	• Supply of contraceptives			✓	✓		
8	**Safe abortion services** • Providing information regarding service availability			✓	✓		
	• Referral for abortion services	✓					
	• Identification and reporting of unsafe abortions				✓		✓
	• Management and reporting of unsafe abortion	✓					
9	Education on avoiding substance abuse and high risk behavior		✓	✓	✓	✓	
10	Formation of health clubs and identifying students who can act as informants of substance abuse among peers			✓		✓	
11	Periodic deworming			✓			
12	Screening for anemia		✓	✓			
13	Supply of IFA tablets/WIFS			✓	✓	✓	
14	Assessment of nutritional status- underweight and overweight and referral to health center for evaluation and management.		✓	✓	✓	✓	✓
15	Regular health classes on good eating habits and exercise			✓		✓	
16	Health education to teachers about ADHD, Adjustment disorders, minor depression and help them to tackle the problems	✓					
17	**Physical or mental abuse** • Identification		✓	✓	✓		✓
	• Treatment/referral	✓					
	• Counseling	✓	✓				
18	Psychological support in cases of emotional breakdown: depression/ anxiety		✓	✓	✓		✓
	• Guidance to form peer groups				✓	✓	✓

19	**Adolescents with poor scholastic performance** • Identifying and mobilization			✓		✓	✓
	• Psychological support			✓	✓	✓	✓
	• Assessing the reason for poor performance and providing guidance and support.	✓					
	• Referral	✓					
	• Counseling to their parents	✓	✓	✓			
20	Treatment of mild forms of short febrile illness, ARI, ADD, conjunctivitis as per CPHC guidelines and timely referral		✓	✓			
21	Management of trauma	✓	✓	✓			
22	Referral of severe cases	✓					
23	Treatment of food poisoning, hepatitis A, malaria, dengue, infectious mononucleosis, tonsillitis, reproductive tract infections as per CPHC guidelines	✓					
24	Identification of refractive errors		✓	✓			
25	Treatment/referral for refractive error, injury and foreign body eye	✓					
26	Identification and treatment/referral of surgical emergencies – appendicitis, intestinal obstruction, ectopic pregnancy, twisted ovarian cyst.	✓					
27	Health education sessions to empower adolescents to cope with the physical and psychological changes during adolescence, empower them to speak up regarding their problems and abuse if any, and creating a healthy relationship between them	✓	✓	✓			
28	Motivating them to avail services from AWC-supplementary nutrition, IFA supplementation, health check-up.				✓	✓	✓
29	**School drop-outs** • Identification				✓		✓
	• Motivation for continuing study				✓	✓	✓
30	Ensuring proper utilization of adolescent services from the health center						✓

31	Identification of adolescents with behavioral problems like juvenile delinquency and referral to health center				✓	✓	✓
32	Referral to guidance clinic	✓					
33	Monitoring nutritional status and prevention of overweight/obesity			✓	✓	✓	
34	Screening for dental cavities and other dental problems		✓	✓	✓	✓	

6. APPARENTLY HEALTHY ADULT MEN (19 - 60 YRS)

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Registration			✓			
2	Health education on healthy life style: healthy diet (low salt, oil and sugar, plenty of fresh fruits and vegetables), regular exercise.		✓	✓	✓		✓
3	Education on health hazards of over-weight/ obesity, sedentary life style, substance abuse, stress relaxation techniques	✓	✓	✓	✓	✓	✓
4	Identifying individuals with family history of NCD, and tracking their BP and blood sugar			✓			

5	**NCD** • Screening for obesity, DM, HTN, DLP		✓	✓			
	• Advise screening for NCD once in a year		✓		✓		✓
	• Regular monitoring of body weight			✓	✓	✓	
	• Treatment for identified cases	✓					
	• Referral for management of complications	✓					
	• Follow-up of cases referred back including drug compliance			✓	✓		✓
6	**Occupational health** • Assessing occupational health and risk for occupational disease		✓				
	• Advise/ evaluate accordingly	✓					
	• Health education on occupational hazards and prevention using personal protective equipment and personal hygiene.	✓	✓	✓	✓	✓	✓
7	**Substance abuse** • Identification of substance abuse		✓	✓	✓	✓	✓
	• Assessment of addictions	✓					
	• Guidance to quit	✓	✓	✓			
	• De addiction and referral	✓					
	• Screening for diseases based on pattern of substance abuse- sputum AFB, LFT, HIV, examination of oral cavity	✓	✓	✓			
	• Family planning services. Advice regarding use of spacing methods			✓			✓
8	Provision of spacing methods			✓	✓		
9	Identification of completed family and advice regarding permanent sterilization			✓	✓		✓
10	Mobilization for permanent sterilization to appropriate centres	✓		✓			
	• Identification and mobilization of infertility cases			✓	✓		✓
	• Referral for evaluation and treatment of infertility.	✓					

11	Detection and treatment of mild form of diseases like short febrile illness, respiratory infections, diarrhea, conjunctivitis as per CPHC guidelines and timely referral		✓	✓			
12	Management of referred & severe cases and referral to higher centre	✓					
13	Detection and treatment of malaria, dengue, typhoid, measles, mumps, leptospirosis, hepatitis A, tonsillitis, ear infection, skin diseases, foreign body, epistaxis, giddiness, bronchial asthma, COPD and referral of complicated cases as per CPHC guidelines	✓					
14	Detection and documentation of RTI/ STI			✓			
15	Detection and treatment of RTI/STI as per CPHC guidelines	✓					
16	Screening and treatment for refractive errors, foreign body eye and referral for ocular trauma, cataract surgery, glaucoma, hypertensive and diabetic retinopathy	✓					
17	Detection and treatment for gastritis, APD	✓					
18	Detection and treatment/ referral for evaluation of musculoskeletal disorders- back pain, other joint pains, trauma and fracture.	✓					
19	Referral of acute abdomen- appendicitis, pancreatitis, intestinal obstruction	✓					
20	**Assaults** • Identification			✓			✓
	• Documentation and treatment	✓					
21	Include service to differently abled Palliative						
22	Social security						

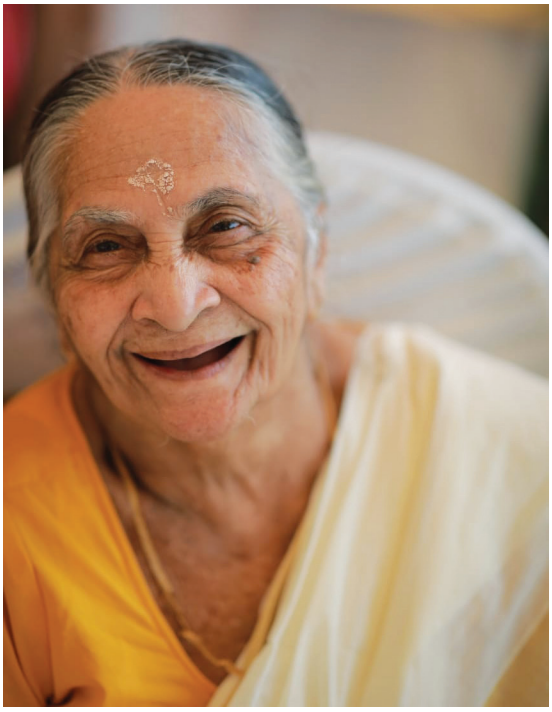
7. APPARENTLY HEALTHY ADULT WOMEN (19 - 60 YRS)

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Registration of women in reproductive age group			✓			
2	**Family planning** • Cafeteria approach	✓		✓	✓		
	• Educating about the importance of family planning	✓	✓	✓	✓	✓	✓
	• Identification of individuals in need			✓	✓	✓	✓
	• Supply of contraceptives			✓	✓		
3	**Safe abortion services** • Providing information regarding service availability	✓	✓	✓	✓	✓	✓
	• Identification of individuals in need			✓	✓	✓	✓
	• Referral for Abortion services	✓					
	• Identification of unsafe and illegal abortions			✓	✓	✓	✓
	• Reporting of unsafe abortions	✓					
4	Identification of menstrual problems- irregular bleeding, excessive bleeding, severe abdominal pain and referral to FHC			✓	✓		✓
5	Detection and documentation of RTI/STI			✓			

6	Detection and treatment of RTI/STI as per CPHC guidelines	✓					
7	Referral for evaluation- fibroid, endometriosis, ovarian cyst, uterine prolapse, malignancy.	✓					
8	**Infertility** • Identification and mobilization of infertility cases			✓	✓		✓
	• Referral for evaluation and treatment of infertility	✓					
9	All women above 30yrs - VIA for detecting malignancy.	✓	✓				
10	Examination to rule out other malignancy- breast cancer, oral cancer, thyroid cancer. Check whether it is mentioned for men	✓	✓				
11	Supply of IFA			✓	✓	✓	
12	Screening and Identification of anemia		✓	✓			
13	Treatment and evaluation of cause of anemia.	✓					
14	Treatment for diseases like- joint pain, back pain and identifying the cause for the same.	✓					
15	Assessing substance abuse		✓	✓			✓
16	Screening for diseases related to substance abuse -oral ulcer, pre-cancerous lesions.	✓	✓	✓			
17	Identifying peri and postmenopausal problems like hot flushes, anxiety, depression	✓	✓				
18	Identification for post menopausal bleeding, uterine prolapse.		✓	✓			
19	Treatment /referral for them	✓					
20	Treatment /referral for arthritis/osteoporosis	✓					

*** In addition to the services depicted for healthy young male.**

8. OLDER PERSONS (60 YRS & ABOVE)



Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identify and register the elderly in their area.			✓			
2	Mobilization for assessment of health status			✓			
3	Assessment of health status: To identify – DM, HTN, CAD, neuropathy, hearing loss, defective vision, bowel disturbances, nephropathy, depression, bronchial asthma, COPD, TB, anemia, nutritional deficiencies, osteoporosis	✓		✓			
4	Health education regarding danger signals of cancer-breast cancer, colon cancer, oral cancer, lung cancer		✓	✓			
5	Treatment / referral for identified clinical conditions-cataract, benign prostatic hypertrophy, mental illness	✓					

6	Follow up to ensure that they are taking treatment- cataract surgery, surgery for prostatic hypertrophy, psychiatric treatment for depression/anxiety.			✓	✓		✓
7	Providing adequate services for bedridden patients: prevention/ treatment of bed sores, catheterization, BP, blood sugar monitoring and treatment.			✓	✓		
8	Ensuring that bedridden patients get adequate services			✓		✓	✓
9	**Advise on:** • Self care: regular medications and regular health checkup • Exercise appropriate for the patient's clinical condition • Prevention of falls • Diet modification according to the health status- DM, HTN, CAD • Stress management techniques	✓	✓				
10	Provide support for self care- administration of drugs, insulin, foot care, fall prevention			✓	✓		✓
11	Treatment/ referral of cases of fall	✓					
12	Identify defective vision, hearing loss, anemia and refer to health center for treatment				✓	✓	✓
13	Support and guidance to access- hearing aids, prostheses, walking stick, wheel chair.		✓		✓	✓	✓

14	Counseling and psychosocial support to elderly without family support		✓				
	• Identification of symptoms of depression/anxiety in elderly			✓	✓		
	• Management and Referral of patients for treatment of depression, anxiety, dementia	✓					
	• Provide support for accessing treatment for depression /anxiety						✓
15	Monitoring the HTN, DM and respiratory status and advise to seek timely treatment			✓			
16	Support to avail social security schemes					✓	✓
17	Taking initiative to form community groups of elderly and identify a common place for them meet every day, communicate with each other and support each other, promote yoga					✓	✓
18	Health education sessions on health care of elderly to be conducted once a month and motivate the community to attend them			✓		✓	
19	Assessing the health care needs of the individual who takes care of the bedridden				✓		✓
20	Management for health care needs of care taker- back pain/shoulder pain	✓					
21	Provide psychological support and motivation to the individuals who take care of the bedridden						✓
22	Health education on health hazards of substance abuse	✓	✓	✓			

23	Identification and mobilization of substance abuse						✓
24	Advice to quit addictions	✓	✓				
25	Referral to de-addiction center if needed	✓					
26	**8.A Older Man** Detection and treatment for urinary tract disorders- incontinence, prostatic hypertrophy, prostate cancer	✓					
27	Screening and referral for diseases depending on pattern of substance abuse - oral cancer, gastric cancer, hepatocellular carcinoma, lung cancer, colon cancer.	✓					
28	**8.B Older Woman** Screening & referral – breast cancer, cervical cancer, ovarian cancer, uterine/endometrial and colon cancer	✓					
29	Detection and treatment for uterine prolapse and urinary incontinence	✓					
30	Screening for risk for falls		✓	✓	✓		

9. ANTENATAL AND POST NATAL

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Early registration of all pregnant women			✓			
2	Ensuring woman take antenatal check-ups (at least 5)			✓			
3	Providing antenatal checkup	✓		✓			
4	Provide Iron Folic Acid tablet from 2nd trimester onwards			✓	✓		
5	Educate mothers regarding importance of taking Folic Acid tablets in peri-conceptional period		✓	✓			
6	Register the TT immunization status			✓			
7	Educate about the importance of TT vaccination			✓			
8	Give Inj. TT at Sub-Centre.			✓			
9	Check blood sugar of pregnant ladies			✓			
10	Refer and follow up for investigations such as Hb, VDRL, HBsAg, Urine albumin, RBS to the health centre.			✓			
11	Monitor weight, BP, anaemia (clinically), during each home visit.			✓			

12	Educate pregnant ladies about warning signs such as oedema, seizures, excessive vomiting, decrease in foetal movements, abdominal pain, bleeding PV, leaking PV, and high grade fever.	✓	✓	✓			
13	Management and referral to higher centres if any of the warning signs are present.	✓					
14	Educate about nutritious diet and healthy eating habits.		✓	✓	✓		✓
15	Educate them regarding physical activity & rest (Rest 8 hrs at night 2 hrs after noon) and recreational activities.		✓	✓			
16	Educate about personal hygiene		✓	✓	✓		✓
17	Advice to attend hospital for delivery.		✓	✓	✓		
18	If any pregnant woman has not attended sufficient number of antenatal check- ups immediately refer her to FHC.				✓	✓	✓
19	Educate them not to take any drug without consulting a doctor & educate about hazards of irrational use of drugs.		✓	✓	✓	✓	✓
20	Educate them regarding the hazards of any exanthematous fever during pregnancy & ask them to report immediately.		✓	✓	✓		
21	Categorize the low risk and high risk antenatal in each visit	✓					
22	Issuing of MCP card			✓	✓ ✓		
23	Refer the patient to the delivery point for registration at 28 weeks of gestation, and if the woman continues to be at low risk, she can have a back referral from the secondary levels, and can continue antenatal care up to 32 weeks at her PHC/CHC.	✓					
24	Referral and proper follow-up of antenatal cases as and when required.	✓					
25	On the day of ANC, conduct classes related to antenatal, postnatal, child care, nutrition, physical activity etc. This should be documented in their MCP cards.		✓				

26	Emergency Obstetric Services, in case of emergency to stabilize the patient before referral.	✓					
27	• Check whether the antenatals are taking Iron & Calcium tabs						
28	Education for family regarding parenting, personal hygiene, minor physical activities and adequate rest, proper nutrition and diet			✓	✓		
29	Education on family planning/spacing methods		✓	✓			
30	Providing family planning services			✓			
31	Advice regarding exclusive breast feeding, legislation, statutory leave arrangements in workplace.		✓	✓		✓	
32	Education on initiation of breast feeding within an hour of birth and exclusive breastfeeding during 1st 6 months of age and continue till 2yrs and beyond.		✓	✓	✓	✓	✓
33	Educating mother and family on new born care, breast feeding, prevention of hypothermia, cord care, immunization.			✓	✓	✓	✓
34	Educate the woman and her family members about danger signals- excessive bleeding PV, foul smelling discharge PV, severe abdominal pain, post partum anxiety/ depression, episiotomy/LSCS suture care, jaundice, seizure.	✓	✓	✓	✓		
35	Assessing the health status of mother- anemia, excessive bleeding PV, foul smelling discharge PV, severe abdominal pain, postpartum anxiety/depression, episiotomy/LSCS suture care, jaundice, seizure.	✓	✓	✓			
36	Educating the mother and family members regarding healthy diet, oral fluids, iron , calcium supplementation, adequate sleep and early mobilization after delivery.		✓	✓	✓	✓	
37	Help the family to avail services like JSY/JSSK/RBSK.			✓	✓	✓	✓
38	Follow up of GDM, PIH		✓	✓			
39	Monitoring weight		✓	✓	✓		

10. OBESITY

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Assessment of obesity (BMI) and classifying as pre-obese, obese or morbid obese.		✓				
2	Monitoring the body weight at regular intervals		✓	✓			
3	Screening for comorbidities		✓	✓			
4	Management of comorbidities	✓					
5	Referral if needed	✓					
6	Dietary counseling	✓	✓	✓	✓	✓	✓
7	Regular exercise: physical exercise plan according to the cardiac/ respiratory status	✓	✓				
8	Quitting smoking , alcohol and other substance abuse	✓	✓	✓	✓	✓	✓
9	Motivation, support and guidance for de-addiction			✓	✓		✓
10	Creating an enabling physical and social environment for behavioral change in the community				✓	✓	✓
11	Address psychosocial issues			✓	✓		✓
12	Follow up of weight reduction strategies during house visits			✓	✓		✓

13	Supporting and motivating the person to continue healthy behavior				✓	✓	✓
14	Encouraging women in reproductive age group to maintain normal body weight	✓	✓	✓	✓	✓	✓
15	Ensure family support to these individuals for sustained motivation for weight reduction.		✓		✓	✓	✓

11. SUBSTANCE ABUSE

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identifying individuals with substance abuse- smoking, chewing tobacco, alcohol, drug abuse and referral to health centre		✓	✓	✓	✓	✓
2	Counseling and guidance to quit substance abuse- explain the health hazards of substance abuse, motivate to quit, assess the readiness to quit, explain the methods to quit, assist quitting, arrange follow up.	✓	✓	✓			
3	Screening for diseases related to type of substance abuse - cough, jaundice, oral ulcers/ precancerous lesions, skin infections,	✓	✓	✓			
4	Referral to de-addiction centers if needed	✓					
5	Educate family members to motivate quitting, explain that it takes time, and ask the partner/family member to provide psychological support for quitting.	✓	✓				
6	Explain measures to prevent relapse	✓	✓	✓			
7	Create an enabling environment for prevention of harmful substance abuse			✓	✓		✓

12. UNDER WEIGHT

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification of cases			✓	✓	✓	✓
2	Identifying underlying causes for underweight and management	✓	✓				
3	Ensuring access to supplementary nutrition			✓	✓	✓	✓
4	Initiation of treatment/ referral depending on severity of underweight	✓					
5	Managing respiratory and GI morbidities	✓	✓	✓		✓	
6	IFA, vitamin A supplementation, deworming, micronutrient supplementation	✓		✓		✓	
7	Monitoring to assess weight gain			✓		✓	
8	Referral if weight gain is inadequate	✓				✓	
9	Nutrition education for selecting healthy food		✓	✓		✓	
10	Health education on personal hygiene and healthy lifestyle				✓	✓	✓
11	Health education on use of safe water, safe cooking practices				✓	✓	✓
12	Promotion of breast feeding			✓	✓	✓	✓
13	Monitoring of food habits			✓		✓	
14	Engage food retailers and caterers to improve the availability, affordability and accessibility of food			✓			✓
15	Ensuring supplementary nutrition through ICDS					✓	✓
16	Follow up of back-referred cases			✓		✓	✓
17	Educating the mothers for healthy cooking and feeding practices		✓	✓	✓	✓	✓

13. DIET

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Breast feeding and complementary feeding • Promotion of exclusive breast feeding till 6 months of age and continuing breast feeding along with complementary feeding afterwards. • Education to mothers and family members regarding the diet for improving the quantity and quality of breast milk. • Information to contact health system in case of problem in breast feeding.	✓	✓	✓	✓	✓	✓
2	Nutrition education to mothers on selection and preparation of healthy food including food hygiene			✓	✓	✓	✓
3	Motivating them to avail services from AWC-supplementary nutrition.				✓	✓	✓
4	Providing information regarding supplementary nutrition and NHE service availability from AWC for adolescent girls and ensuring that they avail the service	✓	✓	✓	✓	✓	✓

5	Ensuring full compliance among the beneficiaries to the WIFS given from schools and AWCs and providing proper NHE			✓		✓	
6	Educating the mother and family members regarding healthy diet, oral fluids, iron, calcium supplementation, adequate sleep and early mobilization after delivery		✓	✓	✓	✓	
7	Referral of severely malnourished children and older individuals for nutritional rehabilitation	✓					

14. NCD DIET

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Health education on healthy life style: healthy diet (low salt, oil and sugar, plenty of fresh fruits and vegetables), avoid junk food, avoid tinned and canned items.		✓	✓	✓		✓
2	Advice for diabetic patients on dietary modification: consumption of small and frequent meals, avoiding sweets and sugar, selecting food and fruits with low glycemic index.		✓	✓			

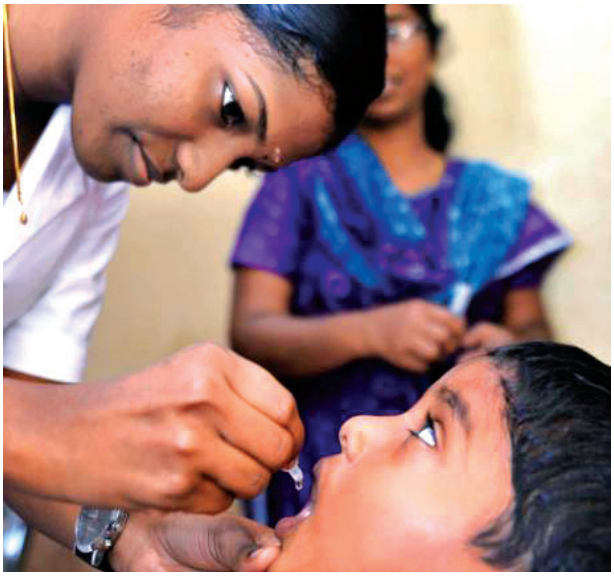
3	Advise for hypertensive patients on dietary modification: healthy diet ,reducing daily salt intake and avoiding food items preserved in salt, advice regarding adequate intake of salt to prevent hyponatremia.	✓	✓	✓	✓	✓	✓
4	Advice on dietary modification for obese and overweight individuals: regulate calorie intake, promote intake of high fibre food and unrefined complex carbohydrates, raw or lightly cooked vegetables, consumption of protein rich diet to aid in weight loss, limit intake of sugar and sweets, drink plenty of water, timing of the main meal of the day at the most active time of the day.	✓	✓	✓	✓	✓	✓
5	Advice for patients with CAD on dietary modification: increase intake of dietary fibre including fruits and vegetables, reduce intake of saturated fats and salt.	✓	✓	✓	✓	✓ ✓	
6	Education about and promotion of organic farming and promoting consumption of local produce.	✓	✓	✓	✓	✓	✓
7	Nutritional support for bed ridden and palliative care patients including linkage to social security schemes.	✓		✓			

15. PHYSICAL ACTIVITY

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Promoting physically active games in schools.				✓	✓	✓
2	Education to mothers on promotion of physical activities among children, and decreasing sedentary habits among children.				✓	✓	✓
3	Regular health classes on exercise.			✓		✓	
4	Education on health hazards of overweight/ obesity, sedentary life style, stress relaxation techniques.	✓	✓	✓	✓	✓	✓
5	Taking initiative to form community groups of elderly and identify a common place for them to meet every day, communicate with each other, support each other and promote yoga.						✓
6	Educate antenatal mother regarding physical activity & rest (Rest 8 hrs at night 2 hrs after noon) and recreational activities.		✓	✓			

7	Educating the mother and family members regarding adequate sleep and early mobilization after delivery.		✓	✓	✓	✓	
8	Interventions in work places for NCD • Promote physical activity in workplaces		✓	✓			
	• Measures to make wellness programmes mandatory in all workplaces both public and private in association with LSG	✓		✓			✓
9	Interventions in community for NCD • Activities to create spaces for exercise (walk ways, cycling tracks, stadiums/ play grounds, swimming pools, community gymnasiums etc) in association with LSG and other agencies/ departments						✓
	• Promote physical activity by organizing sports and games competitions in villages in association with LSG						✓
10	Advice for life style modification for hypertensives : exercise, yoga, stress relaxation techniques	✓	✓	✓	✓	✓	✓
11	Advice for obese persons regarding regular exercise: plan physical exercise according to the cardiac/ respiratory status	✓	✓				
12	Advice to CAD patients regarding regular physical activity,	✓	✓	✓	✓	✓	✓ ✓

16. IMMUNIZATION



Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Listing of beneficiaries in the catchment area and estimating requirement of vaccines and logistics (micro planning) including maintenance of a register			✓	✓	✓	
2	Planning number and venue of immunization sessions required			✓	✓	✓	
3	Procuring materials and logistics	✓	✓				
4	Arranging and conducting sessions			✓		✓	
5	Mobilizing the beneficiaries for immunization sessions			✓			
6	Vaccinating the beneficiaries			✓			✓
7	Identification and reporting of AEFI			✓			
8	Management and referral of AEFI	✓					
9	Maintenance and monitoring of cold chain equipment at the FHC	✓	✓	✓			

10	Immunization sessions at sub centers and outreach sites • Information dissemination regarding the date, time and site of the session			✓			
	• Mobilization of beneficiaries			✓			
	• Transport of vaccines (maintaining proper cold chain) and other logistics.			✓	✓	✓	✓
	• Conduct the vaccination sessions (including delivering the 4 key messages)			✓	✓	✓	✓
	• Reporting of AEFI and maintenance of an AEFI register.			✓			
11	Identifying drop-outs and mobilizing them for vaccination			✓	✓	✓	✓
12	Motivating resistant cases and ensuring their vaccination	✓	✓	✓	✓	✓	✓
13	Bio-medical waste management			✓			
14	Maintenance of registers at the FHC for AEFI and VPD		✓	✓			

17. NCD IN GENERAL

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Promotion of healthy diet and physical activity			✓	✓	✓	✓
2	Ensure regular and adequate supply of guideline based drugs in health institution	✓					
3	Arrange for awareness programme in public and private institutions, community settings, workplaces				✓		✓
4	Conduct awareness programme in public and private institutions, community settings, workplaces		✓	✓			
5	Ensure availability of sports goods and farming instruments in educational institutions			✓	✓		✓

6	**Interventions in work places** • Promote physical activity in workplaces		✓	✓			
	• Measures to make wellness programmes mandatory in all workplaces both public and private in association with LSG	✓			✓		✓
7	**Interventions in community** • Activities to create spaces for exercise (walk ways, cycling tracks, stadiums/ play grounds, swimming pools, community gymnasiums etc) in association with LSG and other agencies/ departments • Promote physical activity by organizing sports and games competitions in villages in association with LSG • Promote community farming by organizing unemployed youth, cooperative societies						✓

18. DIABETES MELLITUS

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Assessing glycemic control in diabetic patients			✓			
2	Treatment with appropriate drugs and advice on regular follow up.	✓					
3	Assessing diabetic patients for complications like- neuropathy, nephropathy, retinopathy and referral to higher center.	✓					
4	Mobilizing social and economic support from community for treatment of retinopathy and nephropathy				✓		✓
5	Assessing comorbidities- HTN, TB, CAD, UTI, fungal infections	✓					

6	For diabetic women in reproductive age group who are planning pregnancy, advice on adequate glycemic control before conceiving.	✓	✓				
7	Titration of insulin dose during pregnancy.	✓					
8	Referral of uncontrolled glycemic status during pregnancy	✓					
9	Timely referral of pregnant ladies with DM to identify fetal complications- macrosomia, fetal malformations.	✓					
10	Asking pregnant women with diabetes for symptoms of UTI and referral to health center			✓	✓		
11	**Advice on** • Dietary modification: consumption of small and frequent meals, avoiding sweets and sugar, selecting food and fruits with low glycemic index.		✓	✓			
	• Self identification of danger signals of hypoglycemia and hyperglycemia		✓	✓	✓	✓	v
	• Timing of drug intake and clearing related doubts.		✓	✓			
	• Life style changes: exercise promotion, avoiding substance abuse, support and guidance for de-addiction.			✓	✓	✓	
	• Importance of regular medication and regular health check up to prevent complications.			✓	✓		
12	• Providing support/guidance for accessing rehabilitative services			✓	✓		✓
	• Special foot wears, prostheses, wheel chair		✓	✓	✓		✓
13	Identifying symptoms of hypoglycemia /hyperglycemia during house visits and asking those patients to attend health center			✓	✓	✓	
14	Advice on self care- foot care (prevention of trauma to feet, keeping the nails short and clean etc.)		✓	✓	✓	✓	

15	Passing the information regarding NCD clinics and motivating the patients to attend them.				✓		✓
16	Organize health education sessions on diabetes – healthy life style.				✓		✓
17	Motivating pregnant women with diabetes for regular health check-up.				✓	✓	
18	Identifying diabetic patients who are unable to go for monthly check-up and inform health worker				✓		✓
19	Identification and mobilization of diabetic patients with non-healing wounds			✓	✓		
20	Follow up of GDM cases for preventing development of DM in future	✓		✓	✓		
21	Establishing and ensuring monthly foot care clinics in FHC	✓	✓				
22	Screening for family members		✓	✓	✓		

19. HYPERTENSION

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	• Regular monitoring of BP and achieving control.			✓			
2	• Screening for complications	✓					
3	• Treatment with appropriate drugs and follow up	✓					

4	• Ensure regular drug intake			✓	✓		✓
5	• Follow up of back referred cases		✓	✓			
6	• Follow up of patients at field level		✓	✓	✓	✓	
7	• Referral for management of complications	✓					
8	**Advise on:** • Life style modification: exercise, yoga, stress relaxation techniques • Dietary modification: Advise regarding healthy diet ,reducing daily salt intake and avoiding food items preserved in salt, advise regarding adequate intake of salt to prevent hyponatremia. • Avoid substance abuse • Advise on danger signals- giddiness, headache, visual disturbances, transient loss of consciousness	✓	✓	✓	✓	✓	✓
9	Support and guidance for de-addiction				✓		✓
10	Screening of family members and tracking of their BP			✓			

20. COPD/BA

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Maintain a register of COPD/BA in the area			✓			
2	Identification and mobilization of cases			✓	✓	✓	✓
3	Management and referral if needed	✓					
4	Pulmonary rehab/physiotherapy		✓				
5	Advice to quit tobacco and to avoid contact with airway irritants/indoor pollution		✓	✓			
6	Ensuring tobacco abstinence	✓	✓	✓	✓	✓	
7	Organize social support groups for helping them maintain abstinence status				✓		✓
8	**Advise on:** • Inhaler usage	✓	✓				
	• Cough hygiene	✓	✓	✓	✓	✓	✓
	• Chest physiotherapy to family members	✓	✓				
	• Symtoms and prevention of COPD / BA to school children		✓	✓			
	• Tobacco and its ill effects to public	✓		✓			
	• Indoor air pollution			✓	✓	✓	✓
9	Ensuring usage of personal protective measures and equipment at work places		✓	✓			
10	Formation of student informer groups in schools for tackling substance abuse			✓			

21. CORONARY ARTERY DISEASE

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Preparation of CAD register including the risk factor profile and co-morbidities		✓	✓			
2	Management based on CPHC guidelines	✓					
3	Referral based on CPHC guidelines	✓					
4	Follow up based on CPHC guidelines	✓	✓	✓			
5	Follow up of back referred cases	✓					
6	Advice to patients regarding diet, physical activity, habits, regular medication and follow up	✓	✓	✓			
7	Ensuring that patient is taking regular medication		✓	✓	✓		✓
8	Health education on identifying symptoms of CAD and its prevention among family members		✓	✓	✓		✓

22. STROKE

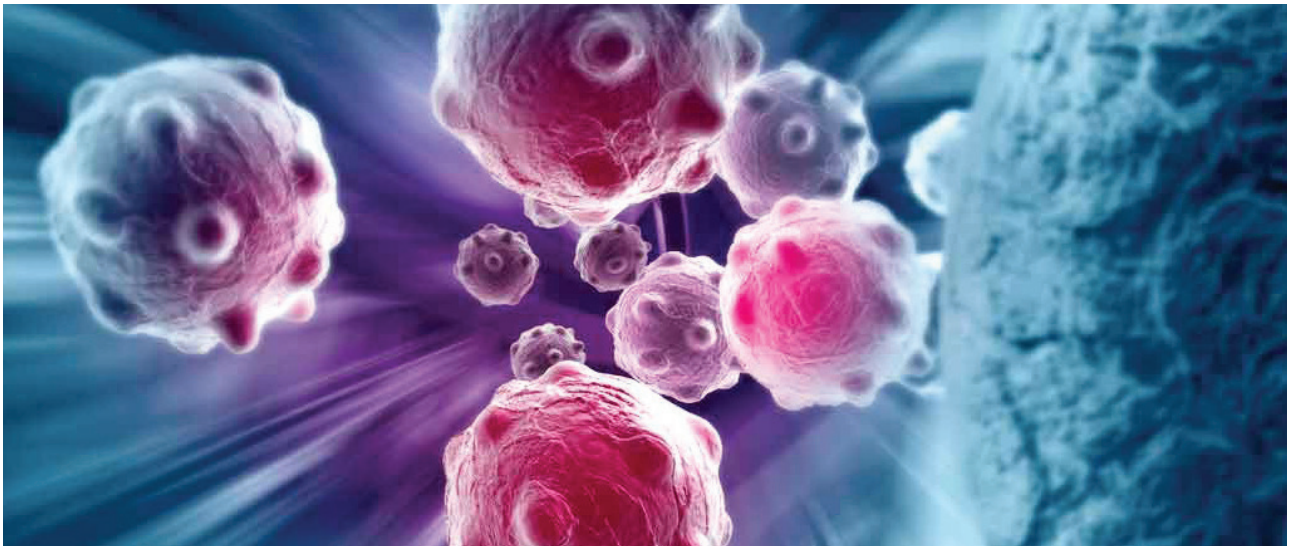
Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification of symptoms of stroke- facial weakness, arm/leg weakness, difficulty in speech (FAST)			✓	✓		✓
2	Immediate management and referral as per guidelines	✓					
3	Follow-up of cases including those referred back	✓		✓	✓		
4	Health education for Lifestyle modification	✓	✓				
5	Health education for family members		✓	✓	✓		

23. MENTAL HEALTH

Sl. No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification and mobilization of individuals with behavioral/ mental disorder		✓	✓	✓		✓
2	Screening for depression		✓	✓			
3	Management of individuals with mental illness like depression and mild anxiety	✓					
4	Counselling for the individual		✓	✓			
5	Referral of individuals with complications as per CPHC guidelines	✓					

6	Follow-up of cases including those referred back	✓	✓	✓			
7	Monitoring for drug compliance and adverse drug effects	✓	✓	✓			
8	Psychological support to family members		✓	✓	✓		✓
9	Ensure social security services			✓	✓	✓	✓
10	Rehabilitation services			✓	✓	✓	✓
11	Managing comorbidities	✓					
12	Counselling to family members	✓	✓				
13	Health education to family members for patient care, early identification of minor changes in behavior			✓			
14	Providing shelter/home care support to destitute/abandoned/ homeless in convergence with SJD/KSSM/other organizations			✓	✓	✓	✓
15	Protection of entitlements of a patient with mental illness in convergence with SJD/KSSM/ other organizations			✓	✓	✓	✓
16	Identify neglect, abuse, restrain of individuals with mental illness				✓		✓
17	Creating an enabling environment to promote positive mental health in the community			✓	✓	✓	✓
18	Promotion of healthy life style, awareness creation on importance of early detection of cancers and early warning signs		✓	✓	✓		

24. CANCER



Sl No	Services	MO	SN	JPHN/ JHI	ASHA	AWW	CHV
1	As the scope for an individual cancer package is limited, the FHC cancer package is predominantly preventive, promotive and palliative, addressing cancer at a community level.			✓	✓	✓	✓
2	Community Based Assessment Check-list (CBAC) for all women and men over 30 years in their population				✓		
3	Mobilization of population to FHC preceded by mobilization events in the coverage area to enhance awareness and ensure high levels of community participation including service utilization.			✓	✓		✓
4	**Cervical cancer** Create awareness regarding symptoms of cervical cancer like bleeding after menopause, bleeding after intercourse, foul smelling vaginal discharge, bleeding between periods,			✓	✓	✓	
5	Screening for cervical cancer in women above 30 years of age using VIA	✓	✓	✓			
6	In case of any positive findings, refer to higher centre	✓					

7	Follow up of patients undergone treatment for cervical cancer and other cancers related to reproductive health • Routine health check up • Assess for any complications/ co-morbidities • Linkage with palliative care if needed • Refer to higher centre, if needed	✓	✓	✓			
8	**Breast cancer** Create breast cancer awareness		✓	✓	✓		
9	Screen high risk group for occurrence of breast cancer	✓		✓	✓		
10	• Personal or family history of breast/ ovarian/colon cancer • Chronic Benign Breast Diseases						
11	Clinical breast examination to any woman over 30 years presenting to the health centre and advise for follow up every year		✓				
12	Promptly refer any person with a suspicious lesion for accurate diagnosis and appropriate treatment	✓					
13	Follow up of patients undergone treatment for breast cancer • Routine health check up • Assess for any complications • Symptomatic treatment if required? • Ensure that every patient complies with therapy advised	✓	✓	✓			
14	• In case of back referral to the FHC, ensure follow up treatment, adhering to the discharge advice from the treating institution. • Linkage with palliative care if needed		✓	✓			
15	**Oral cancers** Create awareness about the ill effects of tobacco and advocate avoidance	✓	✓	✓	✓	✓	✓
16	Encourage and assist habitual tobacco users to quit the habit.						
17	Encourage oral self-examination		✓	✓			
18	Routine examination of oral cavity of patients with history of tobacco use		✓	✓			
19	Screening by Oral Visual Examination	✓					

20	Prompt management and referral of any person with a suspicious lesion.						
21	Follow up of patients undergone treatment for oral cancer • Routine health check up • Assess for any complications	✓					
22	• Symptomatic treatment if required?						
23	• Ensure that every patient complies with therapy advised • In case of back referral to the FHC, ensure follow up treatment adhering to the discharge advice from the treating institution.						
24	Linkage with palliative care if needed						

25. PERSON WITH DISABILITY

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification of individuals with disability in the field area and categorize according to the type of disability.			✓		✓	
2	Integration with SJD and KSSM to prepare an individual care plan for rehabilitation.	✓					
3	Screening for co-morbidities	✓	✓	✓			
4	Treatment for the clinical conditions identified	✓					

5	Referral for rehabilitative services/ corrective and reconstructive surgery.	✓					
6	Referral of parents with history of any child with inheritable disability for genetic counseling and investigations.	✓					
78	Guidance and support to avail hearing aids, crutches, wheel chair, prostheses.	✓	✓	✓	✓	✓	✓
8	Guidance and support to visually handicapped for accessing corneal/ retinal transplantation centers and their follow up.	✓		✓			
9	Guidance and support to obtain disability certificate.	✓	✓	✓	✓	✓	✓
10	Guidance and support to avail social security services.		✓	✓	✓	✓	✓
11	Psychological support for the PWD			✓	✓		✓
12	Arranging for appropriate vocational training.		✓	✓	✓	✓	✓
13	Identification of workplaces which use hazardous equipment which can result in disability and ensuring that employees are provided with appropriate personal protective equipment and ensuring that they use it consistently and properly.		✓	✓		✓	
14	Training for the caretaker to address the needs of people living with disability						
15	Addressing the health care and psychological needs of the care taker			✓	✓		
16	Guidance and support to avail social security services for the caretaker						

26. PALLIATIVE CARE

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification and mobilization of unaddressed cases requiring palliative care			✓	✓	✓	
2	Provide psychological support to the patient to accept the diagnosis and treatment	✓	✓	✓	✓	✓	✓
3	Provide support to the family for treatment and care of the patient	✓	✓	✓			
4	Ensure that the patient is free from pain as far as possible.	✓	✓	✓	✓	✓	✓
5	Provision of quality homebased and community level palliative care			✓	✓		✓
6	Guidance and support to avail social security schemes and services		✓	✓	✓	✓	✓
7	Linkage with other support groups, NGOs and day care centres		✓	✓	✓	✓	✓
8	Integration with LSGD, SJD, SSM		✓	✓	✓	✓	✓
9	Referral for morphine and other specialty services	✓					
10	Training for care takers		✓	✓	✓		
11	Rehabilitative services		✓	✓			

27. COMMUNICABLE DISEASES IN GENERAL

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Awareness generation for prevention and control of communicable diseases			✓	✓	✓	✓
2	Ensure compliance of health advices given by health authorities	✓	✓				
3	Identification and mobilisation of symptomatic cases to facilitate medical care				✓	✓	✓
4	Active case search/ survey during an outbreak		✓	✓	✓	✓	✓
5	Suchithwa mapping and hot spots identification			✓	✓		✓
6	Linkage with WHSNC, LSG, other line departments, NGOs and Harithakeralam mission to address social determinants of health.			✓	✓	✓	✓
7	Detection, initial management and referral as per guidelines	✓					
8	Reporting and monitoring	✓		✓			
9	Line listing of cases		✓	✓			
10	Plan and implement epidemic control activities			✓	✓		✓
11	Enforcement of public health laws	✓		✓			
12	Collection of blood slides in fever symptomatics		✓	✓			
13	Convene monthly WHSNCs and follow-up. Planning and implementation of annual epidemic prevention activities. (Arogya Jagratha)			✓	✓		✓
14	Sample collection/sending for diagnosis	✓	✓				
15	Identify red flag signs, early warning signals & referral if indicated	✓					
16	Surveillance of data from private clinics/hospitals/nursing homes/other systems	✓	✓	✓	✓		
17	Outbreak investigation and response	✓	✓	✓	✓		✓
18	Planning and implementation of annual epidemic prevention activities (Arogya Jagratha)	✓	✓	✓	✓		✓
19	Addressing social determinants of health in the field area affecting public health in coordination with LSGD and concerned line departments/ agencies/missions	✓	✓	✓	✓		✓

28. AIRBORNE INFECTIONS

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Awareness generation on airborne infections, cough hygiene, hand washing and need for isolation.,		✓	✓	✓	✓	✓
2	High risk screening		✓	✓	✓	✓	✓
3	Immunisation (older persons and those who are at risk)	✓		✓			
4	Provision of personal protective measures for patients and contacts				✓	✓	✓
5	Detection, reporting, sample collection/ testing and management as per guidelines	✓	✓	✓			

29. WATERBORNE INFECTIONS

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Sanitary survey of drinking water sources and ensuring chlorination		✓	✓	✓		✓
2	Periodic water quality monitoring			✓	✓		✓
3	Promote personal hygiene measures including proper hand washing techniques		✓	✓	✓	✓	✓
4	Awareness creation on prevention and control of water borne infections , ORT, safe drinking water, food hygiene during fairs, festivals and marriages		✓	✓	✓	✓	✓
5	Prevention of contamination of drinking water sources & water conservation in convergence with LSG, other departments and missions (Haritha keralam, Sujalam)	✓	✓	✓			✓
6	Maintaining ORS depot and stores			✓			
7	Activities in connection with enforcement of public health and food safety laws	✓		✓			
8	Planning and implementation of all activities at community level	✓	✓	✓	✓		✓
9	Plan A management and referral services	✓					

10	Line listing of cases during an out-break		✓	✓	✓		
11	Issue of health cards	✓					
12	sample collection/testing			✓			

30. VECTORBORNE INFECTIONS

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Awareness creation on prevention and control of vector borne diseases		✓	✓	✓		✓
2	Vector survey, source reduction and other field level activities as per NVB-DCP guidelines			✓	✓		
3	Integrated Vector Management Activ-ities			✓	✓		✓
4	Biological vector control methods			✓	✓		✓
5	Promote use of mosquito nets and other personal protection measures to prevent mosquito bites		✓	✓			✓
6	Migrant screening		✓	✓			
7	Active blood smear collection for de-tection of Malaria & Filaria		✓	✓			
8	Mass and contact survey of malaria cases	✓	✓	✓	✓		✓
9	Morbidity management of lymphatic Filariasis	✓					
10	MDA/TAS and follow-up		✓	✓	✓		
11	Implementation of Kala azar elimina-tion strategies in high risk areas	✓					
12	Planning and implementation of all activities at community level as per NVBDCP guidelines	✓	✓	✓	✓		✓
13	Line listing of cases during an out-break Rapid Diagnostic Test for Ma-laria		✓	✓			
14	Initiation of management and referral services		✓	✓			
15	JE vaccination in selected districts	✓	✓	✓	✓		✓

16	Identification and facilitating patients for Morbidity management of Lymphactic Filariasis	✓	✓	✓	✓		✓
17	Sample collection/testing as per guidelines	✓	✓				
18	Reporting			✓			
19	Passive surveillance of Malaria cases			✓			
20	Supervision of field level activities	✓		✓			

31. LEPTOSPIROSIS

Sl No	Services	MO	SN	JPHN/ JHI	ASHA	AWW	CHV
1	Awareness creation on prevention and control of Leptospirosis		✓	✓	✓		✓
2	Rodent control in convergence with line departments			✓	✓		✓
3	Doxy prophylaxis for high risk groups (handling domestic animals, fishing, farming etc)	✓		✓			
4	Planning and implementation of all activities at community level as per guidelines			✓	✓		✓
5	Line listing of cases during an outbreak			✓			
6	Detection, reporting		✓	✓	✓		✓
7	Confirming diagnosis and management as per guidelines	✓					
8	Identification of red flag signs Referral services if needed	✓					

32. HIV/AIDS

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Community awareness for prevention and control measures			✓	✓	✓	✓
2	Identify High risk groups and motivate them for voluntary testing			✓	✓		✓
3	Health education	✓	✓	✓	✓	✓	✓
4	Promote use of barrier methods like male and female condoms			✓	✓	✓	✓

5	Supply of male condoms through sub centres			✓			
6	Motivate all Antenatal women, Tuberculosis patients to attend FICTC for testing			✓	✓	✓	✓
7	Referral of high risk groups to FHCs for screening			✓			
8	Provision of palliative care services	✓	✓	✓			
9	Counselling and diagnostic services through FICTCs in FHCs	✓	✓				
10	Prompt referral to ART centres for treatment	✓					
11	Prophylaxis and management of opportunistic infections in patients with HIV	✓					
12	Counselling and screening of all antenatal women, Tuberculosis, RTI-STI patients	✓	✓	✓			
13	Training of all staff to adapt universal precautions	✓	✓				
14	Referral for post exposure prophylaxis	✓					
15	Provision of palliative care services for needy patients	✓		✓			

33. RTI/STI

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Sexual and reproductive health awareness; personal hygiene awareness			✓	✓	✓	✓
2	Increase awareness regarding the symptoms of RTI/STI			✓	✓		
3	Screening and referral of patients with symptoms suggestive of RTI/STI through weekly clinics			✓	✓		
4	Identify High risk groups (Altered personal sexual behaviours – Males, females & transgenders, substance abusers, skin piercers, recurrent blood donors) and motivate them for HIV & syphilis screening			✓	✓	✓	✓

5	Promote use of barrier methods like male and female condoms			✓	✓	✓	✓
6	Identification and referral of incidences of sexual violence in the community			✓	✓	✓	✓
7	Promote vaccination against Hepatitis B	✓		✓			
8	Sexual and reproductive health awareness; personal hygiene awareness	✓		✓			
9	Supply of male condoms through sub centres			✓			
10	Counselling and screening of all antenatal women	✓	✓	✓			
11	Client education and counselling	✓	✓	✓			
12	Syndromic case management of patients and partners with RTI/STI	✓					
13	Ensuring compliance with treatment	✓		✓	✓		
14	Follow up of patients & partners on treatment	✓		✓			
15	Counselling and screening for HIV & syphilis	✓	✓				
16	Counselling services and Adolescent clinics	✓	✓				

34. TUBERCULOSIS

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification of cases with cough more than two weeks/ weight loss/ prolonged unexplained fever			✓	✓		✓
2	Guiding them to attend health center for investigations and management.			✓	✓		✓
3	Advise sputum AFB	✓	✓	✓	✓	✓	✓
4	Chest Xray/CBNAAT for specimens depending on the suspected site.	✓					
5	Categorize the patient appropriately.	✓					
6	Notification of TB case.	✓					
7	Documentation and reporting through 'Nikshay'			✓			

8	Assessment of health status before initiation of treatment- Hemoglobin, LFT, FBS, HIV.	✓					
9	Initiation of treatment according to the category including chemoprophylaxis for contacts	✓					
10	Referral of MDR TB suspects to higher center.	✓					
11	Advise on importance of regular intake of drugs, cough hygiene, disposal of sputum, chest physiotherapy, screening of family members for TB, chemoprophylaxis for child contacts and special attention to immune ocompromised contacts.	✓	✓	✓	✓	✓	✓
12	Psychological support to the patient and family and provide the information that TB is curable and once the treatment is initiated, the patient becomes non-infectious.	✓	✓	✓	✓	✓	✓
13	Explain to the patients and family the importance of regular uninterrupted treatment for complete cure and for prevention of recurrence and drug resistance.			✓	✓		✓
14	Ensuring patients are completing the treatment	✓		✓	✓		✓
15	Advise on choosing healthy food and avoiding substance abuse.		✓	✓	✓		
16	Detection and treatment of DM, HIV.	✓					
17	Detection and treatment of other comorbidities like HTN, COPD etc	✓					
18	Identification, mobilization and support for de-addiction			✓	✓		✓
19	Management and referral for de-addiction	✓					
20	Identification of adverse drug effects and referral for expert management.	✓	✓	✓			
21	Advise on regular follow up visits			✓	✓		
22	Advise on nutritious diet.			✓	✓		
23	Ensure follow up sputum examination as per the guidelines.	✓		✓			

24	Maintaining a TB register at the center with details to identify defaulters, and along with the TB health visitor (TBHV) take measures to continue treatment.			✓			
25	Counselling and treatment of pregnant women with TB and timely referral in case of complications.	✓	✓	✓			
26	Initiation of ATT in HIV patient and referral to ART center for initiation of ART	✓					
27	Ensuring that the patients are taking medicines regularly and identifying defaulters early and timely referral to the center to see whether the treatment plan has to be reconsidered.			✓	✓		
28	Assessing the difficulties faced by the patient and family in taking treatment, and initiating remedial measures/ discussing with MO at the health center for expert opinion.			✓	✓		
29	Identifying contacts of sputum positive patient eligible for INH chemoprophylaxis and ensuring that they are taking prophylaxis.	✓		✓			
30	Ensuring that pregnant women with TB are taking anti TB drugs regularly, checking for symptoms of adverse drug reactions and are visiting antenatal clinics regularly.	✓		✓			
31	Ensuring that children with TB are taking regular treatment, checking for symptoms of adverse drug reactions and advise the family on nutritious diet to children.			✓		✓	
32	Health education on TB and measures to avoid stigma			✓	✓	✓	✓
33	Support to avail social security schemes		✓	✓			
34	Guidance to form community groups to support TB patients						✓

35. LEPROSY

Sl No	Services	MO	SN	JPHN/JHI	ASHA	AWW	CHV
1	Identification and mobilization of individuals with hypo/hyper pigmented patches			✓	✓		✓
2	Diagnosis, categorization and treatment of leprosy cases/ referral of complicated cases	✓					
3	Registration of leprosy patients		✓	✓	✓		
4	Advice on diet, self care, side effects and complications to look for, social security schemes available, habits		✓	✓			
5	Ensure that all are taking treatment regularly			✓	✓		
6	Monitoring of drug compliance and adverse drug effects	✓	✓	✓			
7	Diagnosis and management of lepra reactions	✓					
8	Educate the family members about the spread & treatment			✓	✓		✓
9	Identification and mobilization of patients with disability to FHC				✓	✓	
10	Refer for rehabilitative services-footwears, reconstructive surgery, crutches in convergence with SJD/KSSM/other organizations	✓					
11	Ensure psychological, social & economic support to the patient			✓	✓		
12	Guidance for vocational training of leprosy patients		✓	✓	✓		
13	Health education sessions in the area on leprosy-mode of spread, importance of regular treatment in prevention of spread and occurrence of complications; prevention of stigma	✓	✓	✓	✓	✓	✓
14	Screening of close contacts of leprosy		✓	✓	✓		

II.Family packages

The family package addresses the needs of all members of the family and other health needs of the family such as drinking water, well chlorination, indoor air quality, household waste disposal and kitchen garden which do not directly come under the individual packages. **Some examples are listed below:**

- Ensure green protocol in family function and in households
- Provision of sanitary latrine and arrangements for proper disposal of sewage Waste management: segregation and management of biodegradable and non-biodegradable waste
- Care for domestic animals: immunization, periodic health check up; awareness on hazards of animal waste and guidance for its proper disposal
- Hygienic management of waste water
- Ensure source reduction and vector control measures in and around the house.
- Management of drinking water sources
- Rain water harvesting and well- water recharging
- Efforts to decrease indoor air pollution-use of chimney/smokeless chulha/ avoiding cigarette smoking/avoiding burning of waste materials
- Ensure adequate ventilation and lighting inside the house
- Encourage the practice of non NCD diet pattern and promote kitchen farming.
- Promote healthy relations between family members
- Environmental modification and protective mechanisms to prevent domestic accidents/ injuries
- Physical activity promotion for family member
- No tobacco, Non-alcoholic and non-substance above environment
- Ensure that the family is registered for eligible health insurance schemes like RSBY/CHIS and making effective utilisation of the same and other health insurance schemes.

III.Ward and Panchayat packages

The health care packages for wards and panchayat should cater to the needs of the community. These include provision of safe drinking water, solid and liquid waste management and creating recreational facilities and open spaces for people for physical exercise. The ward health sanitation and nutrition committees and Arogyasena, led by an elected representative of the locality and health department officials will arrange health care services at the ward-level. Co-ordinating the activities with the interventions of Haritha Keralam Mission is also very significant in this regard. **Some examples of the ward-level packages are given below:**

- Making provision for proper waste disposal in houses and forming self-help groups/ Kudumbasree groups who will collect non-biodegradable waste from houses and providing support to form self help groups/ Kudumbashree and enabling them for collection of non-biodegradable wastes.
- Coordination with Agriculture department for supply of seeds for kitchen garden
- Making provision for playgrounds, parks,

- Making provision for proper waste disposal in houses and forming self-help groups/ Kudumbasree groups who will collect non-biodegradable waste from houses and providing support to form self help groups/ Kudumbashree and enabling them for collection of non-biodegradable wastes.

- Coordination with Agriculture department for supply of seeds for kitchen garden

- Making provision for playgrounds, parks, walkways and other common places for recreation, making healthy relations and promoting a culture of physical activity

- Helping organise people's groups for walking or yoga; making arrangements for sports competitions at ward level.

- Identifying people living in low socio economic conditions and initiating social and economic support through Kudumbashree, social security schemes; ensuring that they are part of the ICDS or public distribution system networks

- Prevention and control of domestic violence through organized social interventions and strengthening the activities of Jagratha Samithies.

- Anti- substance abuse campaign; ensuring that COTPA is implemented strictly.

- Helping organise senior citizens' groups in the community and encouraging better social interaction amongst them.

- Provision of safe drinking water to every household

- Ensuring registration and utilisation of RSBY/CHIS & other health & social sector and financial scheme.

Some examples of panchayat-level packages are given below:

- Making provision for proper disposal of waste; arranging proper management of non-biodegradable waste. To coordinate with Haritha Keralam Mission interventions.

- Managing biodegradable waste: Coordination with agriculture and veterinary departments to provide seeds and saplings for kitchen garden, pig sty etc; support for establishing composting.

- Create space for exercise, cycling tracks, walkways, playgrounds, swimming pools, etc for promoting physical activity. Available spaces like school compounds can also be utilised for the purpose during the schools'non-working hours .

- Conduct campaigns against substance abuse with the help of Arogyasena, Kudumbashree workers, Police and Excise departments, and community-based organizations.

- Establishing common places: library, walkways, office for self help groups.

- Judicious utilization of idle buildings as venues for sub centres, senior citizen gathering places, vocational training points, health clubs etc.

- Promote social farming and kitchen farming and also utilization of unused land for agricultural purposes thereby creating an opportunity for physical activity.

- Ensure good and potable water supply to all; promote water conservation and protection of water sources and promote protection and judicious utilization of water resources.

- Prepare a plan of action for protection of destitute
- Mobilize funds for their care by involving NGOs and CSR wherever possible.
- Prepare a plan or protocol addressing issues of water usage, waste disposal; ensuring that the green protocol is not violated during mass gatherings or festivals or marriages by intimating the LSG and FHC well ahead.
- Keep a registry of animal and bird farms and prepare a plan/protocol for their maintenance, waste disposal and monitoring.
- Prepare a protocol for slaughter houses and market places. Issues of proper disposal of solid waste and waste water and regular health check up of animals to be addressed.
- Registration of all food vending areas.
- Vigilance to be maintained regarding workplace hygiene, health and hygiene of those engaged in food production, use of safe water.
- Establish collection and distribution centres for local agricultural produce
- Preparation of a Panchayat-level plan for disaster management.
- Preparation of a registry of RTAs and development of a plan for preventing road traffic accidents.
- Preparation of Panchayat-level blood donors' forum and organ donors' forum.
- Preparation of an outbreak management plan and strengthening of rapid response team.
- Making available adequate transportation to health facilities within and outside the Panchayat in case of emergencies.
- Address the issue of NCDs and maintain a plan for promoting a health culture and awareness among the community through homestead farming, walkers groups etc
- Address the problem of substance abuse by creating community awareness on the issue and by creating counseling and support groups.
- Address the issue of domestic violence against women, neglect of the elderly, child abuse etc.
- Ensure the enforcement of public health laws to protect the rights of people.

Chapter 5
IMPLEMENTATION AND OPERATIONALISATION

Department of Health Services is responsible for implementation of Family Health Centres. The concept and activities for transforming PHCs to FHCs have been devised by experts from Department of Health services and Medical Education. The activities are being implemented with the support of NHM and LSGI. Kerala Medical Service Corporation Limited will ensure the availability of medicines and equipments in Family Health Centres. Departments like Social justice, Women and child development, Education, Tribal health, Agriculture, Animal Husbandry etc have to be integrated for proper implementation of FHCs. Trainings for LSGI representatives are being conducted in collaboration with Kerala Institute of local Administration.

Activities for implementation of FHCs

- Improvement of basic infrastructure
- Improvement of HR
- Skill based trainings for all categories of staff
- Defining roles and responsibilities of different category staff
- Defining services and responsibility mapping for service delivery
- Strengthening the Sub centres and Ward Health Nutrition and Sanitation Committees
- Developing a team of health volunteers for integrating activities at field level

Improvement of basic infrastructure

When PHCs are being transformed into FHCs, a major change is going to happen in the basic infrastructure. All FHCs are going to be standardised with people friendly infrastructure, facilities and equipments.

Transforming PHCs to FHCs

Essentially FHC is the panchayath level institution to provide comprehensive primary care comprissing health promotion, prevention, curative, rehabilitative & palliative care service.

The service delivery from different levels of care namely Anganwadi, Subcentres and Family health centres are undergoing tranformation. Different steps for implementing these changes are as follows.

1. Equipping institutions to function as FHCs
2. Service operationalization at FHC transformation, initiation and sustenance of service delivery
3. Strengthening the subcentres
4. Implentation of Ward and Panchayat level packages

1.Equipping institutions to function as FHCs

The Local Self Government must take the leadership role in transforming the PHC into FHC in a phased manner.

This should start with a gap analysis study, to identify the shortfalls in the current infrastructure and service delivery issues in the PHC. The LSG can assign this task to a working group, which includes the hospital management committee and the panchayat Aardram Mission committee. The LSGs can then plan projects to address these issues in the order of priority by mobilising resources from all possible quarters, such as the MP/ MLA/NHM funds.

The infrastructure development and equipment should meet the standards specified in the GO. The HMC should monitor and ensure that the transformation goes as per plan, in a sustainable manner

2.Service operationalization at FHC

The FHC is a novel concept and its success is dependent on how the service providers can transform themselves to deliver the level and quality of services that is expected of an FHC. Not just the quality of care, but the hospitality of the staff, cleanliness, comprehensiveness of care, mode of service delivery, implementation, monitoring and evaluation should all undergo this transformation.

Capacity building of service providers through organised training programmes would be the first step in kicking off the implementation process.

3.Strengthening of Sub Centres

As far as possible a Sub-centre should have its own building at a location with easy access to population. The whole infrastructure should be people friendly with sufficient space for outpatient care including immunization, antenatal/postnatal care and other clinics, adequate space for display of communication materials of health messages, including audio visual aids and appropriate community space for wellness activities, including the practice of Yoga and physical exercises. Tablets provided to the field staff as part of eHealth will serve a range of functions such as population enumeration and empanelment, record delivery of services, enable quality follow up, facilitate referral/continuity of care and create an updated individual, family health register, and generate reports required for monitoring at higher levels. Being health and wellness centres, each subcentre should function in

close coordination with their respective Local Self Governments to analyse the health needs of the population and prevailing risk factors in its catchment area and to provide services accordingly. Local Self Governments have significant role in improving the infrastructure and service provision of the subcentres through community mobilization, convergence of different departments and interventions on social and environmental determinants.

4.Implentation of Ward and Panchayat level packages

Field-level services will be provided by Junior Public Health Nurse (JPHN), Junior Health Inspector(JHI), Accredited Social Health Activist(ASHA) and the Anganwadi worker (AWW), with the help of the Arogyasena. The JHI and the JPHN will lead the field-level activities at the sub centre-level, supervised by the HI and the PHN. The ASHA and the Arogyasena will be the link between the health system and the general public, taking care of health service delivery and its utilisation.

The 20-day block system will be the basis of all field-level activities. The ASHAs in each locality will focus on identifying houses which may have some important health issues that need to be addressed (priority houses), and alerting the field worker concerned immediately so that it is addressed without delay. The ASHAs will be aided in this exercise by the Arogyasena. The LSGs will guide the Arogyasena and the health workers in carrying out all the advocacy and community mobilisation needed for organising NCD prevention and communicable disease control activities.

The JPHN/JHI will convene weekly review meetings with all the field staff, including the AWW, ASHA and CHV. The meetings will discuss

- Handing over responsibilities in the absence of a member.
- Sharing of responsibilities if and when required.
- The healthcare services and activities provided.
- The future health requirements of the population
- Other issues that require special attention

The ward-level packages will deliver the services required for institutions like hostels, schools, offices and other work places in every ward. Different service packages will have to be planned locally for the marginalised and vulnerable population – the differently abled, orphans, the destitute, transgenders, widows, tribal/coastal/urban slum dwellers – in each area. The field staff concerned should be responsible for:

- Maintenance and monthly updating of registers
- Identification of local leaders from within the aforementioned groups for facilitating communication
- Giving special attention to the vulnerable within the marginalised population
- Formation of local support groups
- Ensuring conveyance facilities with the help of LSG

Health care service delivery plan

The plan for health service delivery should be developed by the designated JPHN/JHI of each locality, which should be supervised and approved by the PHN/HI. The major steps in the operationalization of these services include:

- Updating the family health register
- Developing individual health care service delivery plan
- Developing family health care service

delivery plan

- Identification of the priority household/areas
- Developing Community-level health care service delivery plan
  1. Ward-level service delivery
  2. Panchayat-level service delivery

Fig . 2

STEP 1 : Family Health Register Updation

The family health register maintained in FHCs should contain the name, age, gender, education, occupation, income and self-reported ailments of every member in families. The register should be updated by field staff annually, during January-February, and then periodically as they go on house visits. The e health platform may be used for the purpose. Variables listed in e-Health data base include demographic details, medical history, behavioural risk factors, anthropometry, blood sugar, blood pressure, environmental parameters of the household (social determinants), occupational details and other relevant details.

This register needs to be updated to include the following:-

1. Risk behavior of individuals - alcoholism, tobacco chewing, smoking, inadequate physical activities.
2. Self reported Morbidities - those diseases which are already diagnosed in an individual and are being managed, including Diabetes, hypertension, TB, CAD/CVA, COPD/ Bronchial asthma, Mental illness, disabilities, under nutrition and over nutrition
3. Physiological states – antenatal, postnatal and lactating mothers.

Analysis of the family health register will provide the following details:-

- The burden of a particular disease in the population
- The common diseases prevailing in a particular area
- Specific health needs of the population.
- The special groups for the respective service packages.
- Health status of the community

STEP 2 : Iindividual Health Care Service Delivery Plan

1.Preparation of individual health care delivery plan

- This essentially include individual level health promotion, prevention, curative care, rehabilitative and palliative intervention and services.
- The health requirements of an individual can be identified by collating the data from the family health register. Any additional data required can be collected with the help of ASHA/AWW/CHV Individual health care plans shall be tailor-made to suit each and every person.
- Each individual package is designed according to the age, special needs and the

diseases the person may have

- For eg: A 60 yr old alcoholic diabetic male will be provided with service packages which deal with diabetes and its management, substance abuse and geriatric issues of the person.
- The service packages are already defined to cater to the common health problems of the community according to the principles of FHC
- Rare needs of a particular population (eg- thalassemia, sickle cell anaemia, multiple sclerosis, epilepsy, haemophilia) which are not addressed in the service packages, will be defined locally and dealt with accor dingly

STEP 3: Family Health Care Service Delivery

- Family health care service delivery is intended to meet the health care requirements of an entire family, with special attention to the individual needs of every member. It also includes the services required for improving the social determinants of health proper housing, safe water supply, sanitation, waste management, means of livelihood and accessibility to health care services Individual service delivery plan should be formulated as explained above, for each family member
- For eg if there are 5 members in a family, namely A, B, C, D & E.
- A is an elderly male with history of diabetes mellitus and is undergoing treatment for the same.
- B is his wife 55yrs of age without any co-morbidities
- C is their son who is a differently abled person.
- D is the wife of C who is pregnant
- E is C and D's five-year-old son
- Individual service delivery plan for each of the persons will be as follows

Name of Person	Service Delivery Packages
A	Elderly + diabetic
B	Apparently healthy woman (18-60 years)
C	Apparently healthy man (18-60 years) + Care to differently abled
D	Apparently healthy woman (18-60 years) + Antenatal care
E	Children (1 to 5 years)

Along with these services based on the health related social determinants as per the need of the family

Family Health care service package for the above mentioned family = Services to A + B + C + D + E + related social determinants as per the need of the family

STEP 4 : Identification of Priority Households/Areas

Assume that each Panchayat has got a population of around 30,000. It is expected that there will be 5 JPHN and 3 JHI. Together, there will be eight field level health workers. In addition, there will be around 25-30 AWW and ASHAs each. The total number of families will be around 8000. That means there are 8000/8 = 1000 households per health worker. If we divide 1000 households into 20-day blocks, each day block will have 50 households. It is assumed that one health worker will visit 15-20 households per day to provide defined services. The rest of the 30-35 households will be visited/co-ordinated by ASHA, AWW and CHV, depending on the health situation. A health worker will be visiting the priority households. Prioritisation of the households/areas should be based on the following:-

1. Houses reported with communicable diseases and those requiring follow up according to IDSP.

2. Households with patients under RNTCP treatment.
3. Houses with older persons.
4. Houses with bedridden patients, patients suffering from NCDs, cancer, CKD, liver diseases, differently abled and mental illness (for those who solicit service).
5. Houses requiring RCH/family welfare services– antenatal, under-fives, newly married couples.

The field workers should visit the priority areas in each of their day blocks. They should enquire about any emerging public health issues in the locality or institutions. The priority areas are listed below:-

1. Areas under surveillance of WHSNC for control of epidemics
2. Areas with high mosquito density
3. Colonies, slums, areas inhabited by SC/ ST/migrant workers
4. BUDS schools/anganwadis/schools
5. Correction homes/juvenile homes/ children's homes/orphanages/old age homes.
6. Areas where public antagonist activities takes place
7. Sewage treatment plants, water treatment plants, public toilets
8. Ward sevakendram if any, present in the area

STEP 5: Community Health Care Delivery Plan

Community-level services will be delivered at two levels, namely ward-level and Panchayat-level, for the ease of administration

1.Ward-level service delivery

The social determinants of health and the requirement of health care services in a ward is easily revealed once the individual and family health care service delivery plan is chalked out. The WHSNC, along with the JPHN, JHI, ASHA, AWW, Kudumbasree, Arogyasena volunteer can then identify the services that need to be provided and work out the ward-level service delivery strategy. The HMC, ADS/CDS, Jagrata samiti, Oorukoottam and local NGOs too have their roles in delivering the services.

2.Panchayat-level service delivery

Once the health requirements and service delivery plans of all wards have been chalked out, the LSGs can easily map the panchayat-level health needs and a matching service delivery plan. The focus, while preparing the panchayat-level service delivery plan, should be on those services that can only be provided across the panchayat. Eg: creating open spaces for play grounds or setting up facilities for waste management

Improvement of HR

Additional human resources are essential for the proper functioning of FHCs as the outpatient timings are being extended till 6pm. There will be minimum of 3 Medical Officers, 4 Nurses, one Labtechnician and 1-2 Pharmacists in an FHC along with the other supporting staff.

Training

Providing comprehensive and continuous training for all category staff is the policy of the government in the context of the mission to ensure quality of service delivery. To achieve this, thorough planning well ahead of the training is required. Some of the training has to be conducted at state level and some at district level. In general objective of each training program includes

- Continuing education and updation of knowledge
- Technical skill development
- Soft skill development

To attain the above said objectives trainings are designed in three domains viz. concept based training, technical skill training and training for soft skill development. The training curriculum is designed in such a way as to effectively incorporate all the desired elements. District level training centres have already been identified to conduct hands on training for Medical Officers, Nurses and other paramedical staff. District level Skill labs will be set up attached to all the district level training centres. Since LSG representatives and officials are also being trained, a liaison with the Kerala Institute of Local Administration is established for conduct of trainings.

Skill development training for Nurses

Skill development training for Nurses is a key area being addressed in the context of transformation of Primary Health Centres to Family Health and Wellness Centres. In the wake of Aardram mission, the staff nurses have glorified roles to perform. The technical and soft skills of the staff nurses have to be improved to execute the new roles in FHCs including pre-check and post check counseling, provision of outreach institutional services, conduct of SWAAS and ASWAASAM clinics. Training will be provided to improve the communication skills of the nurses to ensure people friendly atmosphere in the FHCs.

Preparation of manuals and handbooks

- Training manuals and handbooks for different category of staff has been developed with the help of experts in the concerned area.
- A comprehensive Primary Health Care guideline has been developed for Medical officers to provide comprehensive management of common conditions at Primary level.
- Handbooks for preparing LSGI projects based on Health Status Report (HSR) for Grama, Block and District Panchayats.

Defining roles and responsibilities

Roles and responsibilities of different category of staff in the context of FHCs have been developed by experts in the concerned field in consultation with stakeholders and employee associations and Government orders have been issued.

Chapter 6
ROLE OF LSG IN FAMILY HEALTH CENTRES

The role of LSGs in helping the State attain the Sustainable Development Goals cannot be stressed enough. Health should be at the centre of each and every development plan that LSGs come up with, if it is to go forward with this mission.

Identifying issues which could potentially affect or influence health care delivery and utilisation of services and setting specific targets for the Panchayats to focus on would be the first step. There is an urgent need to step back from the current focus which is entirely on curative care and to re-align the service delivery in such a way that preventive and promotive care gets more attention. While the palliative care movement has taken roots across the State and services are being offered in many places, the quality of care offered leaves much to be desired. The concept of rehabilitative care continues to be alien in the State and services are woefully inadequate. This is one area where the Panchayats will have to invest in much innovation and planning.

The staff in the Department of Health Services should take up the advocacy work and engage the elected representatives to promote health and development projects in the Annual plan. They should also lend their expertise to help the elected representatives identify potential and viable projects, draw up the project plan and implement it effectively. Local self governments should also be encouraged to take the lead in all aspects of planning, funding and implementation of projects as well as the maintenance, monitoring and evaluation of FHCs. Improvement in the general health and well being of the community will bring down morbidities as well as the expenditure on medical care which in turn can be channeled back into health promotional activities.

The LSGI has dual role as a steward and as a provider in the management of Family Health Centres.

As a Steward

- **Identifying the Health Problems**

Identifying the health issues in the region and developing an annual health status report with the help of the working group has to be an important activity that all LSGs need to perform. Apart from data collection through secondary sources, they can also rely on the huge repository of data which will be available at all FHCs as electronic medical records of the entire population. LSGs need to ensure that the data registers at the FHCs are always up-to-date so that it is a clear indicator of the current status of health of the population. The data will help LSGs focus on the immediate health issues in the region and to prioritise these when preparing the annual health status report. LSGs should move ahead by setting specific targets in health sector, which are in sync with the State's set SDG goals.

- **Identifying vulnerable subgroups**

Universal care and equitable service provision should be the guiding principle of every FHC. Identification of marginalised or vulnerable sub groups in the community and ensuring that they are not excluded from the provision of services by FHCs should be the responsibility of LSGs. An analysis of the health data under each FHC, with the help of health workers, should help LSGs identify these special groups who are often left behind

when it comes to accessing or utilising health care services.

The marginalised or vulnerable groups could include migrant workers, the destitute, single person households (usually the elderly), the homeless, children not under the protection of adults (street children), sex workers and the LGBT community. LSGs should devise suitable strategies to reach out to them and incorporate them into the health plan.

- Addressing social determinants of health

The social determinants of health, including safe drinking water, sanitation, environmental cleanliness and scientific waste disposal, empowerment of women and gender equity, elimination of poverty, which are crucial to the health outcomes of a population, has to be at the top of the agenda of LSGs. Programs to address the issues and concerns in these sectors, with the active involvement of other departments like education, agriculture, social justice, veterinary services, rural development, tribal welfare and fisheries should figure in the Plan programs of LSGs under the decentralised people's plan programme. The FHCs too have a role to play in planning these projects which can have a long-term impact on health. A chunk of the initiatives that need to be put in place as part of health promotion activities falls outside the ambit of the Health department and these will have to be facilitated by the LSGs. These include creating open public spaces or opening up school playgrounds for people to walk or exercise, creating fitness or yoga groups, organic farming groups, creating recreational area for children and the like.

- Implementation of various health related Acts

The implementation of the provisions of Public Health Act is another area where LSGs need to be alert. COTPA, Protection of Women from Domestic violence Act, POCSO Act are some other health related areas LSGs has a role.

As a Provider

LSGs will have to address the following concerns when it comes to the provision of services through the Family Health Centres

- Provision of health services through FHCs as per the norms, utilising available resources
- Improvement of healthcare service utilisation by providing better health infrastructure and timely maintenance of facilities.
- Provision of additional human resources, as and when required
- Adequate resource allocation for preventive, promotive, curative, palliative and rehabilitative health care.
- Uninterrupted supply of medicines, lab reagents and equipment
- Conveyance facilities for field, outreach and referral services
- Development of sub centres as nodal points for preventive and promotive healthcare activities
- Ensuring effective fuctioning of ward level health and sanitation committee.
- Community mobilization

The LSGs should also act as instruments in developing a health culture among people that empowers them to be the custodians of their own health. Ensuring the partnership as well as participation of the community should be the responsibility of LSGs and has to be ensured in all activities of FHCs. The local government's involvement should be sought in the management of FHCs and also in setting up an "Arogyasena" in every panchayat. All existing social networks like Ayal Sabha, GramaSabha, Ayalkkoottam, Ward Health Sanitation and Nutrition Committees,

Kudumbasree, ASHA, Anganwadis, Oorukoottam, farming groups, Arts and sports clubs, residential associations, Self Help Groups etc should be made use of in building bridges with the community and implementing health activities at the grassroots. Social monitoring and auditing should be brought in to improve the quality of service and to bring in accountability at all levels. Community partnership and participation in various health programmes are essential for promoting health and well being of any community especially in the context of lifestyle modification and convergence.

- **Community Health Volunteer Teams (Arogyasena)**

Aardram Mission envisages the constitution of community health volunteer teams named "Arogyasena", who will work with and counsel the community, to encourage every individual to take charge of one's own health and thus the overall health of the community. LSGs should constitute Arogyasenas, of at least 500 community health volunteers each for every panchayat, which is approximately one CHV for every 20 to 50 households. Any interested individual, who has a vision of a healthy community and their own role in building it, can be part of the Arogyasena. The health staff in FHCs or the Ayalkoottams or grama sabhas can aid the LSGs in identifying members of the Arogyasena. The ward development committee or the WHSNC can oversee the Arogyasena's functioning at the ward-level and the Panchayat Aardam Mission committee at Panchayat-level.

Arogyasena should be trained in the following aspects.

1. Right-based approach to health
2. Social responsibility of individuals
3. Communicable disease- reporting and control
4. Non communicable disease including mental health
5. Reproductive, child and adolescent health
6. Substance abuse
7. Palliative and rehabilitative care
8. Interventions in improving the social determinants of health
9. Identifying issues regarding waste disposal and providing guidance
10. Social security schemes and insurance schemes including the RSBY/CHIS
11. Services delivered by the Health department
12. Public health laws including laws for the protection of women and children
13. Services to geriatric, marginalised and other vulnerable group
14. Local health research, Health education and Documentation.
15. Disaster preparedness and management, first aid, basic life support, accidents and injuries.

- **Empowering individuals through local groups**

There is a lot of stress on behavioural change communication if positive changes are to be brought in areas like proper waste management, good dietary habits, water literacy, environmental cleanliness and physical activity to develop a health culture in the community. This should be a joint activity that the LSGs should take up, with the help of Arogyasena and other local community groups like Ayalkoottams, Kudumbasree, ward-level jagratha samithis and other voluntary groups.

- **Mobilisation of Resources**

LSGs are responsible for facilitating the smooth and effective functioning of FHCs by providing the right infrastructure, human

resources and logistics. Resource crunch could be an issue faced by LSGs when it comes to the implementation of health plans and hence, resource mobilisation is an area where some innovation might be required. Apart from the funds and human resources provided by the local self governing bodies, various Government agencies and the allocated funds from the State & Central Government programs. An effort should be made to mobilise external funds from NGOs, private institutions or clubs by way of sponsorship or by tapping into the corporate social responsibility (CSR) funds of companies or firms. Contributions as human resources or in kind – as equipment purchase or creating amenities in healthcare institutions may also be mobilised.

As a Converging body

LSGs should assume the leadership role to achieve inter-sectoral coordination when it comes to projects where convergence is important. They should also explore new ways in which convergence can be achieved as far as resource mobilisation and project implementation is concerned. Central and State-sponsored health programmes aside, the development initiatives under other agencies, social sectors and departments can also be tweaked so that the focus is on achieving specific health outcomes.

As institutions delivering health care services for the local self government (LSG) bodies, the FHCs have its tasks cut out. Implementation of the Comprehensive Primary Health Care Programme of LSGs is one such task, which will see the FHCs working in close coordination with various social sectors, including Social Justice, Education, Agriculture, Water supply and SC/ ST Development.

The service delivery teams at FHCs should work at creating an environment conducive to health promotion and disease prevention and ensure that health care is always on the agenda of LSG bodies. The LSGs on the other hand, should be mindful that the social sectors are working in tandem with the Health department towards achieving the defined SDG health goals. Strengthening existing social structures like Ayal sabha, Ward sabha, Gramasabha , Kudumbasree and working with local NGOs and other community organisations can help the LSGs address the social determinants of health effectively. Convergence of on-going initiatives of the Government such as Harithakeralam, LIFE and "Pothuvidyabhyasa Samrakshana Yagnam"at the LSG-level is also crucial to meeting the health goals

Fig 3 : Convergence

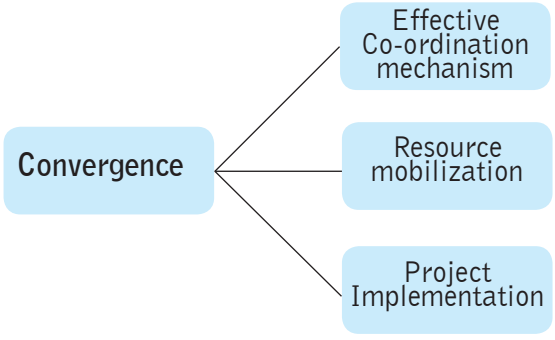


Fig 4 : Convergence Illustration

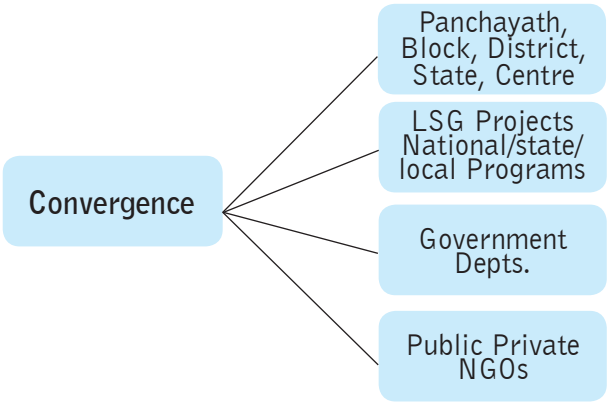
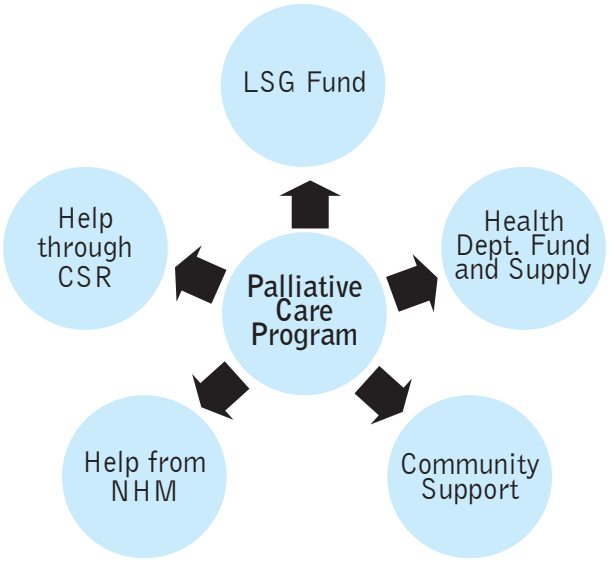


Fig 5 : Example for convergence



Chapter 7
MONITORING AND EVALUATION

Monitoring and evaluation is crucial to any program to ensure that a project is on track and that it delivers the expected output on time. It has to be an exercise in building transparenccy and accountability into the program and not a fault-finding exercise. Multi-level monitoring, at the administrative level and measuring the social impact, is necessary to keep the program in the right track.

The ward-level health and sanitation committees will monitor activities at the ward-level while the sub centre management committee will perform a similar exercise at the sub-centre-level. The functioning of FHCs will be monitored and evaluated by the hospital management committee and the panchayat committee.

The panchayat-level Aardram Mission committee, which includes all elected representatives of the LSG and the heads of all institutions under the LSG, will meet every month to assess and evaluate the health-related activities in the panchayat. A monitoring framework, including indicators, the process and periodicity of data collection, analysis and reports has to be developed for FHCs.

LSGs will also conduct a social audit into all the health programs being implemented, to be executed by a group with wide social representation, as part of its commitment to maintaining accountability and transparency at all levels.

Monitoring Committees

Each LSG should constitute monitoring committees at the following levels

1. Anganwadi level
2. Ward level
3. Sub-center level
4. FHC-level
5. Panchayat-level

The efficiency and effectiveness of all health service delivery packages should be monitored and evaluated by the corresponding monitoring committees in addition to the routine technical monitoring by DMO and block MO. Unbiased monitoring and evaluation would be possible if the monitoring committees are independent of the package delivery system.

The monitoring committees should follow a standard proforma developed by State-level experts which includes input, process, output, outcome and impact indicators. The technical and general components of monitoring should be specified separately in the proforma. The monitoring indicators mentioned below should be considered as a general guideline. Any additional indicator shall be added as per the area-specific issues.

Ward Level

The Ward Health Sanitation Nutrition Committee should convene every month and assess the following

1. Communicable diseases reported per month
2. Actions taken in tackling communicable diseases
3. Non communicable diseases, substance abuse, mental health
4. Palliative and rehabilitative care
5. Identifying dangerous situations like wild animal attacks,trees suddenly getting uprooted etc
6. Waste management
7. Nutritional issues
8. Immunization camps
9. Festivals and fairs.
10. Drinking water, communicable disease-reporting and control
11. Reproductive, child and adolescent health
12. Interventions in improving the social determinants of health
13. Social security schemes, including RSBY/CHS registration and utilisation
14. Services delivered by the health department
15. Public health laws including Women and child protection laws
16. Health status of geriatric, marginalized and other vulnerable group
17. Local health research, Health education and documentation.
18. Disaster preparedness and management, first aid, basic life support, accidents and injuries

The concerned field staff will prepare these reports with the help of health volunteers and ASHA from the available data locally and will monitor it in specified periods.

Sub-Centre-Level

The sub-centre management committee shall be reconstituted with Ayalsabha, Arogyasena members etc. to monitor the following activities

1. Sub-centre infrastructure issues
2. Number of immunization campaigns and the number of children unimmunized
3. IEC activities conducted
4. Communicable disease survellience and preventive measures
5. Communicable diseases reported at the sub-centre level and the actions taken to prevent its spread
6. Community based health promotion and preventive measures for NCD
7. Number of clinics of each category conducted at the sub-centre , the number of patients attending each clinic and

feedback from clients

8. Availability of NCD drugs and reported compliance
9. Palliative and rehabilitative care
10. Nutritional issues
11. Fuctional activities and review of implementation of field level public health program including Anganwadi based activities

FHC- Level

The hospital management committee should monitor the infrastructure and the availability and acceptability of services at the FHCs every month.

1. Whether the infrastructure is in tune with the set standards for FHCs
2. Whether the required lab facilities, equipment and consumables are available at FHCs
3. Whether human resources has been made available as per norms
4. Feedback from patients who have availed various services at the FHCs
5. Functioning of special clinics at FHCs
6. Prevalence of Communicable diseases
7. Non communicable disease clinics and services
8. Mental health program
9. Immunization services
10. Palliative and rehabilitative care
11. Geriatric care and care for disabilities
12. Field work schedules and availability of supervisory staff are available
13. Proportion of field work and supervisory visits completed
14. IEC activities
15. Institutions under the LSG – schools, hostels, factories, old age homes— which have been visited
16. Staff welfare
17. Functional status of subcentres and other field level programme.

Panchayat Level

Every month, on a fixed day, the panchayat-level Aardram Mission committee will review all the monitoring reports and suggest remedial action wherever required. The action taken will be evaluated at the next meeting. All aspects of FHCs should be monitored and corrective steps taken, by the panchayat committee and the health standing committee.

The functioning of FHCs should be planned, implemented, monitored and evaluated by the committees at the State, District and Panchayat-level. FHCs should be very proactive about the health requirements of the families. It has been assigned and the services offered should be revised and tweaked according to the changing health needs. Uninterrupted supply of drugs, lab reagents and chemicals and provision of additional human resources and conveyance facilities are to be ensured by LSGs. The functioning of FHCs should be planned, ensure implementation, monitored and evaluated by the committees at the State, District and Panchayat-level.